Wales Collaboration for Mental Health (WCMH)

UNDER PRESSURE

Report of the

Risk & Quality Review of NHS Mental Health Services

August 2005

Llywodraeth Cynulliad Cymru
Welsh Assembly Government

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Executive Summary

The Risk & Quality Review of NHS Mental Health Services was commissioned by the Health Service Policy and Development Division within the National Assembly in response to a request by the then Minister for Health and Social Services. The aim of the review of priority risk areas was to ascertain the National position and make recommendations for improvements so that patients can be assured of a minimum standard of care. The remit of the review was specifically adults of working age and older adults and excluded services for people with learning disabilities, services for children and adolescents and substance misuse services.

This independent review was undertaken by the Wales Collaboration for Mental Health during a three month period between mid September and mid December 2004. Two-day visits were made by expert review teams, using a consistent methodology, to each of the ten NHS Trusts and one Local Health Board responsible for providing specialist mental health services in Wales. Each review team included a Mind Cymru worker, as well as clinicians.

The findings of the review are remarkably consistent across Wales, and indicate a service system under great pressure, despite the efforts of many dedicated, committed and creative staff. NHS mental health services are consequently exposed to a number of serious risks which include:

- The quality of patient care being compromised
- An increased likelihood of high profile incidents where the safety of the public is jeopardised
- A further reduction in staff morale

The two major indicators of pressure on the system are identified as:

- over-occupancy of inpatient units – at times exceeding 100%
- the high workload of community mental health services.

The following 24 recommendations to reduce risk and improve service quality are made. Each recommendation requires immediate attention and implementation by the relevant agencies responsible for NHS mental health services in Wales:

Recommendation 1
During 2005/06 the Welsh Assembly Government should establish specialist mental health commissioning teams, based on the population base of each of the three NHS Regions, with responsibility for:-

- secondary and tertiary level services
- the development of information services (with public health input)
- developing the partnership between health and social care agencies, and involving housing agencies and voluntary sector providers.

Recommendation 2
Robust SAFF targets and allied performance measures for mental health should be issued by the Welsh Assembly Government for 2005/06 and subsequent years to ensure that the service is seen as a priority area in the NHS. Full implementation of CPA should continue to be pursued through this framework.

Recommendation 3
From 2005/2006 onwards the Welsh Assembly Government should monitor the occupancy of inpatient units exceeding an agreed figure (say 90%). This information should be regularly reported to Trust Boards and to WAG's Health and Social Care Directorate. Occupancy should include patients on leave.

Recommendation 4
During 2005/2006, the relevant NHS Trust Boards and Powys LHB should strengthen community mental health services to ensure they can offer a responsive admission-prevention service on a 24 hour, 7 day a week basis. This may involve crisis resolution and home treatment services, as an additional component of the CMHT.

Recommendation 5
During 2005/2006, commissioners of mental health services, LHBs, NHS Trusts and Local Authorities should work with housing providers to draw up plans to urgently address the difficulties arising from the lack of supported housing for people with mental health problems, to make progress in this key area.

Recommendation 6
By October 2005, the relevant NHS Trust Boards and Powys LHB should review the current arrangements for inpatient mental health services for 16/17 year old adolescents. Where such young people have to be admitted to an adult ward, there should be support from the relevant CAMHS

team, and wards used for this purpose should have staff who are police-checked and with specific training.

Recommendation 7
By December 2005, the relevant NHS Trust Boards and Powys LHB should review admission policies to ensure that decisions regarding the appropriate place for admission for older people are based on clinical need, rather than on arbitrary age cut-offs.

Recommendation 8
By December 2005, the relevant NHS Trust Boards and Powys LHB (in partnership with Local Community Safety Partnership Boards) should ensure that arrangements are in place for staff on adult wards where dual diagnoses are common to have ready access to appropriate training, and advice from specialist substance misuse services when necessary.

Recommendation 9
During 2005/2006, the Welsh Assembly Government should ensure that the relevant mental health commissioning teams produce agreed plans for the provision of equitable low secure forensic services across Wales.

Recommendation 10
By April 2006, mental health commissioners should ensure that effective liaison services are established for each general hospital and A& E department. The special needs of expectant / nursing mothers and people with dementia in general hospital settings should be addressed with support and advice from skilled mental health nurses.

Recommendation 11
During 2005/2006, the Welsh Assembly Government should conduct / commission a review of models of supporting and responding to common mental health problems in primary care, identifying good practice. Guidance, based on the results of the review, should then be issued, by March 2006, for action by Local Health Boards in Wales.

Recommendation 12
By March 2006, mental health commissioners should review and enhance the existing arrangements for transfer of forensic patients from medium secure units to the community, with on-going support from the specialist forensic teams. Mechanisms to resolve disputes regarding consultants in the community taking on RMO status should be established, ensuring

community services receive the support required to manage such patients safely.

Recommendation 13
By April 2006, mental health commissioners, LHBs, NHS Trusts, other mental health service providers and Local Authorities should draw up an agreed, creative, integrated strategy for commissioning mental health services for older people, taking into account the recent Audit Commission reports and the forthcoming National Service Framework for Older People.

Recommendation 14
By April 2006, mental health commissioners, LHBs, NHS Trusts, Local Authorities and other mental health service providers should have made arrangements for training and on-going support for staff in care homes in managing the range of mental health problems (including depression and challenging behaviour).

Recommendation 15
By April 2006, mental health commissioners, LHBs, NHS Trusts, Local Authorities and other mental health service providers should make specific arrangements to monitor the implementation of CPA with older people with mental health problems, within the context of Unified Assessments.

Recommendation 16
By December 2005, the Welsh Assembly Government should ensure that a report on workforce planning in mental health services in Wales is completed. The short-falls in all professional groups need to be carefully considered, and the opportunities for new ways of working evaluated, with an action plan for future progress.

Recommendation 17
By December 2005, the Welsh Assembly Government (health, social care and further education departments) should produce a plan for the development of training opportunities for mental health service staff without a professional qualification.

Recommendation 18
By June 2005, the relevant NHS Trust Boards and Powys LHB must ensure that any remaining mixed wards where access to the female dormitory is through the male dormitory have been reconfigured.

Recommendation 19
During 2005/2006, and in subsequent years, the relevant NHS Trust Boards and Powys LHB must prioritise the maintenance of the physical care environment, despite the lack of long term future for the buildings.

Recommendation 20
During 2005/2006 and in subsequent years, commissioners of mental health services should assess the need for re-provision of inpatient units in the context of a wider programme of service modernisation and redesign; new buildings should be flexible and lessons learned from previous designs.

Recommendation 21
By March 2006, the relevant NHS Trust Boards and Powys LHB should ensure that arrangements are in place for meaningful therapeutic activity to be provided on a regular and extensive basis in every inpatient environment.

Recommendation 22
By March 2006, the relevant NHS Trust Boards and Powys LHB should ensure that robust arrangements are developed for user/carer involvement in the operational management of services.

Recommendation 23
By March 2006, the relevant NHS Trust Boards and Powys LHB should adopt a robust method to conduct routine audits of the proportion of patients having a copy of their own care plan, based on the implementation of CPA.

Recommendation 24
By March 2006, the Wales Assembly Government should review the independent advocacy services for users of mental health services with a view to commissioning equitable services in all parts of Wales. Provision must also be made for people with dementia to have access to advocacy.

1. Introduction

In July 2004, at the request of the then Minister for Health and Social Services, an urgent review of priority risk areas in NHS mental health services in Wales for adults of working age and older adults was commissioned. The review was conducted during a three month period between mid September and mid December 2004. This report describes the findings of the review and makes a number of recommendations for change, in terms of further policy and service developments, as well as identifying good practice.

The findings of this independent Risk & Quality Review of NHS mental health services are intended to be considered alongside the outputs from the following work:

- Service review undertaken by the Audit Commission in Wales. This review will compare the existing arrangements against the standards of the adult mental health National Service Framework. Reports on each Local Health Board / Local Authority area should be available at the same time as the publication of this report.
- The Review of Health and Social Care and Well Being in Wales – mental health project. A six month work programme was agreed for implementation during the latter part of 2004 that will focus on: commissioning, workforce, resources, identification and purpose of mental health working groups.

Together with the review of the National Service Framework for Adult Mental Health, an over-arching Action Plan is to be produced, so that mental health services can move forward in Wales in a focused and coordinated manner *(letter from Mrs Ann Lloyd, Chief Executive, NHS Wales to Chief Executives of Local Health Boards and NHS Trusts, 25th August, 2004)*.

Purpose

The improvement of mental health services is one of the key health priorities for the National Assembly of Wales and the aim of this review was to conduct an urgent assessment of the national position and make recommendations for improvements so that patients can be assured of a minimum standard of care.

The following priority risk areas were assessed in terms of the quality and safety of clinical care provided:

- inter/intra organisational arrangements, and the transitions from primary care to community services, community to/from inpatient units, community to/from forensic services.
- clinical environment: ward (co-morbidity, caseload, case-mix, therapeutic environment), community mental health teams (co-morbidity, caseload, case-mix), clinical workforce, physical environment, culture/clinical leadership.
- clinical risk management: assessment, prioritisation, management of incidents, reporting and learning systems, action plans for dealing with identified risks; information systems.
- Trust Board: level of engagement, information received/requested relating to mental health services, risk management, strategic and operational interface.
- Multi-agency approach: joint working and interface with other agencies.

Project Management Group

The contract to carry out this review was awarded to the Wales Collaboration for Mental Health (WCMH). The Collaborative was established in 2003 and constitutes a partnership of key stakeholders from universities, user and carer organisations, professional groups, voluntary organisations, NHS and social care organisations, with the aim of working in partnership to improve mental health services in Wales.

The following individuals agreed to participate in the review as a member of the project management group with responsibility for the work undertaken, including the production of this report:

- Professor Bob Woods, Director, Dementia Services Development Centre Wales, University of Wales Bangor
  (Convenor of the Project Management Group).
- Lindsay Foyster, Director, Mind Cymru.
- Professor Richard Williams, Professor of Mental Health Strategy, Welsh Institute for Health and Social Care, University of Glamorgan (Chairman, WCMH Steering Group).
- Gareth Morgan, Assistant Director, Institute of Medical & Social Care Research, University of Wales Bangor.
- Professor David Menkes, Director, Section of Psychological Medicine, Institute of Medical & Social Care Research, University of Wales Bangor.

- Professor Nick Craddock, Professor of Psychiatry, Wales College of Medicine, Cardiff University.
- Dr Les Rudd, Director, Wales Centre for Mental Health Services Development
- Professor Keith Lloyd, Professor of Psychological Medicine, Swansea Clinical School, University of Wales Swansea.

Aims and distinctive features of the Review

In making recommendations for the improvement of mental health services within a very tight time-scale, members of the Project Management Group were mindful that this review would need to:

- Focus on the areas of priority that would contribute most to the assurance of acceptable levels of care.
- Focus on strategies and measures protecting users, carers, staff and public from avoidable harm, whilst respecting the rights of users and carers.
- Spend as much time as possible visiting services, talking to front-line staff, users and carers, gaining a broad overview of their experiences, challenges, frustrations and achievements.
- Seek to estimate the extent to which the ever-increasing number of policies and protocols relevant to mental health are having an impact on practice.

In order to achieve these aims, it was necessary to ensure that:

- The whole review process was subject to scrutiny by a user/carer reference group (facilitated by Mind Cymru).
- There was an agreed prioritised set of standards that could be addressed consistently across Wales, based on current guidance and evidence.
- Visiting teams were made up of individuals with extensive experience, with each team having a mix of perspectives, including a representative from Mind Cymru.
- That each visiting team included at least two members drawn from a small core group of reviewers, to ensure consistency of approach across visits.
- Visiting teams had access to a key set of documents provided by each Trust.
- Our approach has been to triangulate information in each area, from interviews, observations and documentation, to feed into themes relating to services across Wales. From its experience of evaluating clinical governance and risk management, the

Commission for Health Improvement (CHI: Framework for risk management for mental health trusts, 2004) considered that a 'robust assessment' could be provided by ascertaining the views of managers and selected staff, with verbal evidence being backed up by specific examples and supported by documentary evidence. The approach of the current review, involving input from a range of key managers and a good cross-section of staff, users and carers, observation and the collection and analysis of available documentation, may equally be seen as providing a robust basis for action. By design, in view of the available time and resources, it lacks the fine-grain analysis of the situation in each Trust that would have been possible with an extensive review in each area. It does, however, offer the opportunity to view an all-Wales snapshot, taking a consistent approach within a limited time-frame. As such, it should provide robust information regarding areas requiring action across most, if not all, parts of Wales, as well as any issues of serious concern that are evident in a minority of areas.

Remit of the review

CAMHS, Learning Disabilities and substance misuse services (except dual diagnosis) are specifically excluded from the remit of the review by the Welsh Assembly Government. Accordingly, these services were not visited during the Review, and they are mentioned in the text of the report only insofar as they might interface with other mental health services, in particular inpatient units.

Acknowledgement

The Project Management Group are most grateful to all the users, carers and staff from numerous agencies who took the time, often with little notice, to meet review teams or to provide written comments or to meet as the Reference Group. The deep commitment to improving mental health services in Wales from all involved is very evident.

2. Methodology

Overview

The following components were involved:

- Establishing user/carer reference group.
- Collate literature: evidence, guidance, research policy documents.
- Workshop involving Project Management Group, reviewers and user/carer reference group to agree set of key standards for use in the review, ensuring coverage of all priority risk areas.
- Two-day visit to each Trust by a multi-disciplinary team, comprising a Mind Cymru worker, a senior nurse, a clinician (psychiatrist or psychologist) and a reviewer with a health or social care management background. Review team agrees themes/issues emerging from each visit.
- Postal survey of Community Health Councils, Mind groups and Reference group.
- Workshop involving core reviewers to draw out themes across Wales and draft recommendations.
- Drafts of report improved by Project Management Group and reviewers.

User/carer reference group

In association with Mind Cymru, and in collaboration with Hafal and Mind Link Cymru, a user/carer reference group was established to provide advice during the preparation, implementation and conclusion of the review. The Reference Group adopted the values which underpin all of Mind's activities; namely autonomy, knowledge, participation and respect. The Group comprised of three service user representatives and three carer representatives from different geographical areas in Wales, namely:

Peggy Gollogly
Karen Harvey
Catherine Jones
Leslie Owen
Stephen Perkins
Sue Sayers.

The role of the Reference group was to:

- Read the relevant tender documents and WCMH submission for the review

- Attend and participate in: the initial planning workshop, mid-term meeting to monitor progress and contribute to a final meeting to evaluate the process
- Advise on the relevant user/carer priority issues for investigation during the whole review
- Comment on the feedback from the Mind Cymru reviewers following the visits and prior to the production of the final report.

Literature Review

An initial literature review of existing standards, guidelines and relevant reports, identified key issues of concern which were presented and discussed at a workshop, held within three weeks of the start of the project, which involved the project management group, researchers, reviewers and members of the reference group. Details of the relevant literature reviewed are set out in Appendix 1.

The literature review highlighted the significance of the following **seven themes** considered to be integral components of good quality mental health services:-

Partnership, co-operation & co-ordination: There was emphasis placed on the importance of multi-agency work, which included co-operation between the Social Services, health authorities, voluntary agencies, forensic services, crisis resolution teams, the police and the independent sector. There should be locally agreed protocols and models in place that have been developed between all these groups. This is vital to foster good relationships and joint working, which in turn produces seamless transitions of care and care co-ordination. The same principle should be applied to multi-disciplinary teams. Local mental health strategic groups are needed to co-ordinate care across geographical boundaries.

Communication: It is important to have good communication and information sharing between different agencies, staff, service users and carers. The sharing of information is especially important between primary and secondary care, and CMHTs and primary care. This is key to preventing 'people falling through the net' and reducing risks. Information should available to all stakeholders 24 hours a day and out-of-hours. Communication skills training should be given to all staff to help them to communicate effectively with patients and carers. The

information given to service users and carers, whether verbal or written, needs to be in a language and format that is easily understood.

Risk assessment and risk management: There should be responsibility at Board level for risk in mental health and protocols and procedures should be disseminated to staff. Training in risk assessment, suicide prevention and violence and aggression de-escalation should be given to all staff. Complete record keeping and high quality history taking is key. Risk management policy should be based on the Care Programme Approach (CPA). Regular audits of standards should be undertaken. There should be a risk profile and a risk register.

Incident reporting: Critical incidents, untoward incidents, security incidents and near misses should be reported and acted upon. There should be an open culture for staff to report incidents. There should be relevant policy and procedures in place that are disseminated to staff and all action plans should be linked to complaints and incident reports. Feedback is vital, managers should feedback all action plans etc. to the staff. In order to reduce risks, root cause analysis and trend analysis is important.

User and carer involvement: Users and carers should be involved in the designing, planning, evaluation and monitoring of the service and staff training. They should also be involved in monitoring the condition of wards. The Trust should respond to feedback from service users in writing and this should be used to improve service delivery.

'Fit for purpose' environment: The privacy, dignity and safety of service users is paramount. Discrimination should be prevented based on age, gender, sexuality, disability, race and ethnicity. The environment should be appropriate for its purpose: for example, Psychiatric intensive care unit (PICU), inpatients or community mental health team (CMHT). On wards there should be single sex areas. Number of beds should be monitored. A range of therapies should be available including psychological, medical and rehabilitation. Safety should be adhered to with alarm systems and clear lines of sight. Safety should be important not only for service users but for staff and visitors. Facilities should be available to lock away property of users and staff.

Workforce: Recruiting and retaining staff is a major problem throughout the mental health services. There should be strategies in place to overcome this. It is important that the staff are highly skilled, motivated

and trained. There should not be a reliance on bank staff and locums. Each mental health service needs an appropriate number of staff, caseload and staff mix. Staff should be responsible for their actions and competency should be assessed and performance monitored. Poor performance should be reported and equally good work should be rewarded. Supervision and leadership should be effective.

Standards adopted by the Review

In reviewing the available standards, it became clear that the self-assessment tool contained in the CHI Framework for risk management for mental health trusts (2004), which built on the CHI Sector Report on mental health services (2003), covered most of the priority risk areas to be reviewed. There was also considerable common ground with the National Patient Safety Agency's 'Seven Steps to Patient Safety' framework.

The CHI tool has six domains:

- Corporate approach
- Risk management systems
- Implementation in directorates
- Human resources
- Care processes
- Environment

Each domain has a number of elements, and at the initial project workshop, participants prioritised these elements, ensuring that those included would cover the key areas of the review, and have the greatest impact on the experience of services for users and carers. Some additional standards were added to the 'Care processes' section, to specifically address the range of transitions included in the review. Some adaptations were also required, in view of mental health services in Wales not being provided by Mental Health Trusts.

Each standard in the CHI tool may be rated as 'yes', 'no' or 'partial' at three levels:

- Basic minimum
- Firm foundations – progress or better practice
- Maturity – leaders in the field

For the purposes of this review, the minimum level was taken for each standard, as the aim is to ensure that users and carers receive at least the minimum acceptable quality of service and care, and to highlight areas of risk where this might not be achieved.

Appendix 3 shows the final standards tool used in this review, as a framework for reviewers and for self-completion by the risk management group in each area.

Review visits

The key feature of the review was a two-day visit to each Trust area by a multi-disciplinary team of four people (representing psychiatry/clinical psychology, mental health nursing, voluntary sector, management/joint working) supported by extensive preparatory work, and a de-briefing / reporting phase. Most of the team were experienced reviewers and had worked in mental health services. There was a core group of four reviewers, with at least two persons from this group being engaged in each of the review visits. The names of the reviewers are included in Appendix 2.

Despite an exceptionally brief lead in period, the project management team received excellent cooperation from each of the following eleven NHS organisations responsible for providing mental health services across Wales:-

- North West Wales NHS Trust
- Conwy & Denbighshire NHS Trust
- North East Wales NHS Trust
- Powys Local Health Board
- Pembrokeshire & Derwen NHS Trust
- Swansea NHS Trust
- North Glamorgan NHS Trust
- Pontypridd & Rhondda NHS Trust
- Bro Morgannwg NHS Trust
- Cardiff & Vale NHS Trust
- Gwent Healthcare NHS Trust.

The review visits were arranged between 11 October 2004 and 26 November 2004. In advance of the visits, each service provider submitted preliminary information for the reviewers, which included a description

of the arrangements for risk management and clinical governance and a description of the role and function of local NHS mental health services.

The eleven NHS organisations were most helpful in arranging detailed programmes for the visits. The programmes facilitated visits by the respective review teams to a cross section of Community Mental Health Teams (CMHTs) and in-patient units.

During the visits interviews were also arranged in two functional sets:

Set 1

- Relevant Trust Board members;
- Trust senior officers, to include Clinical Director, Service Manager, Clinical Tutor;
- Staff with clinical governance responsibility;
- Staff with responsibility for risk management;
- Commissioner(s) / senior manager(s) from social services departments;
- GP(s), Lead Director and senior officer for mental health from LHBs.
- Users and carers; and
- Voluntary sector providers.

Set 2

- Inpatient staff providing inpatient adult mental health care; including nursing (trained and untrained), occupational therapy etc;
- Consultant Psychiatrists, staff grade doctors and trainees;
- Staff from each CMHT, e.g. community psychiatric nurses (CPNs), social workers, psychologists;
- Staff in services for older people with mental health problems; and
- Staff in forensic services.

With a full schedule of visits, group interviews (each usually timetabled for one hour), interviewees travelling to a central location where possible, and the review team working in pairs, the views of approximately 50 people were elicited during each visit. Review teams met at the end of each visit, and produced an overview of themes and issues from the visit, ensuring that evidence included was supported from several sources,

including interviews with different groups, documentation and observation.

Postal survey

A postal survey of local groups affiliated to Mind Cymru and Community Health Councils across Wales, was carried out in an endeavour to identify their particular areas of concern or of good practice. Members of the user/carer reference group were also offered the opportunity to provide written comments.

Final workshop and report

The four core reviewers met with the convenor of the Project Management Group and the Project Manager, and the themes and issues emerging across visits were collated, and organised to address the priority risk areas. Recommendations were drafted to address areas requiring improvement, and aspects of good practice identified.

The standards documents from the 11 visits were also collated and areas needing attention identified.

Drafts of the resulting report were commented upon and improved by reviewers and members of the Project Management Group.

3. Key Findings: Priority risk areas

3.1 Transitions

Patient pathways may involve a number of transitions, each of which carries a degree of risk. These include the person being 'lost' between services or failing to engage with the new service, or of neither service accepting responsibility for the person's care, leaving the person bouncing backwards and forwards between services and not receiving appropriate input.

In considering transitions, the review teams commented on some additional interfaces which gave cause for concern, and which are key to understanding pressures on the system, over and above those identified by the Assembly in the project specification.

Primary care to/from community mental health services

Across Wales, mental health practitioners expressed concerns about 'inappropriate' referrals from primary care teams. In general, Community Mental Health Teams (CMHTs) saw their role as being to provide services for people with severe mental illness but they felt that they were often required to deal with common mental disorders, predominantly anxiety and depression, and to signpost patients to other sources of help. Dealing with people requiring support with bereavement and anger management were cited as examples. It was recognised that people in distress required help and support, but it was thought that this detracted from the main thrust of the service in supporting those with severe mental illness in the community. The preferred option for service development, from the perspective of many mental health practitioners, would involve increased resources for CMHTs who could then remain as the primary recipients of referrals which would then be screened and managed appropriately.

Review teams identified a number of different primary care mental health service initiatives in different parts of Wales:

- three NHS Trusts had appointed mental health Liaison Nurses to support primary care teams. The Primary Care Liaison Scheme, operating in one Trust area has been recognised by the Lundbeck Award for best practice in dealing with depression.
- in two Trust areas, First Access Teams had been established, within the mental health directorate, as the prime agency

responsible for providing services to people with common mental disorders.

- one LHB had recently commissioned a mental health practitioner to conduct a study of approximately 100 General Medical Practitioners to identify their perceived priority areas for service development. The findings identified the need to establish a crisis resolution service and improved links between primary care and local CMHTs.
- one CMHT had identified an 'assessment day' each week, when all new referrals were screened, and relevant sign-posting carried out, as referral information from the primary care teams was seen as inadequate to inform decisions regarding an appropriate response to the person's needs. This approach ensured that the CMHT did not become overwhelmed with the demands of new referrals, and could focus its resources on its core client group.
- In another Trust area, reviewers noted that CPNs were based in many GP practices, and fulfilled a valuable liaison function.
- In a few areas, LHBs had clearly identified primary care counselling services as the appropriate response to this issue, but there could be a lengthy (up to 9 months) waiting list for this service – one LHB identified this delay as a key area of risk for its patients.

Our reviewers found limited evidence of services dedicated to supporting the assessment and management of mental health *within* primary care across Wales. The emphasis was on referral rather than supporting care at primary care level. Reviewers had particular concerns that the First Access services could lead to deskilling of primary and secondary care clinicians by dealing with primary care cases in secondary care. The NICE guidelines on the management of anxiety (clinical guideline 22) and depression (clinical guideline 23), issued in December 2004, emphasise that common mental health problems are normally to be managed by primary care teams, with more severe or treatment resistant problems referred to mental health specialists in secondary care.

Although there were different routes of referral in different places, there was nowhere in Wales where referral routes and the associated care pathways were clearly understood by all providers, referrers and service users. There were also a dearth of formal documents and associated training made available for mental health practitioners and members of primary care teams.

In the words of one clinician it is:

"like running a complex road transport system without anyone needing to understand the highway code or having a driving test".

Consequently, it seems that the potential for preventing deterioration in mental health at an early stage and providing community support to those already known to have mental illness is significantly compromised. CMHTs are being asked to address two large and important areas of need, and run the risk of meeting neither adequately.

Emerging themes

- Primary care teams lack capacity to develop and practise skills in assessing, managing and signposting people with common mental health problems
- Different models of managing mental health in primary care require further evaluation
- Care pathways for people with both common mental disorders and severe mental disorders need to be developed indicating how the primary care team and the CMHT should interface

Community to/from inpatient

The review teams identified that as a rule, there were good links between CMHTs and inpatient units across most of Wales; however, it was notable that the three areas where this aspect was seen as less satisfactory are among the most rural in Wales. It appeared that where inpatient units were located providing easy access for CMHT members to regularly attend multi-disciplinary team meetings on the ward, discharge planning was greatly facilitated. However, in a few areas, comments made by members of CMHTs implied that communication with the local inpatient unit was challenging and the views from the corresponding inpatient units suggested that communications with CMHTs were "good but occasional" or "had improved".

In the majority of areas, difficulty was noted in relation to admissions. Review teams were informed of 'inappropriate' admissions, often occurring in the evenings or at weekends, when CMHT services were not available. In one Trust, one CMHT was able to offer a seven day a week service, but in other parts of the same Trust, only skeleton cover was provided at weekends. Here, the possibilities for avoiding admission were more limited as the CPN on duty would not have knowledge of clients

presenting with a weekend emergency, nor have access to the community team file.

In every Trust area, there were some difficulties reported in discharging patients from inpatient units. A significant number of people within mental health inpatient units, including some on rehabilitation wards, were noted to be delayed in clinical transition. According to official returns (SDR 7/2005), there were 221 delayed transfer of care (DToC) cases in the Trusts/LHB at the time of the visit (census date December 15th) who were patients of adult / older adult mental health services, many of whom were required to stay in hospital for considerable periods of time. In one Trust area alone it was reported that there were 70 cases of DToC within mental health wards at the time of the review visit. In part, this was attributed to the lack of housing options with appropriate support available in the community across Wales, particularly places where support is available from mental health nurses. Absence of other community support facilities was also identified as a barrier to discharge.

Inpatient beds for older people with mental health problems were under pressure in all areas. This was reported to be heightened by the shortage of care homes (with closures having an impact across the whole of Wales), delaying discharge and reducing alternatives to hospital admission. Lack of community facilities for specific groups (e.g. younger people with dementia) also increased this pressure.

Emerging themes

- The need for CMHTs to have effective out of hours arrangements
- Arrangements between inpatient units and CMHTs may be strengthened by a formal protocol
- The need for alternatives to admission to be further developed, including intensive care packages
- Delayed transfers of care are a concern and add to the pressure on inpatient wards
- The availability of a range of supported housing and care home facilities would reduce pressure on inpatient facilities
- Appropriate community based facilities are lacking in most areas, leading to delays in discharge as well as inappropriate admissions

Forensic to/from community and general mental health services

It was noted in all areas that the arrangements to support transitions to and from out-of-area facilities providing high, medium (short and long

stay) and low secure services and local CMHTs gave cause for concern. In all but one area, NHS risk managers acknowledged that there was not yet a robust protocol for transitions between forensic and general mental health services in relation to communication of risk, sharing of information and shared care. This view was reinforced by the Independent External Review, on the circumstances relating to the homicide committed by PK, which was published during this Review (Cardiff LHB, 2004).

Low secure forensic services, including in-reach to prisons and work with courts, were best developed in the most urban and populated areas. In one area the low secure service was only for male patients with no specialist service being offered for female patients. All Trusts were, at times, coping inappropriately with patients falling within the 'low secure' category, by using acute inpatient wards, Psychiatric Intensive Care Units or high dependency wards. The lack of low secure provision was thought to undermine transitions from the medium and high secure units.

The two Regional Medium Secure Units in Wales were making efforts in various ways to improve liaison with community and inpatient services, but problems did arise from both sides. Some consultant psychiatrists, owing to their lack of involvement in discharge planning, were reluctant to accept Responsible Medical Officer (RMO) status for patients being discharged from these units. This practice could undermine good liaison occurring across the multi-disciplinary team. General psychiatry units perceived the Medium Secure Units as, at times, being over-concerned to delineate and define which patients fell outside their remit, rather than providing guidance, based on their skills and expertise, to other mental health practitioners. Greater consultation between forensic services, the Courts and general mental health services was widely called for.

Senior managers and clinicians identified the need for effective commissioning of medium secure provision by means of preparing service level agreements giving details of numbers, admission criteria, standards of care/discharge, location, monitoring arrangements, annual costs etc. for this client group across localities. Health Commission Wales was perceived to be limiting its function to the "spot purchase" of beds in forensic units as opposed to service delivery and development.

Several service users and carers were also concerned about the lack of local forensic facilities resulting in out of area placements; they highlighted the need to consider the implications in terms of damage to

personal relationships, families and social networks and consequent elevated risk of re-offending, as well as the increased risk to community safety because of the greater likelihood of a breakdown in communication in the transition back to the community.

Emerging themes

- A clear strategy for low secure services across the whole of Wales is lacking.
- There is scope for the Medium Secure Units to provide more proactive support and advice to general psychiatry services managing patients with forensic involvement.
- Involvement of the relevant general psychiatrist in discharge planning for patients being considered for discharge from secure units needs to be developed.

Community to/from general hospital

In one hospital, a mental health nursing team has taken on the lead role for liaison with the general hospital wards, and this has proved highly effective, leading recently to the development of a nurse-led out-patient clinic to follow-up patients initially seen in the general wards. At other hospitals, various mental health practitioners undertake this role in addition to their other responsibilities. In two-thirds of areas the liaison role is under-developed to meet the demands of the service, bearing in mind that a significant percentage of all admissions to general hospitals relate to patients with physical illnesses who also suffer from dementia, anxiety disorders, bipolar disorders, schizophrenia, major depression, personality disorders, eating disorders and suicidal behaviour.

During the review, in at least half the areas visited, user and carer representatives reported that some members of staff at A&E departments showed negative attitudes when dealing with people who had self harmed, often making it very clear that they did not consider such patients to be worthy of NHS treatment and care. Carers across Wales told reviewers of the poor care received by older people with dementia when admitted to general hospital wards, with staff often seeming unaware of how to respond to dementia or meet their needs.

Emerging themes

- An effective liaison service in general hospital settings may assist in preventing admissions to mental health wards and contribute to more effective use of general hospital beds through reducing delayed transfers of care.
- Support for staff in general hospital settings in understanding and responding appropriately to people with mental health problems is required.

3.2 Clinical environment

The wards (co-morbidity, caseload mix/load, therapeutic environment, clinical time)

The pressure on inpatient wards was evident in all parts of Wales. Many staff and service users attribute this pressure in part to the service having an unnecessary over-reliance on beds. Reviewers found that with a few exceptions, adult mental illness wards reported that there were occasions when occupancy rates exceeded 100%, with patients 'sleeping out' elsewhere in the hospital or on "short term leave" at home. This represents a major area of risk and would not be acceptable in the "acute" general hospital sector. A full appreciation of patients' needs may be lost in the communication between the primary ward and the ward where the person sleeps; the requirement to find a patient who can go on leave, so another person can be admitted to their bed, may lead to a misappraisal of the risks involved (there is a particular risk of suicide when patients return home on leave, in any event; the report on the homicide committed by PK also highlights that he was granted overnight leave from the medium secure unit because a bed was urgently required by another patient). The significant level of Delayed Transfers of Care in mental health services, detailed previously, adds to the pressures on inpatient units.

To add to the pressured inpatient environment, wards across Wales cater for a wide range of patients, whose needs may be difficult, if not impossible, to meet in one unit. There is a wide age-range: adolescents, if not in full-time education (i.e. school) are not accepted by the child and adolescent mental health services (CAMHS), meaning that young people of 16 and 17 years of age have to be admitted to wards with adults. At the other end of the age spectrum, in two areas, older adults with mental health problems other than dementia (who may be physically frail) are regularly admitted to general adult mental illness wards. In one area, separate provision is made for such patients, but if their mental health problems began before the age of 65, then they must continue to be looked after by the general adult mental health service unless they develop a dementia, whatever the nature of previous contact with mental health services.

Wards also manage a range of types of mental health problems and the absence of low secure units means that some in-patients will have a forensic history. There are no dedicated in-patient facilities for eating

disorders in Wales and facilities for perinatal psychiatry appear to be available only in Cardiff. Hence, the admission of people with these conditions may also be to a general psychiatric ward. To complicate the situation further a large number of patients on such wards are likely to have a dual diagnosis in relation to substance abuse (many staff reported this applied to 'the majority' of patients) and other patients may have a dual diagnosis of a learning disability and a mental health disorder. In addition, most wards across Wales provided for both male and female patients. Taking an overview of this mix of patients, especially in over-occupied wards, this must be considered as representing a significant risk which inevitably impacts on the quality of care as well as on staff.

In a recently commissioned unit in one area the "mother and baby" and "secure" room/facility as well as a 14 bed unit had never been used. However, there were plans to utilise the un-commissioned ward as the office base for community mental health services.

In one area the reviewers were extremely concerned that no more than 30 minutes was allocated for the handover between shifts. This was considered far too short a period to deal effectively with all the issues relating to the wide range of inpatients and their challenging and differing needs.

There was clear evidence, from observation and interviews with staff, users and carers, of lack of engagement between staff and patients on the majority of inpatient wards visited, resulting in lack of stimulation and care. Clinical time for patients was limited. This was exemplified by one service user who commented that his care plan included a regular one-to-one session with his key nurse, but that this was often cancelled because staff were too busy. One ward appeared to have good facilities, but reviewers were told that a lack of physiotherapy staff input meant the gymnasium could not be used, and the doors giving access to an enclosed garden area for the same inpatients were also locked. However, in one unit the Occupational Therapy Department provided activities until eight o'clock in the evening and on other wards there was evidence that nursing staff had facilitated evening and weekend activities as a result of involving voluntary organisations and user groups. These stood out as exceptional examples, but illustrated both the limitations and what could be potentially achieved. A project monitoring engagement, involving a refocusing of the in-patient wards, and developing the nursing role in facilitating activities, appeared to have some promise on one set of

general adult wards, and it was reported that a similar initiative "The Meaningful Day" is to be implemented shortly in another area.

Emerging themes

- Over-occupancy and over-reliance on inpatient beds needs to be monitored and reduced
- Delayed transfers of care add to the pressure on inpatient wards, and are attributed to a lack of appropriate supported housing and other community facilities
- Interfaces with other services (forensic, older adult, substance misuse, CAMHS, learning disability) need to be developed so that patients are appropriately placed, and that staff have appropriate training and support in managing the range of patients using the service
- Gaps in services need to be addressed – e.g. low secure, eating disorders, mother/baby services
- Quality of the therapeutic environment and engagement with patients needs to be monitored and improved

Community Mental Health Teams (co-morbidity, caseload mix/load)

CMHTs are also working under great pressure across Wales. Everywhere, reviewers were told that the caseloads of key workers were unacceptably high, often exceeding 40. There was frustration regarding the impact this had on the quality of care provided. Staff had, for example, been trained in psychosocial interventions for psychosis, but the demands of their caseload prevented them implementing this evidence-based approach, in line with the NICE guidelines on schizophrenia. Teams were aware that caseload numbers are a crude index of workload, and in one team a useful workload assessment was being piloted, so that case-loads could be realistically evaluated – this seemed a commendable approach. The high pressure was compounded by the volume of referrals from primary care, mentioned previously.

Whilst CMHT's offered a multi-disciplinary service, with joint working with Social Services, there were reports in half the areas visited of some facilities being unsuitable and making the task more difficult. For example, there were some CMHTs providing health and social services for older adults who did not share a single co-located base. Although

relationships between health and social services staff were usually excellent at the key worker level, there were some tensions regarding roles within teams, and caseloads at the managerial level. Some teams were led by health, some by social services, and the management of the other agency's staff (and their workloads and working practices) led to some frustration at this level. It was noticeable, however, that mental health nurses and social workers were highly respected by many service users, carers and voluntary agencies.

Service users in the community stated clearly that what was required was a 24 hour/7day per week service. Whilst they welcomed the establishment of services such as crisis resolution and assertive outreach they considered the current provision to be inadequate. Reviewers were told that where crisis resolution services had been established, understaffing was an issue, for example in not providing a 24 hour service. Whilst, these teams seemed to work well nurse to nurse/social worker, they experienced problems in liaison with doctors, due variously to:

- changed or inconsistent admission criteria
- defensive practice, and
- the challenges of working in a large geographical area.

CMHTs do not see themselves to be the "drivers" responsible for managing the referral pathway across secondary and tertiary care hence facilitating a seamless service for users and carers. Services, such as those responsible for assertive outreach and crisis resolution, were considered to be provided by separate specialist teams who operated exclusion criteria. They were not fully integrated with CMHTs, whose team members felt exploited because,

"we have to take all-comers, such as forensic patients in the community".

New services were seen as 'cherry picking' patients rather than easing the load on the CMHT.

In general terms there seemed to be a lack of a coherent and consistent framework for community mental health services and, all too often, there was a shortage of such services in all localities across Wales.

Emerging themes

- Pressure on CMHTs – high caseloads need to be evaluated and monitored; effective out of hours services need to be developed

- CMHTs need appropriate facilities to carry out their functions effectively
- Relationship between CMHTs and new services needs to be managed to ensure a seamless service
- Joint working arrangements between health and social services need to address tensions regarding joint management

Appropriateness of Clinical Workforce

Workforce issues in mental health services are currently the focus of on-going Welsh Assembly Government review and initiatives, and so this review has not attempted to duplicate this work in terms of data collection. Rather, the effects of workforce issues at ward and team level, as evident to our reviewers, have been considered. Under current working arrangements, shortages of Consultant Psychiatrists have a particular impact on many aspects of the service, and a survey undertaken by the Royal College of Psychiatry during the review period quantifies the current situation regarding Consultant posts:

Faculty	**Established posts**	**Number in post**	**Number of vacancies**	**% vacancies**
General Adult and Community	86.25	70.85	15.4	18%
Old Age	36.5	24.5	12	33%
Liaison	2.6	1.6	1	38%

Source: The Royal College of Psychiatry Workforce Survey, October 2004

Not surprisingly, therefore, there are many locum medical staff in post across Wales, which is of concern to users, carers, Community Health Councils and other mental health practitioners alike. The reliance on locum staff was associated, by other mental health practitioners and service users, with a lack of continuity in terms of prescribing and treatment preferences and great concern was expressed that short term locums were often unaware of local policies, protocol and procedures. However, at the time of the review there was a wide variation across Wales in relation to the establishment and recruitment of Consultant Psychiatrists. In one area the establishment was reported to be virtually up to acceptable levels, with one long-term locum appointment not seen as problematic, although it was acknowledged that the establishment of old age psychiatry consultant posts was inadequate. In another area, however, the mental health directorate reported it had six vacant

consultant posts within the medical staffing establishment. One Trust was actively recruiting psychiatrists from Eastern Europe to fill long-standing vacancies.

It was suggested to several reviewers that part of the difficulty in recruitment was because mental health services in Wales were seen as lagging behind those in England, in terms of developing evidence-based services. Furthermore, it is currently anticipated that the proposed new Mental Health Act will require a 7 to 8% increase in consultant numbers, and this may be an underestimate in areas with high rates of detention.

Shortages of Approved Social Workers, Occupational Therapists, Physiotherapists and Clinical Psychologists were also evident, sometimes through recruitment difficulties, but also through a lack of established posts. In one area, the OT department felt confident it could recruit new staff, but was unable to secure agreement to increase the establishment, despite new community initiatives coming on stream. Excessive waiting times for psychological therapy were evident in all areas; in one area, an estimate of 2 years waiting was given, but delays of six to 12 months were the norm. There appears to be a clear need for more posts in psychological services, so that patients may have a real choice of treatment and to enable the implementation of the NICE guidelines on anxiety and depression.

Furthermore, there is a difficulty in recruitment of qualified nursing staff across Wales, especially on older adult wards. This led to long hours of work for some nurses, as the usual procedure in respect of absence from work was for cover to be provided from the service's own 'bank' of staff who already work on the units involved.

There was concern that projections showing an increased requirement for qualified nurses, in the light of service developments, were not being addressed on an all Wales basis, in that managers and staff within the service did not perceive any recent increase in mental health nursing training numbers. They also expressed concerns regarding numbers of nurses likely to retire in the next five years. Consequently, there are widespread doubts as to whether current planning regarding nurse recruitment to mental health services will address the risks already associated with low nurse staffing levels.

A significant percentage of staff within mental health services are unqualified. Whilst some local training initiatives have been developed

between NHS agencies and further education colleges it was suggested to the reviewers that there was scope to plan and co-ordinate such activity across Wales. It is also known that there is greater scope for people who have recovered from mental health problems to participate in assisting others. Such a development could therefore assist with aspects of recruitment and training for unqualified staff and also contribute to improving the quality of the service.

Emerging themes

- Recruitment and retention of staff across professions to fill established posts is problematic
- A need for more posts to be established is evident if services are to offer the range of therapeutic interventions that is widely accepted as appropriate
- Creative work force initiatives, such as training for unqualified staff should be considered to add to the available resource.

Physical environment

There have been many recent redevelopment and environmental improvements to the mental health estate across the whole of Wales, but, with a very few exceptions, wards and services visited remain in unsuitable buildings. In one large Trust, the review team concluded that the vast bulk of provision is unfit for purpose. Disappointingly, this does not simply appear to be an issue in relation to the remaining remnants of the large asylums that have been inherited. Buildings from 15 years ago and some even more recently commissioned were thought to be unsatisfactory in at least some respects. In general terms, the majority of the facilities for inpatient services are not fit for purpose and some do not meet minimum standards of safety, privacy and dignity.

Those Trusts with active re-provision programmes in process, had the difficult task of maintaining buildings which were scheduled for closure in the foreseeable future. This meant that while efforts were made to improve the quality of the care environment on wards (e.g. through the provision of garden areas, replacing of flooring), their design and general condition made it virtually impossible for them to meet modern standards.

- According to users and carers, simple repairs and adaptations can be subject to inordinate delay, and it would appear that there is an immediate need for all NHS estates departments to adopt an

approach that prioritises and responds quickly to requests for repairs impinging on patients' quality of life.

- Reviewers visited mixed wards where the female dormitory is accessed only through the male dormitory. A young female user told us how male patients would behave threateningly to female patients passing through the male dormitory, and that she had been pushed down on a bed. Users and carers (and the reviewers) felt that these arrangements are unacceptable. In at least half of the areas reviewed, there were inpatient wards where females did not have access to a separate area.
- Those staff met by the review team in inpatient ward areas were usually aware of risks associated with ligature points, although there were differences in approach. One ward manager drew the attention of reviewers to one clear high ligature point in a ward dormitory; the approach taken was that with appropriate observation, this was an acceptable risk. In another Trust, following an incident on a ward, low ligature points had been removed, including some aids required by users with disabilities. In half the areas reviewed, risk managers did not consider that ligature points and other self harm risks had been fully dealt with.
- Whilst relatively new wards seen by reviewers on four sites were of high quality, the design did not allow for optimal observation arrangements for staff; it was also noted that new wards for older people lacked the personalised and more domestic atmosphere which is considered desirable.
- Service users and carers expressed their concerns about young children visiting on one acute ward in a smoke filled room.
- The majority of Trusts acknowledged that they did not involve users and carers in auditing safety of the care environment, or in regular checks on its cleanliness.

On the positive side, the new purpose built facilities should clearly help in both service delivery and morale, and were noted to confer patients with much needed dignity. Such facilities are pre-requisites in terms of addressing violence and aggression on wards and in alleviating the challenges of people with dual diagnosis. Problems of stigma may also be reduced by the good atmosphere which was experienced in several wards.

Emerging themes

- Given the majority of the facilities for inpatient services are not fit for purpose and some do not meet minimum standards of safety,

privacy and dignity, investment in the capital programme for provision of high quality inpatient units is urgently required

- Great care must be taken to ensure that new buildings are designed to avoid the pitfalls associated with some of the recently completed units in Wales, and that their design allows flexibility in relation to changing patterns of service provision
- Estates policies should prioritise repairs and improvements enhancing quality of life of users of mental health services

Culture and clinical leadership

It was noticeable that many staff were appreciative of the leadership from "strong" and "good, keen" consultants and from nurse leaders. Most mental health practitioners were highly committed and motivated, and appeared keen to make improvements where possible. However, many were weary from the effects of daily seeking to cope with and manage in the face of heavy workloads, unsuitable physical environments, staff shortages and seemingly low priority for resource allocation. It is not surprising that lack of staff engagement with users was a feature in a significant proportion of clinical environments. Furthermore, it is also not surprising that in many places, reviewers did not gain the impression of an open culture where staff felt able to discuss issues in a blame free environment. In a situation where staff may feel overwhelmed or powerless to change things, it is understandable that users and carers reported they found it difficult to feel involved at the ward / unit level, feeling their concerns were not acted upon sufficiently.

Clinicians with responsibilities for mental health service developments including clinical governance and risk management, did not feel they were able to do justice to their extended role because of heavy clinical commitments and the lack of dedicated sessions for modernising the service. Typically, reviewers were told that two sessions a week were allocated for the important and demanding role of Clinical Director for mental health services by NHS Trusts in Wales. One Trust was reported to be reviewing the time requirement at the time of the review, and a five session per week allocation was being considered. The Clinical Director contribution to developing mental health services, needs to be recognised and safeguarded as well as ensuring capacity to meet the requirements of their clinical practice responsibilities. Balancing clinical and management demands, for the range of clinicians with management responsibilities, places further pressure on a system where, overall, there is a shortage of skilled clinical input.

Emerging themes

- Mentoring, support and dedicated time for clinical leaders, to enable them to provide leadership in service modernisation and development, is needed
- Engagement with service users and carers is problematic at ward/unit level

3.3 Clinical Risk Management

Assessment and prioritisation

In all Trusts there were clear structures in place in relation to risk assessment and management, although it was worrying to note that the Risk Manager was not known to the Clinical Governance Lead within one of the mental health directorates. Furthermore, it was not easy in the majority of areas to identify the connection between the work of risk/clinical governance committees at corporate level with the corresponding groups within mental health services. Similarly, in a few areas, it was difficult to appreciate the way in which clinical governance groups were relating constructively to other forums within mental health directorates.

All Trusts reported having programmes in place to work towards compliance with Welsh Risk Pool and Mental Health Act Commission requirements. Most Trusts reported achieving high compliance with the Welsh Risk Pool Mental Health standard. All but one Trust reported having a risk register that included risks in the mental health area, and which was linked to business planning and service development. However, whilst the Risk Pool standards are clearly useful, it was not evident that what appeared to the reviewers to be major areas of clinical risk were being assessed and prioritised in this scheme. There are also limitations to a self-report approach, which tends to focus on policies, protocols and procedures, rather than practice and the experience of service users and carers.

Specifically, there appeared to be no mechanism for the high occupancy of inpatient units to be monitored and acted upon. With bed occupancy exceeding 100% in some mental health wards, often reflecting high rates of emergency admissions, the demands on staff and facilities are seriously outstripping capacity. This, together with the mix of seriously ill patients with complex problems and dual diagnosis on the inpatient wards, often represents little more than containment for some patients.

Reviewers were informed by staff in many areas of their concerns about the full occupancy of hospital beds and high rates of admission, especially out of hours, because:

> “it leads to early discharge and revolving door syndrome”.

A related concern, frequently voiced by mental health practitioners during the period of this review, centred on the dearth of alternatives to admission for adults or older people with mental health problems, with a wide range of responses to emergencies outside normal working hours. These are handled variously by CALL (a 24 hour voluntary services run call centre), GP out-of-hours services, a duty Consultant Psychiatrist and Approved Social Worker who may be located at considerable distances from each other and the patient. Reviewers considered that CMHTs are attempting to provide a range of services that exceed the capacity of their limited resources, which compromises the quality of care to people with severe and enduring mental health problems. There is a clear requirement for an optimal level of secondary and tertiary care inpatient facilities which is well utilised and "managed" by a comprehensive range of specialist community mental health services. The community services, in turn, need to be adequately underpinned by a sound infrastructure for dealing with mental health issues within primary health care teams.

All Trusts acknowledged that service users were not routinely provided with written information about the risks and benefits of the range of proposed interventions. Half the Trusts said more work needed to be done in training key staff in issues relating to informed consent. This will, in any case, become an additional training need in relation to the Mental Capacity Bill.

In a third of Trusts, it was acknowledged that further work was needed in relation to audit of prescribing practices, although it was clear that pharmacists are becoming increasingly actively involved in mental health services. In all areas, concerns were expressed by NHS staff regarding the interface with specialist substance misuse services, reflecting the challenge of managing patients with a dual diagnosis of mental illness and substance misuse on general psychiatry wards.

Management of incidents, reporting and learning

In general, whilst, there were clear processes for the investigation of serious incidents in the NHS agencies, in several areas it was acknowledged that more could be done to disseminate the findings of the reports produced. Most risk managers had had training in root cause analysis by the time of the review.

All Trusts reported fully participating in the National Confidential Inquiry into suicides, homicides and detained patients. Whilst two-thirds of Trusts reported having a means by which suicides and homicides in the locality could be discussed and lessons learned, this was rarely on a multi-agency basis, as would be best practice, with LHB and local authority involvement.

The number of adverse incidents reported by the mental health directorates across Wales was large compared with other NHS directorates, but the number of complaints small. During their discussions with service users and carers, the reviewers came to the conclusion that there appears to continue to be a reluctance to pursue a 'formal' complaint, partly because of concerns as to whether this would influence care received.

It was noticeable that a high level of incident reporting occurred in four of the smaller inpatient units for older adults visited by reviewers, all located in predominantly rural areas. In certain of these units, functionally mentally ill patients are mixed with those suffering from dementia and there are daily tensions associated with delivering appropriate therapeutic approaches. Such situations present risks for patients and staff alike.

Action plans and implementation against identified risks

Following a serious incident on an adult inpatient ward earlier in the year, one provider has identified clear mental health issues to be addressed in its Clinical Governance Strategy and Three Year Development Plan and its Risk Management Policy and Strategy. The proposed actions have implications in terms of policy and its implementation at all levels of the organisation.

There was little evidence of joint working, for example to address the risks associated with delayed transfers of care associated with the lack of supported housing. There appear to be few, if any, joint NHS and Local Authority risk strategies in place for mental health, or joint incident reporting policies. A joint NHS Trust and Social Services risk strategy for community services had been agreed recently in one area, and reviewers noted the intention to use this as a model for a similar development for mental health services.

There is consistent evidence across Wales that training is quite well supported for mental health staff with evidence of training providing support for clinical practice. However the main focus is on meeting statutory obligations, such as health and safety at work, and there remain a significant number of staff who will not be able to benefit from short term relief to cover their shift / duties that will enable them to take full advantage of training opportunities. In two areas reviewed, there was no induction training dealing specifically with mental health issues relating to risk. In over half the areas visited, there are difficulties in ensuring time is made available for training in relation to key areas of risk, especially for nursing staff. As more areas of training are required, this may become even more of an issue.

In three areas, clinical supervision arrangements were described as 'patchy', with a clear need being identified to ensure that all staff receive and benefit from appropriate supervision, from a supervisor able to establish a supportive and reflective context for staff development.

Reviewers were pleased to note, in three areas, that a useful start had been made to develop training to meet the needs of the large percentage of mental health service employees who are not professionally qualified. This work has been taken forward with the support of the further education sector, and there seems to be potential to provide further guidance and co-ordination in this area.

In each area, reviewers enquired regarding progress in implementing the Care Programme Approach, as this was seen as a major service development that would contribute significantly to the clinical management of risk. Despite the target for the implementation of the CPA being December 2004, implementation appeared well-advanced in less than half the areas visited. The need for staff training and (occasionally) culture change was evident in the remaining areas. Some users told us of difficulties in accessing their care plans, for example. In the majority of Trust areas, implementation was patchy, with some services up and running, and others not yet ready. Where the implementation was seen as depending on the introduction of new IT or (in some older people's services) awaiting the introduction of Unified Assessment, reviewers felt less certain of the timescales involved.

All but two Trusts had a lone worker policy which they considered to be effective; the two Trusts which acknowledged this as an area requiring further work should address this as a matter of urgency.

Information systems

The state of clinical records is problematic and still fragmented in most cases. Access to paper based records is generally poor, meaning that staff are sometimes required to deal with patients without adequate background information available to support their decision making. The lack of access to records on an out-of-hours basis compounds the issues associated with inappropriate admissions to in-patient units. Six Trusts acknowledged there were some difficulties in making clinical records available when required. On the whole, therefore, information systems are as yet very limited in supporting integrated care and reducing the burden of administration for clinical staff.

A common area of concern across Wales is the lack of an integrated information technology system for mental health which serves the needs of the NHS and Local Authority Social Services Departments. Although many CMHT staff can access some information from either system the extent of information available electronically, especially out of hours, is limited. It was reported that in one area the NHS and Social Services are in the process of adopting different systems, both systems being implemented within the next year.

One Trust has a well established system with the potential to capture clinical data to support clinicians in their day to day care and treatment of patients. To date, however, the system has not been rolled out across the whole service and its main use is the production of performance management information which is dependent on the input of data from paper records. It appears there is some concern about the continued viability of the system, in light of the fact that the present day commercial support service may not be available in future.

The mental health directorate in another Trust has recently adopted an Integrated Care Management Action Plan with a view to:-

- incorporate implementation of agreed approach for clinical risk assessment
- implement Care Programme Approach
- implement the FACE recording and measurement system
- take forward interface issues: shared information/joint records/joint training
- co-ordinate implementation of integrated care pathways/NICE guidelines.

A specialist software support service has been commissioned to assist with the implementation of various parts of the action plan and a Project Manager had been appointed with responsibility for implementation, including staff training. Evaluation of the project and its outcomes will be required to identify whether it succeeds in achieving the integrated approach which is essential to good practice in this area.

Emerging themes

- Adoption of coherent and consistent standards for risk management, with a whole systems approach, is required, so that significant areas of day-to-day clinical risk are included in the Board level consideration of risk and its management
- Need for more effective dissemination of lessons learned from incidents and near misses
- Commissioning and performance management of mental health services is underdeveloped
- Need for continued monitoring of implementation of Care Programme Approach
- Training time needs to be protected, with induction training for all staff dealing with specific mental health risk management issues
- Development of meaningful and clinically useful information systems is needed
- Need for joint mental health risk strategies and information systems for health and social services to be developed.

3.4 Trust Board Engagement

Level of engagement

On the whole, when compared with the attention given to other health services, reviewers concluded that the modernisation of mental health services is not high on the agenda of NHS Boards across Wales. The pressures under which both inpatient and community mental health services operate do not seem to be recognised or addressed appropriately at Board level, potentially leading to the extent of risk being under-estimated. The concerns raised in previous sections regarding the numbers and mix of patients, the gaps in staffing and the dependence of the service on buildings that are acknowledged as not fit for purpose, would suggest an urgent need for action.. Across Wales, comments were made by mental health practitioners, service users and carers, in relation to the annual Service and Financial Framework (SAFF) agreements between the Welsh Assembly Government and NHS agencies. The SAFFs represent the main targets of activity relating to accountability and performance management in the NHS. Many people interviewed were of the opinion that the inclusion of more robust mental health SAFF targets is needed to focus the attention of NHS commissioners and providers on giving priority to mental health services.

It would, be unfair to suggest that mental health does not have a profile at Board level in many NHS Trusts. However, the matters considered do not appear to adequately reflect the concerns of the service and service users. Examples of the involvement of Boards reported to reviewers include:

- dealing with individual high profile incidents
- the presentation of awards to local service providers
- receiving composite reports on clinical governance, risk management and finance which incorporated information about mental health services, but seldom gave a comprehensive account of the quality of such services.

Exceptions to this general picture were seen in two areas where Boards were fully aware of and involved in monitoring action plans arising from reports from the Commission for Health Improvement, which had highlighted a number of issues requiring priority attention from Board level. In one of these areas, the Trust has two senior members of staff from the mental health division on the Trust Board and there is a third

member of the Board with responsibility for risk management and clinical governance in mental health, as well as across all other Trust services.

Emerging themes

- Additional key SAFF targets relating to mental health are required
- Indicators of pressures on services need to be reported at Board level
- Workforce issues and physical environments of care need to be included in Board level monitoring of mental health services

Information received and/or requested

Typically, regular performance management meetings are held between Executive Directors and the Mental Health Directorate Management Team, usually on a quarterly basis. In one Trust, it was pleasing to receive evidence of the robust record keeping of meetings which enabled the senior staff to take stock of recent improvements and agree new targets for further service developments.

Information systems were underdeveloped, with an emphasis on providing information on trends in incidents and complaints. In most cases, mental health data could be presented separately. However, reviewers saw no evidence of routine mental health clinical data being collated to report on local morbidity and trends which could inform service planning and development. Indicators of the pressure under which the system was operating were also lacking. Similarly the scope for assessing outputs associated with various treatment options and contributing to the evidence base for mental health services was far from prevalent across Wales. There seems to be scope to develop joint working with public health agencies in Wales to provide better information about the prevalence of mental illness, the provision of treatment services and their outcomes.

Emerging themes

- There is a need to develop effective information systems and performance management arrangements for mental health services
- Mental health services across Wales need to contribute to the development of evidence based practice.

Prioritisation and risk management

All the NHS agencies had accountability structures in place that consider responsibilities for safety and risk. The arrangements, however, only involved staff from the NHS agencies and in most areas there was no evidence submitted to demonstrate the involvement of key partners such as representatives from social services and service users or carers on the governance committees.

It seemed to be the responsibility of senior managers to deal with service difficulties arising from debates and disputes, often involving commissioners, regarding who pays for what. There was no evidence of such disputes being resolved by means of adopting joint working protocols that had been agreed at Board level. In the words of one NHS Executive Director,
"I don't have to think about mental health because "person x" is such a good manager".

Prioritisation of mental health services is perhaps hampered by the following factors:

- Trusts may show an almost perfect score on the Welsh Risk Pool mental health section, despite there being significant gaps in service quality (see section 3.3 above).
- Local Health Boards across Wales have lacked capacity to take a broad view of the mental health services required for the population, and so, for example, have prioritised services such as primary care counselling. Local Health Board populations are often too small for the effective commissioning of more specialised mental health services. Trusts find working with multiple LHB's an added complexity.
- Mental Health directorates have a tradition of coping and managing their problems, rather than engaging in lobbying.
- Some Trusts have significant re-provision plans, which become the focus for strategic thinking, and distract from current risks.
- One Chief Executive described mental health as having lower priority within the Trust because of 'political prerogatives'.

Emerging themes

- Commissioning arrangements for mental health services require review to ensure the whole range of needs is met seamlessly
- Joint strategies for risk management are needed which have wider support and confidence of the public, service users and their carers

and advocates
- There is a need to coordinate risk assessment and performance management arrangements across mental health services

Skills and knowledge

There was evidence in one Trust of dedicated briefing sessions being convened for the Trust Board on mental health and risk management and the same Trust also makes use of its staff journal and other communication networks to disseminate information about mental health services and developments to staff.

In six Trusts, there was clearly a high level of knowledge and skill in relation to mental health at Board level. This did not appear to be a sufficient condition for mental health services to be prioritised. Trust Boards perceived their priorities as being set primarily by all-Wales health service imperatives, with action plans arising from CHI reports operating as a secondary driver. Interest, skills and knowledge of Board members in the mental health area did not appear to have an influence.

Several Executive Directors were acutely aware of the need to decentralise services and to develop modern community based facilities. The main problem was considered to be the financial pressures of the transition period, reflecting the need to maintain specialist services in a central location until appropriate alternative arrangements were in place. There was an acceptance at the most senior level in the Trusts/LHB that maintaining the centralised service model was not an option but, it was equally evident that there was a significant risk associated with over reliance on community based services unless they were adequately resourced.

In many respects, this issue highlights the challenges associated with service re-engineering. There needs to be a transition phase to facilitate alternatives to admission, and this represents a financial as well as a clinical risk.

Emerging themes
- There is a need for transitional funding to develop a modern mental health service.
- Communication strategies in respect of mental health services need to be further developed to address the needs of NHS Board members.

Strategic & Operational interface

Reviewers noted a general feeling of frustration and helplessness associated with the view that more revenue was necessary to bring about significant improvements in the service. This view was:
a) compounded by the perception that mental health services had not benefited from development funds to the same extent as other priority health services in recent years.
b) further exacerbated by the fact that Local Health Boards, on an individual basis, were relatively inexperienced and also too small to commission the full range of specialist mental health services.

The issue seemed to be affecting staff morale. In the opinion of one operational manager:

"It appears that everything is on hold until the outcome of this review (conducted by an external agency and commissioned by Local Health Boards in one Trust area). Paralysis by analysis describes how staff are feeling".

The interface between strategic and operational planning and management was difficult in many areas. Where an active re-provision programme was being developed, capacity and attention was drawn away from day-to-day operational issues. Elsewhere, strategic planning seemed to be driven by current operational issues. Energy was expended on disputes regarding payment for a service for a particular patient, rather than on strategically planning services to meet the identified needs. In some areas, the expertise and experience of service providers was not utilised effectively in considering how to modernise the service. Generally, service users and carers were more likely to report having an input at the strategic rather than the operational level, which resulted in considerable frustration.

Emerging themes

- Commissioning of mental health services requires strengthening
- Users, carers and expert clinicians need to be involved at both operational and strategic levels

3.5 Multi-agency Approach

Interface with other agencies

Local Health Boards

NHS Trusts undertake joint working with each of the Local Health Boards in their area in relation to the commissioning of mental health services. Whilst Powys LHB can manage this function internally, in every other part of Wales, Trusts are commissioned by one or more LHB's to provide services. Gwent Healthcare NHS Trust is required to work with no less than five sets of local commissioners (as well as Health Commission Wales). Trust Boards, and more specifically their respective mental health directorates, found this a major source of difficulty.

In general terms, commissioners were seen as new and varied with expertise in commissioning mental health services thinly spread. Several Trusts were concerned about the use of additional resources allocated as a result of allocating the Townsend formula, for example, to develop crisis resolution or assertive outreach teams in selected areas without due consideration being given to the "whole system". It was reported that some LHBs worked collaboratively to avoid duplication of effort but the gaps and variation in provision highlighted the need for improved performance management. The population covered by LHBs (as well as most NHS Trusts) is typically too small for the effective commissioning of specialist mental health services or to properly track and monitor placements in the private sector.

Emerging themes

- Need to consider optimal population base for commissioning mental health services.

Social Services

The collaboration between mental health staff employed by the NHS and local authority social services departments was very good at the operational level. Across Wales, there were often tensions at managerial level over the relative priorities of their organisations and resource allocations, although these had been overcome in at least one area where the older adult teams were led by social services and teams for adults of working age were led by the Trust. In another area, however, although the CMHT bases were generally co-located with social services staff, the

parallel management system within teams was dysfunctional and evidenced by policy differences between health and social care agencies.

Reviewers heard no evidence of any strategic or other joint commissioning of mental health services under the 'Health Flexibilities' arrangements between health and social services. There had been some use of joint flexibilities monies to develop small scale services e.g. training input on dementia for care homes in one Trust.

A joint risk management strategy between health and social services had been prepared in one NHS Trust area and submitted to a joint partnership board for mental health. However, it was not apparent if there was any executive level representation on the partnership board. In general terms, joint strategies for risk management or incident reporting were not evident and joint working was often effectively hampered as a result of managerial power struggles or a lack of shared vision and direction.

IT systems were incompatible between NHS and Social Services, adding complexity to team working, and making information sharing unnecessarily difficult.

There was a perception amongst many NHS staff that social care provision did not match the level of health care for people with mental health problems, as evidenced by the lack of day care facilities and respite care.

Housing agencies

The supply of suitable housing with appropriate support for people with mental health problems does not seem to have kept pace with the increasing demand for accommodation by the general population. The situation seems to be exacerbated for NHS mental health services as a result of the recent closure of many residential care homes across the whole of Wales.

In most areas CMHTs did not seem to provide much input to care homes and reviews of people in care homes did not seem to be prioritised according to need. However, there was evidence in one area, where an assertive outreach service had been established, of a CMHT developing useful links with local authority supported housing schemes. In one area it was reported that a supportive accommodation scheme was held up by

difficulty in obtaining planning permission, following local opposition to this type of development.

Emerging theme

- Improved collaboration between health and social care agencies, including housing, is essential for developing more effective mental health services.

The Police

Links with the Police were reported to be good. There were concerns however relating to:

- Persons in a state of aggression being escorted by police and left on hospital inpatient units in the care of junior ward staff. Often, the police were required to leave the hospital immediately to deal with other emergencies.
- Transfer of patients between units, such as from an adult mental health inpatient unit (AMI) to a psychiatric intensive care unit (PICU). This was often arranged by the police, but considered inappropriate by service users / carers and the voluntary sector.

Emerging theme

- The NHS and the Police should adopt a joint policy in respect of the safe transfer of patients to inpatient facilities.

Voluntary sector, including service users and carers

The involvement of the voluntary sector was well established on the multi-agency planning groups relating to the development of Health and well-being strategies in each LHB area. Similarly, users and carers had been actively encouraged to participate in several planning groups for service developments which the Trusts had convened.

However, whilst a lot of effort had gone into the planning of new services, users and carers were of the opinion that decisions were being made unilaterally (e.g. day hospital / day care provisions for older people changed without consultation) and their voice was not being heard. Not surprisingly many users and carers informed the reviewers that they had not felt empowered to influence decisions as a result of their engagement with the NHS, which was described as “tokenistic”.

On the whole, NHS mental health services do not appear to take advantage of opportunities to engage effectively with the voluntary sector despite the potentially valuable therapeutic input which could be provided for patients, at various times of the day and at week ends. It appears that rules and regulations, relating to health and safety and insurance, are blamed for a reluctance to engage in positive risk taking of this kind on NHS premises. In the words of one mental health service manager:

"we have to be mindful of health and safety at work".

Advocacy services are developing and present in many parts of Wales, and were represented at meetings with reviewers in the majority of areas, but the services are not adequately resourced to be available to all the service users who might benefit from their input. Services are especially limited for people with dementia. It is worrying to note that the advocacy services that exist are not well accepted by all staff and reviewers were informed of instances when:

- A clinician had been unwilling to engage with a patient in the presence of the advocate, despite the fact that the patient had asked for the advocate to be present
- Staff had facilitated a patient's appointment with an advocate without giving due attention to the safety of the advocate.

It was noticeable that there was no evidence of Trust policies and training to support the implementation of advocacy within the overall care process. Similarly, reviewers did not find evidence of local policies to support service user involvement in mental health services and in some areas many staff did not seem to appreciate the differences between advocacy and service user involvement.

Emerging theme

- The NHS should work in partnership with voluntary sector services to provide more stimulating and meaningful experiences for patients, and to ensure advocacy services are freely available.

Independent sector

It is clear that services provided by the independent sector are essential to the whole spectrum of care for people with mental health difficulties in Wales. The shortage of care homes for people with dementia, for example, has a significant impact on inpatient mental health services for older people.

In some areas across Wales, mental health services supported placements in independent sector facilities. In one area, for example, this involved training and consultation (a joint NHS/local authority service) in respect of older people's services. Difficulties were noted in relation to transitions with an independent sector eating disorders unit in Bristol. Health Commission Wales funds inpatient care at this unit, but it appeared there was a difficulty in funding day care at the unit. This was seen as a significant obstacle to the recovery of patients from South Wales, who had previously benefited greatly from the gradual transition from inpatient to outpatient status which the day care had provided. This exemplifies the need for commissioning to be developed across the secondary/tertiary care interface, and to make optimal use of independent sector facilities where they complement the needs of the NHS.

Independent sector providers play a major role in forensic services, and local community services are involved in important transitions from these settings. The workforce requirements of independent sector providers need to be taken into account in planning professional training in Wales, given the shortage already noted in nursing staff, especially in wards for older people.

Emerging theme

- Opportunities for developing effective partnerships for mental health service provision with the independent sector should be pursued by health and social care agencies, with support and joint training made available

4. Responses from Survey of Key Partners

1. Community Health Councils

The convenor of the Project Management Group informed each Community Health Council (CHC) in Wales about the Review by letter. The CHCs, considered to be in a unique position to observe mental health services and their impact, were therefore invited to submit comments regarding their local situation, to include concerns about NHS mental health services and examples of good practice in their area.

Responses were received from eight (8) out of the nineteen (19) CHCs in Wales. The comments received focused on the following themes:

1.1 *Transitions*

Two CHCs reported on the recent welcomed development of primary care counselling services but noted that the service had become a victim of its own success with long waiting lists. In general, it was thought that there was much scope to improve communication between inpatient units and CMHTs and the CHCs are extremely concerned about the lack of specialist services for young people, reflecting the fact that many young people of 16 and 17 years of age have to be admitted to wards with adults. For adults and older adults, it was highlighted that there should be a more effective rehabilitation service supported by a high level of supported accommodation to avoid “blockage right through the system”.

1.2 *Clinical environment*

The following common themes relating to the NHS workforce were apparent in the CHC responses:

- lack of continuity of treatment due to inability to recruit a consultant psychiatrist
- drug regime changes when the locum changes
- under staffed wards
- staff shortages, sickness and stress have a negative effect on service users. Often appointments are cancelled and people suffer accordingly.

The CHCs identified several potential developments and would welcome:

- A comprehensive 24 hour community service for adults and older adults

- More therapeutic services; two CHCs specifically mentioned complementary therapies: "aromatherapy and Tai Chi should also be far more accessible and affordable to patients".
- Physical health checks for patients of mental health services
- Development of equitable and comprehensive services for the older adult, to include day care services, and to complement the well established memory clinics, psychology service, local Alzheimer Disease groups that are available in some localities.
- Development of specialist services such as eating disorder, low secure, personality disorder, young sufferers of dementia.
- Development of respite facilities and residential services for patients who display challenging behaviour
- More effective rehabilitation.

1.3 *Physical environment*

In most instances the poor state of inpatient units, where many patients are required to live for lengthy periods, were conveyed in terms of the gravest concern. However, CHCs were also concerned about over crowding, and the corresponding reduction in terms of quality of care, on such wards. Furthermore, it was felt that dementia patients require dedicated services and facilities, otherwise their inclusion on general wards leads to difficulties for all patient groups.

It was also reported that wards should also have suitable premises to accommodate children and families on visits, and there should be better maintenance of NHS mental health facilities.

1.4 *Joint working with voluntary sector*

It was felt that NHS mental health services lacked vision and leadership, which could be attributed
"*to continued change in the NHS and the bedding down of Local Health Boards*".
This appeared to be a general criticism of the way in which structural change in the NHS interferes, in their view, with a clear multi-agency strategy, with sufficient capacity to deliver developments in mental health services that have been widely acknowledged as necessary.

Some CHCs were of the opinion that more local voluntary action was required, to complement services provided by Mind and Hafal, and they also acknowledged the potential benefits of joint working between the

key partners in their localities to produce local "Health, Social Care and Well Being Strategies" which had identified mental health as one priority.

1.5 *General comments*

All the CHCs who responded expressed their concerns about the shortfall in terms of service provision, and their views may be summarised, in the words of one respondent, that mental health services have "been grossly under funded for a very long time but in fairness mental health staff are working very hard to improve the situation". There were several remarks about inequity in terms of service provision and service users not receiving similar standards of treatment and care, even within the same locality.

Carers were singled out as one group in need of recognition and dedicated support, and it was also suggested that the NHS should make more effort to work with the advocacy service and voluntary sector to provide more stimulation and improved communication with patients. Specific reference was made to the "Tidal Model" pilot project which was said to enhance engagement on two wards in one hospital.

Mental health promotion was highlighted by two CHCs as a theme which requires further attention and there was concern that the findings of the Welsh Health Survey is under reporting mental ill-health. Reference was made to the proposal by one Mental Health Strategic Planning group to develop mental health promotion in local schools and to the need to provide bilingual literature which could be made available to the general public by members of the primary health care team.

2. Local Mind Groups

Information about the review was also sent to each of the local Mind groups in Wales. It soon became apparent, however, that the representatives of the local groups had been invited to meet with, and submit verbal evidence to the review teams during their visits to the ten NHS Trusts and Powys LHB. Not surprisingly, therefore, the local groups contributed verbal evidence to the review as set out in section 2 of this report and there were no formal written submissions received by the Project Management Group.

3. Reference Group

Members of the Reference Group were invited to submit their own comments about NHS mental health services, as well as providing useful guidance from the perspective of users and carers on the review process. Most themes identified by the group have been reported in the key findings of the review, and include:

- dual diagnosis and the needs of people who misuse substances and also suffer from mental illness;
- the needs of carers and families, and
- the inequitable provision of community based health and social care services.

The Reference Group also highlighted the need for facilities and services which provided personalised and sensitive treatment and care for all persons, especially those from disenfranchised minority groups such as ethnic minority groups and gay people. This was also identified as a risk area for those people who have a degree of gender dysphoria (the trans community) and also suffer from mental illness.

The concerns of the Reference Group related to:

- Prejudicial and phobic reactions from other patients, which has resulted in physical and emotional abuse from other patients
- Lack of understanding among the client group about the way risk strategies within the NHS can ensure patient safety, and how the incident reporting process and risk register is managed
- Ignorance or prejudice within mental health services preventing the involvement of representatives of minority groups to contribute to the development of risk management strategies
- Lack of training opportunities for staff employed in mental health services to deal fairly and sensitively with members of diverse groups
- complaints procedures, and “the fear of reprisals, or threats of personal physical injury”
- medicines management, and the need for appropriate protocols regarding physical medication regimes and treatment for mental illness
- protection of vulnerable patients from staff bullying and oppression, such as advocacy services
- the degree of participation of vulnerable people in the Care Programme Approach

- the management of seclusion, *"as many vulnerable people could undoubtedly be on the receiving end of any aggression, but would also be the ones to be secluded, whilst the antagonist would be allowed to freely roam around the hospital"*.

An evaluation of the review process from the perspective of the user and carer Reference Group is included in Appendix 4.

5. Analysis and Recommendations

1.1 During the course of this review, the review team met with over 500 people including service users, carers, advocates, professionals from every relevant discipline, managers and commissioners from health and social care. Inpatient units and CMHTs were visited in every area of Wales, and the reviewers' own observations added to the weight of documentary evidence gathered. Each review team included experienced, expert clinicians health or social care senior managers and experienced voluntary sector representatives, backed up by a reference group of service users and carers. The over-arching finding of this review is of a service system across Wales that is under great pressure. This pressure exposes the NHS in Wales to a number of serious risks. These include:

- The quality of patient care being compromised, with potential for a high number of negative experiences for service users and carers. These may be neither documented nor reported, of course, but damage the trust between a service and its users which is fundamental to an effective mental health service. In England, two CHI investigations have had as their focus quality of care on inpatient units for older people with dementia.
- An increased likelihood of high profile incidents, where the safety of members of the public is jeopardised, as in the homicide committed by PK reported on during the review.
- An increased likelihood of the safety of service users and carers being compromised, as was evident in accounts of incidents reported to the review team.
- Increased dissatisfaction for staff working in the service, who in the great majority of instances are committed and caring. Most staff, within the constraints of the system, are remarkably creative and innovative and a significant proportion are frustrated by not being able to deliver the quality of service to which they aspire. Low staff morale will further influence the quality of care, increase workforce issues of recruitment and retention, and add to the pressure on remaining staff.
- The NHS in Wales having difficulty in meeting its obligations under Mental Health Act legislation, in relation to the continued difficulty in filling Consultant Psychiatrist posts, and increasing demand from the proposed legislation.

1.2 There are two major indicators of the pressure on the system. The first is over-occupancy of inpatient units; again and again across Wales

occupancy figures of over 100% were reported to us. This represents a high and unacceptable degree of risk, for the reasons cited in section 3.2 (page 25), particularly in view of the mix of patients on acute inpatient wards. According to official figures (SB 66/2004), average bed occupancy during 2003-2004 for 'mental illness' beds was 92.9% and old age psychiatry beds 85.1%. Examining the returns for individual areas indicates that in 8 of the 11 areas *average* occupancy for mental illness beds exceeded 90%; in only one area, was the average occupancy less than 80%. In 7 of the 11 areas, average occupancy in old age psychiatry exceeded 80%, but it was clear there is much more variation here. These figures support the reviewers' concerns regarding limited reserve capacity in acute mental illness wards, reducing the options for responding to emergencies in the community. The increasing demands on inpatient units is further reflected in the steady increase over the last 10 years in the proportion of inpatients detained under the Mental Health Act; this was reported as 23% in 2004, compared with 16% in 1994 (SDR 63/2004), with the increase being relatively greater for male patients.

1.3 The second indicator of pressure is the work-load experienced by CMHTs. This is more difficult to quantify accurately, and the development of useful workload monitoring tools is a priority in this respect. If CMHTs are not functioning effectively, the pressure on inpatient units will increase, and the quality of care experienced by service users and carers will again be at risk.

1.4 Consequently the critical factor, based on the findings of this review, is the need for more effective commissioning of services, and maximising use of resources across Wales, allied with more specific performance management arrangements. The "whole system" approach needs to govern the development agenda, hence avoiding the problems of focusing on isolated problems. The response to the pressure on the system is not then to increase the number of inpatient beds or to add another CMHT; rather, it is to develop community-based services which prevent admission, respond to crises and facilitate safe discharge, thus reducing pressure on inpatient facilities, allowing them to focus safely on those patients who cannot be managed safely in a community context, and improving the quality of community support available.

1.5 The slow progress in implementing the Care Programme Approach (CPA) in around half of the areas provides an indirect index of the pressure on the system, or at least of the lack of capacity to engage and pursue service development. Given that CPA represents the single most

important approach to risk management in the individual case, this was disappointing, especially as it had been the object of a SAFF target, for completion by December 2004.

1.6 In the following sections, the factors contributing to pressure in each area are highlighted. The set of recommendations prioritised by the review team are presented in the appropriate section for ease of reference. These are considered the core action plan to ensure patients receive an adequate standard of care from NHS mental health services in Wales.

Commissioning and performance management

2.1 Although the engagement of Trust Boards with mental health services varied across Wales, it appeared that where it did appear on their agenda (sometimes through interest, sometimes through investigations or external reports) the response was constructive and helpful. Of much greater concern were the commissioning arrangements for mental health services. Despite the co-terminosity of LHBs and Local Authorities, there were few examples of effective joint commissioning, and housing was largely absent from multi-agency working. Although LHBs have had little time to develop skills in the mental health domain, it is clear that their population base is inadequate for commissioning mental health services beyond the primary care level. In terms of specialist services, the role of Health Commission Wales was seen, to date, as involving spot-purchasing rather than commissioning per se. There is a risk that if the commissioning task is broken down between different agencies, disputes regarding 'who pays for what' hinder the commissioning of seamless services.

2.2 There was clearly much greater scope for commissioning services from the voluntary sector, and offering proper rolling contracts for such services. Service users and carers saw the services provided by the voluntary sector as essential; managers and commissioners saw them too often as peripheral, and an easy target for cut-backs.

Recommendation 1

During 2005/06 the Welsh Assembly Government should establish specialist mental health commissioning teams, based on the population base of each of the three NHS Regions, with responsibility for:-

- secondary and tertiary level services
- the development of information services (with public health input)
- developing the partnership between health and social care agencies, and involving housing agencies and voluntary sector providers.

Recommendation 2
Robust SAFF targets and allied performance measures for mental health should be issued by the Welsh Assembly Government for 2005/06 and subsequent years to ensure that the service is seen as a priority area in the NHS. Full implementation of CPA should continue to be pursued through this framework.

Inpatient services
3.0 Among the factors leading to over-occupancy of inpatient units is an over-reliance on hospital admission. In part this is related to lack of community-based alternatives, especially out-of-hours, but in some areas, at least, there were attitudinal factors at work. In one overcrowded ward, we were told that an audit had shown that as many as 25% of admissions were inappropriate. We were surprised at the widespread acceptance of over-occupancy, and recommend that it be addressed as a matter of urgency. The situation is exacerbated by delayed transfers of care, often involving supported housing. In December 2004, 8.4% of mental health beds were occupied by patients falling in this category (221 delayed transfers of care; 2630 beds in the mental health sector), compared with 4.6% in other acute and community hospital beds (SDR 7/2005 and 61/2004). This finding, of over-reliance on hospital beds, replicates that of the CHI Mental Health sector report (2003):

'services are less developed in Wales…an older, more institutional model of care is found.'

High occupancy rates have been reported in mental health wards for many years, and so have not figured as they might be expected to in considerations of risk; this now needs to be redressed.

Recommendation 3
From 2005/2006 onwards the Welsh Assembly Government should monitor the occupancy of inpatient units exceeding an agreed figure (say 90%). This information should be regularly reported to Trust Boards and to WAG's Health and Social Care Directorate. Occupancy should include patients on leave.

Recommendation 4
During 2005/2006, the relevant NHS Trust Boards and Powys LHB should strengthen community mental health services to ensure they can

offer a responsive admission-prevention service on a 24 hour, 7 day a week basis. This may involve crisis resolution and home treatment services, as an additional component of the CMHT.

Recommendation 5
During 2005/2006, commissioners of mental health services, LHBs, NHS Trusts and Local Authorities should work with housing providers to draw up plans to urgently address the difficulties arising from the lack of supported housing for people with mental health problems, to make progress in this key area.

3.2 The pressure on inpatient wards is increased by the mix of ages and types of difficulty on many wards. There was particular concern regarding 16/17 year old adolescents being placed on adult wards, in some areas because of the vagaries of the educational system rather than due to clinical need. There were also concerns regarding older people on such wards, and the lack of low secure forensic provision. Inpatient assessment units were characterised as having a majority of patients with dual diagnoses of mental health and substance misuse difficulties. The range of difficulties – from extreme agitation to complete withdrawal and inactivity – is challenging enough, without the pressure of over-occupancy. Action is urgent: as more and more admissions are prevented (by developing better community services), those who are admitted will be those with the greatest level of need, and inpatient units will have an even more complex set of needs to cater for in the future.

Recommendation 6
By October 2005, the relevant NHS Trust Boards and Powys LHB should review the current arrangements for inpatient mental health services for 16/17 year old adolescents. Where such young people have to be admitted to an adult ward, there should be support from the relevant CAMHS team, and wards used for this purpose should have staff who are police-checked and with specific training.

Recommendation 7
By December 2005, the relevant NHS Trust Boards and Powys LHB should review admission policies to ensure that decisions regarding the appropriate place for admission for older people are based on clinical need, rather than on arbitrary age cut-offs.

Recommendation 8
By December 2005, the relevant NHS Trust Boards and Powys LHB (in partnership with Local Community Safety Partnership Boards) should ensure that arrangements are in place for staff on adult wards where dual diagnoses are common to have ready access to appropriate training, and advice from specialist substance misuse services when necessary.

Recommendation 9
During 2005/2006, the Welsh Assembly Government should ensure that the relevant mental health commissioning teams produce agreed plans for the provision of equitable low secure forensic services across Wales.

3.3 Some inpatient units experienced additional pressure in receiving many calls for admission from general hospital wards and A&E departments. In some areas, liaison teams managed this demand extremely well on a 24 hour, 7 day a week basis, and this should be seen as an essential component of the mental health service, with benefits in reducing pressure on both inpatient wards in mental health and in the general hospital. There is scope for developing nursing advice and support to general wards managing people with dementia, where concerns were raised regarding the quality of care received.

Recommendation 10
By April 2006, mental health commissioners should ensure that effective liaison services are established for each general hospital and A& E department. The special needs of expectant / nursing mothers and people with dementia in general hospital settings should be addressed with support and advice from skilled mental health nurses.

Community services

4.1 The major source of pressure on community mental health services appeared to be the difficulty of maintaining a high quality service to people with severe mental illness (including prevention of admission) whilst providing an adequate response to the demand from primary care of referrals of people with common mental health problems. A number of approaches to managing this tension have been attempted. Our reviewers had concerns regarding the establishment of another layer of service between primary care and the CMHTs, which ran the risk of presenting another set of interfaces, and of being overwhelmed itself. Enhancing skills in the primary care context must be the aim, perhaps by having some members of the CMHT specialising in this supportive role, whilst

others specialise in other aspects (such as psychosocial interventions in psychosis).

Recommendation 11
During 2005/2006, the Welsh Assembly Government should conduct / commission a review of models of supporting and responding to common mental health problems in primary care, identifying good practice. Guidance, based on the results of the review, should then be issued, by March 2006, for action by Local Health Boards in Wales.

4.2 Some pressures were also evident in relation to patients with forensic histories referred to community mental health services. This is heightened by the lack of development of low secure services in many areas of Wales (see Recommendation 7).

Recommendation 12
By March 2006, mental health commissioners should review and enhance the existing arrangements for transfer of forensic patients from medium secure units to the community, with on-going support from the specialist forensic teams. Mechanisms to resolve disputes regarding consultants in the community taking on RMO status should be established, ensuring community services receive the support required to manage such patients safely.

4.3 Older adult community mental health services were under great pressure in many areas. Lack of the whole range of provision of back-up services – such as care homes as well as community-based services such as day care – means that the community service is left to manage, with the impact often felt most severely by family care-givers. There is great scope here for more joint commissioning of services and greater involvement of (the very willing and very experienced) voluntary sector as providers of service on a properly funded basis, as well as a need to work proactively with the independent sector. Training and support for staff in care homes is offered by some services, and is invaluable in enabling homes to continue to manage residents with mental health difficulties, rather than them having to be moved elsewhere, which poses a risk to the resident. The implementation of the CPA approach is being 'rolled in' with Unified Assessment in many areas, which may lead to some delays and it will be important to monitor that it is implemented fully with older adults.

Recommendation 13
By April 2006, mental health commissioners, LHBs, NHS Trusts, other mental health service providers and Local Authorities should draw up an agreed, creative, integrated strategy for commissioning mental health services for older people, taking into account the recent Audit Commission reports and the forthcoming National Service Framework for Older People.

Recommendation 14
By April 2006, mental health commissioners, LHBs, NHS Trusts, Local Authorities and other mental health service providers should have made arrangements for training and on-going support for staff in care homes in managing the range of mental health problems (including depression and challenging behaviour).

Recommendation 15
By April 2006, mental health commissioners, LHBs, NHS Trusts, Local Authorities and other mental health service providers should make specific arrangements to monitor the implementation of CPA with older people with mental health problems, within the context of Unified Assessments.

Workforce issues

5.1 There are key areas of risk identified in the review related primarily to recruitment and retention of staff, but also to the lack of posts (particularly for OTs, Physiotherapists and Clinical Psychologists) which would enhance the therapeutic effectiveness of mental health services in Wales. The reliance on locum psychiatrists and bank nursing staff has been mentioned as a cause for concern in many parts of Wales. The demands of the new Mental Health Act are estimated to require additional psychiatrist time, as well as the impact on other professionals. Senior nurse managers identified their concerns regarding the proportion of nurses due to retire in the next five years, as well as recruitment difficulties in older adult services and needs for additional staff in many service developments. Official figures on NHS staff vacancies in Wales, looking at vacancies unfilled for 3 months or more, confirm the high vacancy rate for Consultant Psychiatrists, particularly in Old Age Psychiatry. However, vacancy factors for Psychiatric Nursing (2.9%), Community Psychiatric Nursing (1.4%) and Clinical Psychologists

(3.5%) are relatively low (figures for Occupational Therapists and Physiotherapists are not provided specifically in relation to mental health services). This suggests that other factors, such as sickness, short-term vacancies and lack of established posts may be responsible for the pressure on non-medical staffing observed by the review team.

There also exists a large pool of unqualified staff within mental health services who could be trained to provide a further range of relevant activities on wards and in the community, and be an invaluable resource in the modernisation and development of services.

Recommendation 16
By December 2005, the Welsh Assembly Government should ensure that a report on workforce planning in mental health services in Wales is completed. The short-falls in all professional groups need to be carefully considered, and the opportunities for new ways of working evaluated, with an action plan for future progress.

Recommendation 17
By December 2005, the Welsh Assembly Government (health, social care and further education departments) should produce a plan for the development of training opportunities for mental health service staff without a professional qualification.

The care environment

6.1 The reviewers expected to find that some areas continued to rely on buildings that have long since ceased to be fit for purpose. This was indeed the case and in many areas business cases have been made for their replacement. However, it is important that whilst services remain in these buildings, due attention is paid to maintenance and up-keep, and to basic safety and dignity issues.

Recommendation 18
By June 2005, the relevant NHS Trust Boards and Powys LHB must ensure that any remaining mixed wards where access to the female dormitory is through the male dormitory have been reconfigured.

Recommendation 19
During 2005/2006, and in subsequent years, the relevant NHS Trust Boards and Powys LHB must prioritise the maintenance of the physical care environment, despite the lack of long term future for the buildings.

6.2 More disappointingly, the reviewers found that relatively new units were also not fit for purpose, and posed particular challenges, for example in relation to observation. Lessons must be learned from these experiences before the next wave of buildings are commissioned. There is a great need for flexible provision, as service configurations and demands change fairly rapidly in the mental health field; a building designed to meet current needs and requirements may be out of date by the time it is planned, built and commissioned.

Recommendation 20
During 2005/2006 and in subsequent years, commissioners of mental health services should assess the need for re-provision of inpatient units in the context of a wider programme of service modernisation and redesign; new buildings should be flexible and lessons learned from previous designs.

6.3 Generally speaking, the care environment, in terms of activity and engagement on inpatient units left room for improvement. This was particularly marked on some wards for older people, who constitute 48% of inpatients in mental health services in Wales (SDR 63/2004). There are however some examples of good practice that could be disseminated across Wales including the involvement of voluntary organisations, such as the Alzheimer's Society, the refocusing of the inpatient ward project and the introduction of the Tidal model.

Recommendation 21
By March 2006, the relevant NHS Trust Boards and Powys LHB should ensure that arrangements are in place for meaningful therapeutic activity to be provided on a regular and extensive basis in every inpatient environment.

User/ carer involvement

7.1 The reviewers identified good examples of efforts being made to promote carer/user involvement across Wales. Generally involvement was better at the level of planning new services, than at operational level. Even where meetings were scheduled to address operational concerns

with user/carer representatives, in some areas these were thought to be little more than tokenistic; actions agreed were not followed through, or meetings were cancelled at short notice, or major service decisions taken without consultation.

Recommendation 22
By March 2006, the relevant NHS Trust Boards and Powys LHB should ensure that robust arrangements are developed for user/carer involvement in the operational management of services.

7.2 There were encouraging instances of involvement of users in planning their care being regarded as a routine. However, in a number of other settings, even giving each user (and/or carer where appropriate) a copy of their care-plan would be viewed as a new departure. This is one of the areas CPA training and culture change will need to address, if an open and transparent culture of risk management at clinical level is to be developed.

Recommendation 23
By March 2006, the relevant NHS Trust Boards and Powys LHB should adopt a robust method to conduct routine audits of the proportion of patients having a copy of their own care plan, based on the implementation of CPA.

7.3 Advocacy provision was mixed across Wales, with some good examples operating well, but little service in others (and some unhelpful attitudes from services to advocacy and advocates). Provision was particularly poor for people with dementia.

Recommendation 24
By March 2006, the Wales Assembly Government should review the independent advocacy services for users of mental health services with a view to commissioning equitable services in all parts of Wales. Provision must also be made for people with dementia to have access to advocacy.

Appendix 1

References

1. Audit commission in Wales. (2002). *Losing Time: developing mental health services for older people in Wales*. Audit Commission Publications: London.
2. Cardiff Local Health Board. (2004). Independent external review into a homicide at Prestatyn, Wales on 25th March 2003.
3. Clinical Governance Support Service. (2002).*Clinical governance standards for mental health and learning disability services*. Royal College of Psychiatrists: London.
4. Commission for Health Improvement. (2003). *Clinical governance review. North East Wales NHS Trust*. The Safety Office: UK.
5. Commission for Health Improvement. (2003). *What CHI has found in: mental health trusts*. Commission for Health Improvement: London.
6. Commission for Health Improvement. (2003). *Emerging themes from mental health trust reviews*. Commission for Health Improvement: London.
7. Commission for Health Improvement. (2003). *Cardiff and Vale NHS Trust (mental health services*).Commission for Health Improvement: London.
8. Commission for Health Improvement. (2003). *Clinical governance review: Ceredigion & Mid Wales NHS Trust*. Commission for Health Improvement: London.
9. Commission for Health Improvement. (2003). *Clinical governance review: Swansea NHS Trust*. Commission for Health Improvement: London.
10. Commission for Health Improvement. (2003). *Clinical governance review: Carmarthenshire NHS Trust*. Commission for Health Improvement: London.
11. Commission for Health Improvement. (2003). *Clinical governance review: Powys Health Care NHS Trust*. Commission for Health Improvement: London.
12. Commission for Health Improvement. (2003). *Clinical governance review: Cardiff and Vale NHS Trust (mental health services).*Commission for Health Improvement: London.
13. Commission for Health Improvement. (2003). *Clinical governance review: Velindre NHS Trust*. Commission for Health Improvement: London.

14. Commission for Health Improvement. (2004). *Clinical governance review of acute and community services and investigation into mental health services: Pembrokeshire and Derwen NHS Trust*. Commission for Health Improvement: London.
15. Commission for Health Improvement. (2004). *Framework for risk management: Mental health trusts*. Commission for Health Improvement: London.
16. Commission for Health Improvement. (2004). *Clinical governance review: Bro Morgannwg NHS Trust*. Commission for Health Improvement: London.
17. Commission for Health Improvement. (2004). *Clinical governance review: North West Wales NHS Trust*. Commission for Health Improvement: London.
18. Commission for Healthcare Audit and Inspection. (2004). *Clinical governance review: Gwent Healthcare NHS Trust*. The Stationery Office: London.
19. Department of Health. (2001). National service framework for older people.
20. Department of Health. (2002). Mental health policy guidance: Adult acute inpatient care provision.
21. Department of Health. (2002). Mental health policy implementation guide: Community mental health teams.
22. Department of Health. (2002). National minimum standards for general adult services in psychiatric intensive care units (PICU) and low secure environments.
23. MIND. (2004). Ward Watch: Mind's campaign to improve hospital conditions for mental health patients. MIND: London.
24. National Institute for Clinical Excellence. (2001). Guidance on the use of donepezil, rivastigmine and galantamine for the treatment of Alzheimer's disease. *Technology Appraisal Guidance* 19.
25. National Institute for Clinical Excellence. (2002). Schizophrenia: core interventions in the treatment and management of schizophrenia in primary and secondary care. NICE: London.
26. National Institute for Clinical Excellence. (2002). Guidance on the use of newer (atypical) antipsychotic drugs for the treatment of schizophrenia. *Technology Appraisal Guidance* 43.
27. National Institute for Clinical Excellence. (2003). Guidance on the use of electroconvulsive therapy. *Technology Appraisal* 59.
28. National Institute for Clinical Excellence. (2003). Olanzapine and valproate semisodium in the treatment of acute mania associated with bipolar I disorder. *Technology Appraisal* 66.

29. National Institute for Clinical Excellence. (2004). Eating disorders: core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders. NICE: London.
30. National Institute for Clinical Excellence. (2004). Self-harm: The short term physical and psychological management and secondary prevention of self-harm in primary and secondary care. NICE: London.
31. National Institute for Clinical Excellence. (2004). Anxiety: management of anxiety (panic disorder with or without agoraphobia, and generalised anxiety disorder) in adults in primary, secondary and community care. *Clinical Guideline 22.* NICE: London.
32. National Institute for Clinical Excellence. (2004). Depression: management of depression in primary and secondary care. *Clinical Guideline 23.* NICE: London.
33. National Institute for Mental Health in England. (2004). Mental health policy implementation guide: developing positive practice to support the safe and therapeutic management of aggression and violence in mental health in-patient settings.
34. National Safety Patient Agency. (2004). Introduction: Seven steps to patient safety. The National Safety Patient Agency: London.
35. National Safety Patient Agency. (2004). Seven steps to patient safety: An overview guide for NHS staff. The National Safety Patient Agency: London.
36. Social services Inspectorate for Wales. (2002). Inspection of adult mental illness services in Wales. SSIW: Cardiff.
37. SDR 61/2004, SDR 63/2004, SB 66/2004 and SDR 7/2005 all from Statistical Directorate, National Assembly for Wales, Cardiff: http://www.wales.gov.uk/statistics
38. Welsh Assembly Government. (2002). Adult mental health services: A national service framework for Wales. Welsh Assembly Government: Cardiff.
39. Welsh Assembly Government. (2003). MENTAL HEALTH POLICY GUIDANCE The Care Programme Approach for Mental Health Service Users A Unified and Fair System for Assessing and Managing Care.
40. Welsh Risk Pool. (2004).Welsh Risk Pool Standards.
41. Welsh Risk Pool Advisory Board. (2003). Annual Assessment of Compliance with Welsh Risk Management Standards 1-21, 30 and 31 by NHS Trusts in Wales.

Appendix 2

Names of researchers and reviewers

a) Researchers
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   - Mr Graham Harper, formerly Director, Flintshire Social Services
   - Dr Mike Jackson, Clinical Psychologist, North West Wales NHS Trust
   - Professor Keith Lloyd, Project Management Group
   - Mr Ian McKechnie, Pembrokeshire & Derwen NHS Trust
   - Professor David Menkes, Project Management Group
   - Ms Lindy Miller, Mind Cymru
   - Mr G Morgan, Project Management Group
   - Dr Rob Poole, Consultant Psychiatrist, North East Wales NHS Trust
   - Ms Mandy Rayani, Senior Nurse, Swansea NHS Trust
   - Mr Harry Teaney, formerly Acting Regional Nursing Officer, North Wales
   - Dr Krishna Singh, Clinical Psychologist, Cambridge
   - Ms Rosemarie Williams, Mind Cymru
   - Professor Bob Woods, Project Management Group

Appendix 3 - RISK REVIEW STANDARDS FOR MENTAL HEALTH SERVICES – OCTOBER 2004

Standard	Evidence (Note impact of policies and protocols on practice)	Met / Partially Met / Not met
1) Corporate Approach		
1.A Leadership:		
1.A.1 There is a named executive on the Board with responsibility for risk management in mental health		
1. A.2.There is an identified lead for risk management in the mental health directorate, whose remit includes sharing information with staff		
1.B Culture: 1.B.1 The Board identifies key indicators to demonstrate a safety culture that is open and fair		
1.C Structures and accountability: 1.C.1 The mental health directorate has a committee that considers matters pertaining to risk management; there are clear lines of accountability and terms of reference for this committee.		
1.D Strategy:		
1.D.1 There is a joint trust and social services risk management strategy, including mental health issues, that has been ratified by the Board. The date of the next review of the strategy is identified.		

Standard	Evidence (Note impact of policies and protocols on practice)	Met / Partially Met / Not met
1.D.2 The risk management strategy is publicised and explained to all relevant staff, be they directly employed or employed by other associated agencies.		
1.E External assessment of risk management: 1.E.1 The trust has programmes in place to work towards compliance with Welsh Risk Pool and Mental Health Act Commission requirements		
1.F Responsibility for risk: 1.F.1 Responsibility for safety and risk management is recognised to be part of all roles and is included in all job descriptions		
1.G Partnership: 1.G.1 There is representation of key partners on the trust's governance committee		
1.H Service user and public involvement: 1.H.1 Key voluntary and service user / carer groups from the mental health domain have contributed to the development of the trust's approach to risk management		

Standard	Evidence (Note impact of policies and protocols on practice)	Met / Partially Met / Not met
2) Risk Management Systems		
2.A Training for risk management:		
2.A.1 There is training in both clinical risk management and health and safety for key staff such as senior managers, clinicians, directors, board members. The trust has defined its mandatory training requirements relating to risk and has associated implementation/ action plans		
2.A.2 There are training programmes for moving and handling, resuscitation, management of violence and aggression, seclusion and rapid tranquillisation etc.		
2.B Incident reporting policy: 2.B.1 There is a joint health and social services policy for incident and near miss reporting for staff. The policy has been ratified by the trust board. It includes a review date, and responsibility for undertaking this is identified. There is a separate policy for serious untoward incidents.		
2.C Reporting incidents:		
2.C.1 All staff have had training in what incidents to report, who to report them to and how to report them.		
2.C.2 There is a definition of serious untoward incidents and guidance on how to report and manage these. This covers issues relating to reporting incidents upwards to the executive team, the trust board and the Local Health Board. There is guidance on what incidents should be reported to the MHAC and how to do this.		

Standard	Evidence (Note impact of policies and protocols on practice)	Met / Partially Met / Not met
2.D Investigation of incidents:		
2.D.1 The risk manager has received training on how to investigate incidents and how to undertake a root cause analysis.		
2.D.2 Patients/carers are informed about the process and outcome of investigations. Staff receive feedback about incidents they have reported. Staff involved in an investigation receive appropriate support.		
2.E Special issues for suicide and homicide:		
2.E.1 The trust is fully participating in the National Confidential Inquiry into suicides, homicides and detained patients.		
2.E.2 There is a multi-agency forum where suicides and homicides in the locality can be discussed and lessons learned.		
2.F Communication: including reporting to the board and dissemination of learning:		
2.F.1 Incident data from the trust database is collated and analysed regularly, showing mental health related incidents separately, and reports produced for the trust board. Trends are shown and learning is shared with all staff.		
2.F.2 Complaints are analysed, trends identified and recommendations implemented. Complaints in the mental health area can be identified separately. This is reported to the trust board. Recommendations and changes to practice arising from complaints are shared with complainants and staff.		

Standard	Evidence (Note impact of policies and protocols on practice)	Met / Partially Met / Not met
2.G Framework for organisational risk assessment:		
2.G.1 All staff have received training in how to conduct risk assessments relevant to their work.		
2.G.2 The trust has an organisational risk assessment toolkit that includes guidance on how to undertake a risk assessment, rating of risk likelihood and severity and how to design and implement actions to manage risks identified, that is relevant to mental health.		
2.H Risk register: 2.H.1 The trust has a risk register that includes risks in the mental health area. The risk register is linked to business planning and service development.		
2.I Information systems:		
2.I.1 The trust has a database for risk management that integrates data from all incidents including complaints and claims, clearly identifying those from the mental health domain.		
2.I.2 There is a system to ensure all incidents rated as serious and above are reported immediately to the risk manager.		
3) Implementation in Directorates		
3.A Directorate systems for developing safe practice: 3.A.1 The clinical director receives copies of all relevant guidance (NICE, NPSA alerts and guidance, MHAC confidential enquiries etc.) and risk management implications for local practice are identified.	*E.g. What steps are the Trust taking to take on board the recent NICE guidelines on deliberate self-harm?*	

Standard	Evidence (Note impact of policies and protocols on practice)	Met / Partially Met / Not met
3.B Risk management of infection control:	*Also in relation to self-harm*	
3.B.1 There is a trust infection control policy, including formal access arrangements to infection control advice for mental health services.		
3.B.2 Staff in mental health services receive appropriate training and updates in infection control issues.		
3.C Medicines management:	*Is there a pharmacist who visits regularly or is part of the (ward) team? Side effect reporting? Outlying / unusual prescribing patterns? Drug use by patients (including alcohol)? Is there a protocol for safe prescribing of methadone in in-patient areas?*	
3.C.1 All clinical areas have copies of the trust formulary, drug administration policies and medicine management policies.		
3.C.2 Care areas participate in audits of prescribing practices, and lessons learned are shared across the mental health directorate.		
4) Human Resources	*How flexible and fair an employer is the Trust? What staffing difficulties / shortages are there? Sickness rates? Staff stress? Leadership issues?*	
4.A Locum medical staff 4.A.1 First time locum staff receive an introduction to the appropriate care area, including written information covering the supervision arrangements, including any circumstances in which they are required to seek supervision and when and how to contact senior staff.	*How reliant is the mental health service on locum staff?*	
4.B Agency and bank staff:	*How reliant is the mental health service on agency and bank staff?*	
4.B.1 Trust staff always check the identity of agency and bank staff at the start of each shift.		
4.B.2 The trust bank will have a mechanism for taking up references and similarly checking that professional registrations are up to date.		

Standard	Evidence (Note impact of policies and protocols on practice)	Met / Partially Met / Not met
4.C Junior medical staff:		
4.C.1 Junior medical staff never work unsupervised and have written guidance detailing any circumstances in which they are required to seek supervision, if necessary. They are confident about when and how to contact senior staff and have regular meetings with the supervising consultant.		
4.C.2 Junior medical staff should know the whereabouts of any relevant guidelines or have their own easy to access copy.		
4.D Induction: 4.D.1 In addition to general trust induction, there is a mandatory organised mental health service induction programme for all staff. This includes a range of risk management issues, such as any limits to the range of duties they are authorised to carry out, any circumstances in which they are required to seek supervision, how to report a safety incident or near miss and how to deal with a complaint. It should also cover issues specific to service delivery, such as training for management of violence and aggression, the local framework for a care programme approach assessment, suicide prevention and how to report an adverse incident and a near miss.		
4.E Clinical supervision: 4.E.1 All staff know who their professional supervisor is and how and when to contact them.		
4.F Managerial supervision:	*Staff appraisals? Workloads e.g. caseloads in CMHT's.*	
4.F.1 Staff with formal supervisory responsibilities have received specific training covering this.		

Standard	Evidence (Note impact of policies and protocols on practice)	Met / Partially Met / Not met
4.F.2 There is a shift handover system, including the identification of higher risk service users and details of any incidents that occurred during the previous shift.		
4.G Education and development:		
4.G.1 There is mandatory training and protected teaching time for all staff. Staffing establishments are calculated to account for time away for education and development.		
4.G.2 All staff have a personal development plan relevant to the service being provided at the time, and this is regularly reviewed.		
4.H Expressing concerns about professional conduct and performance:	*Bullying, intimidation, harassment?*	
4.H.1 Concerns raised by staff are taken seriously and managed sensitively. The safety of service users is seen as of paramount concern in this respect.		
4.H.2 The trust policy on reporting concerns about professional performance or conduct is available and known about in all departments.		
4.I Preventing and managing violence and aggression:		
4.I.1 All departments have conducted a risk assessment of the security risks to staff and to service users, children and visitors. This has informed the measures that have been put in place. All incidents of violent or threatening behaviour are reported. Staff are actively supported in reporting incidents.		

Standard	Evidence (Note impact of policies and protocols on practice)	Met / Partially Met / Not met
4.I.2 Training is available for staff in de-escalating potentially violent situations and in dealing with abusive service users or relatives.		
4.J Lone working: The trust has a lone worker policy and each lone worker is provided with a means of communication and protection as appropriate, based on effective evaluation and environmental risk.		
5) Care Processes		
5.A The trust in the local healthcare community: 5.A.1 The trust and its partners (including social services and the police) have agreed guidelines governing arranging emergency assessment or admission to hospital for service users whose condition has been assessed by GP's, approved social workers and community psychiatric teams, defining the role of the A&E department and the ambulance service.		
5.B Care of vulnerable adults: 5.B.1 There is a policy for protection of vulnerable adults.	*Are staff aware of policy?*	
5.C Child protection: 5.C.1 Induction covers child protection awareness for all staff; all clinical staff are trained in child protection.	*Are children and adolescents admitted to adult units? NB Child protection training is mandatory.*	

Standard	Evidence (Note impact of policies and protocols on practice)	Met / Partially Met / Not met
5.D The care programme approach: 5.D.1 The trust policy on implementing CPA makes specific reference to clinical and organisational risk issues. There are standardised and agreed frameworks in place to assist staff in undertaking risk assessments and developing and documenting care plans for service users.		
5.E Management of seclusion:		
5.E.1 The trust has an open and clear policy for the management of seclusion to prevent harm to service users and others. It incorporates time out, low stimuli environments and restriction of movement within a hospital ward.		
5.E.2 Use of seclusion is always recorded as a safety incident and appropriately documented in the service user's records.		
5.E.3 Service users in seclusion are reviewed as per the policy by a senior member of the care team.		
5.F Child / young person visiting adult inpatient settings:	*Is contact promoted? Prompt Q: How much do you know about patient's family?*	
5.F.1 The trust has a policy for children and young people visiting all mental health settings, referring to the child protection policy.		
5.F.2 There is a clear and documented decision-making process when there are concerns about a child or young person visiting. There should be a child / young person visiting plan documented in the notes		

Standard	Evidence (Note impact of policies and protocols on practice)	Met / Partially Met / Not met
5.G Detention under the Mental Health Act:		
5.G.1 Information for patients related to their detention is available to patients detained under the act, and for carers / relatives of patients.		
5.G.2 The primary allocated carer on the ward acts as an advocate for the service user guiding them through the appeal procedure or finds the service user an independent advocate to do this.		
5.H. Suicide prevention:	*NB Issues relating to leave and absconding are especially important here*	
5.H.1 Trust policy includes CPA (where implemented), risk assessment, safer environment, discharge policy, carer support, use of appropriate medication, dual diagnosis, post incident review and staff training.		
5.H.2 Staff are trained in the use of the policy, including appropriate environmental risk assessments.		
5.H.3 All ligature and other potential self harm areas of ward and service environment are removed or made safe.		
5.H.4 There is incident reporting of risk factors in the environment and in the care of the individual.		

Standard	Evidence (Note impact of policies and protocols on practice)	Met / Partially Met / Not met
5.I Clinical information and the clinical record: 5.I.1 Staff are able to access clinical records at all times. There is a policy governing clinical records developed by the local care records committee. This takes into account the transfer of information between inpatient and community services.		
5.J Service user issues:	*Diversity issues considered? CPA?*	
5.J.1 Concerns raised by service users are taken seriously and services, advice, information or reassurance provided as appropriate.		
5.J.2 Service users are informed of the risks, benefits and outcomes of their treatment in order to make a balanced decision.		
5.K Consent:	*CPA?*	
5.K.1 Service users are provided with written information about the risks and benefits of proposed interventions.		
5.K.2 Key staff are trained to understand the trust's consent policy. This includes consideration of the ethical issues of obtaining informed consent.		
5.L Safe discharge:	*Check in relation to Forensic patients also*	
5.L.1 Where service users are to be discharged home, any immediate package of care required is arranged and the service user is informed of the details.		

Standard	Evidence (Note impact of policies and protocols on practice)	Met / Partially Met / Not met
5.L.2 Discharge strategies are planned in partnership with local primary and community services and the service user and carers.		
5.L.3 There is communication to the GP about discharge and subsequent arrangements for care and follow up.		
5.M Clinical transitions	*Evidence from documentation and interviews*	
5.M.1 There is a clear protocol for communication of risk and sharing of information and transfer of care and shared care within and between agencies.		
5.M.2 This works robustly between general services and forensic services		
5.M.3 This works robustly between general services and specialist services for drug and alcohol		
5.M.4 This works robustly between general services and older people's mental health services		
5.M.5 This works robustly between in-patient services and CMHT or GP care.		
6) Environment	*Ambience – are patients meaningfully occupied? Is there de facto detention? Access issues?*	
6.A Health and safety: 6.A.1 There is an annual risk assessment programme for all health and safety issues, including furniture, fittings and ligature points, service user amenities, stress, waiting and clinical areas etc.		
6.B Environment:		
6.B.1 A safe and clean environment is ensured by regular checks made with the service user groups. Safety is audited by the service user and care groups.		

Standard	Evidence (Note impact of policies and protocols on practice)	Met / Partially Met / Not met
6.B.2 All in-patient areas have areas for females only.		
6.C Place of safety: A designated place of safety should be known to police, social services, GP's etc. The place of safety should be compliant with the Mental Health Act code of practice standards.		

Appendix 4

User / Carer Reference Group

1. Overview

The User Carer Reference Group met initially on 01 October 2004 and subsequent meetings were held at the mid point and towards the end of the review. The first meeting was with the full Project Team at a workshop prior to the field visits and it provided an opportunity to take stock of the literature search, agree the standards for the Review and the terms of reference for the Reference Group. The second meeting, held at the mid point of the Review, was an opportunity for the group to comment on the emerging themes from the initial visits. During the final meeting of the group on 8 December 2004 the users and carers formulated their views and comments about working as a group and their experiences of participating in the review process.

2. Evaluation of Review Process

A 'SLOT' (Strengths, Limitations, Opportunities, Threats) analysis was completed, to assist with the assessment of the experience of the group within the review process, which yielded the following results:

Strengths

- Members of the group had a wide range of experiences and skills, not only in respect of mental health issues, but also in terms of communications skills, ability to read and take in vast amounts of information, verbal and written skills, business skills and understanding of report formatting.
- Massive commitment to the task in hand.
- They were a cohesive and coherent group.
- All members contributed and participated.
- Wide and diverse range of backgrounds including geographically, gender issues, transgender issues, sexuality and nationality.
- A positive and well balanced group.
- One voice.

Limitations

- Constraint of time.
- Composition of Group e.g. Users and Carers asked for, but this could be further broken down by including carers who are also users.
- The content of discussions was often weighted towards service users.
- Lack of preparation time.

- Group members should have had more contact numbers e.g. Reviewers, Project Manager.
- Limited by assumptions made by some of the professionals / academics that service users and carers are not qualified to speak on mental health issues.
- Not knowing outcome of report.

Threats

- The group members were worried that they would not get feedback after the report had been presented to the Minister.
- Group members not wanting to be forgotten in the rest of the process or after the process.
- They asked the question 'Have we been listened to and valued?'.
- Could it be that this type of User Carer Reference group, although integral to the principles of involvement, might be perceived as a 'threat' to the professionals and academics – e.g. culture shift, new way of working.

Opportunities

- 'Opened doors'.
- Opportunity to do well for others.
- Opportunity to influence policy, and to dispel myths and preconceptions about service users and carers.
- Built up confidence and self esteem of all group members.
- Opportunity to learn about research.
- "A wonderful experience". Model for Wales.
- Great to look at things from another perspective, e.g. understanding the kinds of constraints professionals/statutory workers are under.
- Broadened horizons. Valued as equals. Good networking.
- Ability and opportunity to work and socialise with professionals.
- Tremendous feeling of value to be part of making recommendations to the Welsh Assembly Government.
- Brilliant and empowering experience.

3. Reference Group perspectives of the Review Process

3.1 Time constraints

- Insufficient time to ensure adequate representation of both service users and carers for the Reference Group.
- It would have been helpful to have the briefing papers earlier to have adequate time to read and digest the information prior to the initial workshop.
- It would have been useful to have more time for all Project participants to be fully conversant with the expectations, roles and responsibilities.
- The initial workshop was successful in achieving consensus about the standards to be used in the Review. It may have been productive to have a separate time for the training aspect,

3.2 The Review

- It was strongly felt that two days was too short a time to carry out the Review. This was of particular significance with the larger Trusts which meant that some services would not have been visited.

3.3 The NHS Trusts

- Shortage of time for NHS to prepare for the Review may have resulted in some service user/carer and voluntary organisation representatives being unable to participate.
- Consideration needed to be given to the rurality of the Trusts in Wales. Little time was afforded for travel.

3.4 Project Management

- The urgency of meeting the deadline for the composite report to be submitted meant that the Project Manager was unable to attend the final meeting of the Reference Group.

3.5 The Draft Report

- The draft report was not completed and therefore not available for consideration by the Reference Group at their final meeting. The comments made by members of the reference group were based on draft feedback from visits to individual NHS Trusts, a composite report depicting all the emerging themes which would be integral to the final report. The group had also received a mid point report from the Project Manager and verbal feedback from the two Mind Reviewers.

4. Conclusions

- Despite the time constraints the overall experience of the Reference Group was positive. Members felt fully included in the whole of the review process.

They felt that their comments were listened to and their contribution valued by the project team.

- Financial recognition of their expertise gave added value to their participation.
- Staff from Mind Cymru felt privileged to have an integral role in the Review and its implementation. It gave a further opportunity to empower service users and carers and to emphasise the values and principles of Mind.
- The group members developed a strong bond and maturity in a very short length of time. Whilst most of the group had not been involved in such work previously they were able to deal with complex issues very effectively.
- The feedback from the user/carer group members helped the reviewers to remain focussed on the difficult task of completing such a large scale exercise in a very short time.
- The ultimate value of the group was to contribute a real user and carer perspective to the Risk and Quality Review work. In turn, the involvement with the review process appeared to be a positive and empowering experience for the group members.