Cynulliad Cenedlaethol Cymru
Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon
Ymchwiliad i iechyd meddwl yng nghyd-destun plismona a dalfa'r heddlu
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Ymateb gan Arolygiaeth Gofal Iechyd Cymru

National Assembly for Wales
Health, Social Care and Sport Committee
Inquiry into Mental health in Policing and Police Custody
Evidence from Healthcare Inspectorate Wales

Briefing paper: Health, Social Care and Sport Committee

Short inquiry into mental health in policing and police custody.

Healthcare Inspectorate Wales, March 2019

A Our role in relation to mental health services for people in crisis

Mental health inspections

1. HIW assesses whether the NHS is meeting the Health and Social Care Standards through its inspections. For independent providers the primary legislation is the Care Standards Act 2000 and HIW considers compliance with the associated Independent Health Care (Wales) Regulations 2011 and how providers meet the National Minimum Standards for Wales.

Monitoring the Mental Health Act 1983

2. HIW also has responsibility for monitoring how services discharge their powers and duties in relation to patients detained under the Mental Health Act 1983, on behalf of Welsh Ministers. This includes

- Providing a service under the Act where registered medical practitioners authorise and review proposed treatment of patients in certain circumstances
- Reviewing the exercise of the powers of the Act in relation to detained patients and those liable to be detained
- Ensuring individual health boards and independent registered providers discharge their duties so that the Act is lawfully and properly administered throughout Wales
- Investigating complaints relating to the application of the Act.

3. HIW discharges its function through its inspection processes, where it monitors how services use the Act in a variety of areas such as patients within a hospital setting or those that are subject to a Community Treatment Order (CTO) or guardianship. Within our inspection process we review the legal paperwork to ensure it complies with the Act and the revised Code of Practice.

Working with others

4. HIW also works in partnership with a number of organisations in relation to mental health services.

5. HIW is a member of the UK's National Preventative Mechanism (NPM) which is made up of 21 bodies that have responsibility to visit and inspect places of detention. The United Nations' Optional Protocol to the Convention Against Torture (OPCAT) provides a framework for the NPM to focus on strengthening the work of monitoring places of detention. In addition, HIW is a member of the steering group and the sub groups for children and young people and mental health. .

6. HIW takes part in joint inspections, with HMI Probation, of Youth Offending teams throughout Wales. A number of other agencies are also involved with these inspections including Care Inspectorate Wales (CIW), Estyn and Her Majesty's Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS). HIW's focus during these joint inspections is on how the healthcare needs of the young offenders are being met. These include; physical and psychological needs, involvement of CAMHS, sexual health and drug and alcohol treatment strategies.

7. We also work with HMICFRS to consider how the physical and mental health needs of detainees are being assessed and met in police custody suites. Typically these inspections take place once a year in Wales and HIW has attended two out of the last four inspections in an observer capacity.

Forthcoming work

8. The Crisis Care Mental Health Concordat is a joint statement of commitment to improve the care and support for people experiencing, or at risk of, mental health crises and who are likely to be detained under section 135 or section 136 of the Mental Health Act 1983. The statement of commitment is supported by a number of agencies including; Welsh Government, the NHS,

the Police, Welsh Ambulance Services, Local Authorities and the third sector. HIW and HMICFRS have a role in the scrutiny of the impact of the Concordat.

9. HIW's mental health stakeholders have raised concerns around the availability and effectiveness of crisis care services and HIW has decided to undertake a thematic review in this area during 2019/20. This work is due to start early in the new year and an overarching stakeholder group will be convened to inform the study.

B What we find

10. We do not have a role in directly inspecting the care provided by the police or to vulnerable people in custody. However, the role of health does fall within our remit and can provide useful contextual information for the Committee. The sections below summarise relevant findings from recent work which may be of interest.

B.1 Findings from our review of Community Mental Health Teams, 2109

11. In February 2019 we published the findings of our national review of community mental health teams which was conducted jointly with CIW. We are continuing to visit Community Mental Health Teams as part of our ongoing programme of work.

12. Over the course of our review we frequently found disparity and variability in the standards, consistency and availability of treatment, care and support provided by Community Mental Health Teams (CMHTs) across Wales.

13. Access to Services is an area that required improvement across Wales. We found that linkages between General Practice (GPs) and CMHTs needed strengthening, with a lack of clarity regarding the referral criteria into CMHTs, as well as a lack of knowledge of the range of services available for people to be referred to. Whilst some areas are moving towards a more integrated single point of contact for mental health services, which will improve the situation, the picture across Wales is variable.

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

15. Whilst care planning and legislative documentation is, in most CMHTs, being completed in a timely manner, we are not assured that service users and their families / carers are always as involved in developing the care and treatment plan as they would like to be. Whilst most services are meeting the required timescales for assessments and care planning, we found that this did not always equate to good quality care plans. Not all CMHTs are focusing on the quality of, and detail within, records and documentation.

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

17. Several of our inspections also noted concerns regarding the arrangements for medicines management, with the need to develop better audit, guidance and support from dedicated mental health community pharmacists.

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

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

20. Our work has identified significant challenges in relation to access to psychology or therapeutic services with long waiting times in Wales; up to 24 months in some areas. This requires urgent action to address the shortfall in service provision. This involves not only increased recruitment in these disciplines, but looking at more innovative ways of meeting this need. Health boards and local authorities must consider identified unmet needs to inform future commissioning and operational plans.

21. Information technology and universal access to patient/service user records remains a considerable problem in health and social care services. This is

particularly challenging for integrated services such as CMHTs. There is a role for Welsh Government in developing systems that allow for this and to enable safer, more efficient and effective collaborative record keeping.

B.2 Findings from our evaluation of Homicide Reviews, 2016

22. The review, which looked at 13 independent homicide reviews conducted by HIW, found that inconsistencies in the implementation of care and treatment planning in Wales, and of approach in relation to patient risk assessment and risk management, had been a factor in 11 homicides. A key issue was a lack of effective communication or sharing of information, undermining the ability of professionals to make a fully informed diagnosis.

23. Six of our reviews highlighted a lack of effective discharge planning, or aftercare arrangements being in place. We found the standard of documentation to be poor in several cases and that there has been limited information shared with relevant parties in regards to relapse indicators. This is particularly significant as most of the individuals examined during the course of our reviews had a history of relapse, history of repeat admissions and reluctance to engage with services. In these instances, strong discharge arrangements are imperative to ensuring continuity of care.

C.3 Findings from our review of substance misuse services, 2018

24. Our review found that greater joint working is needed between secondary care, primary care, social services and, in particular, mental health services. People often said they found it difficult to get help with their mental health problems and described being 'bounced around' between substance misuse and mental health services. Many people turn to substance misuse because of their mental health problems, but cannot get help with their mental health until they are clean of these substances.

Healthcare Inspectorate Wales

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