Raising the Standard

Improving inpatient mental health care in Wales

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About Mind Cymru

We're Mind Cymru, the mental health charity. We work nationally and locally.

Nationally, we campaign to raise awareness, promote understanding and drive change. We're also the first point of call for information and advice, providing mental health information to people in Wales over a million times every year. Locally, in communities across Wales, independent local Minds provide **life-changing face-to-face support to more than 37,000 people each year.**

Together, we won't give up until everyone experiencing a mental health problem gets support and respect.

Local Minds in Wales

1. Brecon and District Mind
2. Caerphilly Borough Mind
3. Cardiff Mind
4. Conwy Mind
5. Cwm Taf Morgannwg Mind
6. Llanelli Mind
7. Mid and North Powys Mind
8. Mind Aberystwyth
9. Mind in Gwent
10. Mind in the Vale of Glamorgan
11. Mind Ystradgynlais
12. Neath Port Talbot Mind
13. North East Wales Mind
14. Pembrokeshire and Carmarthen Mind
15. Swansea Mind
16. Vale of Clwyd Mind

Introduction

> “Families should be able to feel their loved ones are safe whilst there and that there are enough staff on each ward to give that care.”
>
> **Mind Campaigner**

Mental health hospitals should be places of kindness, understanding and hope. They can provide a safe place for people experiencing some of the most difficult times of their lives, so it is important that those on their wards are treated with respect and care.

Mind’s Raise the Standard campaign in England has shown that this is not always the case. There have been high-profile cases of poor management and issues with the treatment of patients. As part of this campaign, Mind has called for:

- **The UK government to pass a reformed version of the Mental Health Act 1983;**
- **Patients and their loved ones to be included in investigations into failings at mental health hospitals;**
- **Greater investment of resources into staffing and the mental health estate.**

We would like to see these changes happen for Wales too. Making inpatient care safe and supportive is a priority for many people we spoke to for this report, whatever their background. Some of what we heard agreed with the recommendations of the Raise the Standard campaign, but we also heard other things which need to be addressed in Wales.

There are currently opportunities in Wales to improve the experiences of those of us who need inpatient support. The replacement mental health strategy launched for consultation by Welsh government in February 2024 is a perfect opportunity to recognise what is working with mental health inpatient care in Wales and what can be done to improve it. It is positive that the draft strategy includes an action for the development of a Mental Health Safety Programme. Run by the NHS Executive, it will eventually cover all mental health services, but it is expected to begin with an inpatient focus. This will also cover enhancing the mental health estate to be fit for purpose.

On February 2nd 2024, James Evans MS launched a consultation on his proposal for a Mental Health Standards of Care (Wales) Bill. The Bill aims to replace outdated mental health legislation; improve the delivery of mental health plans for Child and Adolescent Mental Health Services and adult services in Wales; improve the accountability of Welsh public sector organisations; help to establish parity between the treatment of physical and mental health; and help to reduce mental health stigma in Wales. These reforms will likely impact the delivery of inpatient care and so we look forward to seeing the outcome of this legislative proposal.

Background

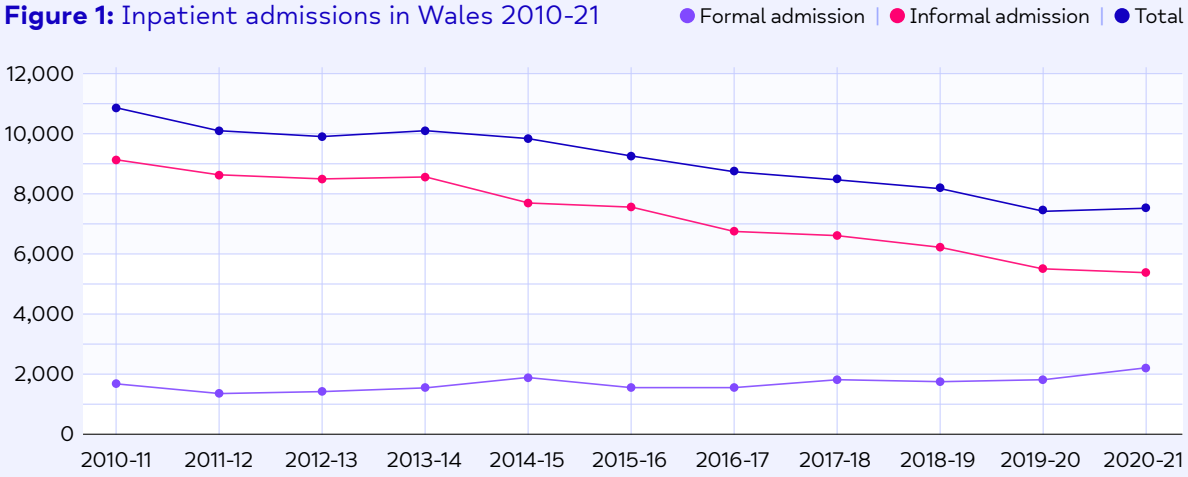
What is inpatient care?

You may be admitted to an inpatient unit for a range of different reasons. It could be so you can have a further assessment, to keep you or those around you safe or because you need treatment and support that cannot be provided at home.

There are two ways you can enter inpatient care. The first is informal admission, where you enter a psychiatric hospital voluntarily after an assessment.

The second is formal admission, where you are detained in hospital under a section of the Mental Health Act (1983) and are therefore not free to leave. There are different powers under which you can be 'sectioned', each with different rules to keep you in hospital. The length of time that you can be kept in hospital depends on which section you are detained under. This means you are kept in hospital even if you do not want to go or do not want to receive treatment.

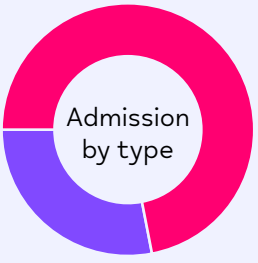
Figure 1: Inpatient admissions in Wales 2010-21



The Welsh government publishes some data about the numbers of people in inpatient hospitals. **In Wales in 2022, 72% of admissions to all mental health hospitals were informal and 28% were formal[1].** It is more common for people to enter hospital voluntarily. Overall, there has been a drop in the number of people being admitted to mental health hospitals. Much of this has come from a drop in the number of informal admissions.

72%
Informal

28%
Formal



For more information on sectioning, please visit the Mind website:
https://www.mind.org.uk/information-support/legal-rights/sectioning/overview/

1. All information on admissions was found at: **statswales.gov.wales/Catalogue/Health-and-Social-Care/Mental-Health/Admissions-to-Mental-Health-Facilities/admissionstomentalhealthfacilitiesbylhb**

Despite knowing how people enter hospital, we know very little about who they are. In mental health care more generally, we know that you are less likely to receive the treatment you need or achieve the outcomes you want if you are from a certain background. We would expect that this is the same for those in inpatient hospitals, but it is almost impossible to tell. Inspections can be a useful way of identifying problems, but we need a more robust, transparent data set to understand experiences of care. It is important that protected characteristics, such as someone's age, ethnicity or sexuality are available and are analysed appropriately.

The Welsh government does publish information about the gender of people in inpatient care. With this data, we can see differences.

Figure 2: Overall admissions to Welsh mental health inpatient settings by gender

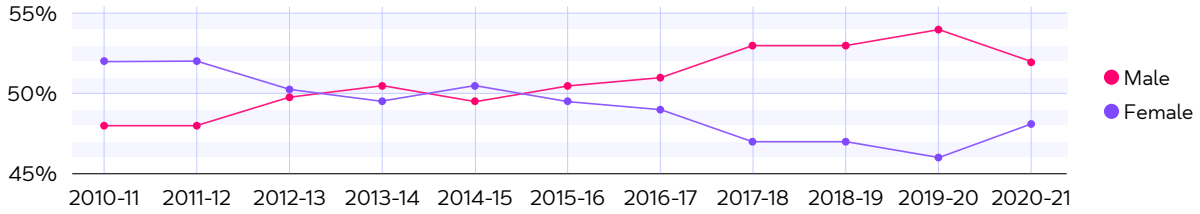


Figure 3: Formal admissions to Welsh mental health inpatient settings by gender

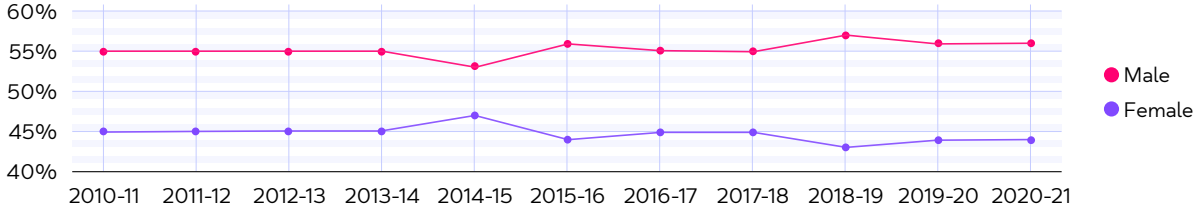
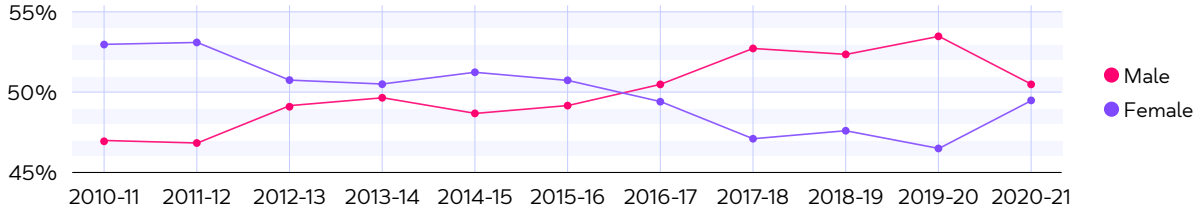


Figure 4: Informal admissions to Welsh mental health inpatient settings by gender



This data clearly shows us that you are more likely to be admitted to a mental health hospital in Wales if you are male. By looking at the data in these charts, we can see that much of this is driven by a higher number of formal admissions. The gap in informal admissions has been narrowing and it would be good to better understand what has been driving this trend. Without this data separated by gender, we simply would not know anything about trends and then seek to improve our understanding of what is driving need for inpatient care.

If we could determine a similar picture for other elements of a person such as their age or racial background, we could help identify, understand and challenge any inequality.

Why does inpatient care need to be improved?

> Rehabilitation, less stigma, ongoing support, access to therapies, mindfulness, coping strategies etc. Better surroundings, outdoor space, gardens. Respect.

Mind Campaigner (when asked about what they would like to change with inpatient care)

Healthcare Inspectorate Wales (HIW)

For this report, we have used 2 main ways of identifying problems with inpatient care in Wales. The first is through reviewing the work and inspections undertaken by Healthcare Inspectorate Wales (HIW).

HIW inspects and monitors all healthcare settings in Wales, including those run by the NHS and those run by independent healthcare providers. As part of their work they track how the Mental Health Act 1983, the Mental Health (Wales) Measure 2010 and other key legislation and guidance are being used in mental health hospitals.

Their recent inspections have consistently pointed out key issues that we cover in this report, such as workforce challenges, patient observations, care planning, governance and the care environment. Through speaking to patients and staff they identify problems and can issue notices calling for improvements where they are needed.

They are authorised to receive complaints and concerns about healthcare settings, which includes inpatient mental health care. In 2022-23[2] they received 164 complaints about mental health and learning disability healthcare services[3]. This was a 9% increase from the previous year. This figure is around three times higher than both 2019-20 and 2020-21. We do not know how many of these complaints were upheld.

For mental health hospitals run by the NHS, the highest number of concerns in 2022-23 related to access, admission, transfer and discharge. Issues with this theme often revolve around problems with patient rights, informed consent and compliance with mental health laws. These problems can be challenging to manage for healthcare providers for a range of reasons, such as a high demand from patients and what resources are available.

For independent settings, most complaints are about the environment of care or the staffing of wards. Under Regulations 30 and 31 of the Independent Health Care (Wales) Regulations 2011, independent settings must also inform HIW about specific things that may happen on a mental health ward, like the death of a patient or serious injury.

From 2022-23, HIW received 902 notifications of incidents of this kind. This was nearly a 20% increase on the year before. Much of this was driven by a large rise in the number of cases of serious injury, which came from more patients self-harming. There are many reasons for this increase, from reduced staffing to patients feeling isolated as a long-term result of the COVID-19 pandemic. HIW's inspections have gradually returned to their normal number, so it is also possible that healthcare providers have improved how they report these issues.

2. All information from 2022-23 for Healthcare Inspectorate Wales is sourced from their *Mental Health Hospitals, Learning Disability Hospitals and Mental Health Act Monitoring Annual Report 2022-2023*, found here: **www.hiw.org.uk/mental-health-hospitals-learning-disability-hospitals-and-mental-health-act-monitoring-annual-5**
3. 84 complaints were for NHS mental health services. 80 were for independent mental health providers.

Engaging people with lived experience

We heard from many different people for this report. A recent survey undertaken by Mind as part of our Raise the Standard campaign asked people for their views on inpatient mental health care.

It showed that inpatient care is not often seen as a safe option for treatment. When asked to imagine that a friend or family member has to enter a hospital for their mental health, only 52% of those we asked were confident that the hospital would keep them safe.

The survey showed that those in charge should do more to improve inpatient care. 27% of people in Wales wanted 'mental health hospitals' to be a priority for government spending within health services. This was third behind Accident and Emergency services and provision of General Practice (GP). 69% of people in Wales thought the 'government' (this question did not refer to either the Welsh or UK governments in particular) should be doing more to protect patients in mental health hospitals from unsafe care and abuse.

For some, inpatient mental health care is a positive experience. However, the information the general public receives about mental health hospitals is often negative. In our survey, 20% of people in Wales had seen news stories about mental health hospitals in the previous 30 days. When these people were asked which emotions they felt when they saw these news stories, 34% felt worried, 33% sad, 22% angry. None were grateful, happy, relieved or optimistic. Overall, 90% expressed a negative emotion. Inpatient mental health care is clearly an emotive issue, one that often seems to be seen in a negative way.

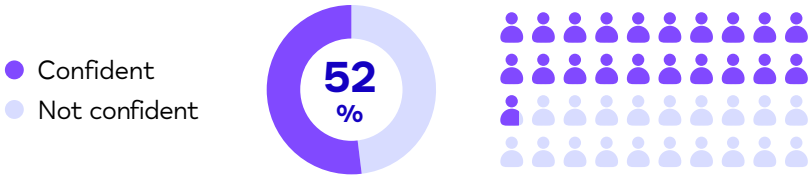
A third (33%) of people in Wales thought that mental health hospitals improve someone's mental health, which was lower than in England (38%). 17% said they made no difference and 10% believed they tend to make patients' mental health much worse. Over a third of people (39%) said that they did not know. This could be due to fewer people having direct experience of a mental health hospital.

The views we have collected have been at the heart of our work in this report, reflecting many of the issues which are presented in other reports. Alongside this research, we spoke to our campaigners in Wales, who come from a wide range of backgrounds. Quotes from them appear throughout this document. Some have direct experience of adult inpatient wards; some have experiences through their family and friends; and others care about making a difference to mental health care in Wales.

Figure 5: Mind Raise the Standard survey results in Wales

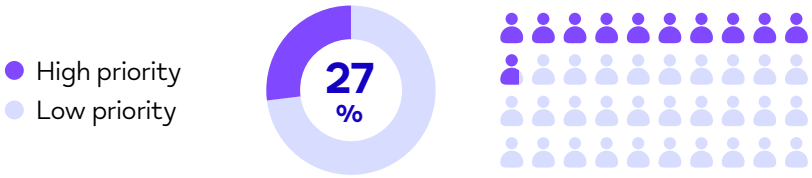
Feeling safe

Only 52% of those we asked **were confident** that the hospital would **keep them safe.**



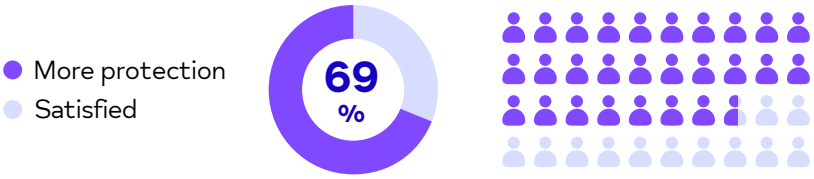
Government priority

27% wanted 'mental health hospitals' to be a **priority for government spending.**



Patient protection

69% thought the 'government' should be doing **more to protect patients.**



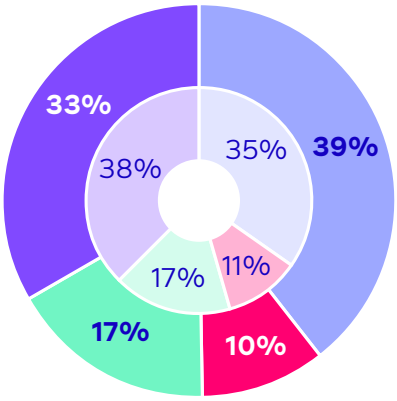
People's opinions on whether mental health hospitals improve someone's mental health

Wales

- Improved - 33%
- No difference - 17%
- Worse - 10%
- Didn't know - 39%

England

- Improved - 38%
- No difference - 17%
- Worse - 11%
- Didn't know - 35%



Through our work, we have identified 3 key areas of focus

Key area 1:
The inpatient estate

Key area 2:
Data, governance and legislation

Key area 3:
Restrictive practice

Key area 1:

The inpatient estate

> My brother suffered with extreme bipolar for 40 years and I must say in general most of the mental health nurses and psychiatrists who supported him in hospital were extremely dedicated to their jobs and had incredible empathy towards their patients. I will always be grateful for the care they gave.

Mind Campaigner

Building the mental health workforce

Entering a mental health hospital as a patient is likely to be one of the most distressing times of a person's life. The staff that they meet during their journey through their care will be crucial to making their treatment effective. For the most part, patients have good relationships with the staff treating them in inpatient settings across Wales.

The work staff do in mental health units is generally very good quality. For example, patients have felt more engaged with the activities staff have provided than in previous years. Even an activity like cooking can develop someone's independence while they are receiving treatment. As HIW recognised: "the positive impact of these activities cannot be underestimated".

However, staff shortages can affect how satisfied patients feel with their treatment. One Mind campaigner explained that after being promised activities on their ward, they often found that staff were too busy to put them on. If staff feel overwhelmed or stretched too thinly, they may struggle to maintain the high quality of care we know they intend to give. Staffing levels matter for the quality of a patient's care.

There are significant challenges across the healthcare workforce in Wales. Recruiting and retaining the right staff with the right knowledge and skills to do their jobs effectively has been an issue.

Many inpatient settings are still feeling the effect of the COVID-19 pandemic. During that time, many people found their mental health deteriorate due to a range of factors. With more people needing support, staff were put under a considerable amount of pressure. The mental health workforce faced difficulties in recruiting and keeping skilled and experienced staff.

We have heard from campaigners that seeing the same staff during their treatment can help them feel that their care matters. In recent years much of the healthcare sector has been relying on the use of temporary workers from agencies. This means that often patients will receive their care from different people during their stay, which can be disruptive and demoralising as they may feel the continuity of their care is broken. Working on developing your independence and personal strengths can be difficult if staffing is inconsistent.

HIW found that 13 of the 18 hospitals they inspected between 2022 and 2023 had issues with their workforce. They saw problems stemming from staff shortages that are likely to have a knock-on effect on patients. Some patients did not have their physical health problems

4. *HIW, Mental Health Hospitals, Learning Disability Hospitals and Mental Health Act Monitoring Annual Report 2022-2023.*

identified in good time. Some units had a lack of specialist professionals on-site, such as occupational therapists and psychologists. Others had issues with lacking enough female staff to make sure female patients could keep their dignity when being observed to keep them safe.

The Welsh government is aware of this problem. Much of the work in the healthcare sector being undertaken at the moment recognises difficulties with both waiting times and staffing shortages. For example, the Senedd's Health and Social Care Committee has been reviewing the impact of the Nurse Staffing Levels (Wales) Act 2016. It was the first legislation in Europe to recognise the link between the numbers and skill mix of nursing staff and the outcomes of patient care. Section 25B of the Act provides a duty to calculate and maintain nurse staffing levels in specified settings. This is due to be expanded to cover mental health inpatient wards. It should be recognised that this would put in place a minimum level of staffing, which we would expect to see Local Health Boards have plans in place to move beyond in order to provide high quality care and support staff with workloads, training and their own wellbeing. This, as well as the workforce strategy from Health Education and Improvement Wales, have been positive developments.

However, we know that many challenges still remain. HIW suggests that Local Health Boards and independent care providers should plan better for the long and the short term to address these shortages. One of our campaigners we spoke to suggested that "mental health staff need more pay" and "more incentive", as well as "more training" to equip them better for the demands of their roles.

This is an urgent issue that needs to be addressed for patient safety. During the pandemic, staffing issues affected the quality of patient observations. One campaigner we spoke to explained that they did not always feel like they were appropriately monitored during their treatment in an inpatient hospital. At one point they were allowed to go for a walk without being checked on. They ended up staying out for much longer without any of the staff realising that they had gone.

With better workforce planning and a supportive, nurturing environment for staff where they feel they can develop, inpatient care will be greatly improved. This will require clear planning and interventions from the Welsh government, where inspections from HIW and feedback from key stakeholders and those with lived experience are listened to and acted upon.

The right environment for care

People deserve dignity and respect in their care. Much of this comes from the physical environment they will be treated in during their stay. This has been a persistent issue. HIW noted that in five of eight hospitals they inspected in 2022-23, they identified problems with missing environmental audits and managing environmental ligature risks. Broken furniture, missing lights or a visible lack of maintenance can lead to safety risks, all of which must be avoided at all costs.

Recent inspections have highlighted issues with:

- Baths and toilets not working
- Cracked windowpanes
- Redecorating not happening when it is needed
- A lack of evidence that ligature risk assessments have been reviewed to ensure that the follow-up actions had been completed and recorded.

One Mind campaigner described their experience of the physical environment as **"very poor"** and it could have been **"greatly improved"**. Alongside what they felt was a lack of access to good therapies and activities and a shortage of staff to **"ensure patient safety"**, they wanted to see great improvements in the physical space for their care. Routine maintenance and replacing items matter. Anything in the physical ward environment that is easily rectified, but has not been done so, may demonstrate a lack of care to patients.

We recommend the Welsh government:

- **Continues to prioritise staffing as a key part of the new mental health strategy.**
- **Continues to invest in the mental health workforce to meet demand through means testing and engagement with partners such as HEIW and HIW.**
- **Reviews the mental health estate and consider where improvements can be made in line with recommendations from HIW and feedback from patients.**

Key area 2:

Data, governance and legislation

> “Whatever you or anyone do will only succeed when the general management practices are improved.”
>
> **Mind Campaigner**

Mind’s Raise the Standard campaign was launched in England in response to a series of high-profile failings at mental health hospitals across the country. Many of these could be traced back to failures of governance. In Wales, we have not seen the same level of high-profile cases in mental health wards. However, many issues that appear in inspection reports or feedback from those we have spoken to indicate that governance is also an issue here.

Governance refers to the overall management of mental health hospitals. This can include everything from filling in the correct paperwork for patients to the work of senior staff and Local Health Boards. It is important to stress that identifying areas of improvement with governance and other areas of inpatient care does not necessarily mean that the quality of patient care is poor. We know that staff work hard for the best outcomes they can.

Most issues around governance are to do with administration. Managing a patient’s medication well, for example, or providing them with the right information during their stay, can help keep them safe. When these processes are disrupted, it can have a real impact on both a patient’s experience on their ward and how successful their care can be.

41 YEARS OLD

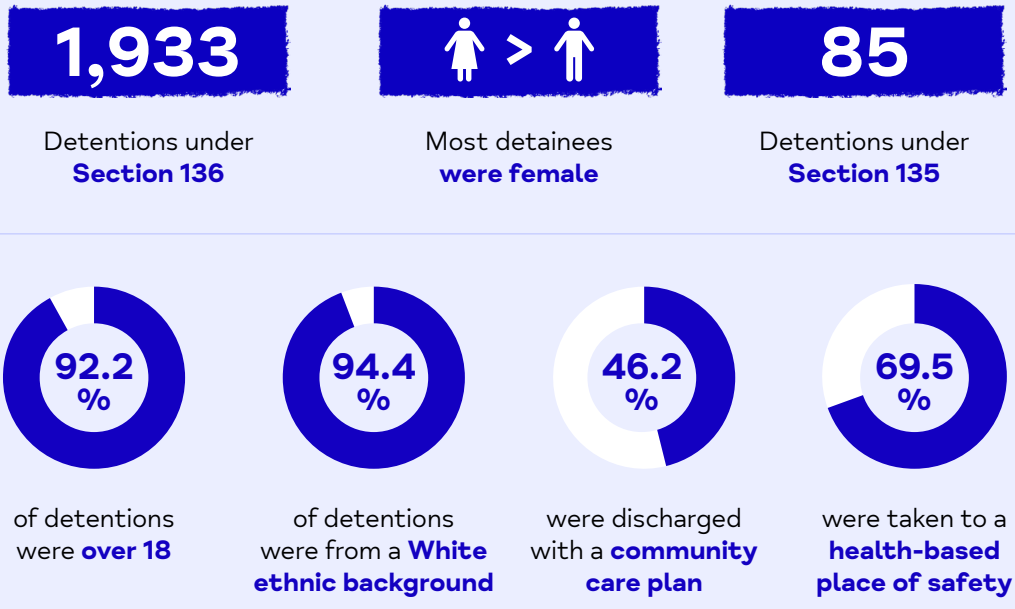
Reforming the Mental Health Act:

One of the major calls of the Raise the Standard campaign has been for the Mental Health Act 1983 to be reformed. The 41-year-old Act is the law in England and Wales which outlines when you can be detained or sectioned and receive mental health treatment whether you want to or not. On 17th October 2023, representatives from Mind handed in a petition to Number 10, Downing Street as part of the campaign. **Over 34,000 people had called for the UK government to bring forward the planned reformed Mental Health Act.**

We know that the current legislation is out of date and the Bill proposed by James Evans MS is understandably only seeking to bring in certain aspects of the reforms needed. We are pleased to see reform of the Mental Health Act included in the Kings Speech for the new UK Government and hope that this will lead to addressing many of the issues people have raised with us.

HIW monitors how the Mental Health Act is used in mental health settings in Wales. Most of their worries with how the Act is applied have been to do with administration. One key example has been how Section 17 leave has worked, which allows patients who are detained in hospital to be absent for a period of time. Some inspections saw that some forms were incorrectly signed, while others noticed that patients were not always as involved as they should be in the process of planning leave.

Figure 6: In 2022, Wales saw:



What the Welsh government publishes is useful. As can be seen above, we know some information, including the number of detentions under Section 135 and 136 of the Act[5]. We also know gender and the proportion of people being detained who are from a White ethnic background. But by only telling us about people from a White ethnic background, we cannot tell if people from one community are more likely to be detained than another.

The reason this matters is that we know in England that people from some ethnic minority communities are more likely to be detained under the Act[6]. In 2022, NHS data showed that the number of people detained per 100,000 people for different ethnic backgrounds was worrying:

- **Black or Black British people had a detention rate of 309.4**
- **People from Mixed Ethnicity backgrounds at a rate of 143.9**
- **Asian or Asian British at a rate of 96.2**
- **Other ethnic groups at a rate of 197.4**
- **People from White backgrounds were detained at a rate of 76.2 per 100,000 people.**

This means that you have been 4 times more likely to be detained under the Act if you are Black and twice as likely if you are from a Mixed Ethnicity background. Without this data being publicly available, we would not know this information.

In Wales, we do not know this information. We do not know if people in Wales who are from a Black ethnic background are more likely to be detained under the Act. We can only assume that it is likely. The Equality Act 2010 says that it is illegal to discriminate against someone based on a number of 'protected characteristics', such as their race, age or sexuality. But if we do not know that, for example, someone is more likely to be detained under the Act if they are of Mixed Ethnicity, then we cannot know if people are being treated fairly. While governance and administration is important, as well as the reforms we have called for in our campaign to reform the Mental Health Act 1983, data is holding us back in Wales from understanding the broadest range of experiences.

5. Information about admissions under the Mental Health Act 1983 can be found here: **https://statswales.gov.wales/Catalogue/Health-and-Social-Care/Mental-Health/Detentions-under-Section-135-and-136-Mental-Health-Act**
6. All information about ethnicity is sourced from the May 2022 UK Parliament research briefing found here: **https://researchbriefings.files.parliament.uk/documents/POST-PN-0671/POST-PN-0671.pdf**

Planning for care

Under Part 2 of the Mental Health (Wales) Measure 2010, you are entitled to receive a Care and Treatment Plan (CTP). CTPs are designed to better recognise the wider social factors that impact our mental health. They cover 8 areas of life, from education to housing. They should be person-centred and focused on recovery.

Data from the Welsh government indicates that most people receiving secondary mental health care have a valid CTP. However, the quality of CTPs has been a consistent issue. In 2022, HIW noted: "we are disappointed to have again this year identified so many issues that could easily be rectified with a robust audit and governance process"[7]. In 2023, they saw that there were examples of good practice across Wales, where "patients were involved in the planning and provision of their own care". However, there were still "considerable" issues across the board, particularly that they were "not always fully completed, kept up to date and completed in accordance with the Mental Health (Wales) Measure 2010".

Mind Cymru has called for improvements to care and treatment planning for patients under both the Mental Health Act (1983) and the Measure for several years. Welsh government data indicates that most people receiving secondary mental health services have a valid CTP, but we know the general quality of them should be improved. Our 10-year review of the Measure recommended that the Welsh government[8]:

1. **Develop mandatory training for care coordinators on producing quality CTPs,** to ensure the training is implemented nationally and monitor uptake.
2. **Develop accessible information and advice about co-production and taking part in care and treatment planning** and ensure it is available for patients and other relevant people including carers, advocates etc.

Incomplete and insufficient CTPs can have negative consequences for patients. Some recent inspections by HIW saw that "a lack of detailed information was recorded" to "reflect patient needs and reasons for interventions in order to ensure safe patient care". This is particularly concerning as the use of restrictive practice should be planned so that it is more likely to be avoided. Better planning and adequate support for staff in how to use CTPs effectively would benefit patient outcomes and ensure they feel treated with dignity and respect.

It is positive to note that the new mental health strategy recognises the need to improve the quality of CTPs and to better involve patients and their families in their development. This commitment needs to be made a reality urgently in order to drive the improvements needed.

We recommend the Welsh government:

- **Develops an updated Welsh Code of Practice for Wales around the replacement Mental Health Act that is equitable and comprehensive.**
- **Improves the collection of data around the Mental Health Act, focusing on protected characteristics.**
- **Outlines what is being done to improve the quality of Care and Treatment Planning in line with recommendations from HIW.**

7. www.hiw.org.uk/mental-health-hospitals-learning-disability-hospitals-and-mental-health-act-monitoring-annual-3
8. Mind Cymru's report can be found here: **https://www.mind.org.uk/media/13351/thementalhealthmeasure_tenyearson.pdf**

Key area 3:

Restrictive practice

> “Restrictive practices should never be used to compensate for staff shortages or other resource difficulties.”
>
> **HIW**

Restrictive practice refers to “a wide range of activities that stop individuals from doing things that they want to do or encourages them to do things that they don’t want to do.”[9] This could be something physical, like restricting someone’s movement, or seclusion, which involves confining a patient to a separate area, such as a room.

The Mental Health Act 1983’s Code of Practice for Wales 2016 is clear that restraint must only be used as a last resort. It should only be used when all other interventions have failed and have not had a successful outcome for the patient. Everyone being treated in a mental health unit should have detailed CTPs explaining and identifying any triggers for behaviours that might lead to the use of restraint.

HIW regularly inspect patient records during their visits and check that restraint is being used effectively. They noted that for 2022-23, restraints were generally well documented and there were appropriate systems in place to monitor any incidents where it was used. Some wards were encouraged to update their polices around restrictive practice. In four hospitals, training to manage aggression and how to handle physical interventions for staff was not good enough, so there was a recommendation to improve it.

In October 2022, the Welsh government published their new Reducing Restrictive Practices Framework. It aims to reduce the use of restrictive practice in hospitals and other settings. It is non-statutory at the time of publication of this report, meaning it is not enforced by law. By making it legally binding, mental health hospitals would need to make sure that they are doing everything they can to avoid the use of restrictive practices.

Currently, no data is published about restrictive practice in Wales. The guidance lists specific areas of data that Local Health Boards should collect, such as the length of time that an incident of restraint happened. Particularly without data on a person’s protected characteristics, such as their age or ethnicity, it is hard to know who is more likely to be restrained, as was highlighted earlier in this report.

9. The Reducing Restrictive Practices Framework can be found here: **www.gov.wales/reducing-restrictive-practices-framework-html**

In 2023, we submitted Freedom of Information (FoI) requests to each of the 7 Local Health Boards in Wales asking whether they held data about these suggested areas. They told us that they held most of this information. However, when we submitted follow-up FoI requests asking to see the data for the last five years, what we received was not as comprehensive as we had expected.

The information in the responses we received was often patchy and incomplete. There are several reasons we were provided as to why this was the case, such as Local Health Boards moving from recording incidents on individual patient records to the new Datix online record software. In understanding this data, it is important to understand that it only shows part of a wider picture. Each incident of restrictive practice will involve many factors that data by itself cannot hope to explore in appropriate depth. What this data can do is indicate trends as well as show why better processes around data collection are needed.

Some Local Health Boards did provide some protected characteristics information. For example, Powys THB indicated in their initial responses that they record patient protected characteristics on CTPs and patient records, whilst Cardiff and the Vale record on Datix and patient records. Swansea Bay UHB, Cwm Taf Morgannwg UHB and Aneurin Bevan UHB all indicated that Datix is only capable of partially recording protected characteristics. These responses demonstrate that consistent data collection is currently not in place. We believe that improving the information that is available for policy makers and key stakeholders will enable better scrutiny, decision making and policy development. This will, in turn, benefit patients in ensuring their care is respectful and always in their best interest.

Despite the inconsistencies with the data we received, we can still draw several conclusions from this work:

1. Restrictive practice must be used for the minimum amount of time necessary. Only three Local Health Boards provided us with information outlining how long each recorded incident lasted. What it told us was that most times restrictive practice was used, it was for less than 5 minutes. But some cases lasted for over an hour, with some instances of restrictive practice that appeared to last for many hours, up to 24 hours in some cases. These are concerning.

2. Some Local Health Boards have used prone restraint on patients. Prone restraint is where a person is held chest down, whether they placed themselves in this position or not, is resisting or not and whether they are face down or have their face to the side. It should only be used in exceptional circumstances and where necessary to maintain the safety of patients and others. The practice was ended in England in 2018 under Seni's Law, a piece of legislation designed to prevent excessive force used on mental health patients. We do not have a similar law in Wales.

3. More information is needed about the use of seclusion, which is "the supervised con nement of a patient in a room which may be locked". This practice can clearly impact a patient's mental health. The effective use of care and treatment plans could help reduce its use. In the data Mind Cymru received from Local Health Boards, only Cardiff and the Vale UHB indicated that they do not support or use seclusion within the Local Health Board.

Restrictive practice in secure mental health hospitals

As part of the Together for Mental Health Delivery Plan 2019-22, the Welsh government commissioned a national review of secure inpatient units[10]. This was published in April 2022. The Making Days Count audit covers the time period August 2020- November 2020 and covers 280 patients in its scope.

It covers all aspects of inpatient care, but examines the use of restrictive practice in secure facilities. Of its limited sample size:

7 in 10 patients had been subject to one or more restrictive interventions.

Verbal de-escalation was the most common form of intervention used (half of patients experienced this in the previous 90 days).

Women were more likely to have experienced restrictive practice than men. 60% of medium secure female patients and 73% of low secure respectively had experienced it in the previous 90 days.

5% of patients had experienced prone restraint, but only 1% in the past 90 days.

19% of patients had been subject to seclusion, 10% in the previous 90 days and more women than men.

This data is more complete than the information we returned from Local Health Boards through our use of FOIs. If we could see similar levels of data collection around restraint in every mental health unit in Wales, patients across the country would likely benefit from better and more targeted care.

We recommend the Welsh government:

- **Makes the Reducing Restrictive Practices Framework guidance statutory, to protect patient safety and rights.**
- **Improves processes and consistency around data collection for restrictive practice.**
- **Explores the extension of Seni's Law to Wales.**

10. www.nccu.nhs.wales/qais/national-reviews/making-days-count/

Conclusion

The work of key stakeholders, such as HIW, as well as testimony from those with lived experience shows that inpatient mental health care is driven by people who care, with the best interests of patients at its heart.

The voices of those with lived experience must be at the heart of every aspect of inpatient care. Patients being treated in inpatient units need the highest levels of compassion and empathy from everyone they engage with. Receiving the right support from staff who feel appropriately resourced and trained to do their jobs effectively can make all the difference.

There are many aspects of inpatient care in Wales that deserve to be praised. In general, staff continue to develop good and genuinely caring relationships with the patients they work with. We have heard clearly about how meaningful activities provide fulfilment and goals during someone's stay.

But it is clear that more work needs to be done, whether improving the quality of Care and Treatment Plans or reviewing the quality of the inpatient estate's infrastructure. The key area of improvement this report has identified has been the collection of the right data. With better information about who is being treated in mental health hospitals, treatment can be better informed and tailored to meet the needs of those receiving it.

We look forward to seeing the difference the proposed NHS Executives inpatient safety programme and the new strategy will bring for inpatient care. We hope to see these recommendations taken on board as part of the implementation of both the strategy and supplementary guidance such as the Reducing Restrictive Practices Framework. This is an exciting opportunity for the Welsh government to take the lead and set a strong example of good practice about what good care should look like.

Research methodology

This report refers to polling undertaken by YouGov on behalf of Mind as part of the Raise the Standard campaign.

The survey was conducted using an online interview administered by members of the YouGov Plc GB panel of 185,000+ individuals who have agreed to take part in surveys. An email was sent to panellists selected at random from the base sample according to the sample definition, inviting them to take part in the survey and providing a link to the survey. (The sample definition could be "GB adult population" or a subset such as "GB adult females"). YouGov Plc normally achieves a response rate of between 35% and 50% to surveys however this does vary dependent upon the subject matter, complexity and length of the questionnaire. The responding sample is weighted to the profile of the sample definition to provide a representative reporting sample. The profile is normally derived from census data or, if not available from the census, from industry accepted data.

All figures, unless otherwise stated, are from YouGov Plc. Total sample size was 2,014 adults. Fieldwork was undertaken between 7th – 8th June 2023. The survey was carried out online. The figures have been weighted and are representative of all GB adults (aged 18+).

YouGov is registered with the Information Commissioner and is a member of the British Polling Council.

Appendix

Healthcare Inspectorate Wales (HIW):

- Mental Health Hospitals, Learning Disability Hospitals and Mental Health Act Monitoring Annual Report 2022-23
- National reviews and reports

Legislation:

- Mental Health Act 1983
- Mental Health Act 1983: Code of Practice for Wales
- Mental Health (Wales) Measure 2010
- Nurse Staffing Levels (Wales) Act 2016

Together for mental health:

- Mental health strategy 2012-22
- Delivery Plan 2019-22

Secure mental health hospitals:

- National Collaborative Commissioning Unit (NCCU): Making Days Count audit of secure mental health hospitals

Mind:

- Raise the Standard campaign
- Treatment in hospital for your mental health
- Review of the Mental Health (Wales) Measure 2010

Welsh government inpatient data:

- StatsWales

Glossary

Capacity: The ability to take a decision about a particular matter at the time the decision needs to be made. Some people may lack mental capacity to take a particular decision because they cannot understand, retain or weigh the information relevant to the decision. A legal definition of lack of capacity for people over 16 is laid out in the Mental Capacity Act 2005.

Care and Treatment Plan/ Planning: A written plan in Welsh or English covering what a patient wants to achieve and which mental health services will help to provide this.

Community Treatment Order (CTO): Written authorisation on a prescribed form for the discharge of a patient from detention in a hospital onto supervised community treatment. They are a mechanism to enable individuals detained in hospital for treatment to be discharged from hospital to be cared for and treated in the community or at home. The discharging hospital can recall the patient to hospital for up to 72 hours. This can be followed by release back into the community, an informal admission or revoking the CTO in place and reimposing the previous detention.

Detention/ Detained: Being held in a hospital compulsorily under the Mental Health Act for a period of assessment or medical treatment for a mental disorder. Also referred to as 'sectioning' or 'sectioned'.

Discharge: A decision that a patient should no longer be subject to detention, supervised community treatment, conditional discharge or guardianship. Discharge from detention is not the same thing as being discharged from hospital.

Formal Patient: Someone who is treated for a mental disorder in hospital and is detained under the Mental Health Act.

Freedom of Information (FoI Requests): The Freedom of Information Act 2000 allows members of the public and press to submit Freedom of Information (FoI requests. If certain conditions are met, FoI requests require public authorities to release any information they hold relating to the request.

Governance: The overall management of mental health hospitals, from senior staff o the administrative paperwork needed to keep up-to-date information on patients currently being treated.

Healthcare Inspectorate Wales (HIW): The independent inspectorate and regulator of healthcare in Wales.

Informal Patient: Someone who is being treated for a mental disorder in hospital and is not detained under the Mental Health Act. Sometimes known as a voluntary patient.

Leave of Absence (Section 17 Leave): Formal permission for a patient who is detained in hospital to be absent from the hospital for a period of time. Patients remain under the powers of the mental Health Act when they are on leave and can be recalled to hospital, if necessary, in the interests of their health and safety or for the protection of others.

Ligature: A ligature is an item or items that can be used to cause compression of airways, resulting in asphyxiation and death. A Ligature (Point Risk Assessment identifies potential ligature points and what actions should be undertaken by the healthcare provider to remove or manage these points for patient safety.

Mental Capacity Act 2005: An Act of Parliament that governs decision-making on behalf of people who lack capacity, both where they lose capacity at some point in their lives and where the incapacitating condition has been present since birth.

Prone Restraint: A form of physical restraint where a person is held chest-down, whether they placed themselves in this position or not, is resisting or not and whether they are face down or have their face to the side. It was outlawed in England under Seni's Law in 2018.

Protected Characteristics: It is illegal to discriminate against someone who has a protected characteristic as de ned under the Equality Act 2010. These include age, disability, race, religion, sex, marriage and civil partnership, gender reassignment, pregnancy and maternity and sexual orientation.

Secondary Mental Health Services: All services provided to an individual for the treatment of their mental health.

Section 135: Section 135 of the Mental Health Act allows a police officer the powers of entry using a warrant obtained from a Justice of the Peace. This is used to gain access to a person believed to be mentally disordered who is not in a public place and if necessary, remove them to a place of safety.

Section 136: Section 136 of the Mental Health Act allows for any person to be removed to a place of safety (section 136 suites) if they are found in a public place and appear to a police officer to be suffering from a mental disorder and in immediate need of care and control.

Join the fight for better mental health!

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