Bundle Mental Health Act Committee 28 June 2019

9.30am, Boardroom, Carlton Court, St Asaph LL17 0JG

1 MHAC19/34 - Apologies

2 MHAC19/35 - Declarations of Interest

3 MHAC19/36 - Minutes of last meeting to be confirmed and review of Summary Action Log

1) To confirm as a correct record the Minutes of the last meeting held on Friday 29th March 2019
2) To deal with any matters arising not dealt with elsewhere on the agenda
3) To review the Summary Action log.

Mental Health Act Committee DRAFT Minutes - March 2019.docx

MHAC Summary Action Plan live version.doc

4 MHAC19/37 - Minutes of the Power of Discharge Sub-Committee

1) To receive the Minutes of the Power of Discharge Sub-Committee meeting held on Friday 29th March 2019 for information purposes.
2) To receive an oral update from the Chair on relevant feedback from the Sub-Committee meeting held earlier this morning. This will include an update in relation to discussions regarding the Hospital Managers' Report.

Draft Minutes Power of Discharge Sub Committee March 2019 v0.1.docx

5 MHAC19/38 - Mental Health Act/Mental Health Measure Performance Report - Wendy Lappin

MHAC19.38 - MHA Committee Performance Report coversheet.docx

MHAC19.38.1 - Performance Report.pdf

MHAC19.38.2 - Appendix Mental Health Slides.pptx

7 MHAC19/39 - Child and Adolescent Mental Health Services (CAMHs) Update - Alison Cowell / Fiona Wright

MHAC19.39 - MHA Committee Report June 2019.docx

MHAC19.39.1 - CAMHs Deep Dive report Final.docx

8 MHAC19/40 - Update on the approval functions for Approved Clinicians & Section 12(2) Doctors in Wales - Eleri Lloyd-Burns

MHAC19.40 - Approved Clinician Section 12(2).docx

MHAC19.40.1 - Breakdown of section 12 and ACs North Wales.docx

MHAC19.40.2 - llythyr 13 06 19. meddygon section 12 doc.doc

9 MHAC19/41 - Independent Mental Health Advocacy Performance Report - Lesley Singleton

MHAC19.41 - IMHA Update.docx

10 MHAC19/42 - Deprivation of Liberty Safeguards - Update Report - Chris Pearson

MHAC19.42 - Deprivation of Liberties Update Report.docx

11 MHAC19/43 - HIW Monitoring Report [for information] - Hilary Owen

MHAC19.43 - Healthcare Inspectorate Wales [HIW] Report.doc

MHAC19.43.1 - Joint Thematic CMHT Review.pdf

12 MHAC19/44 - Issues of Significance to inform Chair's Report to Board

13 MHAC19/45 - Date of Next Meeting

Friday 27th September - Boardroom, Carlton Court

Mental Health Act Committee

Draft Minutes of the Mental Health Act Committee held at 15:00pm
Friday 29th March 2019
Boardroom, Carlton Court

Present

Marian Wyn Jones [Chair]	Vice Chair, BCUHB
Cheryl Carlisle	Independent Member
Lyn Meadows	Independent Member

In Attendance

Alberto Salmoiraghi	Medical Director, MH&LD
Alison Cowell	Assistant Area Director – Children's Services
Andy Roach	Director MH&LD
Chris Pearson	Safeguarding Specialist Practitioner/DoLSs & MCA [VC]
Christine Robinson	Associate Hospital Manager
Heulwen Hughes	Approval Manager for Approved Clinicians [VC]
Hilary Owen	Head of Governance
Jill Timmins	Director of Operations & Service Delivery
Joan Doyle	Unllais
Lesley Singleton	Director of Partnerships
Mark Jones	Wrexham County Council
Rachael Turner	Ward Manager, Hydref Ward
Sandra Ingham	Business Support Manager [BCUHB]
Satya Schofield	Associate Hospital Manager
Wendy Lappin	Mental Health Act Manager

Agenda Item	Action
MHAC19.17 – Apologies Apologies were received from Gill Harris, Steve Forsyth	
MHAC19.18 – Declarations of Interest MHAC19.18.1 There were no declarations of interest made at the meeting.	
MHAC19.19 – Minutes of last meeting and summary action log	

MHAC19.19.1 – Minutes of the meeting held on 3rd January were agreed as an accurate record MHAC19.19.2 – All actions were recorded therein.	
MHAC19.20 – Minutes of Power of Discharge Sub Committee MHAC19.20.1 – Minutes of the meeting held on 14th December were noted. The Chair advised of the plan going forward to streamline future agendas for both Committee and Sub Committee to avoid duplication with a proposal that the two Committees will be held side by side. **Resolved:** That the minutes of the Sub Committee held on 14th December 2018 were received.	
MHAC19.21 – Defining a Health Based Place of Safety for young people under age 18 years – MHA Section 136 MHAC19.21.1 – The report provided details on the number of admissions in 2018, 22 of which were between 13 – 17yrs. It was noted that in previous years, the figures were collated on admissions alone whereas now they are collated for the individual patient taking into account duplicate admissions resulting in a reduction. MHAC19.21.2 – It was agreed that at future meetings, this information would be included in the performance report.	WL
MHAC19.22 – Child and Adolescent Mental Health Services [CAMHS] Update MHAC19.22.1 – It has been a huge challenge to achieve the Mental Health Measures targets due to the number of vacancies within the department. Patients now have a choice of therapists and some are choosing a longer wait time to ensure they see the therapist of their choice. Whilst there are a high number of Welsh speaking therapists in the West there is a need for more, however, the dilemma is whether you employ someone who doesn't have the right qualifications but are Welsh speaking or non-Welsh speaking but the right qualifications. There has been some progress but further work is required. MHAC19.22.2 – It was noted that there had been a slight improvement on therapy services but there were limited details on where this was measured. MHAC19.22.3 – There was genuine belief that the department was in a better position than previously. There has been a reduction in the number of S136 attendances and work is continuing with North Wales Police to look at alternative Care Pathways.	

MHAC19.22.4 – It was noted that the department had been successful with a Transformation bid to provide additional support for people in crisis, this will involve joint working with other departments and Local Authorities. This will help considerably in joining up Social Services and Children's Services planning for what young people in crisis need. This will be non-recurrent funding to help with waiting lists, issues around capacity, model rolled out across Wales called CAPPA this ensure we are using the workforce to the best of ability. MHAC19.22.5 – The Delivery Unit undertook a Deep Dive in December. This was a very useful exercise, report being finalised, recent reviews will give a really good understanding of where the service is at the moment. MHAC19.22.6 – Feedback from Together for Children and Young People not yet been received. MHAC19.22.7 – The Chair asked for clarification on the high number of referrals and asked whether the additional funding will help improve performance against the measure. It was noted that CAMHS was commissioned as a planned service, unscheduled care takes up a huge amount of time and at this time the team are being pulled to manage the unscheduled care. It was hoped the additional funding would address some of the unscheduled care demand which will release capacity to manage planned care. It was reported that all single points of access are functioning consistently across all areas. **Resolved:** That the report be noted.	
MHAC19.23 – Update on the approval functions for Approved Clinicians and Section 12(2) Doctors in Wales MHAC19.23.1 - Currently progressing with new database, further discussions have been held but no feedback has been received to-date. The standard operating procedure is to be shared with Medical Directors across Wales. A meeting has been arranged with NWWIS to look at progress and an update will be provided at the next meeting. An item has also been placed on the MHA Administration Forum for next week. MHAC19.23.2 - Two Mental Health Legislation conferences have been held, both of which were well attended. Feedback has been excellent and it was noted this would continue on an annual basis. MHAC19.23.3 - Following a recent recruitment drive and vacancy adverts being sent out across North Wales GP practices, 5 attended training in February but only 1 has submitted an application to-date. MHAC19.23.4 - Section 12 Panel Meeting – medical indemnity is now being covered by Welsh Risk Pool which does not provide cover for	

independent section 12(2) GPs when carrying out mental health assessments. This was on the agenda to be discussed at the forthcoming All Wales section 12(2) Approval Panel meeting. MHAC19.23.5 - Proposal to offer sessions to work in Mental Health for GPs. This will give them an opportunity to develop a special interest and seek referees when applying for Section 12[2] approval. MHAC19.23.6 - HO asked whether doctors who acted in the capacity of FME has been offered an opportunity to become Section 12[2] doctors given the recent changes to their roles. HH advised that there were currently no application criteria in place for FMEs who were neither psychiatrists or GPs. The All Wales Approval Team would be working with Welsh Government in the future to develop Directions for section 12(2) approval, at which time, separate criteria may be included for applications from FMEs. **Resolved:** That the report be noted	
MHAC19.24 – Independent Mental Health Advocacy Performance Report MHAC19.24.1 – Themes emerging from service user feedback are now fed into local QSEEL meetings for action. Advocacy services are invited to attend the meeting. MHAC19.24.2 - Independent Hospitals have access to their own services and the request for advocacy was very low. It was suggested staff should be provided with awareness training to ensure the service is being offered. E-learning is available but we need to ensure it is fit for purpose and being accessed by staff. MHAC19.24.3 - Discussions were held around the service user feedback and any concerns. It was felt that concerns should be raised as and when they happen and staff should not wait to present at specific meetings. However, themes from concerns will be fed into local QSEEL for action. **Resolved:** That the report be noted	
MHAC19.25 – Deprivation of Liberty Safeguards [DoLS] – Update Report MHAC19.25.1 – It was noted that actions from the previous meeting were distributed with the papers. Laminated copies of DoLs procedures are available on all wards. MHAC19.25.2 - Attendance on the bespoke training is still low, staff are being encourage to attend and managers to record absence and why (data gathered by MH/LD Training & Development Lead) and	

managers informed. Recent meetings with one group of GPs' & Practice staff in West area around MCA and DoLS to ensure people understand the process. **Action:** Line managers to be provided with details of staff who do not attend training. MHAC19.25.3 – Part of risk the current risk register is around governance framework and the requirement for authorised signatories for DoLS. Training has been arranged through DoLS team and countenanced through the Quality and Safety Group. As of report date submission, there are currently 10 authorised signatories in place. A further 20 attended a recent training sessions but only 2 were there to sign up, other attendees were there to learn about the DoLs process MHAC19.25.4 – Risks have been reduced with the additional authorised signatories but need sign up from medical directorate and MH/LD. A conference has been arranged for May 2019 where all authorised signatories will be provided with in-depth information around the function of the role and legal responsibilities. MHAC19.25.5 – Still a number of cases being referred to DoLS Team for potential Court of Protection applications. Court of Protection can only be considered if person is deemed to lack capacity, if a person has capacity, an application for Deprivation of Liberty's cannot be made. At the early stage of considering a potential referral to the Court of Protection, the quality of applications from, Wards are consistently poor in terms of content with little evidence to support the referral (ie; limited capacity assessment undertaken, sometimes wrong decision being considered to be taken to Court (eg; discharge home). **Resolved:** That the report be noted.	CP
MHAC19.26 – HIW Monitoring Report MHAC19.26.1 – Report was noted for information. Update on the Nant y Glyn report to be provided at the next meeting. **Resolved:** That the report be noted.	
MHAC19.27 – Policy Position in relation to the Code of Practice and Mental Health Act MHAC19.27.1 – The code of practice provided details relating to the policies and recommended content that should be in place, this did not refer to specific actions. MHAC19.27.2 - It was noted there was a very structured process within policy group – trajectory of July for all out of date policies to be updated and confirmation will be provided on whether the Division is compliant with the Code of Practice.	

Resolved: The report was noted	
MHAC19.28 – Independent Review of Mental Health Act The report was distributed for information only	
MHAC19.29 – Mental Health Act / Mental Health Measure Monitoring Data MHAC19.29.1 - It was noted the distributed report was now in a new format providing more detailed data than previously Section 4 – There was an increase in the number of Section 4s however the number remains low in comparison to other sections. The Health Board hold regular audits to ensure patients are not being held unnecessarily. Agreed that arrows will be colour coded on future reports. MHAC19.29.2 - It was noted that all lapses are immediately escalated with further discussions held in clinical meetings. MHAC19.29.3 - AS confirmed assurance was regularly provided through the work carried out by WL, in many cases the issues arise from locum doctors and it was felt these would reduce is appropriate inductions were carried out. MHAC19.29.4 – it was noted that the issues were significantly similar to those raised in CAMHS. There has been a large increase in the number of referrals – no investment in community services since the implementation of the measure, the additional funding provided through the transformation will be used to alleviate some of the pressures. There are a large number of patients being treated under part 1a of the Mental Health Act who do not require any additional services going forward. LS provided an outline of the ICan centres currently being set up within Emergency Departments across the Health Board and the proposals for them to be rolled out in the Communities. MHAC19.29.5 – AR suggested discussions need to be held with Welsh Government to move from bed based model to community based pathways. MHAC19.29.6 – Report will be presented to Together for Mental Health Partnership Board in July and Finance & Performance Committee in July.	
MHAC19.30– Proposals for Changes to Mental Health Act Committee and Power of Discharge Sub Committee	

MHAC19.30.1 - AR advised of a scoping exercise that had been carried out to look at the specific guidance from Welsh Government on the legal requirements for both the Power of Discharge Sub Committee and the Mental Health Act Committee.

MHAC19.30.2 - Paper distributed with agenda which was derived following discussions around the duplication on both agenda's. Legal clarification was sought along with the systems used in other Health Boards. There has not been a lot of updated information sing the guidance was initially issued in 2010.

MHAC19.30.3 – The scoping exercise concluded that MHA Committee could be disbanded provided all the items could be discussed in QSE Committee. Given the large remit of this meeting this was not deemed to be appropriate. Various options have been provided:

Option 1, members have already raised concerns about duplication and time constraints.

Option 2 - Whilst the Health Board could move to a different model, Members of the Board may be concerned about doing this at a point when the Health Board remains in Special Measures, particular if then viewed as an outlier in Wales. Furthermore, the current workload of QSE is extensive and given it has only recently moved to bi-monthly meetings this arrangement needs to stabilise before QSE's workload is expanded.

Option 3 – Preferred option - Retain both the MHAC and the POD but rationalise the business currently being presented and hold both meetings on the same day (in a condensed timeframe of morning or afternoon). This would potentially mean changes to the agenda in the following areas:-

- Cease submitting separate IMHA, S136 and CAMHS reports as the data is already incorporated into the overarching performance activity report.
- Remove the MHM compliance section from the performance report as this is already presented to QSE.
- HIW updates – only present these to MHAC not the POD. These reports should only be where HIW have specifically made recommendations concerning the Mental Health Act. NB the wider HIW reports are presented to QSE.

With the preferred choice being Option 3:

MHAC19.30.4 – Under 18yrs Mental Health Act Section 136 data will not be provided as an individual item as this is included within the Mental Health Act Activity Report.

MHAC19.30.5 – The preferred option was option 3 and it was agreed once the Division was out of special measures this can be reviewed again. MHAC19.30.6 – Meetings to remain on a quarterly basis, with no changes to the current attendance, the agenda will be rationalised to avoid future duplication.	
MHAC19.31 – Mental Health Act Committee Draft Annual Report The report was distributed for information.	
MHAC19.32 – Issues of Significance to inform Chair's Report to Board The Chair agreed to raise any issues of significance with the Board	
MHAC19.33 – Date of Next Meeting Friday 28th June 2019 – Boardroom, Carlton Court	

BCUHB MENTAL HEALTH ACT COMMITTEE Summary Action Plan – Live Document – last updated 20/06/2019 22:46				
Officer	**Minute Reference and Action Agreed**	**Original Timescal**	**Latest Update Position**	**Revised Timescale**
28th June 2019				
WL	**MHAC18.39.4** – Verbal update on the review of policies linked to the Mental Health Act to be provided at next meeting	March		
JT	**MHAC19.08** – Approved Clinicians & Section 12(2) Doctors – JT & AS do discuss with Chris Stockport re taking discussions to Cluster Leads meeting	March	HJ to provide detailed report on number of approved clinicians in North Wales	June
CP	**MHAC19.25.2** – Line Managers to be provided with details of staff who do not attend DoLs training	ongoing	Line managers have been advised and process has been adopted going forward	Close

Power of Discharge Sub Committee

Draft Minutes of the Power of Discharge Sub Committee held on Friday 29th March 2019
Boardroom, Carlton Court

Present:

Marian Wyn Jones [Chair]	Vice Chair, BCUHB
Cheryl Carlisle	Independent Member
Frank Brown	Associate Hospital Manager
Jackie Parry	Associate Hospital Manager
Lyn Meadows	Independent Member
Satya Schofield	Associate Hospital Manager
Shirley Cox	Associate Hospital Manager
Shirley Davies	Associate Hospital Manager

In Attendance

Andy Roach	Director of Mental Health & Learning Disabilities
Hilary Owen	Head of Governance
Jill Timmins	Director of Operations & Service Delivery
Sandra Ingham	Business Support Manager [BCUHB]
Wendy Lappin	MH Act Manager [BCUHB]

Agenda Item	Action
POD19.01 – Apologies POD 18.25.1 Apologies were received from Gill Harris, Steve Forsyth	
POD19.02 – Declarations of Interest POD 19.02.1 - There were no declarations of interest made at the meeting.	
POD19.03 – Minutes of Last Meeting & Review of Summary Action Log POD19.03.1 – Minutes of the meeting held on 14th December were agreed as an accurate record with the amendments to attendance. POD19.03.2 – Actions were recorded therein	
POD19.04 – Hospital Manager's Update	

POD19.04.1 – There were 31 hearings from October to December and one discharge. 8 hearings were cancelled, 3 of which were due to sickness. Following discussions with other Health Boards, going forward, hearings will only be arranged once the renewal paperwork has been received from the clinician, this will reduce the number of hearings being cancelled. POD19.04.2 – All hospital managers were compliant with their mandatory training; it was noted that WL will advise when training has expired. New appointments will be required to complete full training before being allowed to shadow hearings. POD19.04.3 - Risk assessments are now being requested prior to hearings taking place.	
POD19.05 – Defining a Health Based Place of Safety for Young People Under 18 years – MHA Section 136 POD19.05.1 - Report distributed for information and members were asked if they had any issues or concerns to raise. POD19.05.2 - AR advised that Adult Mental Health were working closely with CAMHS to ensure the issues around adults in 136 provision, Welsh Government are asking that action is provided on how this is going to change going forward to ensure we are fulfilling our safeguarding duties to children. POD19.05.3 – There has been a significant reduction with admissions down to 22 but this was still thought to be too many. Previous reports counted each individual admission, the new data is for each individual patient resulting in a reduction. Situations were still arising where children were spending excess time in 136 suites, whilst the safety of the child is priority at all times, we continue to try and develop a better solution. POD19.05.3 – A priority solution is required for high risk children and whilst Abergele was being considered, there are issues around resourcing and out of hours. Whilst not acceptable this is the best safeguarding solution we currently have. Issues in the main are out of hours. It was noted that adult clinicians are very flexible and will carry out an assessment on a child with advice from CAMHS colleagues. AR to provide an update on the recruitment day scheduled next month. **Resolved:** That the report be noted and the actions outlined be progressed	AR AR
POD19.06 – Independent Review of Mental Health Act	

POD19.06.1 - Report was distributed for information. The recommendations were published in December; Health Board have provided a briefing paper split in to the 4 principles. Proposed changes to practice that may affect the HB and new ideas not currently being undertaken. • Patients being able to nominate someone to be involved in their care • Advance choice document to express their care and treatment preferences. POD19.06.2 - Strengthening assurance that patients are detained appropriately, this will create additional administration tasks. Increase in section 12[2] doctors required. POD19.06.3 - SS expressed her concern at what she read as implications to the current role of the Associate Hospital Manager, returning to more of a hospital visitor role and not having the power to discharge anymore. WL asked that it be noted these are only recommendations, it does not mean they will be implemented. POD19.06.4 - That the report be noted and updates be provided as and when available. **Resolved:** That the report be noted	
POD19.07 – Consideration of Changes to future POD and MHAC Meetings POD19.07.1 - Paper produced following discussions of the duplication across Power of Discharge Sub Committee and Mental Health Act Committee, legal clarification was sought along with the systems used in other Health Boards. Not a lot of updated information since the guidance issued in 2010. POD19.07.2 – The scoping exercise concluded that MHA Committee could be disbanded provided all the items could be discussed in QSE Committee. Given the large remit of this meeting this was not deemed to be appropriate. Various options have been provided: - **Option 1,** members have already raised concerns about duplication and time constraints. **Option 2** - Whilst the Health Board could move to a different model, Members of the Board may be concerned about doing this at a point when the Health Board remains in Special Measures, particular if then viewed as an outlier in Wales. Furthermore, the current workload of QSE is extensive and given it has only recently moved to bi-monthly meetings this arrangement needs to stabilise before QSE's workload is expanded.	

Option 3 – Preferred option - Retain both the MHAC and the POD but rationalise the business currently being presented and hold both meetings on the same day (in a condensed timeframe of morning or afternoon). This would potentially mean changes to the agenda in the following areas:- o Cease submitting separate IMHA, S136 and CAMHS reports as the data is already incorporated into the overarching performance activity report. o Remove the MHM compliance section from the performance report as this is already presented to QSE. o HIW updates – only present these to MHAC not the POD. These reports should only be where HIW have specifically made recommendations concerning the Mental Health Act. NB the wider HIW reports are presented to QSE. POD19.07.3 – Under 18yrs Mental Health Act Section 136 data will not be provided as an individual item as this is included within the Mental Health Act Activity Report. POD19.07.4 – The preferred option was option 3 and it was agreed once the Division was out of special measures this can be reviewed again POD19.07.3 – Meetings will remain on a quarterly basis with no change at present to attendees. Agenda's will be rationalised to avoid duplication **RESOLVED:** It was agreed by the Sub Committee that option 3 be implemented.	
POD19.08 – Issues of Significance to inform the Chair's Report to the Mental Health Act Committee POD19.08.1 – The Chair agreed to raise any issues of concern in her Assurance report to the Board	
POD19.09 – Date of Next Meeting 28th June 2019 – Boardroom, Carlton Court	

Mental Health Act Committee

28th June 2019

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

To improve health and provide excellent care

Report Title:	Mental Health Act Committee Performance Report
Report Author:	Hilary Owen, Head of Governance Wendy Lappin, Mental Health Act Manager
Responsible Director:	Andy Roach, Director of Mental Health and Learning Disabilities
Public or In Committee	Public
Purpose of Report:	To provide an update in relation to the (Mental Health Act and Mental Health Measure) Activity within the Division
Approval / Scrutiny Route Prior to Presentation:	Divisional Q-SEEL Meeting Divisional Directors Meeting Andy Roach, Director of Mental Health and Learning Disabilities
Governance issues / risks:	The Mental Health Act detentions fall into a category of being legal or illegal (invalid) which may result in challenges from legal representatives on behalf of their clients. All detentions are checked for validity and any invalid detentions are reported through Datix, investigated and escalated as appropriate.
Financial Implications:	The rise of MHA detentions has a financial implication, two doctors are required to assess for some of the sections and a conflict of interest between clinicians as specified under the MHA needs to be avoided. This results in the use of S12(2) approved doctors and those that work as GP's and outside of the Health Board. Legal advice is obtained in relation to some detentions and the use of the Mental Health Act to which there is no budget for.
Recommendation:	The committee is asked to note the report.

Health Board's Well-being Objectives *(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)*	√	**WFGA Sustainable Development Principle** *(Indicate how the paper/proposal has embedded and prioritised the sustainable development principle in its development. Describe how within the main body of the*	√

		report or if not indicate the reasons for this.)	
1.To improve physical, emotional and mental health and well-being for all	√	1.Balancing short term need with long term planning for the future	√
2.To target our resources to those with the greatest needs and reduce inequalities	√	2.Working together with other partners to deliver objectives	√
3.To support children to have the best start in life		3. Involving those with an interest and seeking their views	
4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being		4.Putting resources into preventing problems occurring or getting worse	√
5.To improve the safety and quality of all services	√	5.Considering impact on all well-being goals together and on other bodies	
6.To respect people and their dignity	√		
7.To listen to people and learn from their experiences			

Special Measures Improvement Framework Theme/Expectation addressed by this paper

Governance and Leadership – to ensure compliance with the Mental Health Act and Mental Health (Wales) Measure

http://www.wales.nhs.uk/sitesplus/861/page/81806

Equality Impact Assessment

Retrospective looking report therefore no EQIA

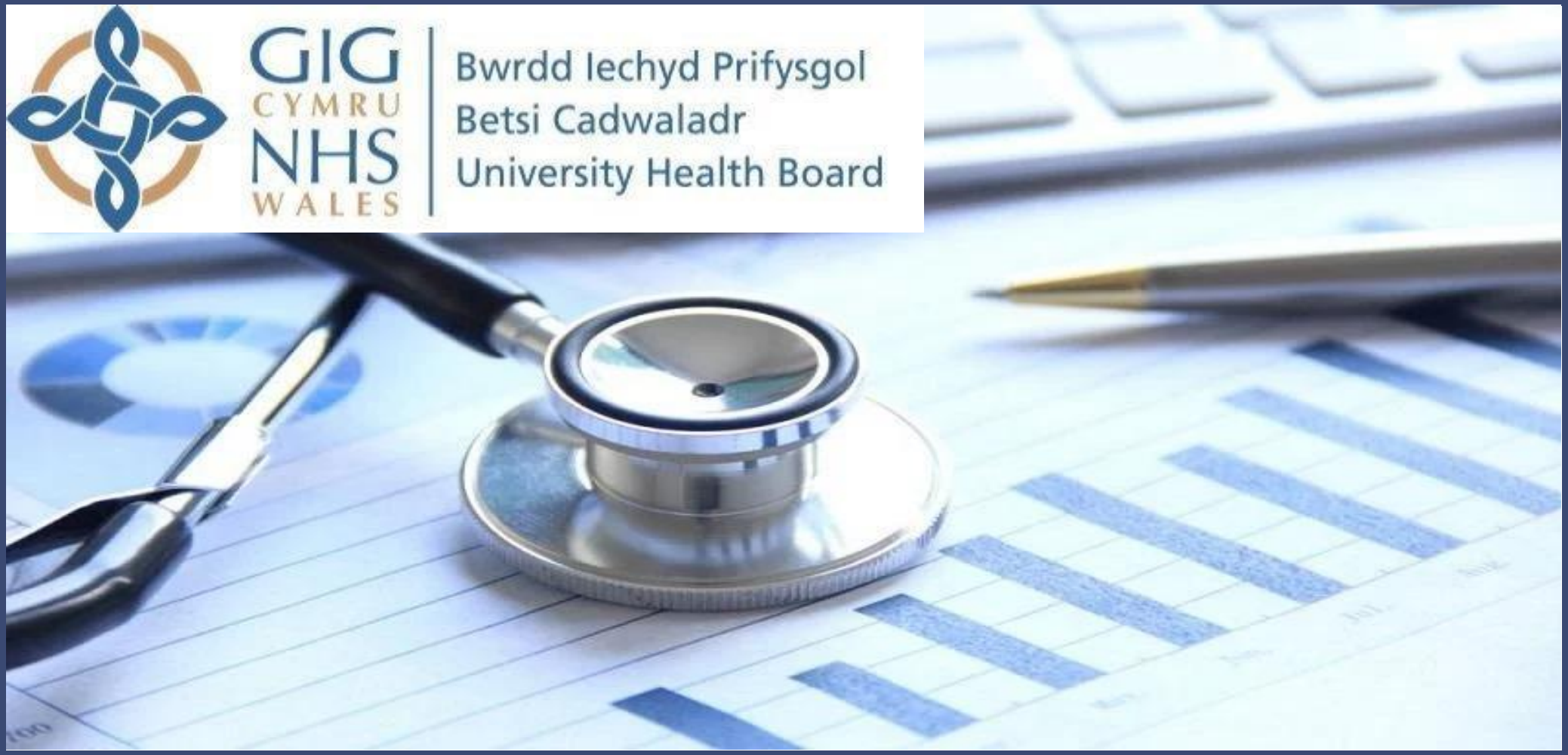
http://howis.wales.nhs.uk/sitesplus/861/page/47193)

Disclosure:
Betsi Cadwaladr University Health Board is the operational name of Betsi Cadwaladr University Local Health Board

Mental Health Act Committee Performance Report

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board



Mental Health Act Committee Performance Report

March 2019

CONTENTS:

Report to Mental Health Act Committee

This report provides assurance to the Mental Health Act Committee of our compliance against key sections of the legislative requirements of the Mental Health Act 1983 as amended 2007. The report also includes an Appendix which details the exceptions being reported under the Mental Health Measure.

Seven Domains

We present performance to the committee using the 7 domain framework against which NHS Wales is measured. This report is consistent with the 7 domain performance reporting for our Finance and Performance Committee and Quality, Safety and Experience Committee. The Mental Health Act and Mental Health Measure committee are responsible for scrutinising the performance for Mental Health indicators under Timely Care and Individual Care.

Advisory Reports & Exception reports

Each report for the Mental Health Act will be presented as an advisory report.

Reports for the Mental Health Measure are consistent with the Exception report process, exception reports are included where performance is either worse than the required standard or the Board require sight of the actions being taken to maintain or improve performance. After we have achieved an indicator for three consecutive months, it will be stood down from exception reporting.

Advisory Report Definitions

Section 5(4) Nurses Holding Power (up to 6 hours): Criteria: "…the patient is suffering from mental disorder to such a degree that it is necessary for his health and safety or for the protection of others for him to be immediately restrained from leaving the hospital". Secondly the nurse must believe that "…it is not practicable to secure the immediate attendance of a practitioner or clinician for the purposes of furnishing a report under subsection (2)

Section 5(2) Doctors Holding Power (up to 72 hours): Criteria is: that an application for compulsory detention "ought to be made". Patient must be in-patient, can be used in general hospital.

Section 4: Admission for emergency (up to 72 hours): Criteria: "it is of urgent necessity for the patient to be admitted and detained under section 2" and that compliance with the provisions relating to application under that section "would involve undesirable delay"

Section 2: Admission for assessment (up to 28 days): Criteria needs to be met:
a) is suffering from mental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period;
b) ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons

Section 3: Admission of treatment (up to 6 months, renewable for 6 months, 12 monthly thereafter): Criteria
a) is suffering from mental disorder of a nature or degree which makes it appropriate for him/her to receive medical treatment in hospital;
b)it is necessary for the health and safety of the patient or for the protection of other persons that he/she should receive such treatment and it cannot be provided unless he is detained under this section;
c)appropriate medical treatment is available for him/her

Section 17A: Supervised Community Treatment, also referred to as a CTO – its duration is up to 6 months, renewable for 6 months and 12 months thereafter.

Section 17E: Recall – the recall can last for up to 72 hrs. The clinical team must decide to release from Recall, Revoke or Discharge

Section 17F: Revocation. Once a patient has been revoked, essentially the Section 3 comes back into force - which can last up to 6 months, renewable for 6 months, then 12 monthly thereafter.

Advisory Report Definitions

Section 135 Warrant to search and remove: Section 135(1) – warrant to enter and remove: Section 135(1) empowers a magistrate to authorize a police constable to remove a person lawfully from private premises to a place of safety. Section 135(2) – warrant to enter and take or retake. Section 135(2) concerns the taking into custody of patients who are unlawfully absent.

Section 136 Place of Safety (up to 24 hours): The powers of section 136 provide authority for a police officer who finds a person who appears to be suffering from mental disorder, in any place other than a private dwelling or the private garden or buildings associated with that place, to remove or keep a person at, a place of safety under section 136(1) or to take a person to a place of safety under section 136(3)

Section 35: Remand to hospital for report on accused's mental condition – for up to 28 days but can be extended to a maximum of 12 weeks.

Section 36: Remand of accused person to hospital – up to 28 days but duration will be set by the Court – maximum of 12 weeks.

Section 37: Hospital Order or Guardianship Order - up to 6 months, renewable for 6 months, 12 monthly thereafter
Section 37/41: Hospital Order with Restrictions – made with no time limit

Section 38: Interim Hospital Order – up to 12 weeks, but duration set by the Court – maximum 12 months

Section 47/49: Transfer of sentenced prisoners (including with restrictions)

Section 48/49: Transfer of other prisoners (including with restrictions) for urgent assessment

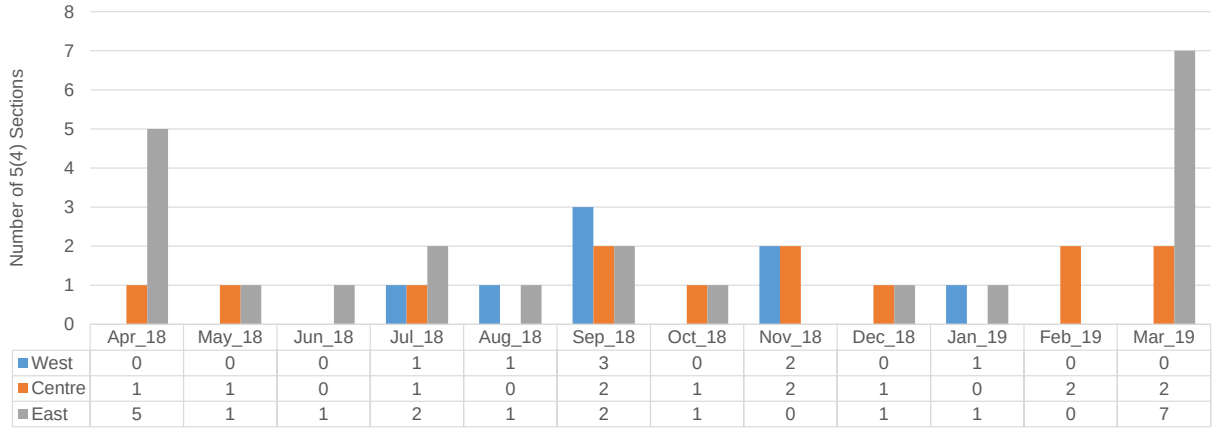
Section 62: Emergency Treatment of a detained patient regardless of section status

Rectifiable Errors: concerned with errors resulting from inaccurate recording, errors which can be rectified under Section 15 of the Act

Fundamentally Defective Errors: concerned with errors which cannot be rectified under section 15

Lapses of section: refers to sections that have come to the end of their time period. It is not good practice for sections to lapse and reasons are investigated.

Section 5(4) - BCUHB	Latest Month	Previous Month	Monthly Trend	Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of Section 5(4) during Quarter		Quarter 5(4) Sections
Section 5: Application in respect of patients already in hospital	9	2	↑	13	8	↑	11	1	East	8
								2	Centre	4
								3	West	1



	Apr_18	May_18	Jun_18	Jul_18	Aug_18	Sep_18	Oct_18	Nov_18	Dec_18	Jan_19	Feb_19	Mar_19
West	0	0	0	1	1	3	0	2	0	1	0	0
Centre	1	1	0	1	0	2	1	2	1	0	2	2
East	5	1	1	2	1	2	1	0	1	1	0	7

A Section 5(4) will be used if a staff nurse feels that it is necessary to detain a patient to await the arrival of a doctor for assessment. The 5(4) will be used if there are no doctors immediately available and the staff nurse feels this is in the best interest of the patient.

All 5(4) sections within this period were appropriate and were either converted to a 5(2) or the patient returned to informal status.

There were two instances where the same person was subject to a 5(4) these were on seperate days.

LAPSES

There were no lapses for this quarter.

WEST

Month	Duration (hh:mm)	Outcome
Jan_19	01:30	Section 5(2)

CENTRE

Month	Duration (hh:mm)	Outcome
Feb_19	02:20	S5(2)
Feb_19	01:10	Section 5(2)
Mar_19	01:55	Section 5(2)
Mar_19	06:00	Informal

EAST

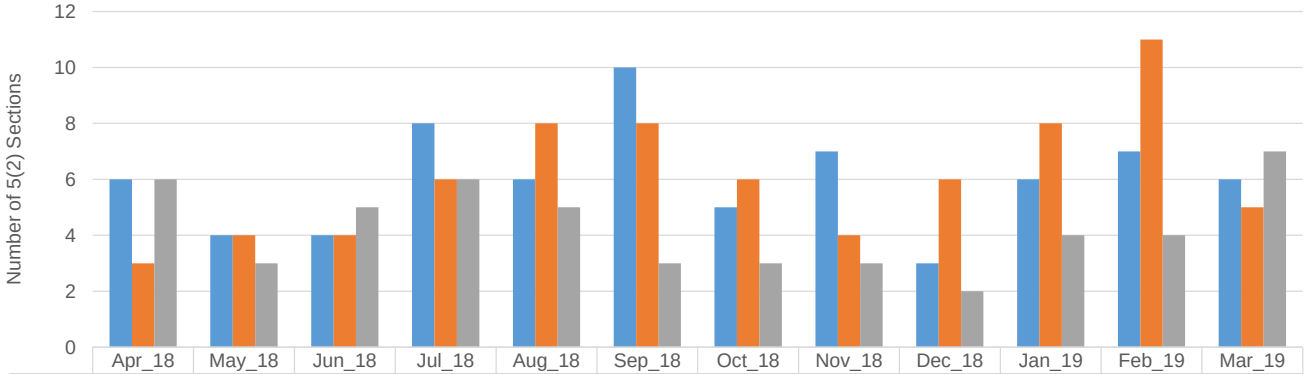
Month	Duration (hh:mm)	Outcome
Jan_19	01:11	Section 5(2)
Mar_19	01:36	Section 5(2)
Mar_19	00:15	Section 5(2)
Mar_19	04:26	Informal
Mar_19	00:15	Section 5(2)
Mar_19	01:45	Informal
Mar_19	01:15	Section 5(2)
Mar_19	03:45	Section 5(2)

Advisory Report - Section 5(2)

Section 5(2) - BCUHB	Latest Month	Previous Month	Monthly Trend
Section 5: Application in respect of patients already in hospital	18	22	↓

Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)
58	39	↑	49

Area Rank by numbers of Section 5(2) during Quarter		Quarter 5(4) Sections
1	Centre	24
2	West	19
3	East	15



	Apr_18	May_18	Jun_18	Jul_18	Aug_18	Sep_18	Oct_18	Nov_18	Dec_18	Jan_19	Feb_19	Mar_19
West	6	4	4	8	6	10	5	7	3	6	7	6
Centre	3	4	4	6	8	8	6	4	6	8	11	5
East	6	3	5	6	5	3	3	3	2	4	4	7

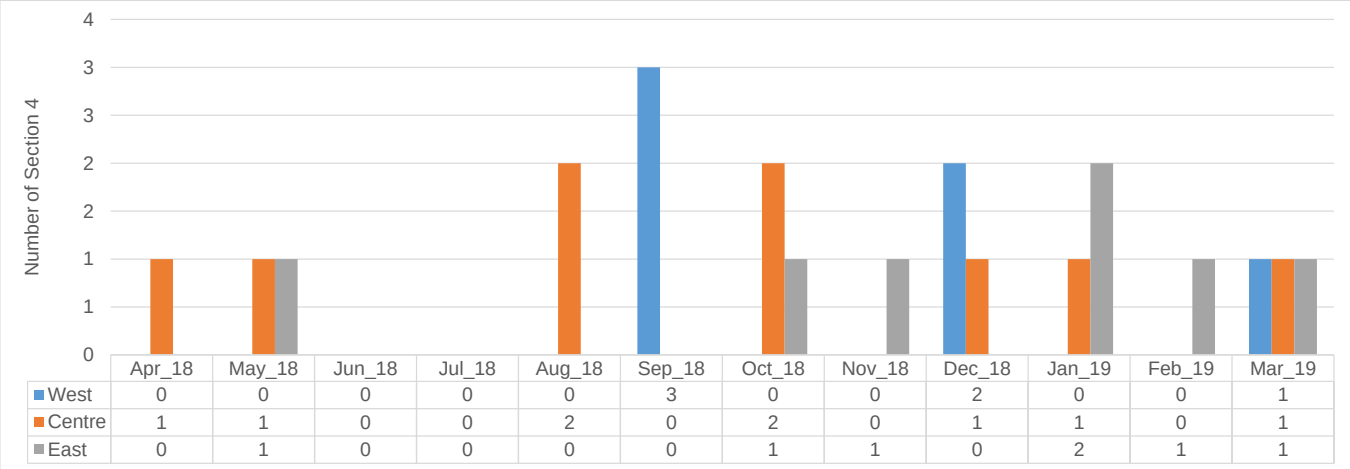
Section 5(2) Outcomes

	Jan 2019	Feb 2019	Mar 2019
Section 2:	11	6	2
Section 3:	2	4	5
Informal:	3	5	6
Lapsed:	0	0	0
Invalid:	0	0	0
Discharged:	3	5	2
Other:	0	0	0

A Section 5(2) on occasions will be enacted within the acute hospital wards, during this quarter there were none.

This quarter there are no exceptions to report.

Section 4 - BCUHB	Latest Month	Previous Month	Monthly Trend	Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of Section 4 during Quarter		Quarter Section 4
Section 4: Admission for assessment: Cases of emergency	3	1	↑	7	7	→	6	1	East	4
								2	Centre	2
								3	West	1



	Apr_18	May_18	Jun_18	Jul_18	Aug_18	Sep_18	Oct_18	Nov_18	Dec_18	Jan_19	Feb_19	Mar_19
West	0	0	0	0	0	3	0	0	2	0	0	1
Centre	1	1	0	0	2	0	2	0	1	1	0	1
East	0	1	0	0	0	0	1	1	0	2	1	1

The use of section 4 is a relatively rare event and figures remain low.

Section 4 will be used in emergency situations where it is not possible to secure two doctors for a section 2 immediately and it is felt necessary for a persons protection to detain under a section of the Mental Health Act.

WEST

Month	Duration (hh:mm)	Outcome
Mar_19	06:15	Discharged

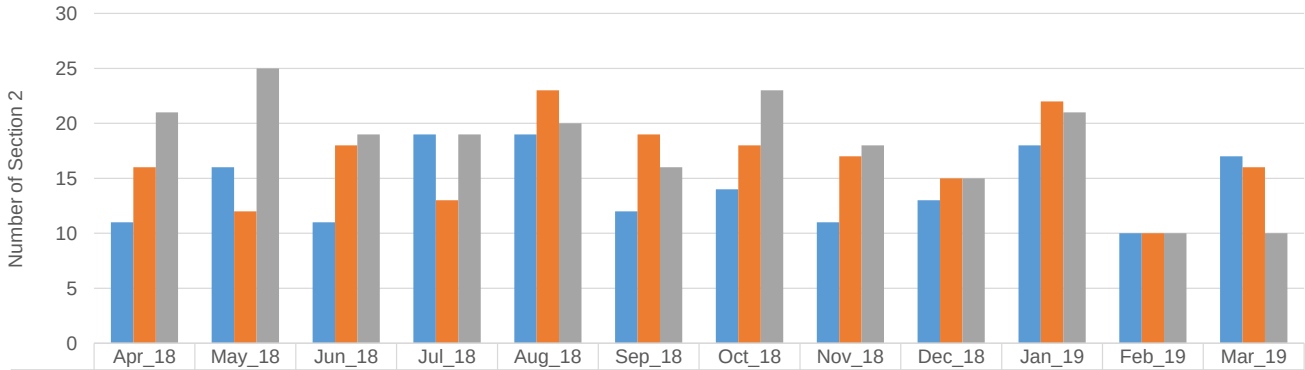
CENTRE

Month	Duration (hh:mm)	Outcome
Jan_19	19:00	Section 2
Mar_19	07:50	Section 2
	03:00	

EAST

Month	Duration (hh:mm)	Outcome
Jan_19	10:20	Section 2
Jan_19	04:40	Section 2
Feb_19	46:00	Section 3
Mar_19	24:25	Section 2

Section 2 - BCUHB	Latest Month	Previous Month	Monthly Trend	Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of Section 2 during Quarter		Quarter Section 2
Section 5: Admission for assessment	43	30	↑	134	144	↓	147	1	Centre	48
								2	West	45
								3	East	41



	Apr_18	May_18	Jun_18	Jul_18	Aug_18	Sep_18	Oct_18	Nov_18	Dec_18	Jan_19	Feb_19	Mar_19
West	11	16	11	19	19	12	14	11	13	18	10	17
Centre	16	12	18	13	23	19	18	17	15	22	10	16
East	21	25	19	19	20	16	23	18	15	21	10	10

* data is an as at position and is subject to change

Section 2 Outcomes

	Jan 2019	Feb 2019	Mar 2019
Section 3:	8	11	3
Informal:	16	16	13
Lapsed:	0	0	0
Pending:	0	0	0
Discharged:	9	10	5
Transferred:	6	7	3
Invalid and Other:	1	0	0

It is hard to interpret these figures in isolation. However it has to be noted that in the East there are more beds and these figures are on the basis of the applications as opposed to address of residence.

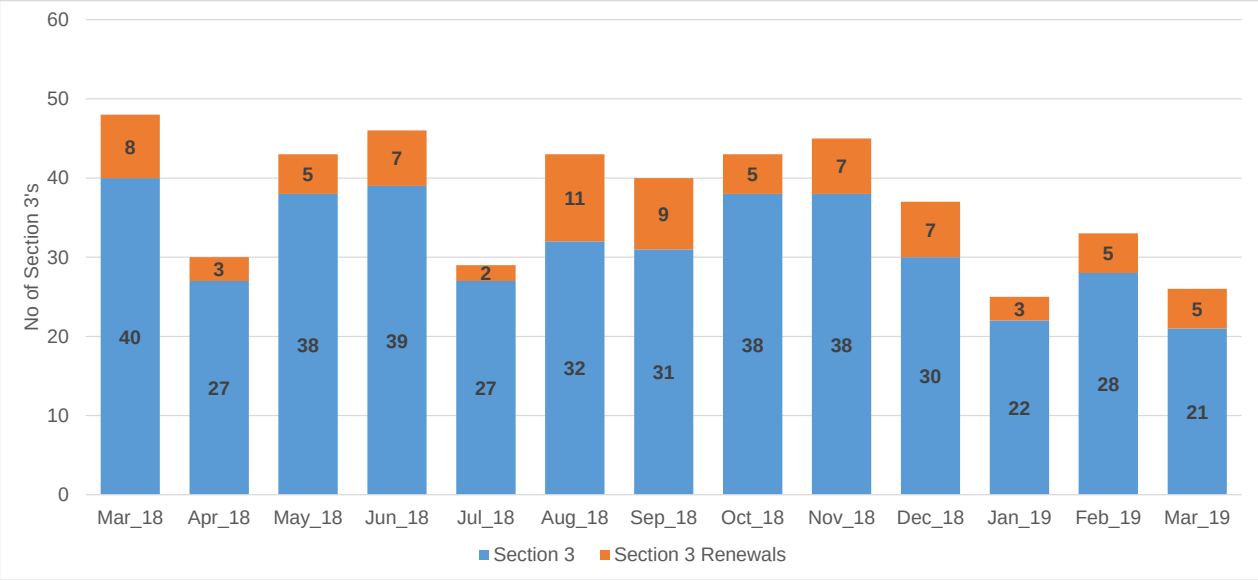
There were no under 18's placed on a Section 2 this quarter.

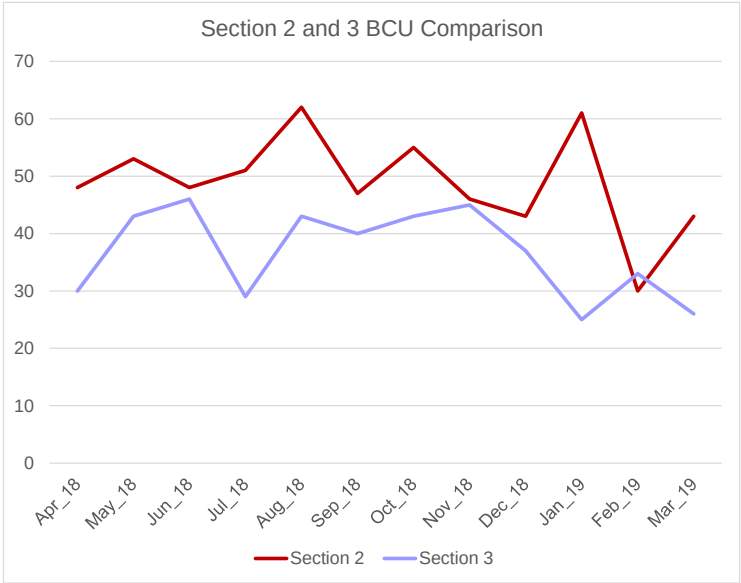
EXCEPTIONS:

There are no exceptions to report for this quarter.

Advisory Report - Section 3

Section 3 - BCUHB	Latest Month	Previous Month	Monthly Trend	Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of Section 3 during Quarter		Quarter Section 3
Section 3 (Including Renewals): Admission for treatment	26	33	↓	84	125	↓	110	1	West	29
								2	Centre	28
								3	East	27



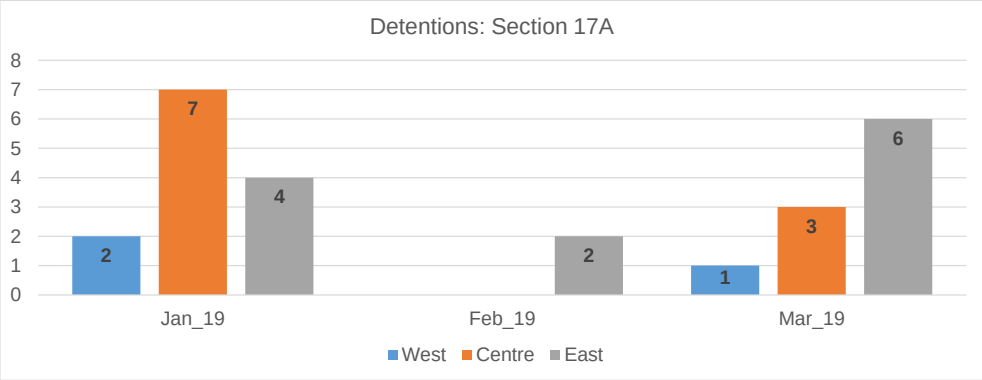


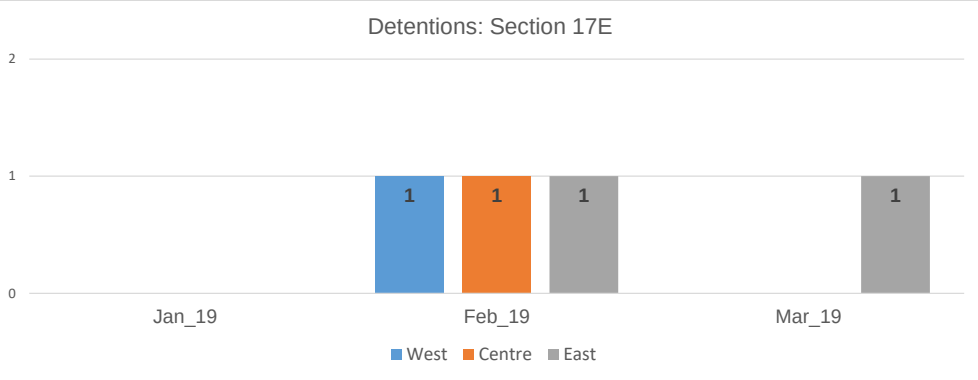
* data is an as at position and is subject to change

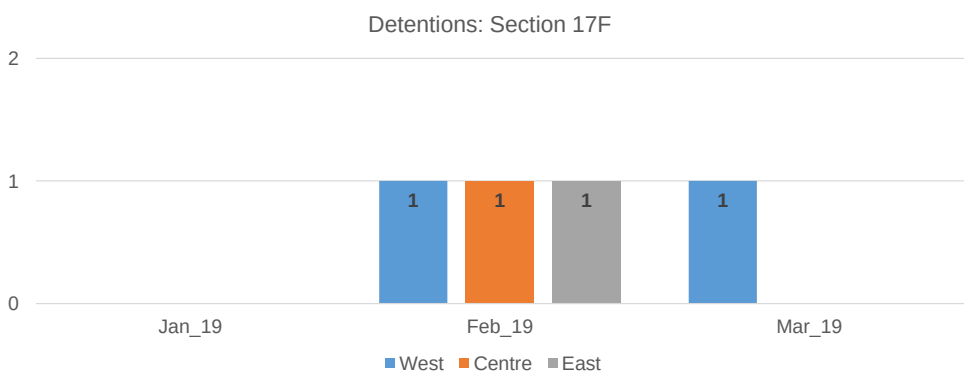
These numbers also include any renewal sections undertaken within the month. As with the data for section 2 it is hard to interpret these figures in isolation and previous months figures are prone to change due to admissions into the Health Board.

This quarter one under 18 year old was made subject to a Section 3.

Section 17 A-F - BCUHB	Latest Month	Previous Month	Monthly Trend	Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of Section 17 during Quarter		Quarter Section 17
Section 17A (Including Renewals)-17F: Community Treatment Orders	12	8	↑	33	26	↑	30	1	East	15
								2	Centre	12
								3	West	6







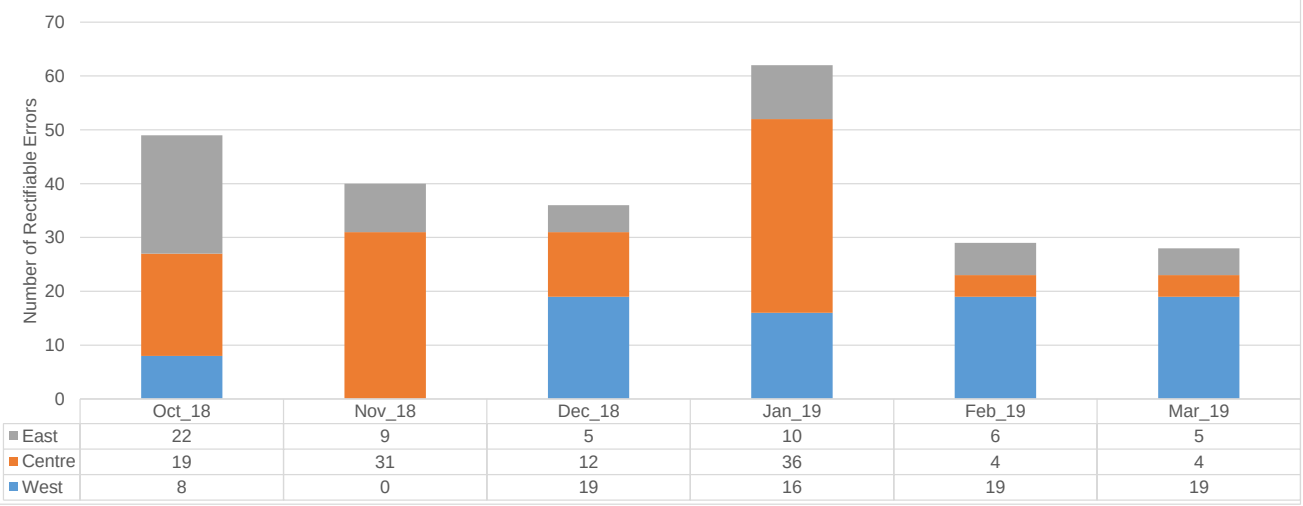
This quarterly data 17A shows the numbers of patients who are being placed on a CTO for the first time, as well as any renewals within the month.

The number of patients subject to a CTO at the end of March: West: 10, Central: 18 and East: 20.

There are no exceptions to report in relation to CTOs this quarter.

Advisory Report - Mental Health Act Errors

Fundamental and Rectifiable Errors	Latest Month	Previous Month	Monthly Trend	Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of Errors during Quarter		Quarter Errors
Fundamental and Rectifiable Errors in line with Health Boards in Wales	28	29	↓	119	128	↓	113	1	West	54
								2	Centre	44
								3	East	21



	Oct_18	Nov_18	Dec_18	Jan_19	Feb_19	Mar_19
East	22	9	5	10	6	5
Centre	19	31	12	36	4	4
West	8	0	19	16	19	19

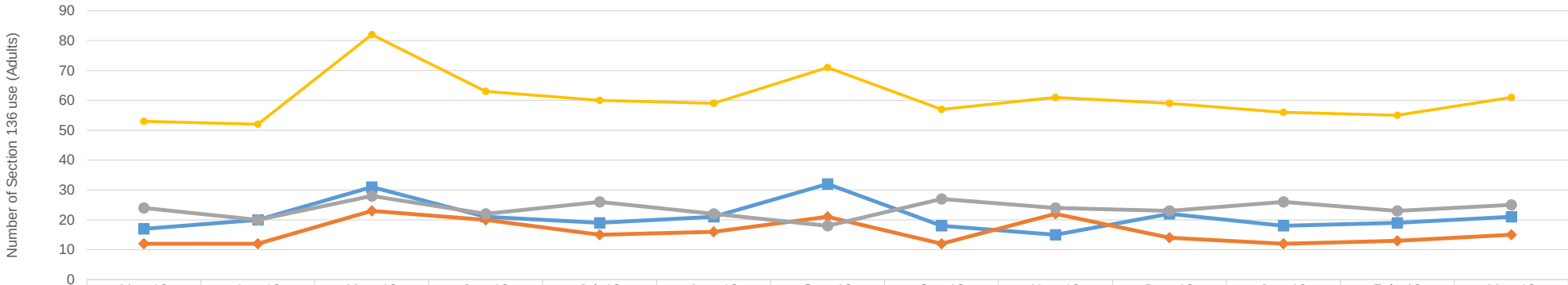
Rectifiable Errors

The number of rectifiable errors is gradually decreasing.

In relation to the other health boards throughout Wales BCUHB accounted for 46% of all rectifiable errors for the period of January - March 2019.

Within this period there are no exceptions to report in relation to errors or section lapses.

Section 135 - 136	Latest Month	Previous Month	Monthly Trend	Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of S.136 during Quarter		Quarter S.136 detentions
Section 135 and 136: Patient transfers to a place of safety (Adults)	61	55	↑	172	177	↓	184	1	East	74
								2	West	58
								3	Centre	40



	Mar_18	Apr_18	May_18	Jun_18	Jul_18	Aug_18	Sep_18	Oct_18	Nov_18	Dec_18	Jan_19	Feb_19	Mar_19
West	17	20	31	21	19	21	32	18	15	22	18	19	21
Centre	12	12	23	20	15	16	21	12	22	14	12	13	15
East	24	20	28	22	26	22	18	27	24	23	26	23	25
BCU	53	52	82	63	60	59	71	57	61	59	56	55	61

The data above does not include S135 or under 18's.

The trend for S136 for the last quarter appears to be on a downward turn although the total figures for 2016/17 = 669, 2017/18 = 664, and 2018/19 = 761.

There were 6 x S135 assessments across the Health Board this quarter resulting in 2 x S2 admissions, 3 x S3 admissions and 1 person was discharged following assessment.

East - one S136 was granted the 12 hour extension due to the patient not being fit for assessment, this person was discharged and referred to CMHT services.

There were two persons who were noted to be in Custody as the first place of safety in the East. one resulted in informal admission and one discharged (no mental disorder).

Advisory Report - Section 135 and 136

Section 136	Latest Month	Previous Month	Monthly Trend
Section 136: Patient transfers to a place of safety (Adults)	61	55	↑

Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)
172	177	↓	184

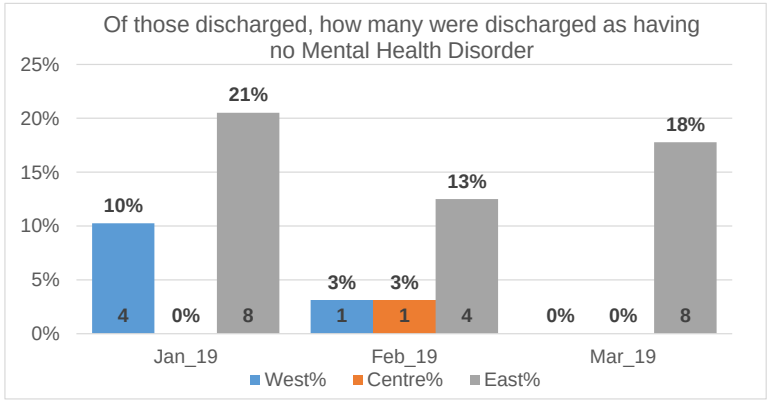
Area Rank by numbers of S.136 during Quarter		Quarter S.136 detentions
1	East	74
2	West	58
3	Centre	40

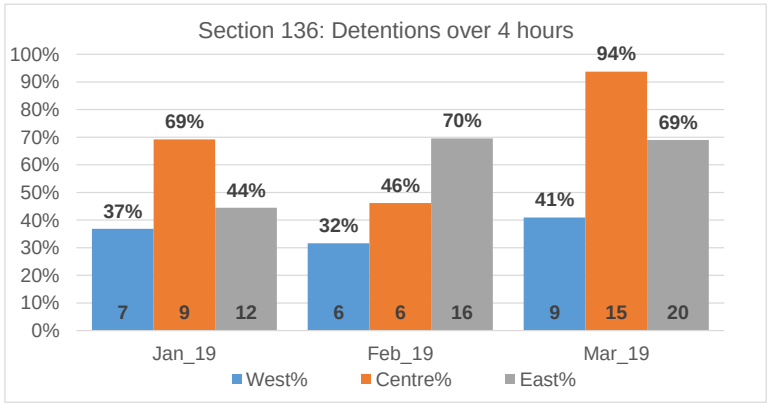
Section 136 Outcomes

	Jan 2019	Feb 2019	Mar 2019
Discharged:	39 65.00%	32 66.67%	45 70.31%
Informal Admission:	11 18.33%	8 16.67%	12 18.75%
Section 2:	10 16.67%	8 16.67%	6 9.38%
Section 3:	0 0.00%	0 0.00%	1 1.56%
Other:	0 0.00%	0 0.00%	0 0.00%

Section 136 - Known to Service

	Jan 2019	Feb 2019	Mar 2019
Yes	24	24	38
Yes (percentage)	41.38%	46.15%	56.72%





The data shows figures from outcomes recorded and whether a patient is known to service.

Whilst a large proportion of 136's are discharged those with no mental disorder alone tends to be around 20% there was an increase to 31% for January.

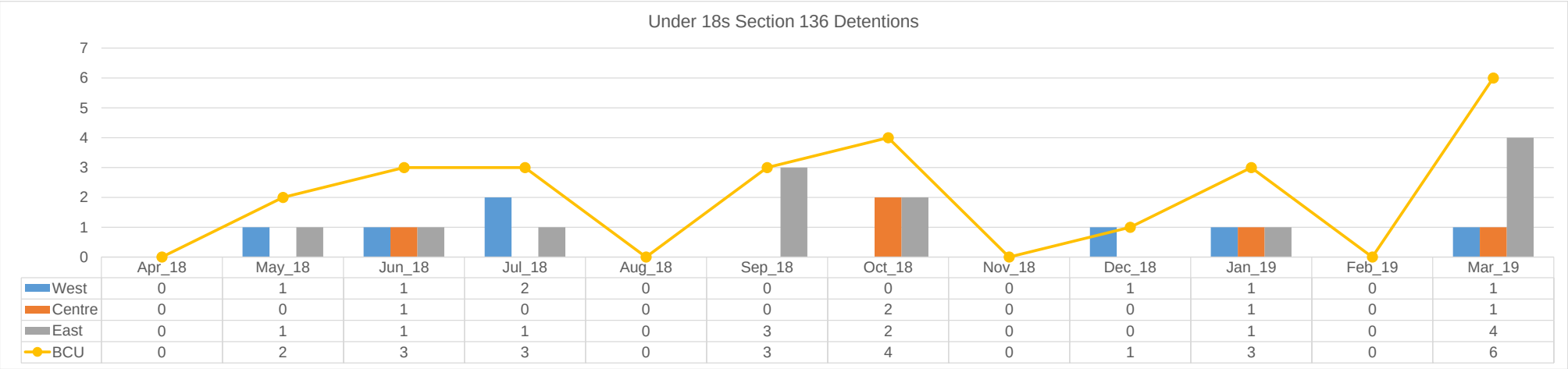
Total percentages for the months for those discharged with no mental disorder are:
January 31%
February 19%
March 18%

Total percentage for the months for detentions over 4 hours are:
January 48%
February 51%
March 66%

There has been one instance this quarter where a 12 hour extension was required.

Advisory Report - Section 136: Under 18 detentions

Section 135 - 136 (Under 18)	Latest Month	Previous Month	Monthly Trend	Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of S.136 (<18) during Quarter		Quarter <18 S.136 use
Section 135 and 136: Patient transfers to a place of safety (<18)	6	0	↑	9	5	↑	6	1	East	5
								2	Centre	2
								2	West	2



	Apr_18	May_18	Jun_18	Jul_18	Aug_18	Sep_18	Oct_18	Nov_18	Dec_18	Jan_19	Feb_19	Mar_19
West	0	1	1	2	0	0	0	0	1	1	0	1
Centre	0	0	1	0	0	0	2	0	0	1	0	1
East	0	1	1	1	0	3	2	0	0	1	0	4
BCU	0	2	3	3	0	3	4	0	1	3	0	6

A total of 9 under 18's were assessed this quarter between the ages of 14 and 17 years. One assessment resulted in voluntary admission to an age appropriate bed.

The tables below shoe the ages of young people assessed and the outcomes for the period April 18 - March 19.

Under 18 Assessments

AGE	No of Assessments
12	0
13	1
14	4
15	7
16	5
17	8

Outcome of Assessments

Outcome	Number
Returned Home	16
Returned to Care Facility	3
Admission to childrens ward	0
Admission to Adult ward	1
Admission NWAS/CAMHS	3
Admission OOA	1
Other (Friends, Hotel, B&B)	1 (stayed in S136 suite till transfer)

Advisory Report - Section 136: Under 18 Admissions

Month of Admission	Place of Assessment	Outcome	Assessing Clinician	Total Hours	Age
January	Hergest	Discharged	CAMHS	7:00:00	17
January	Ablett	Discharged	CAMHS	09:30	15
January	Heddfan	Discharged	CAMHS	17:45:00	15
March	Heddfan	Discharged	Adult Consultant	03:00	16
March	Hergest	Discharged	CAMHS	15:45	16
March	Heddfan	Discharged	CAMHS	02:20	16
March	Ablett	Voluntary Admission	CAMHS	19:14	14
March	Heddfan	Discharged	CAMHS	12:25	15
March	Heddfan	Discharged	CAMHS	04:25	15

Out of the 9 young persons assessed 7 originated from their own home, 1 from a care home and 1 from supported living accomodation.

6 out of the 9 detentions were initiated out of hours.

The Assistant Area Directors of the CAMHS service are notified straight away if a young persons, 15 and under who is detained under a S136. Within hours the MHA office notify, out of hours the responsibility lies with the duty staff.

Average PoS hours: 10:09 hrs this is a decrease on the previous quarter figures of (12:52 hrs).

Under 18's admitted to Adult Psychiatric Wards

There were no admissions to Adult Psychiatric Wards this quarter.

The table below shows the county that the young persons originated from and where they were assessed for the period April 18 - March 19

County Originated from and where assessed.

County	East	Central	West
Wrexham	7	2	
Flintshire	4		1
Denbighshire	2	3	1
Conwy			1
Gwynedd			2
Ynys Mon			2
Out of Area			

T

Advisory Report - Forensic

Section	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019
Section 35:	0	0	0	0	0	0	0	0	0	0	0	0
Section 37:	3	2	2	3	3	3	4	4	3	2	2	2
Section 37/41:	6	6	6	6	6	6	6	7	8	7	10	10
Section 38:	0	0	0	0	0	0	0	0	0	0	0	0
Section 47:	0	0	0	0	0	0	0	0	0	0	0	0
Section 47/49:	6	6	6	5	6	6	5	5	5	5	5	5
Section 48:	0	0	0	0	0	0	0	0	0	0	0	0
Section 48/49:	0	0	1	1	1	1	1	1	1	1	0	0
Section 3:	3	4	3	3	3	3	3	3	3	3	2	2
Informal:	0	0	0	0	0	0	0	0	0	0	0	0
Total:	18	18	18	18	19	19	19	20	20	18	19	19

Ty Llywelyn Medium Secure Unit is a 25 bedded all male facility. The nature of the forensic sections does not always generate rapid activity.

There are times when section 3 patients will be detained within the unit.

The unit is now fully functional and can accommodate 25 patients.

Total Transfers for the Quarter

	Jan 2019	Feb 2019	Mar 2019
Internal Transfers	15	13	11
External Transfers (Total)	5	6	5
External Transfers (In)	3	3	2
External Transfers (Out)	2	3	3

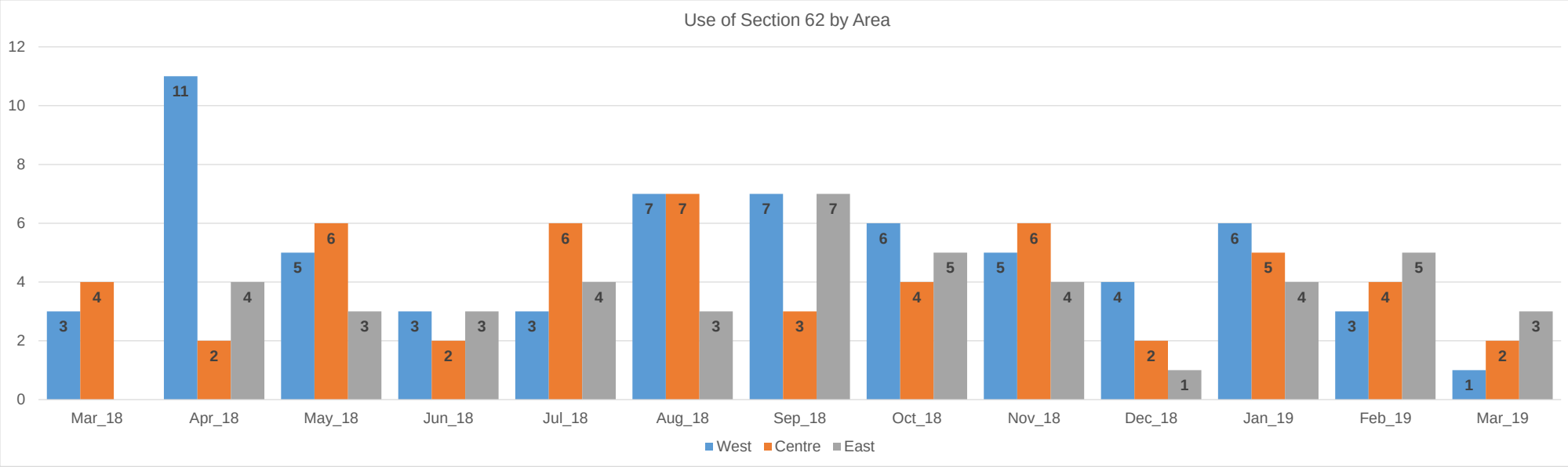
Internal Transfers
This data only includes detained patient transfers between BCU facilities, including the transfer of rehab patients which will be part of their patient pathway.

External Transfers
This data only includes detained patient transfers both in and out of BCU facilities. The majority will be facilities in England and will also include any complex cases requiring specialist service. Those repatriated are returning to their home area or transferring in for specialised care.

The table details IN - where the patient has come from and their local area and OUT where the patient has gone to.

Month	Transfers In
Jan_19	Denbigh Infirmary (Denbighshire)
Jan_19	Aintree Hospital (Flintshire)
Jan_19	CoCH (Flintshire)
Feb_19	Ty Grosvenor (Wrexham)
Feb_19	Ashworth (Denbighshire)
Feb_19	Tan Y Castell (Wrexham)
Mar_19	trans in from Maudsley (Gwynedd)
Mar_19	Newhall (Wrexham)

Month	Transfers Out
Jan_19	New Hall (Gwynedd)
Jan_19	Back to HMP Berwyn (Repatriated)
Feb_19	St Mary's Warrington (Wrexham)
Feb_19	Transferred to Hereford (Repatriated)
Feb_19	John Moore Hospital, Oxford (Repatriated)
Mar_19	External Transfer Woking (Gwynedd)
Mar_19	Ty Grosvenor (Flintshire)
Mar_19	Ty Grosvenor (Wrexham)

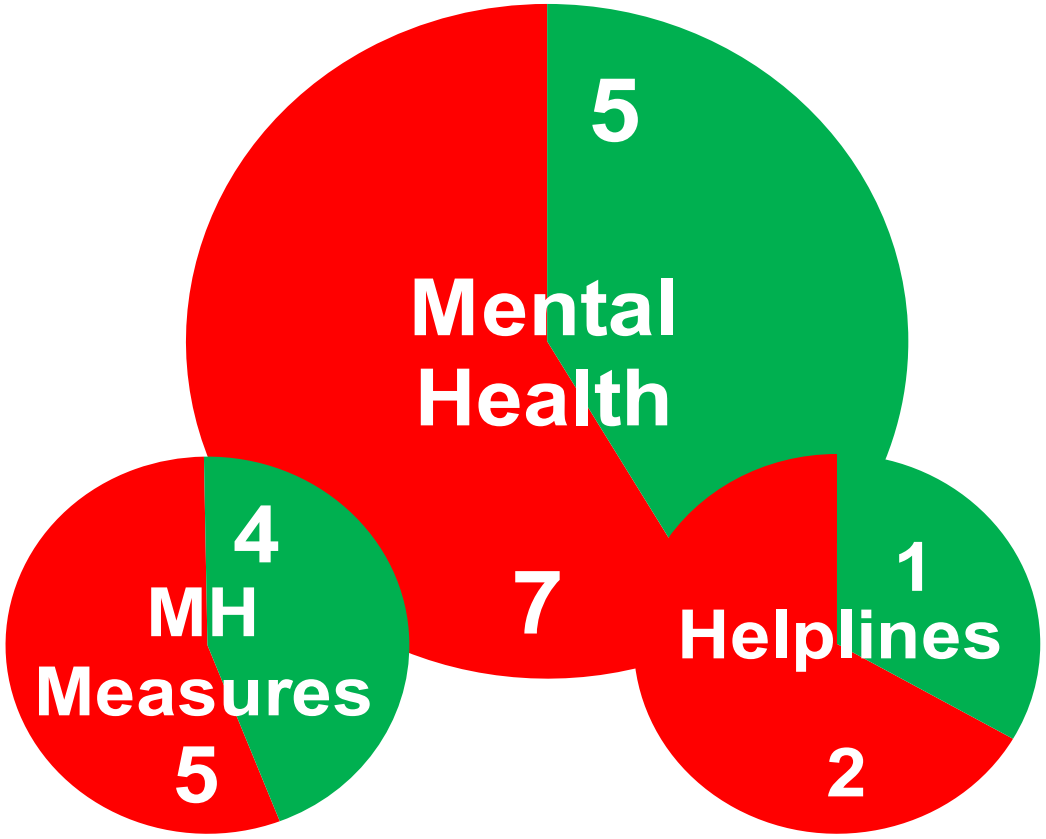


Monitoring of section 62 is a requirement of the Code of Practice (25.38).

Reason for S62 use:
Medication changes
Patient no longer able to give consent to treatment or refusing consent
ECT
Awaiting a Second Opinion Appointed Doctor (SOAD) to arrive and three month consent to treatment has expired.

Chapter 4 - Summary

Mental Health



Measure	Status	(Target)
MHM1a - Assessments within 28 Days	75.70%	>= 80%
MHM1b - Therapy within 28 Days	68.00%	>= 80%
MHM1a - Assessments within 28 Days (Adult)	75.70%	>= 80%
MHM1b - Therapy within 28 Days (Adult)	66.30%	>= 80%
MHM1a - Assessments within 28 Days (CMAHS)	75.20%	>= 80%
MHM1b - Therapy within 28 Days (CAMHS)	80.90%	>= 80%
MHM2 - Care Treatment Plans (CTP)	90.40%	>= 95%
MHM3 - Copy of Agreed plan within 10 Days	100%	100%
Advocacy Arrangements	100%	100%
Helplines: CALL	210.5	Improve
Helplines: DAN	37.8	Improve
Helplines: Dementia	8.0	Improve

Integrated Quality and Performance Report

Quality, Safety & Experience Committee Version

March 2019

Chapter 4 – Mental Health

Assessment / Therapy within 28 days (Adult)

LM 074A	% of assessment by the LPMHSS undertaken within 28 days of the date of referral: Adult	Target >= 80%	Plan	Mar-19	75.70%	Wales Benchmark	N/A	Executive Lead	Andy Roach	Status	↑	Months in Exception	6+
LM 075A	% of therapeutic interventions started within 28 days following an assessment by LPMHSS: Adult	Target >= 80%	Plan	Mar-19	66.30%	Wales Benchmark	N/A	Executive Lead	Andy Roach	Status	↑	Months in Exception	6+

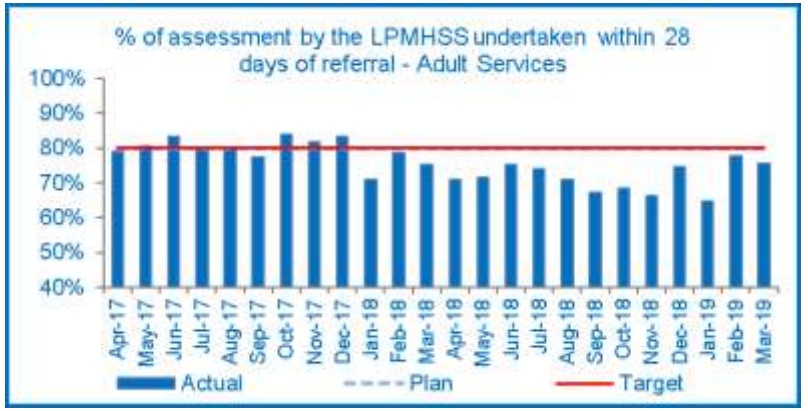
Actions: Patients are treated in turn has been widely adopted which has impacted on performance and is clinically the right action for patients

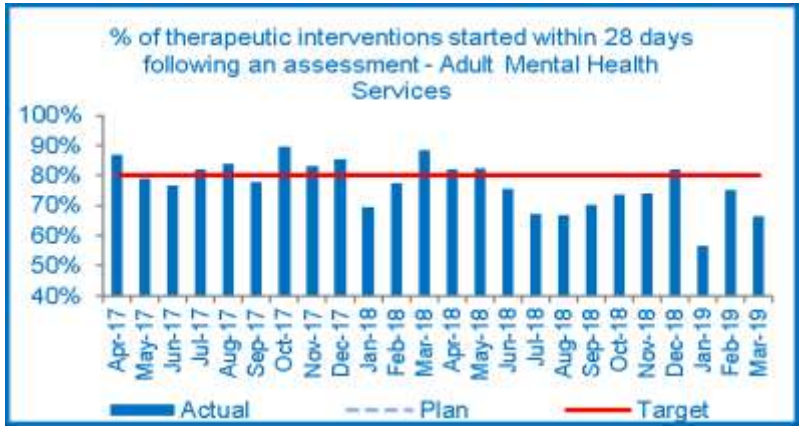
- Timely weekly reporting direct to teams
- MHM Lead(s) supporting allocated area to increase focus on specific issues / actions plan
- Regular and timely data cleansing & validation
- Closer monitoring & scrutiny of referral activity
- Increased Senior Manager focus & support
- Clinical & Social care staff deployed to focus on areas performing below target
- Exploring other opportunities to respond to demand
- STR workers are now in post and working through the interventions backlog identifying patients who still require interventions

Outcomes: Further education

- Correct & validated information
- Teams timely informed and engaged
- Decreased waiting times
- Recruitment

Timelines: Whilst the Division expects to meet the target, the deep dive interventions in relation to the percentage of patients who are assessed and discharged with no therapeutic intervention; means the solution to target achievement is a complete service transformation for this identified group. Timescales will be agreed dependant on pilot opportunities with Primary Care. The Division have twinned with Cardiff & Vale who have already progressed this approach.





Integrated Quality and Performance Report

Quality, Safety & Experience Committee Version

March 2019

Chapter 4 – Mental Health

Assessment/ Therapy within 28 days (CAMHS)

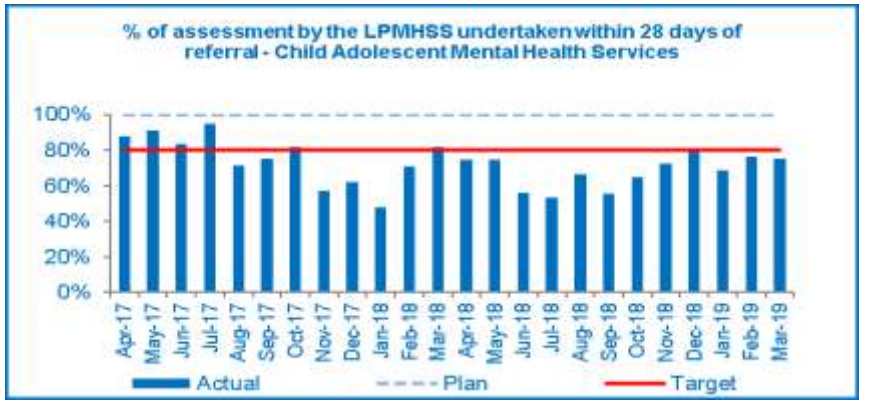
LM		Target	Plan			Wales		Executive		Status	Months in	
074B	% of assessment by the LPMHSS undertaken within 28 days of the date of referral: CAMHS	>= 80%		Mar-19	75.20%	Benchmark	N/A	Lead	Andy Roach	↑	Exception	6+
075B	% of therapeutic interventions started within 28 days following an assessment by LPMHSS: CAMHS	>= 80%		Mar-19	80.90%	Benchmark	N/A	Lead	Andy Roach	↑	Exception	6+

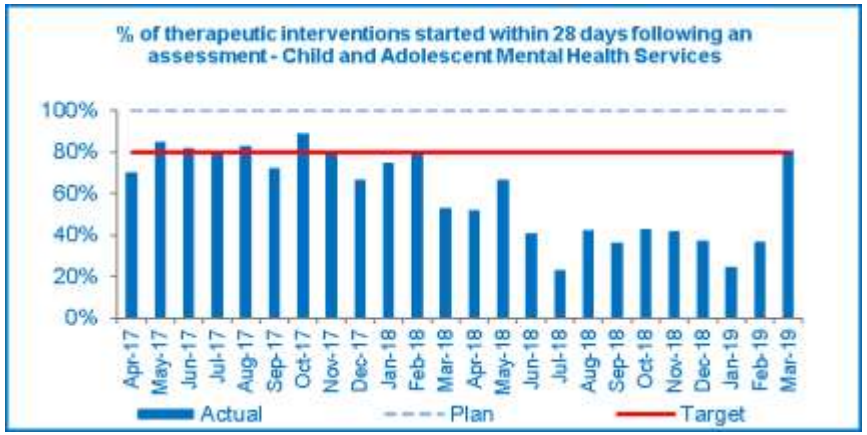
Actions:

- Weekly demand and capacity meetings being held.
- All urgent referrals are assessed within 12 – 24 hours, target is 48 hours.
- Recruitment to vacancies including reconfiguring the workforce with WOD support to create different posts
- Management of long term sickness due to serious illness in central area
- Trajectories produced for each team
- Non-recurrent funding secured with agency staff appointed across the teams
- Funding secured as part of Local Authority Crisis bid
- Recurrent Psychological Therapies funding secured – training being arranged
- Refresh of Crisis bid to be undertaken and submitted to Welsh Government for 2019/20 funding

Timelines Based on current demand and current/known capacity:

- West: Assessment targets will be maintained. Therapy targets will be met in April 2019
- Central: Assessment targets and Therapy targets will require recruitment to the vacancies, cover for sickness and an additional investment of 6 WTE to meet the current demand during 2019.
- East: Assessment targets will be maintained, Therapy targets will be met in March 2019. Forecasts assume no significant increases in demand or reduction in capacity.





Integrated Quality and Performance Report

Quality, Safety & Experience Committee Version

March 2019

Chapter 4 – Mental Health Care Treatment Plan

DFM 085	% of LHB residents (all ages) to have a valid CTP completed at the end of each month	Target >= 90%	Plan 89.7%	Mar-19	90.40%	Wales Benchmark	5th	Executive Lead	Andy Roach	Status	↑	Months in Exception	6+

Actions:

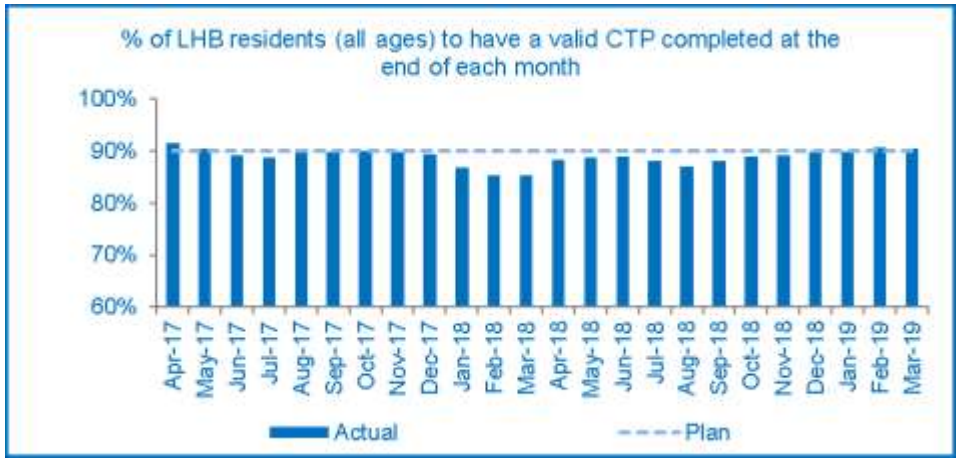
Detailed & timely reports disseminated to teams and individual care coordinators.
The Mental Health Measure Leads are aligned to local areas to improve performance and overall quality of services to patients.
Regular data cleansing & caseload validation
Close and regular monitoring of activity and compliance rates
Developed and implemented local action plans to improve targets.

Outcomes

Further education
Correct & validated information
Teams informed and engaged

Timelines

With sustained focus, the Division expects to be back on track Q1.



Chapter 4 – Mental Health Helplines

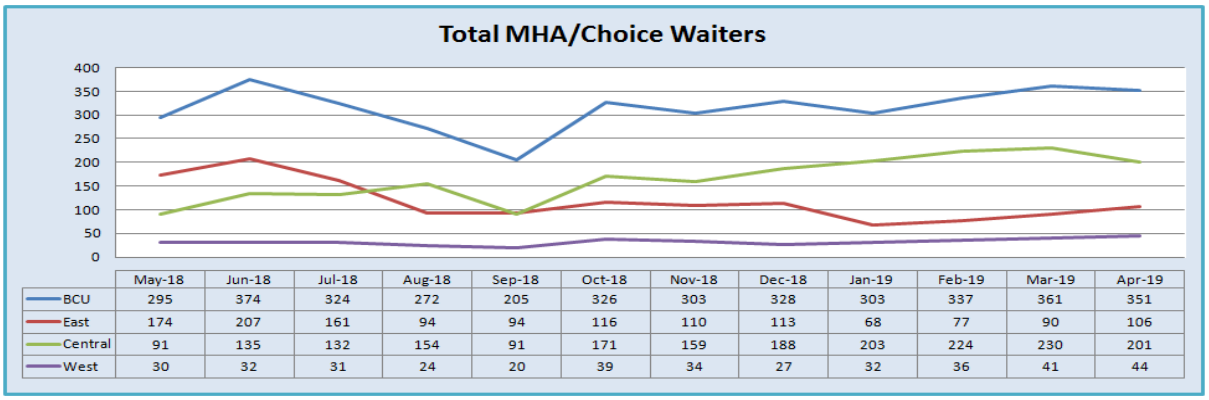
DFM 082	Number of mental health calls to the 'CALL' helpline	Target Improve	Plan Improve	Qtr3 18/19	210.5	Wales Benchmark	2nd	Executive Lead	Andy Roach	Status	↓	Months in Exception	6+
DFM 083	Number of calls relating to dementia to the 'Dementia' helpline	Target Improve	Plan Improve	Qtr3 18/19	8.00	Wales Benchmark	1st	Executive Lead	Andy Roach	Status	↓	Months in Exception	6+
DFM 084	Number of calls relating to drugs and alcohol to the 'DAN 24/7' helpline	Target Improve	Plan Improve	Qtr3 18/19	37.80	Wales Benchmark	1st	Executive Lead	Andy Roach	Status	↑	Months in Exception	6+

A variety of Promotional events have occurred during Q3 to increase the usage of the helplines. This has included attendance at Health awareness events, use of social media, working with Capital FM radio and Filming with ITV Wales in a barber shop (LL19 Barbers) about their work with men and mental health and the ICAN work. A new shift manager has also been appointed , so more events can be attended thus increasing awareness of all the helplines and the DAN mobile van, which has a digital advertisement of the DAN & C.A.L.L. Helplines travels throughout various locations in Wales to promote the helpline services

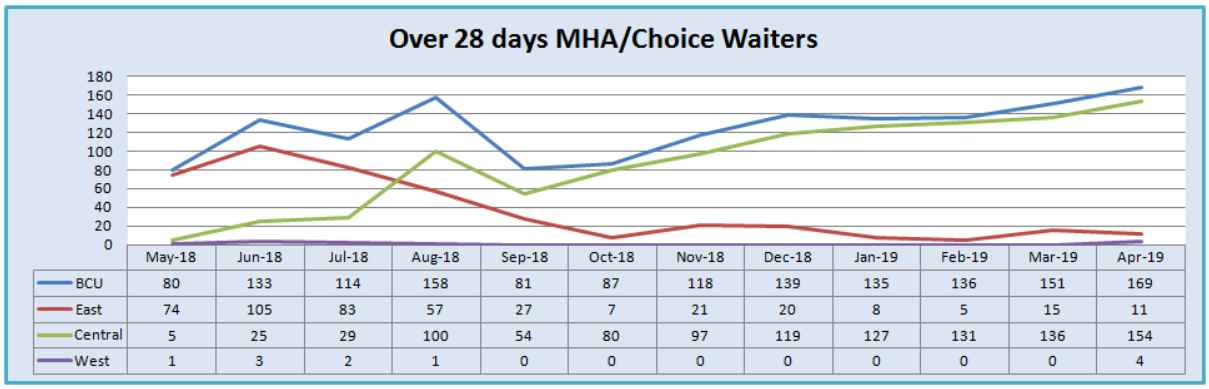
CAMHs Services update – MHA Committee June 2019

Assessment

There were 351 children and young people waiting for a Mental Health Assessment (Choice Appointment) as at the end of April 2019, of which 136 had been waiting more than 169 days. The longest wait for one child stood at 18 weeks in Central Area.

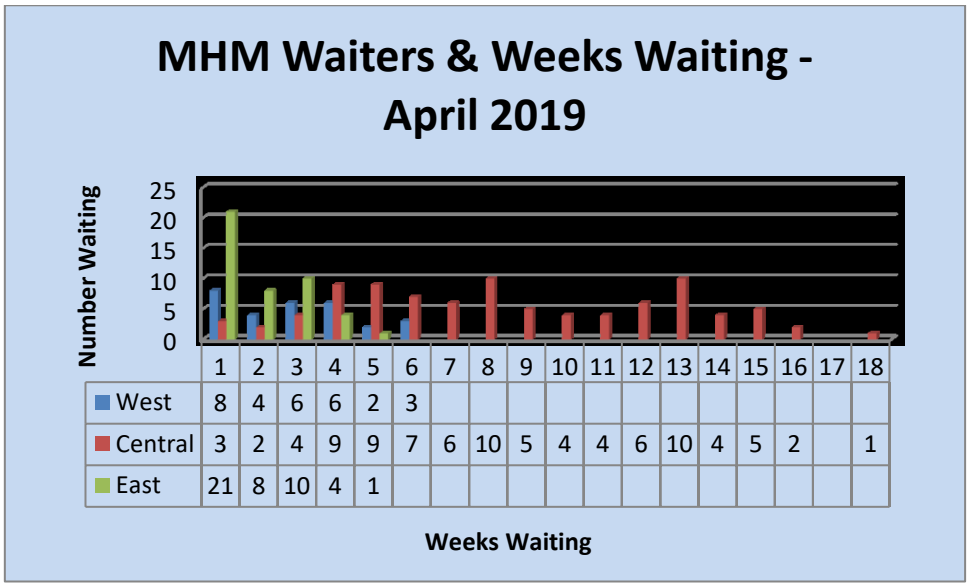


	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
BCU	295	374	324	272	205	326	303	328	303	337	361	351
East	174	207	161	94	94	116	110	113	68	77	90	106
Central	91	135	132	154	91	171	159	188	203	224	230	201
West	30	32	31	24	20	39	34	27	32	36	41	44



	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
BCU	80	133	114	158	81	87	118	139	135	136	151	169
East	74	105	83	57	27	7	21	20	8	5	15	11
Central	5	25	29	100	54	80	97	119	127	131	136	154
West	1	3	2	1	0	0	0	0	0	0	0	4

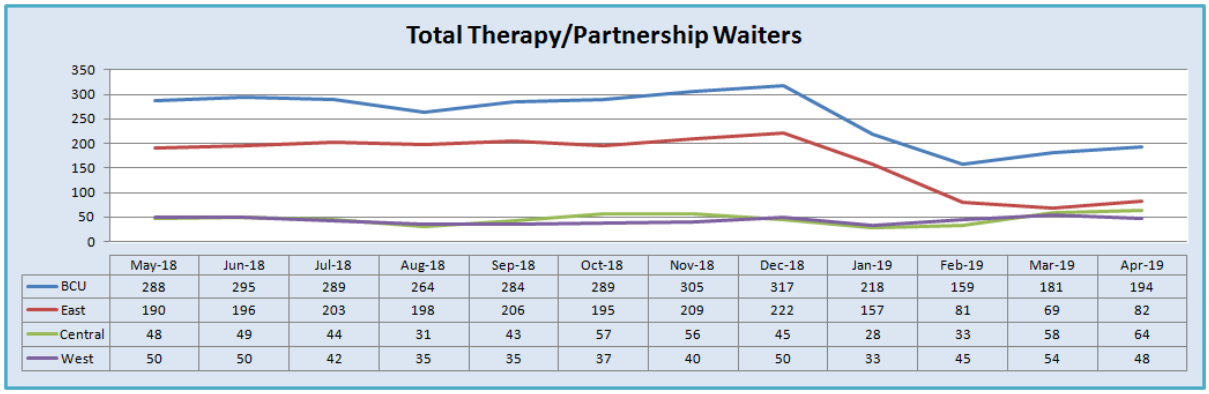
The graph below details the numbers waiting and weeks waiting for an assessment, for those children and young people that are eligible under the Mental Health Measure as at the end of April 2019.



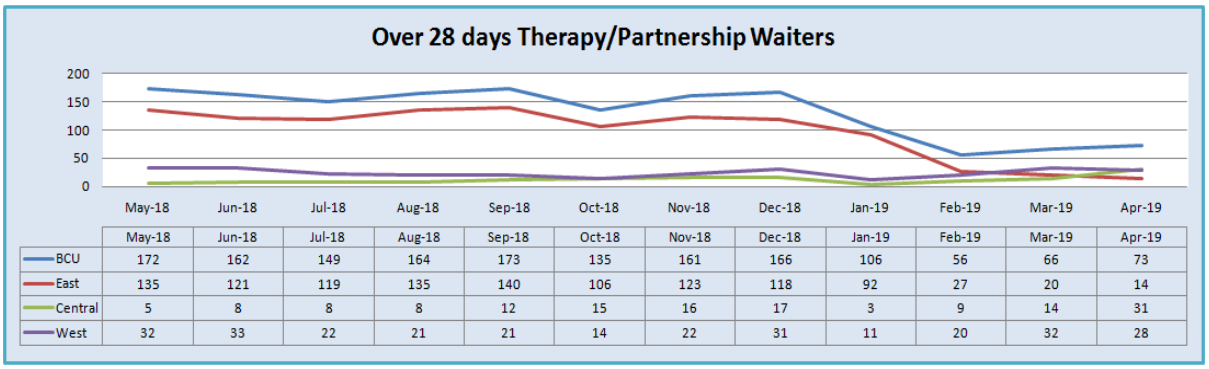
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
West	8	4	6	6	2	3												
Central	3	2	4	9	9	7	6	10	5	4	4	6	10	4	5	2		1
East	21	8	10	4	1													

Therapy

There were 194 children and young people waiting for a Therapy appointment (Partnership) as at the end of April 2019, of which 73 had been waiting more than 28 days. The longest wait stood at 18 weeks.



	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
BCU	288	295	289	264	284	289	305	317	218	159	181	194
East	190	196	203	198	206	195	209	222	157	81	69	82
Central	48	49	44	31	43	57	56	45	28	33	58	64
West	50	50	42	35	35	37	40	50	33	45	54	48



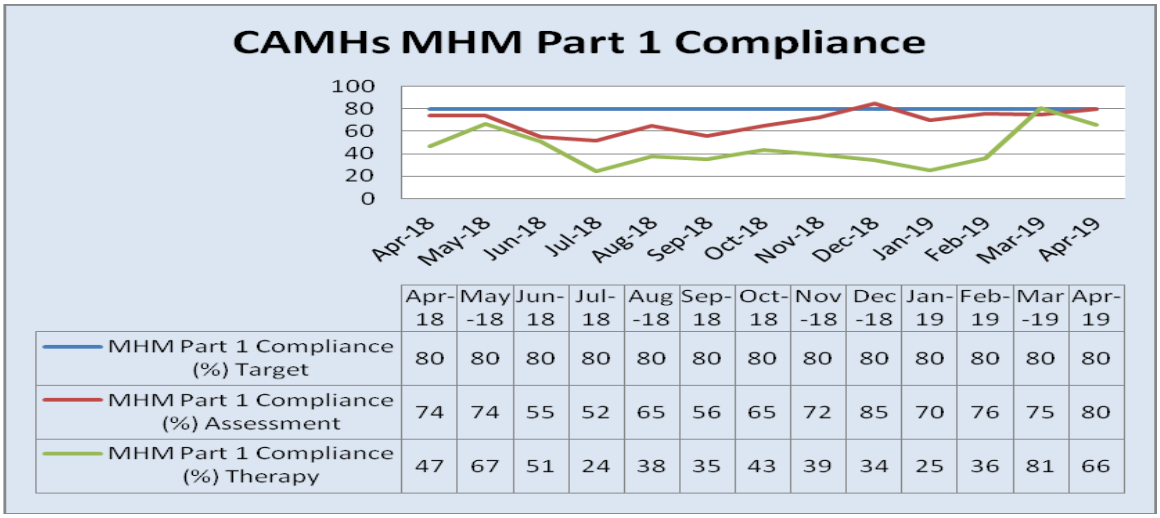
	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
BCU	172	162	149	164	173	135	161	166	106	56	66	73
East	135	121	119	135	140	106	123	118	92	27	20	14
Central	5	8	8	8	12	15	16	17	3	9	14	31
West	32	33	22	21	21	14	22	31	11	20	32	28

MHM Part 1 targets

Delivery against the 80% targets regionally in April was as follows:

Assessments – 80% Therapeutic interventions – 66%

The graph below provides details of MHM Part 1 compliance regionally for assessments and therapy:



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
MHM Part 1 Compliance (%) Target	80	80	80	80	80	80	80	80	80	80	80	80	80
MHM Part 1 Compliance (%) Assessment	74	74	55	52	65	56	65	72	85	70	76	75	80
MHM Part 1 Compliance (%) Therapy	47	67	51	24	38	35	43	39	34	25	36	81	66

Our profile to achieve the MHM Part 1 80% target for assessment is September 2019 and for intervention it is October.

Domain	Delivery Measure	Target	Reporting Frequency	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
TIMELY CARE	The percentage of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral CAMHS	80%	M	49%	48%	52%	60%	67%	88%	91%	91%	92%	100%	100%	100%
TIMELY CARE	The percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS CAMHS	80%	M	66%	68%	69%	72%	73%	73%	85%	94%	95%	95%	96%	96%

MHM Part 2

The table below details the number of patients receiving secondary care in each of the teams and of those how many have a valid CTP. The overall position in April is that 88%. Work is ongoing including review and monitoring of compliance within the weekly performance meetings to ensure that the target is met and maintained in the coming months.

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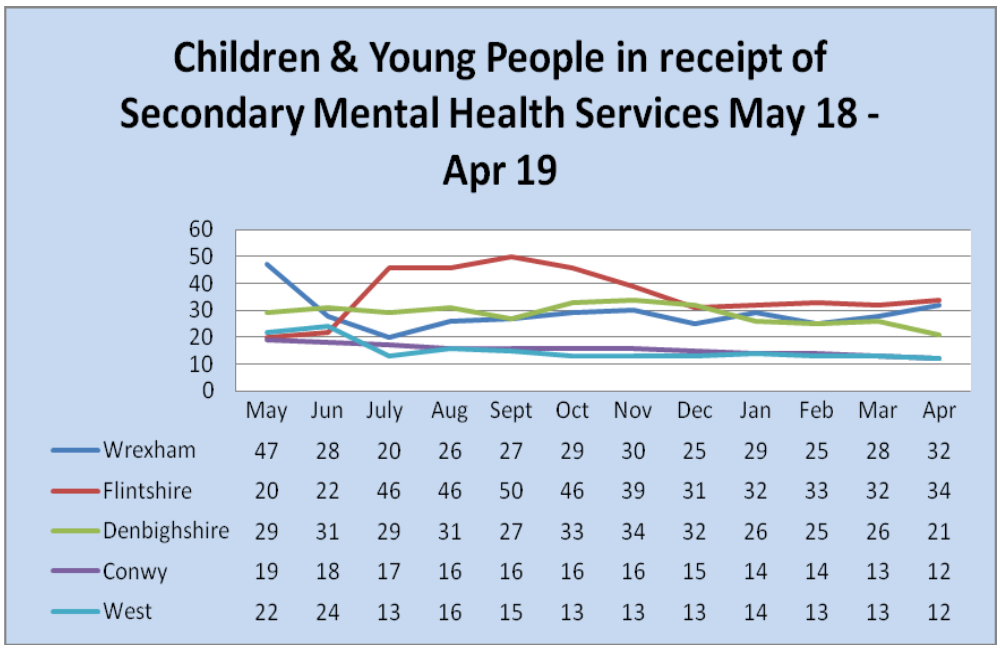
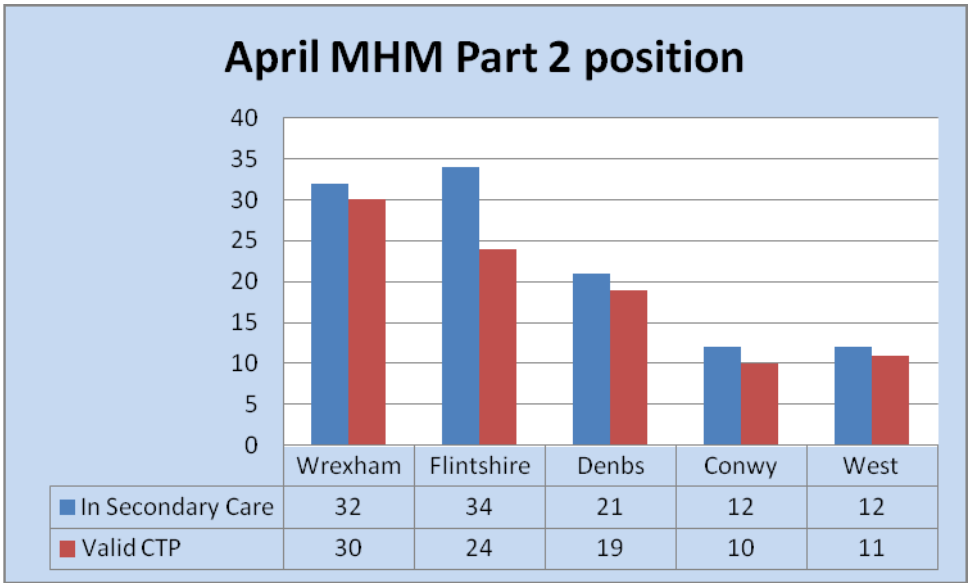
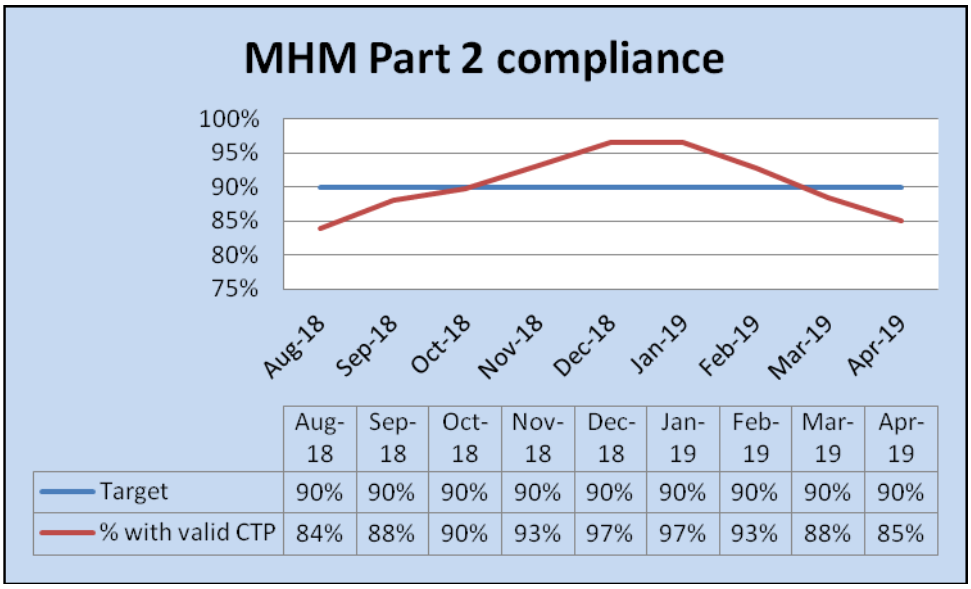






Section 136 and Children placed on an adult ward

The table below details Section 136 Assessments undertaken and admissions to adult wards. There was one S136 undertaken during April 2019. The number of S136 assessments significantly reduced in 2018/19 from the previous year.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
S136 Assessments Undertaken													
2014-15	1	1	2	1	1	4	4	3	3	0	1	2	23
2015-16	2	0	7	1	0	0	2	1	2	1	0	3	19
2016-17	4	7	1	2	4	4	6	3	3	1	3	4	42
2017-18	12	6	3	7	2	3	3	5	2	2	2	2	49
2018-19	0	2	3	3	0	3	4	0	1	3	0	6	25
2019-20	1												1
Admissions to Adult Ward													
2014-15	0	1	0	0	1	1	0	0	1	0	0	0	4
2015-16	0	0	1	0	0	2	0	0	1	0	0	5	9
2016-17	0	1	0	0	0	1	0	0	0	0	1	0	3
2017-18	0	0	0	0	0	0	0	0	0	1	0	0	1
2018-19	1	0	0	0	0	0	0	0	0	0	0	0	1
2019-20	0												0

Summary of work in progress

Bids are being finalised for submission to Welsh Government in application of the Service Improvement funding recently identified. Funding has been identified to manage demand for CAMHs in order to meet the Mental Health Measure targets and demand to meet the new Neurodevelopmental waiting list targets, Crisis Services, Psychological Therapies, Eating Disorders and Perinatal mental health.

Formal approval of a bid submitted to Welsh Government in partnership with the six Local Authorities has been confirmed, the funding will support Looked after Children and those on the Edge of Care. A Programme Manager has been appointed with further recruitment for Project Managers in each Area underway.

Training for CBT, EMDR and IPT is being arranged for clinicians from all teams following receipt of Psychological Therapies funding. Additional Family Therapists for each Area will also be recruited utilising this funding.

The report from Miller Research is being finalised and shared with the senior management team to validate the content which will then be shared with the CAMHS Clinical Advisory Group, the recommendations will inform the discussions that are underway regarding the Service User model being developed.

Delivery Unit (DU) visits took place across the teams in March and April with the formal report due to the Health Board in June/July. Informal feedback received from the DU at the end of the visit was positive with no major concerns. Specific positive feedback was received in relation to the integrated Primary/Secondary Care model in BCU CAMHs and in relation to how well the CAPA model has been embedded within all teams.

Betsi Cadwaladr University Health Board

Community CAMHS (Tier 3) Deep Dive Report

1. Purpose

As a result of on-going performance concerns, specifically not meeting the Mental Health Measure targets for assessment and therapy the Board requested a deep dive into Community CAMHS to understand the issues leading to not meeting the targets and design actions for improvement. The deep dive took place on 9.1.19.

This report summarises the initial findings from the Deep Dive into the CAMHS service and recommendations for addressing the current demand and capacity gap and reflects the feedback received from the Delivery Unit following their review in April 2019.

During 2018 – 19 the Delivery Unit undertook a comprehensive All Wales review of CAMHS Part 1 of the Mental Health Measure, the review of BCUHB was undertaken during the first 2 weeks of April 2019.

2. Background

The current service model was developed through close collaborative working across CAMHS in North Wales; aiming to reduce variation, simplify and increase access, and deliver the specific requirements of the Mental Health (Wales) Measure 2010 for children and young people.

Commitment to treating all children equally, regardless of who refers, long predates the formal introduction of the Mental Health (Wales) Measure in 2012. This is based on the evidence that the source of referral does not predict acuity with some of the most high risk young people being detected and supported to access the service by professionals in other settings who know them well.

The North Wales service model reiterated and consolidated this commitment, and considerably reduced variation in several other aspects of service delivery; all of which was supported by the then Clinical Programme Group and the Mental Health Measure Project Board within BCUHB and at a national level also.

Specialist CAMHS has had a longstanding approach – over 20 years – of moving more towards an earlier and preventive intervention approach, focused on four main activities each delivered to build capacity and capability in front line services – consultation, training, joint collaborative and partnership working and universal and targeted interventions in community settings.

2.1 The Legislative Framework: the Mental Health (Wales) Measure 2010

The Mental Health (Wales) Measure 2010 deals with accessing and receiving care and interventions within primary and secondary mental health services:

Part 1 seeks to ensure more mental health services are available within primary care.
Part 2 gives all people who receive secondary mental health services the right to have a Care and Treatment Plan.

Part 3 gives all adults who are discharged from secondary mental health services the right to refer themselves back to those services.
Part 4 offers every in-patient access to the help of an independent mental health advocate.

Part 1 of the Measure seeks to strengthen the role of primary care in delivering effective mental health care and treatment, and sets out the requirement that local primary mental health support services will be provided throughout Wales. The Measure places statutory duties on all Local Health Boards (LHBs) and Local Authorities in Wales to have joint schemes for the provision of local primary mental health support services. LHBs and Local Authorities will deliver such services in partnership, and it is expected that the services will, in the main, operate within or alongside existing GP practices.

The Mental Health Measure **(statutory)** requirements for **Local Primary Mental Support Services** are:

a) The carrying out of primary mental health assessments in accordance with Part 1 of the Measure;
b) The provision for individuals of local primary mental health treatment (interventions), where required, following assessment;
c) The making of referrals to other services which might improve or prevent a deterioration in the individual's mental health;
d) The provision of information and advice for individuals and their carers about other services that are available to them; and
e) Information, advice and other assistance for primary care providers (GPs and practice staff) so as to improve the services related to mental health which they provide or arrange.

2.2 Key features of the North Wales Specialist Community CAMHS Service Model

2.2.1 A whole system approach

North Wales Community CAMHS embraces a whole system approach, designed to reduce unnecessary variation, increase timely access to the right help at the right time, reduce the number of gaps and transitions between different parts of the service, and manage risk. The approach also allows for assessment of and intervention within the wider systems around a child, not presuming that what is being presented is always *because* the problem lies within the child. The role of the service is to:

- Identify and respond in primary care to the needs of children and young people who present with mental health disorders, and deliver evidence based assessment and interventions where needed in primary and secondary care.
- Support children, young people and families within their systems, by increasing awareness of mental health, knowledge about what helps, and where to go if self-help is not sufficient.
- Work with the wider front line universal workforce and associated systems to increase capacity for managing emerging mental health problems by

introducing evidence based programmes alongside colleagues in partner agencies and in wider health services.

- It is important to note that not all presentations of distress and altered mood are due to a mental health illness or disorder and that environmental factors such as parenting, schooling and the family system can also be an area of focus to help young people improve their emotional wellbeing.

2.2.2 A long term vision

Demand on services has increased significantly as more people are seeking help. BCUHB has seen a 19% increase in accepted referrals, with a total of 4,798 referrals accepted YTD (end of Feb 2019). Specialist CAMHS cannot and should not meet all the need alone. By successfully integrating the primary and secondary care functions within specialist community CAMHS, capacity can be 'flexed' to meet gaps in different parts of the system. The vision has always been to reach further 'upstream' to place additional mental health expertise into front line services, supporting GPs, schools and targeted services such as Children's Social Services and Youth Justice in their day to day work; supporting others to quickly recognise what does and doesn't need to be referred into specialist mental health services whilst also building understanding, capability and capacity in non-mental health roles. Examples of exemplary practice happening across North Wales are; School Hubs (West), Family Wellbeing Practitioner in Primary Care (Denbighshire), Friends Resilience (Wrexham), Managing Self Harm in Education (North Wales), ADTRAC (North Wales), and CAMHS Practitioners based in youth justice settings across the region.

Upstream and targeted interventions increase access to help and support mental health and wellbeing at an earlier stage, reaching children and young people closer to home and in familiar environments; combining resources and expertise to provide flexible care that fits around children's needs (Children's Commissioner, March 2019). This vision can only be realised when core services are adequately funded and staff with the right levels of skill are in post.

2.2.3 One access route for all aspects of help from Specialist CAMHS

Access is inclusive, and simple. The Specialist CAMHS Single Points of Access were introduced at a Local Authority level under the Mental Health (Wales) Measure (2010) to provide a single point for accessing all forms of help from Specialist CAMHS for children, young people and their families, and for professionals. Its aim is to improve access to specialist services for those who need them most, and to quickly offer advice to referrers at the time of the request for those who do not need specialist help. The CAMHS-SPoAs do not accept requests directly from young people or parents at this stage.

All professionals working with or offering services to children, young people or their families can contact their local Specialist CAMHS-SpoA. This includes professionals from primary health care settings (GPs and practice staff), and any multi-agency service working with children, young people and families, because:

a) Those who see the child on a frequent basis are often in the best position to notice change, describe in detail what is happening and provide ongoing support and intervention in consultation with CAMHS.
b) Managing demand at the front door allows quicker identification and response for children and young people who have mental health disorders and severe and/or complex mental health and require specialist input. Risk is identified and managed and urgent help is delivered where required. Children are not therefore sitting on waiting lists without first having their needs considered in collaboration with referrers.
c) Not all children and young people need specialist help, this may not be clear to referrers, and discussion about concerns is welcomed and actively encouraged. CAMHS-SPoAs also help to identify alternative sources of help for those who do not need specialist input.
d) Children and young people frequently tell us that they don't want to tell their story to lots of different people before being offered help and early discussion between professionals can reduce the likelihood of a child or young person experiencing unnecessary or multiple assessments.

2.2.4 Integrated primary and secondary care specialist functions

There are two important principles at the heart of delivering effective CAMHS - stepped' and 'matched' care. 'Stepped care' is a system of delivering and monitoring interventions so that the most effective but least resource intensive intervention is delivered to people first. The most useful models of stepped care allow for individual need to be 'matched' to an appropriate level of service to meet that need. This could mean that individuals with mild to moderate mental health problems are matched to less specialist or 'lower-intensity' interventions in primary care and people with more severe or multi-faceted mental health problems are matched to more intense interventions within secondary care, with clear pathways to 'step up' and 'step down' according to need.

Effective implementation of stepped and matched care requires intervention at all levels and emphasises the need to develop a whole systems approach designed to enable effective connection between primary health care, social care services, schools and Specialist CAMHS. A system that successfully combines these elements requires a safe, fast and effective clinical decision-making function to ensure that the Specialist CAMHS workforce gets to intervene directly where needed, as quickly as possible; and that children, young people and families who do not need Specialist CAMHS are advised and where appropriate signposted accordingly. It is important to minimise waiting times whilst at the same time ensuring that nobody is inappropriately denied the intervention they require. In North Wales, further development of the whole system approach with and alongside partner agencies is an important component of the vision.

Evidence suggests that where stepped and matched care are both in place, the demand on a service is kept to a minimum whilst still achieving good clinical outcomes. It is very difficult if not impossible to deliver relatively seamless stepped and matched care in specialist CAMHS if the primary and secondary care functions are separate, as families would have to be referred between different levels of service, wait to be seen by different staff and repeat their stories numerous times.

2.2.5 Service Delivery

Services in BCUHB are delivered on an area basis, each area serving two co-terminus Local Authority areas. The same service model is delivered in all areas, tailored to the needs of the local population and taking into account the multi-agency landscape.

The Choice and Partnership approach has been implemented in some North Wales teams for a number of years however since the beginning of 2018 all CAMHS teams have adopted the model in line with national recommendations. The model is used in CAMHS teams across the world. The Choice and Partnership Approach CAPA is a continuous service improvement model that combines personalised care and collaborative practice with service users to enhance effectiveness, leadership, skills modelling and demand and capacity management. The model is based on lean methodology and the seven helpful habits that include handling demand, process mapping, flow management and use of care bundles to reduce variation. The model is in keeping with Prudent Healthcare Principles and its recovery and resilience based approach facilitates service delivery in keeping with the duties laid out under the Mental Health Measure Wales (2010). The model comes with tools to measure adherence and all North Wales Teams show high and improving levels of adherence as model implementation progresses.

2.2.6 Mental Health Measure Performance Targets

Under the Mental Health Measure there are 3 targets monitored by Welsh Government and the board.

% of assessment by CAMHS undertaken within 28 days of the date of referral; target 80%

% of therapeutic interventions started within 28 days following an assessment; target 80%

% of patients receiving secondary care who have a valid CTP; target 90%

2.2.7 Concurrent Reviews

During 2018 – 19 a number of significant reviews are taking place by Welsh Government of all Health Boards, the findings of which will contribute to the Deep Dive being undertaken.

- T4CYP visit December 2018 – review of implementation of the T4CYP strategy with a particular focus on the mental health crisis pathway, report received 5th April 2019. A separate report will be provided in response.

- WG Delivery Unit – All Wales Assurance Review of Primary Care CAMHS. To determine the level of growth in CAMHS following commencement of the Measure and WG investment; to evaluate whether there is a demand and capacity mismatch; to determine variances in service performance in Wales.

- CAMHS Network are undertaking stakeholder engagement workshops focussing on the successes and challenges of all stakeholders in Primary Care CAMHS within each Health Board footfall. To identify the achievements of co-working as well as trying to problem solve on some of the challenges.

3 Deep Dive:

3.1 Process

The deep dive considered:

a) What works well within the present service
b) What process differences exist between geographically based teams
c) The empirical data relating to service demand , capacity and patient flow
d) Problem solving and opportunities for improvement.

The event was well attended with good representation from the service clinicians, managers and administrators. A small number of attendees were from outside of BCU representing social services.

3.2 General Findings

1. Increase in Demand against last year - CAMHS referrals including self-harm risk assessments up by 19%, and an increase of 56% in Neurodevelopment referrals (YTD end of Feb 2019 position.) The service accepts referrals from professionals who work with children and young people. The service works in an integrated manner across primary and secondary mental health care. Referrals are mainly received from primary health care, education and social services.
2. The process map shows more similarities between the three geographical areas than differences. Minor variations are related to the stage of CAPA implementation with teams working to increased adherence through regular measurement and continuous service improvement reviews.
3. The services across all three geographical areas are deficit of good clinical and managerial IT systems to support efficient use of resources
4. Performance against the National Targets for access to CAMHS services has been variable and does not consistently meet the requirements for patients to be assessed within 28 days of referral or to commence treatment within 28days of assessment in all Areas.
5. Performance in December 2018 was 79.65% from GP referral to assessment with 28 days against the target of 80%. However only 38.3% of patients had therapeutic intervention started within 28days of assessment (target 80%)
6. Performance by March 2019 saw a deterioration in assessment waits with 75% from GP referral to assessment with 28 days, however 81% of patients had therapeutic intervention started within 28days of assessment (target 80%)
7. Performance against the care and treatment planning is good, with delivery against the 90% target usually achieved.

3.3 Performance information:

3.3.1 NHS Benchmarking

NHS Benchmarking should be the start of the conversation, this annual report measures CAMHS activity, resources and performance across the UK. There are well understood and acknowledged difficulties with the data findings due to the many variables in systems and service models between Wales and England, and within Wales, so much so that the DU have not been able to use it for their All Wales Review. Both the validity and triangulation of the data is problematic, the definitions are unclear and interpreted differently. This is due to the attempt to capture activity and resources by comparing what are clearly different service models in England and within Wales resulting in 'apples being compared with pears' using definitions that are widely considered to not meet the requirements of gathering consistent and comparable data, the KPIs used are English definitions using the I.A.P.T framework which is impossible for Wales to report against, resulting in incorrect findings being reported

However this data is public and needs to be understood, hence the narratives supporting it are critical, for example BCUHB does not capture non face to face contacts (telephone and Safeguarding multi-agency meetings) or indirect care provided through the SPoAs to practitioners working with families, some Health Boards and Trusts do, resulting in activity data being reported as low and the workforce being reported as well resourced. Our current IT infrastructure cannot facilitate this data collection. It is important to note that the workforce resource is based on our integrated service, includes Primary, Secondary and inpatient care which is not comparable with any other Health Board in Wales.

3.3.2 BCUHB

Data is collated on a monthly basis and captures see Appendix 1

1. Total Referrals
2. Number of referrals accepted into the service
3. Assessments (Choice appointments) undertaken
4. Self-harm assessments undertaken
5. Waiting numbers for all referrals – assessments and therapy
6. Longest waits and average waits
7. Performance against MHM Part 1 target of 80% to be seen within 28 days for assessment and therapy
8. Performance against MHM Part 2 of 90% validity of Care and Treatment Plans for those in Secondary Care.

3.4 Data Analyis and Recommendations

3.4.1 Acceptance of Referrals

The NHS Benchmarking information reports that nationally 77% of referrals are accepted by the service. In BCU this figure is lower at 72%, indicating a higher number of referrals not being considered to need specialist CAMHS. However even after the removal of referrals not requiring access to the service the level of referrals being accepted is still considerably higher (c65%) than the national level at 3,820 referrals accepted per 100,000 population (compared to 2320 nationally).

These NHS benchmarking referral figures include patients on neuro-developmental pathways. Referral acceptance rates excluding ASD is reduced to 3,139 per 100,000 population.

In summary according to the NHS Benchmarking the rate of referral is higher in BCU than in the majority of the UK. Within these referrals there is a larger proportion that are not accepted by the service, however the overall rate of acceptance to service remains higher than across the majority of the UK even when ND pathway referrals are excluded according to the NHS benchmarking report.

However there are a number of analysis questions to be asked, including whether these referrals include accepted for professional consultation (EIPS) and assessment or just assessment? BCUHB CAMHS offers a single point of access under agreed LPMHSS Part 1 scheme, the service accepts telephone enquiries from professionals resulting in a range of outcomes including advice, signposting, professional consultation and primary mental health assessment. These enquiries do not compare directly with referrals/requests for assessment in the traditional sense that will be received by services that do not provide the advice and signposting element directly from CAMHS under their LPMHSS.

Recommendation 1: Referral Data Collection & Analysis

- In order to fully understand the reasons for the growing demand it is necessary to consider what referrers expect from the service, the knowledge base of referrers and what alternative pathways and early interventions exist that may avert a referral to the specialist service. The findings of the CAMHS Network Stakeholder events should support this recommendation
- Further data analysis - break down of referrals that require assessment versus contact for advice and signposting, by source to understand which referrers have highest level of referrals to assist targeted training or resources.
- Triangulation of referral source rate of referral and rate of acceptance i.e. are there referrers with high levels of referral and low levels of acceptance
- A snapshot audit of referrals not accepted by the three services should be undertaken to:
  a) Consider consistency in reasons for declining referral
  b) Themes in referrer pattern not needing specialist services
  c) Themes in what service is required for the child or young person, with consideration as to whether this service currently exists

3.4.2 Variation between geographical Areas

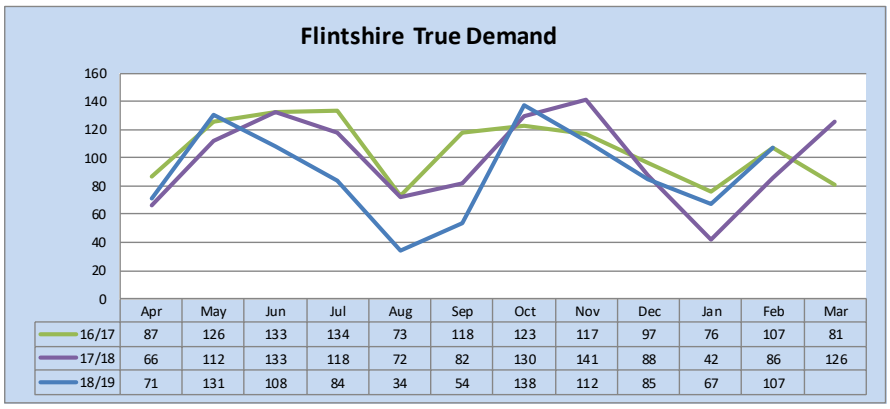
There is considerable variation in demand between the three geographical areas. This needs to be understood in relation to population health need and raises the following questions:

a) Is there evidence that population need is reflected in the variation in referral volumes shown below
b) Are patients in West accessing alternative services
c) Are the resource pan BCU allocated in line with the demand patterns i.e. is the scale of the department in East twice that available in West (assuming similar case mix).
d) Can resources be realigned to reflect areas of greatest demand?

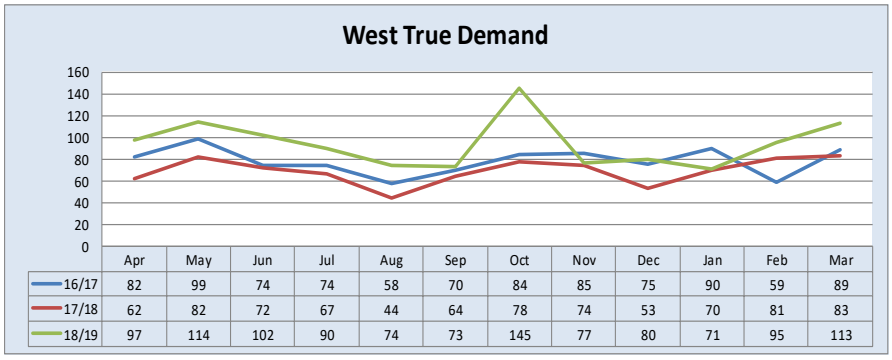
The total referrals after ROTT and monthly average for the last 3 years shows the East referrals equating to nearly 50% of the BCU realised demand:

	East			Centre			West			All CAMHS		
	16/17	17/18	18/19	16/17	17/18	18/19	16/17	17/18	18/19	16/17	17/18	18/19
Average	216	202	214	78	99	130	78	69	93	372	370	436
YTD	2,333	2,179	2,349	856	1,120	1,431	850	747	1,018	4,039	4,046	4,798
		Increase on last year			Increase on last year			Increase on last year			Increase on last year	
			8%			28%			36%			19%

Furthermore the monthly variation in referrals appears seasonal for East and Centre suggesting a higher proportion of referrals from education than in West as referrals drop over the school holidays to a greater extent than in other areas. This is most notable for Flintshire residents, although Conwy, Denbighshire and Wrexham show a similar monthly pattern (just not as extreme):



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
16/17	87	126	133	134	73	118	123	117	97	76	107	81
17/18	66	112	133	118	72	82	130	141	88	42	86	126
18/19	71	131	108	84	34	54	138	112	85	67	107	



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
16/17	82	99	74	74	58	70	84	85	75	90	59	89
17/18	62	82	72	67	44	64	78	74	53	70	81	83
18/19	97	114	102	90	74	73	145	77	80	71	95	113

Note the school time variation in referrals has a direct correlation to increase in waiting list in October each year and this increase is seen greatest in East. This was seen across Wales and across all ages.

Recommendation 2: Understand Demand

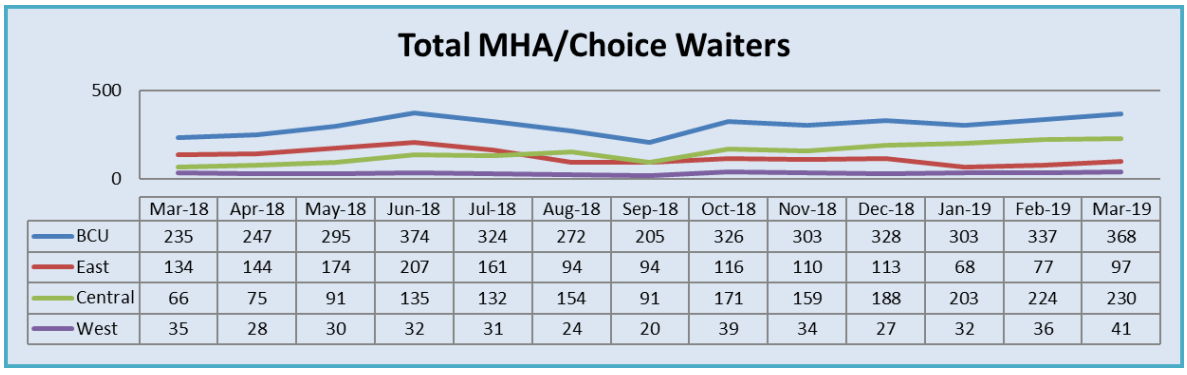
- Investigate population health need and relationship to referral patterns
- Investigate the population health needs and impact on demand
- Consider Re-alignment of resources to match geographic demand or adjust borders of demand to rebalance to demand (the latter may not be possible due to alignment with partners)
- Explore with Education impact of school terms on patterns of referral

a) Consider be given to flexibility in staffing to match term time referrals.
b) Term time working
c) Restricting leave during October
d) Temporary Workforce increases October- November

3.4.3 Activity

Activity is collated routinely for the number of assessments undertaken and the number of self-harm assessments taken. (see Appendix 1). The service has experienced difficulties in routinely capturing all activity for advice, consultation and the different therapy modalities and has therefore been unable to provide this data robustly for both local and benchmarking purposes.

The service were keen to point out the tension between managing the routine demand and the disruptive nature of unscheduled demand and support for the paediatric wards and the use of CAPA to job plan the requirements for staffing to caseload and contacts. A significant increase has been seen in the number of self - harm initial assessments being undertaken (See Appendix 1), please note this does not include follow up activity which will also have seen an increase accordingly.

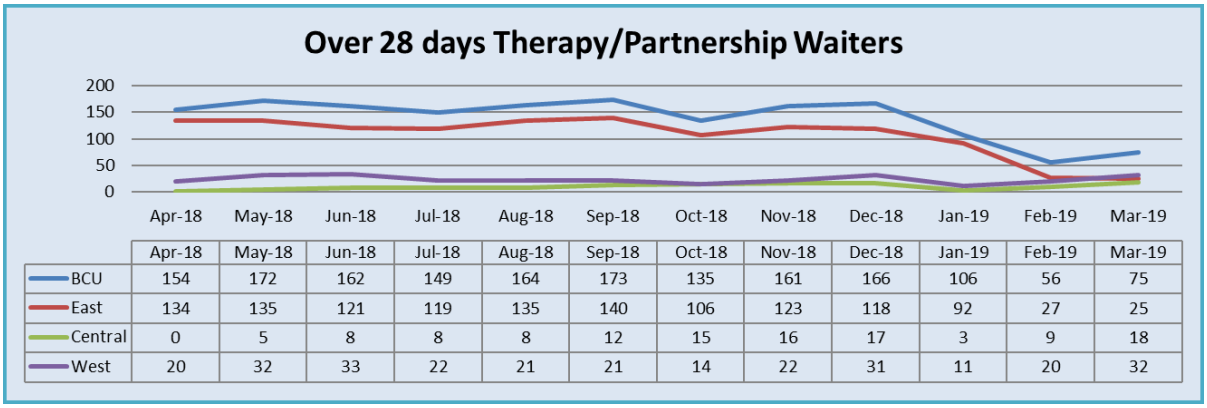


	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
BCU	235	247	295	374	324	272	205	326	303	328	303	337	368
East	134	144	174	207	161	94	94	116	110	113	68	77	97
Central	66	75	91	135	132	154	91	171	159	188	203	224	230
West	35	28	30	32	31	24	20	39	34	27	32	36	41

All three sites confirm they risk stratify patients and ensure urgent patients are seen promptly, adversely affecting the routine wait times.

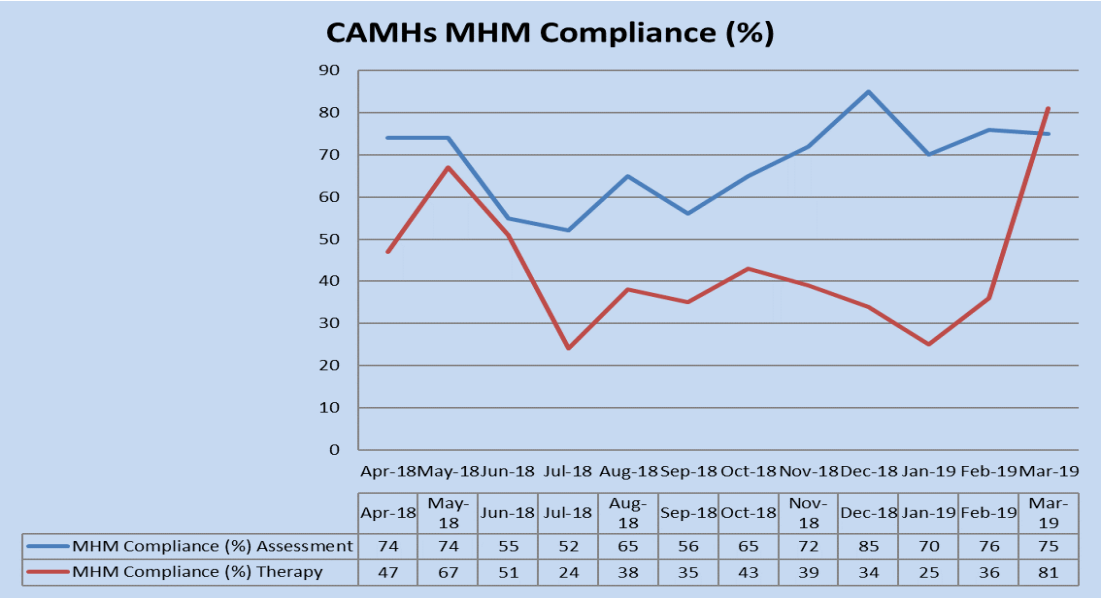
It is noted that the improvement in therapy waiting in October is artificial and generated due to the pattern in school term referrals and the lag to patients being assessed within 28 days and then referred for therapy within 28 days i.e the low number of referrals in August results in a dip in the volume of over 28 day waits in October.

It is important to note that the long waits in the East were addressed during the last 5 months of the year following recruitment of agency practitioners and the hard work from the team.



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
BCU	154	172	162	149	164	173	135	161	166	106	56	75
East	134	135	121	119	135	140	106	123	118	92	27	25
Central	0	5	8	8	8	12	15	16	17	3	9	18
West	20	32	33	22	21	21	14	22	31	11	20	32

The end of March MHM performance also shows an improved position due to the increase in capacity enabled by recruitment of agency practitioners.



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
MHM Compliance (%) Assessment	74	74	55	52	65	56	65	72	85	70	76	75
MHM Compliance (%) Therapy	47	67	51	24	38	35	43	39	34	25	36	81

Recommendation 3: Activity Data Collection & Analysis

- Service to review with support from colleagues in IT the data collection and reporting for advice, consultation and therapy
- Monitor adherence to CAPA to ensure that the maximum efficiency is achieved.
- Consider segmentation of scheduled and unscheduled resource and activity

3.5 Individual Patient review

The three geographical areas reviewed 10 sets of case notes. It was agreed that the sample size was too small to be considered statistically representative of overall service delivery.

The review also identified some common administrative and record keeping issues, including challenges in management of complex integrated case note structure and some governance shortcomings in terms of signing each sheet in the record. These issues were consistent with those identified in standard review and audit cycle of case files governance. Verbal examination of this in the deep dive recognised the administrative burden experienced by the CAMHS service and the inadequacy of patient administration services and absence of electronic or continuous records. It is recognised that many areas of the health board experience such challenges but the absence of any mental health record keeping administrative system and volume of paperwork increases both risks and impact for the CAMHS service.

40% of referrals were from Education and 40% from GP, 10% from Community Paediatrician and 10% unknown. Therefore only 40% of patients within this sample were covered by the MHM reporting target.

Reasons for referral included 30% suicidal or self-harm, 40% anxiety, 10% depression and 20% conduct issues. It was noted that the 2 of the 3 self-harm/ suicide referrals came from education. Therefore reverting to GP referral would increase clinical risk to individuals, risk to the population and importantly also increase pathway length for children and their families, whilst increasing the workload for GPs.

The process mapping had identified patients are triaged as urgent or routine. Urgent is serious self-harm/suicide risk, eating disorders and psychosis. Those waiting on the routine list will cover all clinical presentations, risk stratification will primarily be related to severity and risk rather than clinical presentation. If someone had severe anxiety and was housebound and neglecting themselves to the point of harm then this would be urgent.

3.6 Table Top observations

The capacity to manage referrals is affected by demand for urgent review of patients admitted to paediatric wards or suite 136 areas. Services are segmented for this part of the work, however when a S136 happens which is now infrequent the resource required is high when it occurs. Demand for unscheduled care has increased. This is not reflected clearly in the data as there are several data sets that measure different types of unscheduled care. Present ratio of staff inhibits flexibility to carve out more time without adversely impacting on assessment and intervention targets. A bid was submitted last year to Welsh Government that would provide solutions however this was unsuccessful.

Many of these young people present in high levels of distress due to environmental factors rather than mental illness with resulting high risk behaviour that requires a multi-agency collaborative response and alternative pathways for assessment and respite other than paediatric wards, s136 suites and psychiatric beds.

Recommendation 4:

- Continue to support training of paediatric ward staff in awareness and management of mental health conditions to ensure that admissions to paediatric wards are managed safely and mental health is de-stigmatised.
- Resubmit the crisis pathway bid to Welsh Government.
- Work with the 6 Local Authorities to delay the Children's Transformation Programme which focusses on children on the edge of care, who are looked after or are being reunited with their family.
- Work with adult mental health division to implement Parliamentary Transformation bid for crisis care.

3.6 Quality

The MHM performance data reflects only a small proportion of the work undertaken by the teams. It does not measure patient satisfaction or other quality indicators for performance, hence the development in North Wales to measure other aspects of quality.

There are a number of developments in CAMHS that will assist in measuring quality in addition to the performance targets. Wales is developing a national process for peer review of services – Royal College of Psychiatrist's Quality Network for Community CAMHS which we are contributing to. The teams have been involved in the QNCC reviews both as reviewers and participants. These reviews are reported in to the Quality and Safety Groups with action planning as required.

During this past year the teams have been using quality outcome tools to measure distance travelled and patient satisfaction. These measures look at the global functioning of the young person, the goals they would like to work towards during therapy and their overall experience of the service they received. They are taken from the CAMHS Outcome Research Consortium database. In addition, the measures are taken at the beginning, mid-treatment and discharge from the service. This provides valuable feedback to clinicians and service users with the intent of streamlining and improving the therapeutic experience.

Currently the data collected regarding the ongoing functioning of the young person and the progression towards their goals during treatment shows definite improvement through the stages of treatment. Whilst this is heartening the data set is incomplete and the sample size not yet sufficient to perform meaningful statistical analysis. Continued use of the measures will allow us to analyse this thoroughly in future.

The service has rolled out implementation of the demand and capacity model CAPA, a WG requirement, it has been well embedded in Central Area for some years the other Areas more recently. The CAPA model is a continuous service improvement model and adherence is high and improving as implementation progresses. CAPA provides objectives for capacity demand management, skills development and evidence based care. Outcome measures will provide quality indicators. The team's implementation of CAPA has been given national attention through the Bevan exemplar programme and was presented in a workshop at the NHS confederation in 2018.

CAPA enables the service to accurately identify the required capacity to meet the demand, hence the understanding that there is inadequate resourcing and workforce to meet the current demand.

The links with education are strong and ensure that a holistic approach is taken to managing the care of children and young people. The relatively small size of the teams and the large range of functions they are expected to deliver restricts cross - team working to support the variances in demand across BCU without having significant impact on the ability to flex capacity to manage local variations in demand and range of skills to deliver multiple care pathways and psychological therapies. .

Recommendation 5: Quality of Care

- Continue embedding CAPA within the service and ensuring adherence
- Continue to use the outcome tools recently implemented and report findings.
- Ensure continuous learning through QNCC reviews, Putting Things Right, patient and referrer feedback.

3.7 Workforce

The service believe that with an increase in workforce the service could deliver to access times. In particular the ability to recruit sustainably as opposed to use of short term initiatives to address waiting times through use of agency practitioners and locums would be beneficial to delivery of a sustainable service.

CAPA is a sophisticated demand and capacity model that enables performance management of the service and calculates the workforce capacity required, this is informing workforce planning and the business case for additional capacity.

It is acknowledged that the NHS benchmarking suggests that the workforce in BCUHB is well resourced, it is well understood that this finding is based on resource information which is not useful for comparisons ie, the definition of the service and what is captured as a resource differs between Health Boards.

The benchmarking data shows BCU workforce to be nearly twice the mean and therefore understanding is needed as to the proportion of the workforce providing primary as opposed to secondary care services.

When services are under resourced they deal with the highest acuity first. This means that whole team caseloads consist of higher levels of complex cases which require much more indirect work either multi-agency meetings, Safeguarding, inpatient case conferences, consultation with other practitioners working with the family, telephone contacts. Due to workforce shortages the team are having to take on staff with lower skills levels and train them.

In addition the higher proportion of training required to be able to deliver psychological therapies in line with WG psychological therapies directive will impact on WTE activity. North Wales has a large range of evidence based therapies as part of its offer. This is a success from a quality perspective however it has an impact on capacity for example, some psychological therapies require 1.5 hours of patient contact per appt not 1 hour – this is not reflected in activity data. DBT (Dialectical Behaviour Therapy) for the highest risk patients has a weekly 3 hour group session and a weekly consultation group for staff – this reduced the capacity for high patient contact but reduced hospital admission.

Recommendation 6: Workforce & Capacity

- Request support from IT to establish consistent patient data systems across the service that can capture all contacts and outcomes.
- Continue to work with NWIS and IT on developing an electronic record (WCCIS)
- Continue to develop teams to empower members to make changes for continuous improvement
- Ensure that the teams are supported to undertake training and experience learning from other CAMHS Teams through QNCC for example.
- Review of adherence to CAPA to optimise benefits for patients
- A detailed analysis of the cost base for the service needs to be completed with a view to considering the bottom up cost of providing the service, it would be valuable to undertake this as a cost per contact and exclude fixed overheads from these costs to establish whether fixed costs are artificially inflating service costs or not.
- Consideration needs to be given as to the proportion of the cost arising from the Tier 4 Service as many providers will not operate this level of service and so not have the high cost of in-patient beds.

3.8 Process Maps

The process maps showed commonality of the high level processes, with opportunities to further standardise processes across BCU. The administrative burden was demonstrated and it was clear that managing waiting lists was a burden on administrative resources.

4. Discussion Points

The WG targets for CAMHs are set around referral from GPs. All services accept and risk stratify referrals from multiple resources. Each referral is risk stratified on basis of patients presenting requirements identified in the referral.

Points for discussion:

a) Is risk stratification consistently applied between services
b) Should GP referrals be treated differently to support delivery of the access requirements? This would increase clinical risk and demand on Primary Care as the gateway.
c) Is it possible to equalise waiting times across BCU by more appropriate use of resources or by changing organizational/team boundaries.

5. Delivery Unit All Wales Assurance Review of Primary Care Child and Adolescent Mental Health (CAMHS)

The Delivery Unit have undertaken a comprehensive review across Wales into the delivery of services providing part 1 of the Measure. The review of BCUHB occurred the first 2 weeks of April 2019. The Senior Management Teams were provided with verbal feedback and a written summary note of their findings which included positives and areas for improvement, and notably no immediate concerns that require intervention. The full report is anticipated in the next 2 months.

Their key observations and findings included:

- Passionate & supportive teams.
- Single point of access evidencing timely response & decision making.
- Integration has positive impact on team relationships and culture
- Evidence of unscheduled care response in all regions, there is variation between teams due to demand and capacity
- Focus of the service on Consultation with schools (varies across the regions).
- Variety of psychological modalities clearly in evidence in practice.
- Psychologically driven and informed service across the professions
- Prescribing is not the 1st point of intervention
- CAPA embedded, consistent use of language
- Lack of clarity around compliance with the Part 1 duty to assess

- Distinct challenges between the patient choice focus of CAPA and the Mental Health Measure requirements.
- Not all Health Boards Part 1 schemes consider unscheduled care
- Integrated model is not integrated with Social Care

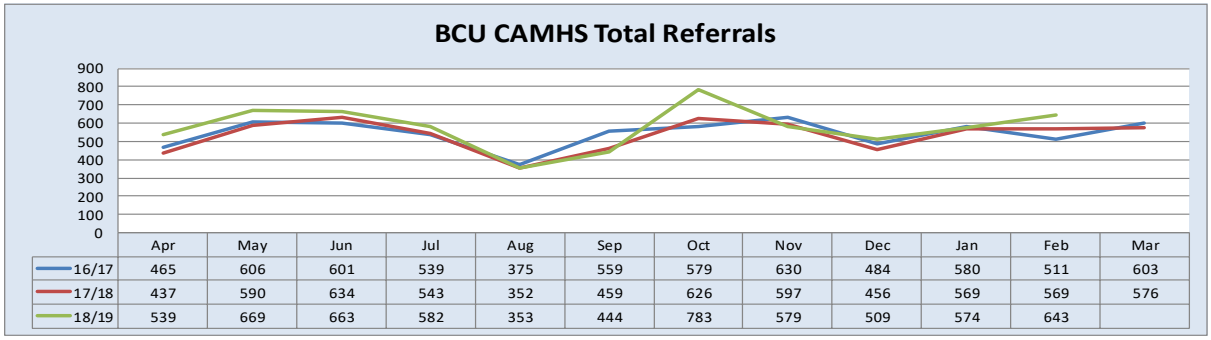
- Although benefits of integrated team is positive some blurring of boundaries between primary and secondary care creating a lack of clarity around thresholds for Part 1 & Part 2
- EIP – Consultation work not being recognised as Part 1 work. Intensity of consultation work significant. Data reporting not a true reflection of the service provision.

Next Steps

- **Collate recommendations from the Deep Dive, the T4CYP report and DU recommendations into an action plan.**
- **Implement Recruitment Strategy with support from WOD**
- **Implement Children's Transformation Programme with 6 Local Authorities – Children who are Looked After or Edge of Care**
- **Work with Adult Mental Health to implement Crisis Pathway**

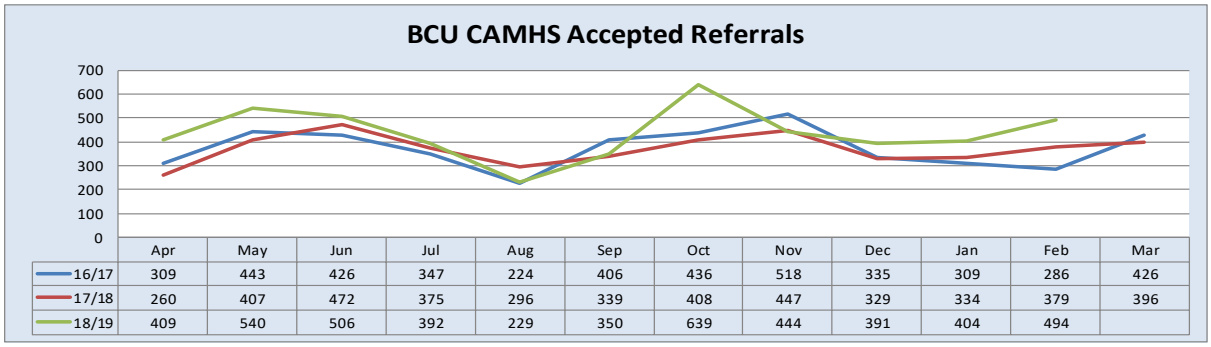
Appendix 1

Total Referrals



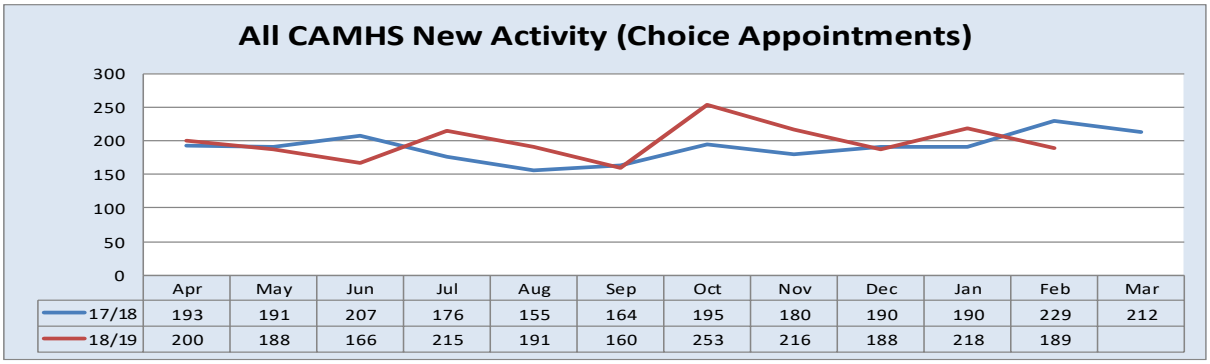
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
16/17	465	606	601	539	375	559	579	630	484	580	511	603
17/18	437	590	634	543	352	459	626	597	456	569	569	576
18/19	539	669	663	582	353	444	783	579	509	574	643	

Accepted Referrals



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
16/17	309	443	426	347	224	406	436	518	335	309	286	426
17/18	260	407	472	375	296	339	408	447	329	334	379	396
18/19	409	540	506	392	229	350	639	444	391	404	494	

Assessments undertaken



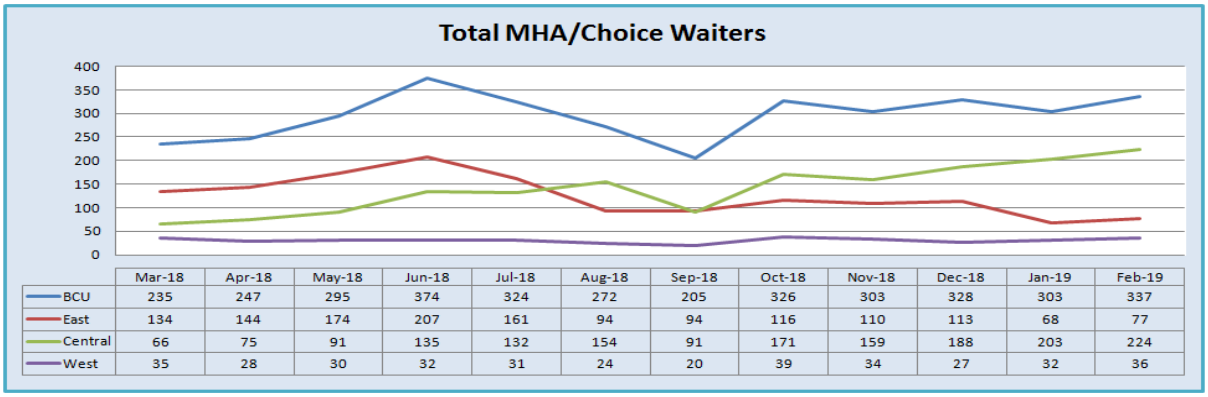
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	193	191	207	176	155	164	195	180	190	190	229	212
18/19	200	188	166	215	191	160	253	216	188	218	189	

Self-harm assessments undertaken

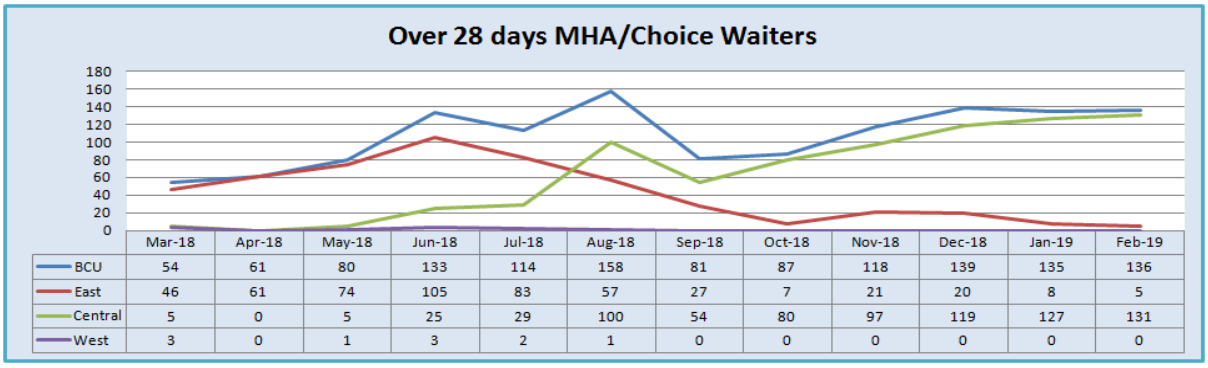
Total	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Year To date	Full Year	YTD % +/-
2018-19	72	70	86	56	37	74	77	76	71	75	81		775		19%
2017-18	62	71	71	51	48	51	71	48	55	49	48	47	625	672	3%
2016-17	55	64	61	43	49	50	62	67	50	50	55	88	606	694	-6%
2015-16	64	74	74	51	39	50	57	75	54	51	55	69	644	713	25%
2014-15	44	45	44	43	32	45	34	43	43	57	54	75	484	559	20%

Waiting numbers – Assessments and Therapy

Assessments

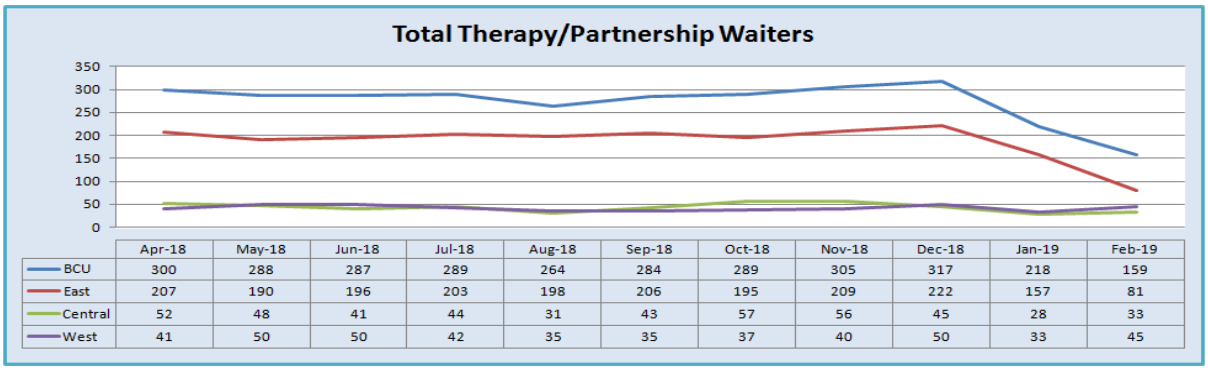


	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
BCU	235	247	295	374	324	272	205	326	303	328	303	337
East	134	144	174	207	161	94	94	116	110	113	68	77
Central	66	75	91	135	132	154	91	171	159	188	203	224
West	35	28	30	32	31	24	20	39	34	27	32	36

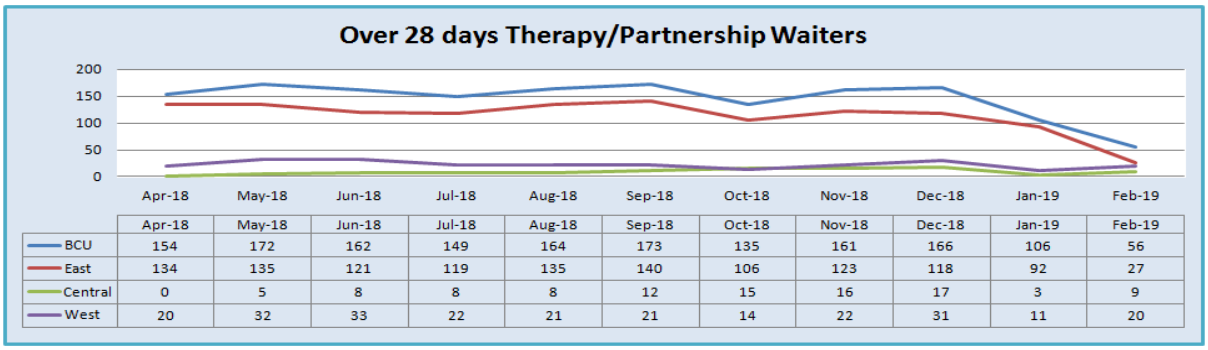


	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
BCU	54	61	80	133	114	158	81	87	118	139	135	136
East	46	61	74	105	83	57	27	7	21	20	8	5
Central	5	0	5	25	29	100	54	80	97	119	127	131
West	3	0	1	3	2	1	0	0	0	0	0	0

Therapy

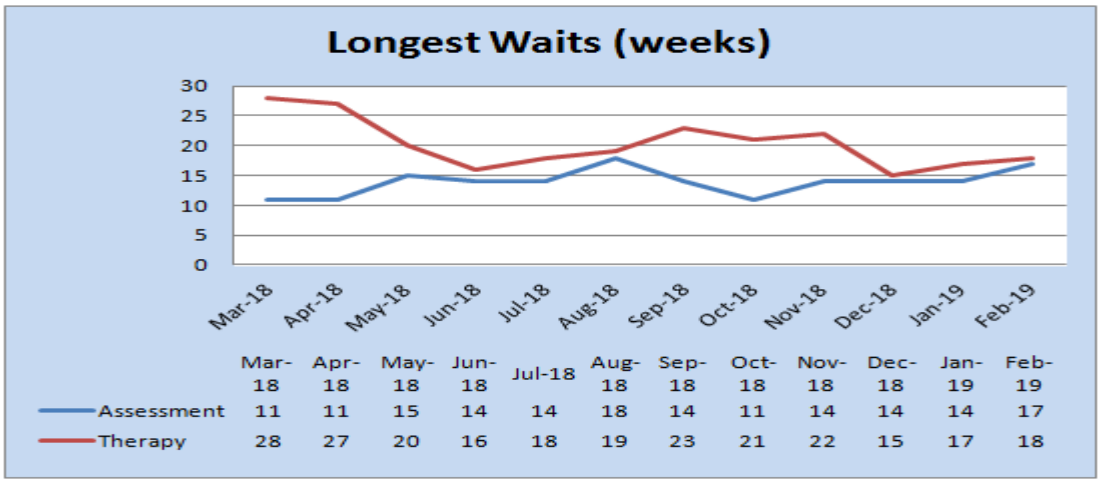


	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
BCU	300	288	287	289	264	284	289	305	317	218	159
East	207	190	196	203	198	206	195	209	222	157	81
Central	52	48	41	44	31	43	57	56	45	28	33
West	41	50	50	42	35	35	37	40	50	33	45

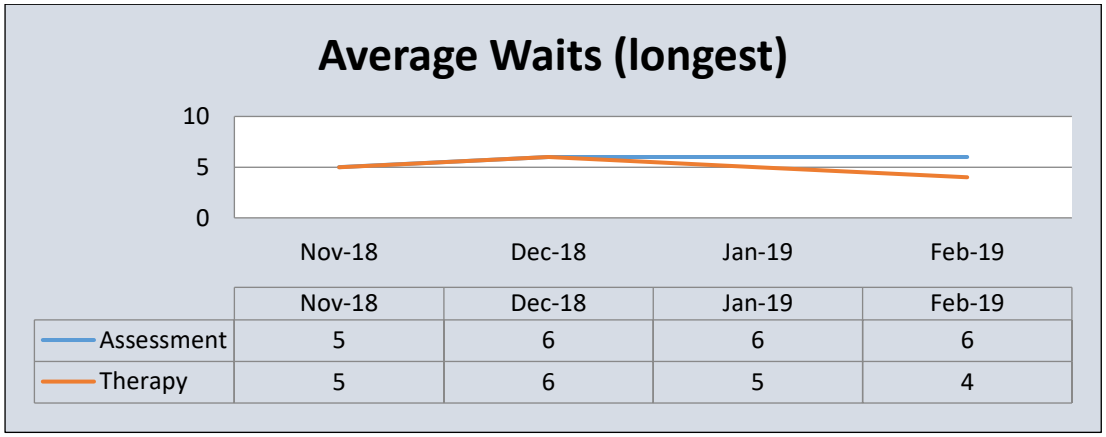


	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
BCU	154	172	162	149	164	173	135	161	166	106	56
East	134	135	121	119	135	140	106	123	118	92	27
Central	0	5	8	8	8	12	15	16	17	3	9
West	20	32	33	22	21	21	14	22	31	11	20

Longest waits and average waits



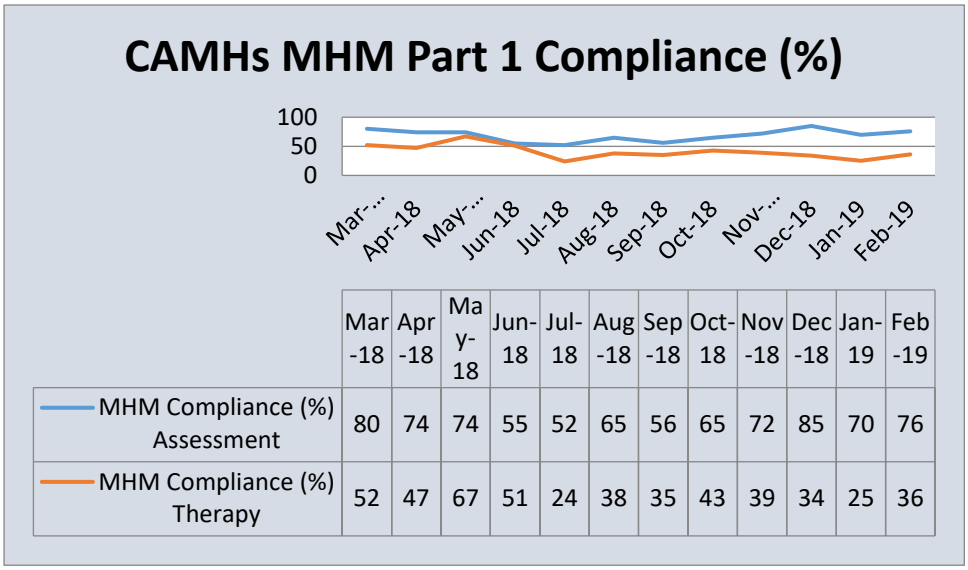
	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
Assessment	11	11	15	14	14	18	14	11	14	14	14	17
Therapy	28	27	20	16	18	19	23	21	22	15	17	18



	Nov-18	Dec-18	Jan-19	Feb-19
Assessment	5	6	6	6
Therapy	5	6	5	4

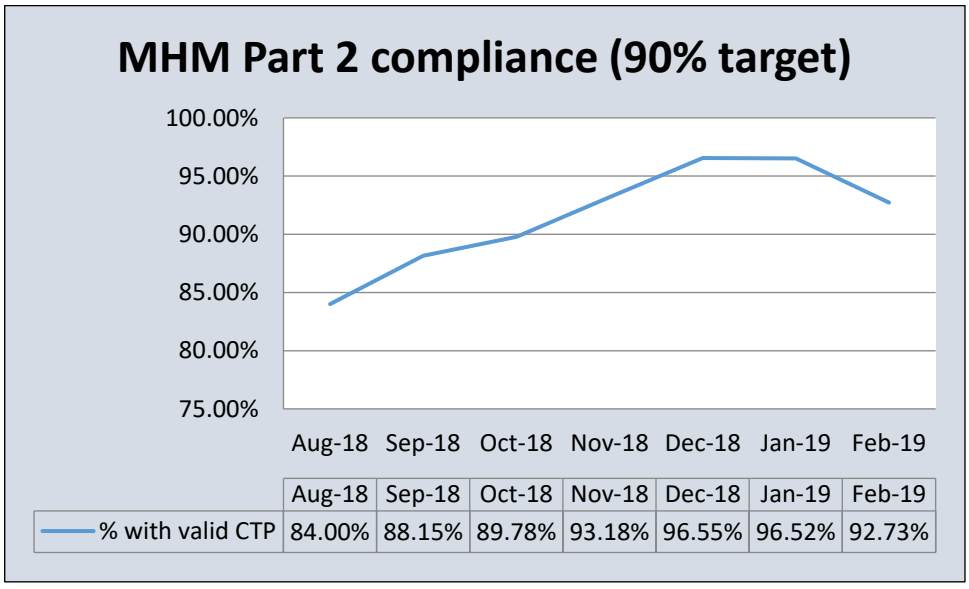
Please note the average wait is collated by Area, the above graph shows the longest average wait.

Performance against MHM Part 1 target



	Mar -18	Apr -18	May- 18	Jun- 18	Jul- 18	Aug -18	Sep -18	Oct- 18	Nov -18	Dec -18	Jan- 19	Feb -19
MHM Compliance (%) Assessment	80	74	74	55	52	65	56	65	72	85	70	76
MHM Compliance (%) Therapy	52	47	67	51	24	38	35	43	39	34	25	36

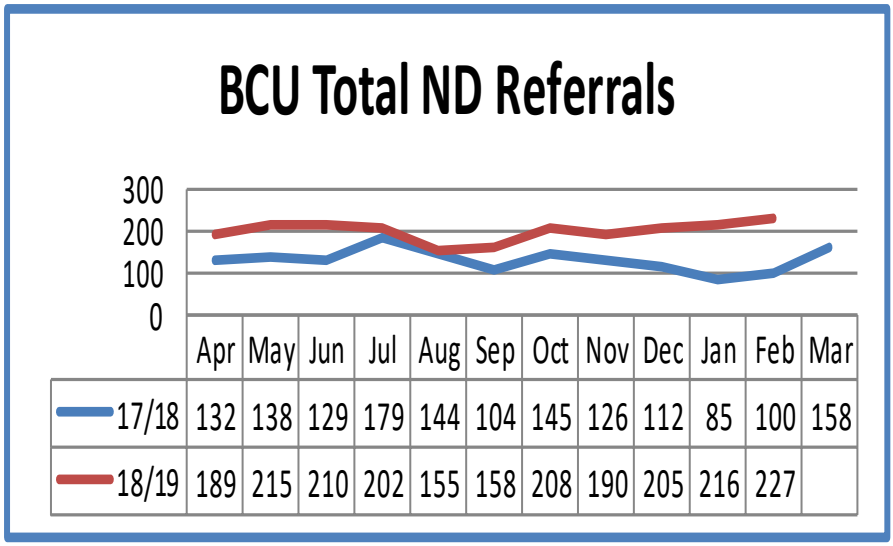
Performance against MHM Part 2 target



	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
% with valid CTP	84.00%	88.15%	89.78%	93.18%	96.55%	96.52%	92.73%

Please note that issues with accurate reporting arose in July 2018 which have been rectified.

Total ND Referrals


BCU Total ND Referrals
300
200
100
0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
17/18 132 138 129 179 144 104 145 126 112 85 100 158
18/19 189 215 210 202 155 158 208 190 205 216 227

Mental Health Act Committee **28th June 2019**	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board ***To improve health and provide excellent care***

Report Title:	Update on the approval functions of Approved Clinicians & section 12(2) Doctors in Wales
Report Author:	Heulwen Hughes, All Wales Approvals Manager for Approved Clinicians and section 12(2) Doctors
Responsible Director:	Dr Evan Moore, Executive Medical Director
Public or In Committee	Public
Purpose of Report:	To provide an update on the arrangements and service developments for the approval and re-approval of Approved Clinicians and section 12(2) Doctors in Wales. Additions and removals to the all Wales registers of Approved Clinicians and section 12(2) Doctors (due to the timing of the Committee meeting, the report will contain information from the previous month).
Approval / Scrutiny Route Prior to Presentation:	The report has been scrutinised by the Medical Director prior to submitting to the Committee.
Governance issues / risks:	Ensuring the All Wales process is being implemented.
Financial Implications:	
Recommendation:	To note the arrangements for approval and re-approval of Approved Clinicians and section 12(2) Doctors in Wales.

Health Board's Well-being Objectives *(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)*	√	**WFGA Sustainable Development Principle** *(Indicate how the paper/proposal has embedded and prioritised the sustainable development principle in its development. Describe how within the main body of the report or if not indicate the reasons for this.)*	√
1.To improve physical, emotional and mental health and well-being for all	√	1.Balancing short term need with long term planning for the future	
2.To target our resources to those with the greatest needs and reduce inequalities		2.Working together with other partners to deliver objectives	

3.To support children to have the best start in life		3. Involving those with an interest and seeking their views	
4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being		4.Putting resources into preventing problems occurring or getting worse	
5.To improve the safety and quality of all services		5.Considering impact on all well-being goals together and on other bodies	
6.To respect people and their dignity			
7.To listen to people and learn from their experiences			

Special Measures Improvement Framework Theme/Expectation addressed by this paper

http://www.wales.nhs.uk/sitesplus/861/page/81806

Equality Impact Assessment

(If no EqIA carried out, please briefly explain why. EqIA is required where a change of policy or direction is envisaged and/or where budgets are being reduced. It is particularly important that the biggest, most strategic decisions are subjected to an EqIA – see http://howis.wales.nhs.uk/sitesplus/861/page/47193)

Update on the Approval Functions of Approved Clinicians and Section 12(2) Doctors in Wales 5 March – 7th June 2019

Situation

Betsi Cadwaladr University Health Board is responsible for initial approval, re-approval, suspension and termination of Approved Clinicians and section 12(2) Doctors in Wales.

Background

The change introduced to the Mental Health Act 1983 was the abolishing of Responsible Medical Officers (RMOs) and Community Responsible Medical Officers (CRMOs) and the introduction of Approved/Responsible Clinicians (ACs and RCs) in their place.

The Minister for Health and Social Services agreed that as of the 3rd November 2008 Wrexham Local Health Board (LHB) would act as the Approval Body for Approved Clinicians and section 12(2) Doctors on behalf of the LHBs in Wales. The transfer of function from Wrexham Local Health Board to Betsi Cadwaladr University Health Board took place on the 1st October 2009.

Service Developments

New web-based MHA Register for Wales

The feedback at the Department of Health National Reference Group (NRG), in respect of how the database is working in England, was discussed at the last panel meeting. The NRG had reported the use was minimal and was not adding the value they had hoped and were disappointed in the developments received from LAB Lateral. The All Wales Approval Panel were adamant that local records were completely up to date, and supported the local service provision.

In terms of assuring complete accuracy of information, a review of the absolute value of progressing a National Database in Wales is being undertaken

The Approval Team met with members of the BCUHB Informatics Team in May and were assured that the current Microsoft Access databases were secure and should continue to be used. With the increase in cost to use the services of LAB Lateral, the decision to continue with the current databases, ensures financial stability of the all Wales budget. The team were informed that once the current databases are saved within the data warehouse, they could be accessed securely by NADEX users across Wales.

The Team are currently carrying out a data cleanse of the database in readiness for the changes.

Arrangements for Approval of Approved in Wales

Two portfolios have been received to date. One from a psychiatrist who is not on the GMC Specialist Register and one from a Mental Health/Learning Disabilities nurse. Both portfolios have been assessed by the Panel and both applicants have been requested to submit additional evidence. At the time of writing this report, one applicant has submitted the additional evidence and this will be assessed by 18th June 2019.

Approved Clinician/section 12(2) Induction and Refresher Training

The next induction/refresher training will take place from 10thy to 12th September 2019 in Wrexham. Training dates for two of the 2020 courses have been secured.

Additions and Removals to the all Wales registers of Approved Clinicians and section 12(2) Doctors 5th March – 7th June 2019

Approved Clinicians (ACs)

New Applications Received	**8**
Number of applications from professions other than Psychiatrists	
Mental Health/Learning Disability Nurse	1
Social Worker	0
Occupational Therapist	0
Psychologist	0
Number of applications approved	6
Number of ACs already approved in England	5
Number of applications with panel (including portfolios)	2
Number of applications not approved	0
Re-approval Applications Received (5 Yearly)	**12**
Number of applications re-approved	9
Number of applications with panel	3
Number of applications pending awaiting further evidence	0
Number of applications not approved	0
Number of ACs reinstated following suspension	**1**
Number of re-approvals which have come to an end	**2**
Expired	1
Retirement	0
No longer working in Wales	1
No longer registered with professional body	0
AC requested	0
Registered without a licence to practise	0
Total Number of Approved Clinicians on Register (Includes re-approvals)	**400**

Section 12(2) Doctors

Number of Applications Received:	**6**
New Applications Received	**3**
Applications from GPs	1
Applications from Psychiatrists	2
Application from Forensic Medical Examiner	0
Re-approval Applications (5 years)	
Applications from GPs	1
Applications from Psychiatrists	0
Applications from Forensic Medical Examiners	0
Number of Applications with Panel	**2**
Transferred from AC register	**0**
Number of Approvals which have come to an end:	**2**
Expired	1
Become an Approved Clinician	0
No longer working in Wales	0
No longer registered	0
Registered without a licence to practice	0
Retired	1
Under Police Investigation	0
RIP	0
Suspended from Medical Practitioners List	0
Total Number of S12(2) Doctors currently approved (Includes re-approvals)	**152**

Breakdown of section 12(2) doctors in North Wales

As at 20th June 2019

	Anglesey	Conwy	Denbighshire	Flintshire	Gwynedd	Wrexham	TOTAL
Section 12(2) GPs	1	4			3	2	**10**
Section 12(2) Psychiatrists		4	4	2	2	2	**14**
Approved Clinicians	2	14	19	11	13	20	**79**

Please note that the above numbers are of section 12(2) doctors (not ACs) who have been approved in Wales. There may well be section 12(2) psychiatrists working in BCUHB who have been approved in England who aren't recorded on the All Wales database.

Cyfarwyddwr Corfforaethol a Chyfarwyddwr Statudol Gwasanaethau Cymdeithasol
Corporate Director and Statutory Director of Social Services
Awen Morwena Edwards

Gofynnwch am/Ask for: **Morwena Edwards**
☎ (01286) 679468 Ein Cyf /OurRef: **AME**
awenmorwenaedwards@gwynedd.llyw.cymru Eich Cyf /Your Ref:

14th June 2019

Dear Evan

Re: Section 12(2) Doctors

I have been advised by Andy Roach to write to you as Medical Director in order to escalate the matter.

I have been discussing with colleagues in the Mental Health Division about my concerns about the lack of availability of Section 12 (2) Doctors for quite some time. I have also raised the matter at the Together for Mental Health Board. Unfortunately despite these discussions, the matter continues to be a problem, and in some ways has worsened.

In a meeting with Andy Roach and Dr Alberto Salmoiraghi on the 12th June, it became evident that if we are to find a solution to the problem that it must be given the highest possible level of attention. They were clear that it was a Health Board matter and not a specific Mental Health Divisional issue, and as such, they were not able to action the solutions.

As a Local Authority who employs AMHPs to work with Section 12 Doctors we clearly must alert you to the concerns being fed back to us by our staff. I do not believe we in Gwynedd are alone in our concerns about this high risk issue, and given vulnerable individuals are not being provided the right provision under this duty, it is vitally important that the matter is given urgent attention and a solution found as soon as possible.

The problem stems from the lack of availability of doctors that are willing to undertake Section 12 work. Some of the work undertaken so far seems to suggest a few avenues that could be considered:-

Swyddfa'r Cyngor
Caernarfon
Gwynedd LL55 1SH
01766 771000
www.gwynedd.gov.uk

- It is apparent that the current fee levels paid by the Health Board for the work needs to be increased in order to attract more interest by Doctors, as many state that the current fee is not enough to cover the work. The current fee also includes travel costs, which clearly makes working in the more rural parts of Gwynedd less attractive.
- It may be helpful to consider the possibility of reviewing this provision alongside the locality (cluster) development that is happening currently.
- There may be an opportunity to strengthen the requirements within the GP Contract to include this and possibly to discuss this as part of the locality work.

In the meantime, whilst solutions are being worked through we are obviously having to manage very often situations without having Section 12(2) doctors.

At our meeting with Andy and Alberto we discussed the best course of action for staff to take whilst the problem remains acute. For your information, the advice we have been given from Andy and Alberto, which does concur with legal advice we have been given, is that we need to advise our AMHPs **not to assess** individuals in these circumstances if they cannot secure a Section 12 (2) doctor to approve their assessment.

In emergency situations the AMHP may consider the use of a section (4). If this is not suitable, the patients will be left in the community until a section (12) doctor is available. These individuals have been deemed a risk to themselves and/or others, therefore the situation is untenable for both the patients and their carers/families. Families will therefore be advised to contact the Police if there is a risk to the patient or themselves, thus putting further pressure on the Police to respond to Mental Health matters. Unfortunately we will have no option but to follow this advice.

I would be grateful if you could provide me with information about how you think the matter can be taken forward, and the timescale for doing the required changes. As you can appreciate, this isn't a problem that has just arisen and therefore I would be grateful if everything can be done to find a sustainable and quick solution.

If I can be of any further help in terms of finding a solution, please do not hesitate to contact me.

Thank you for your attention in the above matter, and I look forward to hearing from you.

Kind Regards

Morwena Edwards
Corporate Director

c.c.

Marian Parry Jones – Vice Chair, Chair of T4MH Board, BCUHB

Gary Doherty – Chief Executive, BCUHB

Dr Chris Stockport – Executive Director, Community, BCUHB

Andy Roach – Executive Director, Mental Health Division, BCUHB

Dr Alberto Salmoiraghi – Clinical Director, Mental Health Division, BCUHB

Lesley Singleton – Partnership Lead, Mental Health Division, BCUHB

Mannon Trappe – Senior Manager, Gwynedd Council

Mental Health Act Committee 28th June 2019	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board ***To improve health and provide excellent care***

Report Title:	Independent Mental Health Advocacy (IMHA)
Report Author:	Lesley Singleton, Director of Partnerships MH/LD
Responsible Director:	Andy Roach
Public or In Committee	Public
Purpose of Report:	To provide an update on the IMHA performance reported to Welsh Government for the period January – March 2019 and emerging themes that have been identified by service users
Approval / Scrutiny Route Prior to Presentation:	Contract monitoring data supplied by Providers for March 2019
Governance issues / risks:	The Health Board is required to have effective IMHA in place to ensure compliance with the Mental Health Measure. Feedback from service users through advocates provides an opportunity for quality improvements in service provision
Financial Implications:	No changes
Recommendation:	To note the performance report submitted to Welsh Government and the themes that service have users raised with the IMHA Service.

Health Board's Well-being Objectives (indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)	√	**WFGA Sustainable Development Principle** (Indicate how the paper/proposal has embedded and prioritised the sustainable development principle in its development. Describe how within the main body of the report or if not indicate the reasons for this.)	√
1.To improve physical, emotional and mental health and well-being for all	√	1.Balancing short term need with long term planning for the future	
2.To target our resources to those with the greatest needs and reduce inequalities	√	2.Working together with other partners to deliver objectives	
3.To support children to have the best start in life		3. Involving those with an interest and seeking their views	√

4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being	√	4.Putting resources into preventing problems occurring or getting worse	√
5.To improve the safety and quality of all services	√	5.Considering impact on all well-being goals together and on other bodies	√
6.To respect people and their dignity	√		
7.To listen to people and learn from their experiences	√		

Special Measures Improvement Framework Theme/Expectation addressed by this paper

http://www.wales.nhs.uk/sitesplus/861/page/81806

Equality Impact Assessment

(If no EqIA carried out, please briefly explain why. EqIA is required where a change of policy or direction is envisaged and/or where budgets are being reduced. It is particularly important that the biggest, most strategic decisions are subjected to an EqIA – see http://howis.wales.nhs.uk/sitesplus/861/page/47193)

Disclosure:
Betsi Cadwaladr University Health Board is the operational name of Betsi Cadwaladr University Local Health Board

Purpose

This report updates the committee on the Independent Mental Health Advocacy (IMHA) performance data reported to Welsh Government for the period of January 2018 to March 2019. It also identifies themes raised by service users, as collated by the IMHA Service.

Background

Part 4 of the Mental Health (Wales) Measure 2010 specifies that all inpatients in Wales who are receiving assessment or treatment for a mental disorder are entitled to request support from an IMHA. Part 4 of the Mental Health Measure was extended in 2012 to include individuals detained under sections 4, 5(2) and 5(4) of the 1983 Act and informal (i.e. non-detained) inpatients in hospitals or registered establishments in Wales (including those in non-mental health settings) who are receiving assessment or treatment for a mental disorder.

There are currently contracts in place for the provision of IMHA advocacy support from three providers covering all of North Wales.

Awareness Raising

The IMHA Service has an on-going role to develop the awareness of the IMHA service to health and social care staff, whilst ensuring patients and carers are aware of their rights. It is crucial to have a rolling programme to ensure a level of awareness and understanding of the IMHA role is maintained amongst staff, service users and carers.

Ongoing awareness of the role of an IMHA is required, and this is work planned each quarter to address, including the work with the School of Nursing at Bangor University, focusing on training Year 3 student Nurses.

Numbers of referrals from independent hospitals has increased in the last 6 months, which is encouraging, and there is a small increase in the 3 DGH’s which is also encouraging.

Service User Feedback

No new themes have been raised with the IMHA service in the last quarter, however the following themes are ongoing:

- Turnover of clinical staff/locums remains an issue re continuity of care.
- Safeguarding concerns when there is consistently a lack of qualified staff on duty.
- Patients placed on a CTO are not encouraged or suggested that they could access an advocate, although this has improved.
- Lack of follow on help/support in the community remains an issue, and there are plans to address these concerns in local priorities.

The IMHA Service Managers have all been invited to local QSEEL meetings of the Mental Health Division Quality and Safety Meeting. It is expected that the themes raised by service users will be discussed and clear actions agreed to resolve. The next review meeting of the IMHA service with the provider is on the 22nd July 2019.

The committee should be assured that if there are any issues highlighted to the advocacy service that require immediate attention then this happens and they do not have to wait to attend a meeting.

Data Reporting

A copy of the IMHA performance report to Welsh Government for June 2018 to March 2019 is enclosed.

During 2019/19 referrals to the IMHA service were consistently around 300 a quarter, increasing in quarter 4 to 328. The service is delivered with 9 full time, fully qualified advocates in post.

To date the service has been able to meet the 5-day target for all patients.

Mental Health Measure (Part 4) - quarterly Submission Proforma

Local Health Board	Betsi Cadwaladr ULHB	Summary 2018/19

Indicator			Data Relating To Quarter Ending: Jun-18	Sep-18	Dec-18	Mar-19
1	**Total number of all hospitals within the Local Health Board [end of quarter census snapshot]**		36	37	37	37
2	**Total number of all hospitals which have arrangements in place to ensure advocacy is available to qualifying patients? [end of quarter census snapshot]**		36	37	37	37
3	**Total number of WTE Independent Mental Health Advocates (IMHAs) in the Local Health Board at the end of the quarter [end of quarter snapshot]**		9	9	9	9
4	**What is the qualification status of the IMHAs in the Local Health Board (see indicator 3)** **[end of quarter census snapshot]**	Number of WTE IMHAs who satisfy appointment requirements	9	9	9	9
		Number of WTE IMHAs who are working towards the IMHA diploma	1.72	0.72	0.14	0.14
		Number of WTE IMHAs who have successfully completed the IMHA diploma	7.28	8.28	8.86	8.86
		Number of WTE IMHAs who have any additional qualifications	5.45	5.45	6.45	6.45
5	**Does your advocacy provider have or is working towards a recognised advocacy quality performance mark (select from drop down list)?**		Yes	Yes	Yes	Yes
6	**Number of new qualifying patients accepted into IMHA services during the quarter:** **[quarterly count]**	Compulsory patients	223	213	215	242
		Informal/voluntary patients	100	94	83	86
		Total number of new qualifying patients accepted into IMHA services during the quarter	323	307	298	328

7	**Number of qualifying patients currently in receipt of IMHA services at the end of the quarter - i.e. the caseload:** **[end of quarter snapshot]**	Compulsory patients	144	123	114	125
		Informal/voluntary patients	42	60	150	33
		Total number of qualifying patients currently in receipt of IMHA services at the end of the quarter	186	183	145	158
8	**Number of qualifying patients discharged from IMHA services during the quarter:** **[quarterly count]**	Compulsory patients	212	102	174	171
		Informal/voluntary patients	108	65	82	87
		Total number of qualifying patients discharged from IMHA services during the quarter	320	167	256	258
9	**Of the qualifying compulsory patients who had their first contact with an IMHA during the quarter, how many had waited:** **[quarterly count]**	Up to and including 5 working days following their request for an IMHA	223	213	215	242
		6 working days or more following their request for an IMHA	0	0	0	0
		Total number of qualifying compulsory patients who had their first contact with an IMHA during the quarter	223	213	215	242
10	**Of the qualifying informal/voluntary patients who had their first contact with an IMHA during the quarter, how many had waited:** **[quarterly count]**	Up to and including 5 working days following their request for an IMHA	100	98	83	86
		6 working days or more following their request for an IMHA	0	0	0	0
		Total number of qualifying informal/voluntary patients who had their first contact with an IMHA during the quarter	100	98	83	86

Mental Health Act Committee

28 June 2019

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

To improve health and provide excellent care

Report Title:	***Deprivation of Liberty Safeguards (DoLS) Update Report***
Report Author:	Chris Pearson, Safeguarding DoLS Manager/Specialist Practitioner
Responsible Director:	Gill Harris, Executive Director of Nursing and Midwifery
Public or In Committee	Public √ Committee √ Any case scenarios are confidential and though anonymised are based on actual cases and are for In Committee only
Purpose of Report:	The DoLS Supervisory Body are accountable to report all data relating to deprivation because patients are detained in hospital under statutory legislation. The report also provides a wider perspective on the recruitment and training of Best Interest Assessors (BIA); Supervisory Body functions and responsibilities; the provision of training, advice and support delivered to BCUHB staff.
Approval / Scrutiny Route Prior to Presentation:	This is a standing item for the MHA Committee that requires an oversight of DoLS and its activity and relationship to the use of the Mental Health Act 1983 (as amended 2007) and training and development for staff in mental health settings.
Governance issues / risks:	DoLS activity and issue of risks and mitigating factors are addressed within the governance framework of the Area Safeguarding Forums; MH/LD Safeguarding Forum; Consent, Capacity Strategic Working Group; Safeguarding Performance and Governance Group; Quality and Safety Group. The Mental Health Act Committee report on DoLS is shared with these groups given there is an interrelationship and interface with DoLS, Mental Capacity Act and the Mental Health Act 1983 and related Codes of Practice.
Financial Implications:	Not applicable
Recommendation:	The Committee is asked to note the content of the report

Health Board's Well-being Objectives *(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)*	√	**WFGA Sustainable Development Principle** *(Indicate how the paper/proposal has embedded and prioritised the sustainable development principle in its development. Describe how within the main body of the report or if not indicate the reasons for this.)*	√

1.To improve physical, emotional and mental health and well-being for all	√	1.Balancing short term need with long term planning for the future	√
2.To target our resources to those with the greatest needs and reduce inequalities	√	2.Working together with other partners to deliver objectives	√
3.To support children to have the best start in life		3. Involving those with an interest and seeking their views	
4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being	√	4.Putting resources into preventing problems occurring or getting worse	√
5.To improve the safety and quality of all services	√	5.Considering impact on all well-being goals together and on other bodies	√
6.To respect people and their dignity	√		
7.To listen to people and learn from their experiences	√		

Special Measures Improvement Framework Theme/Expectation addressed by this paper

http://www.wales.nhs.uk/sitesplus/861/page/81806

Equality Impact Assessment

An Equality Impact Assessment has been completed using Parts A & B on 3 June 2019. The outcome shows there is no necessity to carry out a full EqIA as they will be completed on any individual based policy or procedures prior to any strategic decision making presented to MHAC. No such documents are presented for agreement in this Report.

Deprivation of Liberty Safeguards (DoLS) Update Report

1. Purpose of Report

1.1 The report provides the Quarter 4 and end of the year activity on DoLS and other related issues. The report also identifies current challenges of capacity and demand of DoLS applications and any mitigating actions; any development and matters relating to Best Interest Assessors (BIA); and any challenges to the role and functions of the Supervisory Body. The report specifically highlights the provision of training to mental health and learning disability health board staff and the interface between Mental Capacity, DoLS and the Mental Health Act 1983.

2. Introduction/Context

2.1 The Deprivation of Liberty Safeguards was introduced in April 2009. The safeguards as set out in Schedule A1 are an amendment to the Mental Capacity Act 2005 introduced by the Mental Health Act 2007. DoLS is supported by a supplement to the Mental Capacity Act Code of Practice. The safeguards were introduced to ensure that any deprivation of liberty of a person who may lack capacity complies with the Convention on Human Rights (ECHR). A DoLS authorisation provides a legal framework and protection when a deprivation of liberty is considered unavoidable and in the person's best interests when in a hospital setting.

2.2 DoLS activity is reported annually to Healthcare Inspectorate Wales (HIW). This annual report is completed jointly by HIW and Care Inspection Wales (CIW). They produce an All Wales Monitoring report on DoLS activity within Health Boards and Local Authorities. It should be noted that these reports analyse DoLS data from the previous year's information produced by Health Boards and Local Authorities (i.e.; data for 2015/16 is reported at mid-term autumn in 2018). So it is difficult to compare current data in real time.

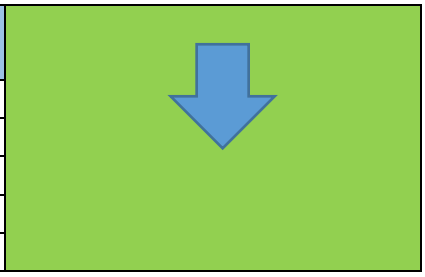
2.3. The latest available Health Inspectorate Wales Monitoring Report for 2017/18 shows that Health Boards (HBs) and Local Authorities (LA) in Wales received a total 14,743 new DoLS applications; an increase of 8% from the previous year. HBs had a 5% increase from 2016/17 to 20117/18.

2.4. The period following the Supreme Court judgement in the case of *P v Cheshire West* [2014] and P & Q v Surrey CC [2014], showed a vast increase in the next two years of DoLS applications. From the hiatus of applications in 2015/16, the following year saw a further huge increase by 22%. The subsequent years to 2018/19 show more of a levelling off of applications which suggests that a more consistent plateau has been reached between a variant of 750 to 800 cases in a year.

Figure 1a

Total Number of BCUHB DoLS Applications:

Year	Total DoLS Applications
2014/15	414
2015/16	787
2016/17	854
2017/18	792
2018/19	744



2.5 Figure 1a Narrative:

2.5.1 While there is a downward trend in applications received by the DoLS Team, this is not the full picture. First of all, there is anecdotal evidence to suggest that wards are not putting in a DoLS when it applies (at the point of admission onward when a patient lacks capacity) or are put in so late the patient is nearer discharge or in fact is discharged before any action is taken but still it means the patient is unlawfully deprived of their liberty in such instances.

2.5.2 The number of applications that are granted by BCUHB help tell a more detailed story about DoLS. The actual number of applications granted since 2015/16 seem to suggest the issue is complex. The number of BIAs in post to complete assessments has varied in each year of reporting with 2017/18 being the lowest number of qualified BIAs 0.6 for the first 6 months (Team Manager) and 1.6 post in the subsequent 6 months of that year. In each of those years the number of applications now seems to have reached a plateau over the past two years. The increase in the number of BIA posts to the DoLS Team, to 3 WTE during the latter part of 2018/19, should result in a slight increase in DoLS applications granted. Also during 2019/20 a predicted increase in applications is expected as more BIAs' will engage with staff on site and enable insight into recognising situations where a patient meets the criteria for a DoLS for those currently under-reported.

Figure 1b

Applications Activity	Applications				
	West	**Central**	**East**	**England**	**Total**
Q1	26	58	75	16	175
Q2	16	68	85	11	180
Q3	22	66	74	20	182
Q4	25	65	109	8	207
Total	89	257	343	55	744

2.6 Figure 1 Narrative:

There are significantly lower applications from the West area compared to East and Central. This has always been the case since the DoLS Manager started making comparisons in 2017. However, as we increase the number of available BIAs, we

should see a steady increase in 2019/20 because of a greater presence of BIAs' on the wards. Additionally the Team Manager has provided bespoke training (see section 6 below) to staff within Community Hospitals in the West division. The DoLS team collectively at the point of receiving an application or clinical engagement with the DoLS Manager or BIA involve frequent discussions with wards in mental health units when DoLS or the Mental Health Act 1983 should apply.

The number of applications completed during Q4 showed a significant rise and it remains to be seen if this is replicated during 2019/2020.

Figure 2:

Activity in Q4	Q4				
	West	Central	East	England	Total
Applications	25	65	109	8	207
Allocated	6	31	45	4	86

3. Deprivation of Liberty Safeguards:

3.1 The DoLS Team are pleased to report that the three newly appointed BIAs have completed their Best Interest Assessor training at Manchester University and were all successful in gaining their accredited Award in January 2019. They have all been given opportunities to shadow experienced BIA in assessing patients and they are now deemed to have the necessary skills and experience to undertake assessment independently. There has been a very steady increase over the year in the overall number of DoLS applications received over each quarter. The number of these applications allocated to a BIA has increased by 16%:

Figure 3:

	Q1	Q2	Q3	Q4
Applications	175	180	182	207
Applications Allocated to BIA	46	55	56	86
Assessed by BIA	43	54	42	65
Granted	28	33	41	25
Not Granted	15	17	14	22

	Q1	Q2	Q3	Q4
Applications Allocated to BIA %	26%	31%	31%	42%
Assessed by BIA %	93%	98%	75%	76%
Granted %	65%	61%	98%	38%
Not Granted %	35%	31%	33%	34%

During Q1 and Q2, we saw a 5% increase in the number of patients being assessed by a BIA. With this being said, the number of applications being allocated to a BIA increased in Q3 and Q4 but the number of patients then being assessed reduced.

4. The Supervisory Body and Signatories:

4.1 Since December 2018, the DoLS Manager put in a governance framework to identify and support newly appointed signatories to carry out the function and role of a Supervisory Body. The DoLS Team Manager is providing bespoke training in undertaking the role, functions and responsibilities of a Signatory; providing access to information around current guidance and relevant case law; peer support and reflective practice. A Conference for Signatories included a key-note Barrister to take place in May 2019. Unfortunately confirmation by the deadline dates of potential attendees was so few; it was not viable to hold the event. A new date is being set for autumn 2019. At the point of writing this report there has been 9 training sessions for staff and we have trained 31staff (see also Section 6, Training) We have a potential list of 76 named individuals (Band 8a and above) who have been nominated as signatories by their line managers. 13 of those staff have been nominated from within Mental Health/Learning Disability Division with more potential names to be added from the West area.

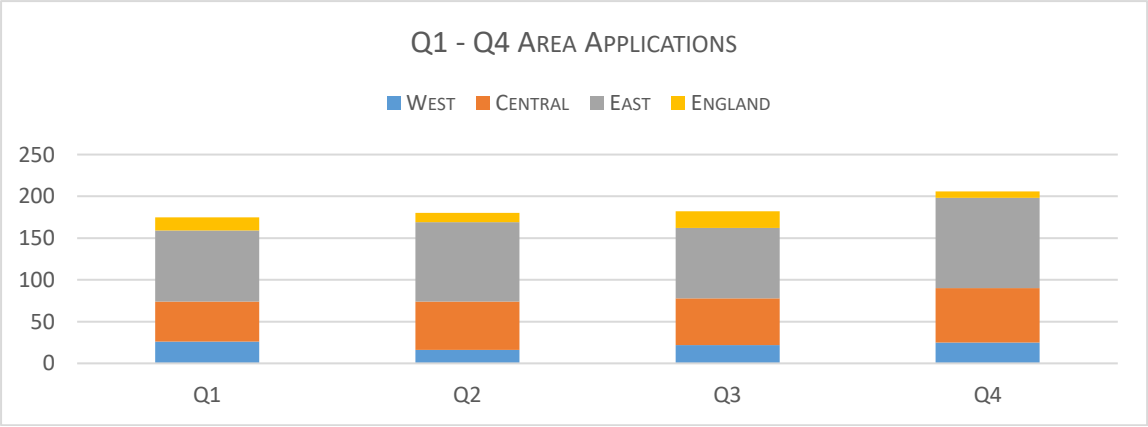
4.2. The increase in the active provision of Supervisory Body signatories and BIAs should reduce the risks to the health board of patients who are unlawfully detained because of delays in assessments or granting a DoLS.

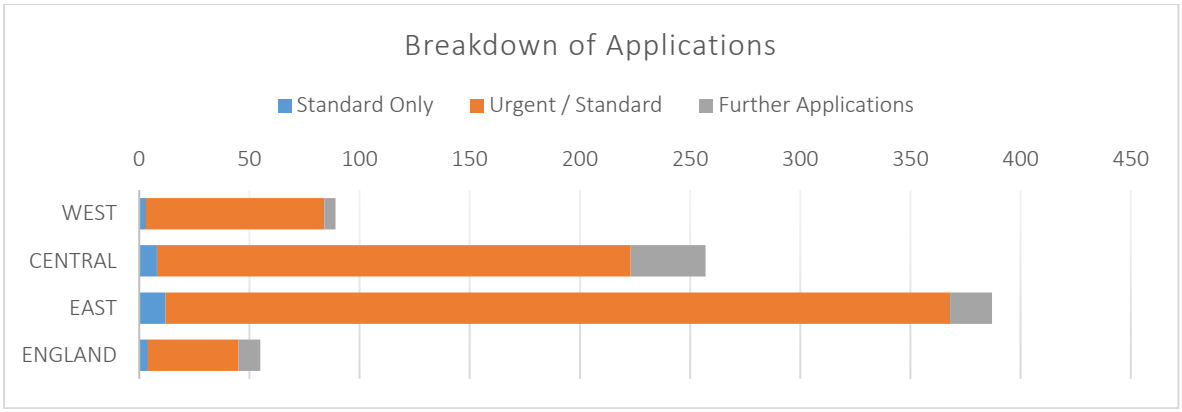
5. DoLS Activity

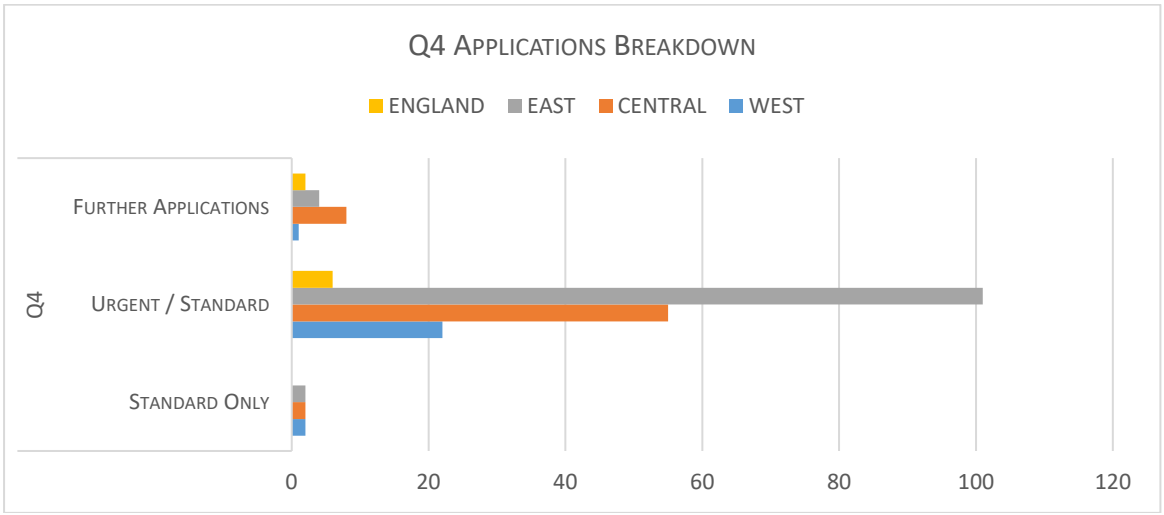
5.1 The information below sets out some key information around DoLS and relevant data. If there are issues to address there is a narrative added to the data activity.

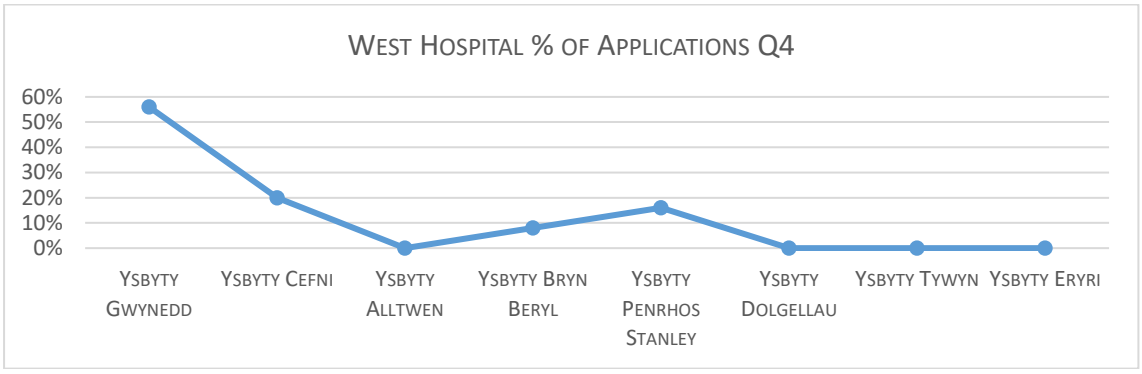
The range of applications for a request for a DoLS is outlined in Figure 4 below.

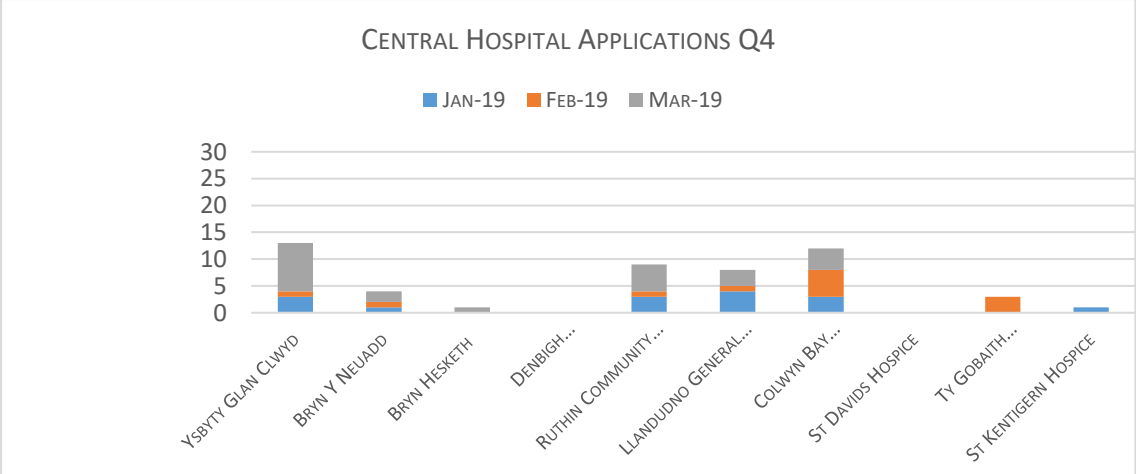
5.2 Figure 4: Applications by Areas:

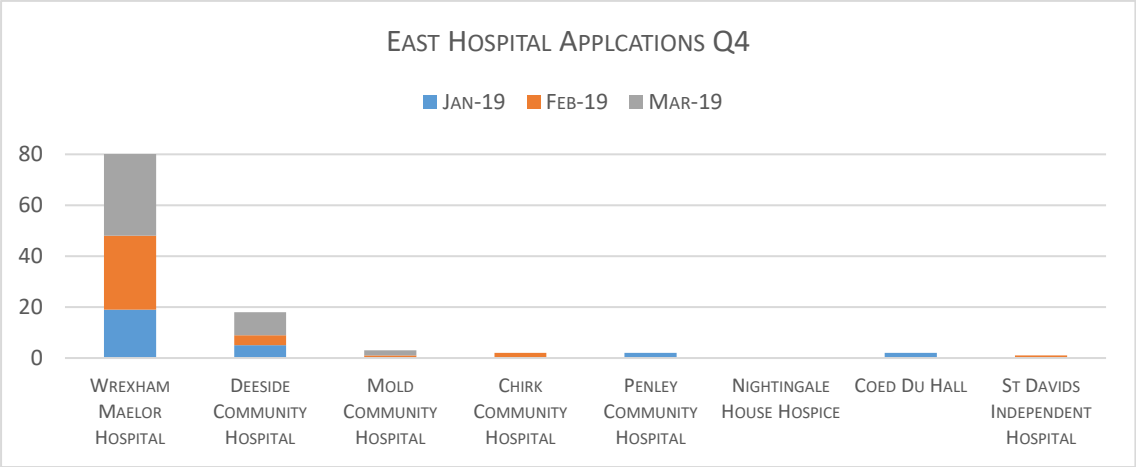



Breakdown of Applications
Standard Only
Urgent / Standard
Further Applications
0
50
100
150
200
250
300
350
400
450
WEST
CENTRAL
EAST
ENGLAND


Q4 Applications Breakdown
ENGLAND
EAST
CENTRAL
WEST
Q4
Further Applications
Urgent / Standard
Standard Only
0
20
40
60
80
100
120


West Hospital % of Applications Q4
60%
50%
40%
30%
20%
10%
0%
Ysbyty Gwynedd
Ysbyty Cefni
Ysbyty Alltwen
Ysbyty Bryn Beryl
Ysbyty Penrhos Stanley
Ysbyty Dolgellau
Ysbyty Tywyn
Ysbyty Eryri





5.2 Figure 4 Narrative:

There has been an on-going rise in applications in the East division which is double the amount of applications for both Central and West combined. It is recognised that there is on-going work to do to increase the number of applications that are referred by Central and West. All the BIAs are now indepedently operational and link to area safeguarding teams. The presence of a BIA regularly in contact and familiar with the hospital wards in their area should encourage and increase the level of awareness of DoLS and when applications need to be made.

5.3 There has been additional work undertaken by the DoLS Manager in Q4 period providing training to staff in community hospitals in the West Division. Additionally, the training to staff involved as signatories also has shown to have an influence on a rise in applications in Q4. These factors should contribute to a rise in DoLS applications when all the BIAs become independently operational and link to area safeguarding teams.

Figure 5: Data relating to Non-Compliance with Forms

Issues	Q4				
	West	Central	East	England	Total
Total Application Received	25	65	109	8	207
Issues with Forms	13	27	62	0	102

Q4:

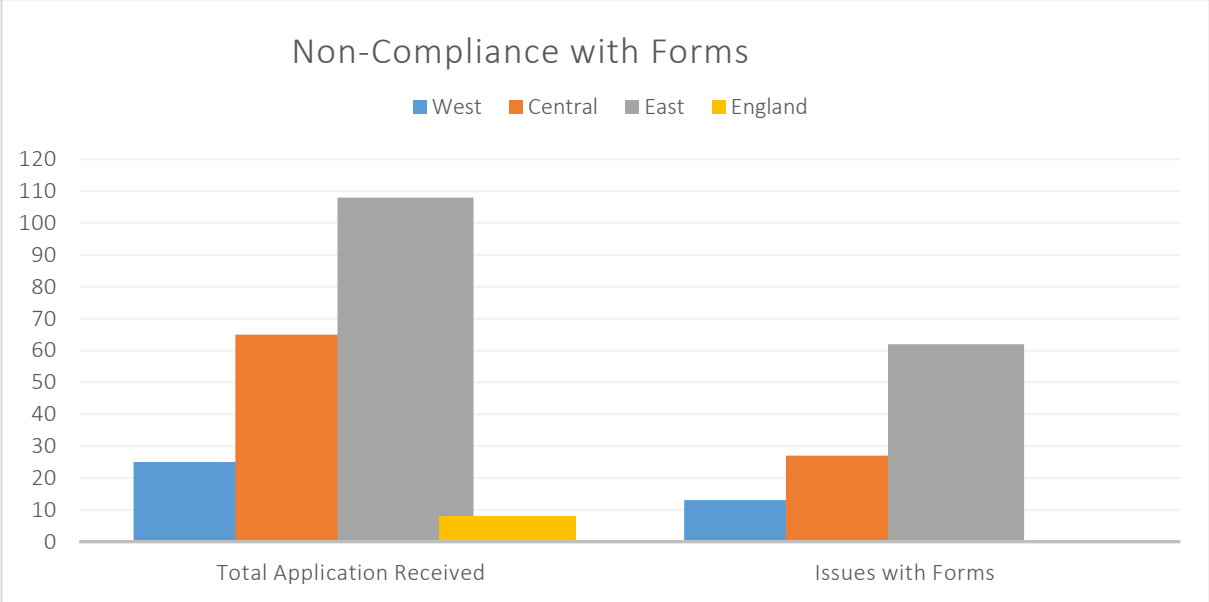


Figure 6:
Non- Compliance Q1-Q4

Issues	Q1- Q4				
	West	Central	East	England	Total
Total Application Received	89	257	343	55	744
Issues with Forms	53	136	183	10	382
Mental Health Wards	6	44	34	0	84
Issues with Forms from MH Units	10	10	12	0	32

5.4 Figure 5 & 6 Narrative:

With the support of the Information Officer within Corporate Safeguarding enabling the DoLS Team to collect and collate information on DoLS has given a greater breadth and depth of analysing data since April 2018. There is a considerable amount of activity within the team dealing with receiving applications that have minor and major issues with their completion compliance, sometimes to the point of contradiction; eg; patient referred for a DoLS but ward have ticked the individual has capacity.

5.6 In more specific areas relating to Mental Health Units, 32 cases had major issues either relating to the completion of the form (e.g. not signed/dated/time) or in 5 cases referred for DoLS when the case clearly shows that the patient is objecting to their treatment for mental disorder and so must be detained under the Mental Health Act as set out in the revised Code of Practice MHAct 2016 under Ch 13, 13.33 -13.38. This scenario is raised in every single mandatory MCA/DoLS training session which the DoLS Team provide every month across the MH/LD Division. There seems to be the notion in these cases (5 cases) that DoLS is a less restrictive alternative to the use of the Mental Health Act when in fact it is not an alternative at all for patients who lack capacity and who are objecting to their care and treatment for their mental disorder. While the DoLS Team is constantly providing support and advice on actions to be considered in every DoLS application, it is not sustainable for them to take on actions that lie clearly within mental health. So from a governance perspective, from 01 May 2019, the DoLS team will raise a Datix for every case that meets a significant breach of DoLS or unlawful detention in any clinical setting.

5.7 It may seem pedantic to raise issues on the non-compliance of lacking signatures or identifying the correct time and date when a DoLS has been applied by the Managing Authority. However, more recently the DoLS team has had to seek advice from Legal and Risk (Wales) Services on an unprecedented number of Court of Protection cases within the past 4 months (6 cases). Legal advice highlights that in 4 cases that the Managing Authority not responding in timescale to a DoLS application has meant an unlawful detention occurring. This scrutiny puts matters in a critical domain within the Court of Protection of being criticised for not getting DoLS applications right from the beginning. 10+ years on from the introduction of DoLS Managing Authorities should be getting the right. The number of cases within mental health/learning disability of non-compliance shows the message is yet to be imbedded in practice.

5.8 There are a range of issues identified more globally across BCUHB within the applications at the point of receipt by the DoLS Team. These include not identifying individuals lacking capacity to be accommodated in hospital; not specifying what levels of care and treatment individuals receive; whether individuals are objecting to being in hospital; not putting on the form relevant signatures, times or dates that correspond to legal requirements. Any major issues with applications are returned to the sender with an outline of how to correct the form. Even then, we have to constantly chase up applications being amended and returned to the DoLS Team.

5.9 There are emerging issues about hospital wards expecting the S12 Doctor, who is assessing in terms of DoLS, to provide some clarity in terms of mental health when there are questions around someone's capacity to go home. The role of the s12(2) Doctor is clearly to determine if the individual patient has a mental disorder and is eligible for DoLS in hospital. It is not the role of the s12(2) Mental Health Assessor to assess capacity and suitability to go home, this should be referred instead to the relevant mental health team if a mental health case or to the MDT or community team. In Q4, the DoLS Team have identified delayed transfers of care because some Local Authority social workers are asking wards specifically in the East area to complete mental capacity assessments about

going home when it is the social workers decision to complete such assessments given they are the decision maker. I will be raising this matter within the appropriate corporate safeguarding forum as this seems to be an on-going issue that BIAs identify in their assessments.

Figure 7: Application Requests Not Granted

NOT GRANTED: Q1-Q4

NOT GRANTED**	Q1	Q2	Q3	Q4	Total
Not Granted	15	17	14	22	68
Capacity	3	3	4	5	15
MHA	4	2	4	5	15
No Mental Disorder	0	0	1	0	1
Ferreira#	3	1	1	5	10
Discharge Prior to BIA completing Form 3 & 3a	0	0	3	1	4
Discharged Prior to Full Assessment	0	1	0	5	6
Discharged Prior to Form 5 Completed	3	10	1	2	16
Discharged Prior to Form 5 Authorised	1	1	0	4	6
Died Prior to Full Assessment	0	0	0	1	1
Died Prior to Form 5 Completed	1	0	0	0	0
Died Prior to Form 5 Authorised	1	0	0	0	0

Referred for a DoLS application but note referred to the Supervisory Body because meets criteria set out in the Ferreira case law by the Court of Appeal [2018]

** includes out of area placements in hospital

5.10 Figure 7: Narrative:

There are a number of issues emerging from cases that are not granted. There are a significant number of cases that suggest that an application for DoLS that need not have been requested because the patients met the criteria for the MHAct 1983 (as amended 2007). Similarly, the number of patients on assessment by the BIA is deemed to have capacity when clearly the criteria for a DoLS is the person lacks capacity about the decision to be accommodated in hospital. At least from a positive perspective the BIAs are supporting the individual's rights to the right legislative framework that should be used and also considering the less restrictive alternative.

BIA assessors are also considering case law as in Ferreira when the Court of Appeal determined that patients at end of life care do not meet the criteria for a deprivation of liberty. There is a health warning on this case, it is yet to progress to appeal to the Supreme Court.

The 32 cases in which patients are discharged prior to the completion of the DoLS process does need to be highlighted as the DoLS team perspective is that applications are put into the DoLS team far too late and near to discharge already being considered. Too often the DoLS team are informed after the event when we check if an individual remains on the ward. This is a statutory responsibility of the Managing Authority (ward)

to notify any change in circumstances, especially discharge from hospital. The DoLS Manager ensures this is emphasised at all DoLS training but it needs to be embedded in practice. This is an issue across all areas, including mental health. The next report to the MHAC will analyse this data and issue in more detail in the Q1 report in September 2019.

6. Training

6.1 Currently the DoLS Team (DoLS Manager and a BIA) provide training across BCUHB at Level 2 and Level 3. This training is mandatory for mental health and learning disability division. There are now outcomes in place for all managers of staff to be notified via ESR if a staff member has not turned up for training and the reasons for not doing so. This governance now sits firmly where it should be, with the relevant manager rather than oversight by the DoLS team.

	Q1	Q2	Q3	Q4
MCA/DoLS Mandatory & Bespoke Training				
Mandatory MH and LD	109	37	42	29
Bespoke	30	23	108*	45
Training for Supervisory Body (Signatories)	n/a	n/a	n/a	9
TOTAL	139	60#	150	83
#80 Student Nurses				

6.2 The progression and development of a handbook for level 1 candidates and their managers (who will oversee competence) is now in progress and will replicate the content on Level 1 on–line mandatory awareness training. This is specifically aimed at staff who do not have access to on-line learning (eg Estates). The DoLS Team are currently exploring procuring this booklet. Discussion on this aspect involves a wider stakeholder group in BCUHB so there have been delays but is overseen by the DoLS Manager reporting to the Mandatory Training Review Group.

6.3 Despite the pressures in the Team in managing DoLS applications and the issues that arise from them, the Team have managed to deliver training during Q1 to Q4 as follows.

Figure 8: Mandatory and Bespoke Training

Training	Q1	Q2	Q3	Q4
Mandatory	109	37	42	29
Bespoke	30	23	108	54
Total overall	139	60*	150	83

*** No training provided in Aug 2018**

6.4 The DoLS Manager over the past year has attended the newly formed MH/LD Safeguarding Forum and contributed towards any issues relating to mental

capacity and DoLS. Additionally, in Q3 the DoLS Manager has attended Safeguarding Forums in West and Central areas and an invitation has been given to attend the East Forum in July 2019. One important outcome from the West Forum was an invitation to the DoLS Manager to provide bespoke training to staff connected to the 6 community hospitals over 2019/2020. This should result in time in greater awareness of DoLS and an increase in appropriate applications.

6.5 BIA Network**:** The DoLS Team Manager currently leads on supporting a regional network held quarterly for BIAs across the 6 Local Authorities and also includes IMCA, s12(2) Doctors, and Supervisory Body officers from each of the attending agencies. The objectives are to share and discuss good practice and the impact and discussion of updated case law. One meeting is set aside as an annual event for all BIAs, IMCAs and S12(2) Doctors. This event is already open to Local Authority Supervisory Body staff. This year has seen the most successful event to-date in Q4 with a input from a leading Barrister and sharing anonymised BCUHB case scenarios so learning lessons can be considered about good practice. This event has been reported in the recent Corporate Safeguarding newsletter (see Appendix 1) and received high praise for its content and application of exploring issues relating to mental capacity and DoLS.

7. Advice and Support:

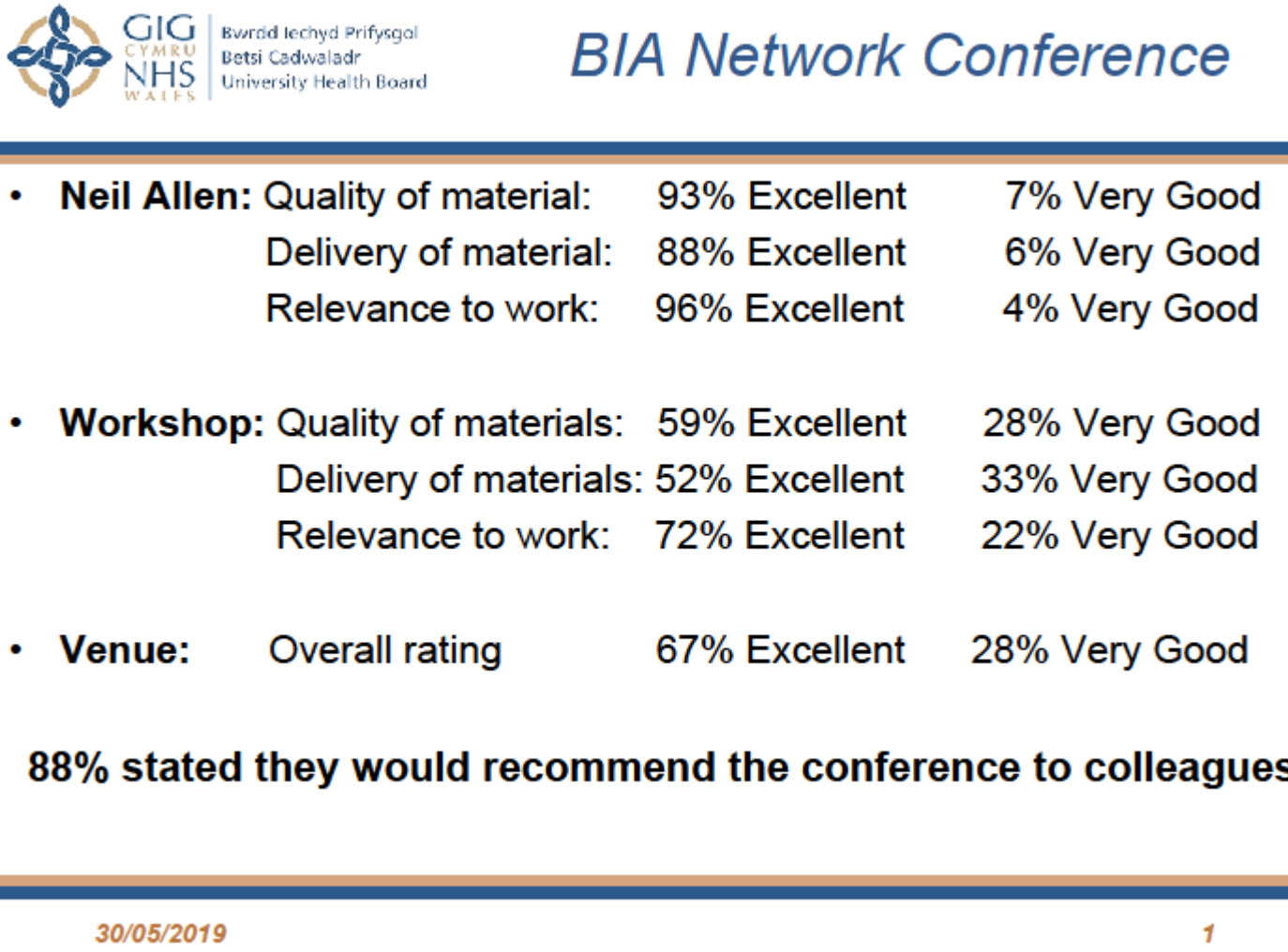
7.1 The DoLS Team continuously provide day to day support and advice to staff about mental capacity issues and its application, as well as advice on completing applications under DoLS. The DoLS Team have in place a governance scrutiny around receiving applications from hospitals and, if necessary, will elicit further information that is required as part of the DoLS process. It may at times be seen as pedantic to return DoLS applications for further information from Ward Managers however our concerns are the same as everyone, the patient is at the heart of the process so we wish to ensure the legal framework around DoLS is adhered to in all the process. We are there to support and enable staff to get it right first time and we will support any ward staff who wish us to deliver training on the application of MCA 2005 or DoLS outside the current mandatory reporting mechanism for mental health and learning disability. Contact in the first instance is through bcu.dolsadmin@wales.nhs.uk

8. Recommendation

8.1 That Committee note the content of the report.

APPENDICES

Appendix 1: BIA North Wales Network Conference:



ASPECTS OF INTEREST FROM THE CONFERENCE

•Neil Allen informative

•Case studies

•Legislations

•Meeting colleagues

•LPS Information

•Clarification of DoLS

•Case law updates

•Interactive nature of course

•Revising forms

BIA Network Conference

COMMENTS TAKEN FROM THE CONFERENCE

•“Excellent conference”

•“Fantastic presentation by Neil Allen”

•“Good idea of mixing up individuals on numbered tables”

•“An even better conference than last year”

•“To make it compulsory for psychiatrists to attend”

•“Workshops and case discussions were great”

•“Great to speak with fellow professionals, very well planned”

•“Enjoyed the whole day”

•“Excellent day well done to all who organised it”

Mental Health Act Committee

28th June 2019

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

To improve health and provide excellent care

Report Title:	Healthcare Inspectorate Wales (HIW) Monitoring Report
Report Author:	Wendy Lappin, Mental Health Act Manager
Responsible Director:	Andy Roach, Director of Mental Health and Learning Disabilities
Public or In Committee	Public
Purpose of Report:	To provide an updated in relation to the inspections conducted by Healthcare Inspectorate Wales, to highlight findings in relation to the Mental Health Act and the Mental Health Wales Measure.
Approval / Scrutiny Route Prior to Presentation:	This paper prior to presentation at the Power of Discharge Committee Meeting has been presented at the MH&LD Q-SEEL meeting for the Senior Management Team and the Divisional Directors Meeting
Governance issues / risks:	None
Financial Implications:	None
Recommendation:	The committee is asked to note the report

Health Board's Well-being Objectives *(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)*	√	**WFGA Sustainable Development Principle** *(Indicate how the paper/proposal has embedded and prioritised the sustainable development principle in its development. Describe how within the main body of the report or if not indicate the reasons for this.)*	√
1.To improve physical, emotional and mental health and well-being for all	√	1.Balancing short term need with long term planning for the future	√
2.To target our resources to those with the greatest needs and reduce inequalities	√	2.Working together with other partners to deliver objectives	√
3.To support children to have the best start in life		3. Involving those with an interest and seeking their views	√
4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being	√	4.Putting resources into preventing problems occurring or getting worse	√

5.To improve the safety and quality of all services	√	5.Considering impact on all well-being goals together and on other bodies	√
6.To respect people and their dignity	√		
7.To listen to people and learn from their experiences	√		

Special Measures Improvement Framework Theme/Expectation addressed by this paper

Governance and Leadership – to ensure compliance with the Mental Health Act and Mental Health (Wales) Measure.

http://www.wales.nhs.uk/sitesplus/861/page/81806

Equality Impact Assessment

Retrospective looking report therefore no EqIA required.

(If no EqIA carried out, please briefly explain why. EqIA is required where a change of policy or direction is envisaged and/or where budgets are being reduced. It is particularly important that the biggest, most strategic decisions are subjected to an EqIA – see http://howis.wales.nhs.uk/sitesplus/861/page/47193)

Disclosure:
Betsi Cadwaladr University Health Board is the operational name of Betsi Cadwaladr University Local Health Board

Healthcare Inspectorate Wales (HIW) Monitoring Report

1. Purpose of report

To provide an update in relation to the Inspections conducted by Healthcare Inspectorate Wales (HIW) within a period of twelve months. To highlight findings in relation to the Mental Health Act and Mental Health Wales Measure.

2. Introduction/Context

HIW is the independent inspectorate and regulator of all health care in Wales.

HIW conduct announced and unannounced visits to services offered by Betsi Cadwaladr University Health Board. Their primary focus is on:

Making a contribution to improving the safety and quality of healthcare services in Wales

Improving citizen's experience of healthcare in Wales whether as a patient, service user, carer, relative or employee

Strengthening the voice of patients and the public in the way health services are reviewed

Ensuring that timely. useful, accessible and relevant information about the safety and quality of healthcare in Wales is made available to all

This report provides assurance that following inspections and recommendations that these actions are followed up.

3. Inspections (within the last 12 months)

3.1 Ablett Unit UPDATE

Inspection Date: 16-18 January 2019
Publication of report due: 17th April 2019

The summary of the report found that the Ablett Unit provided safe care, delivered by committed staff. Improvements that had been made were recognised which benefited the patient experience. However, further developments were noted to be required to ensure the hospital reflects future service provision needs.

The summary highlights that staff interacted and engaged with patients respectfully, patients were complimentary of the care received, staff were positive about their work and support received and that there are established governance arrangements that assisted staff in the provision of safe and clinically effective care.

Improvements are noted within the summary to be in relation to supporting patients to help maintain their independence and dignity, storage of medication arrangements and mental health service provision within the health board to meet meet the needs of its population.

No immediate concerns were identified and no immediate assurance issues identified.

In relation to the Mental Health Act and the Mental Health Measure the improvement plan highlights the actions below:

Improvement Needed	**Service Action**	**Timescale**
The health board must ensure that copies of all detention papers are available in the current patient's record	Detention papers are filed in patients' records, compliance check carried out by audit (Modern Matron)	Complete
The health board must ensure that all disciplines submit their heading reports in a timely manner.	The Matron will ensure that dedicated time will be allocated for practitioners to complete reports in a timely manner. Escalation process put in place for non-compliance.	Complete
The health board must ensure that capacity assessments are completed, and that copies of these are available in the patient's record	Capacity Assessments are filed in patients records, compliance check carried out by audit. (Modern Matron)	Complete
The health board must ensure that Care and Treatment plans are written from the patient's first person perspective.	Ongoing training being provided by the Head of Nursing. Compliance check carried out by audit (Modern Matron). The Acute Care Pathway is being reviewed to include a prompt (Head of Operations).	31st May 2019
The health board must review the range of risk assessment documentation that is being used and where possible amend to a more uniform format	The WARRN risk assessment documentation is the agreed tool in use across the division. A review will be undertaken to ensure all assessments are in this agreed format with no deviation. (Service Manager)	Complete

3.2 Nant Y Glyn CMHT UPDATE

Inspection date: 6 – 7 of November 2018 joint review with CIW
Publication of report due: 11th March 2019.

The summary of the report found that the service provided safe and effective care, quality of patient care and engagement to be generally good, improvements were noted in relation to access to the service and referral process in the past two years, a person centred approach was evident with engagement with service users and their family where appropriate, discharge arrangements were satisfactory and staff were clear about their responsibilities and aware of reporting processes in relation to safeguarding.

It is highlighted that there was some evidence that the service was not fully compliant with all health and Care Standards (2015) and the Social Services and Well-being (Wales) Act 2014. Advice and information about advocacy services was not provided in a consistent manner, quality of record keeping was variable and the approach to provision of care tended to focus on service users' needs rather than strengths.

The report found that the service did well and positive feedback was received from service users, the application of the Mental Health Act and Mental Health Measure is highlighted as an area that the services does well and the link with the MHA administrator.

Improvements are noted within the summary to be in relation to the environment, file management, access to psychology and psychotherapy services, some aspects of care planning and risk management, advocacy and contact whether through single point of access, vulnerable adult teams and electronic systems.

No immediate concerns were identified and no immediate assurance issues identified.

In relation to the Mental Health Act and the Mental Health Measure the improvement plan highlights the actions below:

Improvement Needed	**Service Action**	**Timescale**
Measures must be set in place to ensure that all service users are re-assessed when their care is transferred to the CMHT.	All transfers to CMHT are discussed as part of MDT or SPOA to ensure accurate up to date information received. Assessments take place timely and appropriate fashion for all patients. This will be monitored during supervision and file audit. Snapshot has been taken which has not highlighted any deficits.	Complete

Care plans should be reviewed in order to ensure that they take into account service users' strengths as well as needs.	This will be implemented in the CTP strength based training. (County Manager, Health). Regular quality assurance reviews of case file records to include: themes from the HIW Action Plan be planned and undertaken in 2019. (Team Managers and QS Managers (LA))	31/08/2019
Measures must be taken to ensure that the progress notes reflect the individual elements of identified need within the care plans and the outcomes to be achieved.	Supported via Local training on record keeping and monitored via supervision file audit. (County Manager, Health).	31/08/2019

3.3 Hergest Unit

Inspection date: 4 - 5 of September 2018
Publication of report due 6 December 2018

The summary of the report found that the Hergest Unit provided safe care, however, it is highlighted that the health board must ensure that their provision of mental health services meets the requirements of its population and ensuring that patients access the most appropriate service in a timely manner. The summary highlights that staff interacted and engaged with patients respectfully, and that there are established governance arrangements that assisted staff in the provision of safe and clinically effective care.

Improvements are noted within the summary to be in relation to the capacity of mental health services within the health board to meet the need of the population, medicines management practice and arrangements for maintaining safe and secure environment of care.

No immediate concerns were identified and no immediate assurance issues identified.

In relation to the Mental Health Act and the Mental Health Measure the improvement plan highlights the actions below:

Improvement Needed	**Service Action**	**Timescale**
The Health Board must ensure that there is a record of what information the patient has received under Section 132 of the Act, along with the details and outcomes of the discussion, as guided by the	To be included in existing rolling programme of Mental Health Act training already implemented across the division. All registered nurses to be	Complete

Code, chapter 4.	made aware of recording standards regarding the explanation of rights under section 132.	
The health board must ensure that all disciplines submit their heading reports in a timely manner.	Issue to be highlighted in Mental Health Act training. Information leaflet to be developed to advise staff of their responsibilities with regard to timely submission of hearing reports.	Complete
The health board must ensure that statutory consultees record their discussion with the SOAD.	Information leaflet to be developed to advise statutory consultees of their responsibilities. A communication is to be provided to those staff identified as statutory consultees on SOAD forms to advise them of the requirement to record in the notes following conversation.	Complete

3.4 Abergele CAMHS

Inspection date: 25 – 27 June 2018
Publication of report: 28 September 2018

The visit focused on the Kestrel Ward CAMHS.

The summary of the report found that all employees interacted and engaged with patients respectfully, established evidence of governance for safe and clinically effective care and multi-disciplinary working with coordinated engagement of community and paediatric teams. Improvements were highlighted around the upkeep of outside areas, information displayed and systems for maintaining the safety of patients and staff this was in relation to personal alarms and nurse call buttons within the reach of the bed.

In relation to the Mental Health Act and the Mental Health Wales Measure the improvement plan highlighted the actions below.

Improvement Needed	**Service Action**	**Timescale**
The Health Board must ensure that the ward displays relevant patient information in a suitable	Source and display age appropriate Mental Health Act Information posters.	Complete

format.		
The Health Board should consider including body maps in all patient records	Discuss the pros and cons of using body map recording with adolescents in the next safety sub committee	Complete

4. Assessment of risk and key impacts

Outstanding HIW Actions are reviewed within the area Q-SEEL meetings on a monthly basis.

Policies –Policies are an ongoing project that requires updating and change as statute and documents change.

The MHLD Policy Implementation Group is working to ensure policies are kept up to date and reviewed by appropriate personal, this is reported on monthly to the divisional Q-SEEL meeting and reported up to QSG.

5. Equality Impact Assessment

This is a retrospective report therefore no EQIA required.

6. Conclusions / Next Steps

Policies – On going.

HIW Inspections – Inspections will be reported on and information updated on a three monthly basis.

7. Recommendations

It is recommended that the Committee notes this report.

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Arolygiaeth Gofal **Cymru**
Care Inspectorate **Wales**

Joint Thematic Review of Community Mental Health Teams

Thematic Report

Review date: 2017-2018

Publiction date: 7 February 2019

Contents

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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that people in Wales receive good quality care.

Our values

We place patients at the heart of what we do. We are:

Independent
Objective
Collaborative
Authoritative
Caring

Our priorities

Through our work we aim to:

Provide assurance:
Provide an independent view on the quality of care.

Promote improvement:
Encourage improvement through reporting and sharing of good practice

Influence policy and standards:
Use what we find to influence policy, standards and practice

Care Inspectorate Wales (CIW)

Our purpose

To regulate, inspect and improve adult care, childcare and social services for people in Wales.

Our values

Our Core values ensure people are at the heart of everything we do and aspire to be as an organisation:

Integrity: We are honest and trustworthy.

Respect: We listen, value and support others.

Caring: We are compassionate and approachable.

Fair: We are consistent, impartial and inclusive.

Our strategic priorities

We have identified four strategic priorities to provide us with our organisational direction and focus over the next three years. These are:

To consistently deliver a high quality service

To be highly skilled, capable and responsive

To be an expert voice to influence and drive improvement

To effectively implement legislation.

Foreword

This report brings together HIW and CIW's joint work over the last two years and aims to highlight key themes and issues arising from our inspections of Community Mental Health Teams (CMHT) across Wales.

Over the course of this review we frequently found disparity and variability in the standards, consistency and availability of treatment, care and support provided by Community Mental Health Teams across Wales. Welsh Government, Health Boards and Local Authorities need to carefully consider and examine the areas we have highlighted and act on our recommendations so that people living with mental illness will receive equitable care wherever they live in Wales.

We believe the findings and recommendations are of interest to service users, their relatives and carers who are accessing or have accessed community mental health services and we would like to take this opportunity to thank the people and staff across Wales who participated in this review and shared their experiences with us openly and honestly. We hope they will recognise their input and realise how their experiences have helped guide our findings and recommendations.

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Arolygiaeth Gofal **Cymru**
Care Inspectorate **Wales**

Key Findings

In this section we outline the key issues found over the course of our review. Further information about how we approached the review, and our detailed findings and recommendations follow in subsequent sections of the report.

Access to Services

We found that initial access to services is an area which requires improvement within most Community Mental Health Teams (CMHTs) across Wales. In particular, the linkages between CMHTs and General Practice (GPs) need strengthening. It appears there is often a lack of clarity regarding the referral criteria into CMHTs, as well as a lack of knowledge of the range of services available for people to be referred to. This needs attention and new ways of working are required to simplify referral and assessment processes, and reduce waiting times. Some areas are moving towards a more integrated single point of contact for mental health services, which will improve the situation, however the picture across Wales is variable. More work needs to be done to improve consistency in relation to referrals, assessments and service provision across Wales. Improved understanding of service provision within and between the GPs and CMHTs will improve timely access to the most appropriate care.

We found variability across Wales in the response to people experiencing mental health crisis or in urgent need. We found that some service users receive immediate intervention and support but others experience a delayed response, for example having to attend A&E departments on more than one occasion or having difficulty contacting services out of hours. We also found that a significant number of people did not know who to contact out of hours and were not satisfied with the help offered. This means that people accessing services in a crisis cannot be assured that their needs are always responded to appropriately and in a timely manner.

Better listening and learning, especially from service users' experiences of access and their journey through the systems, will ensure improvements are designed around their needs and that service users are, and remain, at the centre of service provision.

Care Planning

We found that because of the diligence and hard work of staff, care planning and legislative documentation is, in most CMHTs, being completed in a timely manner. However, we are not assured that service users and their families/carers are always as involved in developing the care and treatment plan as they would like to be. This may be a training issue or a lack of communication between care co-ordinators and service users. Nevertheless, it is an area that needs attention. Similarly, we are not assured that all CMHTs routinely offer advocacy services on assessment or at significant points during a service user's care. Additionally, carers' assessments are not undertaken routinely to identify if and what information, advice, assistance or support they may need to care for the service user.

Whilst Welsh Government figures[1] indicate that most services are meeting the required timescales for assessments and care planning, we found that this did not always equate to good quality care plans. Not all CMHTs are focusing on the quality of, and detail within, records and documentation.

1 www.statswales.gov.wales/Catalogue/Health-and-Social-Care/Mental-Health/Mental-Health-Measure

We are satisfied that individually, health boards and local authorities carry out sufficient audit of documentation including care and treatment planning. However, there is less evidence of the joint audit and analysis of documentation and outcomes for service users. Improvement is required in this aspect.

Whilst all health boards scrutinise Mental Health Act (MHA) documentation, the quality and expertise of this differs from health board to health board. There needs to be more standardisation across Wales.

Delivery

We found that the working environments within most CMHTs needs improvement with some clinical areas not fit for purpose. Whilst staff attempt to work effectively and efficiently both clinically and collaboratively, their working environment does not always facilitate this. More needs to be done to resolve these problems.

Whilst we are assured that health boards and local authorities have clear oversight of the quality of care provided within their relevant CMHTs, many health boards are in a time of transformation. We heard of many significant areas of strategic service development, however, there remains a duty to ensure service users receive the appropriate care from the appropriate person at the appropriate time, whilst wider transformation of services takes place.

We are concerned regarding the arrangements for medicine management, with the need to develop better audit, guidance and support from dedicated mental health community pharmacists.

We found that there are a range of different support services being offered across Wales, many tailored for particular regions. However, in some areas there are issues regarding the ability to access some third sector and other support services. This is because eligibility for some third sector (voluntary) and other support services is dependent upon eligibility to receive CMHT support. This can be a barrier to proactive preventative care. The third sector can offer invaluable support in addressing the needs of people experiencing poor mental health and that this is a resource that should be embraced and used more frequently where available.

Nationally, we have found that access to psychology or therapeutic services within secondary, primary and third sector is very limited and there are long waiting times in Wales; up to 24 months in some areas. This requires urgent action to address the shortfall in service provision. This involves not only increased recruitment in these disciplines, but looking at more innovative ways of meeting this need. Health boards and local authorities must consider identified unmet needs to inform future commissioning and operational plans.

We are not assured that there is robust scrutiny of discharge planning and consequently, service users may not always be discharged from CMHTs in a safe and timely way, with the appropriate support or information to access primary care or third sector (voluntary) services if required. More consideration needs to be given to ongoing community support to ensure that the risks associated with discharge from services are minimised.

Governance

In most areas we heard about new strategies and approaches for mental health services that include plans to develop new models of service delivery to more effectively meet the needs of the population. Whilst this is encouraging to see, the current needs of people in receipt of services must continue to be met and all efforts made to ensure safe, good quality services are being provided.

Information technology and universal access to patient/service user records remains a considerable problem in health and social care services. This is particularly challenging for integrated services such as CMHTs. There is a role for Welsh Government in developing systems that allow for this and to enable safer, more efficient and effective collaborative record keeping.

We found in some areas, people are supported to provide feedback on services via third sector organisations, however, this is an area for further development. In general there are a lack of opportunities available for people to provide feedback on treatment, care and support services and limited information given on how to raise a concern. More work needs to be done to ensure that the voice of those in receipt of services is heard, listened to and acted upon.

We noted challenges relating to resources amongst CMHTs with issues in relation to staff recruitment and retention, although most CMHTs are considering different ways of addressing this. We are satisfied that whilst staff training is improving in most teams, more work is required to ensure that staff are up to date with mandatory training topics. We found that staff supervision systems were robust in health and in social care, with supervision and support on a day to day basis from both organisations clearly evident. There is a need for local authority staff to receive formal, recorded, one-to-one supervision to ensure that they have an opportunity to discuss on-going training, development and well being.

Recommendations

No.	Recommendation
1.	Health boards should ensure there is clarity over the criteria for accessing CMHTs and the various community support teams that exist. In particular GPs and primary care practitioners need to have the information and support to enable them to provide the best possible advice for service users.
2.	CMHTs need to ensure that service users are clear on how to access or contact services out of hours, or in the event of crisis or serious concern.
3.	Health boards need to ensure that information relating to the ‘Putting Things Right’ process is available at all CMHT locations.
4.	CMHTs need to improve the way that they oversee the handling, monitoring, and lessons learned aspects of concerns/complaints.
5.	Health boards and local authorities need to look at ways to improve awareness of advocacy provision amongst their staff and develop local monitoring of CMHT engagement with advocacy services, to ensure service users have access to the support they require on assessment at significant points within their care.

No.	Recommendation
6.	Significant work is required from health boards to improve the provision and maintenance of safe and clinically appropriate facilities for CMHT service users and staff.
7.	CMHTs need to improve the recording of risk assessments within CTPs to ensure risks and management plans are more comprehensively recorded, more detailed and relevant to individual circumstances and particular situations.
8.	CMHTs need to ensure that CTPs are of sufficient quality, with evidence that service users have been involved in their development, and that the resulting CTPs are relevant to the outcomes the service user wishes to achieve.
9.	CMHTs must ensure copies of CTPs are given to service users and their relatives, where consent has been provided for this to happen.
10.	Health boards ensure regular audits are performed to ensure that service users are not detained under section 4 of the MHA for longer than 72 hours.
11.	Health boards and Local Authorities need to ensure there is joint access to relevant CMHT records. This has a clear potential adverse impact upon the standard of care being provided and needs to be addressed as a matter of priority.
12.	Health boards need to ensure there are clear lines of accountability, staff training, dedicated pharmacy support and robust auditing processes to oversee and implement medicines management within community services, especially within CMHTs.
13.	CMHTs need to ensure that all staff complete mandatory adult and child safeguarding training.
14.	CMHTs need to ensure that carers' assessment of needs are routinely offered.
15.	CMHTs need to undertake an audit of discharges to measure the quality and timeliness of discharge planning in order to help improve services and outcomes for service users.
16.	CMHTs need to review the role of the care co-ordinator and establish whether the service users are receiving the correct input from the most appropriate professional.
17.	CMHTs and care co-ordinators in particular, need to ensure discharge planning is robust and meets with legislative requirements.
18.	CMHTs need to develop processes to evaluate the effectiveness of information, advice and assistance that is provided for service users.
19.	Health boards need to explore and utilise the support that may be offered by third sector services across Wales, with a need to take advantage of the range of community groups and mental health support services available to patients in their local communities.

No.	Recommendation
20.	Much more work is needed to increase the availability and timely access to psychological therapies across Wales. Health boards need to improve resources in this area and look at different ways of making sure sufficient psychological services were being provided.
21.	Health boards and local authorities need to work together to improve joint processes for driving the improvement of services. This includes the need for greater alignment of processes within CMHTs including integrated records and data collection.
22.	Welsh Government needs to ensure that the implementation of the Welsh Community Care Information System (WCCIS) progresses with pace.
23.	All CMHT staff should receive training in the following: • Mental Health Act; • Social Services and Well Being Act; • First Aid and the use of defibrillators.

What we did

In its 2016-17 Operational Plan, Healthcare Inspectorate Wales (HIW) proposed to undertake a thematic review relating to mental health services in the community. This decision was primarily a response to a report published by HIW in March 2016: *Independent External Reviews of Homicides – An Evaluation of Reviews Undertaken by HIW since 2007*[2]. This review collated common themes which emerged and assessed the impact that the reviews had on the provision of mental health services across Wales.

The broad issues highlighted within the evaluation report included:

- Care planning, assessment and engagement with families/carers
- Risk management
- Diagnosis
- Discharge and aftercare planning
- Integrated and co-ordinated services
- Communication and information sharing.

Given the integrated nature of community mental health services, it was agreed that the review would be carried out jointly with Care Inspectorate Wales (CIW), and that CIW's 2017-19 adult services' engagement programme would include a focus on community mental health services.

Scope

The review was conducted in two phases. Phase one of the review consisted of seven joint inspection visits to selected CMHTs within each of the seven health boards[3]. Our inspections comprised of:

- A self assessment completed by each health board and local authority
- Interviews with selected CMHT staff
- Review of patient documentation including care plans and assessments
- Review of systems in place to plan and coordinate the provision of care and treatment to patients
- Interviews with service users and carers.

2 See: www.hiw.org.uk/reports/natthem/2016/homicideevaluation/?lang=en

3 ABUHB – South Caerphilly CMHT www.hiw.org.uk/docs/hiw/inspectionreports/180216caerphillycmhten.pdf
ABMUHB – Swansea (Area 2) CMHT www.hiw.org.uk/docs/hiw/inspectionreports/180131swanseacentralcmhten.pdf
BCUHB – Deeside CMHT www.hiw.org.uk/docs/hiw/inspectionreports/180131deesidecmhten.pdf
C&VUHB – The Links CMHT www.hiw.org.uk/docs/hiw/inspectionreports/180329thelinksen.pdf
CTUHB – Cynon CMHT www.hiw.org.uk/docs/hiw/inspectionreports/180219cynoncmhten.pdf
HDUHB – South Pembrokeshire CMHT www.hiw.org.uk/docs/hiw/inspectionreports/180326southpembrokeshireen.pdf
PTHB – Welshpool CMHT www.hiw.org.uk/docs/hiw/inspectionreports/180131welshpoolcmhten.pdf

Phase two built upon phase one findings and sought, through engagement with strategic and clinical leads across Wales, views on the issues previously identified and plans for improvements issued during phase one inspections. Engagement activity was undertaken by HIW and CIW with people who use services, carers, third sector and regulated service providers. A Community Mental Health survey was also undertaken to receive responses from people who used community mental health services. The second phase of this review set out to refine our understanding and assess:

Access to Services

- Effectiveness of arrangements, including referral processes and criteria to CMHTs.

- **Care Planning**
  - Quality and quantity of information collated to assist with care planning and assessments.
  - Compliance with the Mental Health (Wales) Measure 2010 and Social Services and Well Being (Wales) Act 2014, in relation to care planning and assessments, including clinical care and crisis intervention.
  - Compliance with the Mental Health Act (MHA) 1983, including community treatment orders.

- **Delivery**
  - Infrastructure, integration and co-ordination of services within CMHT teams, including effectiveness of Multi-Disciplinary Teams (MDTs), resources, case loads and information sharing arrangements.
  - Understanding the mechanisms used for communication/information sharing with patients, their families and carers.
  - Timeliness and accuracy of discharge arrangements and the robustness of aftercare planning for patients.
  - Links to and availability of other support services.

- **Governance**
  - Leadership and governance.
  - Quality Assurance of services.

Methodology

The joint thematic review focused on community adult mental health services (people between the ages of 18-65). Primarily we looked at Community Mental Health Teams (CMHTs)[4] and made inspection visits to CMHTs based in each health board[5]. The inspections included interviews with selected CMHT staff (NHS and local authority) responsible for providing and co-ordinating the care and treatment, service users and family or carers. We also undertook documentation and systems reviews to help form our findings. Relevant policies and guidance were utilised as a baseline for the review, and included:

4 Community Mental Health Teams (CMHTs) support people living in the community who have complex or serious mental health problems. Mental health staff from both the local authority and health work in a CMHT.

5 These inspection visits totalled seven, one per health board.

- Mental Health (Wales) Measure 2010 [referred to as the Measure in the report]
- Mental Health Act 1983 [referred to as the Act in the report]
- The Social Services and Wellbeing Act (SSWBA) 2014
- Health and Care Standards 2015
- Together for Mental Health A Strategy for Mental Health and Wellbeing in Wales 2016.

Community Mental Health Survey

Service users, their relatives and carers are at the centre of HIW and CIW's approach to inspection and review. Therefore, as part of this thematic review, HIW and CIW sought to capture the views of service users and their relatives/carers. Along with face to face interviews we undertook a confidential survey to ascertain what the service users and their families/carers felt about the quality of the services provided. We had 280 responses made up as follows:

Family member or carer:	127 responses
Previous service user:	51 responses
Current service user:	102 responses.

Some of the findings have been incorporated into the text of the report. Further detailed results can be found in Appendix B.

Stakeholder Reference Group

HIW's Mental Health Stakeholder Group acted as the thematic review stakeholder group. Membership included: Hafal, Advocacy Support Cymru, Mental Health Foundation, Mental Health Alliance, Gofal, Mental Health Matters in Wales, Unllais, Hafan Cymru, Diverse Cymru, Bipolar UK, HUTS, Gwalia, Small Steps Project, Ponthafren Association. The group was used to ensure that relevant organisations were kept suitably informed with the plans and progress for the review, as well as to provide guidance and scrutiny for our review where necessary. In addition, CIW liaised with the Association of Directors of Social Services (ADSS) Cymru.

The Review Team

To support our work we utilised expertise comprising of Mental Health Nurses and Social Workers as well as Mental Health Act administrators.

What we found

Quality of Service User Experience

Our review found that in general the service experienced by people in most CMHTs requires improvement. Although progress is being made in improving some aspects of services such as access, there continues to be improvement required with regard to:

- Including service users and their carers/relatives in enhancing service provision.
- Reducing referral and assessment times.
- Simplifying the referral and assessment process.
- Access to advocacy services.

Timely Access

The principle of timely care is that people have access to appropriate services as quickly as possible based on the persons' clinical need. We found that CMHTs across Wales are aware of and are addressing issues in relation to referral pathways and some are moving towards a more integrated single point of contact to ensure prompt referrals to the most appropriate team.

Health and Care Standard 5.1 Timely Access:
All aspects of care are provided in a timely way ensuring that people are treated and cared for in the right way, at the right time, in the right place and with the right staff.

Quality Standards for Local Authorities 1c:
Work with people as partners to undertake an assessment of personal well-being outcomes in a timely manner.

Quality standards for local authorities issued under section 145 of the Social Services and Well-being (Wales) Act 2014.or a more detailed paragraph version. The code of practice in relation to measuring social services performance is issued under section 145 of the Social Services and Well-being (Wales) Act 2014. This code of practice contains the performance measurement framework for local authorities in relation to the exercise of their social services functions. The performance framework is made up of quality standards and performance measures.

We would expect to see evidence that referrals, assessments and treatments are undertaken in a timely way consistent with national timescales, care pathways and best practice. Additionally, the NHS Outcomes and Delivery framework 2017-18 requires that people in Wales have timely access to services based on clinical need and are actively involved in the decisions about their care.

What we found:

We found that overall people's experience of accessing services was variable with some expressing satisfaction with the timeliness of response and others experiencing delays.

We found the processes for accessing mental health care cumbersome and difficult to navigate across Wales. For instance, difficulty in understanding the different referral criteria for the various community support teams and the appropriateness of each team in relation to the service users' identified need meant that many referrals to CMHTs, especially from GPs, were submitted with limited or incorrect information. This resulted in referrals often being sent back to the GP for further detail, delaying access to assessment and support for people. We saw response times vary from the same day (within 4 hours) to the Welsh Government target of within 28 days. Over a half of service users in our survey told us they waited 4 weeks or longer to be seen by a CMHTs following referral (54%).

Welsh Government figures and our survey (73%) show that GPs are the main source of referral, however analysis of GP referrals undertaken by one Welsh health board showed that 68% were not accepted into CMHT's for ongoing care. This highlights the need for further work to be undertaken specifically to raise awareness and understanding about the mental health referral process across GP practices.

The problems created by the complexity of referral processes are compounded by the variety of access points for services across Wales. For example, some community services have different access points for individual services, where others have a single point of access where referrals are triaged[6] and the service user is signposted to the most appropriate service. There are no processes in place to check whether this signposting is successful in meeting the service users' needs and organisations cannot be assured that people's needs are always being met. There is with a risk that people's mental health may deteriorate or relapse due to untimely or inappropriate care.

We also looked at access to services for people experiencing mental health crisis or urgent need and again found variability across Wales. Some, service users received immediate intervention and support, whilst others experienced a delayed response, for example having to attend A&E departments on more than one occasion or having difficulty contacting services out of hours.

Most CMHTs provide an out of hours service (after 5 pm and on weekends), albeit delivered in different ways. Importantly, our survey told us that only half of people who had accessed mental health services knew how to contact the CMHT out of hours service (49%) and only around two fifths of people who had contacted a CMHTs out of hours service said they received the help they needed (43%). A significant number of service users did not know who to contact and were not satisfied with the help offered. This means people who need to access services in a crisis cannot be confident their needs will be responded to appropriately and in a timely manner.

The majority of family members or carers told us that they had concerns about the safety or wellbeing of their family member or the person they care for, themselves or other people (83%). However, less than two thirds of family members or carers said that they would know who to contact in the event of a crisis or serious concern (60%). Additionally, only just under a half of family members or carers that contacted the CMHT in a crisis or with a serious concern, told us that they got the help they needed (45%).

6 Triage generally is a process of sifting and prioritizing both in terms of urgency and relevance.

Nevertheless, Welsh Government told us that over the last 12 months, there has been a decrease in the number of adverse incidents reported due to service users experiencing delays in accessing urgent support. We were told this is a result of improved processes and engagement between referrers and crisis teams, more appropriate escalation to secondary care when required and the tightening of processes between all community services.

No.	Recommendation
1.	Health boards should ensure there is clarity over the criteria for accessing CMHTs and the various community support teams that exist. In particular GPs and primary care practitioners need to have the information and support to enable them to provide the best possible advice for service users.
2.	CMHTs need to ensure that service users are clear on how to access or contact services out of hours, or in the event of crisis or serious concern.

Individual Care

We found that people are not being routinely offered the opportunity to feedback their views on the services provided, nor given information on how to raise a concern. Whilst in some areas CMHTs are obtaining service user feedback via third sector surveys, this is not consistent throughout Wales and we did not see any evidence of improvements made to services as a direct result of people's feedback. We did however hear of some innovative practice with service users involved with service development boards and recruitment panels.

Health and Care Standard 6.3 Listening and Learning from Feedback

People who receive care, and their families, must be empowered to describe their experiences to those who provided their care so there is a clear understanding of what is working well and what is not, and they must receive an open and honest response. Health services should be shaped by and meet the needs of the people served and demonstrate that they act on and learn from feedback.

SSWBA Code of practice in relation to measuring social services performance 3.1 and 3.2: Measuring well-being

Focussing on people's individual outcomes means that local authorities **must** look beyond formal service provision and work with people and communities to identify and plan for support and opportunities that can help people achieve what matters to them.

Local authorities **must** ensure that the range and level of services provided support the delivery of the outcomes that matter to people.

We expect to see evidence that individual service users, their family and/or carers' voices are listened to and that health boards and local authorities use these experiences to shape future services, as required in the Together for Mental Health Delivery Plan 2016-19, the NHS Outcomes and Delivery Framework 2017-18, and the Social Services and Well-being (Wales) Act 2014 Code of practice in relation to measuring social services performance. We would also expect to see evidence of compliance with legislation and guidance to deal with concerns, incidents, near misses and claims as set out within the NHS Concerns, Complaints and Redress arrangements (Wales) 'Putting Things Right' and Local Authority arrangements as set out in *A guide to handling complaints and representations by local authority social services (2014)* guidance.

Additionally, we expect to find regular monitoring and audit of these arrangements, and examples of lessons learned and honest and open engagement with all who access the services.

What we found:

There were not always systems in place that enabled service users and relatives to provide written or verbal feedback and there was a lack of clear information on how to raise a concern.

We did find evidence of developing practice by involving service users in service change. For instance, in some CMHTs arrangements are in place for service users to be included on staff interview panels, at service development events and also to provide feedback on services. Additionally, some health boards are linking with third sector organisations to explore ways to engage and learn from service users' experiences. However, these initiatives are not consistently seen across Wales and very few are jointly developed between health boards and local authorities specifically for CMHTs.

We were told patient feedback forms/questionnaires and 'Putting Things Right' guidance are available for in-patients but not always available in community services. During the course of our fieldwork it was widely acknowledged that this information needs to be in waiting rooms, treatment rooms and could also be discussed as part of the discharge plan.

Many areas told us they use complaints as one means of measuring patient satisfaction. Whilst we saw, from minutes of meetings, that there are quality assurance and health and safety reporting processes, with evidence of senior representation on each other's boards (health and local authority), it remains unclear how lessons are learned and shared in a meaningful way. This is because we identified inconsistencies in how complaints about CMHT services are handled. Although there is some alignment between NHS and Local Authority concern reporting processes since the local authority complaints arrangements were introduced in 2014, there are still distinct differences between procedures. This sometimes results in lengthy and inconsistent responses to complaints, duplication of effort, and in some complaints not being handled at all. We also found within health boards, concerns were not always being recorded and logged in accordance with 'Putting Things Right'. Therefore, it was unclear whether they were being monitored, investigated, themes highlighted and lessons learnt. It was also unclear how improvements were being measured and monitored and whether this was undertaken via action plans, sharing of information with relevant teams, or through monitoring by senior managers.

Overall, we found improvement was needed to ensure systems and organisational structures effectively support service users and carers to contribute to the review/evaluation of services and to service development.

No.	Recommendation
3.	Health boards need to ensure that information relating to the 'Putting Things Right' process is available at all CMHT locations.
4.	CMHTs need to improve the way that they oversee the handling, monitoring, and lessons learned aspects of concerns/complaints.

Advocacy

Service users are not routinely offered advocacy services at significant points of their care pathway.

Health and Care Standard 6.2 Peoples Rights

Health services embed equality and human rights across the functions and delivery of health services in line with statutory requirements recognising the diversity of the population and rights of individuals under equality, diversity and human rights legislation.

Social Services and Well-being (Wales) Act 2014
Code of practice in relation to measuring social services performance:
Quality standards for local authorities.
Social services and Well-being (Wales) Act 2014 – Part 10 Code of Practice (Advocacy)

This code sets out the requirements for local authorities to:

a. ensure that access to advocacy services and support is available to enable individuals to engage and participate when local authorities are exercising statutory duties in relation to them; and
b. to arrange an independent professional advocate to facilitate the involvement of individuals in certain circumstances. Paragraph 45 of the code states local authorities **must** arrange for the provision of an independent professional advocate[7] when a person can only overcome the barrier(s) to **participate fully** in **the assessment, care and support planning, review and safeguarding processes** with assistance from an appropriate individual, but there is no appropriate individual available.

We expect to see evidence that service users' individual needs are recognised, and when required, advocacy services are offered in a timely and responsive manner. This would enable service users who are most vulnerable, to receive support to explore choices and options before making decisions about their lives.

7 **Independent professional advocacy** – involves a one-to-one partnership between an independent professional advocate who is trained and paid to undertake their professional role as an advocate. This might be for a single issue or multiple issues. Independent professional advocates must ensure individuals' views are accurately conveyed irrespective of the view of the advocate or others as to what is in the best interests of the individuals.

What we found:

Under Part 4 of the Measure, the provision of advocacy covers any service user who is subject to a CTO[8] where the hospital responsible for them is situated in Wales. The over-arching duties under section 6 of the SSWBA require that any person exercising functions under the Act must in so far as reasonably practicable, ascertain and have regard to people's views, wishes and feelings. We could not be assured that service users were routinely being offered advocacy services at assessment or at significant points throughout their care.

Our survey found that less than a quarter of service users and previous service users were offered the support of an advocate (22%), especially for assistance with initial assessments, mental health review tribunals, hospital manager hearings or CTP reviews. Advocacy support ensures services users can participate fully in assessment and care planning and making decisions about their future. Due to the lack of record keeping regarding an active offer of advocacy support, we did not see evidence that this was consistently and routinely happening.

In addition, it is not clear joint commissioning arrangements ensure sufficient and appropriate advocacy resource is available consistently across Wales. Senior CMHT managers could not assure us that advocacy services were routinely and consistently being offered to service users because current quality assurance reporting systems do not provide evidence that advocacy has been offered. It was acknowledged not all staff recognised the importance of making this offer at an early stage. We saw that most health boards had links with statutory advocacy organisations, and some had a contract to provide advocacy services, but this was usually for inpatients and not always for people in the care of CMHTs. In order to ensure compliance with the Measure, the Mental Health Act Code of Practice, and the SS&WBA a more systematic/routine offer of advocacy to service users is required.

Throughout Wales we found that advocacy representatives do not come regularly to the CMHT services to meet patients, or attend Mental Health Review tribunals, case reviews or CTP reviews.

No.	Recommendation
5.	Health boards and local authorities need to look at ways to improve awareness of advocacy provision amongst their staff and develop local monitoring of CMHT engagement with advocacy services, to ensure service users have access to the support they require on assessment at significant points within their care.

8 A Community Treatment Order (CTO) is a legal order made by the Mental Health Review Tribunal or by a Magistrate. It sets out the terms under which a person must accept medication and therapy, counselling, management, rehabilitation and other services while living in the community.

Delivery of Safe and Effective Care

We are assured that health boards and local authorities have oversight of the quality of care provided within their CMHTs. However, in the context of significant service transformation it is important for senior managers to maintain focus on ensuring service users continue to receive the appropriate care from the appropriate person at the appropriate time whilst the wider organisational changes are being introduced.

Safe Care

We were not assured that due care and attention was being given to CMHT environments which directly impacted on service users' dignity and privacy as well as staff safety.

Health and Care Standard 2.1 Managing Risk and Promoting Health and Safety

People's health, safety and welfare are actively promoted and protected. Risks are identified, monitored and where possible, reduced and prevented.

Quality standards for local authorities: Code of practice in relation to measuring social services performance.

Local authorities must work with people who need care and support and carers who need support and relevant partners to protect and promote people's physical and mental health and emotional well-being.

We would expect to see evidence that risk management and health and safety are embedded within services and that all possible measures are taken to prevent serious harm or death. We would want to see safety notices, alerts and up to date information available to help identify and manage any potential risks or emerging issues.

What we found:

We found environmental concerns at most of the CMHT areas we visited. Many involved unsuitable premises which impacted on the privacy and dignity of service users such as the absence of clinical rooms for administration of medication. Additionally, many of these had environmental risk assessments which indicated that there was outstanding work directly relating to staff safety and infection control, for example, no hand wash basin or safety alarms in individual rooms.

All health boards and local authorities described similar processes for ensuring appropriate actions were undertaken to address any environmental shortcomings, for example, through Health & Safety (H&S) audits and infection control audits which are discussed in operational groups. However, our work indicated that these arrangements were predominantly for inpatient or residential facilities. Further exploration showed that most health boards and local authorities have very few routine environmental audits or H&S audits of CMHT premises.

The importance of providing an inviting reception area was acknowledged by CMHTs and some service users reported experiencing sensitive, caring and professional response from reception staff.

No.	Recommendation
6.	Significant work is required from health boards to improve the provision and maintenance of safe and clinically appropriate facilities for CMHT service users and staff.

Care and Treatment Plans

We found that health boards and local authorities have individual programmes of audit to ensure compliance with national standards. However, there are areas for improvement specifically:

- the quality of collaborative audits between both services;
- the quality of Care and Treatment Plans (CTP);
- the involvement of service users and their relatives/carers in developing the plans.

Health and Care Standard 6.1 Planning Care to Promote Independence

Care provision must respect people's choices in how they care for themselves as maintaining independence improves quality of life and maximises physical and emotional wellbeing.

Quality standards for local authorities: Code of practice in relation to measuring social services performance

Local authorities must work with people who need care and support and carers who need support and relevant partners to protect and promote people's physical and mental health and emotional well-being.

Part 2 of the Measure and the Mental Health (Care Co-ordination and Care and Treatment Planning) (Wales) Regulations 2011 place duties on care-co-ordinators in relation to the preparation, content, consultation and review of care and treatment plans. Service users should be involved in planning their care and treatment, where practicable. All SSWBA Codes of Practice reinforce that local authorities must work with people who need care and support and carers who need support to define and co-produce personal well-being outcomes that people wish to achieve.

This means that mental health professionals must engage with service users to identify and plan the delivery of a range of services to meet their needs. Engagement should include the co-production of a care and treatment plan between the service user, mental health service providers and the care coordinator, as well as the setting of goals to achieve the agreed outcomes within the plan. It should also include the monitoring of the delivery of services, with any amendment of the plans undertaken through a planned and systematic review process. Engagement should also apply to the families and/or other significant people in the lives of the service user, subject to their ongoing agreement and consent.

We would expect to see that service users are encouraged and supported to participate in planning their care. There should be on going risk assessments and individual care planning involving all those relevant to the person's care. There should be evidence of multi-disciplinary-professional-agency working to support service users to reach their full potential.

What we found:

We found the quality of Care and Treatment Plans (CTPs) was variable across Wales. Whilst some areas reflected aspects of good multi-disciplinary person centred work, most documentation did not provide sufficient evidence of the discussions, assessments, investigations and decisions made by the multi disciplinary team around service users' care, treatment and support in accordance with regulatory requirements. There was also a lack of recorded evidence of carers' assessments being offered.

We found improvement was needed in the recording of risk assessments to ensure risks and management plans are more comprehensively recorded, more detailed and relevant to individual circumstances and particular situations.

Although service users told us that they and their carers had sometimes been involved in the writing of their CTPs and that some recorded the views of service users in their own words, this was not consistently the case. In addition we found CTPs were sometimes not signed and did not evidence that service users (or where appropriate their carers) were provided with a copy. This means that people cannot see for themselves that their CTPs are current and relevant to outcomes they wish to achieve. There is more work to be done to ensure that copies of CTPs are given to service users and their relatives where consent has been provided for this to happen. We found in our survey that under half (48%) of service users were given an opportunity to have a copy of their care plan.

It was clear that within the CMHTs, health board and local authorities have individual routine quality audits of service user care plans in place. However, whilst senior managers attend each organisation's quality assurance meetings, there is less evidence that there are joint quality assurance audits undertaken. It would be beneficial if there were unified audits which looked at the CMHT as a whole integrated team rather than two co-located services. It would also foster closer working relationships and integrated service provision. There were also concerns raised in some areas regarding the quality of the audits, suggesting that there is sometimes a tendency to look at the presence of care plans rather than quality of them. This is an issue that requires action to address.

Our survey findings suggest a number of additional areas which would benefit from closer scrutiny in CTP audits. These include the involvement of service users in the development of their care plan (only 23% feeling involved) and feeling that a member of their family, or someone else close to them, was not involved as much as they would have liked (51%).

We saw some evidence of staff engaging well with people. Positive comments from relatives and carers who were involved in care planning included almost half saying that their CMHTs staff offered sufficient time to express their views and family members or carers confirming that they felt listened to during these discussions. Three quarters of service users felt that their CMHT worker usually listened to them carefully (76%). We found many people in receipt of a service from their local CMHT felt well supported by their mental health workers and were treated with dignity and respect. Some people interviewed expressed satisfaction in their relationship with their worker. Comments included:

"Everyone is so welcoming"

"Staff go out of their way to provide support"

"Without this service I would not be here"

"Staff demonstrate human qualities; respectful and trustworthy practice"

Welsh Government has a 90% achievement target for service users to have a valid CTP within 6 weeks of allocation to a care co-ordinator.

Care and treatment plan (CTP) compliance, by LHB, service and month (March 2018)

	Total number of patients resident in the LHB with a valid CTP at the end of the month	Total number of patients resident in the LHB currently in receipt of secondary Mental Health services at the end of the month	Percentage of patients resident in the LHB, who are in receipt of secondary mental health services, who have a valid CTPs
Wales	21,135	23,753	89.0
BCUHB	4,899	5,736	85.4
PTHB	980	1,033	94.9
HDUHB	2,182	2,371	92.0
ABMHB	2,854	3,213	88.8
CTUHB	2,288	2,657	86.1
ABUHB	2,892	3,183	90.9
C&VUB	5,040	5,560	90.6

Mental Health (Wales) Measure Part 2 – Care and Treatment Plans (Statswales.gov.uk)

In Wales, there were 23,753 service users in receipt of secondary mental health services during June 2018. Of these, 21,135 (89.0%) had a valid Care and Treatment Plan (CTP), with half of the CMHTs meeting the 90% target. This is despite CMHTs reporting that caseloads are high and care co-ordinators are inundated with work. This is a credit to the diligence and conscientiousness of staff.

Part 3 of the Measure provides eligible service users with an entitlement to request an assessment (usually by a member of the CMHT) should they feel that their mental health is deteriorating. Welsh Government has a target of 100% for assessment of service users within 10 working days of their request.

Outcome assessment report compliance, by LHB and month

	Number of outcome assessment reports that were sent up to and including 10 working days after the assessment had taken place	Number of outcome assessment reports that were sent after 10 working days after the assessment had taken place	Total number of outcome of assessment reports sent within the month	Percentage of outcome assessment reports sent less than or equal to 10 days after the assessment had taken place
Wales	84	4	89	95.5
BCUHB	16	2	18	88.9
PTHB	1	0	1	100.0
HDUHB	6	0	6	100.0
ABMUHB	2	0	2	100.0
CTUHB	4	2	6	66.7
ABUHB	12	0	12	100.0
C&VUHB	44	0	44	100.0

Part 3: Assessment of Former Users of Secondary Mental Health Services – Outcome assessment report compliance, by LHB and month (Statswales.gov.wales)

We commend the hard work of front line staff in developing outcome assessment reports for service users in a timely way (95.5%). Our review, however, indicated that less than half (43%) of previous service users knew they could refer themselves to their CMHTs if they felt that they were relapsing.

It is evident that throughout Wales, there needs to be greater emphasis on explaining and engaging service user and service user relatives with the process of developing CTPs.

No.	Recommendation
7.	CMHTs need to improve the recording of risk assessments within CTPs to ensure risks and management plans are more comprehensively recorded, more detailed and relevant to individual circumstances and particular situations.
8.	CMHTs need to ensure that CTPs are of sufficient quality, with evidence that service users have been involved in their development, and that the resulting CTPs are relevant to the outcomes the service user wishes to achieve.
9.	CMHTs must ensure copies of CTPs are given to service users and their relatives, where consent has been provided for this to happen.

Record Keeping and Mental Health Act Documents

Whilst all health boards have arrangements in place for scrutinising Mental Health Act documentation, the quality of these arrangements, and expertise available to do so, differs from health board to health board. The quality of the documentation needs improvement; this may be due to training needs and the recruitment of appropriate staff to undertake the role of care co-ordinator.

Health and Care Standard 3.5 Record Keeping

Good record keeping is essential to ensure that people receive effective and safe care. Health services must ensure that all records are maintained in accordance with legislation and clinical standards guidance.

We would expect to see documentation and service user records maintained according to the standards set by individual professional bodies. Entries should be clear and support clinical judgements formed from appropriate risk assessments. There should be clear documentation in line with legal requirements on:

- the administration of the Mental Health Act;
- section expiry dates;
- records in regard to any hospital manager reviews and mental health tribunals; and
- detained service users should be aware of their rights and this is recorded.

What we found:

We found that although each health board has a governance structure to ensure that the legal documentation required by the MHA is reviewed on a regular basis, the overall quality of record keeping in most health boards did not meet the required standards. For instance, because staff were not always aware of the parts of the Mental Health Act which informs their work, aspects of record keeping were not compliant with legislation or guidance.

In one area we found a disproportionate number of service users detained under section 4[9] of the MHA. It appears that there is a direct link between this and the limited availability of section 12[10] doctors[11] in that area. Section 4 is an emergency admission which only allows a doctor to admit a patient for 72 hours therefore, the Act requires that two doctors agree if a service user is to be detained for a longer period. Insufficient staffing is not an acceptable reason to keep service users under section 4. Health boards must ensure, in line with the Code of Practice that there are sufficient section 12 doctors on their register.

We found recording of documentation varied across Wales with the majority of local authority and health boards continuing to use separate electronic systems. In addition some records (mainly medical) continued to be kept in paper format, which means that access and storage of records is a problem. Communication across health and social care was further complicated as staff employed by either health or local authority organisations had different degrees of access to the main databases or intranets of each other's organisations.

Managers also informed us that current electronic systems do not always provide routine reports in relation to some key factors such as the offer of advocacy or carers assessments.

Recently, a great deal of work has been undertaken across Wales to offer more support/training to MHA managers with the development of the All Wales MHA Forum. This provides a network of contact details for MHA administrators and offers support to all health boards. This is a significant move towards supporting consistency in MHA documentation and monitoring throughout Wales and can be a conduit to provide a framework for standard setting.

No.	Recommendation
10.	Health boards must ensure regular audits are performed to ensure that service users are not detained under section 4 of the MHA for longer than 72 hours.
11.	Health boards and Local Authorities need to ensure there is joint access to relevant CMHT records. This has a clear potential adverse impact upon the standard of care being provided and needs to be addressed as a matter of priority.

9 Section 4 of the Mental Health Act 1983 is used in emergencies, where only 1 doctor is available at short notice. Unlike a section 2 or 3, you can be detained with a recommendation from only 1 doctor. You can be kept for up to 72 hours. This gives the hospital time to arrange a full assessment.

10 Section 12(2) of the Mental Health Act 1983 requires that, in those cases where two medical recommendations for the compulsory admission of mental disordered person to hospital, or for reception into guardianship, are required, one of the two must be made by a practitioner approved for the purposes of that section. See: www.rcpsych.ac.uk

11 A section 12 doctor is a doctor trained and qualified in the use of the Mental Health Act 1983, usually a psychiatrist. They may also be a responsible clinician, if the responsible clinician is a doctor.

Medicines Management

There are varied arrangements for medicine management across CMHTs in Wales. Some areas have robust policies and procedures with clear accountability and guidance, while others have more informal arrangements with no dedicated mental health pharmacists, limited external audit and poor facilities.

Health and Care Standard 2.6 Medicines Management

People receive medication for the correct reason, the right medication at the right dose and at the right time.

We would expect to see evidence of compliance with legislation, regulatory and professional guidance and with local guidance for all aspects of medicines management. That there was timely, accessible and appropriate medicines advice and information for service users, carers and staff and that service users understood the purpose and correct use of their medication or alternate treatment options. We would also expect to see robust systems in place to report reactions and adverse incidents and that these are managed appropriately.

What we found:

We found a variety of issues across CMHTs regarding safe administration and storage of medication. For example we found:

- Neither room or fridge temperatures were regularly checked.
- CMHTs need to consider making wider use of the physical monitoring forms in relation to depot[12] injections.
- Medication and medication transport policies/guidelines were not available in the clinical rooms.
- No named pharmacist attached to a CMHT to attend meetings, oversee stock management, and to undertake independent medication chart audits.
- Poor stock checks and recording of medicine administration.
- Poor environmental facilities.

In view of the lack of compliance with legislation, clear regulatory and professional guidelines and an absence of local guidance for medicine management, there is the potential for harm and error. Health boards, specifically regarding CMHTs, need to evaluate their processes for medicines management with a view to aligning with the requirements of in-patient care which includes dedicated pharmacists and regular audit.

No.	Recommendation
12.	Health boards need to ensure there are clear lines of accountability, staff training, dedicated pharmacy support and robust auditing processes to oversee and implement medicines management within community services, especially within CMHTs.

12 A depot injection is a slow-release, slow-acting form of a service users usual medication. It's administered by injection, and it is given in a carrier liquid that releases it slowly so it lasts a lot longer.

Safeguarding

We are satisfied that both health and local authority senior managers have oversight of safeguarding referrals and any on going concerns. CMHTs demonstrated an increasing awareness about safeguarding issues; some are actively incorporating key safeguarding prompts within their assessment documentation.

Health and Care Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk

Health services promote and protect the welfare and safety of children and adults who become vulnerable or at risk at any time.

Quality standards for local authorities: Code of practice in relation to measuring social services performance. Local authorities must take appropriate steps to protect and safeguard people who need care and support and carers who need support from abuse and neglect or any other kinds of harm[13].

We would expect to see effective local safeguarding strategies that combine preventative and protective elements with a thorough understanding of safeguarding procedures across all staff working in CMHTs in line with the Social Services and Well-being (Wales) Act 2014. Staff should receive training according to their role to enable an understanding and application of the principles of safeguarding.

What we found:

It was not always clear whether consideration was routinely given to whether people were at risk of harm, abuse or neglect. For example, in one specific case we saw documentation relating to concerns about the safety of a service user's children but there was no evidence of any further consultation with the respective child safeguarding team. This highlights the need for a more robust approach to linking with and recording contact with child and adult safeguarding teams.

Organisational arrangements for dealing with safeguarding referrals varied, with some services having centralised safeguarding teams whilst in other services team managers held the designated lead manager role. The important factor, whatever the organisational arrangements, is to ensure that the roles and responsibilities are understood and they have the capacity and knowledge to carry out these responsibilities. We found some staff did not feel confident in their knowledge of safeguarding policy and procedures and these matters were not routinely discussed at allocation and team meetings. Although training is provided on a routine basis in most CMHTs, we found not all staff had completed the mandatory adult and child safeguarding training.

No.	Recommendation
13.	CMHTs need to ensure that all staff complete mandatory adult and child safeguarding training.

13 Abuse, neglect and harm are defined in the Social Services and Well-being (Wales) Act 2014.

Carer Assessments

We are not assured that all carers are receiving a carer's assessment to identify any support or assistance they may need to care for the service user.

Health and Care Standard 6.1 Planning Care to Promote Independence

Care provision must respect people's choices in how they care for themselves as maintaining independence improves quality of life and maximises physical and emotional wellbeing.

Part 3 Code of Practice (assessing the needs of individuals)

A local authority must assess whether the carer[14] has needs for support (or is likely to do so in the future) and if they do, what those needs are or are likely to be.

We would expect to see evidence in line with Health and Care Standards 2015, and SSWBA that carers of service users who are unable to manage their own health and well being are supported. The SSWBA requires local authorities to offer carers an assessment of their needs where it appears they may have need for support. The provision of information, advice and assistance is also a core part of what must be provided. Carers must feel they are equal partner in their relationship with professionals.

What we found:

The State of Caring 2018 report reveals that 74% of carers across Wales say they have experienced mental health illness as a result of their caring role. In comparison to the whole of the UK the figures show that Wales ranks slightly above the UK average of 72% on this aspect. 61% of carers in Wales also feel their physical health has declined due to their role.

With care support provided by the UK's unpaid carers being an estimated £132 billion per year it is significantly more than the NHS' annual budget in Wales £6,381 million 2016-17 (Statswales.gov.uk). With 11.2% of the total amount spent on supporting people with mental health problems, it is troubling when our survey shows that only half of family members or carers say they feel valued in their caring role (50%).

We were told by senior managers that staff were sensitive to carers' needs and rights but they acknowledged case records did not always reflect this. Staff and managers report there is generally a low up take of assessment and support services by carers of people with mental health needs. In some services carers' champions have been introduced to try to raise the profile of carers and encourage staff awareness of the issues. However, we are not assured that senior managers are fully aware of the quality or quantity of carers assessments offered by CMHTs. Our survey indicated that only 23% received an offer or an assessment of their own needs. Furthermore when we asked for reassurance that care co-ordinators were reminded about assessments and were ensuring that these were taking place within the team, senior managers were unable to give us conclusive information.

14 A carer is defined in the Act as a person who provides or intends to provide care for an adult or a disabled child. In general, professional carers who receive payment should not be regarded as carers for the purposes of the Act, nor should people who provide care as voluntary work.

> We also found that almost three quarters of family members or carers said that they didn't have sufficient information about the services available to support their family member or the person they care for (70%). A similar proportion said they felt they didn't have sufficient information about their eligibility for those services either.
>
> The lack of awareness and support for carers by CMHTs has an impact on their own mental health and well-being. Nevertheless, some carers spoke warmly about the services provided by third sector organisations in providing support and recognition of the role they undertake.

No.	Recommendation
14.	CMHTs need to ensure that carers' assessment of needs are routinely offered.

Discharge

We are not assured that there is robust scrutiny around whether the legal requirements of discharge planning are being met. Consequently service users may not be receiving safe and timely discharges with the appropriate support or information to access primary care or third sector (voluntary) services if required.

Health and Care Standard 6.1 Planning Care to Promote Independence

Care provision must respect people's choices in how they care for themselves as maintaining independence improves quality of life and maximises physical and emotional wellbeing.

Quality standards for local authorities: Code of practice in relation to measuring social services performance

Local authorities must work with people who need care and support and carers who need support to define and co-produce personal well-being outcomes that people wish to achieve.

Local authorities must work with people who need care and support and carers who need support and relevant partners to protect and promote people's physical and mental health and emotional well-being.

We would expect to see evidence of an agreed discharge care plan, with on-going support provided, where necessary, by a range of mental health professionals in the community, which can include support from both statutory and voluntary agencies. In addition to a person's GP, this team of professionals could include: Community Psychiatric Nurses (CPNs), Social Workers, Psychologists, Occupational Therapists (OTs) and support workers who can provide a range of services encompassing monitoring and administering medication; providing 'talking therapies' and giving long-term support.

What we found:

We consistently found, across all CMHTs that CTP and risk assessment documentation needed to be updated prior to discharge, especially when there were transitional arrangements between CMHT and other services[15]. We found in most CMHTs that service users were not routinely being advised of their right to re-refer back to services without going through their GP. People who had experience of mental health services indicated variable experience regarding discharge and re-referral arrangements and from the evidence we have seen, we were not assured that CMHTs are consistently delivering quality or timely discharge from care for service users. Furthermore there are no robust systems in place to measure the quality and timeliness of discharge planning and the follow up with relevant services. With this lack of monitoring and audit there is a lost opportunity to learn lessons and improve services.

One area identified as having an impact on untimely discharges was high case loads for care co-ordinators[16], specifically those cases managed by consultants.

Careful planning is required in order for patients to be discharged in a safe manner. All discharges need to include any identified discharge needs, and involve service users. However, this isn't always happening due to workload challenges and service users are being discharged late or with incomplete CTPs. This is an area for improvement to ensure service users are receiving the correct level of care by the most appropriate member of the CMHT.

In our survey almost half of family members or carers said that they weren't involved at all in the discussions leading to the decisions for CMHT support to be discontinued (49%), and less than a third of family members or carers told us that they were provided with information about who to contact if they had further concerns about the health or wellbeing of their family member, or the person they care for, following discharge from the CMHT (32%).

According to the Mental Health Act, and the Mental Health Code of Practice for Wales, there are stipulated areas which need to be discussed prior to discharge. The following examples highlight some of the issues facing care co-ordinators.

Service users should be supported to find suitable accommodation

The availability of specialist support housing is variable and whereas some service users told us they had been given support to access council accommodation, others reported a long wait before appropriate accommodation became available. Additionally, only a quarter of family members or carers told us that the CMHTs provided advice with finding accommodation for their family member and only 34% of service users confirmed that their accommodation needs were met with the help of CMHTs. We asked senior managers what was available in their area in relation to this issue. With the exception of north Wales most could give examples of good engagement with local authority and third sector services and confirmed that there was good partnership working around accommodation.

15 When service users move between other services such as the CMHTs, private hospital sector, Children and Adolescence Mental Health Services (CAMHS) and older persons mental health services.

16 A care coordinator is the main point of contact and support for ongoing mental health care. They keep in close contact while the service user receives mental health care and monitor how that care is delivered – particularly outside of hospital. They are also responsible for carrying out an assessment to identify any health and social care needs. A care coordinator is usually a mental health professional.

However, despite existing policies, strategies, and legislation emphasising the importance of joined up and collaborative working, the experience of many staff on the ground was that this is not happening enough in practice. It is positive to note that some areas have been looking at alternative ways to meet local accommodation needs and Gwent Partnership[17] are exploring the use of some unique services such as a host family scheme, sanctuary provision and short-term crisis house residential support. Additionally, they are looking at the provision of an acute inpatient and crisis resolution home and treatment team to provide care to service users with significant mental health needs delivered by staff with specialist mental health expertise in their own home.

Personal care and well being

In preparation for discharge there should also be discussions to maintain personal care and wellbeing such as attending regular physical health checks with their GP or practice nurse. Our survey indicated that only 26% of family members or carers said that the CMHT provided advice with finding support for any physical health needs their family member or the person they care for had. In addition, only half of service users who needed support for physical health said that their CMHT gave them help or advice with finding support for these needs (48%). When challenged most senior managers told us that letters were sent to GPs to notify of any discharge plans and first appointments were made, where necessary. Additionally, ABMUHB told us that they have purposely developed some of their depot clinics within GP buildings to try and improve working relationships.

Benefits

Another area that should be explored prior to discharge is an assessment for entitlement to benefits and where appropriate support to access these. However, only 10% of family members or carers said that they were provided with information about direct payments to support their needs as a carer and nearly three quarters of service users and previous service users said that the option to receive direct payments to help meet their care and support needs was never discussed with them (73%). This represents a significant number of service users and their carers who believe that they did not have relevant financial support prior to discharge.

Our work has shown that there are variations across Wales regarding the quality of discharge planning and the availability of local services. Attention needs to be given by CMHTs to ensure that discharge reviews take place in a timely and meaningful way.

No.	Recommendation
15.	CMHTs need to undertake an audit of discharges to measure the quality and timeliness of discharge planning in order to help improve services and outcomes for service users.
16.	CMHTs need to review the role of the care co-ordinator and establish whether service users are receiving the correct input from the most appropriate professional.
17.	CMHTs and care co-ordinators in particular, need to ensure discharge planning is robust and meets with legislative requirements.

17 Gwent Strategic Partnership for Mental Health and Learning Disabilities.

Links/Access to other services

We found that there are a range of different support services being offered across Wales, many tailored to particular regions. However, a consistent message was that on a day-to-day basis there is often poor communication and a lack of joined up working across agencies. Psychology services within secondary, primary and third sector are also very limited and waiting times reflect the urgent need for successful recruitment in this discipline. Our overall conclusion is that all CMHTs managers need to use evidence of unmet need to inform planning and service development in partnership with service users and voluntary organisations.

Health and Care Standard 6.1 Planning Care to Promote Independence

Care provision must respect people's choices in how they care for themselves as maintaining independence improves quality of life and maximises physical and emotional wellbeing.

Quality standards for local authorities: Code of practice in relation to measuring social services performance

Local authorities must actively encourage and support people who need care and support and carers who need support to learn and develop and participate in society.

Local authorities must support people who need care and support and carers who need support to safely develop and maintain healthy domestic, family and personal relationships.

Local authorities must work with and support people who need care and support and carers who need support to achieve greater economic well-being, have a social life and live in suitable accommodation that meets their needs.

Part 9 Section 162 of the Social Services and Well-being (Wales) Act 2014

Co-operation and partnership – Arrangements to promote co-operation: adults with needs for care and support and carers.

Together for Mental Health Delivery Plan: 2016-19 states that "Access to services should be based on individual need, recognising individuals may need access to both talking and non-verbal therapies in order to express and explore their mental health problems. Good practice and the knowledge and experiences of delivering to diverse and sometimes complex groups must be shared across Wales."

We would expect to see evidence in the CTP of the outcomes agreed with the service user regarding some or all of the areas set out in section 18 of the Measure and in SSWBA. We would also expect to find that support is provided to develop competence in self-care and promote rehabilitation and re-enablement.

What we found:

We saw very little written evidence of links being established with other agencies to maintain wellbeing. CMHTs across Wales need to review processes and linkages with the crisis intervention teams or alcohol and drug misuse teams to ensure timely referrals. Additionally, there is a need to implement systems to assess the effectiveness of information and signposting to address service user needs. People reported mixed experiences around accessing information about services at an early stage in their involvement with professionals. Some indicated both the timing and method of information provision was something services needed to consider, particularly in relation to the service users' health and ability to retain or process information which can be a factor in mental health problems deteriorating.

We found CMHT reception areas contained a variety of information leaflets, but in some cases there was a lack of information provided in the Welsh language making the organisation non-compliant with Welsh language legislation. Our survey indicated that almost three quarters of family members or carers said that they didn't have sufficient information about the services available to support their family member or the person they care for (70%), whilst a similar proportion of family members or carers also felt that they didn't have sufficient information about their eligibility for those services either.

Generally, people in receipt of a service from the CMHT feel they are supported to engage in community activities. Most senior managers told us that the availability of third sector services can be dependent upon funding and commissioning priorities. They confirmed that in some areas, eligibility for some third sector and other support services is dependent upon eligibility for CMHT involvement and this could be a barrier to proactive preventative care. This is not consistent with the preventative or early intervention agenda.

We found varied levels of engagement with the third sector across Wales, sometimes dependant upon the region and the different needs of the specific population. There was though, a consistent message that on a day-to-day basis there is often poor communication and a lack of joined up working across agencies, and in particular across health, social care and housing services. However, we did hear of examples of good innovative partnership working. For example in a bid to develop services an innovative pilot project, jointly funded by Aneurin Bevan University Health Board and the Police and Crime Commissioner for Gwent, was set up, aimed at reducing demand on police officers where mental health is an underlying factor, managing risk and harm in relation to mental health crisis and to ensure that appropriate care and support is delivered in a timely way. Any emergency calls to Gwent Police are monitored by an Approved Mental Health Professional (AMHP) who works alongside staff in the control room and assists them in managing risk and harm to those with a mental illness or suffering a crisis. The AMHP has access to both the Police Force and the Health Board computer systems, which enables them to build a picture of the incident and the people involved.

There were also examples of services being provided by third sector organisations which ensured that people had access to good quality information at the right time to meet their needs and the requirements of the SSWBA. These included, Community Connector posts[18], sponsored by MIND in Blaenau Gwent, and well-being advocates placed in GP surgeries under an initiative taken by West Wales Action for Mental Health, (WWAMH)[19]. CMHTs in the BCUHB area are involved in the Bringing Agencies Together initiatives led by Unllais[20], which help showcase the range of community groups and mental health support services available to patients in their local communities. It is clear that the third sector has a wealth of experience and expertise that health boards and local authorities need to ensure they utilise in the most effective way.

Within Welsh Government's national strategy *Prosperity for All* there is a commitment to build on the capacity of communities by using approaches such as social prescribing.[21] Social prescribers are staff, mainly linked to GP surgeries who are usually social workers or local authority employees. We spoke to senior managers in areas where this scheme has been implemented and based on referral rates and feedback from GPs it seems to be working well generally. The aim is to link service users to non-clinical resources to support wellbeing and recovery. However, in relation to CMHTs, service users told us they were not aware of this service, suggesting that the CMHTs are either unaware of the resource or are not, where available, highlighting the social prescriber linked to their GP surgery.

CMHTs are aware of the geographical challenges in their areas and recognised the importance of people accessing services closer to home. Despite population needs analysis being completed for each health board, most CMHTs agreed that there has not been a robust review of unmet needs, or a mapping exercise to establish exactly what services are available in their location and determine any gaps in provision.

A noteworthy example of this is the Hafod Community Mental Health Team, a joint service between BCUHB and Denbighshire County Council. It is the first in Wales, and only the fourth in the UK, to receive the Accreditation for Community Mental Health Services from the Royal College of Psychiatrists. The accreditation has been given in recognition of their exemplary practice across 31 key areas identified by mental health professionals, carers and service users. A service user who has regular support from the Hafod Team said:

> **"My experience is very positive because of the people around me who support me. They do their jobs because they believe in it, and when you have the right people around you it's better. Everyone needs something different, I need someone who lets me talk and listens and I have this."**

18 Community Connectors work throughout the area and aim to reconnect people back into their communities. Community Connectors also work with many groups and organisations to help people find activities and groups that can help people improve their well-being.

19 West Wales Action for Mental Health (WWAMH) is an organisation involved in a broad range of activities to promote mental health and helps ensure people have access to independent and impartial information.

20 Unllais is a development, information and training agency that provides support to the voluntary sector, service users and carer organisations working in the field of mental health in North Wales. Through partnerships promote good practice in the planning, provision and monitoring of mental health services.

21 Social prescribing facilitates patients with a range of social, psychological and physical problems to access a wide range of local interventions and services provided by the voluntary sectors and others.

Service users' mental health is likely to worsen when faced with lengthy delays for psychological therapies, making recovery more difficult. These delays can also have a substantial impact on their lives, including their relationships, employment and accommodation. A theme across Wales is the general shortage of psychology services, with severe delays in accessing these services. This situation has been recognised by the Welsh Government which has allocated additional funds to health boards to help address the lack of sufficient resource. Health boards told us they were continually trying to improve resources and look at different ways of making sure sufficient psychological services were being provided.

Welsh Government has set a 28 day achievement target for interventions in primary care to support recovery and prevent unnecessary deterioration in health. This table represents the number of service users waiting for and starting therapeutic interventions for the month of June 2018.

Waiting times for a therapeutic intervention, by LHB and month

	Number of patients who had waited up to and including 28 days from LPMHSS assessment to the start of a therapeutic intervention	Number of patients who had waited over 28 days and up to and including 56 days from LPMHSS assessment to the start of a therapeutic intervention	Number of patients who had waited over 56 days from LPMHSS assessment to the start of a therapeutic intervention	Total number of therapeutic interventions started during the month	Percentage of therapeutic interventions started within 28 days following LPMHSS assessment
Wales	1,200	133	82	1,415	84.8
BCUHB	188	26	24	238	79.0
PTHB	107	29	3	139	77.0
HDUHB	121	6	6	133	91.0
ABMUHB	140	18	5	163	85.9
CTUHB	288	14	13	315	91.4
ABUHB	290	33	6	329	88.1
C&VUHB	66	7	25	98	67.3

Part 1: Local Primary Mental Health Support Services
Waiting times for a therapeutic intervention, by LHB and month
(Statswales.gov.wales)

To meet this target health boards across Wales are being prudent and innovative with many exploring the training of staff within the CMHTs to deliver specific therapies. For instance, ABUHB have recently recruited two extra psychologists and are presenting a bid for additional monies for cognitive behavioural therapists. ABUHB's plan is to train and support a group of mental health nurses to provide specific Cognitive Behavioural Therapy (CBT) and Dialectical Behavioural Therapy (DBT) groups. The expectation is that the nurses will be predominantly in the community and it is anticipated that this will reduce waiting times for therapies in the community. The health board told us that here are no waiting times for psychological therapies in-inpatient services within this health board.

Service users indicated that where these issues were addressed, through direct service provision such as the involvement of support workers or engagement with third sector organisations, they valued the services received. We heard of examples where statutory and commissioned services are assisting people to maintain links with family members, to attend social community activities and to develop skills and confidence.

No.	Recommendation
18.	CMHTs need to develop processes to evaluate the effectiveness of information, advice and assistance that is provided for service users.
19.	Health boards need to explore and utilise the support that may be offered by third sector services across Wales, with a need to take advantage of the range of community groups and mental health support services available to patients in their local communities.
20.	Much more work is needed to increase the availability and timely access to psychological therapies across Wales. Health boards need to improve resources in this area and look at different ways of making sure sufficient psychological services were being provided.

Quality of Management and Leadership

Governance Arrangements

We saw a move towards stronger clinical governance and clearer lines of accountability, changing cultures and developing better systems to measure outcomes. We have seen significant changes to divisional structures and heard about different ways of working for the future.

Information technology remains a considerable issue and Welsh Government needs to expedite support for health boards to enable safer, more efficient and effective record keeping.

Health and Care Standards: Part 2

Effective governance, leadership and accountability in keeping with the size and complexity of the organisation are essential for the sustainable delivery of safe, effective person-centred care.

Mike – can you reference CoP 8

Code of Practice on the Role of the Director of Social Services

The director of social services must have regard to the well-being duty and other overarching duties in relation to how the local authority exercises all its social services functions. The director of social services must show strategic leadership in ensuring all care and support services in the local authority area seek to promote the well-being of all people with care and support needs.

The director of social services must similarly seek to develop an effective environment to promote co-operation in relation to people with care and support needs with external partners, including the Local Health Board, the third sector and independent sector. Paragraphs 52 to 56 set out the role of the director in relation to formal partnership arrangements provided for by Part 9 of the Act which can be used for this purpose.

We would expect to see evidence of effective leadership through setting direction, pace and drive, and developing people. The strategies for should be set with a focus on outcomes, and choices based on evidence and people insight. The approach must be through collaboration building on common purpose. Health services should be innovative and improve delivery, plan resource and prioritise, develop clear roles, responsibilities and deliver models, and manage performance and value for money. Health boards should foster a culture of learning and self-awareness, and personal and professional integrity.

The SSWBA provides a legislative framework to support the transformation of the way people's needs for care and support are met and make social services in Wales sustainable. We would expect to see:

- A focus on people – ensuring people have a voice and control over their care and support.
- Measuring success in relation to outcomes for people rather than process.
- Delivery of a preventative and early intervention approach to minimise the escalation of need and dependency on statutory services.
- Effective cooperation and partnership working between all agencies and organisations.
- Improving the information and advice available to people and ensuring that everyone, irrespective of their needs, is able to access that information.
- The development of new and innovative models of service delivery, particularly those that involve service users themselves.

What we found:

Senior managers told us that due to increasing demand and reducing resources, the effectiveness of local senior management joint structures in resolving issues and leading joint service development and improvement is sometimes unclear.

Services have been subject to considerable organisational change in recent years which has disrupted local relationships and working practices. Discussions with senior managers across Wales indicated the Local Mental Health Partnership Boards (LPBs)[22] initiated under the Welsh Government 10 year Strategy Together for Mental Health are developing differently across Wales. In some areas a review of the model of service delivery for mental health services is underway, providing an opportunity to evaluate the present organisational structures and service provision, but not always involving all partners. Although needs analysis work has been undertaken, not all services have up to date commissioning strategies for mental health services in place. It is not clear therefore that commissioning of advocacy, engagement with housing, education and development of employment opportunities in addition to support services provided by the third sector are well targeted and sufficient to meet need.

We heard senior managers from both health boards and local authorities speaking about the need for stronger clinical governance and clear lines of accountability, focussing on changing the culture and improving systems to measure outcomes for service users. Some health boards and local authorities already have improvement plans in place and are actively implementing change by reviewing current governance arrangements, looking at gaps in accountability and for health, improving ward to board reporting and for local authority improved service to council reporting. Others have made significant changes to divisional structures and are proposing very different ways of working for the future.

Operational managers from health and social services were seen to work well together in the CMHT. There was mutual respect and cooperation and staff in general felt well supported by their line managers and other managers on the sites. We were told serious incidents and practice learning was regularly discussed at team and management meetings. This ensures that the CMHTs are learning from previous incidents and looking at improved ways of working for the future.

However, joint governance structures were not so well aligned. Across Wales and within each individual CMHT we found numerous recording systems in place, and not all staff had access to these records because health and social systems were not integrated. A number of CMHTs continue to use paper records and to complicate issues some have different multi-disciplinary paper records within the teams, this makes managing records and collating accurate data on CMHT services almost impossible. Additionally, whilst there are arrangements for audits to be reviewed at individual and joint senior management level, it is not always clear how effective these are in driving improvement. Consequently, interviews with senior managers did not provide assurance that there are effective joint processes in place to ensure appropriate data collection to guide future service delivery.

22 The Local Mental Health Partnership Boards (LPBs) will oversee the delivery and implementation *Together for Mental Health – A Strategy for Mental Health and Wellbeing in Wales* and its Delivery Plan; guiding and monitoring progress, and facilitating co-ordination of the cross-cutting approach required across Welsh Government, Statutory Agencies, the Third and Independent Sectors.

> The new Welsh Community Care Information System (WCCIS) is gradually being rolled out across Wales and is anticipated to address the information sharing interface within health boards and between local authorities and health boards, including CMHTs. It is envisaged that there will be better communication between teams and improved information collation for strategic planning. The implementation of the WCCIS needs to progress with pace in order to improve efficiency of operation in a service that is encountering high levels of demand, and to support the requirements of the H&CS and the SS&WBA.

No.	Recommendation
21.	Health boards and local authorities need to work together to improve joint processes for driving the improvement of services. This includes the need for greater alignment of processes within CMHTs including integrated records and data collection.
22.	Welsh Government needs to ensure that the implementation of the Welsh Community Care Information System (WCCIS) progresses with pace.

CMHT Resources and Capacity

There continues to be a staff recruitment and retention issue across CMHTs, although most CMHTs are looking at different ways of working to address the problems.

Health and Care Standard 7.1 Workforce

Health services should ensure there are enough staff with the right knowledge and skills available at the right time to meet need.

Part 8 Code of Practice on the Role of the Director of Social Services (Social Services Functions)

The director of social services has a strategic leadership role to promote high standards across the care and support workforce, including the private and third sectors.

The director must ensure a whole sector workforce plan is in place which identifies and secures implementation of measures to ensure a sufficiently large, skilled, safe and focused workforce to promote the well-being of people with care and support needs.

We expect to see evidence of effective workforce plans which are integrated with service and financial plans to ensure services are meeting the needs of the population, through an appropriate skill mix with staff having language awareness and the capability to provide services through the Welsh language. We also expect to see evidence of promoting continuous improvement of services, through better ways of working, and conformation that staff are trained, supervised and supported appropriately.

What we found:

We identified issues in relation to the recruitment and retention of all CMHT staff. With staff vacancies and sickness rates within CMHTs[23] increasing and pressure on existing staff to meet demands, it is encouraging to see some health boards actively looking at reasons for and ways to improve retention and recruitment of staff such as, succession planning and strategic mapping of the workforce to address gaps in teams.

A further complication is the volume/remit of psychiatry workloads, such as home treatments, delivering training, assessments, supervision and care co-ordinator role, resulting in increased pressure to meet demands. Whilst the MHA clearly sets out the choice of professionals capable of undertaking the care co-ordinator role, most health boards state that medical staff (psychiatrists) are usually assigned this role, despite concerns raised as part of HIWs mental health homicide reviews. These reviews highlighted the difficulty for service users in accessing the consultant care co-ordinator and the complications that arise with undertaking the co-ordinator role (as intended in the Act), along side a large and complex workload. It also reinforces a mental health service culture that emphasises the need to actively and assertively maintain long term engagement with some service users rather than closing cases when they disengage. However, it is recognised that in some instances service users with short term complex needs may be better off initially allocated to a medical member of staff.

We were consistently told that, at present consultant psychiatrists' case loads are too high and many health boards are looking at different way of working to reduce these. The challenge is to find ways of modifying roles to take on new or shared responsibilities. Although the majority of service users and previous service users told us that a Community Psychiatric Nurse (31%) or a psychiatrist (23%) was in charge of organising their care and services, there is an indication that there is an increase in the appointment of social workers to this role, to the point where they are nearing maximum capacity.

Staff Supervision and Appraisals

Staff supervision systems were robust in health and in social care. However, although supervision and support on a day to day basis is evident, formal recorded one-to-one supervision is not undertaken as routinely as is necessary to ensure staff have an opportunity to discuss on-going training, development and well being.

23 Swansea Central (Area 2), South Caerphilly, Deeside and Welshpool CMHT.

Health and Care Standard 7.1 Workforce

Health services should ensure there are enough staff with the right knowledge and skills available at the right time to meet need.

Part 8 Code of Practice on the Role of the Director of Social Services (Social Services Functions)

The director of social services has a strategic leadership role to promote high standards across the care and support workforce, including the private and third sectors.

The director must ensure a whole sector workforce plan is in place which identifies and secures implementation of measures to ensure a sufficiently large, skilled, safe and focused workforce to promote the well-being of people with care and support needs. This includes in relation to recruitment and retention, pre-employment vetting, registration, reward, addressing poor performance, career pathways, competency and qualification requirements, skill mix, training needs, evidence based practice, compliance with codes of practice and contributions to workforce data.

We expect to see evidence of systems being in place to ensure that annual appraisals and regular supervision are taking place for all CMHT staff. Appraisals need to incorporate issues such as staff well being and other aspects of their work. We would also expect to see other systems of support such as reflective practice groups, debriefs following serious incidents or medication errors.

What we found:

Overall, we found that staff working in social care were receiving the same level of appraisal of their work as their health colleagues. This was encouraging as it is important that staff receive appraisals of their work to ensure good and poor practice is acknowledged, areas of development are identified and an individuals' progress is facilitated.

Whilst we found that staff vacancies and sickness rates within the majority of CMHT[24] is increasing pressure on existing staff to meet demands, the majority of staff told us they felt well supported by managers on a daily basis in relation to ad-hoc incidents and enquiries.

The multidisciplinary nature of CMHT gives the opportunity to provide a comprehensive service to meet the complex needs of individuals. The organisational and management arrangements deployed within CMHT, need to support professional accountability confidence and development. We found that in some teams, pressures were being experienced by some parts of the workforce more than others for example where psychiatrists were undertaking the care coordinator role, where there were difficulties in recruiting Section 12 doctors or social workers to undertake the AMHP role. Senior managers need to ensure that staff have confidence in these issues being addressed through regular, service wide, evaluation of staffing needs in order to support staff performance and morale.

24 Swansea Central (Area 2), South Caerphilly, Deeside and Welshpool CMHT.

Staff Training

We are satisfied that staff training is improving across most CMHTs, although there are areas where specific training needs to be developed.

Health and Care Standard 7.1 Workforce

Health services should ensure there are enough staff with the right knowledge and skills available at the right time to meet need.

Staff should be enabled to learn and develop to their full potential.

Part 8 Code of Practice on the Role of the Director of Social Services (Social Services Functions)

The director of social services has a strategic leadership role to promote high standards across the care and support workforce, including the private and third sectors.

The director must ensure a whole sector workforce plan is in place which identifies and secures implementation of measures to ensure a sufficiently large, skilled, safe and focused workforce to promote the well-being of people with care and support needs. This includes in relation to recruitment and retention, pre-employment vetting, registration, reward, addressing poor performance, career pathways, competency and qualification requirements, skill mix, training needs, evidence based practice, compliance with codes of practice and contributions to workforce data.

We would expect to see evidence that staff are encouraged to maintain and develop competencies in order to develop to their full potential. We would expect to see a robust mandatory training matrix and a system to ensure all staff have received the training according to the grade in which they work.

What we found:

We found that mandatory training topics throughout all health boards are similar and this is also the case for local authority staff. However, compliance rates for mandatory training vary between health and local authority organisations. Local authority staff told us that although there was good access to skills based or specialist training in some teams, in other areas staff found it difficult to undertake training due to staff shortages and workloads not allowing time to attend.

We saw that some health boards have placed major investment in staff training, although we did identify some gaps regarding knowledge of the MHA in CMHTs. ABMUHB told us that their MHA administrators deliver training to CMHTs, providing bespoke training packages where required. Additionally the SS&WBA is not on the training agenda for health staff, with the provision of this training last taking place in 2014, before the Act's implementation. To ensure all staff are fully aware of how aspects of the Mental Health Act and SS&WBA impact on the work they undertake there is need for further investment particularly amongst health staff.

It remains a concern that not all CMHT staff receive First Aid training or training in the use of defibrillators. With staff working in isolation and with a very vulnerable service user group this training should be considered as mandatory.

No.	Recommendation
23.	All CMHT staff should receive training in the following: • Mental Health Act; • Social Services and Well Being Act; • First Aid and the use of defibrillators.

Conclusion

The intention of this review was to identify key themes arising from HIW and CIW's joint inspections of Community Mental Health Teams (CMHT) across Wales. Overall, we found that people receive an acceptable quality of care from hard working and compassionate staff.

With 43% of service users and previous service users telling us that the services provided completely met their needs or met most of their needs, it is important to recognise that staff are delivering a responsive service during challenging times. Significantly, whilst the performance data suggests that compliance with CTP targets is satisfactory, much more work is required across Wales to ensure that these are of a high standard and that service users are fully involved with and engaged in the development of their CTPs.

Whilst it is clear that progress is being made in many areas, there is scope to improve services and to develop a more seamless, integrated approach to community mental health care across Wales. We understand that economic constraints pose significant challenges to ensuring services are designed to meet current and future demands, and acknowledge that these transformations are not achievable or sustainable without partnership working across public, private and third sectors. Therefore, it is encouraging to see increasing collaboration between all sectors. However, there is still more progress to me made.

In 2018 the Welsh Government published its Plan 'A Healthier Wales' which emphasises the need to move services to communities. For there to be a successful transition of mental health services from in-patient to community care there needs to be an investment in new ways of working with clear improvement plans and resources supported by staff development. Whilst we have seen these kind of improvements being made, positive practice is not always shared or adopted across CMHTs. There are opportunities within Wales for greater levels of joint working and making better use of the third sector to support service users. Welsh Government should consider how issues raised in this report can be tackled on an all Wales basis.

The findings of this review indicate that there is still significant improvement required across Community Mental Health services to be in a position to meet the vision set out in Together for Mental Health, the Welsh Government strategy to improve mental health care in Wales.

What Next?

We expect Welsh Government, health boards and local authorities to carefully consider the findings from this review and our recommendations set out in Appendix A.

To service users and their families, and/or carers we hope we have captured the accounts you have shared with us and that this review will help make service provision in your area more accessible and tailored to meet your needs.

Appendix A – Recommendations

As a result of the findings from our review, we have made the following overarching recommendations which Welsh Government, health boards and local authorities should address.

No.	Recommendation	Regulation/Standard
1.	Health boards should ensure there is clarity over the criteria for accessing CMHTs and the various community support teams that exist. In particular GPs and primary care practitioners need to have the information and support to enable them to provide the best possible advice for service users.	Health and Care Standard 5.1 Timely Access.
2.	CMHTs need to ensure that service users are clear on how to access or contact services out of hours, or in the event of crisis or serious concern.	Health and Care Standard 5.1 Timely Access.
3.	Health boards need to ensure that information relating to the 'Putting Things Right' process is available at all CMHT locations.	Health and Care Standard 6.3 Listening and Learning from Feedback.
4.	CMHTs need to improve the way that they oversee the handling, monitoring, and lessons learned aspects of concerns/complaints.	Health and Care Standard 6.3 Listening and Learning from Feedback.
5.	Health boards and local authorities need to look at ways to improve awareness of advocacy provision amongst their staff and develop local monitoring of CMHT engagement with advocacy services, to ensure service users have access to the support they require on assessment at significant points within their care.	Health and Care Standard 6.2 Peoples Rights.
6.	Significant work is required from health boards to improve the provision and maintenance of safe and clinically appropriate facilities for CMHT service users and staff.	Health and Care Standard 2.1 Managing Risk and Promoting Health and Safety.
7.	CMHTs need to improve the recording of risk assessments within CTPs to ensure risks and management plans are more comprehensively recorded, more detailed and relevant to individual circumstances and particular situations.	Health and Care Standard 6.1 Planning Care to Promote Independence.
8.	CMHTs need to ensure that CTPs are of sufficient quality, with evidence that service users have been involved in their development, and that the resulting CTPs are relevant to the outcomes the service user wishes to achieve.	Health and Care Standard 6.1 Planning Care to Promote Independence.

No.	Recommendation	Regulation/Standard
9.	CMHTs must ensure copies of CTPs are given to service users and their relatives, where consent has been provided for this to happen.	Health and Care Standard 6.1 Planning Care to Promote Independence.
10.	Health boards ensure regular audits are performed to ensure that service users are not detained under section 4 of the MHA for longer than 72 hours.	Health and Care Standard 3.5 Record Keeping.
11.	Health boards and Local Authorities need to ensure there is joint access to relevant CMHT records. This has a clear potential adverse impact upon the standard of care being provided and needs to be addressed as a matter of priority.	Health and Care Standard 3.5 Record Keeping.
12.	Health boards need to ensure there are clear lines of accountability, staff training, dedicated pharmacy support and robust auditing processes to oversee and implement medicines management within community services, especially within CMHTs.	Health and Care Standard 2.6 Medicines Management.
13.	CMHTs need to ensure that all staff complete mandatory adult and child safeguarding training.	Health and Care Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk.
14.	CMHTs need to ensure that carers' assessment of needs are routinely offered.	Health and Care Standard 6.1 Planning Care to Promote Independence.
15.	CMHTs need to undertake an audit of discharges to measure the quality and timeliness of discharge planning in order to help improve services and outcomes for service users.	Health and Care Standard 6.1 Planning Care to Promote Independence.
16.	CMHTs need to review the role of the care co-ordinator and establish whether the service users are receiving the correct input from the most appropriate professional.	Health and Care Standard 6.1 Planning Care to Promote Independence.
17.	CMHTs and care co-ordinators in particular, need to ensure discharge planning is robust and meets with legislative requirements.	Health and Care Standard 6.1 Planning Care to Promote Independence.
18.	CMHTs need to develop processes to evaluate the effectiveness of information, advice and assistance that is provided for service users.	Health and Care Standard 6.1 Planning Care to Promote Independence.

No.	Recommendation	Regulation/Standard
19.	Health boards need to explore and utilise the support that may be offered by third sector services across Wales, with a need to take advantage of the range of community groups and mental health support services available to patients in their local communities.	Health and Care Standard 6.1 Planning Care to Promote Independence.
20.	Much more work is needed to increase the availability and timely access to psychological therapies across Wales. Health boards need to improve resources in this area and look at different ways of making sure sufficient psychological services were being provided.	Health and Care Standard 6.1 Planning Care to Promote Independence.
21.	Health boards and local authorities need to work together to improve joint processes for driving the improvement of services. This includes the need for greater alignment of processes within CMHTs including integrated records and data collection.	Health and Care Standards: Part 2.
22.	Welsh Government needs to ensure that the implementation of the Welsh Community Care Information System (WCCIS) progresses with pace.	Health and Care Standards: Part 2.
23.	All CMHT staff should receive training in the following: • Mental Health Act; • Social Services and Well Being Act; • First Aid and the use of defibrillators.	Health and Care Standard 7.1 Workforce.

Appendix B – HIW Survey Results

Healthcare Inspectorate Wales and Care and Social Services Inspectorate Wales' Thematic Review of Community Mental Health Services: Survey. We received responses from almost all regions of Wales, certainly each Health Board was represented. Some Local Authority areas did not have respondents because this was a target population (identified CMHT's) and the respondents were only a sample of the whole population of Wales. The results are therefore only a part of the collective findings of the review.

Survey Information:

Family member or carer:	127 responses
Previous service user:	51 responses
Current service user:	102 responses
Total responses:	**280**

Family member or carer survey results:

Were you provided with contact names and numbers for the Community Mental Health Team?

	%	
Yes	65	53
No	57	47
Total	**122**	**100**

How involved were you in discussions about the care treatment and support options for your family member or the person you care for?

	%	
Very involved	34	27
Quite involved	29	23
Not very involved	34	27
Not at all involved	27	22
Total	**124**	**100**

Did you feel you were given sufficient time in these discussions to express your views?

	%	
Yes	47	47
No	52	53
Total	**99**	**100**

Did you feel you were listened to in these discussions?

	%	
Yes	46	46
No	53	54
Total	**99**	**100**

Did you feel you had sufficient information about the services available to support your family member or the person you cared for?

	%	
Yes	34	30
No	81	70
Total	**115**	**100**

Did you feel you had sufficient information about their eligibility for those services?

	%	
Yes	36	29
No	87	71
Total	**123**	**100**

Did you feel valued in your caring role?

	%	
Yes, completely	17	14
Yes, to some extent	45	36
No	62	50
Total	**124**	**100**

Were you offered an assessment of your own needs as a carer?

	%	
Yes	23	23
No	76	77
Total	**99**	**100**

Were you provided with information about direct payments to support your needs as a carer?

	%	
Yes	11	10
No	101	90
Total	**112**	**100**

Were you supported to apply for direct payments?

	%	
Yes	9	8
No	102	92
Total	**111**	**100**

Did you have concerns about the safety or wellbeing of your family member or the person you care for, yourself or anyone else?

	%	
Yes	103	83
No	21	17
Total	**124**	**100**

Did you know who to contact in the event of a crisis or serious concerns?

	%	
Yes	74	60
No	50	40
Total	**124**	**100**

Was action taken in response to any concerns you made?

	%	
Yes	44	45
No	54	55
Total	**98**	**100**

Did the Community Mental Health Team provide help or advice to you or your family member or the person you care for with finding support for any physical health needs they had?

	%	
Yes	25	26
No	70	74
Total	**95**	**100**

Did the Community Mental Health Team provide help or advice to you or your family member or the person you care for with finding support for any accommodation needs they had?

	%	
Yes	18	25
No	54	75
Total	**72**	**100**

Did the Community Mental Health Team provide help or advice to you or your family member or the person you care for with finding support for any employment or education needs they had?

	%	
Yes	9	12
No	64	88
Total	**73**	**100**

Did the Community Mental Health Team provide help or advice to you or your family member or the person you care for with finding support for any social needs they had (being able to go out when they wanted to)?

	%	
Yes	25	26
No	73	74
Total	**98**	**100**

To what extent were you involved in the discussion leading to the decisions for the service from the Community Mental Health Team to be ended?

	%	
Very involved	10	12
Quite involved	8	10
Not very involved	24	29
Not at all involved	40	49
Total	**82**	**100**

Were you provided with information about who to contact if you had further concerns about the health or wellbeing of your family member or the person you care for after their support from the Community Mental Health Team ended?

	%	
Yes	34	32
No	71	68
Total	**105**	**100**

Service users and previous service users survey results:

How were you referred to your Community Mental Health Team?

	Previous service user		Current service user		Total	
	Number	%	Number	%	Number	%
By my GP	37	73	73	73	110	73
I referred myself	3	6	7	7	10	7
Other	11	22	20	20	31	21
Total	**51**	**100**	**100**	**100**	**151**	**100**

How long did it take to get seen by your Community Mental Health Team following your referral?

	Previous service user		Current service user		Total	
	Number	%	Number	%	Number	%
About 1 week	7	16	20	28	27	24
About 2 weeks	4	9	10	14	14	12
About 3 weeks	3	7	7	10	10	9
About 4 weeks or longer	29	67	34	48	63	55
Total	**43**	**100**	**71**	**100**	**114**	**100**

When was the last time you saw someone from your Community Mental Health Team?

	Previous service user		Current service user	
	Number	%	Number	%
In the last month	3	7	59	63
1 to 3 months ago	6	13	16	17
4 to 6 months ago	3	7	8	9
7 to 12 months ago	9	20	2	2
More than 12 months ago	24	53	9	10
Total	**45**	**100**	**94**	**100**

How easy or difficult did you find it to access support from your Community Mental Health Team?

	Previous service user		Current service user		Total	
	Number	%	Number	%	Number	%
Very easy	4	8	18	18	22	15
Quite easy	10	20	37	38	47	32
Quite difficult	14	29	21	21	35	24
Very difficult	21	43	22	22	43	29
Total	**49**	**100**	**98**	**100**	**147**	**100**

Thinking about your needs, what did you feel about how often you were seen by your Community Mental Health Team?

	Previous service user		Current service user		Total	
	Number	%	Number	%	Number	%
I was not seen enough when needed	33	67	50	51	83	56
I was seen the right amount of times	15	31	47	47	62	42
I am seen more often than needed	1	2	2	2	3	2
Total	**49**	**100**	**99**	**100**	**148**	**100**

Did you feel that the Community Mental Health Team worker usually gave you enough time to discuss your needs and treatment? (This might be about your care, housing or accommodation, benefits, finances, medication advice, advocacy services, contact numbers, support groups, GP surgery.)

	Previous service user		Current service user		Total	
	Number	%	Number	%	Number	%
Yes	24	53	65	73	89	66
No	21	47	24	27	45	34
Total	**45**	**100**	**89**	**100**	**134**	**100**

Do you feel the CMHT worker usually listens to you carefully when you meet?

	Previous service user		Current service user		Total	
	Number	%	Number	%	Number	%
Yes	30	67	74	80	104	76
No	15	33	18	20	33	24
Total	**45**	**100**	**92**	**100**	**137**	**100**

Were you offered the support of an advocate? (An advocate might help you access information you need, go with you to meetings to support you or speak for you in situations where you don't feel able to speak for yourself.)

	Previous service user		Current service user		Total	
	Number	%	Number	%	Number	%
Yes	3	7	28	29	31	22
No	41	93	68	71	109	78
Total	**44**	**100**	**96**	**100**	**140**	**100**

Who was the person in charge of organising your care and services? (This person could have been anyone providing your care, and may have been called a care coordinator or key worker.)

	Previous service user		Current service user		Total	
	Number	%	Number	%	Number	%
A Community Psychiatric Nurse	11	29	26	32	37	31
A GP	8	21	7	9	15	13
A Mental Health Support worker	4	11	5	6	9	8
A Psychiatrist	5	13	22	27	27	23
A Psychotherapist/ Counsellor	7	18	5	6	12	10
A Social Worker	3	8	11	13	14	12
Other	0	0	6	7	6	5
Total	**38**	**100**	**82**	**100**	**120**	**100**

Did you know how to contact this person if you had a concern about your care?

	Previous service user		Current service user		Total	
	Number	%	Number	%	Number	%
Yes	31	66	83	86	114	80
No	16	34	13	14	29	20
Total	**47**	**100**	**96**	**100**	**143**	**100**

To what extent did the services provided meet your needs?

	Previous service user		Current service user		Total	
	Number	%	Number	%	Number	%
Completely met my needs	4	9	16	16	20	14
Met most of my needs	11	23	31	32	42	29
Met some of my needs	18	38	37	38	55	38
Did not meet any of my needs	14	30	13	13	27	19
Total	**47**	**100**	**97**	**100**	**144**	**100**

To what extent did you feel involved in the development of your Care plan?

	Previous service user		Current service user		Total	
	Number	%	Number	%	Number	%
Very involved	5	11	28	29	33	23
Quite involved	11	24	28	29	39	27
Not very involved	15	33	23	24	38	27
Not at all involved	15	33	17	18	32	23
Total	**46**	**100**	**96**	**100**	**142**	**100**

Did you receive or were you given an opportunity to have a copy of your care plan?

	Previous service user		Current service user		Total	
	Number	%	Number	%	Number	%
Yes	8	20	50	61	58	48
No	32	80	32	39	64	52
Total	**40**	**100**	**82**	**100**	**122**	**100**

Did you have formal meetings or reviews with your care coordinator to discuss how your care was working? (This meeting may have been called a Care Programme Approach (CPA) or Care and Treatment Plan (CTP) meeting or case review.)

	Previous service user		Current service user		Total	
	Number	%	Number	%	Number	%
Yes	7	16	46	52	53	40
No	37	84	43	48	80	60
Total	**44**	**100**	**89**	**100**	**133**	**100**

To what extent did you feel involved in the discussions and decisions made about your care and support during your formal meeting or review?

	Previous service user		Current service user		Total	
	Number	%	Number	%	Number	%
Very involved	4	9	21	23	25	18
Quite involved	11	24	32	35	43	31
Not very involved	21	46	24	26	45	33
Not at all involved	10	22	14	15	24	18
Total	**46**	**100**	**91**	**100**	**137**	**100**

Were you given the opportunity to challenge any aspect of your care and treatment plan that you disagreed with during your formal meeting or review?

	Previous service user		Current service user		Total	
	Number	%	Number	%	Number	%
Yes	9	24	44	61	53	48
No	29	76	28	39	57	52
Total	**38**	**100**	**72**	**100**	**110**	**100**

To what extent do you feel that your accommodation needs were met by the services provided through the Community Mental Health Team?

	Previous service user		Current service user		Total	
	Number	%	Number	%	Number	%
Completely met	8	24	22	41	30	34
Partially met	7	21	16	30	23	26
Not met at all	18	55	16	30	34	39
Total	**33**	**100**	**54**	**100**	**87**	**100**

To what extent do you feel that your employment needs were met by the services provided through the Community Mental Health Team?

	Previous service user		Current service user		Total	
	Number	%	Number	%	Number	%
Completely met	2	8	10	22	12	17
Partially met	3	12	11	24	14	20
Not met at all	20	80	25	54	45	63
Total	**25**	**100**	**46**	**100**	**71**	**100**

To what extent do you feel that your education needs were met by the services provided through the Community Mental Health Team?

	Previous service user		Current service user		Total	
	Number	%	Number	%	Number	%
Completely met	2	9	11	26	13	20
Partially met	2	9	15	36	17	27
Not met at all	18	82	16	38	34	53
Total	**22**	**100**	**42**	**100**	**64**	**100**

To what extent do you feel that your social needs (being able to go out when you wanted) were met by the services provided through the Community Mental Health Team?

	Previous service user		Current service user		Total	
	Number	%	Number	%	Number	%
Completely met	1	3	21	31	22	22
Partially met	13	42	21	31	34	34
Not met at all	17	55	26	38	43	43
Total	**31**	**100**	**68**	**100**	**99**	**100**

Did your Community Mental Health Team give you any help or advice with finding support for your physical health needs?

	Previous service user		Current service user		Total	
	Number	%	Number	%	Number	%
Yes	3	25	19	56	22	48
No, I asked for help but didn't get any	9	75	15	44	24	52
Total	**12**	**100**	**34**	**100**	**46**	**100**

Was the option to receive direct payments to help meet your care and support needs ever discussed with you?

	Previous service user		Current service user		Total	
	Number	%	Number	%	Number	%
Yes	1	4	21	36	22	27
No	22	96	37	64	59	73
Total	**23**	**100**	**58**	**100**	**81**	**100**

Did you know how to contact the Community Mental Health Team Out of Hours service?

	Previous service user		Current service user		Total	
	Number	%	Number	%	Number	%
Yes	16	40	51	53	67	49
No	24	60	45	47	69	51
Total	**40**	**100**	**96**	**100**	**136**	**100**

If you have felt the need to contact the Community Mental Health team's Out of Hours Service, did you get the help you needed?

	Previous service user		Current service user		Total	
	Number	%	Number	%	Number	%
Yes	4	18	25	56	29	43
No	18	82	20	44	38	57
Total	**22**	**100**	**45**	**100**	**67**	**100**

If you have needed to contact the Community Mental Health Team in a crisis in the last 12 months, did you get the help you needed?

	Current service user	
	Number	%
Yes	30	42
No	42	58
Total	**72**	**100**

Do you know how to request a further service from the Community Mental Health Team if you have concerns about your health or care?

	Current service user	
	Number	%
Yes	18	37
No	31	63
Total	**49**	**100**

Did your Community Mental Health Team involve a member of your family, or someone else close to you, as much as you would have liked?

	Previous service user		Current service user		Total	
	Number	%	Number	%	Number	%
Yes	6	21	30	56	36	43
No	21	72	21	39	42	51
They have involved them too much	2	7	3	6	2	6
Total	**29**	**100**	**54**	**100**	**83**	**100**

Do you know that you can refer yourself to your Community Mental Health Team if you felt that you were relapsing?

	Previous service user	
	Number	%
Yes	22	43
No	29	57
Total	**51**	**100**

Do you know who to contact if you have a crisis or relapse?

	Previous service user		Current service user		Total	
	Number	%	Number	%	Number	%
Yes	19	44	53	56	72	52
No	24	56	42	44	66	48
Total	**43**	**100**	**95**	**100**	**138**	**100**