Mental Health & Learning Disabilities

Tue 24 March 2026, 13:30 - 16:00

Agenda

13:30 - 13:45 15 min

1. PRELIMINARY MATTERS

Chair

1.1. Welcome and Introductions

Chair

1.2. Apologies for Absence

Chair

1.3. Declarations of Interest

Chair

1.4. Minutes of the Previous Meeting

Chair

MHLDC 20260324 1.4 Minutes of Previous Meeting MHLDC 20260120 Minutes.pdf (13 pages)

1.5. Committee Action Log

Chair

MHLDC 20260324 1.5 Action Log.pdf (4 pages)

13:45 - 13:55 10 min

2. ITEMS FOR APPROVAL / RATIFICATION / DECISION

2.1. Development of Committee Annual Programme of Business 2026/27

Director of Corporate Governance

MHLDC 20260324 2.1 Development of Committee Annual Programme of Business Cover Report.pdf (3 pages)
MHLDC 20260324 2.1 Development of Committee Workplan Appendix A MHLDC 2026-27 Forward Work Plan (1).pdf (6 pages)

13:55 - 15:45 110 min

3. ITEMS FOR DISCUSSION

3.1. Mental Health Act Compliance Report

Chief Operating Officer

MHLDC 20260324 3.1 Mental Health Act Compliance Report.pdf (41 pages)

3.2. Mental Health Services related Performance and Outcomes, including Quality, Safety and Activity

Chief Operating Officer

MHLDC 20260324 3.2 Mental Health Services Related Performance and Outcomes.pdf (28 pages)

3.3. Assurance in respect of Dementia Standards

Director of Nursing

- MHLDC 20260324 3.3 Assurance in resepect of Dementia Standards.pdf (9 pages)
- MHLDC 20260324 3.3 Assurance in respect of Dementia Standards Appendix 1.pdf (38 pages)

3.4. Maindiff Court Mental Health Inspection report

Director of Nursing

- MHLDC 20260324 3.4 Maindiff Court Mental Health Inspection Report Presentation.pdf (7 pages)
- MHLDC 20260324 3.4 Maindiff Court Mental Health Inspection Report Appendix 1 Improvement Plan - Update January 2026.pdf (9 pages)
- MHLDC 20260324 3.4 Maindiff Court Mental Health Inspection Report Appendix 2.pdf (32 pages)

3.5. Mental Health Act Bill Update

Chief Operating Officer

- MHLDC 20260324 3.5 Mental Health Act Bill Update.pdf (6 pages)

3.6. Mental Health Maturity Assessment

Chief Operating Officer / Director of Digital

- MHLDC 20260324 3.6 Mental Health Maturity Assessment.pdf (5 pages)
- MHLDC 20260324 3.6 Mental Health Maturity Assessment Appendix 1 Name of Programme.pdf (5 pages)
- MHLDC 20260324 3.6 Mental Health Maturity Assessment Appendix 2 NHS Wales.pdf (23 pages)
- MHLDC 20260324 3.6 Mental Health Maturity Assessment Appendix 3.pdf (8 pages)

3.7. Mental Health and Learning Disabilities Division: IMTP Priorities

Chief Operating Officer

- MHLDC 20260324 3.7 Mental Health and Learning Disabilities Division IMTP Priorities.pdf (7 pages)

15:45 - 15:55
10 min

4. ITEMS FOR INFORMATION

4.1. Power of Discharge (PoD) Sub-Committee Update

PoD Chair

- MHLDC 20260324 4.1 Power of Discharge (POD) Sub Committee Minutes 24.02.26.pdf (8 pages)

4.2. Review of Committee Programme of Business 2025/26

Director of Corporate Governance

- MHLDC 20260324 4.2 Review of Committee Programme of Work 202526 Cover Report_.pdf (4 pages)
- MHLDC 20260324 4.2 Review of Committee Programme of Work Appendix A MHLD FWP 2025-26 APPROVED1.pdf (9 pages)

15:55 - 16:00
5 min

5. OTHER MATTERS

5.1. Items to be Brought to the Attention of the Board and other Committees

Chair

5.2. Any Other Urgent Business

Chair

5.3. Date of the Next Meeting: 29th June 2026

Chair

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN/ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

MINUTES OF THE MENTAL HEALTH AND LEARNING DISABILTIIES COMMITTEE

DATE OF MEETING	Tuesday 20th January 2026 13.00-16.00
VENUE	MS Teams

PRESENT	Penny Jones, Chair
	Paul Deneen, Vice Chair
	Helen Sweetland, Independent Member
IN ATTENDANCE	Rani Dash, Director of Corporate Governance
	Leanne Watkins, Chief Operating Officer
	Louise Turner, Divisional Director of Mental Health and Learning Disabilities
	Rebecca Goode, Head of Operational Transformation
	Nadine Gould, Divisional Nurse for MH & LD
	Sandra Mason, Assistant Director of Mental Health & Learning Disabilities
	Paul Rice, General Manager for MH&LD
	Amy Buckley, Assistant Divisional Nurse, MHLD
	Sara Garland, General Manager, Family and Therapies
	Tracey Partridge Wilson, Deputy Director of Nursing
	Mark Griffiths, CAMHS Consultant and Clinical Director
	Naomi Murtagh, Board Business Manger
	Gavin Thomas, Governance Support Officer
APOLOGIES	Dafydd Vaughn, Independent Member
	Phillip Robson, ABHUB Vice Chair
	Tracy Daszkiewicz, Director of Public Health
	Seema Srivastava, Medical Director
	Polly Frazer. Aspiring Board Member

MHLD/0120/01	**Welcome and Introductions** The Chair welcomed everyone to the meeting.
	Apologies for Absence Apologies for absence were noted.
	Declarations of Interest

	The Chair asked if anyone had any Declarations of Interest pertaining to items on the agenda. There were no Declarations of Interest to note.
MHLD/0120/02	**Draft Minutes of 09 September 2025 Meeting** The minutes of the Mental Health and Learning Disabilities Committee held on 09 September 2025 were reviewed and agreed as a true and accurate record of the meeting. The Committee **APPROVED** the minutes.
MHLD/0120/03	**Committee Action Log** The Committee received the action log and was content with progress made in relation to completed actions and noted no outstanding actions. The Committee **NOTED** the action log.
MHLD/0120/04	**Review of Committee Programme of Business 2025/26** Rani Dash (RD), Director of Corporate Governance, provided the Committee with an overview of updates to the Committee forward workplan for 2025/26. The Committee **APPROVED** the updated Committee forward work plan and **NOTED** any updates would be brought forward to each future Committee meeting for oversight.
MHLD/0120/05	**Mental Health Act Compliance Report** The Committee received the Mental Health Act Compliance Report for the period July to October 2025. Sandra Mason (SM), Assistant Director of Mental Health & Learning Disabilities, introduced the report and confirmed that overall activity under the Mental Health Act had remained within expected variation for the quarter. SM reported that although detentions had been higher than average in some areas, no underlying causes had been identified. SM highlighted a 67% decrease in the use of

Section 4 detentions, attributed to improved availability of Section 12 approved clinicians and strengthened monitoring processes.

SM noted that Section 136 detentions continued to be higher than average, although repeat detentions had reduced. SM confirmed that work with multi-agency partners was ongoing to promote alternatives to Section 136 where clinically appropriate.

In addition, SM reported that Hospital Managers' Hearings had taken place regularly and that all previous backlogs had been cleared, with no overdue hearings in the reporting period. The Committee also noted a decrease in new Community Treatment Orders (CTOs), although overall numbers had remained higher than average.

Paul Deneen (PD), Independent Member, sought clarification on the sustained increase in Section 136 usage and requested reassurance that sufficient capacity existed to support individuals appropriately. Leanne Watkins (LW), Chief Operating Officer, outlined the ongoing work with police partners under the Right Care, Right Person approach, noting early improvements in alternative crisis pathways and clinical input through the "111 press 2" service. LW acknowledged that further development was required, particularly in relation to resources, workforce resilience, and geographical coverage.

PD raised further concerns about unlawful detentions and documentation errors, noting earlier improvements but a more recent rise. PD requested a deeper understanding of underlying causes and the impact of training for substantive and temporary staff.

ACTION: Chief Operating Officer

LW confirmed that training programmes were in place and that the division would continue to track performance through divisional assurance processes. SM agreed to work with departmental training leads to review errors, identify themes, and undertake further analysis, including consideration of locum and agency staff practice.

The Committee discussed the importance of timely scrutiny, the quality of medical documentation, and

	consistency in training attendance. The Committee emphasised the reputational and legal risks associated with errors and welcomed the proposed work to strengthen assurance. The Committee **NOTED** the report and the activity trends under the Mental Health Act.
MHLD/0120/06	**Mental Health Services related Performance and Outcomes, including Quality, Safety and Activity** Leanne Watkins (LW), Chief Operating Officer, introduced the report and highlighted the scale and complexity of activity across adult Mental Health and Learning Disability services. LW advised that, overall, performance against agreed trajectories had been maintained, with some areas demonstrating sustained improvement, while other areas remained challenging and required further transformation to ensure long-term sustainability. The Committee noted strong performance within primary mental health care services, supported by improved digital processes, including robotic process automation, which had reduced referral processing times and supported compliance. Recovery and care planning compliance had remained high, with continued focus on maintaining quality during planned transitions to new digital systems. In relation to psychological therapies, the Committee noted ongoing pressures on waiting times. LW advised that significant work was underway to review demand, map current provision and redesign service models to support earlier access and more sustainable delivery. LW acknowledged that this would require fundamental changes to workforce deployment and care pathways, and confirmed that this work would continue over the coming months. Amy Buckley (AB), Assistant Divisional Nurse, Mental Health and Learning Disabilities, presented the quality and patient safety elements of the report. The Committee noted significant progress in strengthening governance and assurance processes, including:

- the establishment of a divisional policy and control group to oversee policy development and implementation;
- improvements in clinical documentation quality, supported by regular audits and targeted feedback; and
- daily review of incidents and "safe to start" checks across inpatient areas, enabling timely escalation and learning.

AB advised that a revised Therapeutic Observation and Engagement Policy had been ratified, with a structured training programme underway. Interim arrangements had been implemented to ensure that temporary and agency staff were aware of expected standards.

In addition, the Committee noted focused improvement work relating to the management of deliberate self-harm, including the introduction of a seven-minute briefing to support consistent and compassionate practice. Early evidence had suggested improvements in documentation quality and incident management.

The Committee noted that complaint volumes had remained broadly consistent, with marked improvement in the management of overdue cases. AB reported that significant progress had been made compared to previous years, supported by clearer processes and improved support for clinical teams responding to concerns.

Patient feedback collected through formal systems had remained limited; however, it was acknowledged that alternative mechanisms were in place to capture positive feedback directly from service users and carers. The Committee agreed that triangulated sources of feedback provided a more representative picture of service quality.

In relation to safeguarding, the Committee noted improved collaboration with corporate safeguarding teams and a reduction in inappropriate safeguarding referrals, reflecting clearer guidance and enhanced professional judgement.

AB provided assurance regarding recent Healthcare Inspectorate Wales (HIW) inspections of Mental Health and Learning Disability services. Inspections had been generally positive, with no immediate actions required. Common themes for improvement had primarily related to estates and environmental issues. Staff feedback following inspections had been largely positive, with teams reporting that they felt supported and better prepared through inspection-readiness activity.

Sara Garland (SG), General Manager, Family and Therapies, presented the CAMHS performance update and advised that sustained compliance had been achieved against early intervention standards. Minor performance variation had been attributed to administrative issues, which had since been addressed.

Significant discussion focused on neurodevelopmental services, where demand had continued to increase. The Committee noted progress made through service transformation, including a move towards a needs-based model, improved engagement with families and schools, and the development of new digital resources to support parents and carers. Despite these improvements, the Committee acknowledged ongoing capacity pressures and the need for continued monitoring.

The Committee welcomed feedback indicating that schools and families had responded positively to clearer pathways and improved communication.

The Committee:

- **NOTED** the report and the overall position on performance, quality, safety and activity;

- **RECOGNISED** the significant improvement work undertaken across services;

- **ACKNOWLEDGED** ongoing challenges, particularly in psychological therapies and neurodevelopmental services; and

	• **AGREED** that further updates would be brought to future meetings on service transformation, national performance metrics and demand pressures.
MHLD/0120/07	**Restrictive Practice and Associated process Report** Amy Buckley (AB), Assistant Divisional Nurse, Mental Health and Learning Disabilities, presented the report and outlined the approach to restrictive practice, including physical restraint, chemical restraint, segregation and enhanced observations. AB advised that reducing restrictive practice had continued to be a key quality and patient safety priority across the division. The Committee noted that, within Learning Disabilities services, participation was underway in an all-Wales pilot requiring focused post-incident reviews of restrictive interventions recorded on Datix. Early feedback had indicated improved analysis and learning, although some data quality and completion issues were being addressed as part of the pilot phase. It was noted that, subject to national evaluation, the approach was intended to be rolled out more widely. In relation to adult mental health services, AB advised of the introduction of a Safety Pod within the Psychiatric Intensive Care Unit (PICU). This initiative aimed to support de-escalation and reduce the need for restrictive interventions. Early feedback from staff and service users had been positive, and formal evaluation of the pilot was ongoing. For older adult services, the Committee noted the implementation of the SafeWards model on a pilot ward. AB advised that SafeWards principles had been embedded to improve communication, strengthen therapeutic relationships and reduce conflict. Initial feedback had been encouraging, and further roll-out was being considered. The Committee noted the establishment of a divisional dashboard to provide daily oversight of enhanced levels of care across inpatient services. This dashboard had been reviewed through daily touchpoint meetings, enabling early identification of risk, improved escalation and consistent oversight of restrictive practices.

	AB further highlighted the role of revised policies and training in supporting safe and proportionate practice. The Committee noted that the Therapeutic Observation and Engagement Policy had been ratified and that training had been rolled out across services. Particular emphasis had been placed on trauma-informed care, proportionality and the use of restrictive interventions only as a last resort. The Committee welcomed the strengthened assurance processes, including thematic reviews of incidents, auditing of Positive Behaviour Support plans (particularly within Learning Disabilities services), and plans to introduce more regular triangulated reporting at divisional level. During discussion, the Committee commended the clarity of the report and the focus on continuous improvement. The Committee emphasised the importance of maintaining an appropriate balance between patient safety and the reduction of restrictive practices, noting the complexity of need within inpatient services. The Committee: • **NOTED** the report and the progress made in reducing and monitoring restrictive practices. • **AGREED** that further updates would be brought to future meetings on evaluation outcomes and wider implementation. **ACTION: Chief Operating Officer**
MHLD/0120/08	**Work undertaken to ensure inpatient safety of mental health units and the reduction of waits in the community** Leanne Watkins (LW), Chief Operating Officer, and Louise Turner (LT), Divisional Director of Mental Health and Learning Disabilities, advised that many of the key issues relating to inpatient safety and performance had already been covered under earlier agenda items, including discussions on performance, quality, safety and activity. LT reminded the Committee of the ongoing work aligned to national inpatient safety standards, including

	improvements in care planning, risk assessment, discharge processes and national reporting metrics. The Committee noted that further work was underway in collaboration with national teams and Welsh Government colleagues to clarify definitions and reporting requirements for inpatient safety metrics. This work aimed to ensure consistency, accuracy and alignment with national expectations. In relation to community waiting times, the Committee acknowledged that pressures had remained across several service areas and that work was ongoing to address demand, improve pathways and support more timely access to services. LT advised that this work had been closely linked to wider service transformation programmes, including psychological therapies and community-based models of care. Given the overlap with earlier discussions and the developing nature of the national work, it was agreed that a more detailed report would be brought back to a future Committee meeting once further progress had been made. The Committee **NOTED** the verbal update provided. **ACTION: Chief Operating Officer**
MHLD/0120/09	**Assurance Report in respect of Mental Capacity Act and DOLS** Tracey Partridge Wilson (TPW), Deputy Director of Nursing, presented the report to the Committee. TPW advised that significant progress had been made in embedding Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) principles into everyday practice across the Health Board. TPW reported that a tiered MCA training programme had been implemented, comprising Level 1 training for non-patient-facing staff, Level 2 training for patient-facing staff, and Level 3 workshops for registered clinicians. Training uptake had been strong, with positive feedback indicating improved staff confidence in applying MCA principles.

	The Committee noted that audit activity had demonstrated improvements in the quality of capacity assessments and best-interest decision-making, alongside improved engagement with legal services in complex cases. In relation to DoLS, it was reported that urgent authorisations had been used appropriately, and that proposals to strengthen assessor capacity had previously been presented to the Executive Committee. The Committee was advised that demand for DoLS assessments had remained high, reflecting national pressures, and that reliance on privately commissioned Section 12 assessments had continued to present cost and capacity challenges. Work had been underway to identify opportunities to make better use of existing clinical assessments to support decision-making and reduce reliance on external provision. The Committee noted ongoing improvement actions, including monitoring training compliance through ESR, delivering bespoke workshops for teams with lower uptake, embedding standardised MCA documentation templates within the Welsh Nursing Care Record, and strengthening links with safeguarding processes and mortality reviews. TPW further highlighted work to improve accessibility, including the use of easy-read formats and interpreter support. TPW further advised that, looking ahead, Mental Health officers had been actively engaged with the All-Wales MCA/DoLS network to align training and assurance arrangements and to prepare for the anticipated Liberty Protection Safeguards (LPS) consultation in 2026. The Committee was reassured that preparatory work had been underway to support future implementation once national requirements became clearer. Paul Deneen (PD), Independent Member, sought clarification on the inclusion of MCA considerations within mortality reviews and on plans to build internal assessment capacity. TPW confirmed that MCA compliance was now routinely considered as part of governance reviews and that further detail on assessment capacity could be brought back to the Committee if required.

	The Committee: • **NOTED** the Assurance Report and the progress made in strengthening MCA and DoLS compliance. • **ACKNOWLEDGED** the ongoing challenges associated with demand, backlog pressures and assessor capacity. • **SUPPORTED** the continued focus on training, audit and system improvements. • **AGREED** that further updates would be provided as national developments, including the LPS consultation, progressed. **ACTION: Chief Operating Officer**
MHLD/0909/10	**Power of Discharge Sub-Committee** Paul Deneen (PD), Independent Member, advised that the Sub-Committee had met in November 2025 and that the update was provided for information and assurance. PD explained that the Sub-Committee had continued to oversee the effective operation of Hospital Managers' powers of discharge and the associated governance arrangements. The Committee was informed that feedback from Associate Hospital Managers had been considered, alongside discussion on how discharge processes could be further strengthened. The Committee noted that the Sub-Committee had reviewed the most recent Mental Health Act Compliance information to support ongoing assurance and learning. PD reported that work had been underway to strengthen governance and oversight arrangements for Associate Hospital Managers, including proposals to introduce a more structured approach to individual review, appraisal and record-keeping. This was intended to ensure that training needs, performance and terms of office were clearly documented and monitored. Training requirements,

	including induction, refresher training and chairing skills, had also been discussed. The Committee noted the contribution of Mental Health Officers and support staff involved in the operation of the Sub-Committee and acknowledged the importance of the Sub-Committee's role in providing assurance on lawful and timely discharge decision-making. The Committee **NOTED** the update on the work of the Power of Discharge Sub-Committee.
MHLD/0909/11	**Items to be Brought to the Attention of the Board and Other Committees** The Committee considered items arising from the meeting that required escalation to the Board and/or other Committees for information, assurance or further scrutiny. The Committee **AGREED** that the following matters should be brought to the attention of the Board and relevant Committees: • **Mental Health Act developments**, including the forthcoming Mental Health Act Bill, with a detailed update to be scheduled for a future Committee meeting and subsequently escalated to the Board as appropriate. • **Right Care, Right Person** and associated crisis pathway developments, including sanctuary-type provision and the impact on mental health services, to be monitored and reported back. • **Psychological Therapies and Neurodevelopmental Services**, recognising sustained demand pressures and the need for continued Board-level awareness of service transformation and workforce implications. • **National mental health strategy and programme requirements**, including the cumulative impact of national data and assurance requests on operational services.

	• **Healthcare Inspectorate Wales (HIW) inspection findings**, particularly where estate and environmental issues were identified, to ensure wider organisational visibility and assurance. • **National Reportable Incidents (NRI)**, with a request for a deeper review of NRI processes and performance to be considered by the People, Quality and Safety Oversight Committee (PQSOC). • **Mental Capacity Act and Deprivation of Liberty Safeguards**, including preparation for the Liberty Protection Safeguards consultation, to remain under review and be escalated as national developments progressed. The Committee also requested that future reports presented to the Board and Committees include clear explanations of acronyms and terminology to support transparency and accessibility.
MHLD/0909/12	**Any Other Urgent Business** There was no urgent business.
MHLD/0909/13	**Date of the Next Meeting**:24 March 2026

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

Outstanding	Overdue: In Progress	Not Due	Completed	Transferred to another Committee

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
January 2026	**MHLD 2201/3.2**	Chief Operating Officer to provide a deep dive on documentation errors, including themes, causes, and training needs (especially relating to locum/agency staff)	Chief Operating Officer	**March 2026**	**Completed** and update captured in the Mental Health Act Compliance Report
January 2026	**MHLD 2201/3.2**	Chief Operating Officer to monitor and report back on Section 136 trends and the impact of the *Right Care, Right Person* approach.	Chief Operating Officer	**March 2026**	**Completed** and update captured in the Mental Health Act Compliance Report
January 2026	**MHLD 2201/3.2**	Chief Operating Officer to bring forward an update on training programme effectiveness to reduce	Chief Operating Officer / Committee Secretariat	**March 2026**	**Completed** and update captured in the Mental Health Act Compliance Report

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD
ACTION LOG

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
		unlawful and rectifiable errors.			
January 2026	**MHLD 2201/3.3**	Chief Operating Officer to provide the Committee with further updates on: Neurodevelopmental (ND) service pressures, needs-based pathways progress and Waiting list recovery work	Chief Operating Officer	**March 2026**	**In Progress -** A brief update is included in the performance section for the March meeting and the Committee Members will be aware of the wider Board discussions.
January 2026	**MHLD 2201/3.3**	Chief Operating Officer to develop quarterly reporting with triangulated data to strengthen oversight of Restrictive practices	Chief Operating Officer	**March 2026**	**In Progress** - A comprehensive update was given at the last meeting which was late January and there isn't a significant update. Propose that the Committee receive an update at the next committee together with the PMVA compliance.

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD
ACTION LOG

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
January 2026	**MHLD 2201/3.3**	Chief Operating Officer to ensure a more detailed update on inpatient safety work and related national metrics is brought to the next meeting.	Chief Operating Officer / Committee Secretariat	**March 2026**	**Complete –** The January report is included for information and we will in future include a slide as part of the performance update. MHLD IQPD - Inpatient metric...
January 2026	**MHLD 2201/5.2**	Committee Secretariat to schedule the Mental Health Act Bill update for the March Committee meeting	Committee Secretariat	**March 2026**	**Complete – Item added to FWP for March meeting**

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD
ACTION LOG

All actions in this log are currently active and are either part of the Committee's forward work programme or require more immediate attention, such as an update on the action or confirmation that the item scheduled for the next Committee meeting will be ready.
Once the Committee is assured that an action is complete, it will be removed. This will be agreed at each Committee meeting.

	CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: DATE OF MEETING:	24 March 2026
CYFARFOD O: MEETING OF:	Mental Health and Learning Disabilities Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Mental Health and Learning Disabilities Committee Forward Work Plan 2026/27
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Director of Corporate Governance
SWYDDOG ADRODD: REPORTING OFFICER:	Governance Support Officer

**Pwrpas yr Adroddiad
Purpose of the Report**

Ar Gyfer Penderfyniad/For Decision

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

The Mental Health and Learning Disabilities Committee is asked to consider the draft Committee Forward Work Plan appended to this report for approval. The Forward Work Plan has been developed with due regard to recommendations from the Committee Self-Assessment 2025-26 and to enable the Committee to: -

- Fulfil its Terms of Reference;
- seek assurance and provide scrutiny on behalf of the Board, in relation to those items identified within the Committees terms of reference, and,
- seek assurance that governance, risk, and assurance arrangements are in place and working well.

Cefndir / Background

The Mental Health and Learning Disabilities Committee supports the Board by providing assurance on the delivery of its aims and objectives, as set out in the Health Board's Standing Orders. In fulfilling this role, the Committee operates in accordance with the standards of good governance established for NHS Wales.

In line with good governance practice, the Mental Health and Learning Disabilities Committee has a Forward Work Plan that has been developed to ensure statutory requirements for items of Committee business are scheduled in across the year. The Forward Work Plan can therefore be utilised as a tool for

informing and pre-empting committee business and support the agenda setting process.

The Committee will support the Health Board in discharging its accountabilities and responsibilities for the achievement of the Health Board's objectives and organisational requirements in accordance with the standards of good governance determined for the NHS in Wales.

As appropriate, the Committee will advise the Board and the Accountable Officer (Chief Executive) on where and how its system of governance and assurance may be strengthened and further developed.

Where required, the Committee will provide accurate, evidence based (where possible) and timely advice to the Board in respect of citizen experience and the quality and safety of directly provided and commissioned services.

Asesiad / Assessment

The Committee is requested to approve the Committee forward work plan as outlined in **Appendix 1** noting that the work plan will be presented at each Committee meeting for oversight and noting.

Argymhelliad / Recommendation

The Committee is requested to:

RECIEVE and **APPROVE** the proposed Committee work plan and **NOTE** that it will be brought forward to each future Committee meeting for oversight

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item.

Amcanion cydraddoldeb strategol Strategic Equality Objectives [Strategic Equality Objectives 2020-24]	Choose an item. Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Choose an item. Choose an item. Not applicable to this report

Annual Programme of Business for 2026-27

Mental Health and Learning Disabilities Committee

This Annual Programme of Business has been developed with reference to:

- Aneurin Bevan University Health Board's Standing Orders;
- The Health Board's Integrated Medium-Term Plan and related Annual Delivery Plan;
- The outcomes of the Committee's self-assessment for 2025/26
- The Board's Strategic Risk Register; and
- Key statutory, national and best practice requirements and reporting arrangements.

Area of Focus as per Standing Orders:
The Mental Health and Learning Disabilities Committee will focus on all aspects of the Health Board's activities to contribute to the agreement of a strategic direction for mental health, learning disabilities and child and adolescent mental health services (CAMHS) in the areas of Gwent. The Committee's purpose is to monitor the effectiveness and efficiency of service delivery for mental health, learning disabilities and CAMHS services and identify areas for improvement; and monitor the appropriate delivery of the functions of Hospital Managers in response to Chapter 11 of the Mental Health Act 1983 (co-ordinated on behalf of the Committee by the Mental Health Act Managers Group). In respect of the achievement of the Boards' strategic aims, objectives and priorities, the Committee will seek assurance regarding: • arrangements for discharging its functions and meeting its responsibilities regarding mental health, learning disabilities and CAMHS issues and especially the Health Board's compliance with the Mental Health Act 1983, Mental Capacity Act 2005, Equality Act 2010 (where relevant) and associated legislative and statutory frameworks • arrangements for responding to the above legislation that this is being undertaken appropriately in accordance with its stated objectives and the requirements and standards determined for the NHS in Wales. In undertaking this work the Committee will have close liaison with other committees of the Board, especially the Patient Quality, Safety and Outcomes Committee • implementation of the National Dementia Standards within the health board.

MATTERS TO BE CONSIDERED (Report Title)	Lead	Frequency of Report	Schedule of Meetings			
			QTR 1 Apr to June 29/06/26	QTR 2 July to Sept 08/09/26	QTR 3 Oct to Dec 08/12/26	QTR 4 Jan to Mar 23/03/27
Preliminary Matters						
Attendance and Apologies	Chair	**SI**	✓	✓	✓	✓
Declarations of Interest	Chair	**SI**	✓	✓	✓	✓
Minutes of the Previous Meeting	Chair	**SI**	✓	✓	✓	✓
Committee Action Log	Chair	**SI**	✓	✓	✓	✓
Committee Governance						
Development of Committee Annual Programme of Business 2027/28	DoCG	**AN**				✓
Review of Committee Programme of Business 2026/27	DoCG	**SI**	✓	✓	✓	✓
Committee Annual Report 2026/27 • Annual Review of Committee Terms of Reference 2026/27 • Annual Review of Committee Effectiveness 2026/27 • Outcome of Annual Review of Committee Effectiveness 2026/27	DoCG	**AN**				✓

3

Committee Risk Report	DoCG	**SI**	✓	✓	✓	✓
Committee Core Business						
Mental Health Act Compliance Report	COO	**SI**	✓	✓	✓	✓
Power of Discharge (PoD) sub-Committee Update	PoD Chair	**SI**	✓	✓	✓	✓
Annual Benchmarking Report	COO	**AN**				✓
Right Care Right Person Presentation Update	COO	**AN**	✓			
Mental Health Services related Performance and Outcomes, including Quality, Safety and Activity	COO	**SI**	✓	✓	✓	✓
111 Press 2 Performance and Outcomes	COO	**AN**	✓			
Assurance in respect of Mental Capacity Act and DOLS	DON	**Bi-AN**	✓		✓	
Mental Health Estates Strategy	COO	**Bi-AN**		✓		✓
MH&LD Division: Staff Wellbeing & Engagement	COO	**AN**			✓	
Staff Security, including Violence and Aggression, specific to MH&LD Services staff	COO	**AN**			✓	
Assurance in respect of CAMHS Services	COO	**Bi-AN**		✓		✓
Assurance in respect of Dementia Standards	DoN	**Bi-AN**		✓		✓

MH&LD Divisional Risk Report	COO/ DoCG	**Bi-AN**		✓		✓
Mental Health Estates Strategy	COO		✓			
MENTAL HEALTH & LD DIVISION: IMTP Priorities						
Models of Care	COO	**AN**		✓		
Partnerships	COO	**AN**				✓
Quality Improvement	COO	**AN**		✓		
Workforce	COO	**AN**			✓	
Digital Transformation	COO	**AN**				✓

Lead Officer	
Key	
CEO	Chief Executive
DoCG	Director of Corporate Governance
DoF&P	Director of Finance & Procurement
DoSP&P	Director of Strategy, Planning & Partnerships
COO	Chief Operating Officer
DPH	Director of Public Health
DoT&HS	Director of Therapies & Health Science
DoW&OD	Director of Workforce & Organisational Development
DoN	Director of Nursing
MD	Medical Director
DOD	Director of Digital
HoQI	Head of Quality Improvement for MHLD
Chair	Chair

Frequency of Inclusion	
Narrative of Reason why Included in the FWP – other reasons to be developed as part of FWP discussions	
SI	Standing Item
An	Annual
1/4ly	Quarterly
BI	1/2 yearly
Schedule of Meetings	
√	Scheduled agenda item in FWP
D	Deferred from this agenda
√D	Deferred Scheduled agenda item
W	Withdrawn from FWP
T	Transferred to another Committee
IC	Matter discussed In Committee

Agenda Item:

	CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: DATE OF MEETING:	24 March 2026
CYFARFOD O: MEETING OF:	Mental Health & Learning Disability Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Mental Health Act Update Report Q3 2025-26
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Leanne Watkins, Chief Operating Officer
SWYDDOG ADRODD: REPORTING OFFICER:	Louise Turner, Divisional Director MH&LD

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The report provides activity information on the use of the Mental Health Act over Quarter 3, October – December 2025 and provides a comparison of activity over the previous quarter. Where available, other information sources will be used in order to highlight any trends, patterns or variation over time.

The report is presented to provide assurance to the Committee on the compliance with the legislative requirements of the Mental Health Act.

Cefndir / Background

This report provides assurance in respect of the work that has been undertaken by Mental Health and learning Disabilities (MHLD) Services during the quarter, that those functions of the Mental Health 1983 (the Act) which have been delegated to officers and staff, are being carried out correctly; and that the wider operation of the 1983 Act in relation to the Local Health Board's area is operating properly.

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The hospital managers must ensure that patients are detained only as the Act allows, that their treatment and care is fully compliant, and that patients are fully informed of, and are supported in exercising their statutory rights. Hospital Managers must also ensure that a patient's case is managed in line with other legislation which may have an impact, including the Human Rights Act 1998 and the Data Protection Act 1998.

The health board requires that a quarterly report to be submitted that summarises the work of the Mental Health Act department and identifies how it has fulfilled the duties required of it.

Asesiad / Assessment

This report is designed to provide information on trends and analysis of the use of the Mental Health Act and associated processes and to provide assurance to the Health Board that there are adequate governance arrangements in place to ensure the fair and lawful application of the act. The Mental Health and Learning Disabilities Division will continue to develop and refine the report as required.

The full quarterly report is attached, and identifies a number of themes for discussion, these are summarised below:

- General activity and detentions under the Act during this period were higher than previous quarters however this was in line with normal variation in activity between periods with no specific underlying reasons identified.

- There was 1 unlawful detention identified within this quarter. Both doctors gave their address as St. Cadoc's hospital on the medical recommendation forms. Section 12(3) of the Mental Health Act states that only one medical recommendation may be given by a registered medical practitioner that is on the staff of the hospital to which the admission is proposed. This type of error is rare but the Mental Health Act Administration have emailed staff to inform them of this scenario and the training programme updated to include this.

- Since the last quarter there has been a decrease in the number of rectifiable errors, from 15 in Q2 to 10 in Q3. Of the rectifiable errors recorded during this quarter, 4 required amendments to the recording of the patient's name, 3 required further information on the medical recommendation forms and 3 required amendments to the section of the HO14 which records whether the patient is an inpatient or outpatient of the hospital. There has been a consistent fall in rectifiable errors from 23 in Q3 2024/25 to 10 in Q3 2025/26 and although it is pleasing to note the decrease in errors, the training programme is at an early stage and therefore we continue to monitor the impact. The training programme is facilitated by an experienced MHA administrator around receipt and scrutiny of MHA documentation. Attendance is being closely monitored to ensure full compliance with all relevant staff, including agency

and locums to ensure consistent standards of Mental Health Act practice within the Health Board.

- The use of Section 136 has decreased by 22% in comparison to the previous quarter, a reduction in detentions from 126 to 98. However, this continues to be higher than the 5 year average of 88. The number of patients subject to repeat 136 detentions has decreased from 10 in Q2 to 7 in this quarter. The Adult Directorate continue to engage with multi agency partners to seek alternatives to detention.

  In respect of 136 detention trends, over the past 5 years the numbers have increased as follows.

	2021/22	2022/23	2023/24	2024/25	2025/26
Section 136	318	326	401	444	429*

  The implementation of RCRP is unlikely to have a significant impact on the number of 136 detentions as these would fall into the highest risk category, e.g. risk of harm to self or others, where police intervention would always be necessary. The impact of RCRP should be seen at the lower levels of risk, where the police may have attended in the past, is now addressed by other open access mechanisms, e.g. crisis intervention via 111#2 or urgent GP visits redirected to MHLD services.

  In terms of the general rise in 136 detentions over time, there are several factors which may affect this. These would be around the increase in drug and alcohol use where there are limited other alternatives to admission, particularly where there is non compliance with community treatment. The Health Board does not currently have alternatives to ward admission for this group of people.

  We about to introduce a mechanism to audit and monitor the number of 136 police consultations and outcomes, so that further analysis can take place in this area. Plans are also being developed to provide an outreach service as part of crisis intervention services as however, which may avoid escalation into the need for 136 detention. Other contributory factors that may lead to a Section 136 detention include the increasing number of individuals who are homeless, experiencing financial difficulties, and lacking adequate support.

- The number of CTOs continues to be higher than average, with 21 new CTOs recorded. This is an increase from 12 in the previous quarter. It is likely that the increase in Section 3 detentions is contributing to the higher CTO activity, as only patients detained under specific sections of the Mental Health Act, such as Section 3, are eligible for discharge on a CTO. This means that any upward trend in Section 3 admissions will naturally expand the pool of patients who can appropriately be considered for CTOs.

Training programme

The MHA office have implemented a new comprehensive training programme for Health Board staff. This training package includes face-to-face classroom-based training on the following aspects of the MHA:

- Scrutiny and completion of MHA detention documentation and process
- Staff roles and responsibilities under the act
- Overview of Tribunal process, documentation, legal timeframes and the Health Board responsibilities for the provision of reports and attendance at the tribunal
- Report writing for MH&LD staff, particularly for the preparation of medical and nursing reports for the tribunal and managers hearings
- CTO treatment order training, scrutiny of documents, legal responsibilities under the CTO framework, including 'right to recall' by the responsible clinician if the order needs to be revoked to a section 3.
- Consent to treatment training to ensure that the Health Board complies with MHA act in the detention process. This includes 2nd opinion doctor procedures.

The training program commenced August 2025, with 280 staff from all staff groups i.e. medical, nursing and OT attending in the last 7 months. Ward staff were the initial target to address the deficits highlighted by the errors in documentation, this has since been widened to include community staff.

There are 2 days of training per week, with the intention that a further c200 staff are trained in the 12-month period.

There are plans in place to expand training to include sessions on case law for responsible clinicians and registered nurses. This is addition to regular training on Care & Treatment planning and WAARN delivered by the training department.

The MHA office staff also take part in the MH&LD Divisional mock ward HIW process to highlight any areas where additional training is required. Staff are then encouraged to attend the training sessions to increase knowledge in each if the areas.

An audit tool is being developed by the MHA team to evaluate the quality of legal documentation in the clinical notes, with a report generated for each ward. This will generate a scoring system to highlight areas of practice that need to be improved with training provided to address any deficits in knowledge.

Argymhelliad / Recommendation

The Committee is asked to receive the information provided on the use of the Mental Health Act.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	Not applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2. Safe Care 4. Dignified Care 7.1 Workforce 6.2 Peoples Rights
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Not Applicable Not Applicable
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Not Applicable
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve the access, experience and outcomes of those who require mental health and learning disability services Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	The Mental Health Act (1983) Mental Health Act Code of Practice for Wales (Revised 2016)
Rhestr Termau: Glossary of Terms:	Included within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	N/A

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans;

	investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• **Workforce**	Choose an item.
• **Service Activity & Performance**	Not Applicable
• **Financial**	Not Applicable
Asesiad Effaith Cydraddoldeb **Equality Impact Assessment** (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Integration - Considering how the public body's well-being objectives may impact upon each of the well-being goals, on their objectives, or on the objectives of other public bodies Collaboration - Acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its well-being objectives

Report on the use of The Mental Health Act, 1983

October – December 2025

(Quarter 3)

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1. Introduction

This report provides information relating to the use of the Mental Health 1983 (the Act) within Aneurin Bevan University Health Board during Quarter 3, 2025/26. The purpose of the report is to ensure that the Mental Health Act 1983 is being carried out and operating properly within the health board.

2. Summary

There has been a combination of trends in quarter 3 2025/26. These have been summarised below:

- General activity and detentions under the Act during this period were higher than average, however this was in line with normal variation in activity between periods with no specific underlying reasons identified.

- There was 1 unlawful detention identified within this quarter. Both doctors gave their address as St. Cadoc's hospital on the medical recommendation forms. Section 12(3) of the Mental Health Act states that only one medical recommendation may be given by a registered medical practitioner that is on the staff of the hospital to which the admission is proposed. This type of error is rare but the Mental Health Act Administration have emailed staff to inform them of this scenario and the training programme updated to include this. Since the last quarter there has been a 33% decrease in the number of rectifiable errors, Of the 10 rectifiable errors recorded during this quarter, 4 required amendments to the recording of the patient's name, 3 required further information on the medical recommendation forms and 3 required amendments to the section of the HO14 which records whether the patient is an inpatient or outpatient of the hospital. There has been a consistent fall in rectifiable errors from 23 in Q3 2024/25 to 10 in Q3 2025/26 however although it is pleasing there is a drop in errors and are hopeful the training programme is having a positive impact it is too early to be sure. The training programme is facilitated by an experienced MHA administrator around receipt and scrutiny of MHA documentation. Attendance is being closely monitored to ensure full compliance with all relevant staff, including agency and locum to ensure consistent standards of Mental Health Act practice within the Health Board.

- The use of Section 136 has decreased by 22% in comparison to the previous quarter. However, it continues to be higher than average. No specific reasons have been identified for this. The number of patients having repeat 136 detentions has decreased from 10 in quarter 2 to 7 this quarter. The Adult Directorate are continuing to engage with the Police to seek alternatives to the 136 process for frequent attenders.

- The number of CTO's continues to be higher than average, with a 75% increase in new CTOs recorded between Quarter 2 and Quarter 3. Although no single underlying cause has been identified, the increase in Section 3 detentions is likely to contribute to higher CTO activity, as only patients detained under specific sections of the Mental Health Act, such as Section 3, are eligible for discharge on a CTO. This means that any upward trend in Section 3 admissions will naturally expand the number of patients who can be considered for CTOs

Use of the different sections are shown in the table below. These are in comparison to average numbers based over the previous 5 years (April 2020 – December 2025).

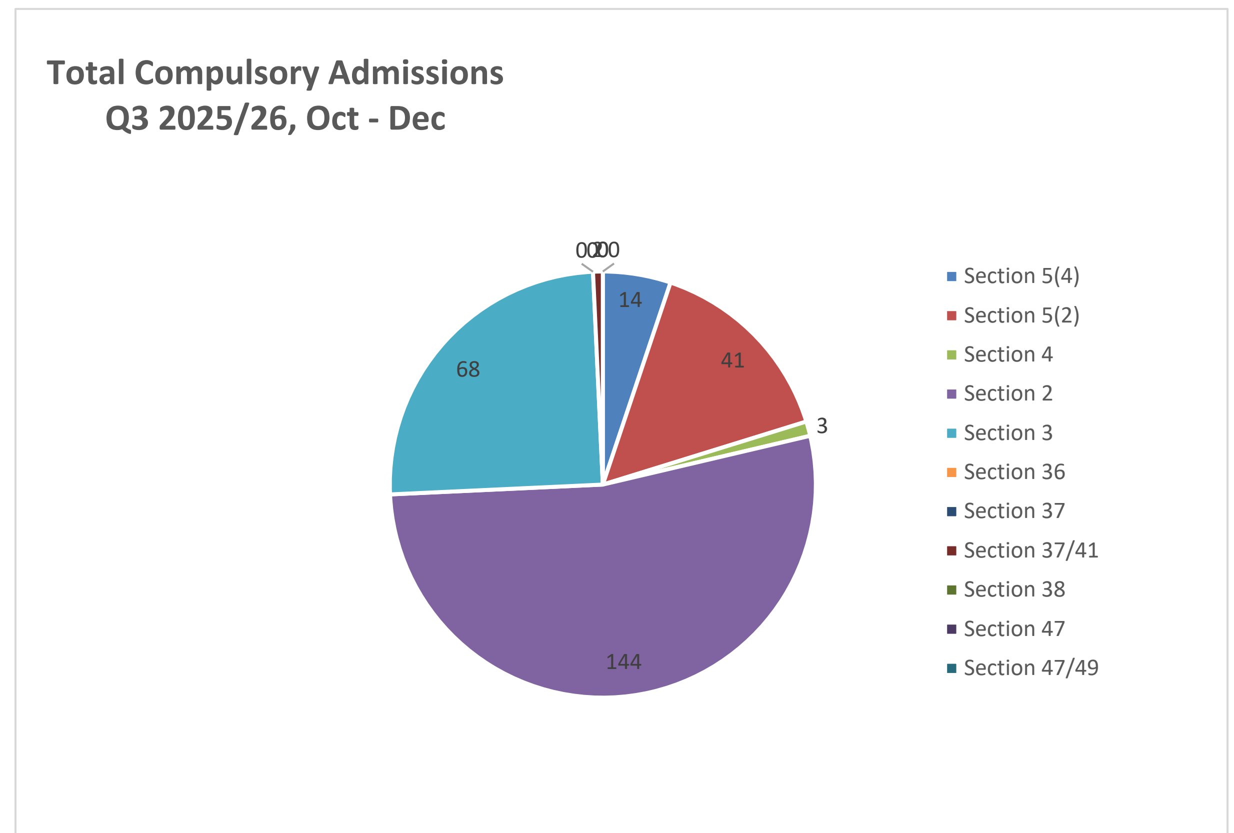
Section of MHA	Average per Qtr.	Qtr. 3	Trend	Notes
5(4)	10	14	↑	A higher-than-average use of these holding powers.
5(2)	32	41	↑	A higher-than-average use of these holding powers.
2	123	144	↑	A higher-than-average use of this section.
3	48	68	↑	A higher-than-average use of this section.
4	3	3	▬	An average number of patients were detained on Section 4 during the quarter.
17A (CTO)	7	21	↑	A higher-than-average number of CTO patients during the quarter.
135	4	3	↓	A slightly lower than average use of this section, however there are data completeness issues with the gathering of Section 135 data.
136	88	98	↑	A higher than average use of this section.

Part III	3	3	▬	An average number of Part III detentions.

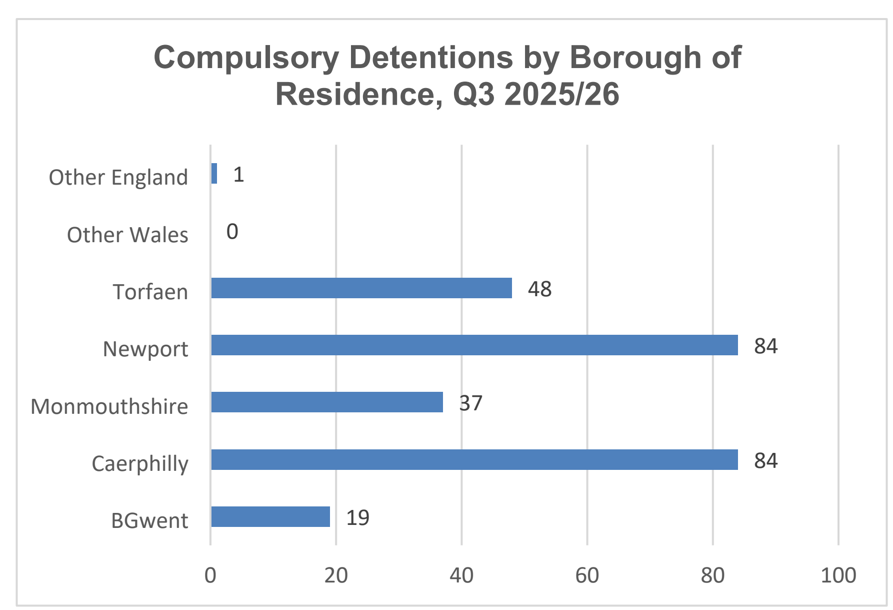
3. Findings and Information

3.1 Inpatient Mental Health Act Activity, Q3 2025/26

Data on the use of compulsory admission under the MHA by quarter is show below. The pie chart provides a high-level summary on the use of the Act by section across all ages/specialities in the Health Board.



A breakdown of all compulsory admissions by borough of residence of each patient is show below. This shows that there is some variation in the number of detentions by borough in comparison to population size. Caerphilly, Newport and Torfaen had the highest number of detentions per population.



Borough	Detentions Q3 2025/26	Population (000's)	Detentions per 1,000 population Q3 2025/26 (Previous Qtr.)
Caerphilly	84	176	**0.5 (0.3)**
Newport	84	163	**0.5 (0.5)**
Monmouthshire	37	94	**0.4 (0.4)**
Torfaen	48	93	**0.5 (0.4)**
Blaenau Gwent	19	67	**0.3 (0.3)**

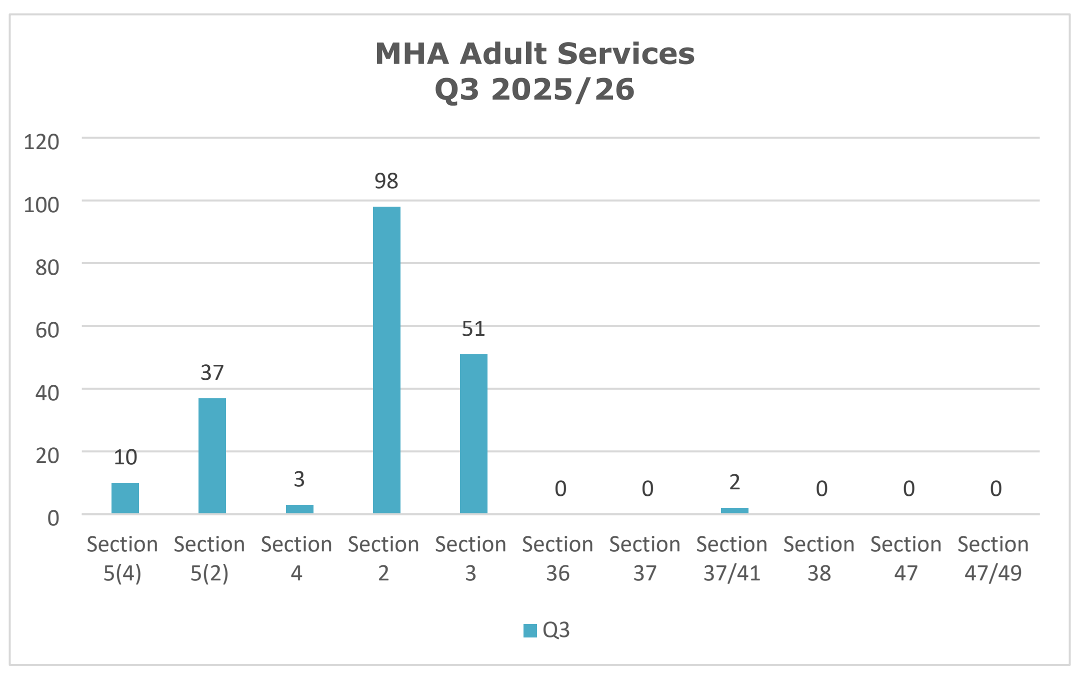
In comparison to the previous quarter these has been a 25% increase in the overall number of patients detained under the Act. Compared to the same quarter of last year (24/25) there has been a 24% increase.

Section	Q3 2024/25	Q4 2024/25	Q1 2025/26	Q2 2025/26	Q3 2025/26
Section 5(4)	14	9	11	4	14
Section 5(2)	33	31	35	35	41
Section 4	5	6	3	1	3
Section 2	124	140	122	122	144
Section 3	41	48	51	54	68
Section 35	0	0	0	0	0
Section 36	0	1	0	0	0
Section 37	1	0	0	1	0
Section 37/41	2	3	0	0	2
Section 38	0	0	0	0	0
Section 47	0	0	0	0	0

Section 47/49	0	0	0	0	0
Section 48	0	0	0	0	0
Section 48/49	0	0	0	1	1
TOTAL	**220**	**238**	**222**	**218**	**273**

3.1.1 MH Adult Compulsory Admissions under the MHA 1983

A breakdown of all compulsory admissions to mental health wards of all adults under 65 years of age is shown in the chart and table below. It can be seen that just under half (49%) of all admissions are under Section 2 (Assessment) of the MHA, with 25% of detentions under section 3 (Treatment) and 1% under Section 4. 23% of all adult detentions were under Section 5 of the Act. There was an overall increase (29%) in the number of detentions compared to the previous quarter.

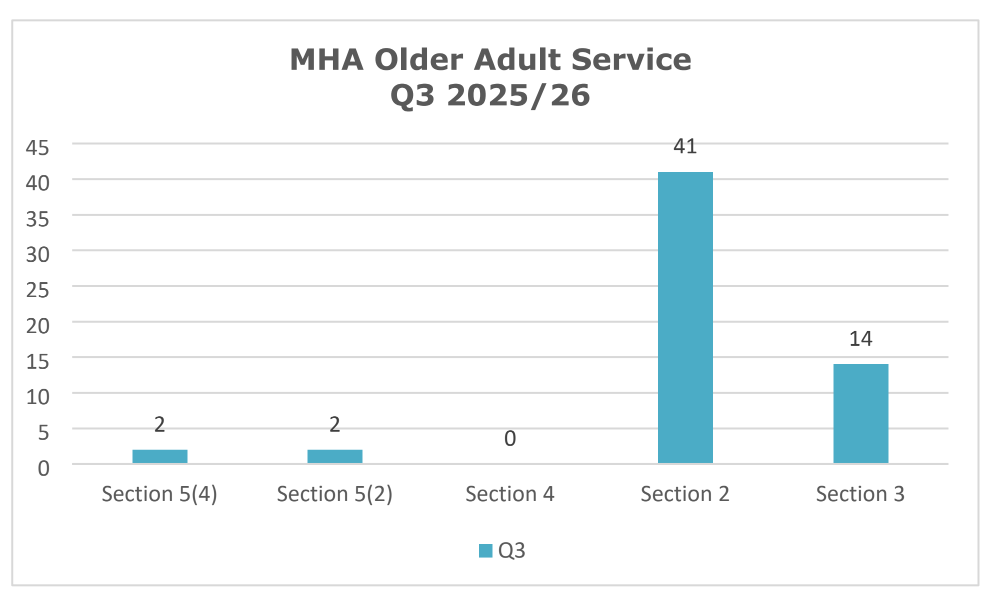


Section	Q3 2024/25	Q4 2024/25	Q1 2025/26	Q2 2025/26	Q3 2025/26
Section 5(4)	10	8	9	2	10
Section 5(2)	32	28	29	29	37
Section 4	3	4	3	1	3
Section 2	86	90	84	83	98
Section 3	23	35	40	40	51
Section 35	0	0	0	0	0
Section 36	0	1	0	1	0

Section 37	1	0	0	0	0
Section 37/41	2	3	0	0	2
Section 38	0	0	0	0	0
Section 47	0	0	0	0	0
Section 47/49	0	0	0	0	0
Section 48	0	0	0	0	0
Section 48/49	0	0	0	1	1
TOTAL	**157**	**169**	**165**	**157**	**202**

3.1.2 MH Older Adult Compulsory Admissions under the MHA 1983

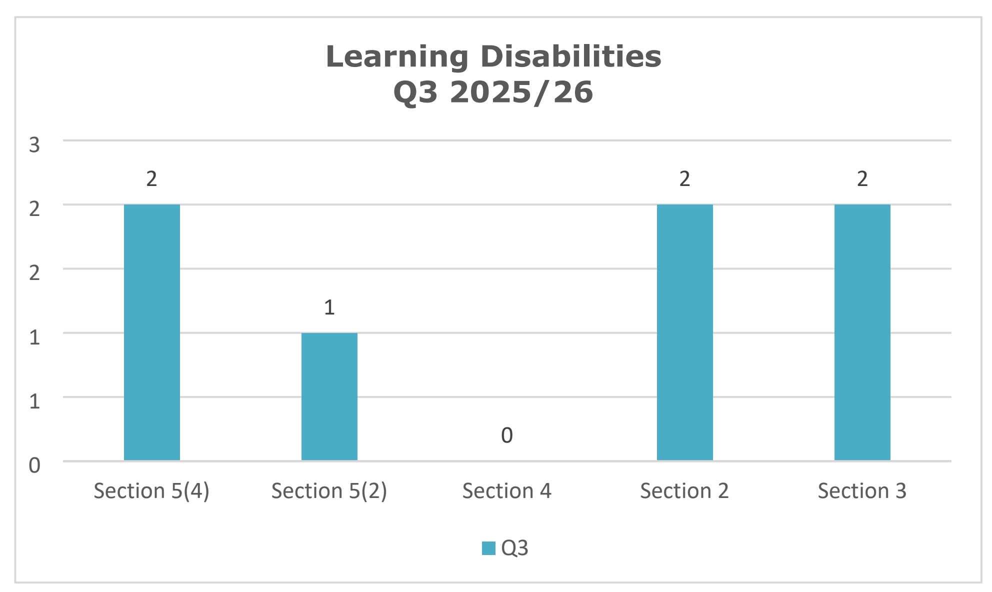
Within the older adult population patients admitted and detained, 93% were admitted under Sections 2 or 3 of the MHA with 6% admitted under Section 5 provision. There was an 18% increase in the number of detentions compared to the previous quarter.



Section	Q3 2024/25	Q4 2024/25	Q1 2025/26	Q2 2025/26	Q3 2025/26
Section 5(4)	4	1	2	1	2
Section 5(2)	1	3	3	5	2
Section 4	2	2	0	0	0
Section 2	33	45	34	30	41
Section 3	18	11	8	14	14
TOTAL	**58**	**62**	**47**	**50**	**59**

3.1.3 Learning Disabilities Compulsory Admissions under the MHA 1983

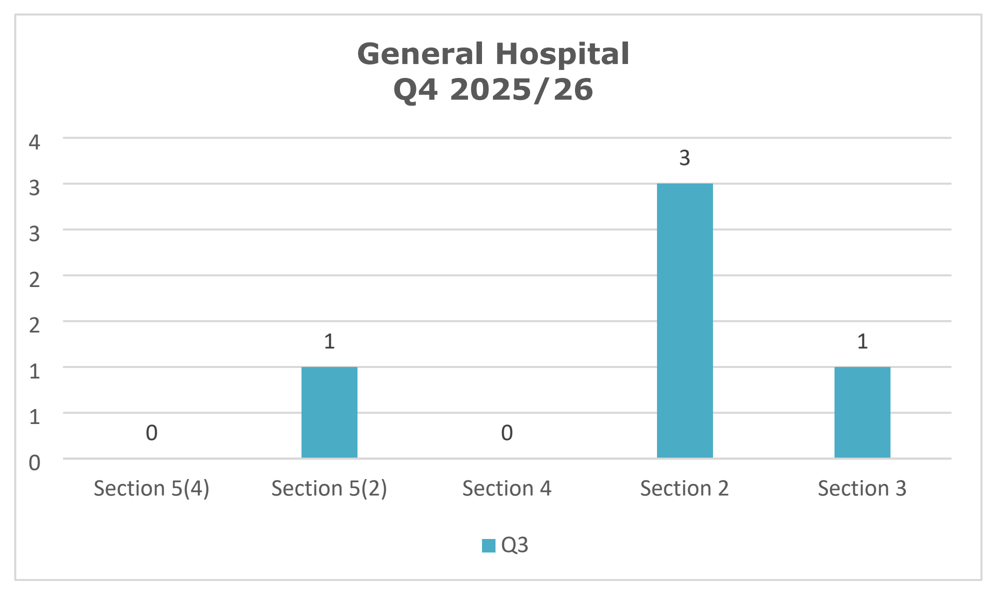
For individuals with a learning disability requiring admission under the MHA, 57% were admitted under Sections 2 or 3 of the MHA with 43% admitted under Section 5 provision. There was a 133% increase in the number of detentions compared to the previous quarter.



Section	Q1 2024/25	Q4 2024/25	Q1 2025/26	Q2 2025/26	Q3 2025/26
Section 5(4)	0	0	0	1	2
Section 5(2)	0	0	0	1	1
Section 4	0	0	0	0	0
Section 2	2	3	2	1	2
Section 3	0	2	2	0	2
TOTAL	**2**	**5**	**4**	**3**	**7**

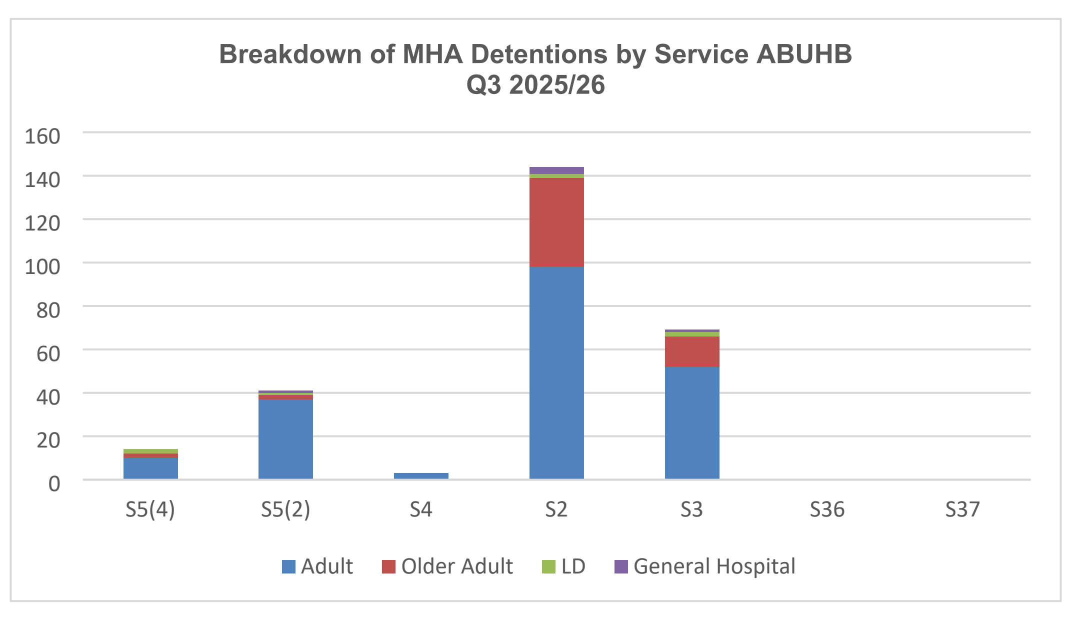
3.1.4 General Hospital Compulsory Admissions under the MHA 1983

For patients detained under the MHA in a General Hospital setting, 80% were admitted under Sections 2 or 3 of the MHA with 20% admitted under Section 5 provision. There was an overall 44% decrease in the number of detentions compared to the previous quarter.



Section	Q3 2024/25	Q4 2024/25	Q1 2025/26	Q2 2025/26	Q3 2025/26
Section 5(4)	0	0	0	0	0
Section 5(2)	0	0	3	0	1
Section 4	0	0	0	0	0
Section 2	3	2	2	8	3
Section 3	0	0	1	1	1
TOTAL	**3**	**2**	**6**	**9**	**5**

The below chart shows the total number of MHA detentions broken down by service for quarter 3, 2025/26.

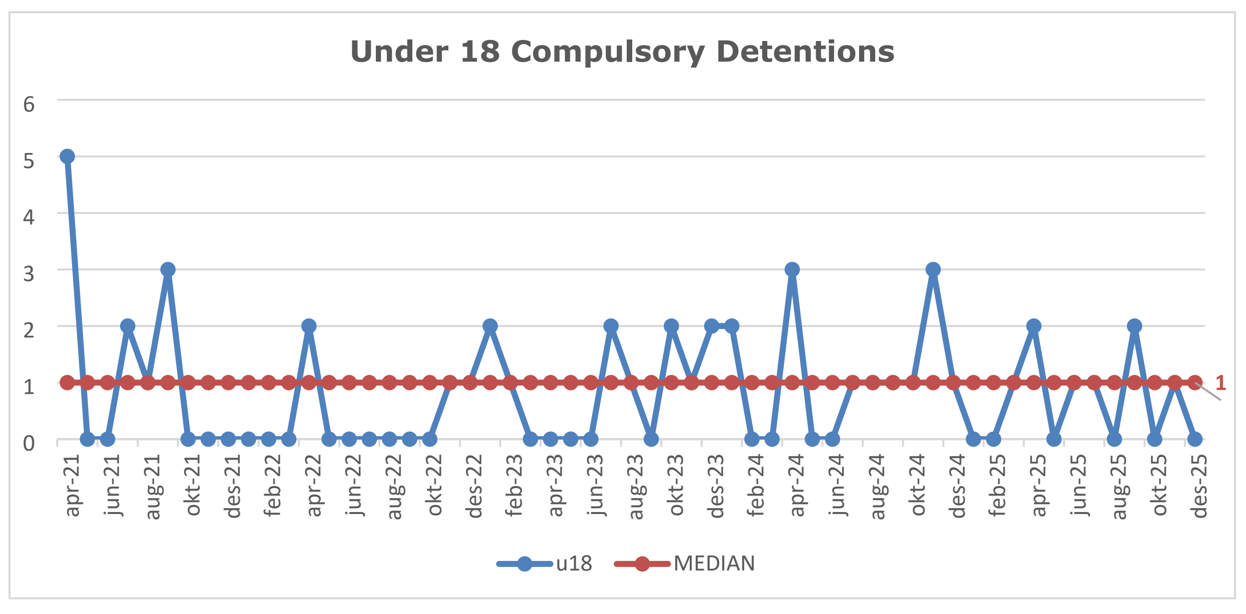


3.1.5 Total Number of Under 18s Compulsory Admissions under the MHA 1983

Within Aneurin Bevan there is no dedicated Children and Young Persons CAMHS inpatient provision. Access to emergency provision for a bed in Ty Cyfannol extra care area for up to 72 hours is provided locally for 16–17-year-olds, with younger patients normally being admitted to a paediatric ward if necessary.

There was an overall 67% decrease in the number of detentions compared to the previous quarter.

Under 18 years Detentions	Q3 2024/25	Q4 2024/25	Q1 2025/26	Q2 2025/26	Q3 2025/26
Section 5(4)	1	0	0	0	0
Section 5(2)	1	0	0	0	0
Section 2	3	1	2	2	1
Section 3	0	0	1	0	0
CTO	0	0	0	1	0
TOTAL	**5**	**1**	**3**	**3**	**1**



A higher number of admissions is a safety concern due to the limitations of the environment on a busy adult acute ward. Where there is an increase in Under 18 detentions under the MHA this is highlighted and escalated to the

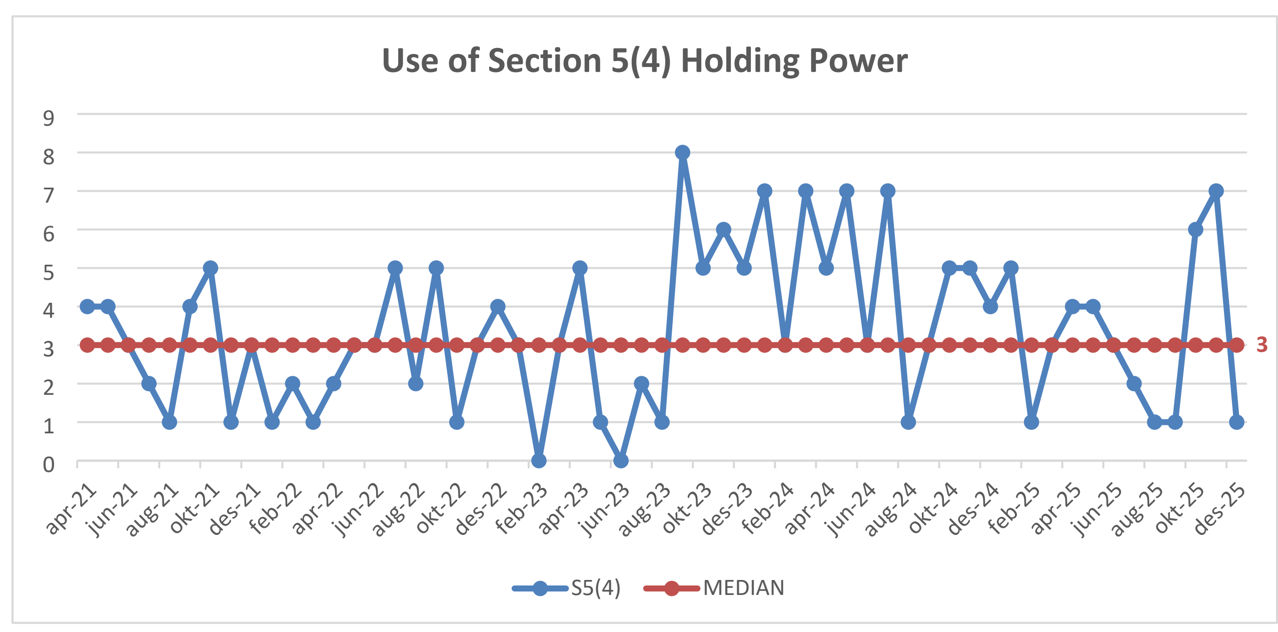
CAMHS and Adult senior lead nurses. Access to CAMHS specialist inpatient provision has also been escalated to Welsh Government previously. The MHA Administration Department monitors the trends on a regular basis.

3.2 Trend Analysis of the main compulsory admissions across all services from April 2021 to December 2025

This section briefly highlights any trends noted in the use of the Mental Health Act.

3.2.1 Section 5 – Holding Powers

- increase compared to the previous quarter. This increase is significant and currently being monitored by the Mental Health Act administration
- 71% of these resulted in a doctor/approved clinician detaining the patient under Section 5(2).
- 7% of these resulted in the patient being detained under section 2.
- 21% of these lapsed without Section 5(4) is used by mental health and learning disabilities nurses in mental health in patient settings for up to 6 hours to allow for a further assessment to take place.
- There were 14 uses of this holding power over the quarter. This is a 250% further detention under the MHA.



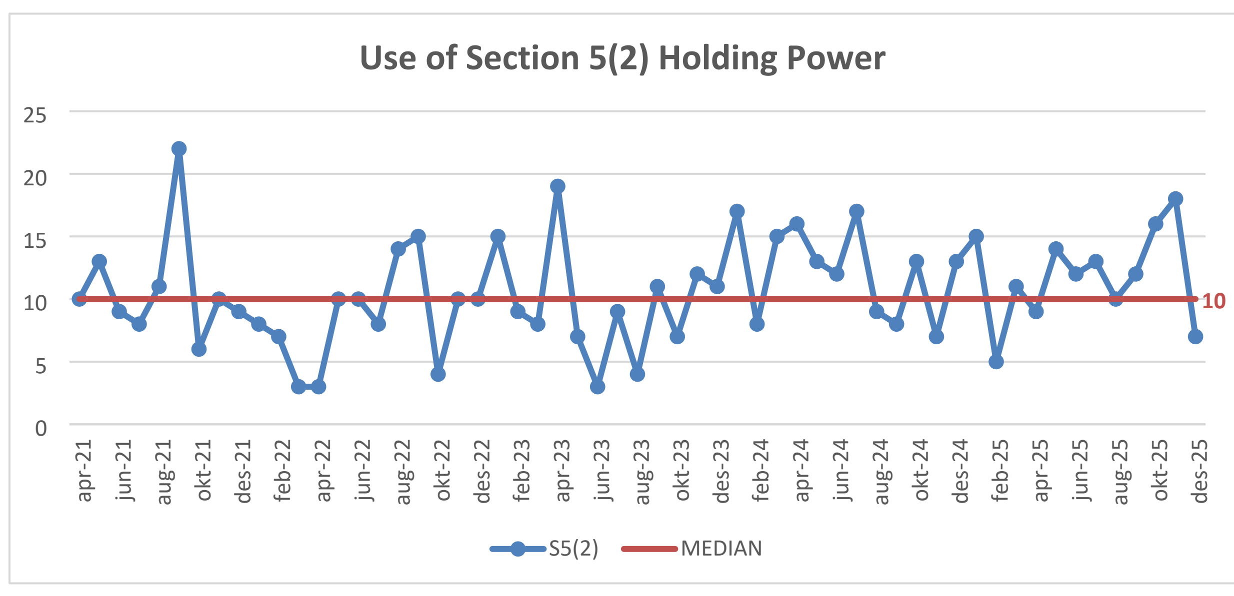
Outcome of Section 5(4) – Q3 2025/26

Outcome	Total
Lapsed	3
Ended	0
Section 5(2)	10
Section 2	1

Section 3	0
Total	**14**

Section 5(2) is used by doctors in both mental health and general hospital settings to detain an in-patient for up to 72 hours to allow for a mental health act assessment to take place.

- There were 41 uses of this holding power over the quarter. This is a 17% increase compared to the previous quarter.
- 54% of these resulted in the patient being detained under section 2.
- 7% of these resulted in the patient being detained under section 3.
- 39% of these ended or lapsed without further detention under the MHA. Although not unlawful to allow the detention to lapse it is not good practice, this is being monitored by Mental Health Act Administration and any increase will be reported to Senior Management.



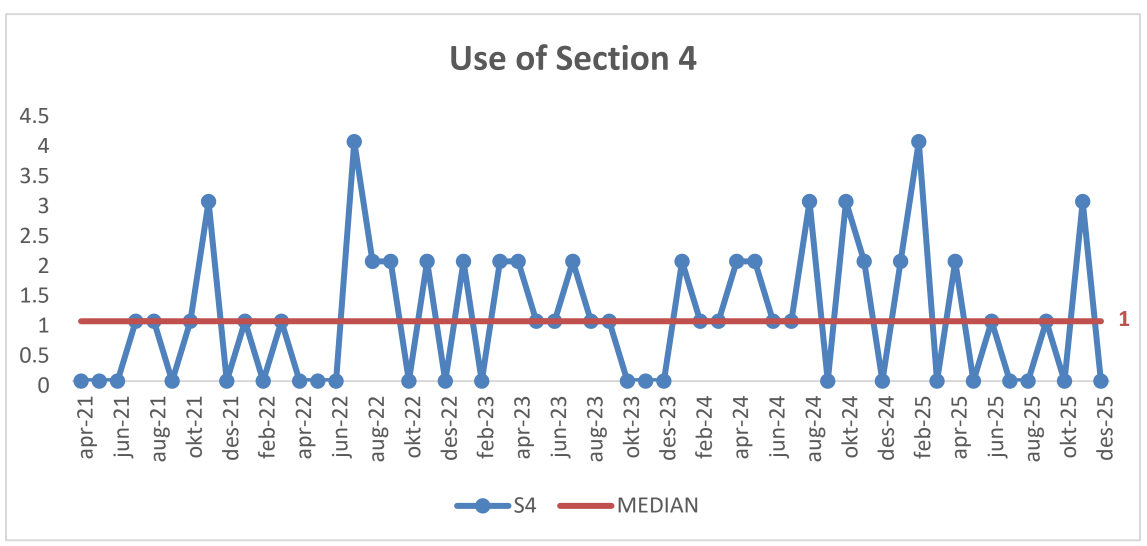
Outcome of Section 5(2) – Q3 2025/26

Outcome	Total
Lapsed	4
Ended	12
Section 2	22
Section 3	3
Total	**41**

3.2.2 Section 4 – Admission for Emergency

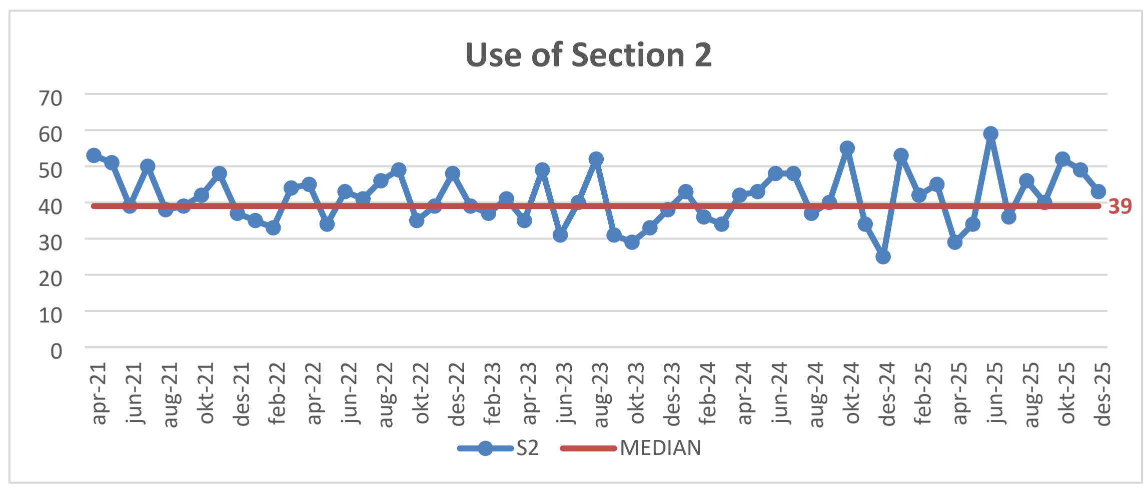
The use of section 4 can be made on the basis of a single medical recommendation supported by the AMHP application and is used when admission to hospital is urgent and it would be unsafe to wait for a second medical recommendation for admission under section 2.

- Section 4 was used on 1 occasion during this quarter. This is a 200% increase compared to the previous quarter.
- All uses of section 4 this quarter were proportionate and reasonable in the circumstances.
- 100% of section 4 admissions were converted to section 2 within 24 hours of admission to hospital.



3.2.3 Section 2 – Admission for Assessment

The use of section 2 provides for someone to be detained in hospital for assessment and treatment of their mental disorder.



- A total of 144 detentions were made using section 2 in this quarter. This is above the quarterly average (based on the past 5 years) of 123. Whilst there is some variance month to month and quarter to quarter, the use of section 2 is consistently within expected controls. This is an increase of 18% in comparison to the previous quarter. Although this could be a normal variation, the increase in the use of this detention will be monitored by the Mental Health Act Administration and any trends will be reported to Senior Managers
- These accounted for 53% of all detained admissions.
- 68% of these were in adult mental health services.
- 28% of these were in older adult mental health services.
- 2% of these were within a general hospital setting.
- 1% of these were within the learning disabilities service.

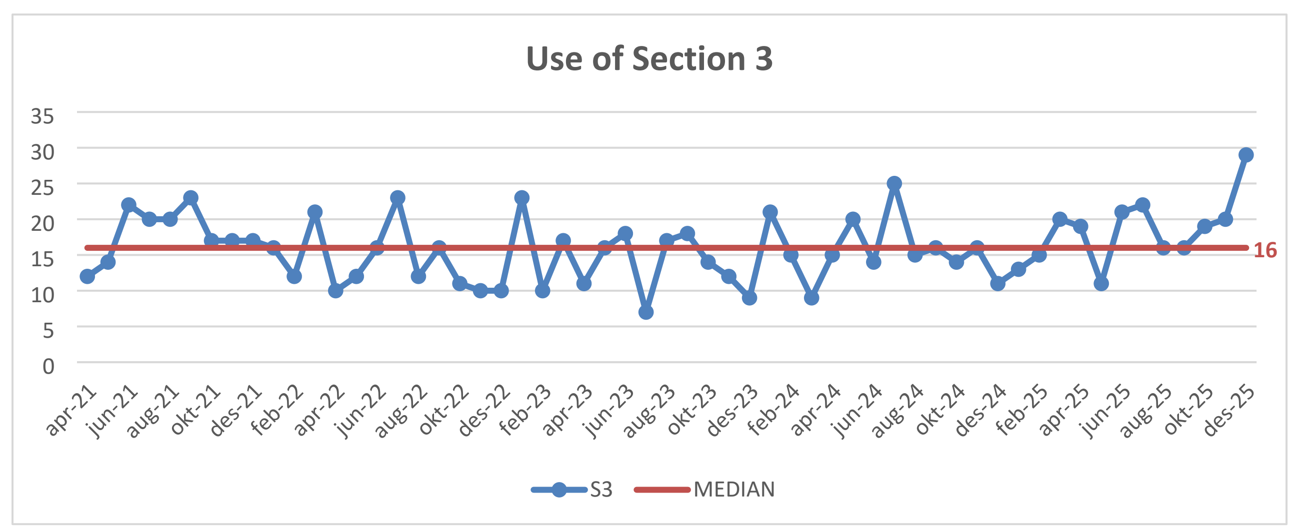
Outcome of Section 2, Q3 2025/26

Outcome	**Total**
Expired	5
Regraded S3	40
Transferred	5
Deceased	0
Ended: 0-3 days	7
Ended: 4-14 days	32
Ended: 15-28 days	55
Total	**144**

- During this quarter 3% of section 2 detentions were allowed to lapse. It is considered poor practice to allow a section 2 to lapsed as it raises the question whether the patient met the criteria to be discharged at an earlier stage of the detention. Where detentions are allowed to lapse the MHA Administration Department highlights this issue to the relevant medical and ward staff. The Mental Health Act Administration have included this scenario within the training programme.

3.2.4 Section 3 – Admission for Treatment

The use of section 3 provides for someone to be detained in hospital for treatment of their mental disorder.



- A total of 68 detentions were made using section 3 in this quarter. This is higher than the quarterly average (based on the past 5 years) of 48. Whilst there is some variance month to month and quarter to quarter, the use of section 3 is consistently within expected controls. There has been a significant increase of Section 3 detentions, there does not seem to be any reason for this but the Mental Health Act Administration are recording and monitoring activity around the use of this detention.
- These accounted for 25% of all detained admissions. This is an increase of 26% in comparison to the previous quarter.
- 75% of these were in adult mental health services.
- 21% of these were in older adult mental health services.
- 3% of these were within the learning disabilities service.
- 1% of these were within a general hospital setting.

Outcome of Section 3, Q3 2025/26

Outcome	Total
Expired	0
Ended	29
Regraded-CTO	6
Renewed	0
Transferred	2
Deceased	0
Ongoing (as of 26/02/2026)	31
Total	**68**

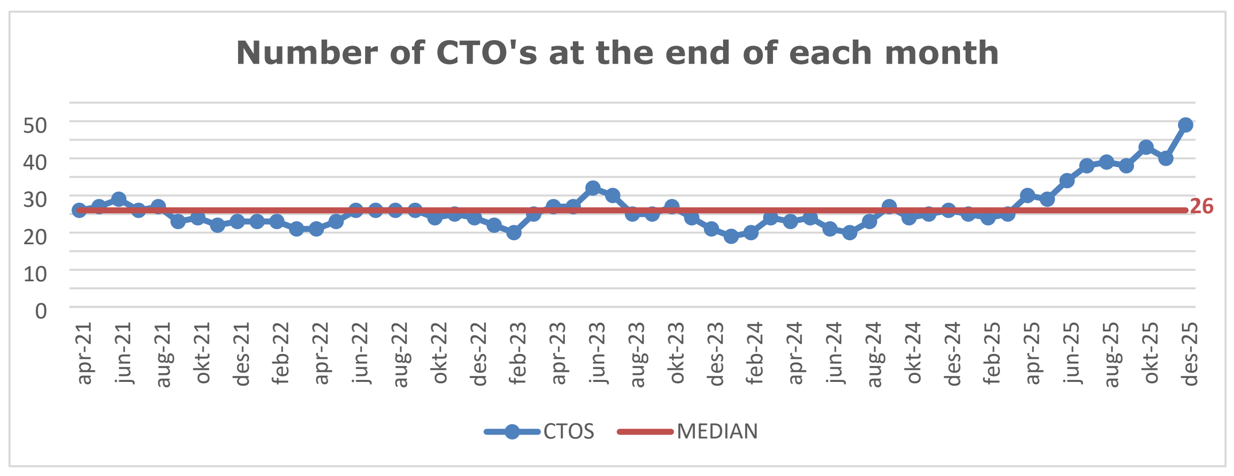
3.2.5 Renewal of In-patient Detentions under the MHA 1983

The table below shows that the number of renewals of inpatient detentions has increased by 57% in comparison to the previous quarter.

Section	Q3 2024/25	Q4 2024/25	Q1 2025/26	Q2 2025/26	Q3 2025/26
Section 3 renewal	13	9	9	7	11
Section 37 renewal	1	1	1	0	0
Section 47 renewal	0	0	0	0	0
TOTAL	**14**	**10**	**10**	**7**	**11**

3.2.6 Section 17A – Community Treatment Orders

There were 49 Community Treatment Orders in place as at 31st December 2025.



A summary of the use and changes to Community Treatment Orders can be seen in the below chart.

Power	Q3 2024/25	Q4 2024/25	Q1 2025/26	Q2 2025/26	Q3 2025/26
CTOs made	7	6	15	12	21
CTOs extended	8	7	5	4	12
Recalled to hospital and not admitted	2	0	1	6	1
Recalled to hospital and revoked	3	5	4	4	5
Discharged from CTO	5	2	2	4	5

3.3 Unlawful Detentions and Errors

A brief summary of unlawful detentions, section papers that failed medical scrutiny and sections papers with rectifiable errors during the quarter is provided below.

3.3.1 Unlawful detentions

There was 1 unlawful detention identified within the quarter. Where errors are identified the Mental Health Act Administration office will immediately inform the Mental Health Act Team Manager and the ward/clinical team who will inform the patient and the clinical team will determine the appropriate next steps such as undertaking a new assessment. A DATIX will also be completed to ensure the incident is investigated and best practice.

	Q3 2024/25	Q4 2024/25	Q1 2025/26	Q2 2025/26	Q3 2025/26
Unlawful Detentions	**3**	**1**	**3**	**2**	**1**

- Invalid Section 3 – Both doctors gave their address as St. Cadoc's hospital on the medical recommendation forms. Section 12(3) of the Mental Health Act states that only one medical recommendation may be given by a registered medical practitioner that is on the staff of the hospital to which the admission is proposed.

3.3.2 Failed Medical Scrutiny

The Health Board has 14 days to undertake medical scrutiny of section papers. Where medical scrutiny identifies that further information is required the papers are returned to the doctor who completed the assessment highlighting what further information is required and returned within the 14-day period.

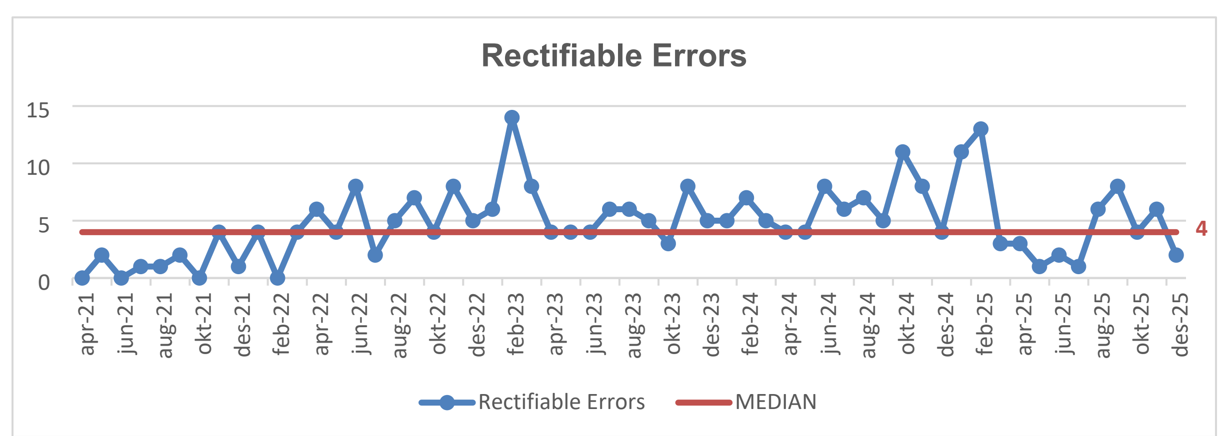
	Q3 2024/25	Q4 2024/25	Q1 2025/26	Q2 2025/26	Q3 2025/26
Failed Medical Scrutiny	**0**	**2**	**1**	**0**	**2**

3.3.3 Rectifiable Errors on Documents

Rectifiable errors are considered a 'slip of a pen'. Section 15 of the Mental Health Act allows for any documents containing rectifiable errors to be amended by the professional who completed the form within 14 days of the date the person was admitted onto a section. Common rectifiable errors include names not stated in full, misstating of places including hospitals and patients addresses, names or places being inconsistent, spelling errors, nearest relative address missing and deletions not being completed.

There has been a 33% decrease in the number of rectifiable errors this quarter. Despite this there is evidence of a continued need for training around the receipt and scrutiny of MHA documentation. The MHA Administration Department are currently conducting training sessions around this with attendance being closely monitored to ensure all staff attend the training.

	Q3 2024/25	Q4 2024/25	Q1 2025/26	Q2 2025/26	Q3 2025/26
Rectifiable errors on document	**23**	**27**	**26**	**15**	**10**



3.4 Use of Police Powers Sections 135 & Section 136

3.4.1 Section 135 – Warrant to search and remove person

Section 135 empowers a magistrate to authorise a police constable to remove a person lawfully from private premises to a place of safety.

Section 135 is split into two categories as follows:

- Section 135(1) warrant applied for by an AMHP (the local authority) if reasonable cause to suspect that a person is suffering from a mental disorder.
- Section 135(2) warrant by any constable or other person authorized (*will generally be a health professional)*) to remove someone already liable to be detained and remove to a place they are meant to be.

- There are data completeness issues with the compilation of section 135 data. The MHA Administration department has confirmed that the above data is not complete and has been unable to capture the true activity information for the data periods due to not receiving all copies of executed Section 135 warrants. There are on-going inter-agency

discussions between Health, Local Authorities and Gwent Police to ensure that all Section 135 activity is correct and is collected in a timely manner.

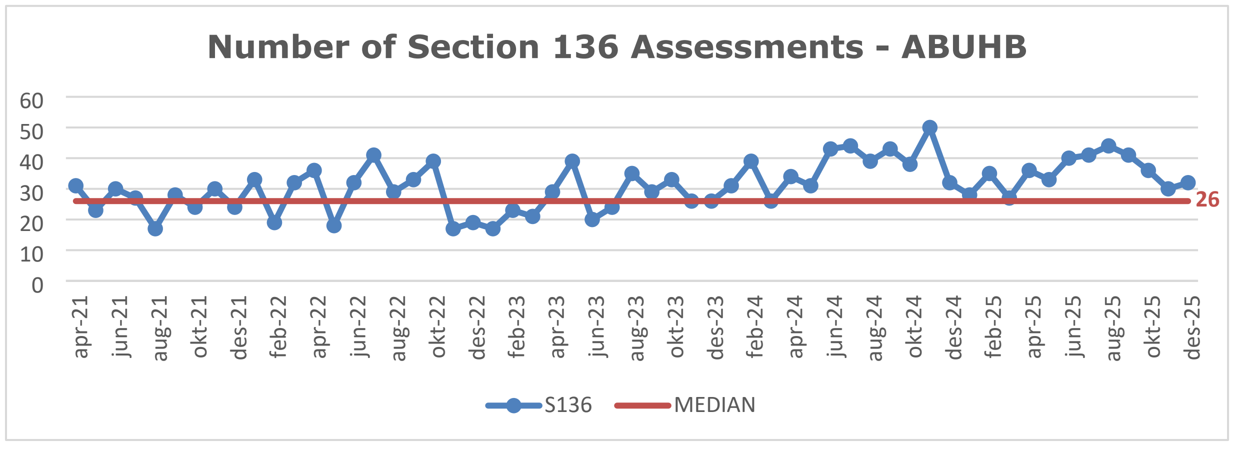
- The table below provides a summary of all available data. This includes both Section 135(1) and Section 135(2).

Section 135 of the MHA	Q3 2024/25	Q4 2024/25	Q1 2025/26	Q2 2025/26	Q3 2025/26
Assessed and admitted informally	0	0	0	0	0
Assessed and discharged	0	0	1	0	0
Assessed and detained under Section 2	2	5	1	3	3
Assessed and detained under Section 3	1	1	1	0	0
Assessed and CTO Revoked	0	1	0	0	0
Other	0	0	0	0	0
Total	**3**	**7**	**3**	**3**	**3**

3.4.2 Section 136 – Removal of Mentally Disordered Persons to a Place of Safety

Section 136 of the Mental Health Act, 1983 empowers a police officer to remove any person appearing to be suffering from mental disorder and in immediate need of care and control from a public place to a place of safety.

A breakdown on the number of 136 assessments undertaken at the 136 Suite (Place of Safety) at St Cadoc's Hospital is shown in the table below.

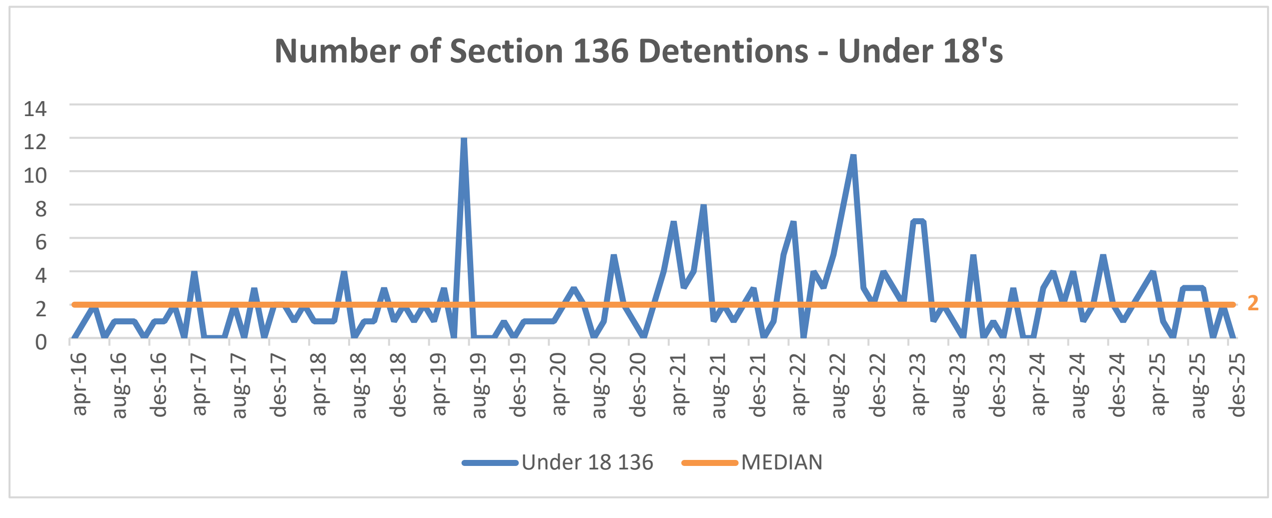


- A total number of 98 assessments took place in quarter 2. This is a 22% decrease on the previous quarter; however, this is still above the quarterly average (based on the past 5 years) of 88.

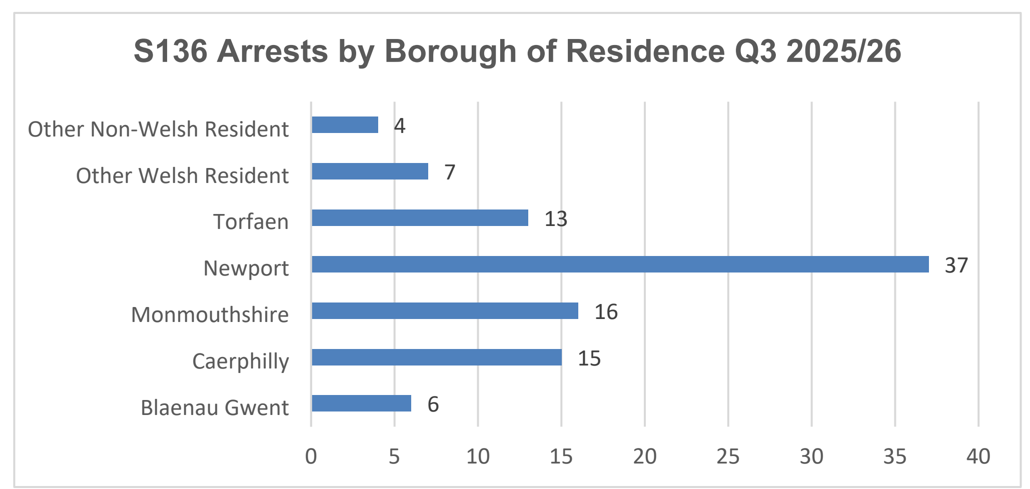
A breakdown of the outcome of 136 assessments is shown in the table below.

Section 136 of the MHA	Q3 2024/25	Q4 2024/25	Q1 2025/26	Q2 2025/26	Q3 2025/26
Assessed and admitted informally	22	11	14	26	7
Assessed and detained under Section 2	21	16	26	33	35
Assessed and detained under Section 3	0	2	1	0	2
Assessed and detained under Section 4	1	0	0	0	0
Discharged – no follow-up required	29	23	32	25	28
Assessed and Recalled under CTO	0	0	0	0	0
Discharged – with follow-up plan	46	38	36	40	24
Section 136 lapsed	1	0	0	3	2
TOTAL	**120**	**90**	**109**	**126**	**98**

A breakdown of the number of under 18's undergoing 136 assessment is shown in the graph below.



A breakdown of assessed patients by borough shows that Newport and Caerphilly had higher demand than other boroughs, together accounting for 60% of all assessments.

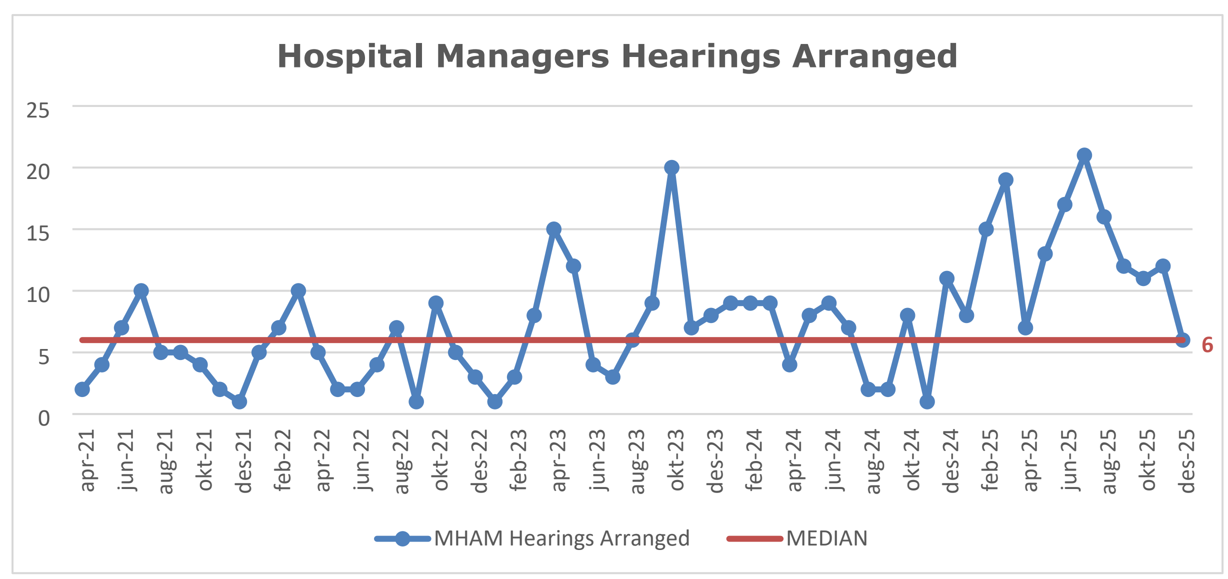


A breakdown of all 98 events shows that the majority of patients were male patients; alcohol and/or drugs being a related factor in 37% of all cases; 2% of cases were under the age of 18yrs. No assessments were undertaken at a police station.

Section 136 of the MHA	**Q3 2024/25**	**Q4 2024/25**	**Q1 2025/26**	**Q2 2025/26**	**Q3 2025/26**
TOTAL	**N=120**	**N=90**	**N=109**	**N=126**	**N=98**
Gender:					
% Male	45%	56%	46%	40%	57%
% Female	55%	44%	48%	59%	42%
% Other	-	-	6%	1%	1%
Place of Safety:					
% Hospital	100%	100%	99%	100%	100%
% Police Station	0%	0%	1%	0%	0%
% Under 18 Years	8%	7%	5%	7%	2%
Use of Illicit Substances:					
% Alcohol	20%	24%	21%	14%	24%
% Drugs	9%	9%	12%	14%	4%
% Both Alcohol and Drugs	8%	4%	5%	3%	8%
Where Assessment took place:					
% Hospital	99%	100%	100%	98%	98%
% Police Station	0%	0%	0%	0%	0%
12 Hour extension required /granted	1%	2%	3%	1%	1%

3.5 Mental Health Act Managers Hearings

A Managers hearing is required to be held before every renewal of detention or extension of CTO. The Code of Practice for Wales states that 'if a responsible clinician does not hold a review period the period of detention or CTO expires, this should be considered a very serious matter to be urgently reviewed". Patients and their Nearest Relatives can also apply to choose to appeal their detentions.



A summary of activity and outcome of hearings is provided in the table below.

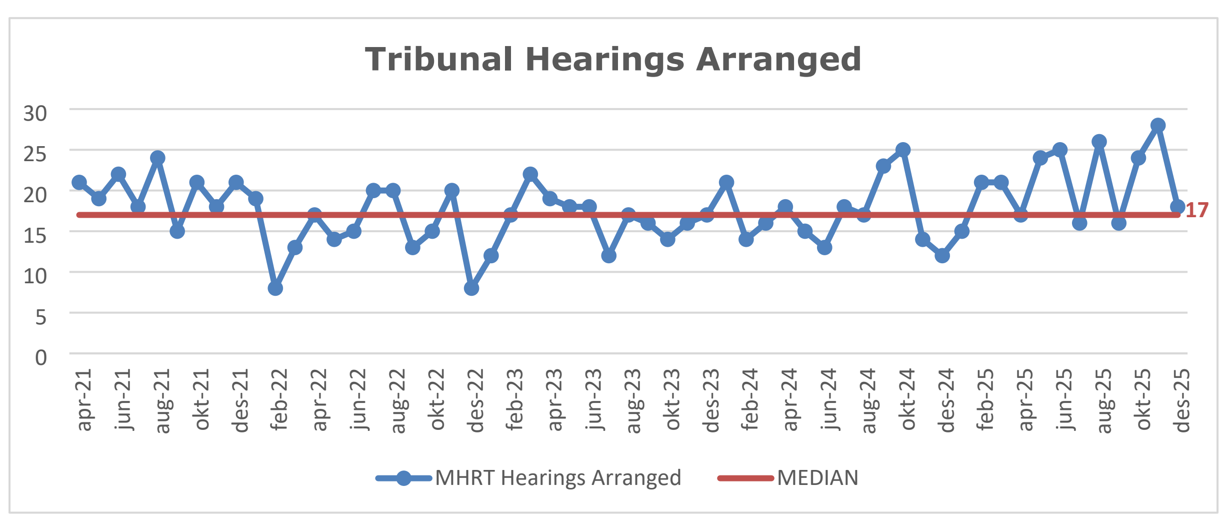
Hospital Manager Hearings	Q3 2024/25	Q4 2024/25	Q1 2025/26	Q2 2025/26	Q3 2025/26
Applications by patient – Inpatient	**0**	**0**	**0**	**0**	**0**
Applications by patient – CTO	**0**	**0**	**0**	**0**	**0**
Renewal Hearing Applications – Inpatient	**24**	**21**	**20**	**22**	**21**
Renewal Hearing Applications – CTO	**8**	**12**	**4**	**17**	**15**
Barring Hearings	**1**	**1**	**0**	**0**	**0**
Hearing cancelled before being heard	**20**	**15**	**20**	**17**	**11**
Hearing held - Patient Discharged by Hospital Managers	**0**	**0**	**0**	**0**	**0**
Hearing held – Section continued	**0**	**27**	**17**	**32**	**17**

A significant number of managers' hearings continue to be cancelled. This is usually because the patient has either been discharged prior to the hearing being held or been transferred to another hospital under different hospital managers.

3.6 Mental Health Review Tribunals

There continues to be a trend for patients to apply for a Tribunal hearing as opposed to Manager's hearings within the Health Board, this could be due to the Tribunal having more powers than the Hospital managers or a patients Legal Rep preference. The MHRT is a statutory independent body for hearing appeals against detention.

The chart below highlights the activity and outcomes of Tribunals arranged over the last two years. Overall, the number of hearings appears to be relatively consistent over the period of the last 12 months, with a 21% increase in the number of hearings arranged in Q3 in comparison to the previous quarter.



The activity and outcomes of arranged tribunals over the quarter is summarised in the table below.

MH Review Tribunal Hearings	Q3 2024/25	Q4 2024/25	Q1 2025/26	Q2 2025/25	Q3 2025/26
Applications by patient – Inpatient	**32**	**46**	**46**	**50**	**52**
Applications by patient – CTO	**1**	**3**	**4**	**3**	**4**
Renewal Hearing Applications – Inpatient	**8**	**7**	**8**	**6**	**14**

Renewal Hearing Applications – CTO	**4**	**2**	**3**	**0**	**4**
Referral by MOJ	**3**	**3**	**3**	**1**	**0**
Referral by Welsh Ministers	**0**	**1**	**0**	**5**	**0**
Outcomes: Hearing Cancelled before being heard	**26**	**23**	**29**	**34**	**30**
Outcomes: Patient Discharged by MHRT	**1**	**4**	**4**	**3**	**7**
Outcomes: Section Continued	**24**	**30**	**33**	**21**	**33**

This shows that a significant number of Tribunals continue to be cancelled before being heard. This is usually because the patient has either been discharged prior to the hearing or they have exercised their right to withdraw.

4. Description of Sections

<u>Longer Term Sections</u> (medication can be given)

Section 2 Admission for assessment – up to 28 days

Mental Health Act assessment undertaken by 2 registered medical practitioners, where practicable by one who knows the patient. One must be Section 12(2) approved. An Approved Mental Health Professional (AMHP) must also assess, preferably at the same time as at least one registered medical practitioner.

Criteria needs to be met –

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

2 x medical recommendations (HO4), 1 x application from AMHP (HO2)

Section 3 Admission of treatment – up to 6 months, renewable for 6 months, 12 monthly thereafter

Mental health act assessment undertaken by 2 registered medical practitioners, where practicable by one who knows the patient. One must be Section 12(2) approved. An Approved Mental Health Professional (AMHP) must also assess, preferably at the same time as at least one registered medical practitioner. Criteria needs to be met –

a) is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment in hospital; and
b) it is necessary for the health and safety of the patient or for the protection of other persons that he should receive such treatment, and it cannot be provided unless he is detained under this section; and
c) appropriate medical treatment is available for him.

2 x medical recommendations (HO8), 1 x application from AMHP (HO6)

Short Term Sections ***(medication cannot be given)***

Section 4 **Admission for emergency – up to 72 hours**

Mental health act assessment undertaken by a registered medical practitioner, where practicable by one who knows the patient. An Approved Mental Health Professional (AMHP) must also assess the patient – ideally at the same time. Criteria needs to be met –

"it is of urgent necessity for the patient to be admitted and detained under section 2" and that compliance with the provisions relating to application under that section *"would involve undesirable delay"*

1 x medical recommendation, (HO11) 1 x application from AMHP (HO10)

Section 5(2) **Approved Clinician Holding Power – up to 72 hours**

Mental health act assessment undertaken by a registered medical practitioner. Criteria is –

that an application for compulsory detention "ought to be made".

1 x Form HO12

Section 5(4) **Nurses Holding Power – up to 6 hours**

Criteria is:
if it appears to a nurse of the 'prescribed class' firstly that *"…the patient is suffering from mental disorder to such a degree that it is necessary for his health and safety or for the protection of others for him to be immediately restrained from leaving the hospital".* Secondly the nurse must believe that *"…it is not practicable to secure the immediate attendance of a practitioner or clinician for the purposes of furnishing a report under subsection (2)…"* In other words, the doctor or approved clinician (or their deputy) cannot attend in time to provide a report under section 5(2).

1 x Form HO13

<u>Community Treatment Order and related sections</u> (medication can be given)

Section 17A **Community Treatment Orders – up to 6 months, renewable for 6 months (17A+) 12 monthly thereafter (17A ++)**

Criteria is:
the patient is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment;
it is necessary for his health and safety or for the protection of other persons that he should receive such treatment;
subject to his being liable to be recalled ... such treatment can be provided without his continuing to be detained in a hospital;
it is necessary that the responsible clinician should be able to exercise the power under section 17E (1) below to recall the patient to hospital;
appropriate medical treatment is available for him

Form CP1

Section 17E **Recall of a CTO. Duration is up to 72 hours, which starts once the patient has been admitted to the hospital.**

Criteria is:
a change of mental state or increase in risk.

Form CP5

Section 17F **Revocation of a CTO patient who has been recalled to hospital – the section is the re-introduction of the Section 3 or Section 37 (depending on what section they were on previous to the CTO) - up to 6 months, renewable for 6 months, 12 monthly thereafter**

Criteria needs to meet the same as Section 3 –

a) is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment in hospital; and

b) it is necessary for the health and safety of the patient or for the protection of other persons that he should receive such treatment, and it cannot be provided unless he is detained under this section; and
c) Appropriate medical treatment is available for him.

Revocation requires the written agreement of an AMHP.
Form CP7

Places of Safety Sections ***(medication cannot be given)***

Section 135 **Warrant to search and remove**

Section 135(1) – warrant to enter and remove

Section 135(1) empowers a magistrate to authorize a police constable to remove a person lawfully from private premises to a place of safety.

A warrant may be issued if, on having information on oath from an approved mental health professional (AMHP), it appears to the magistrate that there is reasonable cause to suspect that a person believed to be suffering from mental disorder is:
Criteria is:
has been, or is being, ill-treated, neglected or kept otherwise than under proper control, in any place within the jurisdiction of the justice, or being unable to care for himself, is living alone in any such place

Section 135(2) – warrant to enter and take or retake

Section 135(2) concerns the taking into custody of patients who are unlawfully absent.

A magistrate can issue a warrant to take or retake the patient if it appears, on information on oath by any constable or any *"other person authorised by or under this Act… to take…or retake a patient who is liable under this Act"*, that:

There is reasonable cause to believe that the patient is to be found on premises within the jurisdiction of the justice; and

That admission to the premises has been refused or that a refusal of such admission is apprehended.

Section 136 Place of Safety – up to 24 hours

The powers of section 136 provide authority for a police officer who finds a person who appears to be suffering from mental disorder, in a place to which the public has access, to remove him to a place of safety if the person:

Criteria is:
Appears to be suffering from mental disorder and to be in immediate need for care or control, the constable may, if he thinks necessary to do so in the interests of that person or for the protection of other persons, remove that person to a place of safety…

Part 3 - Sections in relation to patients concerned with criminal proceedings or under sentence

Section 35 Remand to hospital for report on accused's mental condition – for up to 28 days but can be extended to a maximum of 12 weeks *(medication cannot be given)*

An approved clinician (at the hospital) is required to provide a report to the court. The court must be satisfied (on the written or oral evidence of any doctor) that:

(a) …there is reason to suspect that the accused person is suffering from mental disorder; and
(b) …it would be impracticable for a report on his mental condition to be made if he were remanded on bail

Section 36 Remand of accused person to hospital – up to 28 days but duration will be set by the Court – maximum of 12 weeks *(medication can be given)*

The Section 36 is to allow a Crown Court to remand an accused person to hospital for the purposes of treatment. The court must be satisfied (on the written or oral evidence of two doctors, one of whom must be section 12(2) approved) that the patient:

(a) …is suffering from mental disorder of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment; and
(b) appropriate medical treatment is available for him

Section 37 **Hospital Order or Guardianship Order - up to 6 months, renewable for 6 months, 12 monthly thereafter *(medication can be given)***

Section 37 enables a Crown Court or a magistrates' court to order a person to be detained in hospital for treatment (or make a person subject to guardianship) when otherwise they may have imposed a prison sentence. The "hospital order" or a "guardianship order" is given as an alternative to imprisonment, a fine, or probation if appropriate.

The court must be satisfied (on the written or oral evidence of two doctors, one of whom must be section 12(2) approved) that the patient:

is suffering from mental disorder and that either –
(i) the mental disorder from which the offender is suffering is of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment and appropriate medical treatment is available for him; or
(ii) in the case of an offender who has attained the age of 16 years, the mental disorder is of a nature or degree which warrants his reception into guardianship…;and

…the court is of the opinion, having regard to all the circumstances including the nature of the offence and the character and antecedents of the offender, and to all other available methods of dealing with him, that the most suitable method of disposing of the case is by means of an order under [section 37].

Section 37/41 **Hospital Order with Restrictions – made with no time limit *(medication can be given)***

A Crown Court may, if necessary for the protection of public from serious harm, place restrictions onto a hospital order at the time of making the order under section 37.

The restrictions, Section 41, sets out that the Court must have regard to *"…the nature of the offence, the antecedents of the offender and the risk of his committing further offences if set at large…" and if it is necessary "for the protection of the public from serious harm…"* the Court can order that the patient is subject to the special restrictions of the section.

An order made under section 41 is known as "a restriction order", and is commonly referred to as "section 37/41" or a "hospital order with restrictions".

In addition to the requirements for making an order under section 37, the Court must receive oral evidence from at least one of the registered medical practitioners who gave evidence under section 37.

Section 38 **Interim Hospital Order – up to 12 weeks, but duration set by the Court – maximum 12 months *(medication can be given)***

To allow a court to send a person who has been convicted but not yet sentenced to hospital, to assess the person's response to medical treatment. The court must be satisfied (on the written or oral evidence of two doctors, one of whom must be section 12(2) approved) that the patient:
(a) …is suffering from mental disorder; and
(b) that there is reason to suppose that the mental disorder from which the offender is suffering is such that it may be appropriate for a hospital order to made in his case,

the court may, before making a hospital order or dealing with him in some other way, make an order (…referred to as "an interim hospital order") authorising his admission to … hospital…

Section 47
Section 47/49 **Transfer of sentenced prisoners (including with restrictions) *(medication can be given)***

Allows the Secretary of State for Justice to order the transfer to hospital of a sentenced prisoner following conviction. The Secretary of State must be satisfied (from the reports of two doctors, one of whom must be section 12(2) approved) that the patient:

(a) … is suffering from mental disorder; and
(b) that the mental disorder from which that person is suffering is of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment; and
(c) that appropriate medical treatment is available for him.

The Secretary of State must have "…regard to the public interest and all the circumstances…"

A direction made under section 47 is known as a 'transfer direction'. A transfer direction may be accompanied by the special restrictions of section 41, by virtue of section 49. Such a direction is known as a "restriction direction" and is commonly referred to as 'section 47/49' or a 'transfer and restriction direction'

Duration - the transfer direction (including a restricted section 47) ends at the earliest date of release (EDR). At this time the patient, unless discharged by the responsible clinician, will be treated as though a hospital order had been made (and is referred to as a 'notional section 37').

Section 48
Section 48/49

Transfer of other prisoners (including with restrictions) for urgent treatment

Allows the Secretary of State for Justice to order the transfer to hospital of a prisoner who is not sentenced but in urgent need of treatment. The Secretary of State must be satisfied (from the reports of two doctors, one of whom must be section 12(2) approved) that the patient:
… is suffering from mental disorder of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment; and he is in urgent need of such treatment; and appropriate medical treatment is available for him

The section only applies to:

- persons detained in a prison, not being a person serving a sentence of imprisonment or persons falling within the following groups
- persons remanded in custody by a magistrates' court;

- civil prisoners, that is to say, persons committed by a court to prison for a limited term, who are not persons falling to be dealt with under section 47;
- persons detained under the Immigration Act 1971 or under section 62 of the Nationality, Immigration and Asylum Act 2002 (detention by Secretary of State).

It is known as a 'transfer direction'. A transfer direction may be accompanied by the special restrictions of section 41, by virtue of section 49. Such a direction is known as a "restriction direction" and is commonly referred to as 'section 48/49' or a 'transfer and restriction direction'. A restriction direction must be given in respect of

- persons detained in a prison, not being a person serving a sentence of imprisonment
- persons remanded in custody by a magistrates' court;

Duration - the period of detention is variable and can continue to the time of sentence; the Secretary of State can also issue a warrant to return the person to prison at any before the Court disposes of the case.

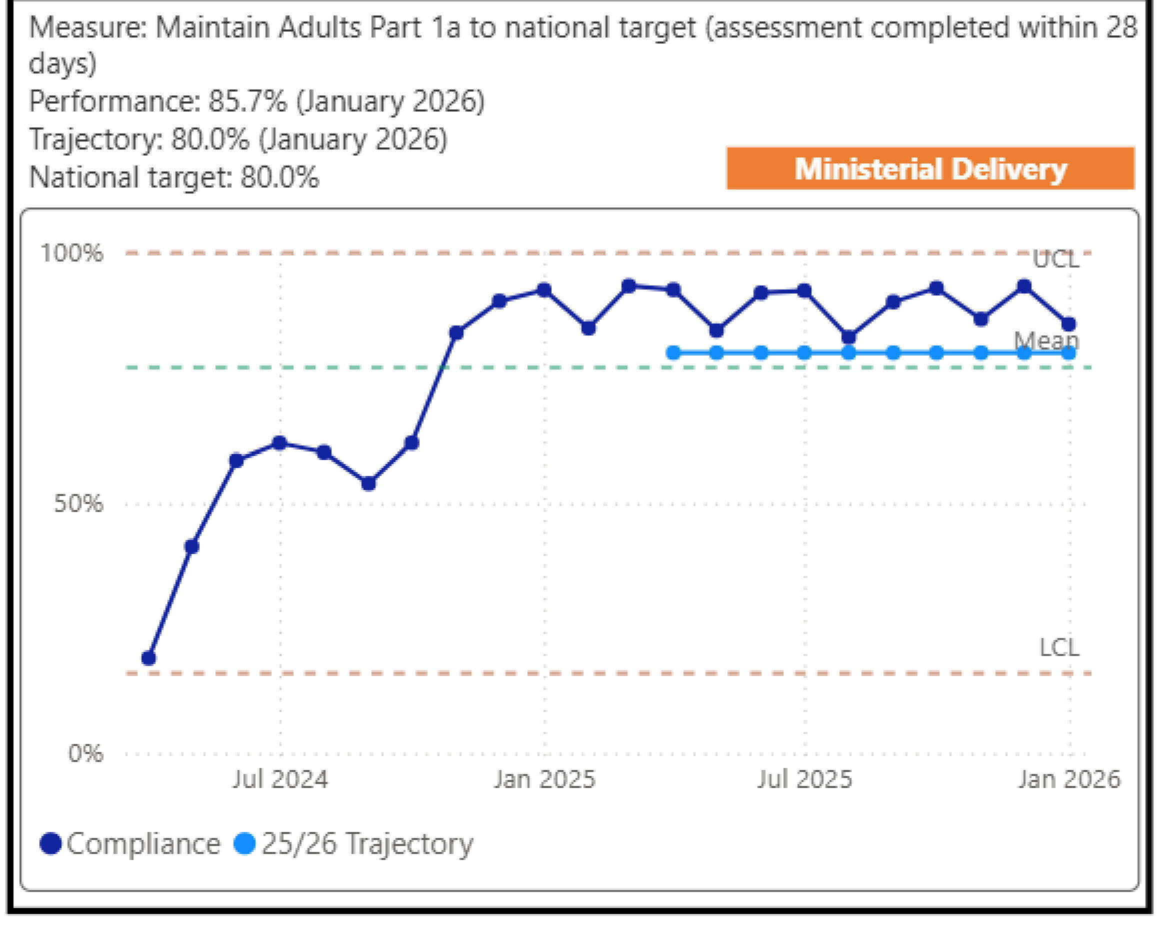
5. Glossary of Terms

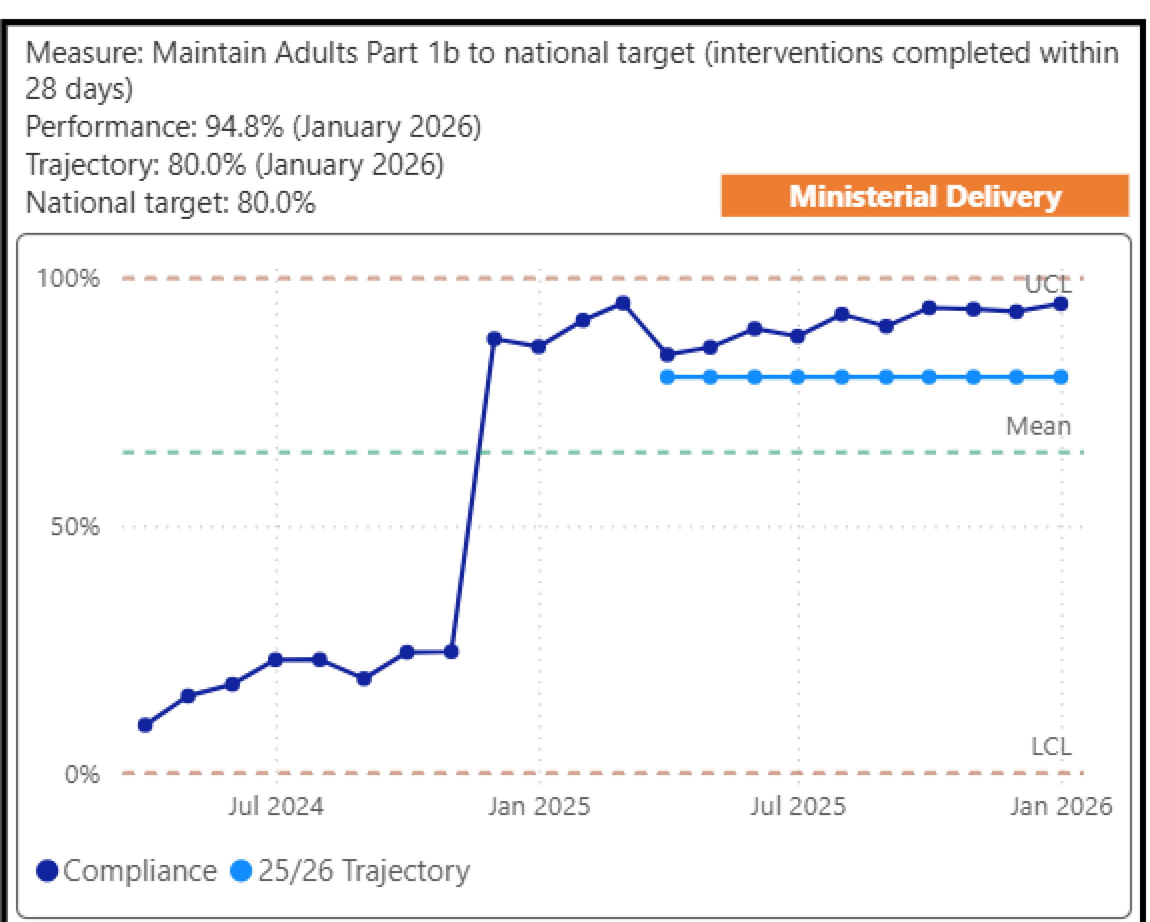
AMHP	Approved Mental Health Professional. AMHPs are mental health professionals who have been approved by a local social services authority to carry out certain duties under the Mental Health Act.
CAMHS	Children and Adolescent Mental Health Services
CTO	Community Treatment Order
Detained patient	A patient who is detained in hospital under the Act or who is liable to be detained in hospital but who is currently out of hospital (e.g., on section 17 leave).
Hospital Managers	Independent individuals who carry out functions on behalf of the Board.
Informal patient	Someone who is being treated for mental disorder in hospital and who is not detained under the Act.
MHA	Mental Health Act 1983.
MHRT	Mental Health Review Tribunal for Wales. They safeguard patients who have had their liberty restricted under the Mental Health Act and review cases of patients who are detained in a hospital or living in the community subject to a conditional discharge, community treatment or guardianship order.
Recall	Where it is necessary for a CTO patient to be recalled into hospital.
Revoke	Patients for who a CTO has been rescinded following a recall.
Sections	Parts of the Mental Health Act 1983 which allow particular types of detention.

MH&LD Committee March 2026

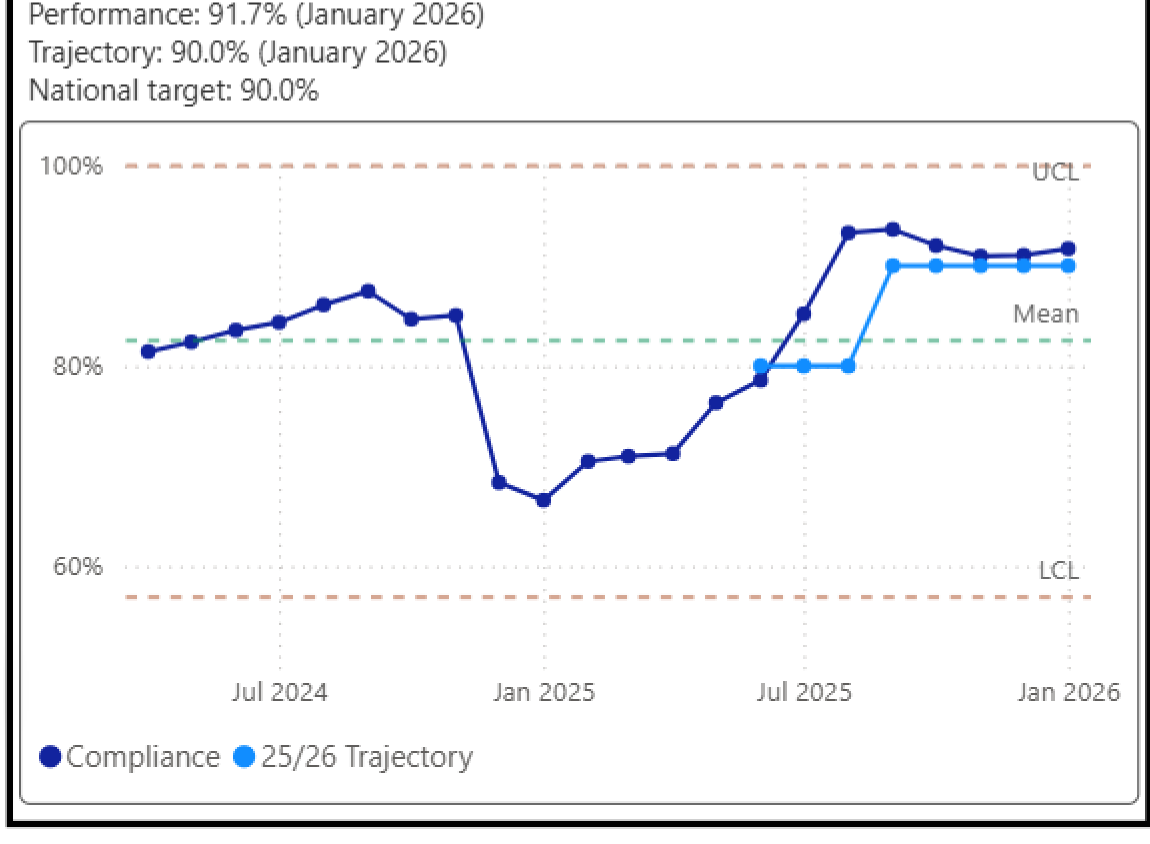
Mental Health: Performance

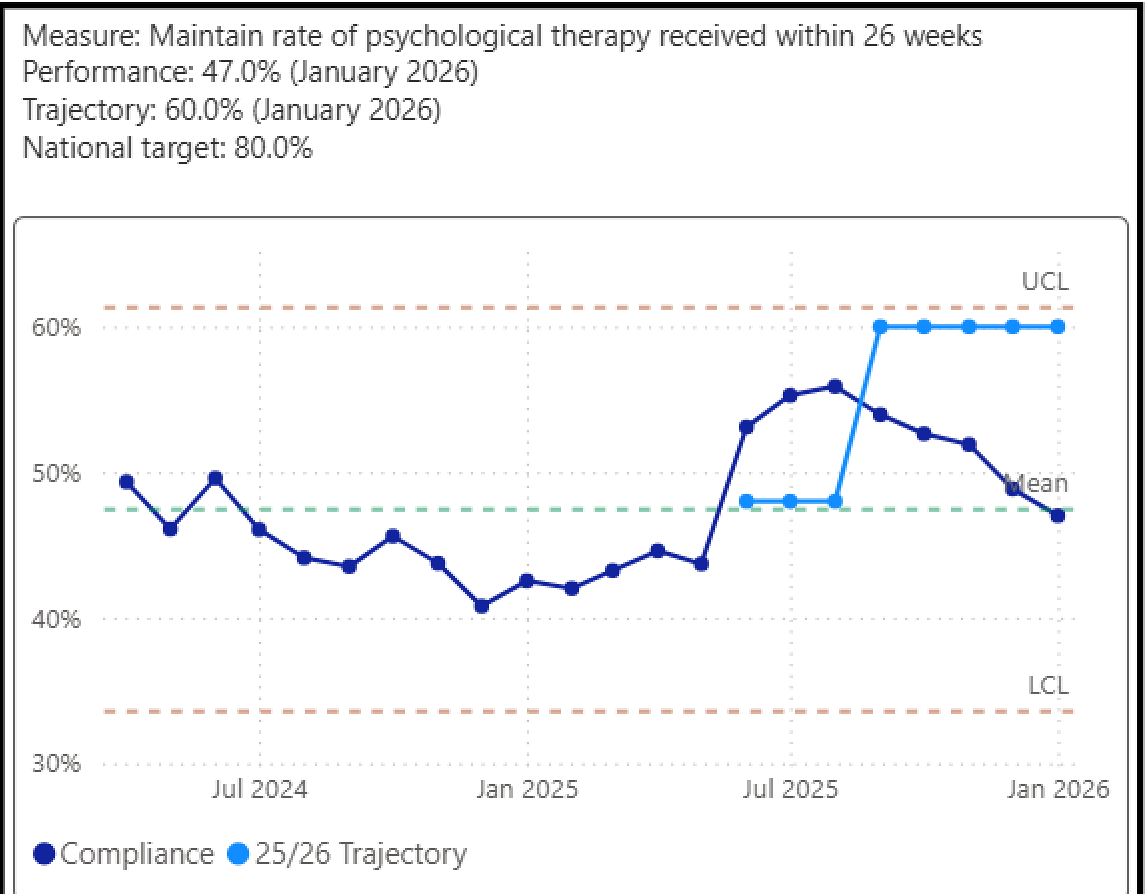
Adults: Part 1a & 1b



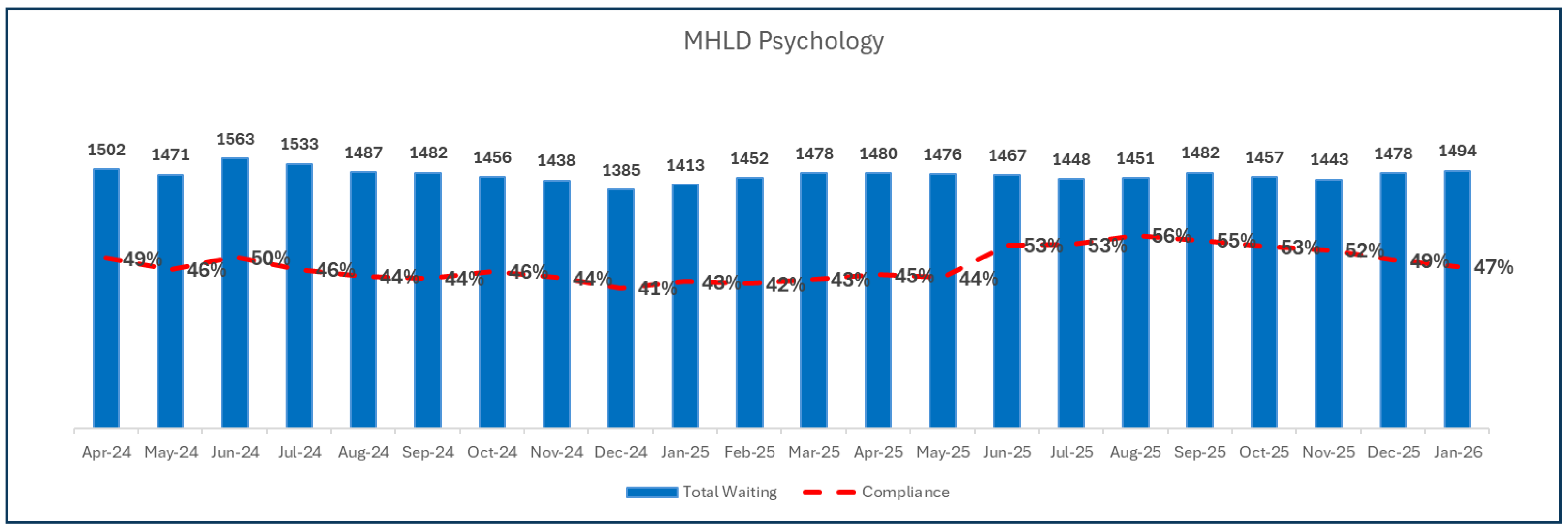


Adults: Part 2 & Psychological Therapies





Adults: Part 2 & Psychological Therapies

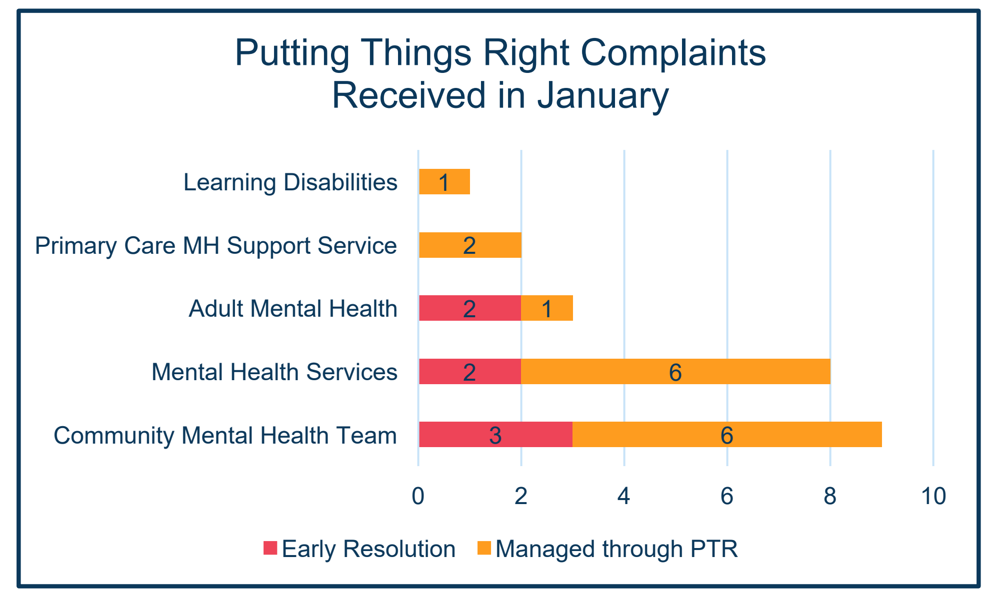


- All dashboards now in place for all adult teams.
- Continued data discrepancies between Qlik and WCCIS and on-going work around RTT clock resets for DNA/CNAs
- Booking process mapping completed and future state process under development

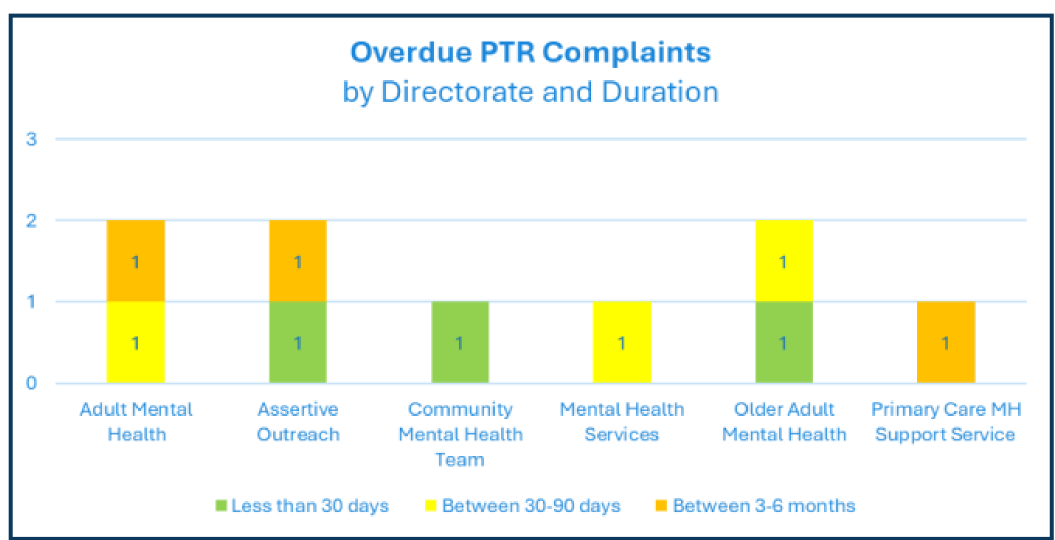
- Workflows re-tested in validation environment.
- Joint pathway clusters work ongoing with PCMHSS
- Vacancies impacting on capacity and performance
- Ongoing data cleansing work delayed due to staff absences
- Revised recovery plan being developed by end Feb

Mental Health:
Quality & Patient Safety

PTR Overview & Compliance

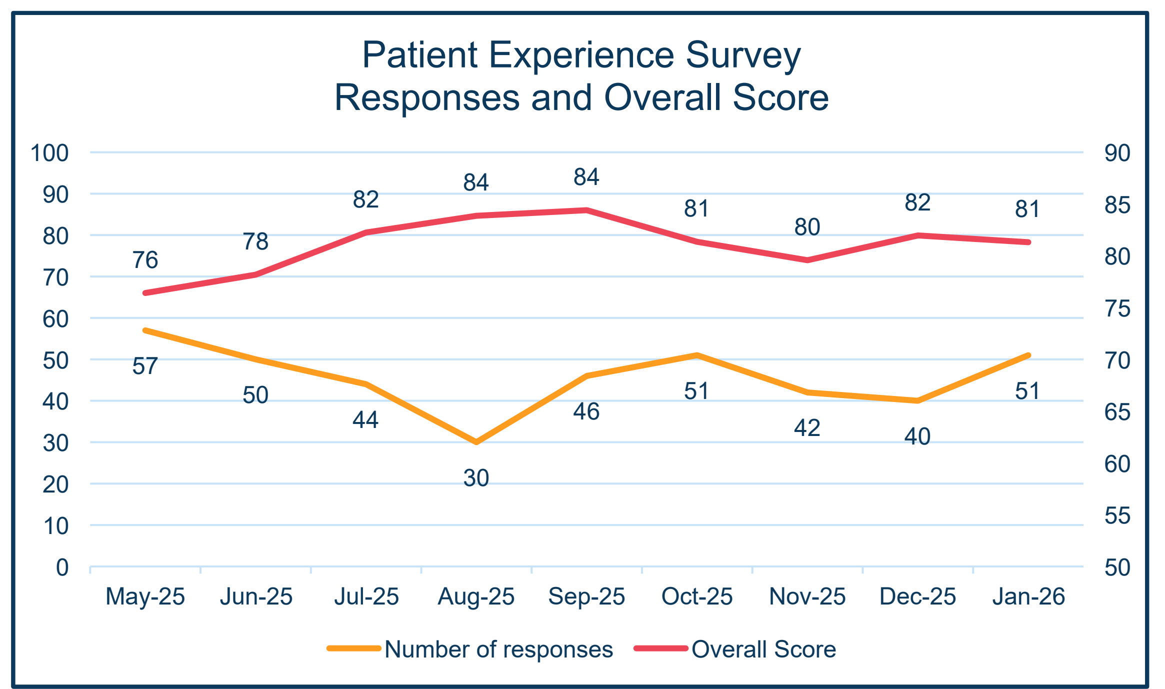


- January saw **23 concerns** (highest since Apr 2025): 7 Early Resolution, 16 Formal.
- **9 overdue formal complaints**, with **3 >3 months overdue**.
- Compliance has improved over 18 months, with a **step-change in Nov 2025**.
- Early Resolution averages **61% since July 2025**; December expected to improve.
- **Target:** 75% compliance for both PTR and Early Resolution.
- New template forms now in use to support consistent, timely closure.



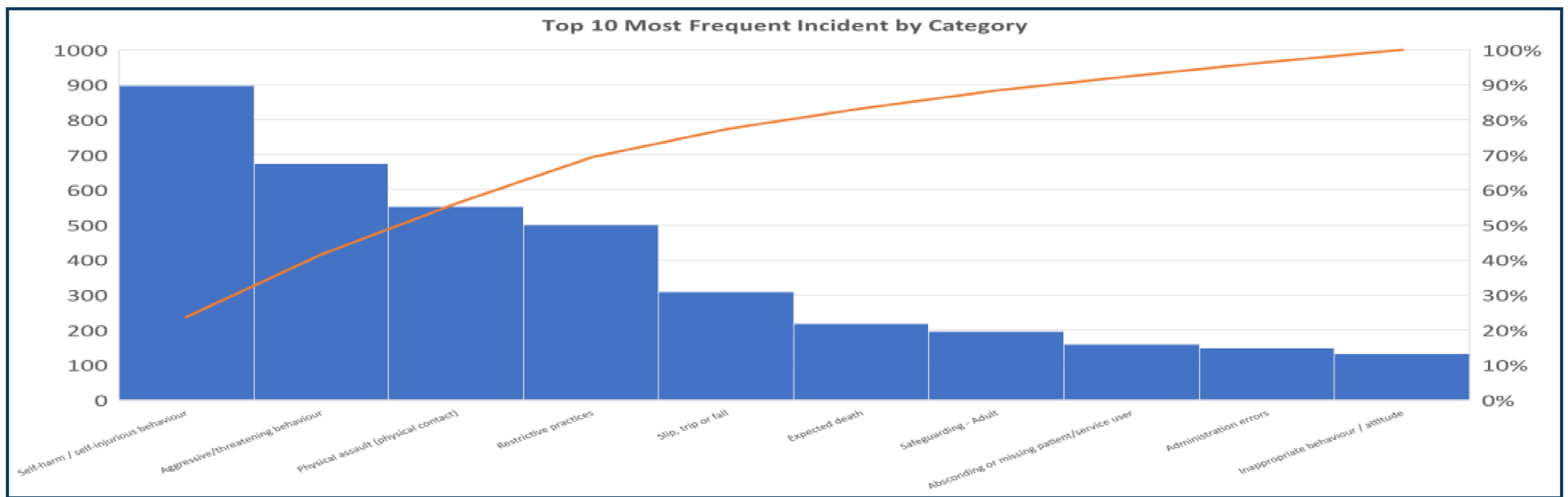
Patient Experience (CIVICA)

- Response rates remain **very low** in MH&LD despite a small rise in January.
- Satisfaction improved from **76** → **84** during 2025, but remains variable.
- Patient cohort requires a **bespoke approach** to accurately capture experience.
- Opportunities to improve response rates:
  - **Closed social media groups**
  - **Wider ABUHB comms**
  - **Posters**
  - **Inclusion in discharge letters**
- New **Wales-wide survey** launched May 2025 providing additional insights.



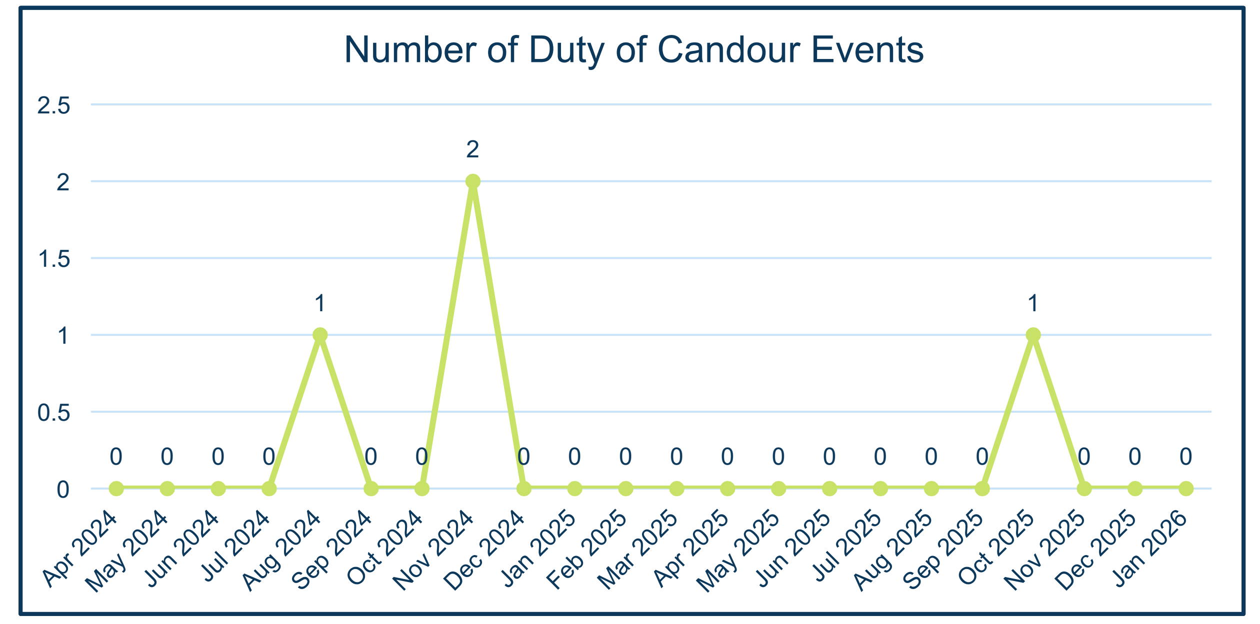
Patient Safety Incidents (DATIX)

- Incident reporting fell **~20% vs Jan 2025**.
- The **decline in interim harm assessments** reflects incomplete manager reviews.
- One catastrophic and one moderate harm incident were both **downgraded to no harm** after investigation.
- **Open incidents** remain a risk: older cases represent **unknown, unmitigated harm potential**.
- Self-harm, aggression, physical assault and restrictive practices **all decreased in January**.
- Pareto analysis highlights **consistent top incident categories** across months.



PSI, DoC, NRIs & EWNs

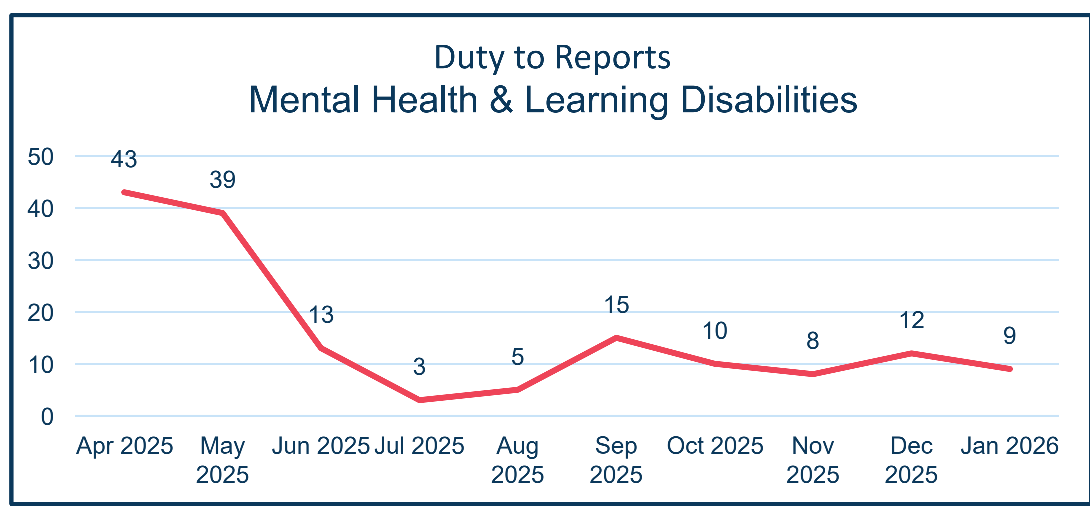
- **1 new NRI** in January (inpatient suicide) — **6 total** this financial year.
- **1 NRI due for closure** in February.
- **4 new EWNs** in January (59 YTD).
- **No Never Events** in January.
- DoC: Only **1 incident recorded this financial year**.
- Significant risk: **700 historic incidents** have missing interim harm assessments, all auto-triggering DoC and representing a **large unknown governance risk**.



Risk, IPC & Safeguarding

- **Overdue risks reduced** from 98 to 88; oldest dating back to Nov 2024.
- Highest current risks:
  - **Non-payment of invoices**
  - **ABI commissioning**
  - **Caerphilly LA project withdrawal**
- Corporate QPS developing a **monthly dashboard** to strengthen oversight.
- IPC: No new infections recorded in December, though **C. diff, E. coli and Kleb** remain above last year's levels.
- Safeguarding Duty to Report cases **stabilised at ~10 per month**.
- Compliance reporting (child & adult competencies) continues to highlight **training gaps**.

Organism	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	FY 25/26 TOTAL	Number of cases for 2025/26 to achieve a reduction	Count equivalent period fy24/25
C DIFFICILE	1	0	1	0	0	0	0	0	0	2	0	0
STAPH AUREUS	0	0	0	0	0	0	0	0	0	0	0	0
E COLI	0	0	0	0	0	0	1	0	0	1	0	0
KLEBSIELLA	0	0	0	0	0	1	0	0	0	1	0	0
PSEUDOMONAS	0	0	0	0	0	0	0	0	0	0	0	0

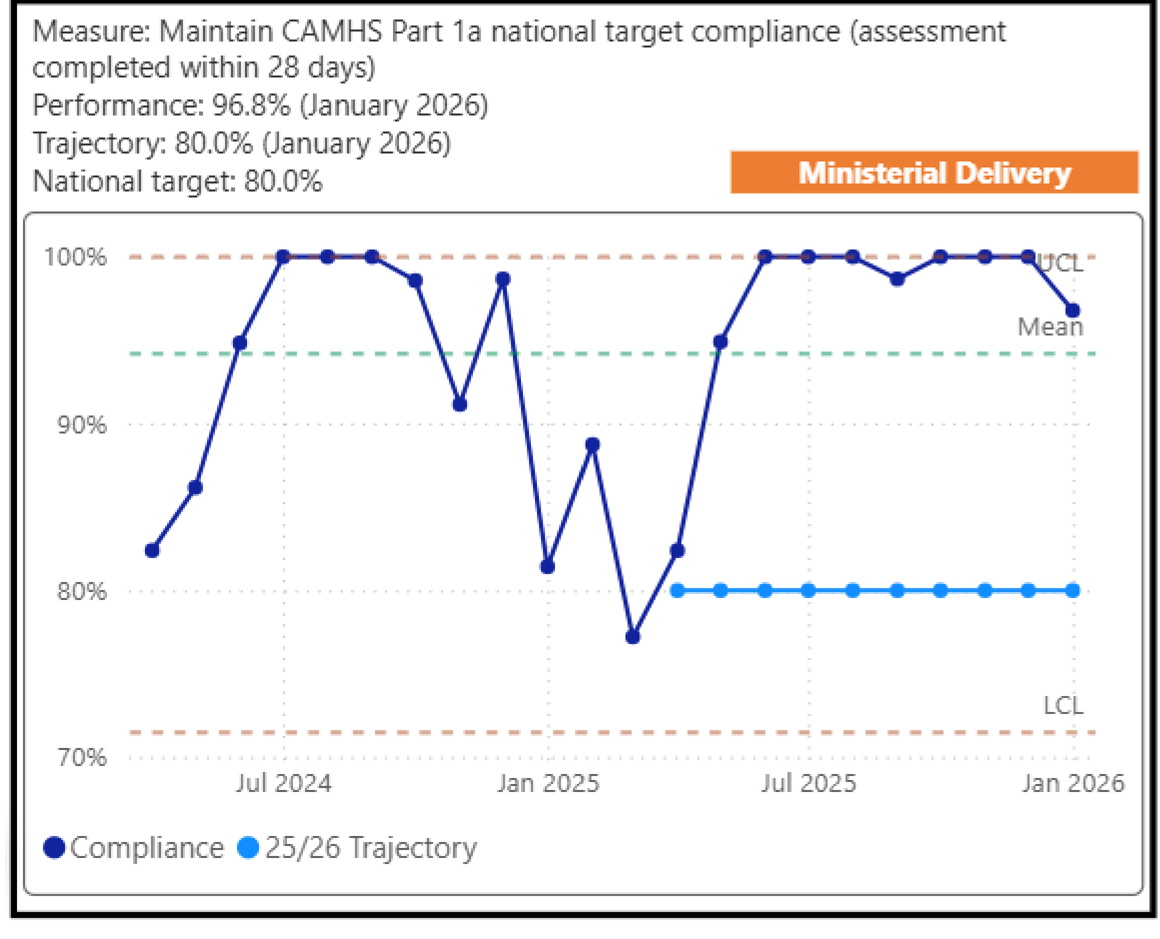


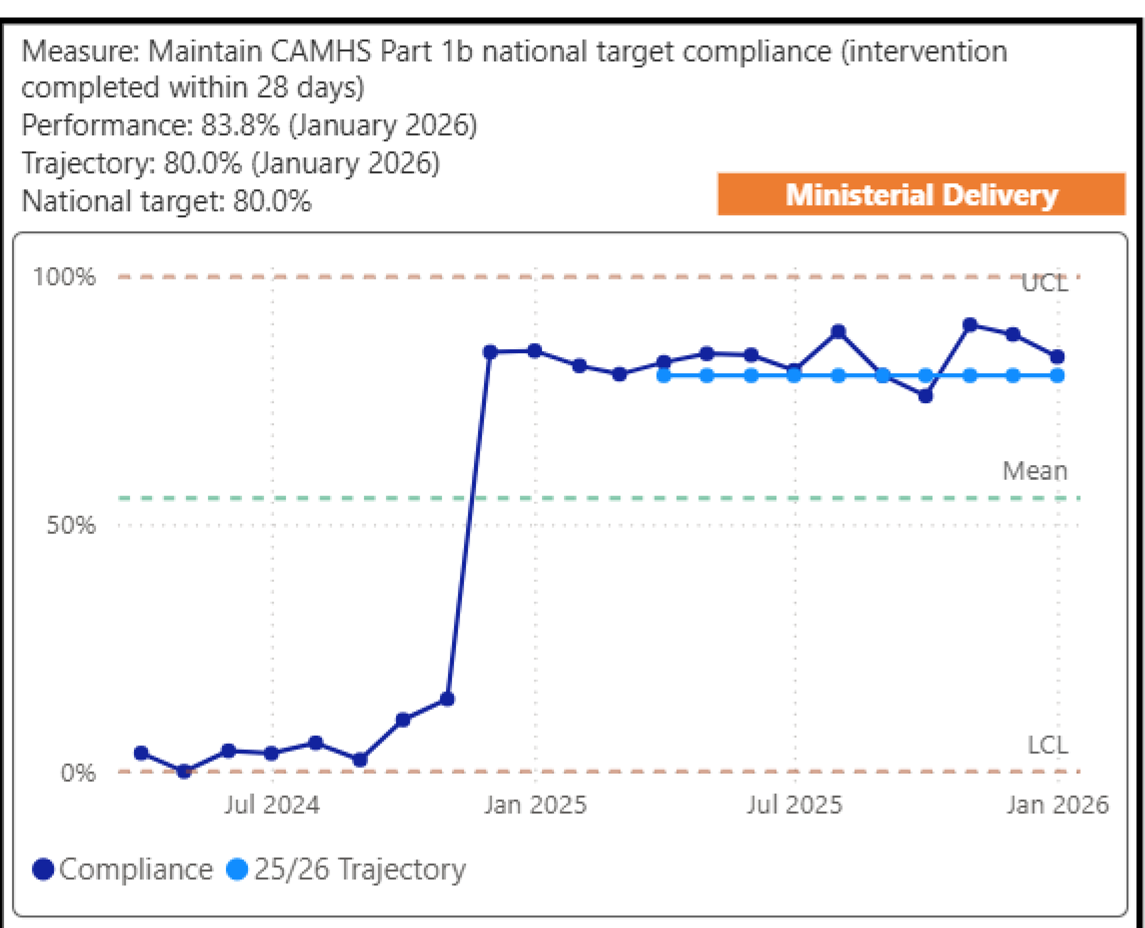
Quality Improvement Projects

Project	Summary	Improvement Actions and Outcomes
Ty Cyfannol Placement Padlet	Ty Cyfannol have created a student placement interactive padlet, that is updated by clinical lead staff for students to receive an induction and continued learning during the placement.	Both Students and Staff provide feedback to the padlet. This allows information to be updated accordingly and allows Students to be nurtured and informed during their placement. The work continues to be updated and will be cross-referenced to other ward placements for quality improvement on behalf of the student attending MHLD ABUHB.
Introduction of Sensory objects/work for patients who face dysregulation on ward	Ty Cyfannol Nursing and Occupational Staff has identified a possible need for the use of sensory objects to help patients who are dysregulated whilst as inpatient. This project is yet to begin, but evidence is currently being collected to support the use of sensory objects and to create a business plan for funding to purchase items.	Ty Cyfannol Nurisng and Occupational Staff to work with QPS in order to develop a business plan for funding, supportive by evidence and research. Then to complete a project summary and PDSA cycles.
Text Messaging Pilot in Upper Mon CMHT	A pilot to reduce DNAs and waiting lists by texting reminders to patients.	Demonstrated a significant reduction in DNAs and in waiting lists. Plan to begin rolling out to CMHTs and other Community Teams.
Blood samples on Talygarn	To improve the standards in admission blood testing including prolactin, HBA1c and CK	Blood panel completion increased from 14% to 67%
The introduction of use of VdT MoCA on Pillmawr Ward	The implementation of an engagement framework for rehab wards.	Engagement has significantly increased. The objective is to roll out to open rehab

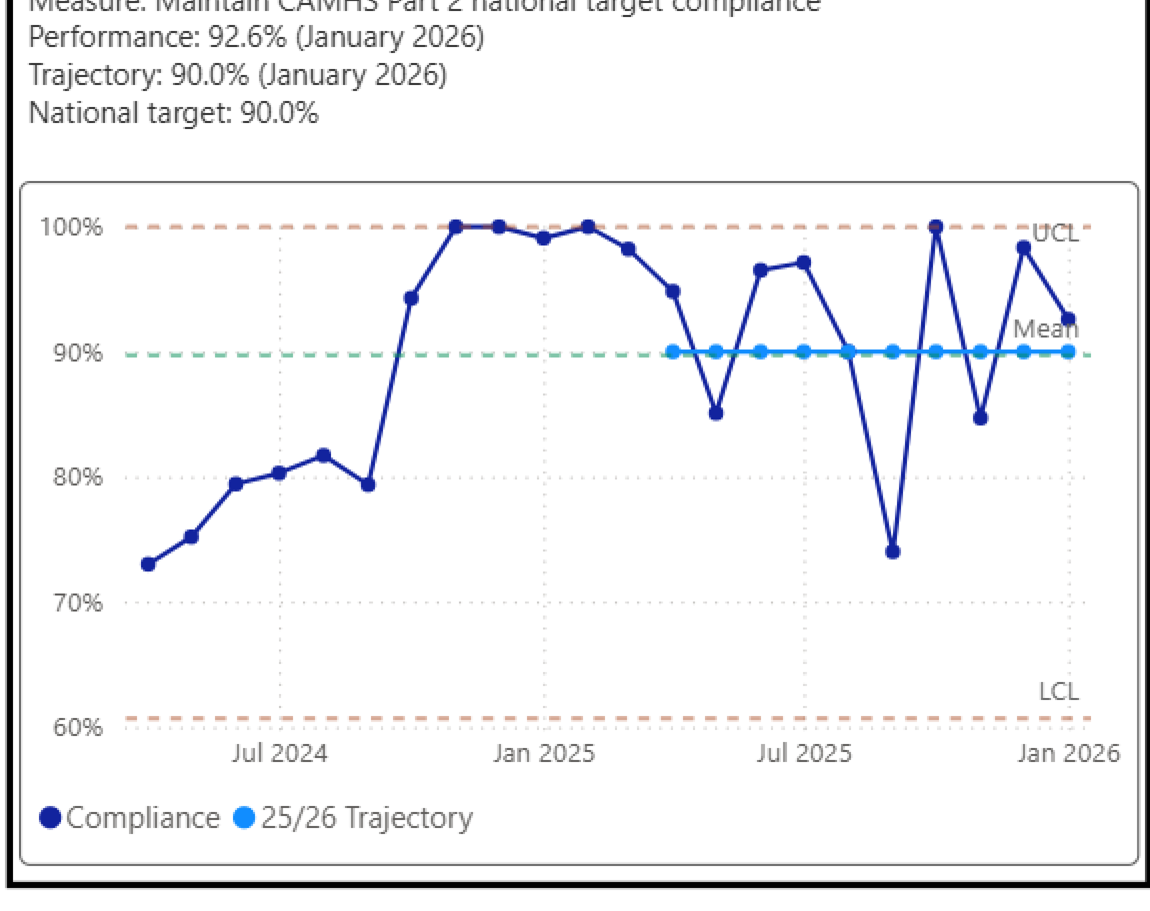
CAMHs

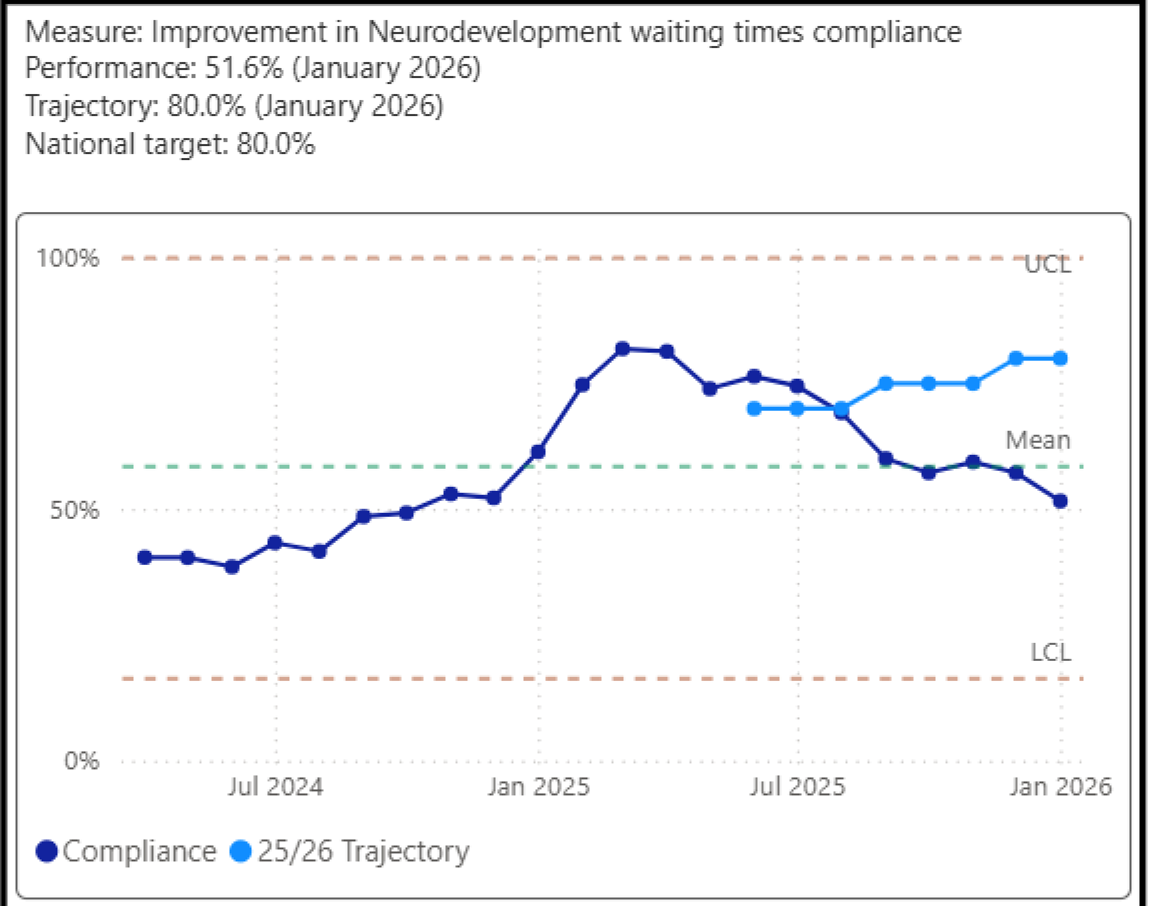
CAMHS: Part 1a & 1b





CAMHS: Part 2 & ND





CAMHS Performance Descriptor: Jan 2025 – Jan 2026

CAMHS performance descriptor

Conversion rate data gathered from Teams (rest of data pulled from Qlik & validated)

Performance Descriptor	Target	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26
CAMHS Referrals Received		54	40	50	58	44	43	48	33	40	68	51	39	42
CHOICE CAMHS RTT %	80%	83.33%	94.28%	100%	95.00%	93.80%	98%	98.36%	95%	94%	93.27%	91.15%	92.5%	93.21%
CTP %	90%	98%	98%	98%	98.00%	74.00%	96.2%	98%	98%	76%	100%	98%	98%	90%
CHOICE to NCP Conversion Rate	65%	77.92%	79.68%	79.68%	67.64%	67.74%	72.85%	73.56%	71.35%	70%	69.35%	68.75%	69.35	69.75%
ND RTT %	80%	61.36%	74.75	81.41%	81.38%	73.95%	76.24%	74.31%	69.14%	60.01%	57.38%	59.39%	56.87%	
ND Referrals Received		284	359	388	258	331	368	476	150	270	362	349	304	

PCAMHS	Target	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26
1A Referrals Received		161	125	102	109	52	100	115	71	75	107	110	116	83
Part 1A MHM (appt attended within 28 days of referral)	80%	81.43%	87.30%	81.25%	83.61%	94.94%	100%	88.94%	81%	82%	83.25%	86.25%	83.25%	85.30%
Part 1B MHM 28 days following IA	80%	84.21%	81.96%	84%	82.67%	85.71%	84%	80.34%	80%	81%	81.48%	82.56%	84.65%	89.25%

Section 136 Data *(Obtained from MHA office)*	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul- 25	Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26
	1	2	3	2	1	0	3	3	2	2	2	0	3

Neurodiversity

Current Pressures

The ABUHB CAMHS ND service continues to experience significant pressure due to a combination of rising demand and reduced operational capacity.

Waiting lists have grown from 1,069 in April 2025 to 1,699 in January 2026 with 808 children waiting over 26 weeks.

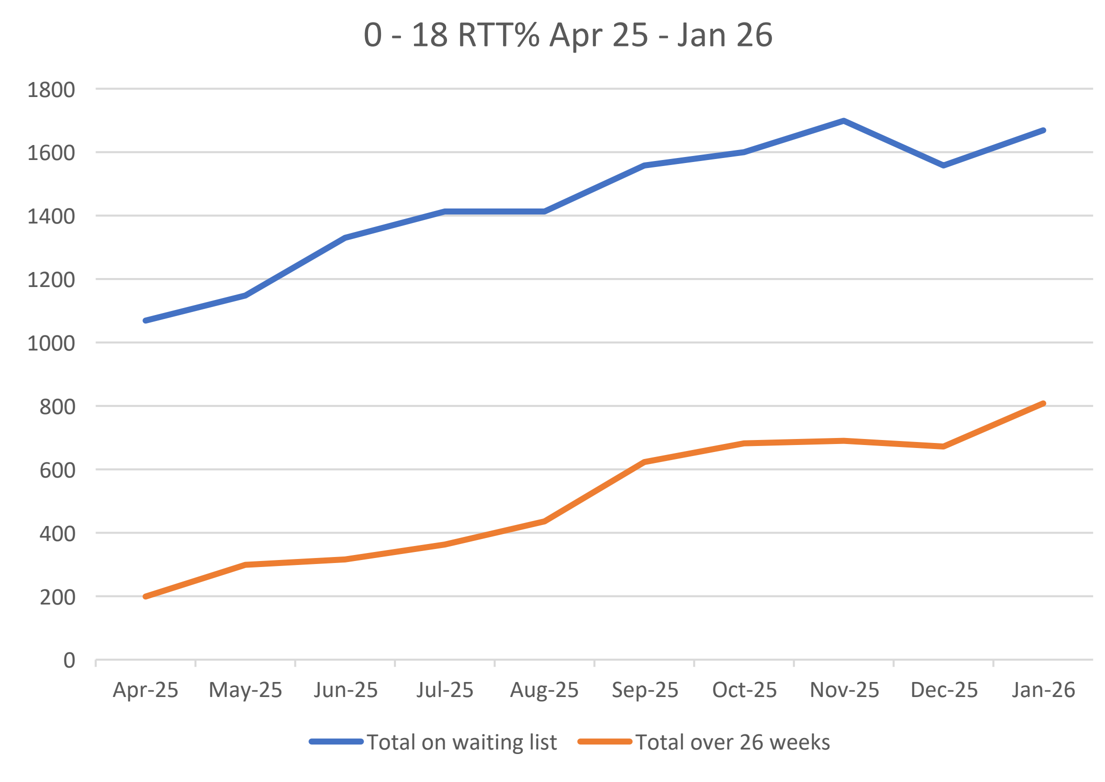
These challenges are impacting the ability to meet the 26-week RTT target and deliver timely assessments and interventions.

However, the service has maintained the ministerial target of retaining longest week waiting under 52 weeks.

The following slides capture the hard work of the service to meet the continuing volume of referrals being submitted and ensure the needs of children and young people are being met.

ND Performance

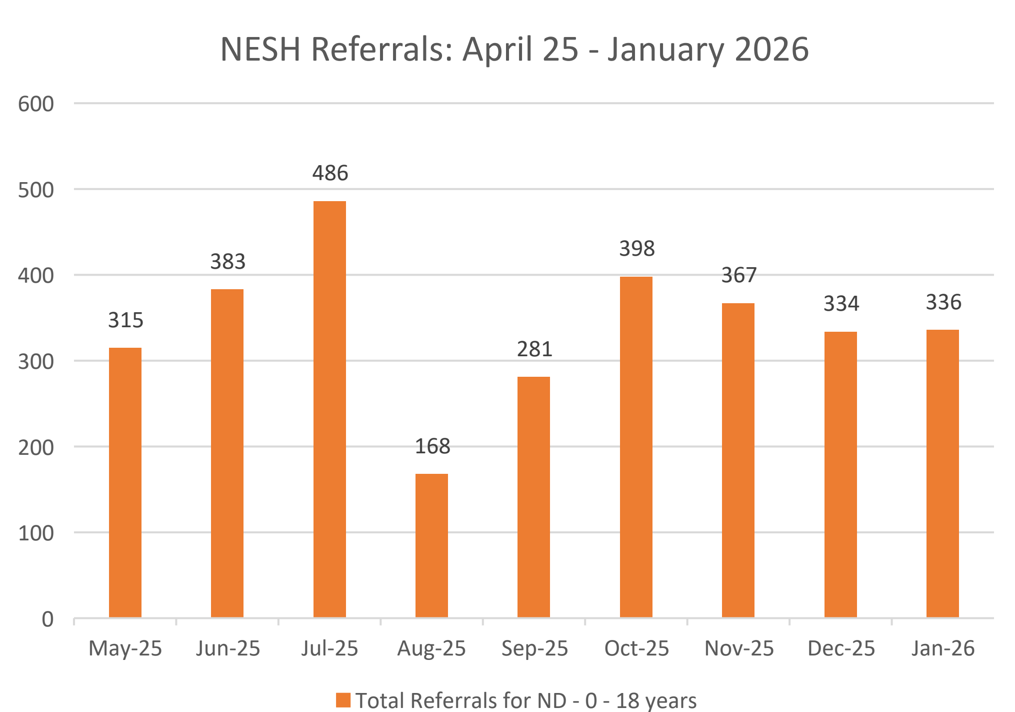
	Total on waiting list	Total over 26 weeks	Total RTT %
Apr-25	1069	199	81.38%
May-25	1148	299	73.95%
Jun-25	1330	316	76.24%
Jul-25	1413	363	74.31%
Aug-25	1413	436	69.14%
Sep-25	1558	623	60.01%
Oct-25	1600	682	57.38%
Nov-25	1699	690	59.39%
Dec-25	1558	672	56.87%
Jan-26	1669	808	51.59%

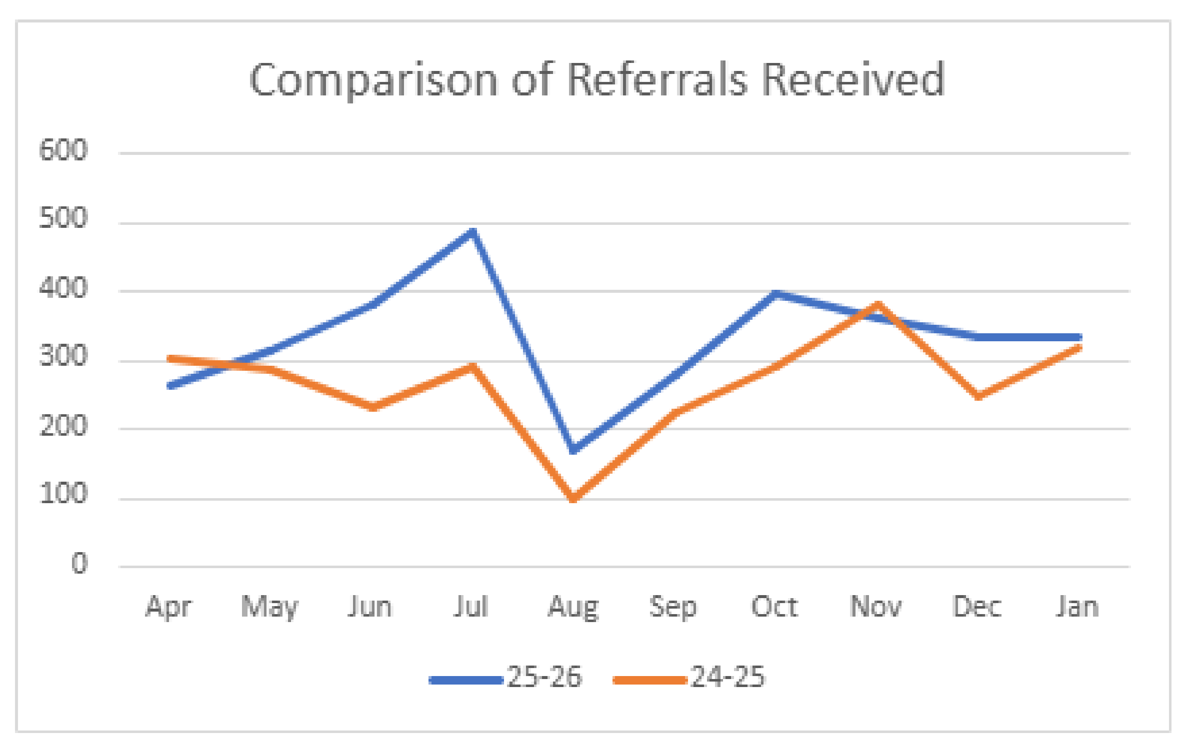


Consistent growth in demand of referrals
Higher criteria in accepting for ND assessment in place
Numbers waiting over 26 weeks has increased due to numbers accepted onto waiting list 6 – 9 months ago
Pressure on maintaining improved RTT% as move towards needs-led model is being embedded

Neurodiversity

Current Demand:

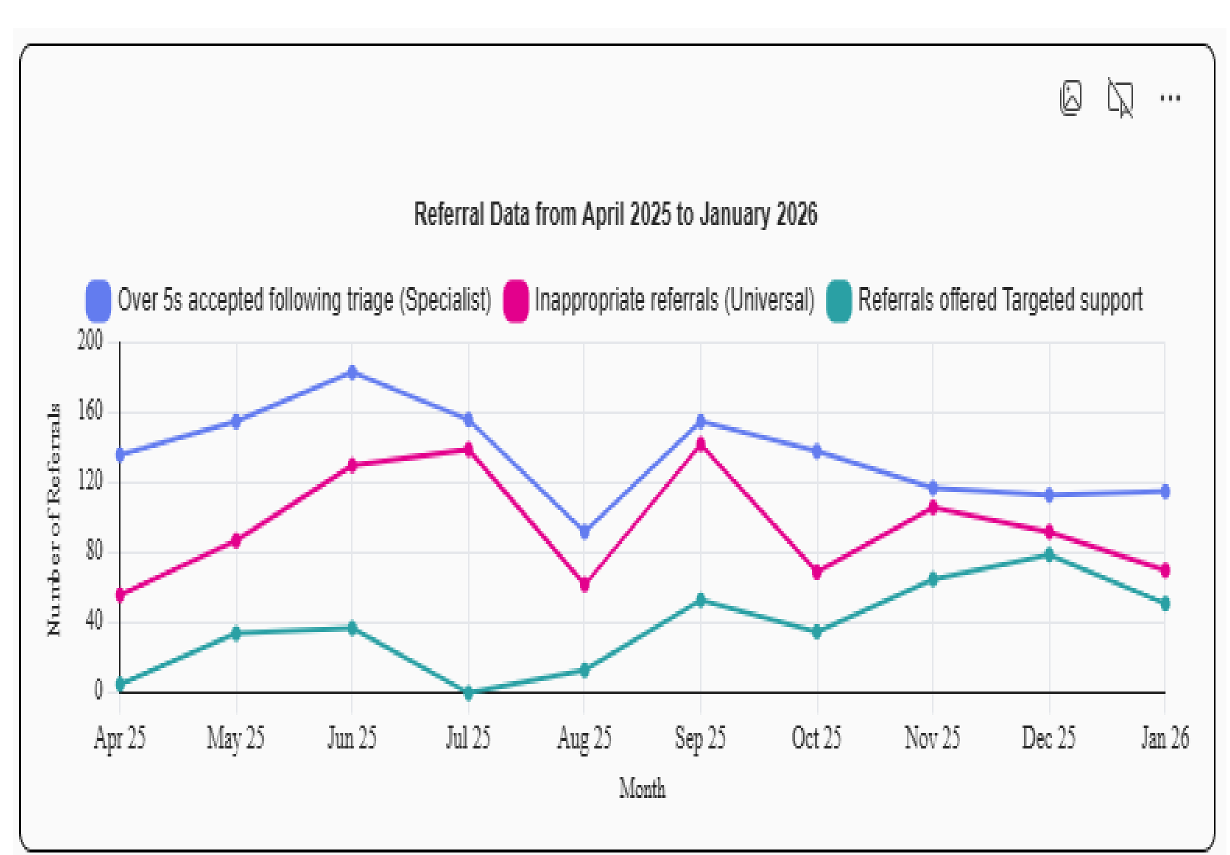




	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
25-26	264	315	383	486	168	281	398	361	334	336
24-25	304	287	232	290	100	226	291	382	249	320
% inc / dec	-13.16%	9.76%	65.09%	67.59%	68%	34.34%	36.77%	-5.5%	34.14%	5%

Neurodiversity

Evolvement of Targeted Approach of the Neurodiversity Early Support Hub since April 2025



The data shows clear variation in referral outcomes over the ten-month period. Specialist triage acceptance remained the highest of the three pathways, with a noticeable peak in June 2025 followed by a gradual stabilisation.

Outcomes of Universal support fluctuated significantly, suggesting referrals are still being submitted with lack of pervasive information to support an ND assessment.

Targeted support referrals started low but increased steadily, reaching their highest levels toward the end of the period. This is positive to how the needs-led model is starting to become embedded.

Overall, the trend suggests improving identification of children who would benefit from Targeted support, while also highlighting ongoing work needed around education, early advice and ensuring referrals meet the appropriate threshold.

Neurodiversity

Addressing Legacy Waiting List

The 'legacy waiting list' refers to those children / young people aged 5 – 18 years accepted on the waiting list before 28th April 2025. Screening of referrals was very binary i.e. yes or no
There are 25 children remaining and will be booked into March 2026.

This was when the ND transitioned to become the Neurodiversity Early Support Hub (NESH) and screening has become more needs-led focussed.

All core capacity has focussed on booking in these assessments. However, alongside this has been the ongoing needs-led work:

- Screening outcomes being universal, targeted or specialist
- Raised threshold for accepting onto the waiting list
- Targeted work – contacting parents & schools for further information
- Emotional regulation parent groups
- Gwent Neurodiversity Website due to launch w/c 16th March 2026

Neurodiversity

Activity for January 2026

Screening

Definition: "Screened" means that one of the ND clinicians carefully reviews the referral along with parent information

Referrals to be screened: 348
Number of referrals screened: 236
Referrals remaining: 363

Activity
Under 5s: 16
Core 5 – 18yrs: 153

Total number of assessments: 169

Projected Activity for February 2026

Screening

Definition: "Screened" means that one of the ND clinicians carefully reviews the referral along with parent information

Referrals to be screened: 363
Projected no of referrals screened: 250
Referrals remaining: 400

Activity
Under 5s: 20
Core 5 – 18yrs: 128

Total number of assessments: 148

Projected Activity for March 2026

Screening

Definition: "Screened" means that one of the ND clinicians carefully reviews the referral along with parent information

Referrals to be screened: 400
Number of referrals screened: 250
Referrals remaining: 375

Activity
Under 5s: 20
Core 5 – 18yrs: 152

Total number of assessments: 172

Neurodiversity

The ND service continues to face sustained pressure, with referral demand increasing and waiting lists growing from 1,069 in April to 1,699 in November, including a rise in children waiting over 26 weeks.

Despite this, the service has consistently maintained the ministerial requirement of keeping the longest wait below 52 weeks.

The pause in needs-led targeted provision allowed the team to focus on clearing the legacy waiting list, with only 25 cases remaining, all scheduled for completion by March 2026.

Screening processes have strengthened, improving consistency in directing referrals to Universal, Targeted, or Specialist pathways.

Referral patterns show rising demand, fluctuating Universal outcomes linked to referral appropriateness, and steady growth in Targeted support, indicating increasing alignment with the needs-led model.

Projected activity for early 2026 demonstrates continued momentum in screening and assessments as the service moves toward fully embedding the Neurodiversity Early Support Hub approach.

CAMHs: Quality & Patient Safety

Quality & Safety

Patient & Staff Experience & Stories

<u>PCAMHS</u> - Multiple comments reflective of PCAMHS staff and their professionalism, conduct and expertise from wider CAMHS service
Staff feedback from patients and families their thanks to them – MF received compliments that her therapeutic intervention had helped the YP feel confident accessing trauma work and secure in the knowledge that CAMHS could help them.

<u>Continuing Care</u> - Implementation of a more user-friendly health assessment, which enables the practitioner and the young person to walk through the document quicker and encompasses all information that has previously been collated, therefore young people and families are not having to consistently re tell their story. Following the initial pilot families were asked to complete a questionnaire on their experience.

Families and colleagues provided the following feedback:

"I felt it flowed better than the complex needs assessment"

"The previous document did not flow and made the process more difficult for families and clinicians to follow"

"Much better assessment format and more meaningful and accessible"

<u>CALDS</u> - are in a really fortunate position to have Parent peer support worker Part of this role – is attending our understanding behaviours of concerns group. Here is some parental feedback regarding the role

- What difference (if any) did it make having someone with lived experience participating in the group?

"Encouraged engagement in a meaningful way- someone with lived experience."

"It made a massive impact and was really useful."

"Interesting listening to others in a similar situation made me feel a little more normal."

"Made a huge difference. Felt understood and could relate the teachings to real life."

"I feel better that we're not alone in this situation."

Our per support mentor takes and active part within our MDT's clinical conversation and contributes to development of processes within CALDS – using her own lived experience to influence care quality.

<u>CAMHS DAT</u> - QR codes for patients have been developed and circulated, alongside professional feedback forms. Those QR codes have been added to signature blocks on emails.

Feedback from Q3 service user experience forms: 6, which for a small service was positive

Feedback included:

<u>What was really good about your care?</u>

The empathy, kindness and knowledge that my support worker shared to me helped me come off hard substances completely and I've been around two months clean now. I'm so happy with the support I've received and have recommended this support to my closest friend who also struggles with addiction. I found it was incredibly easy to get along with my support worker and she gave me things to make sure I do to stay healthy (i.e. eat and drink) - this means a lot because it showed she cares and the support I have received has led to me having little to no thoughts about hard substances which I am so thankful for because I didn't see an escape from the addiction. Now I do, and I know I can beat it and I know people are there to support me and I cannot thank you enough for the help.

<u>Please tell us about anything you didn't like or anything that needs improving?</u>

Nothing needs improving

1 Patient and staff experience and stories

Incident Reporting

2 Incident Reporting, Falls, Pressure Ulcers, Medicines Management and Mortality

- Sadly CAMHS DAT experienced 2 deaths in the last month. Staff have received debriefs and support offered. Prudics and IRGs have attended, with service threshold lowered to those identified as close contacts. We are hoping to be included into a lessons learnt session

- CAMHS Dietetics Person-Centred, **Safe, Timely, Effective, Efficient, Equitable.**

We have identified an issue with yp being assessed in Choice appt – PCAMHS or Core mainly and it being noted that they have eating difficulties, are losing weight or have weight loss are missing meals, or need support to gain weight. They are referred to dietetics and then on hold until the work with the team begins – this could be a significant wait and there could be further weight loss.

Quality & Safety

Complaints, Concerns & Compliments

PCAMHS - Informal complaints with themes of waiting times – manage this at a local level with call backs to parents offering containment, validation and reassurance – where appropriate offering ad hoc reviews if appears deterioration in presentation
MP complaint – across 3 service areas – in process currently (03.03.26)

CALDS - has received 2 PTR complaint actions within the 2 years that I have been in post. both have raised time frames as a common theme in addition to other identified concerns. Compliments are shared within the team – and used by individual staff members as part of their PADR, and revalidation processes.

Collaboration with families and young people is valued by CALDS – over the years parents and CYP have been involved with team development activities – production leaflets, specialist community of practice events and interviewing for new members of staff.

Continuing Care - The team has received positive feedback from carers regarding the implementation of packages of care and the support the team has given both to families and the Practitioners that work with them. CC will work closely with CALDS and CAMHS teams when complaints arise that may involve a request for additional support and funding and requests for CC.

The new health assessment form has become more person centred and ensure that families and young people are able to collaborate and share their experiences and views on the care that is required. The DST also enables families to participate, this also includes the use of advocates or most recently a Turkish interpreter to ensure a full understanding of the process was shared.

3
Complaints, concerns and compliments

Health Safety & Security

Service reported a number of health and safety concerns of late with Pollards Well, which have included flooding, tripped hazards and leaking roofs and also Rats external to the building. There is ongoing building work on the roof but this has been started but not continued. CALDS is currently based in Pollards Well – issues ongoing with

- Heating – 2 settings on or off
- IT – intermittent due to the flooding prior to Christmas, requires extensive fix. Budget agreement pending.
- Roof – leaks, replacement required
- Leaks – flooding in corridor
- Rodents – number of rats spotted outside of doors into building.

Open Datix – violence and aggression directed towards member of staff. Investigation ongoing (CALDS)

Open Datix – for fall on premises of PW relating to a member of staff – due to equipment on site after flooding of building. Investigation ongoing.

Quality & Safety

Infection Control & Prevention

No infection reported

Safeguarding

Safeguarding

Continuing care - 3 staff are non-compliant currently for Level 3 Safeguarding but have been booked on the training on the 9th March 2026.

1 staff member is due and needs to book training as their competency expired in February.

Supervision takes place monthly for all staff and is stored in personal files.

Bi _annual safeguarding supervision with Safeguarding Team – recently discussed 2 cases in relation to risks and Domestic Violence concerns.

PRUDIC Incident in February - very difficult for all staff that worked with the young person, debriefs were undertaken and support given through supervision.

Again during focus monitoring all reports and information is reviewed and DTR's and Datix are raised if required.

CAMHS DAT - Compliance with M&S training is above 80%, the team have completed safeguarding supervision (x2 required in a year). This was provided to us a team as our work is highly specialised.

As per the recommendations from 'our bravery Brought Justice' 2024 Gwynedd, implementation of the CSERQ (Child Sexual Exploitation Risk Questionnaire) roll out has been implemented across iCAMHS. The CSERQ can help identify potential risk early, allowing for timely intervention and supporting professional judgement on deciding when to make a child at risk report.

PCAMHS - 80%+ compliance in PCAMHS for level1,2,3 child safeguarding and level 1 adult safeguarding
Staff aware to cc in corporate safeguarding when submitting DTR – have contact information to discuss concerns with corporate

Quality & Safety Priorities

- Ongoing service improvement – with development of SBAR's to identify the need to grow the team to respond to growing number of red rag rated cases being held within the service.
- Clean up of WCCIS and data collection methods ongoing
- Development of new transition process and pathways ongoing with support from adult LD teams.

As per the rise in complex alcohol use in the under 18's presenting to the CAMHS Drug and Alcohol Team, a scoping exercise has commenced capturing need and service responses across Wales. As there are no beds available to safely detox an under 18 young person, this results in delays in care, increased risk in developing health issues, disengagement and loss of trust in service provision and more often than not- results in A&E admissions with emergency detoxes which increases trauma.

- Audits conducted as required – i.e. staff case notes if same staff member is highlighted for issues around process/admin
- Questionnaires/1:1s regularly held to share difficulties, learning and how they can be implemented
- Locally – we adjust what isn't working to fit within the parameters of PCAMHS i.e trauma reviews/intervention (embedding CRIES8 into assessments, reviews with trauma clinicians before accessing trauma therapy)

Re QI plan to hold quarterly meetings TOR and dates to be disseminated, to feed into this meeting and hold a list of QI projects in CAMHS and work with each clinical area to be looking at potential areas for improvement.

Agenda Item:

	CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	24 March 2026
CYFARFOD O: **MEETING OF:**	Mental Health and Learning Disabilities Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	2025/2026 Dementia Annual Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Jennifer Winslade, Executive Director of Nursing
SWYDDOG ADRODD: **REPORTING OFFICER:**	Tanya Strange, Head of Nursing Amanda Whent, Lead Nurse Dementia

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Welsh Government's Dementia Action Plan and the AllWales- Dementia Care Pathway Standards set out clear expectations for improving the rights, experiences and outcomes of people living with dementia and those who care for them. The Regional Dementia Strategic Partnership, bringing together health, social care, third sector organisations and Dementia Friendly Communities, has continued to take a proactive, whole system approach to delivering these national requirements. Significant progress- has been achieved through multiagency workstreams focused on improving access, responsiveness, person- -centred pathways and strong partnership working across the Gwent region.

During 2025–2026, the Partnership has overseen substantial developments including the expansion of community b-ased dementia support, strengthened Memory Assessment Service pathways, enhanced carer education, and continued progress against the Dementia Friendly Hospital Charter. This collaborative work has been shaped by citizen and carer feedback and reflects a regionwide commitment to improving quality, safety and experience. The Board is asked to CONSIDER the Annual Report for assurance of progress made to date and to note areas where further support will be required- to sustain and strengthen delivery of the dementia programme moving forward.

Background:

In 2021, Improvement Cymru published the *AllWales Dementia Care Pathway Standards*—20 person centred standards designed to improve consistency, quality and outcomes for people living with dementia and carers. Launched nationally in 2022, the standards are organised under four themes (Accessible, Responsive, Journey, and Partnerships & Relationships) and align closely with the Dementia Action Plan for Wales. Delivery in Gwent is intentionally whole system, spanning health, social care, third sector and Dementia Friendly Communities to ensure coherent pathways across settings.

The Regional Dementia Strategic Partnership, reporting through the Regional Leadership Group and Regional Partnership Board, provides the governance, leadership and joint decision making to embed the Standards across the five Gwent local authorities and Aneurin Bevan University Health Board. Dedicated workstreams drive improvements in access, pathway responsiveness, carer education, and hospital experience under the Dementia Friendly Hospital Charter, with progress framed by lived experience feedback.

Delivery of the Dementia Standards is central to the Health Board's quality, safety and experience ambitions, supports equitable access, and underpins patient flow by reducing avoidable deterioration and admissions through earlier support, targeted education for carers, and person centred pathways. This is reflected in regional progress on community engagement, Memory Assessment Service (MAS) pathway improvements, carer education (MEC), and hospital based person centred care.

Implementation leverages multiagency assets including community dementia hubs, dementia advisors/connectors, learning and development, and monitoring, so people can access information, assessment, diagnosis and post diagnostic support closer to home, with smoother transitions between community and hospital.

The Partnership oversees bi-monthly progress reviews, uses agreed data sets and workstream KPIs, and responds to patient/carer feedback to target improvement and reduce variation, with annual reporting to the Health Board. Programme delivery currently benefits from regional funding; however, national funding arrangements beyond 2027 remain uncertain, requiring active oversight of sustainability, prioritisation and risk.

The programme supports the Health Board's Quality Strategy and Patient Experience and Involvement Strategy, Health and Care Standards (e.g., Dignified Care; Peoples' Rights), and IMTP priorities for ageing well and independence, ensuring dementia care is person centred, equitable and evidence informed.

Asesiad / Assessment

The Dementia Programme continues to deliver a region-wide, multi-agency approach to implementing the All-Wales Dementia Care Pathway Standards. Progress during 2025–2026 demonstrates clear improvement across all workstreams, with actions aligned to strategic priorities, system flow, carer support, prevention, and person-centred care. Oversight is provided through the Regional Dementia Strategic Partnership, with bi-monthly performance review, KPI

monitoring and a strengthened focus on assurance, variation reduction and lived-experience feedback
.
Summary Assessment of Actions Taken

A comprehensive overview of all actions delivered across the dementia workstreams during 2025–2026 is provided in the attached Dementia Annual Report. The report sets out the evidence, activity, and outcomes achieved through each workstream in detail, demonstrating how the programme has progressed against the All-Wales Dementia Care Pathway Standards and regional priorities. The summary below highlights the key areas of progress and assurance for the Board and focuses on the elements most relevant to oversight, governance and strategic decision-making.

1. Community Engagement
Significant progress has been achieved in widening reach and improving access to dementia information and support. Forty community engagement events were delivered, engagement with diverse and intergenerational groups expanded, and Dementia Hubs were fully launched across all five local authorities. The Dementia Friendly Communities Network now includes over 400 participants, complemented by new programmes such as the Dementia Aware Trainer initiative, podcasts, Padlet resources and strengthened collaboration with local employers. These developments have enhanced preventative messaging, early access to advice, and community-based support.

2a. Memory Assessment Service (MAS) Pathway
This workstream has focused on increasing equity, accessibility and consistency of diagnostic pathways. Ten national and regional data measurement sets have been implemented to support benchmarking and improvement. New resources, including pathway leaflets and patient information, have been produced, and MAS partners are actively engaging people living with dementia and carers. Work has also advanced on innovative diagnostic research, including participation in the Sandbox blood biomarker study, positioning Gwent as an early adopter in Wales.

2b. Carers' Education and Support
The Mapping, Education and Carers (MEC) programme has substantially expanded its offer, delivering a standardised Gwent-wide Carers Information Course across all boroughs in face-to-face and virtual formats. Carers are routinely offered Positive Approaches to Care (PAC) training and receive new resource packs (digital and paper). A Carers Padlet is in development to streamline access to up-to-date information, and the DAVID document has been introduced to improve communication and reduce avoidable admissions or delays in crisis situations. Early trials of hospital-based carers hubs have commenced.

3. Dementia Connectors
A regional Dementia Connector model has been established, with role descriptors, skills frameworks and Welsh Government funding enabling new posts within Dementia Hubs and MAS. Connectors now provide personalised, proactive support to help people navigate services, optimise wellbeing and access timely help. A commissioning review is underway to strengthen Service Level Agreements with third sector partners to secure consistency and future sustainability.

4. Dementia Friendly Hospital Charter
The Health Board has continued to implement the Charter's three year action plan, with strong multidisciplinary engagement. Ward teams have delivered VIPSbased improvement plans, strengthened inclusion of carers through John's Campaign, expanded dementia volunteers and introduced bedside boards to support communication and personcentred care. Senior nurse presence has increased visibility and coaching, while intranet resources and guidance have improved staff access to specialist advice. Collaborative work has also extended to HMP Usk and Prescoed, with grantfunded programmes supporting meaningful engagement across hospital and community settings.

5a. Learning and Development
The Dementia GoodWork Learning and Development Framework has driven improvements in workforce competency and confidence. Mandatory dementia awareness compliance is at 81.7% to date, with a wide range of specialist sessions delivered across care homes, community settings, hospitals and partner organisations. Bite-size learning, induction programmes, external expertise and multi-agency training have strengthened capability across all levels. The end of practice educator funding presents a challenge, with future capacity for delivery flagged as a key risk.

5b. Monitoring
A structured monitoring approach is now embedded, with workstream leads supported to map available data, identify gaps and align with national reporting requirements. Work continues with performance teams across health, local authorities and third sector organisations to ensure coherent data sharing and analysis. Monitoring is strengthened through KPIs, AMaT ward audits, patient and carer feedback, and enhanced benchmarking activity.

Programme Assurance, Risks and Mitigation

The Dementia Programme has delivered meaningful improvements across all workstreams, demonstrating strong partnership working, system-wide coordination, and increasing alignment with the All-Wales Dementia Care Pathway Standards. The impact on quality, experience and access is particularly evident through strengthened community engagement, improved diagnostic pathways, enhanced carer support, and more person-centred hospital care. Progress is reinforced through bi-monthly reviews, KPI monitoring, patient and carer feedback, and maturing data and governance arrangements.

At the same time, the Partnership has identified a set of strategic risks that require continued monitoring and mitigation to maintain progress. These include future funding sustainability, workforce capacity, increasing diagnostic demand, variation across boroughs, hospital-based dementia care challenges, data and monitoring complexity, rising carer support needs and system flow pressures. These risks are recognised and actively managed through established governance forums, and the Partnership has set out clear, deliverable mitigation actions to reduce variation, strengthen sustainability and improve outcomes for people living with dementia and their carers. Continued Executive support will be essential to ensuring delivery of the next phase of the dementia improvement programme.

Dementia Programme Risk and Mitigation

Risk Area	Description of Risk	Impact on Quality / Safety / Performance	Current Mitigation	Further Actions by the Regional Dementia Strategic Partnership
1. Sustainability of Funding (post-2027)	National funding beyond 2027 is not yet confirmed, creating uncertainty for Dementia Hubs, Dementia Advisors, and L&D delivery.	Potential loss of capacity, reduced community access, slower progress on Standards, and increased pressure on core services.	Active monitoring of WG updates; alignment of workstreams to strategic priorities; use of RIF funding to maintain delivery.	• Develop a sustainability plan with costed options for 2027 onwards. • Identify priority functions for core-funding protection. • Strengthen evaluation data to demonstrate impact/value to support investment decisions.
2. Workforce Capacity (loss of practice educator; staff absence)	A reduction in dedicated dementia education roles limits ability to meet training demand and maintain competency levels.	Reduced workforce preparedness, variation in practice, and slower implementation of Dementia Standards.	Use of multi-agency facilitators; continuation of bite-size and induction sessions; dementia champions supporting awareness work.	• Create a revised multi-agency L&D delivery model. • Explore joint funded educator posts across the region. • Consider digital training assets to reduce dependency on face-to-face educators.
3. Increasing Diagnostic Demand (MAS pathway)	Rising diagnosis rates and activity through MAS will create increased pressure on follow-up, post-diagnostic support, and community services.	Longer waiting times; risk of unmet need; potential impact on early intervention.	Introduction of MAS booking centre; pathway streamlining; research participation to modernise diagnostics (e.g., biomarkers).	• Expand the MAS Community of Practice to standardise improvements. • Strengthen integration between MAS and Dementia Advisors/Connectors. • Model projected demand to inform future capacity planning.
4. Variation Across Boroughs / Providers	Differences in local capacity, community support offers, and third-sector provision create inequity in access and delivery.	Inconsistent experience for people living with dementia and carers; variation in outcomes; governance complexity.	Shared governance through Regional Partnership Board; regional standards; Dementia Hubs model improving consistency.	• Complete commissioning review for Connector roles and dementia support services. • Consider single regional dashboards/KPIs. • Implement regional pathway documentation (MAS, Carers Packs, DAVID).
5. Hospital Based Dementia Care	Need for continued improvements in dementia-friendly	Impact on patient wellbeing, flow,	VIPS improvement plans; John's	• Strengthen linking of dementia priorities to 6 Goals, Falls, and UEC

(charter progress challenges)	environments, meaningful engagement, carer involvement, and staff confidence.	experience, and safety; risk of avoidable distress, prolonged stay or incidents.	Campaign; dementia volunteers; bedside boards; senior nurse visibility.	pathways. • Roll out Meaningful Engagement Programme to all divisions. • Continue AMaT audits and feedback loops.
6. Data and Monitoring Complexity	Multiple systems and organisations with differing datasets make coherent performance reporting challenging.	Limited ability to provide consistent Board-level assurance; risk of missed trends or variation.	Workstream mapping of datasets; national alignment; bi-monthly reporting through the Partnership.	• Explore a unified regional dementia data set (community + MAS + hospital + carers). • Explore shared dashboards with LA and 3rd sector partners. • Align monitoring to national dementia KPIs when published.
7. Carer Support Demand Outstripping Supply	Growth in carer education needs and emotional support is outpacing delivery capacity (MEC).	Increased risk of carer breakdown and preventable hospital admissions; lower satisfaction.	Expansion of Carers Information Course; digital resources; DAVID document; virtual delivery options.	• Increase collaboration with community and voluntary organisations. • Develop blended (digital + in-person) support model. • Map unmet need and prioritise high-impact groups.
8. System Flow and UEC Interface	Pressure on discharge and ward moves impacts people living with dementia disproportionately.	Delays, distress, deconditioning, increased length of stay.	Alignment with 6 Goals; senior nurse leadership; bedside boards; Dementia Friendly Hospital Charter.	• Strengthen dementia considerations in UEC pathway redesign. • Enhance discharge communication tools (DAVID, connectors, carers hubs).

The risks identified are appropriately recognised, monitored, and mitigated through established governance arrangements. The Regional Dementia Strategic Partnership has clear, deliverable actions in place to reduce variation, strengthen sustainability, align to national standards, and improve outcomes for people living with dementia and carers. Continued regional partnership and executive support, particularly around workforce and financial sustainability, will be central to maintaining progress and delivering the next phase of the dementia programme.

Going Forward: Strategic Priorities for the Dementia Programme

Looking ahead, the Regional Dementia Strategic Partnership will continue to take a proactive, whole-system approach to strengthening dementia care across Gwent. Building on the progress achieved in 2025–2026, the Partnership will prioritise sustainability, equity, and improved outcomes for people living with dementia and their carers. A key focus will be on ensuring that the actions set out in the risk and mitigation plan are delivered at pace, supported by robust governance,

transparent performance monitoring and a commitment to reducing variation across the region.

The coming period will involve strengthening the financial resilience of the programme in preparation for the end of Welsh Government funding in 2027. Work will include producing a costed sustainability plan, identifying essential functions for potential core-funding, and using strengthened evaluation data to demonstrate system-wide impact. Workforce capability and capacity will remain central, with a focus on developing a sustainable multi-agency learning and development model and increasing the use of digital learning resources to maintain competency across the wider workforce.

Ensuring the Memory Assessment Service pathway can meet rising diagnostic demand will be a key priority. The Partnership will support MAS to standardise practice through its Community of Practice, strengthen integration with Dementia Advisors and Connectors, and model future activity to inform long-term planning. Alongside this, work to improve equity of access across the five boroughs will continue, including refreshed commissioning arrangements, consistent pathway documentation and the development of unified regional dashboards.

Improving dementia friendly hospital care will remain a core commitment. The Programme will continue to embed VIPSbased improvement plans, expand meaningful engagement interventions, and ensure dementia related priorities are visible in unscheduled care redesign, discharge planning and key patient flow pathways. Data improvement will also be a priority, with the Partnership progressing the development of a single regional dementia dataset, expanding shared dashboards and aligning to national dementia KPIs once published.
The Partnership will also focus on strengthening the support available to unpaid carers. This will include expanding blended learning opportunities, enhancing collaboration with voluntary and community partners, and mapping unmet need to ensure support is prioritised for those at highest risk of carer breakdown. Work to improve system flow for people living with dementia, particularly at discharge, will be progressed through enhanced communication tools such as DAVID, expanded connector roles and increased presence of carer support in hospital settings.

Collectively, these actions demonstrate a clear and proactive forward plan that prioritises sustainability, consistency, lived experience feedback and measurable improvement. The Partnership remains fully committed to delivering a high quality, person centred dementia programme for Gwent and will continue to provide the Board with assurance on progress, risks and outcomes as work advances.

Argymhelliad / Recommendation

Th Committee is asked to:

- **CONSIDER** the Dementia Annual Report and the assurance provided regarding progress across all workstreams during 2025–2026.
- **ACKNOWLEDGE** the significant improvements achieved through the Regional Dementia Strategic Partnership, including strengthened pathways, enhanced community engagement and improved person-centred hospital care.
- **NOTE** the identified risks and the actions underway to mitigate these across the region.

- **ENDORSE** the forward strategic priorities and planned actions that will sustain delivery of the Dementia Standards and reduce variation across Gwent.
- **SUPPORT** the continued development of strong regional governance arrangements to oversee delivery, assurance and risk management.
- **RECOGNISE** the contribution of people living with dementia, carers and partners whose feedback has shaped the programme's progress and future priorities.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2.1 Managing Risk and Promoting Health and Safety 3.1 Safe and Clinically Effective Care 4.1 Dignified Care 6.2 Peoples Rights
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well Older adults are supported to live well and independently
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Work in partnership with carers to continue awareness raising, provide information and improve practical support for carers Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse Improve the access, experience and outcomes of those who require mental health and learning disability services Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	National Dementia Standards National Dementia Action Plan Quality Strategy Patient Experience and Involvement Strategy Mental Capacity Act
Rhestr Termau:	

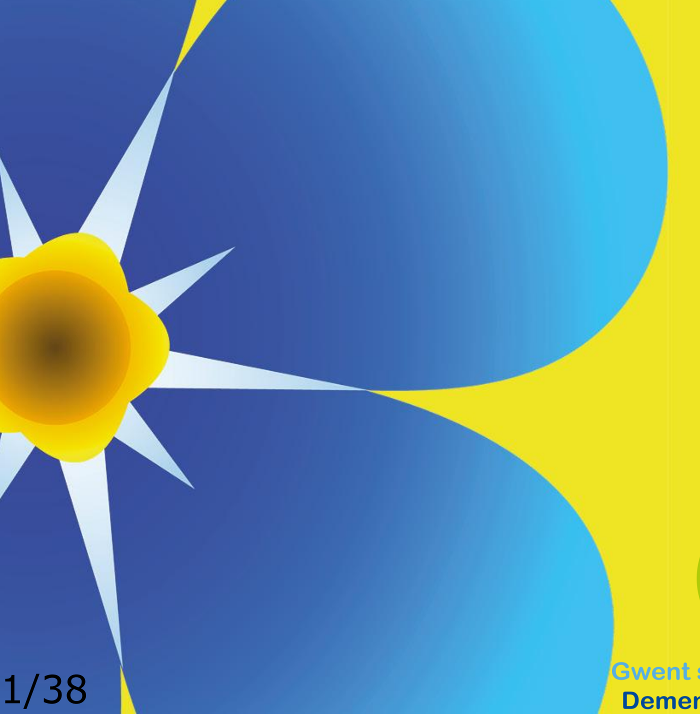
Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Regional Dementia Strategic Partnership

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• **Workforce**	Yes, outlined within the paper
• **Service Activity & Performance**	Yes, outlined within the paper
• **Financial**	Not Applicable
Asesiad Effaith Cydraddoldeb **Equality Impact Assessment** (EIA) completed	Choose an item. An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs Collaboration - Acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its well-being objectives

Annual Progress Report

All-Wales Dementia Pathway of Care

February 2025- 2026.



Person-Centred Dementia Care Team

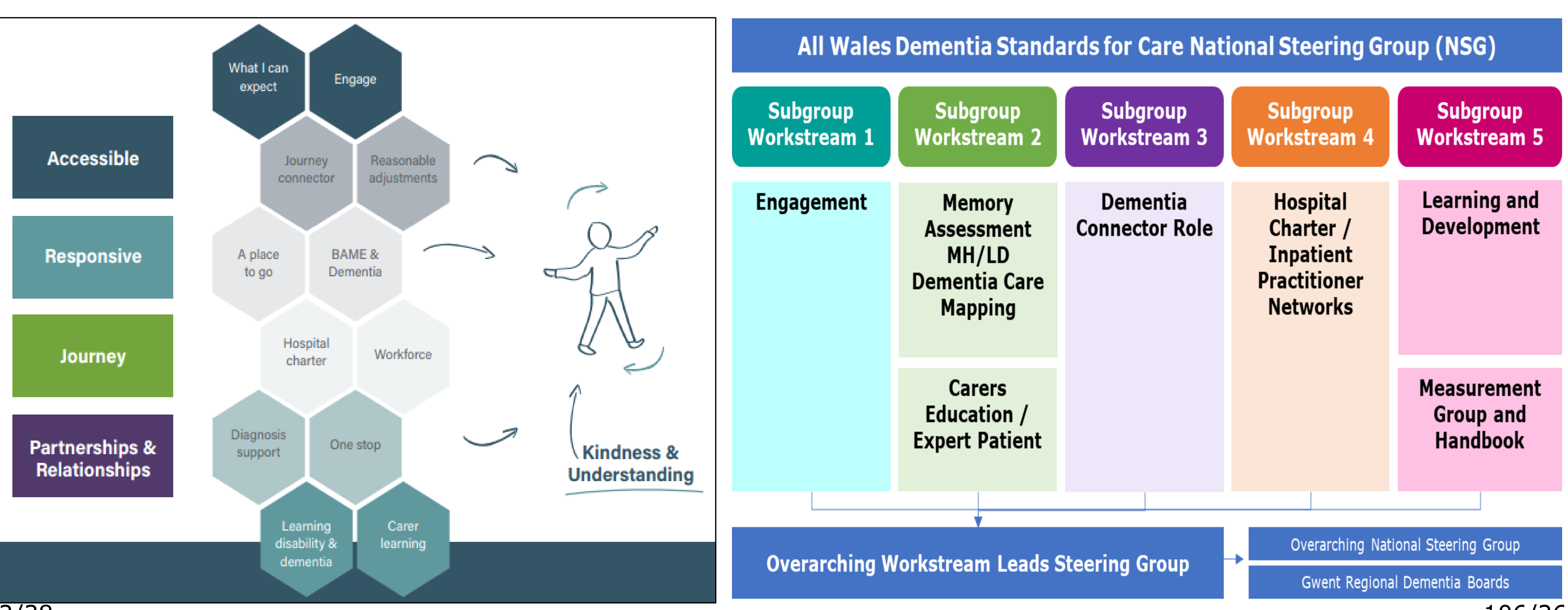
We are committed to supporting the workforce to deliver and embed the highest standard of dementia care for patients and carers.

Gwent sy'n Deall Dementia
Dementia Friendly Gwent

Dementia Standards for Pathways of Care

The Regional Dementia Strategic Partnership, chaired by Aneurin Bevan University Health Board, continues to make good progress towards the requirements outlined within The All-Wales Dementia Care Pathways of Standards.

This Annual Report identifies the priorities and actions taken over the 12-month period **February 2025/2026**, set out under each of the **5 priority areas**.

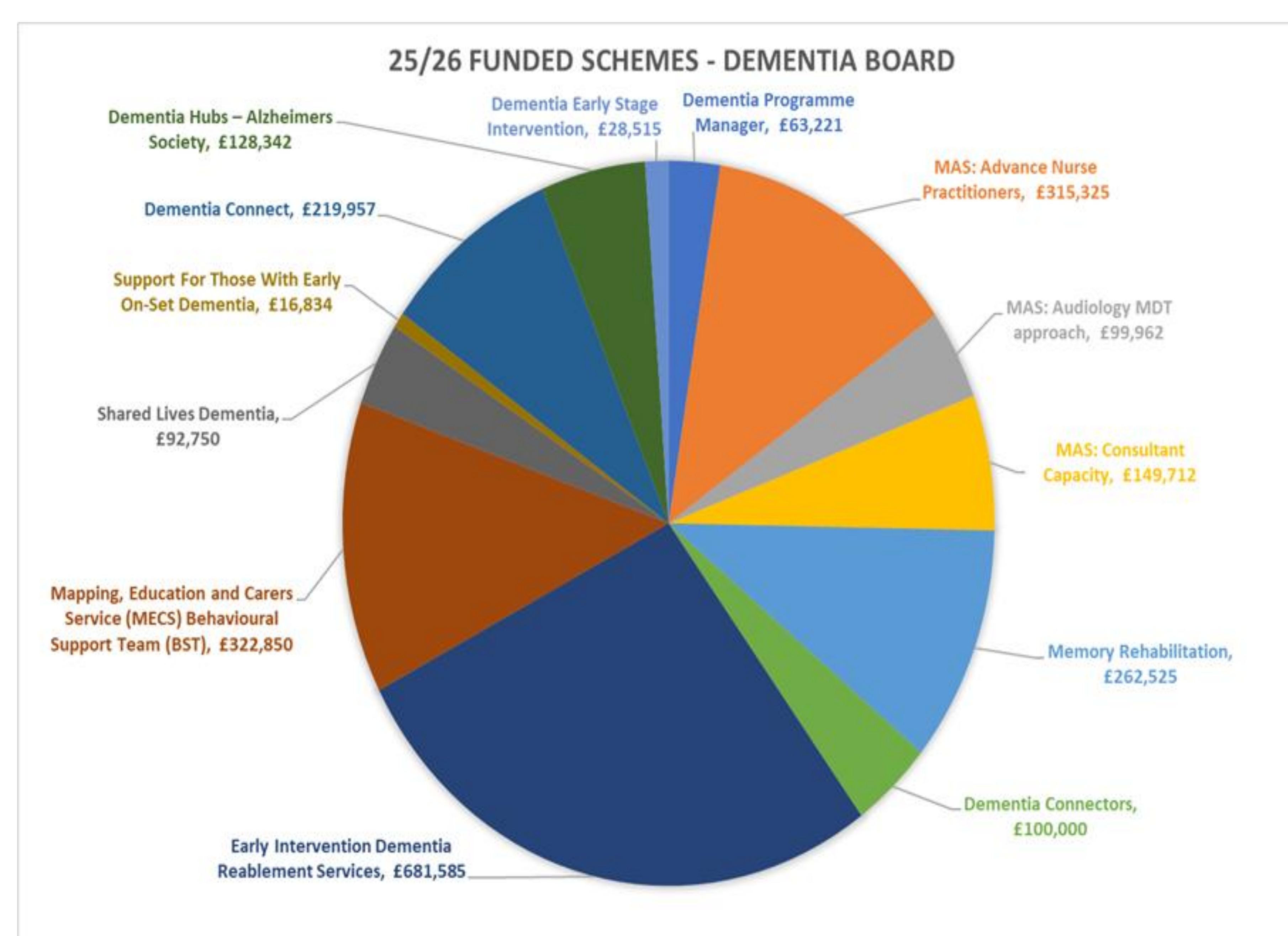


Funded Dementia Schemes

The Dementia Strategic Partnership Board has a total funding allocation of **£2.48m in 2025/26** to deliver the projects within the Dementia programme.

The RIF (Regional Integrated Funds) currently support several programmes of work which deliver against identified priorities and gaps in care.

The programmes identified remain under review and the Welsh government have not yet identified future funding allocation following 2027.



Workstream 1

Community Engagement

In Collaboration with Dementia Friendly Gwent's' **475** members, there has been engagement with many groups and communities.

During the past year, over **40** events took place across many parts of the community including engaging with diverse populations and intergenerational opportunities with children throughout the community.

The events focused on raising awareness of dementia, promoting understanding, seeking views, gathering experience feedback and enhancing collaboration through partnership working.

Collaboration and Partnership

During the last year, closer relationships have been built with the organisers of **Parkrun**. Promoting the risks of social inactivity and the benefits of the aim of the discussions is to make '**Parkrun'** dementia friendly. Parkrun provides an excellent opportunity to promote wellbeing and reduce the risks of inactivity.

Torfaen Talks partners with Dementia Friendly Gwent to launch Podcast Series in 2026

Dementia Friendly Gwent with the Health Board is proud to announce the launch of a brand-new **podcast** series with Torfaen Talks! This special series shines a spotlight on the inspiring work happening across Gwent to create communities that are supportive, inclusive, and understanding of people living with dementia and their families.

Charity No: 1172466

Beginners Couch to 5K

A supportive walking/ running programme for people living with dementia and their carers — open to everyone!

Get moving at your own pace in a friendly, understanding environment.

Together we'll work towards taking part in the Riverfront Parkrun!

- Dementia-aware and inclusive
- No running experience needed
- Carers and companions welcome
- Build fitness, confidence, and community

Every Thursday , 11am-12pm

First Session meet at Riddershins Centre, Sebastopol

age connects torfaen.

Tel: 01495 769264

Email: sportsconnect@ageconnectstorfaen.org

Age Alive community event Newport-wellbeing

In 2025, **Dementia Hubs** were implemented in each local authority across Gwent as a pilot. In January 2026, the formal launch of the hubs took place, supported by the **27** multi agency partners, citizens of Gwent and **HTV Wales.**

These spaces allow professionals, volunteers and community members to access **information, advice and support** supporting people concerned about their memory, living with dementia or caring for someone with dementia.

In total, **1303** visits were made to the Dementia Hubs as of end of January 2026.

Community Engagement and Feedback: The hubs have been described as a "lifeline" by families, offering crucial support and information during difficult times. This engagement has also provided valuable feedback for improving dementia care and support services in line with the All-Wales Dementia Pathway of Care.

Positive Outcomes: The hubs contributed to raising awareness of dementia, and early diagnosis, post diagnostic support and increased community awareness, working to enhance the overall quality of life for individuals with dementia.

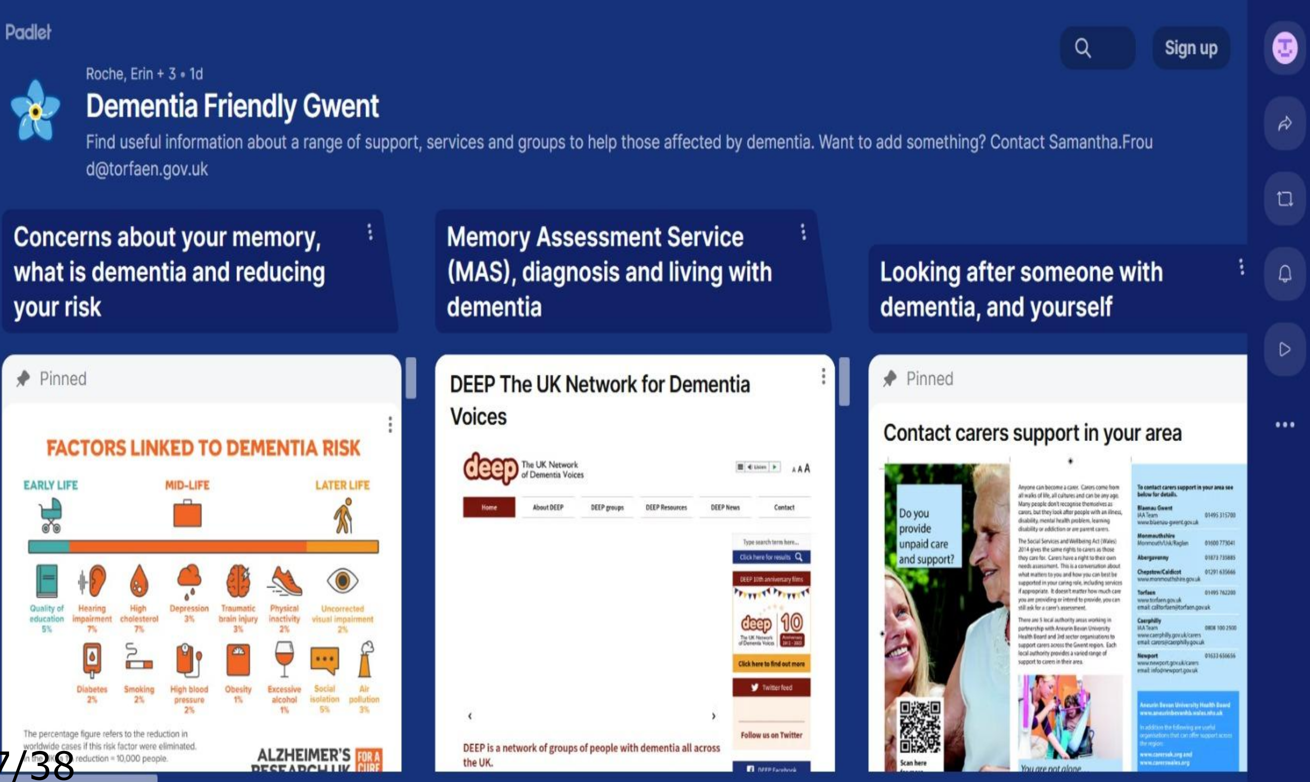
"I wanted to come back into the dementia hub and say thank you for all the information you gave me. I have passed this onto my Nan who wanted me to thank you too, she was very grateful" *– Citizen*

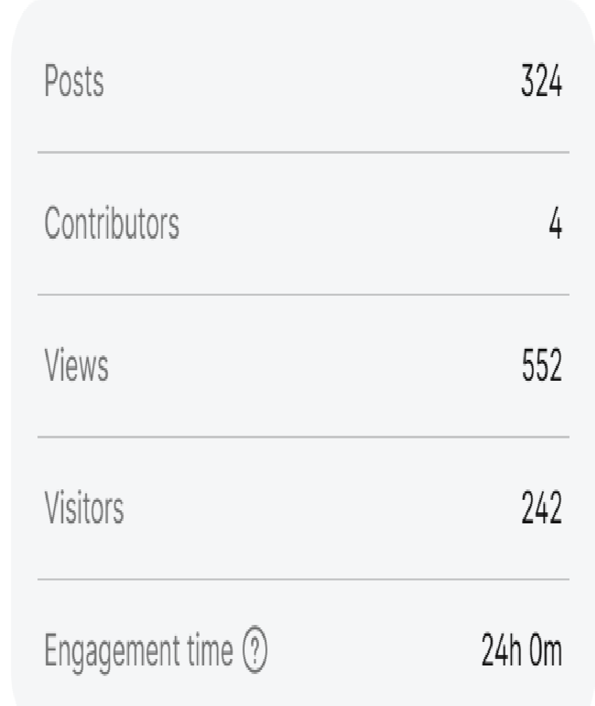
Dementia Aware Sessions –Creating Dementia Aware Communities

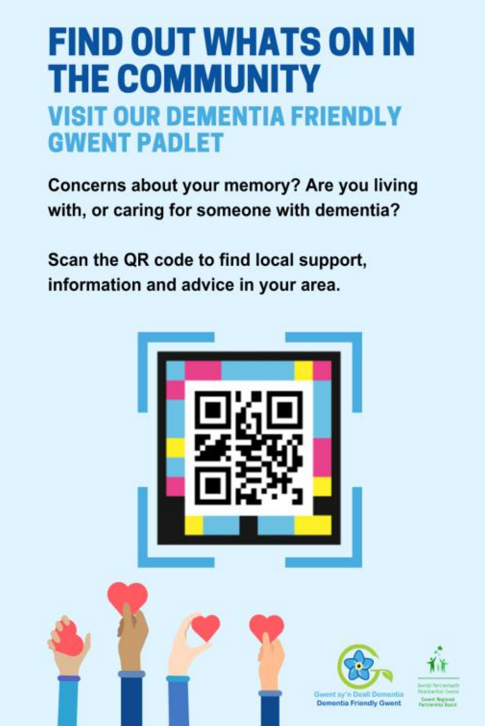
There are now **44** Dementia Aware **Session Leaders**

Between October 2025 and February 2026, **84** people attended a Dementia Aware session.

A co-produced **Regional Dementia Padlet** has been developed and launched in January 2026. This contains information and signposting.







Dementia Action Week Dementia Action Week 19 – 23 May 2025

Dementia Wards Aneurin Bevan

- Annwylfan held an afternoon tea garden party with the opening of their new garden.
- Sycamore Ward arranged for a singers and multiple activities going on throughout the week.

Opal Team held information sessions for staff, visitors and patients. Lunch time sessions were held to focus on hydration- sessions on different wards providing water-based fruits, drinks and focusing on the importance of hydration.

Our **regional partners** joined us, aiming to make 7000 Dementia Friends – that's 1000 a day! running virtual information sessions every weekday.

Held a **"Let's Talk Brain Health"** information session designed to help people optimise their cognitive well-being. This session covered a range of topics, including:

- **Understanding Dementia**: Learn about the different types of dementia and understand how they affect individuals differently.
- **Risk Factors**: Discover the 14 risk factors for dementia.
- **Reducing Risk**: Explore ways to reduce the risk of dementia and taking control of brain health.
- **Memory Assessment Services**: Get information about the pathway for dementia diagnosis and support.
- **Dementia Hubs**: Learn about the dementia hubs located in each local authority area, which provide information and support for people living with dementia, their families, and carers.

The Patient Experience Dementia Team held **Roadshow** events at each hospital site to share the best practice, resources and information.

Workstream 2(a)

Memory Assessment Service Pathway

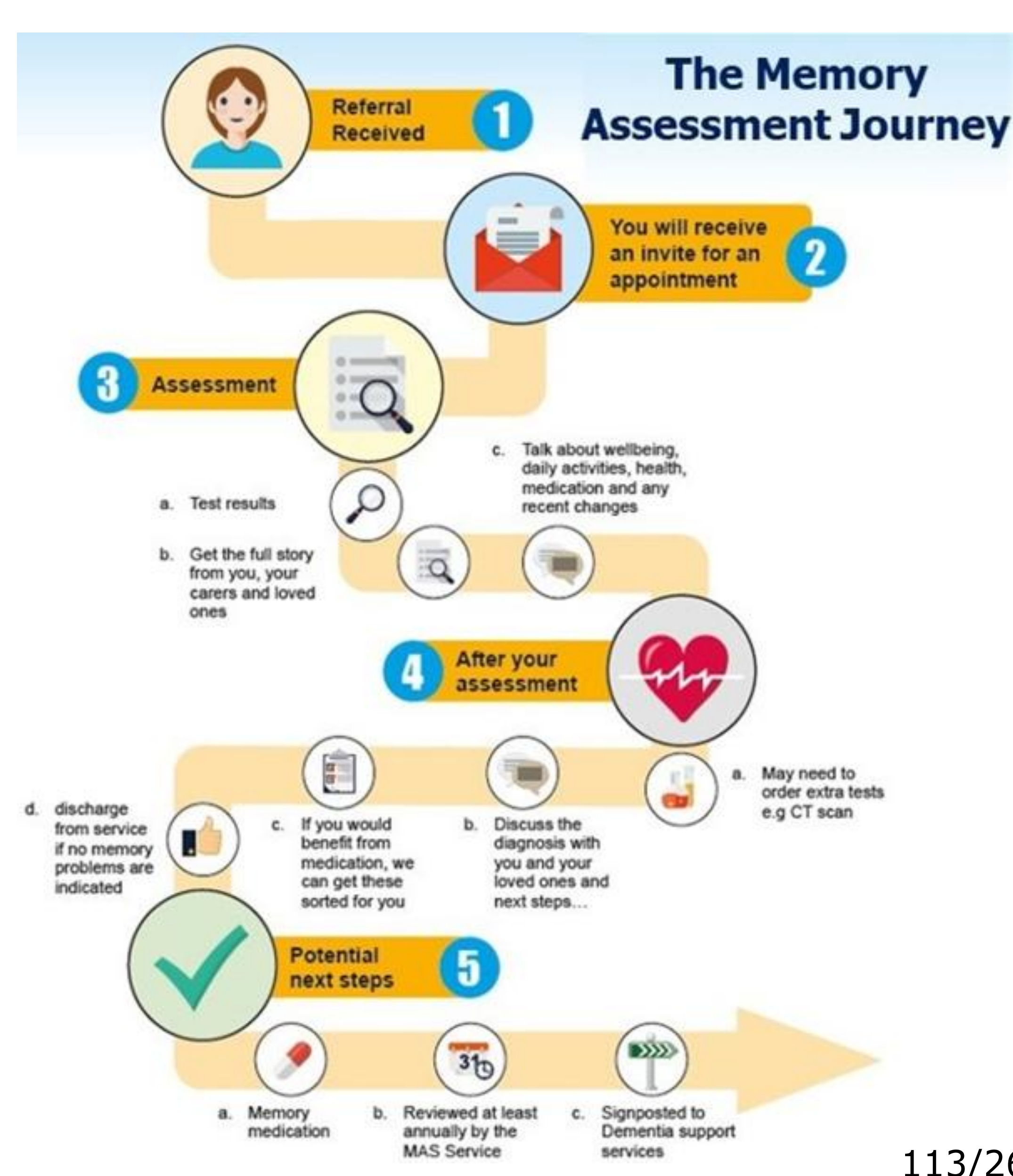
The aim of **Workstream 2(a)** is to ensure the development and creation of a seamless and **robust pathway** for people assessed and diagnosed with Dementia, their carers and others engaged with people living with Dementia.

Memory Assessment Journey leaflet has been developed to send out with all new appointments for MAS.

MAS Website now live including all contact details, services offered, directions.

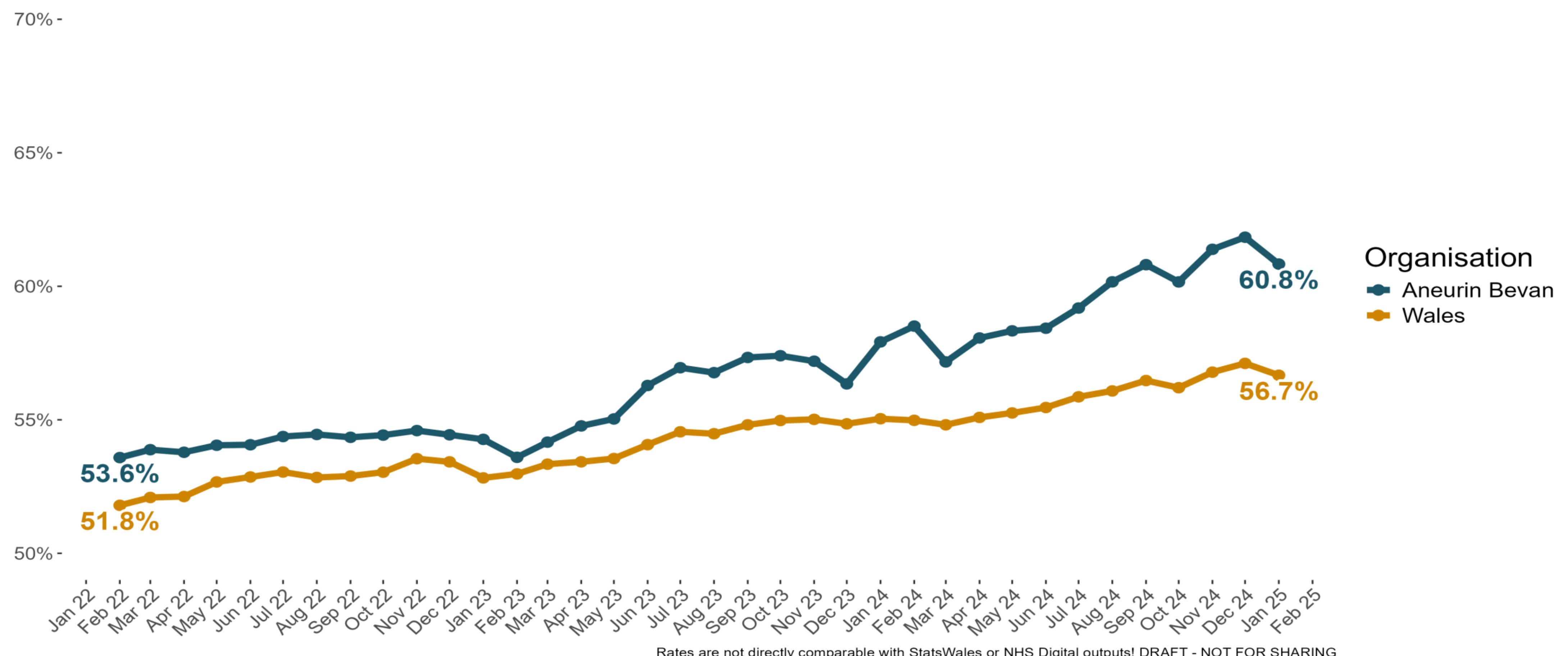
MAS Central Referral and Booking Centre in place 1st December 2025-11th January 2026. Currently in final review stages of proposed model document. This will improve equity of access across all boroughs. It will allow patients and carers to choose their appointment time and place, and potentially reduce wait times, by using more efficient systems.

SANDBOX Research Study underway – Led by Dr Chineze Ivenso, looking at blood biomarkers in assisting early diagnosis of dementia. Aneurin Bevan are the first Health Board in Wales to work with this research study.

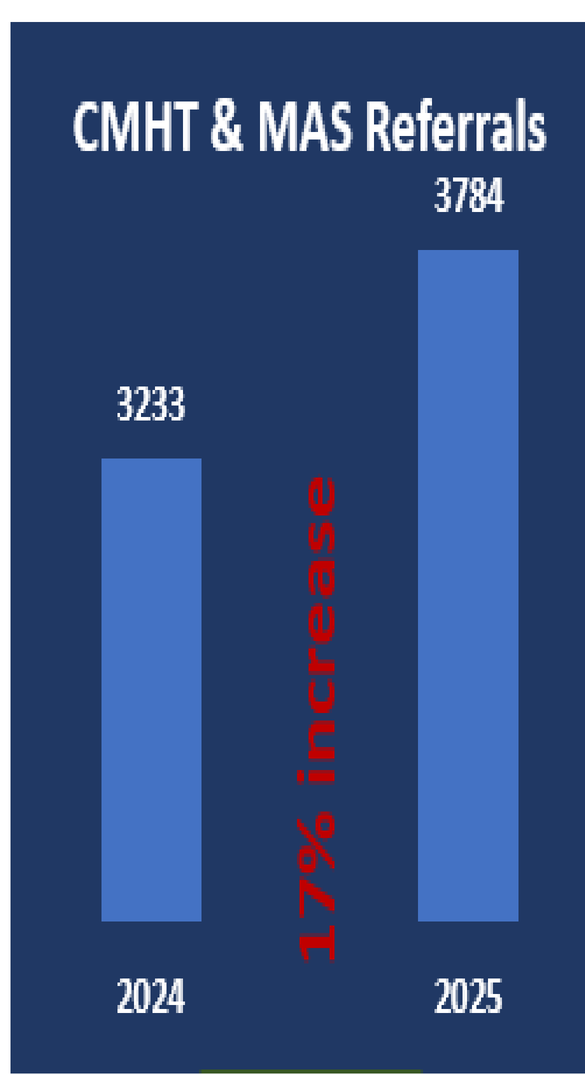


Estimated Dementia Diagnosis Rates: Aneurin Bevan University Health Board

In 2025 **Memory Assessment Services (MAS)** across ABUHB delivered **21,297** appointments, this is an **increase of 668** appointments**.** There have been further additions to the pathway for support following diagnosis as well as identification and recognition of dementia. Currently the diagnostic rates in the Health Board is above the Wales average.



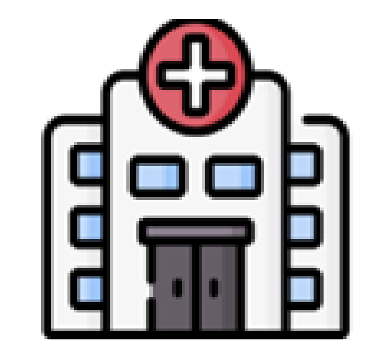
Impact of Improved MAS Pathway.

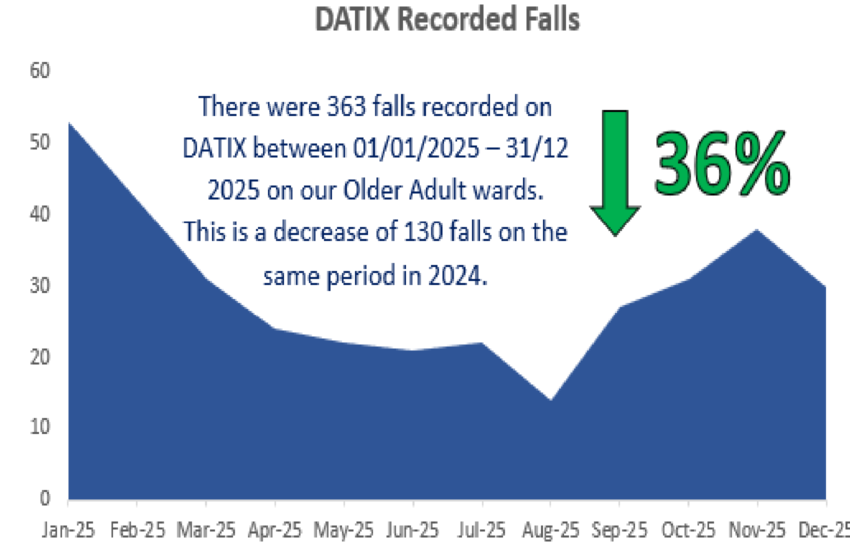


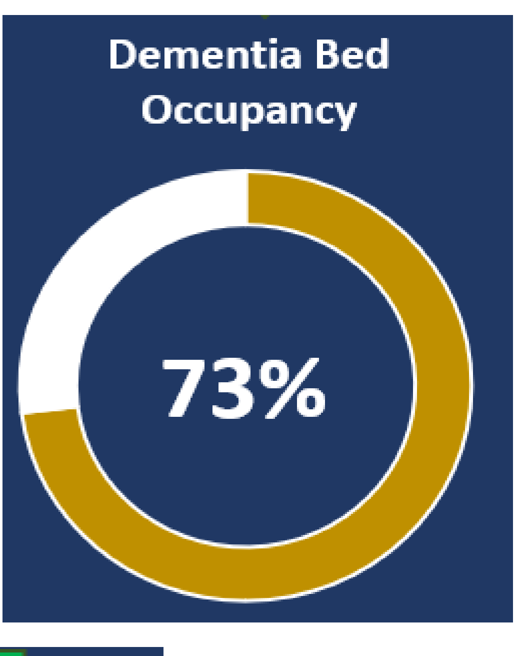
Older Adult Psychiatric Liaison
Delivered **21,375** hospital appointments.

This is an **increase** of 757 from 2024 (4%)

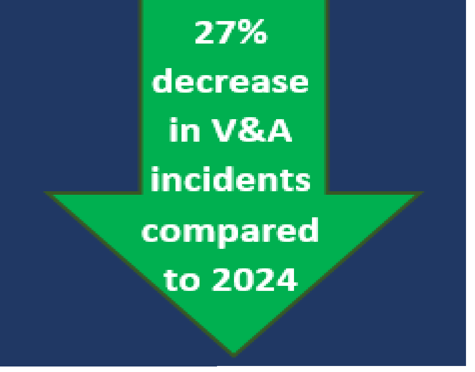
OPAL completed on average 187 appointments







Memory Assessment Services delivered 21,297 appointments

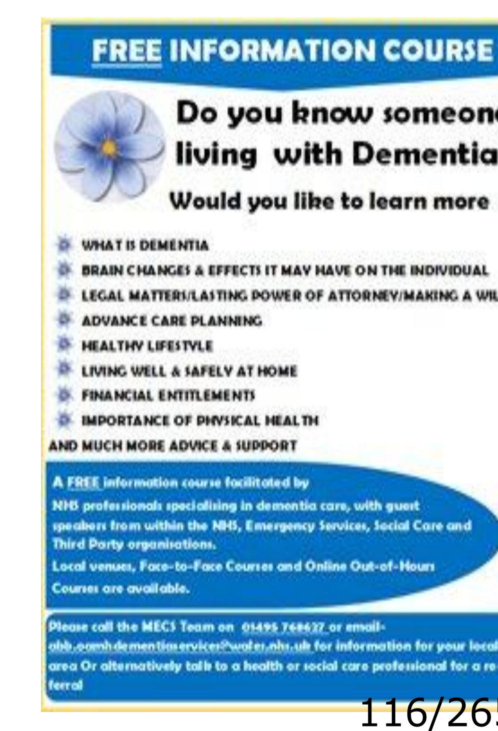


Workstream 2(b)

Carers Education and Support

Workstream 2(b) aims to ensure that people living with dementia, carers and families are offered learning, education and skills training. This offer will be 'stage of condition' appropriate and will be provided at significant points of a person's journey.

- The **MEC** (Mapping, Education and Carers) team, have developed a Gwent wide **Carers Information Course** that now runs in six-week blocks in all five Gwent region boroughs. **374 referrals** have been received.
- Carers are also offered **Positive Approaches to Care** training, which is a person-centred approach and intervention in dementia care.
- A **resource pack** for Carers has been developed and is in use. This is in both paper and digital formats.
- The team are currently developing a **Padlet** for Carers to access a wide variety of up-to-date information.
- **National Exercise Referral Scheme** across Monmouthshire continues to run with input from MECS who facilitate Carer Information Sessions.
- **Courses** are also working in conjunction with Cognitive Stimulation Therapy groups in Torfaen with the hopes of expanding this across Gwent.
- **Carers Courses** will soon join with Sporting Memories (Newport Dragons).

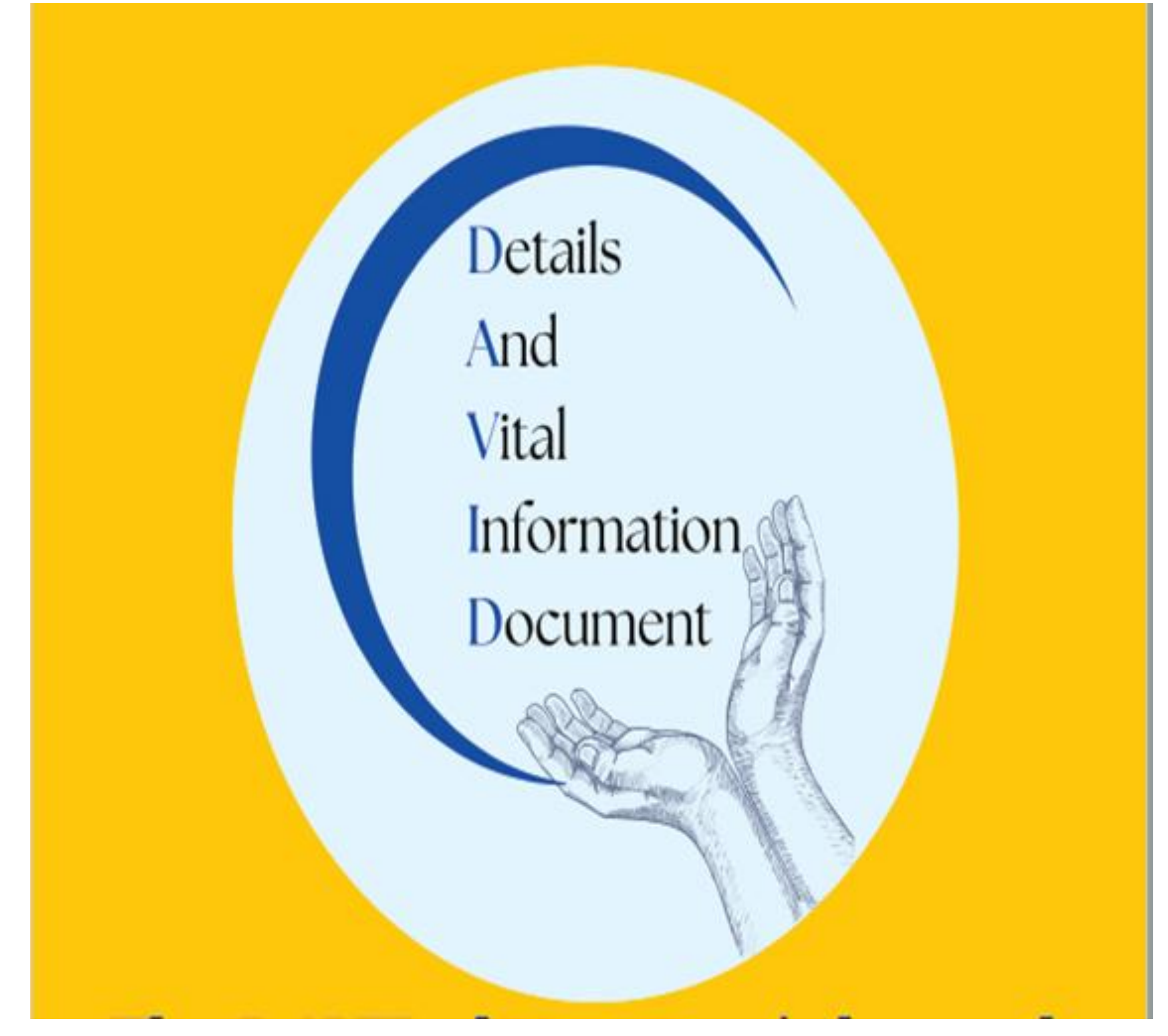


Details and Vital Information Document (DAVID)

In June 2025 the ***DAVID*** document was developed and launched by Dawn Morgan, Mapping, Education and Carers lead.

DAVID is a booklet designed to give **carers a voice** in an emergency situation, or when they are unable to communicate for themselves.

The booklet aims to provide **accurate information** in a timely manner, not only about the carer, but also the person they care for. This in turn will help facilitate the right treatment, right care, and to understand individual wishes, avoid or reduce hospital admission and may also help to facilitate discharge.



Workstream 3

Dementia Advisors

Dementia Advisors

Provide support for people affected by dementia to access services within their local area, around their diagnosis, emotional support, benefit advice, LPA applications, assistive technology grants, finance, Hebert Protocol registration, Blue Badge application, DVLA driving assessment, companions, bus pass, Welsh Water, winter fuel schemes, access to tele care, dementia research application, needs and carers assessments applications. We continue to review our Carers Information and Support Programme (CrIsP).

In 2025, Welsh Government allocated **100k** to each Health Board to increase the dementia advisor provision.

The Alzheimer's Society are currently commissioned to provide this service.

Dementia advisors are based at each **dementia hub and Memory service** in the five local authority areas.

Although this is a strong offer, the **rise in diagnostic rates** will mean an increase in demand. It is predicted that further resources will be required going forward.

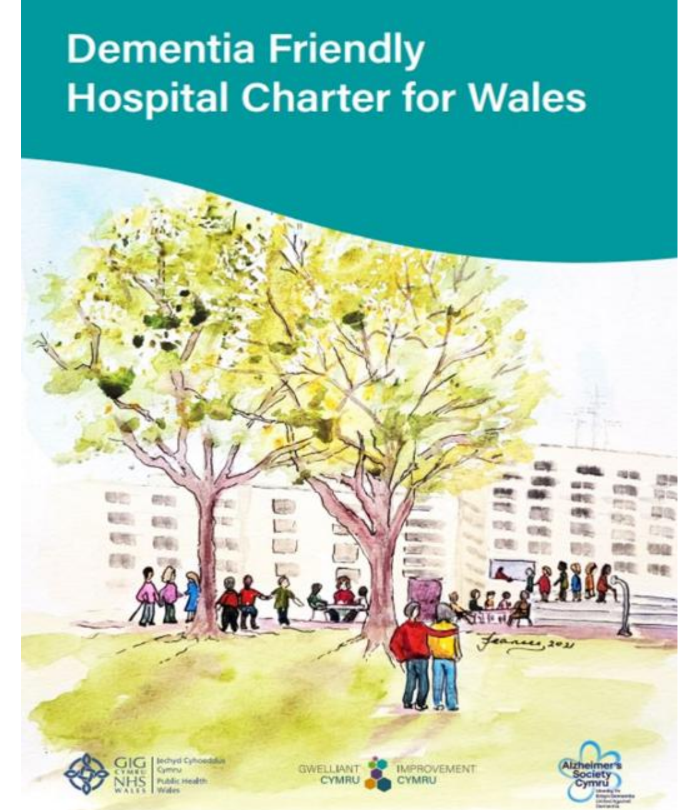
"I was so unsure to begin with, I thought it was the end for me and my Dementia Adviser helped me sort things out when my family couldn't." (Person living with dementia)

Workstream 4

Dementia Friendly Hospital Charter

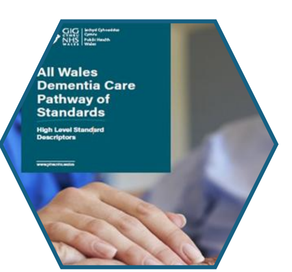
The **Dementia Friendly Hospital Charter** was adopted by the Health Board in 2022. The Charter aims to improve the experience of people living with dementia when they are in hospital. Staff must recognise an individual's personhood, diversity and preferences, recognising the importance of dignity, respect and kindness to embed person-centred dementia care. Much has been done across Aneurin Bevan University Health Board including better support for, and inclusion of carers.

The **3-year action** plan sets out priorities for **2025 – 2028**.



Dementia Hospital Plan Priorities 2025-2028: Our Focus

All Wales Dementia Standards



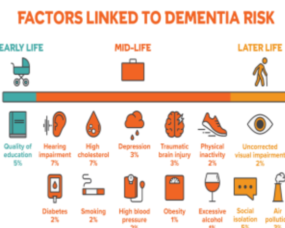
Dementia Friendly Environments

Learning and Development

Dementia Friendly Hospital Charter

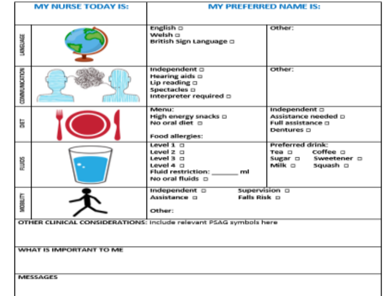
Dementia Volunteer Companions

Raising awareness/ prevention.



Meaningful Engagement

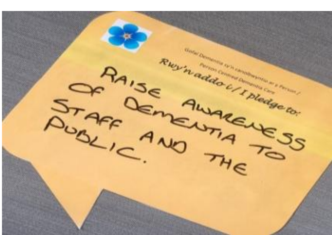
Person Centred Care, Getting to know me!



Patient / Carer Feedback

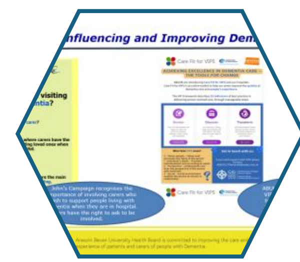
Using feed back to learn and improve care

Dementia Champions



Carers support, John's Campaign

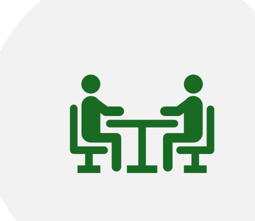
VIPS ward Improvement Plan



Examples of Achievements in 2025/26. Hospital Priorities in Practice

Wards have **proactively engaged** in Ward Improvement Plans to help improve patient experience in their areas.

CIVICA patient experience feedback themes



Professional case discussions and the visibility of the Patient Experience and Involvement Team at ward level, providing coaching, advice and signposting, are having a very positive impact.

Staff feedback evidences that having the dedicated dementia intranet pages and access to expert advice through the dedicated e-mail address has significantly helped.

Alignment with other priority workstreams such as 6 goals, Welsh Ambulance emergency care pathway, deconditioning, nutrition and hydration, discharge groups etc help ensure dementia is a consideration is all areas of care.

Care Fit for VIPS

Aneurin Bevan University Health Board continues to work towards introducing **Care Fit for VIPS** into our hospitals.

Care Fit for VIPS is an online toolkit to improve the quality of dementia care using the internationally recognised VIPS framework. The Toolkit supports hospitals to embed person-centred care based on VIPS principles:

- Valuing people
- Individualised Care
- Persons Perspective
- Supportive Environment

The toolkit is based on Professor Dawn Brooker's widely recognised VIPS framework for **person-centred care**.

Over recent years **15 Ward areas** have implemented VIPs, and a dedicated VIPs tab is now available on the intranet for all areas to access.

Person Centred Meaningful Activities and Engagement

There is clear **research evidence** to show that engaging people in meaningful activity and engagement has significant benefits both to physical and psychological recovery.

NHS Charities Together grant funding has enabled the Team to make significant progress over the past year in rolling out meaningful activities in ward settings.

Phase 1 in general hospitals showed a very positive impact on patient experience. This work continues.

Phase 2 is in progress and will embed a multi-disciplinary approach in the community.

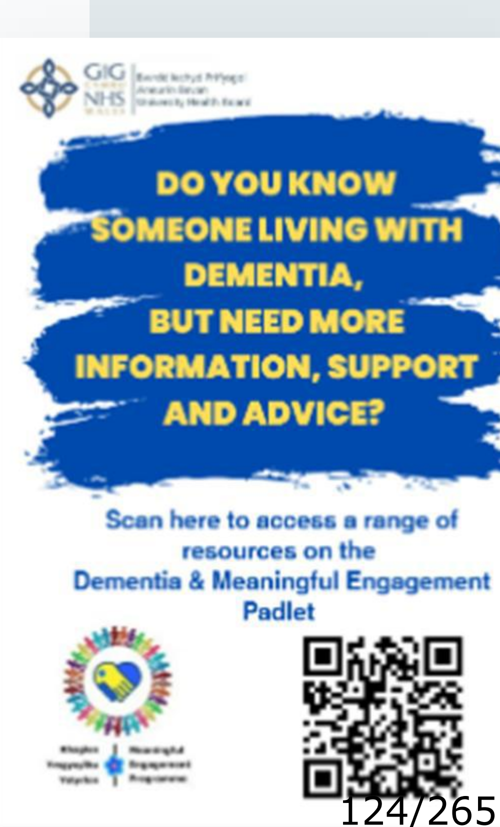
Going forward, the Team aim to develop and **rollout** a meaningful activity strategy to a range of care homes in Gwent, HMP Usk, the hospital wards within ABUHB.

Roll out will be supported by a **practitioner's forum** to support staff, volunteers and carers gain skills, knowledge and confidence to deliver non-pharmacological interventions and embed **person-centred** meaningful activity.

Through the work being carried out for the Meaningful Engagement Programme it was identified that **access to information** resources to support were limited.

Staff needed information to be easily accessible and in one place. In 2025, the Meaningful Engagement Padlet was created.

The **Padlet** provides information, resources, signposting to agencies, departments and services which can help support someone with dementia, their carer and staff. The Padlet is available in **Welsh** and is linked to the intranet and internet.



Understanding as much as you can about the person living with Dementia and working with carers and relatives can help you better understand and tailor activities and engagement for each individual, supporting what matters to them.

Supporting Staff

Over the past year, the team has made numerous visits across Health Board sites to provide **dementia-specific advice**, support, and signposting for staff, visitors, and patients.

These visits ensure that **colleagues feel supported** in delivering high-quality dementia care and that **patients and families** have access to the guidance they need throughout their healthcare journey.

Meaningful Engagement: Activity Pack
Summer
June - August
AVAILABLE NOW
Dementia & Meaningful Engagement
Summer Theme Pack

Meaningful Engagement: Activity Pack
Winter
December - February
AVAILABLE NOW
Dementia & Meaningful Engagement
Winter Theme Pack

Meaningful Engagement: Activity Pack
Spring
March - May
AVAILABLE NOW
Dementia & Meaningful Engagement
Spring Theme Pack

The Patient Experience and Involvement Team (PE&IT) Team have created **Themed Activity Packs** to distribute to all divisions – Ward Activity Coordinators, Volunteers, MAS clinics, Care Homes etc

The packs include a printed suggestion of themed activities, which will include a **'what you will need'** to complete the activity – incorporating the resources delivered by PE&I Team.

These packs will be launched each season a total of **4 times a year**

The packs aim to **encourage** the implementation of Meaningful Activities in all areas, by all members of staff, ensuring Meaningful Engagement remains relevant to person centered care.

The packs include easy **step by step** suggestions to conduct the activities.

The **Activity Co-Ordinator** role has been introduced into some Divisions. Due to some disparity in role functions, a Task and Finish Group has been developed to explore uniformity of roles and provide a supportive structure for those staff already in post.

The role is intended to provide meaningful engagement, emotional, physical and mental support, and stimulation.

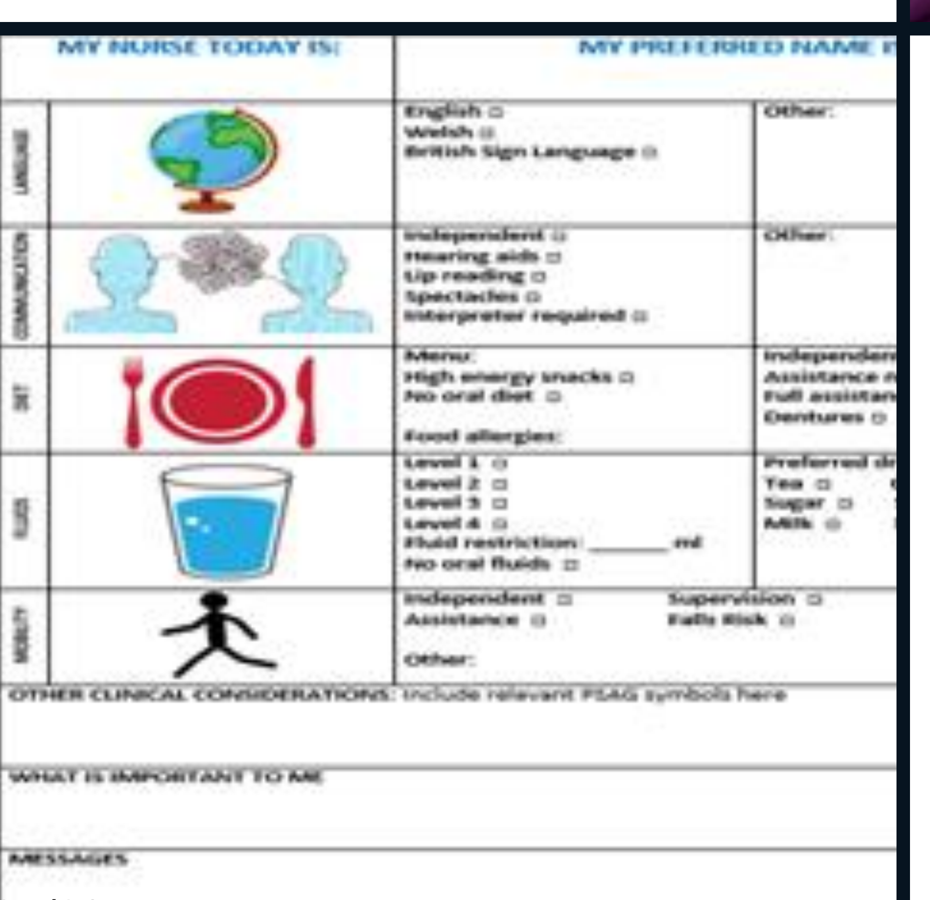
Progress so far:

- 10 Activity Coordinators currently in post
- Task and Finish Group set up with representation from all divisions
- Peer Support group for Activity Coordinators in place
- Support from The Patient Experience and Involvement Team – Regional Meaningful Engagement Dementia Activity Coordinator has worked closely with each Activity Coordinator
- Induction and framework developed/ uniform introduced

Next Steps

A role function scoping exercise has been completed to better understand the current position. This is to be presented to the Divisional Nurse team for consideration of a sustainable model going forward.

Dementia Friendly Environments



MY NURSE TODAY IS:

LANGUAGE		English ☐ Welsh ☐ British Sign Language ☐	Other:
COMMUNICATION		Independent ☐ Hearing aids ☐ Lip reading ☐ Spectacles ☐ Interpreter required ☐	Other:
DIET		Menu: High energy snacks ☐ No oral diet ☐ Food allergies:	Dentures ☐
FLUIDS		Level 1 ☐ Level 2 ☐ Level 3 ☐ Level 4 ☐ Fluid restriction: ______ ml No oral fluids ☐	Tea ☐ Sugar ☐ Milk ☐
MOBILITY		Independent ☐ Assistance ☐ Other:	Supervision ☐ Falls Risk ☐

OTHER CLINICAL CONSIDERATIONS: Include relevant PSAG symbols here

WHAT IS IMPORTANT TO ME

MESSAGES

The Dementia Team have supported a wide range of requests across all areas of the Health Board, including ward spaces and clinic environments. This has included work on **signage**, bedside boards, and the use of the Kings Fund **Environmental Assessment**

Through this approach, the Team are helping each area move towards a more **Dementia Friendly environment**, working closely with our Maintenance Teams to ensure improvements are implemented effectively.

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

ABUHB Dementia Champion Whatsapp Channel

Please scan the QR code to request access to the Dementia Champion whats app Channel. This channel will provide a platform to receive Dementia related updates and announcements for our Champions.

This is a confidential, closed channel, accessible to workforce only.

abb.pcctdementia@wales.nhs.uk

Dementia Champions

Over the last year, the PE&IT have developed and implemented a **Dementia Champions Campaign** to help:

- Raise awareness of the role
- Develop and support existing Dementia Champions
- Listen to their feedback
- Recruit new Dementia Champions
- Share the resources available to Dementia Champions
- Share the Reflective Workbook
- Identify those that wish to continue to be a Dementia Champion
- Update the Corporate Register of Dementia Champions
- Provide Dementia Daisy Pin Badge

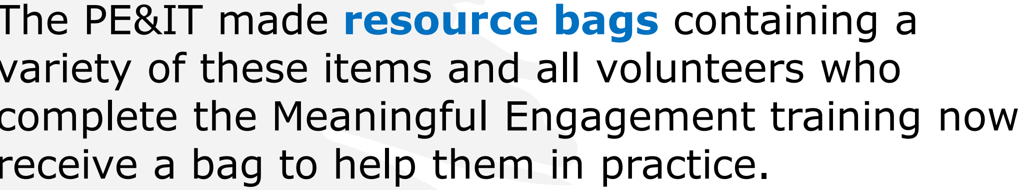
227 Dementia Champions are currently on the distribution list.

Two **staff videos** have been developed to showcase the role of Dementia Champions and are used as part of our training.

A "**WhatsApp"** group is now established with Information governance support following feedback from staff around access to information.

Volunteer Dementia Companions

Volunteers feedback that they would find smaller items like reminiscence cards, dominoes, playing cards, word searches helpful to encourage meaningful activity.


The PE&IT made **resource bags** containing a variety of these items and all volunteers who complete the Meaningful Engagement training now receive a bag to help them in practice.

Currently there are **61** active Companions

43 of these have been recruited between April 2024 & November 2025

34 active companions have completed the Dementia Awareness & Meaningful Training sessions

10 resource packs delivered to individual volunteers

Good News Stories

Alan – Alan is a regular volunteer on Hafan Deg ward and has become an integral part of the team. He often arranges special events, hosts quizzes and bingo and provides information on how patients are doing. The person he is and the work he undertakes on the ward is valued and appreciated by staff and patients.

Brett – Supported Brett during his induction process with this case with a person with a diagnosis of Dementia, to complete the *This is Me* document during his visit. This was a good exercise for Brett to get to know the client and implement skills to complete the document.

Gillian – Gillian attended a Dementia Training session to support her volunteer role at Chepstow Hospital, following this training, a *Care Home in Chepstow*, participating in the Meaningful Engagement Programme expressed that they would benefit from volunteer visits at mealtimes. Gillian responded to this request and supported the home twice. I hope this was beneficial for the home. I hope to continue this with Gillian for her induction and Gillian now attends once a week to offer her friendly service to the residents.

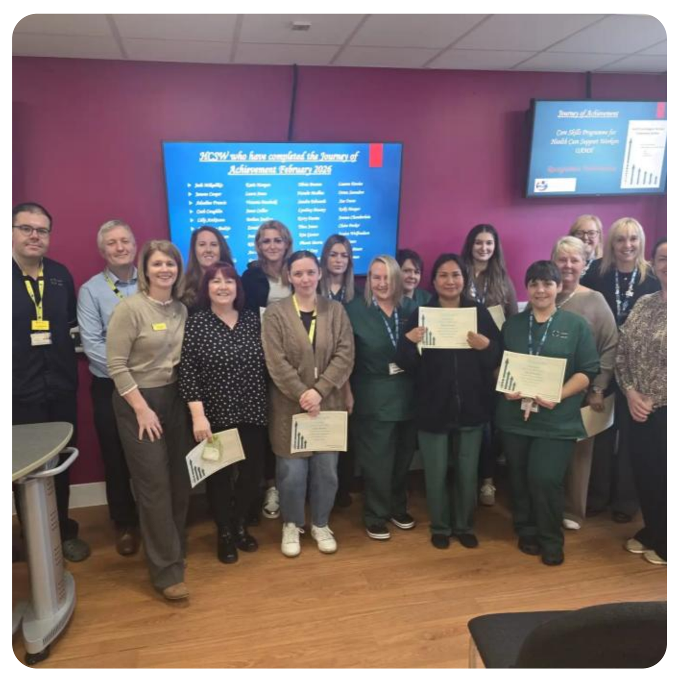
Intergenerational Practice

Over the past year, the Team have proactively developed meaningful **intergenerational activities** programmes in partnership with schools, colleges, wards and care homes. We know this approach supports:

- Reduction in loneliness/isolation
- Reduction in behaviours that are distressing
- Increased creativity/ mobility
- Increased knowledge about person-centred dementia care
- Reduction in falls
- Positive experience for patient and staff feedback.

The Team have linked the **16 care homes** in the Meaningful Engagement programme to the intergenerational programme with the aim of increasing the relationship between these areas and supporting with learning from schools, hospitals and care homes who already participate in the scheme.

In collaboration with the Health Board, **YYFM** radio production, Hengoed Primary School and **Singing for the Brain** in Caerphilly, children and people with dementia worked together and recorded a wonderful story and play and learned about each other along the way.



Older Adult Mental Health – Dementia Care Wards

- **Education**: Staff training in Positive Approach to Care, Living Well with Dementia, Therapeutic Observations.
- The **Journey of Achievement** core skills training for our HCSW's commenced.
- **Dementia Care Mapping**: three monthly cultural maps and individual referrals.
- Plan to implement **Patient Observation and Reflection Tool (PORT).**
- **FIND ME- Research Project** exploring the role of carers while the person living with dementia is admitted to the dementia wards.
- **Carers Education / support**: Some 1:1 support offered to carers of the person living with dementia while an inpatient.

AMaT Ward Accreditation Programme

- **Annwylfan Ward** achieved Silver Accreditation in December 2025.
- **Cedar Parc and Sycamore** have achieved Bronze Accreditation in November 2025, with Sycamore working towards Silver assessment in February 2026.

Older Adult Mental Health Ward - Environmental Improvement

Cedar Parc Ward received capital funding to have all of their bedroom doors replaced as part of a wider Health Inspector Wales action plan. The doors have "Visomatic" panels to aid patients' privacy and dignity.

Sycamore Ward received capital funding to have lighting replace with LED lighting, which has brightened the space up, especially the internal corridors with no natural light providing an improved environment for patients.

Annywlfan Ward had a refurbishment of their outdoor space. April 2025 with an official opening 'Garden Party' in July attended by people residing on the ward and their family members, staff, volunteers and senior health board managers.

It was important that the **dignitary** officially opening the garden was a person residing on the ward and had showed great interest throughout the refurbishment

Impact reviews indicated **improvement in wellbeing** and reduction in incidents reported.

Workstream 5(a)

Learning and Development

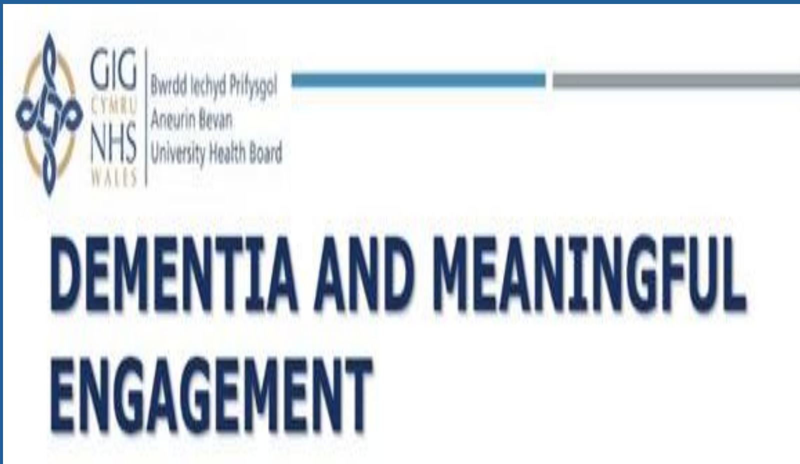
At the heart of the **Dementia GoodWork Learning and Development Framework** is what matters to people living with dementia, and aims to empower patients, carers and health and social care staff to ensure dementia care is person centred.

What we achieved during 2025/2026:

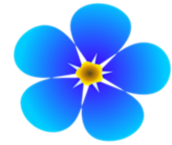
A series of **learning** provided by specialists in areas of practice as well as Staff Induction sessions, meaningful engagement and external learning opportunities have been secured and shared with all ABUHB and Regional **multi agency services workforce, Nursing and Residential Care homes and prison care units** within the 5 boroughs.

Although much has been achieved this year and there are clear priorities identified in the workstream 5 action plan the delivery of the learning will be a major challenge.

The achievement of securing a **practice educator** from the NHS together charity for the period of 18 months ended on October 1st, 2025. There is no further funding identified to allow for continuation of this level of learning opportunities and therefore no room for growth to meet demands.



Training Delivery



A total of **1,049** staff received training through the reporting period.

Breakdown of Sessions Delivered:

- 51 sessions delivered directly within **care homes**
- 24 monthly open-access sessions available to all staff across the **Health Board**
- 2 bespoke sessions delivered to **Hospice of the Valleys**
- 4 **RCN Cadets** Sessions
- 2 **A+E** specific Sessions
- 4 Dementia Experience Sessions
- Including **prison** staff.

Sessions throughout 2026 are scheduled for once monthly in different locations and are open to all staff.

The previous **Bite Size** sessions were reviewed and recommenced from 4th September 2025 with sessions including:

- Brain Health, RITA, Oral Care,
- Nutrition and Hydration
- Future Care Planning,
- Pain Management and Speech and Language.
- Sessions are delivered by facilitators who are
- experts in their field.

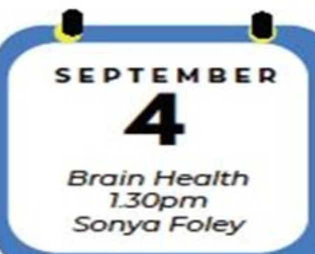
As of December 2025, **251** staff have attended the Bite Size sessions

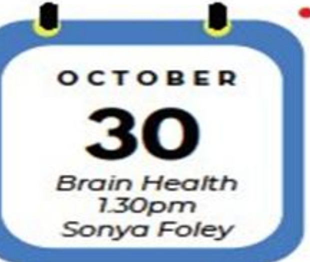
These sessions are scheduled to run for a further 12 months.

In addition to this we have created a library of Bitesize videos to improve access for all staff.

Dementia

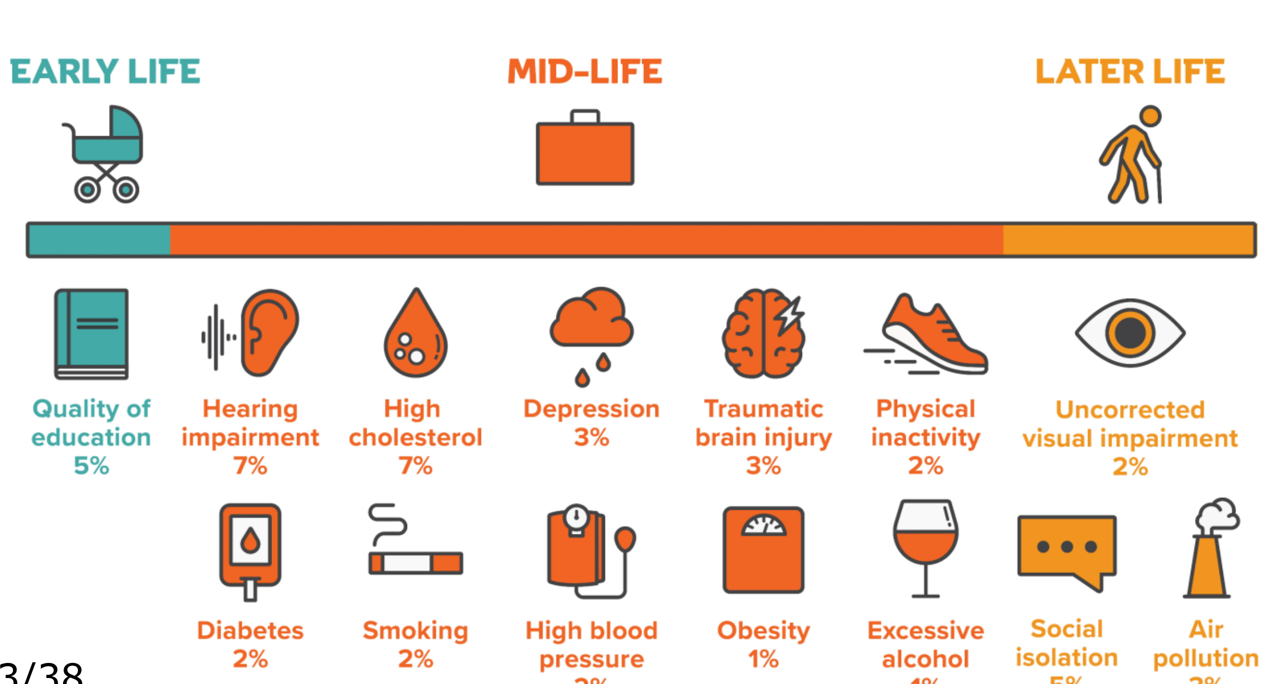
Bitesize Sessions





Brain Health

The newly developed Prevention, Brain Health information session promotes awareness of the **14 risk factors** for dementia with the aim of increasing knowledge and understanding of a healthy brain and reducing risks associated with dementia.



Dementia Experiential Learning Day

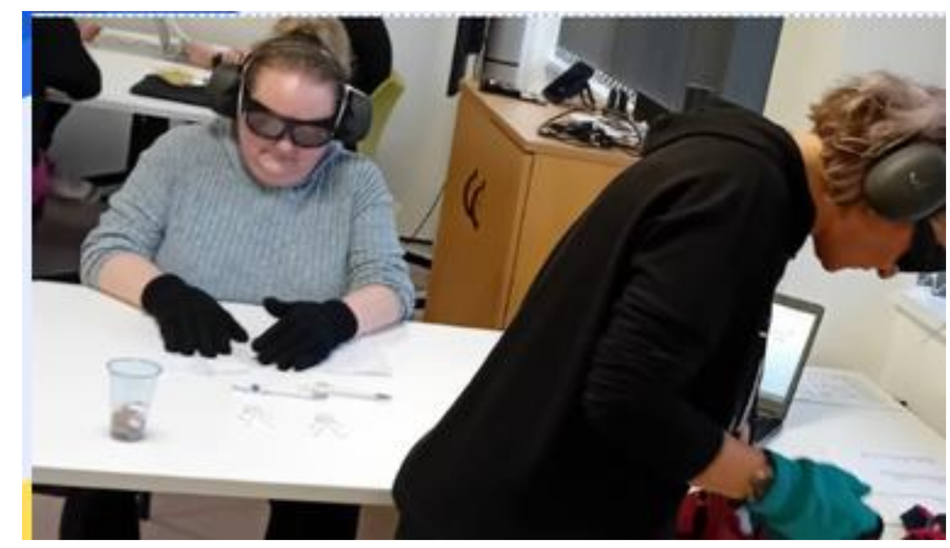
In response to requests from staff who had visited The "Dementia Bus" (private provider £1000 per visit to Health Board) a **bespoke** Dementia Experience Learning day was developed.

The Team secured funding from the Regional Workforce Group to help purchase a variety of **learning aids** to assist the plan of learning.

The day is delivered by **specialist clinicians**, audiology, pain management, optometry, Mental Health and patient experience and involvement dementia specialist practitioner.

3 further dates have been agreed throughout **2026**, multi-agency and multidisciplinary attendance.

A bespoke **Influencer** session was created for the **Older People's Commissioner** and **Gwent Councillors** to attend with other senior staff in health and local authorities.



Workstream 5(b)

Monitoring

The Dementia Team have supported workstream leads to identify what **data** is already collected and where there are gaps. The Team has also connected with performance and measurement leads within quality assurance departments, Local authority, wider Health Board and our Dementia Friendly communities, to collaborate on this work.

The **National Audit For Dementia** is currently under review, national KPI and benchmarking targets will be shared with Health Board when agreed.

The Health Board has an annual reporting process for Dementia which is supported by the **Regional Dementia Strategic Partnership**.

AMaT audit process monitors Ward Standards

Patient, carer and staff experience is monitored through the Patient Experience and Involvement Team and reported on annually. Wards have proactively engaged in Ward Improvement Plans to help improve **patient experience** in their areas.

Professional case discussions and **coaching** alongside the visibility of the Patient Experience and Involvement Team at ward level are having a very positive impact.

Staff feedback suggests that having the dedicated dementia intranet pages and access to **expert advice** through the dedicated e-mail address has significantly helped.

Local and National benchmarking and **recognition**.

Listening to People and Responding to Feedback

Created Dementia Hubs across all five local authority areas to improve access to information and support described as a *"lifeline"* by families.

Developed the DAVID Document to give carers a voice in emergencies and ensure staff understand the person—created directly in response to carers' needs

Created multiple **Padlets** (Regional Dementia Padlet, Meaningful Engagement Padlet, Carers Padlet) improving access to guidance / signposting.

Introduced bespoke **dementia training**, including the Dementia Experiential Learning Day, as staff requested deeper understanding of the lived experience.

Expanded Dementia Aware Sessions and trained additional Session Leaders to meet demand from staff and community partners.

Created Memory Assessment Journey leaflet to improve communication with patients/carers following unclear pathways feedback

Improved ward environments (lighting, signage, gardens) following patient/carer feedback about orientation, comfort and dignity.

Developed themed activity packs after staff reported needing easy-to-use tools to support meaningful engagement.

Designed volunteer resource bags after volunteers said they needed small, practical activity items to better support patients.

Strengthened communication pathways e.g. single point of access, supporting communication with wards etc

Responded to Civica feedback themes (e.g., boredom, lack of activity on wards) by delivering training, resources and improvement plans.

Enhanced the Dementia Champions campaign based on staff requests for visibility, clarity of role and improved communication

Delivered Carers Information Courses to meet carers' requests for more support, knowledge and skills.

Expanded intergenerational practice following positive feedback about benefits to wellbeing, connection and activity.

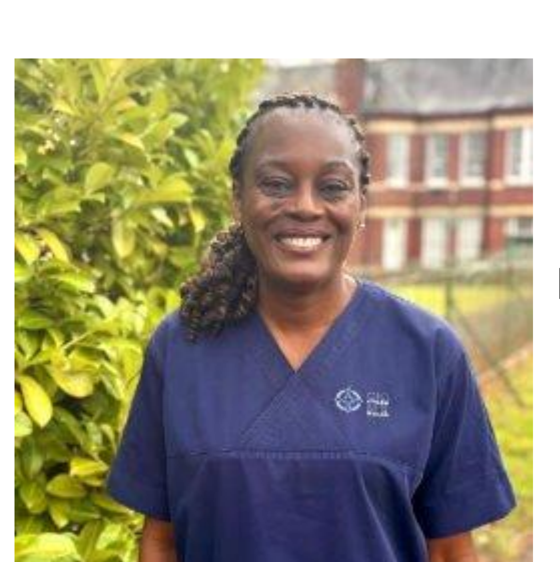
Built meaningful activity programmes responding directly to patient/staff feedback on the importance of engagement for recovery and wellbeing.

Recognition of Good Practice

The Home-Based Memory Rehab Team from Older Adult Mental Health , Occupational Therapy were **highly commended** in the award for Excellence in Rehabilitation in the Advancing Healthcare Awards Cymru

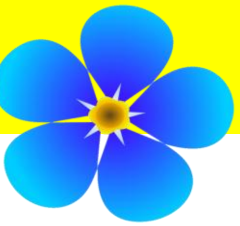
Lisa Payne, Ward Manager, Sycamore Ward received **runner-up** for Nurse of the Year for the RCN Awards 2025

Amanda Strange, HCSW in MECs **won** HCSW of the year for ABUHB, as well being a **runner up** in the RCN Awards for HCSW of the Year



Dr Ivenso has **won** an Innovation in Health Care award for MediWales for her work with Dementia research.

Conclusion



The Regional Dementia Strategic Partnership continues to drive delivery of the All-Wales Dementia Action Plan and Dementia Standards.

This year has seen significant progress across all dementia workstreams, with improvements grounded in collaboration, co-production and person-centred care. People's feedback has directly shaped developments, ensuring services focus on what matters most.

Feedback from people living with dementia, carers and staff is shaping improvements and ensuring services are person centred. The partnership remains committed to continuous learning, inclusion and improving lived experience across the region.

Despite future funding uncertainty, the partnerships shared vision and regional collaboration place Gwent in a strong position to continue improving dementia care.

Ongoing review of the dementia programme will be overseen by the Regional Dementia Strategic Partnership.

HIW Inspection (03839)
Ty Skirred, Maindiff Court Hospital
6-8 October 2025

Mental Health and Learning Disabilities Committee

24 March 2026

Situation

Inspection Dates:

6-8 October 2025 (Unannounced)

Report Published:

15 January 2026

Service Inspected:

Ty Skirrid Unit – 15-bed male rehabilitation (detained & informal)

Purpose:

Evaluate patient experience, safe/effective care, leadership & workforce

Background

- Ty Skirrid operates as an Model: Unlocked rehab with strong relational security; MDT-led care; focus on skills & community re-integration

- Inspection team included a HIW inspector, clinical reviewers and a patient experience reviewer.

- Feedback was collected from patients and staff via questionnaires

Assessment

Strengths Identified

Patient Experience & Therapeutic Relationships
- Respectful, calm staff–patient interactions; positive relational security
- Dedicated OT and psychology input (1:1, group, focused) with timely access

Clinical Practice & MDT Working
- Effective MDT arrangements; patients and carers involved in ward rounds
- Care & Treatment Plans aligned with the Measure; MHA documentation legally compliant

Leadership, Workforce & Governance
- Stable workforce; positive ward leadership
- Effective divisional governance links

Areas for Improvement

Therapeutic Activities & Advocacy
- Clarify roles/ownership for structured activities; strengthen activity timetable
- Strengthen recording of advocacy offer/uptake in notes

Environment & Estates
- Introduce vision panels to support sleep hygiene
- Create access to additional room/space
- Ensure estates issues receive priority to support therapeutic environment
- Include high-level cleaning in schedules; storage solution for laundry room

Clinical Documentation & Information Recording
- Ensure timely upload of CTP review minutes to WCCIS
- Ensure patient legal status recorded on medication charts

Staffing & Skill Mix
- Address staff feedback on single RN at night, maintain safe skill mix

Immediate Concerns (resolved during inspection)

One recently outdated paliperidone injection identified – escalated to nurse in charge; pharmacy weekly checks confirmed.

Recommendations

- HIW identified 13 areas for improvement.
- The Health Board identified 23 individual service actions.
- As at 21/01/26, 18 of these actions have been completed, with 5 still in progress.

Recommendations

Actions: In progress

Improvement Needed	Service Action	Original Timescale	Update January 2026
The health board must explore if vision panels can be installed to improve sleep hygiene.	Minor Works costings to be obtained to determine next steps.	April 2026 due to Health Boards minor works procedures	Action remain the same, will explore costings and Capital allocation in new financial year (April 2026) in line with Health Boards minor works procedures
The health board must explore if a room on the site can be made available to the Unit on a more consistent, if not permanent, basis.	Ward Manager to re-explore availability of a room on site to use on a regular basis with the Senior Nurse	Meeting with Senior Nurse 5/12/2025 to discuss options	Explored utilising Lindisfarne – currently not visible due to no access to the network. Can explore IT works in April 2026. Options explored in the main building present logistical and privacy/dignity challenges. **Timescale extended to April 2026**
The health board should consider the staff feedback regarding only on registered nurse on duty by, which impacts on their ability to take a break or leave the ward**.** This must include mitigations for any risks, such as appropriate level of skill mix on duty, a two-nurse checks for certain medications, and they needs for the registered nurse to leave the ward.	Ward is currently undergoing an establishment review to consider options or alternatives to address the staffing levels	Establishment rev iews completed in January 2026	This action has been considered, no additional funding for 2nd qualified. Escalated to Division and provided an options appraisal. To be discussed as part of ward establishment reviews.
This must include mitigations for any risks, such as appropriate level of skill mix on duty, a two-nurse checks for certain medications, and they needs for the registered nurse to leave the ward.	The future of Maindiff Court site is currently under review as part of the wider health board Mental Health & Learning Disability & estates strategy	Ongoing	Ongoing
The health board must ensure that policies and procedures are reviewed and ratified in a timely manner. These should be prioritised according to their level of clinical risk.	Ensure all policies and procedures are reviewed in the Divisional Policy Group and prioritized by clinical risk.	Ongoing	Ongoing

Oversight

Improvement plan monitored by:

- Senior Management Team
- Quality Management Group
- Quality Patient Safety Listening and Improvement Forum
- Quality Patient Safety and Outcomes Committee

Appendix C - Improvement plan

Service: Ty Skirrid Unit, Maindiff Court Hospital

Date of inspection: 6-8 October 2025

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Risk/ finding/ issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Original Timescale	Update January 2026
1.	The health board should ensure that roles, responsibilities and ownership of structured activities is strengthened.	Health and Care Quality Standards 2023 Person-centred / Effective	1. Ward to update activities timetable to reflect role of staff to undertake each activity.	Ward manager/ Occupational Therapist	1/12/2025	Completed - will continue to update as necessary
			2. Activity timetable is on display on main ward and individualised available in each patient bedrooms		Complete	
2.	The health board must explore if vision panels can be installed to improve sleep hygiene.	Person-centred / Effective	3. Minor Works costings to be obtained to determine next steps.	Service Improvement Manager	April 2026 due to Health Boards minor works procedures	Actions remain the same, will explore costings and Capital allocation in new financial year (April 2026) in line

Risk/ finding/ issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Original Timescale	Update January 2026
						with Health Boards minor works procedures
			4. To be added to the Mental Health Capital Priorities register for funding.		Complete	
3.	The health board must explore if a room on the site can be made available to the Unit on a more consistent, if not permanent, basis.	Person-centred / Effective / Workforce	5. Ward Manager to re-explore availability of a room on site to use on a regular basis with the Senior Nurse	Ward Manager	Meeting with Senior Nurse 5/12/2025 to discuss options	Explored utilising Lindisfarne - currently not visible due to no access to the network. Can explore IT works in April 2026. Options explored in the main building present logistical and

Risk/ finding/ issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Original Timescale	Update January 2026
						privacy/dignity challenges. **Timescale extended to April 2026**
4.	The health board should strengthen the recording of advocacy offer and uptake / decline.	Person-centred / Effective	6. Discuss and offer advocacy in patients' 3-weekly ward rounds.	Ward Manager	4/12/2025 (1st Patient Ward Round)	Complete - advocacy added to pre ward round documentation
			7. Document advocacy discussions and outcomes in the ward round entry.	Ward Manager	4/12/2025 (1st Patient Ward Round)	Complete
5.	The health board should seek to introduce community meetings to supplement daily morning meetings.	Person-centred / Effective	8. Meetings are now in place on a monthly basis	Ward Manager	4/12/2025 (1st Patient Ward Round)	Complete
6.	The health board must continue to stringently assess	Effective / Safe / Leadership	9. Maintain established process for rehab referrals, overseen by the Responsible Clinician and agreed via MDT.	Clinical Director for Adult Mental Health	Complete and continue to monitor	

Risk/ finding/ issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Original Timescale	Update January 2026
	patient moves and admissions, as far as possible and despite known bed pressures, to ensure staff and existing patient safety and wellbeing.		10. Any patients transferred outside of this process are agreed with the locality responsible clinician.		Complete and continue to monitor	
7	The health board should ensure that estates issues affecting the unit are given sufficient attention and priority to maintain a therapeutic environment.	Person-centred / Effective / Safe	11. Outstanding maintenance lists to be reviewed weekly by dedicated housekeeper and escalations sent to the directorate Service Improvement manager to escalate appropriately.	Ward Manager	Complete and continue to monitor	
			12. Escalate issues to the directorate Service Improvement Manager as needed.		Complete and continue to monitor	

Risk/ finding/ issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Original Timescale	Update January 2026
8.	The health board should ensure that: • High level cleaning is included in cleaning schedules • A storage solution is found for the patient laundry room.	Person-centred / Safe	13. Meeting scheduled for the facilities manager to address these issues.	Ward Manager/ Facilities Manager	Meeting scheduled 12/12/25	Complete, confirmed high level cleaning is on domestic cleaning schedules and completed weekly.
			14. All Patients' belongings have now been returned to bedrooms and areas decluttered.		Complete and continue to monitor	
9.	The health board must ensure that patient's legal status is included on medication charts.	Effective / Safe	15. Continue weekly checks of medication charts to ensure patient legal status is included.	Pharmacist/ SHO/Responsible Clinician	Complete	
10.	The health board should ensure that Care and Treatment Plan review minutes are uploaded onto	Effective / Safe	16. Remind all staff of the correct procedure for uploading review minutes onto WCCIS.	Ward Manager/ Senior Nurse	Complete and continue to monitor via AMAT and Divisional	

Risk/ finding/ issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Original Timescale	Update January 2026
	WCCIS in a timely manner.				Audit processes	
			17. Monthly audit of compliance with WCCIS		January 2026	Complete (100% compliant end of December)
11.	The health board should ensure that aspects of Mental Health Act documentation are strengthened, as set out in the body of this report.	Effective / Safe	18. Capacity Checklist for Mental Health Act is now in place to ensure there is consistency in approach and remains in line with the code of practice.	Responsible Clinician/ Mental Health Act Admin Manager to provide oversight	Complete and continue to monitor via Clinical Director	
			19. Monthly audit of MHA documentation		Complete and continue to monitor via Clinical Director	
12.	The health board should consider the staff feedback regarding only on registered nurse on duty by, which impacts on their ability to take a break or leave the ward.	Workforce	20. Ward is currently undergoing an establishment review to consider options or alternatives to address the staffing levels	Lead Nurse	Establishment reviews completed in January 2026	This action has been considered, no additional funding for 2nd qualified. Escalated to Division and provided an options appraisal. To

Risk/ finding/ issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Original Timescale	Update January 2026
	This must include mitigations for any risks, such as appropriate level of skill mix on duty, a two-nurse checks for certain medications, and they needs for the registered nurse to leave the ward.					be discussed as part of ward establishment reviews.
			21. Options Appraisal has been developed to address immediate safety concerns on site.		Options appraisal complete. Awaiting discussions - to take place in December 2025	Completed - Lindisfarne closed 27 November 2025
			22. The future of Maindiff Court site is currently under review as part of the wider health board Mental Health & Learning Disability & estates strategy		Ongoing	Ongoing
12.	The health board must ensure that policies and procedures are reviewed and ratified in a timely manner. These should be prioritised	Effective / Safe / Leadership	23. Ensure all policies and procedures are reviewed in the Divisional Policy Group and prioritized by clinical risk.	Divisional Policy Group	Ongoing	Ongoing

Risk/ finding/ issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Original Timescale	Update January 2026
	according to their level of clinical risk.					

OVERSIGHT AND MONITORING

Oversight and monitoring of the improvement plan will be undertaken by the following groups: -

- Action Plan meeting
- Directorate Quality Patient Safety Meeting
- Divisional Quality Patient Safety Meeting
- Senior Management Team
- Quality Management Group
- Quality Patient Safety Outcomes Committee

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative

Name (print): Nadine Gould

Job role: Divisional Nurse

Date: 27/11/25 – UPDATED 22/01/26

Results

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By organisation	In progress	Partially complete	Partially complete overdue	Overdue	Total	Awaiting approval	Rejected	Approved	Unable to complete	Total
Organisation wide	3	0	0	8	11	12	0	0	0	23

Organisation wide

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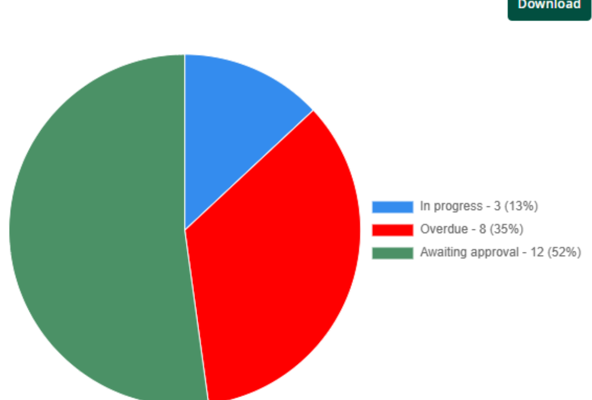
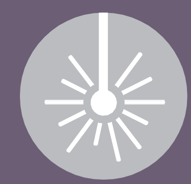


Hospital Inspection Report (Unannounced)

Ty Skirrid Unit, Maindiff Court Hospital, Aneurin Bevan University Health Board

Inspection date: 6, 7 and 8 October 2025
Publication date: 15 January 2026



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

Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people

Our values

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

- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and diversity through our work
- Proportionate - we are agile and we carry out our work where it matters most

Our goal

To be a trusted voice which influences and drives improvement in healthcare

Our priorities

- We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety
- We will work collaboratively to drive system and service improvement within healthcare
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities.

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1. What we did

Full details on how we inspect the NHS and regulate independent healthcare providers in Wales can be found on our website.

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection at Maindiff Court Hospital, Aneurin Bevan University Health Board on 6, 7 and 8 October 2025. The following hospital wards were reviewed during this inspection:

- Ty Skirrid Unit - 15 beds providing male rehabilitation services. At the time of the inspection, the patient cohort included forensic, those detained under the Mental Health Act, and informal patients
- Lindisfarne – three step-down beds providing independent living with a reduced staffing presence.

Our team, for the inspection comprised of one HIW senior healthcare inspector, three clinical peer reviewers (one of whom was the nominated Mental Health Act reviewer) and one patient experience reviewer.

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of seven questionnaires were completed by patients or their carers and 13 were completed by staff. Feedback and some of the comments we received appear throughout the report.

Where present, quotes in this publication may have been translated from their original language.

Note the inspection findings relate to the point in time that the inspection was undertaken.

2. Summary of inspection

Quality of Patient Experience

Overall summary:
The service prioritised patient independence, supporting skill development for successful community reintegration. Patients had access to tailored therapeutic input, needs-based assessments, and meaningful activities. While the overall approach was positive, the structure and consistency of activity provision could be strengthened.

Staff-patient interactions were consistently respectful, calm, and informed, with staff demonstrating a commitment to meaningful engagement. However, aspects of the physical environment require improvement to support patient wellbeing, particularly in relation to sleep hygiene.

Patients were actively encouraged to take responsibility for daily tasks, such as laundry and accessing community services. Staff promoted autonomy through a decreasing degree support, aligned with the rehabilitation model of care.

For detained patients, leave was generally well facilitated and balanced against individual risks and preferences. Leave arrangements were reviewed regularly to ensure continued appropriateness.

Patients' rights under the Mental Health Act were upheld, with access to written information, advocacy services, and involvement from families and carers where appropriate.

There was clear evidence of patient engagement in care planning and treatment, including participation in ward rounds and pre-meeting check-ins. Overall, patient engagement levels were found to be good.

This is what we recommend the service can improve:

- The roles, responsibilities and ownership of activities could be strengthened
- Aspects of the environment should be strengthened
- Proximity of the smoking area to the main unit building should be reviewed

This is what the service did well:

- Staff-patient interactions were respectful and calm
- There was good relational security between staff and patients
- There was a good range of therapeutic input available to patients, with a focus on skills development and community re-integration

Delivery of Safe and Effective Care

Overall summary:
The unit operates an unlocked rehabilitation model of care, underpinned by robust individual risk assessments and strong relational security between staff and patients.

Admissions were carefully managed; however, an inherent level of risk remains. We recommend the health board uses this inspection to reinforce the importance of continuing to stringently assess patient moves and admissions, as far as possible and despite wider bed pressures.

The multidisciplinary team (MDT) comprised a broad range of healthcare professionals. Staff reported feeling heard and respected during ward rounds and MDT forums. Patients confirmed consistent involvement in ward round meetings, receipt of information about their care and treatment, and opportunities for family and carer involvement where desired.

Patients benefited from dedicated occupational therapy and psychology input, tailored to individual needs. This included one-to-one, group, and focused support.

Care planning was well aligned with the Mental Health (Wales) Measure, with comprehensive care and treatment plans that reflected the Measure's domains and were regularly reviewed. All patients had access to a named nurse acting as care co-ordinator.

Records for patients detained under the Mental Health Act 1983 were reviewed and found to be legally compliant.

Incidents of challenging behaviour requiring escalation were low. The unit worked collaboratively to minimise escalation risks through individualised, evidence-based risk assessments, reviewed regularly and as needed.

While some environmental improvements had been made, such as the renovated kitchen, the overall indoor and outdoor spaces would benefit from further enhancement to support a therapeutic setting.

This is what we recommend the service can improve:

- Patient moved and admissions to the unit must continue to be stringently assessed to ensure staff and patient safety and well-being
- Estates issues affecting the unit should be given sufficient attention and priority to maintain a therapeutic environment
- Aspects of care documentation recording

This is what the service did well:

- There was a good range of therapeutic input available to patients from dedicated Occupational Therapy staff and Psychology provision, as required
- There was evidence of effective MDT arrangements
- Care Planning was well aligned with the Mental Health (Wales) Measure, and all detained patients were done so legally.

Quality of Management and Leadership

Overall summary:

Governance and oversight processes were found to be effective, supporting clear information flow between the unit, senior nursing leadership, and divisional-level forums.

We observed good nursing and medical leadership on the unit. Staff worked collaboratively throughout the inspection, with positive feedback received regarding the ward manager. The senior nurse was visible, knowledgeable, and actively engaged with patients.

The workforce was generally stable. While bank staff were used to some extent, efforts were made to ensure consistency by deploying regular bank staff familiar to patients.

Mandatory training and annual appraisal rates were maintained at a good overall level, except for basic life support (BLS) and Mental Health Act training. Imminent plans were in place to address these gaps. Staff were supported to pursue further learning and development aligned with their roles and career aspirations, including formal management, vocational, and nursing training.

The unit maintained close working relationships with other mental health services, the local authority, and supported living providers to facilitate appropriate placements and timely discharge planning. Although some delays were noted, discharge planning remained a central focus, with regular meetings held to monitor progress.

This is what we recommend the service can improve:

- Staff training gaps must be strengthened at the earliest opportunity
- Staff feedback should be reviewed and considered by the health board
- Policies and procedures must be reviewed and updated, according to their clinical priority and level of risk

This is what the service did well:

- Staff feedback in relation to line management and senior managers was generally positive
- There was evidence of good partnership working for the benefit of patients and effective operation of the unit
- Audit activities were undertaken and generally well scored.

3. What we found

Quality of Patient Experience

Patient feedback

We spoke to number of patients informally during the inspection and received seven completed patient questionnaires, and one patient/ carer questionnaire.

Patient comments included:

> *" I don't have much to say. It is the best place I've been… It would be good for more activities though"*

> *" More outdoor activities"*

Family and carer comments included:

"Bigger visitors room, it's very small"

"It's costly [to get to the hospital] and public transport is poor to hospital"

Person-centred

Health promotion

The service focused on maintaining and building patients independence to aid skills development and independence for community living. This included access to dedicated unit staff and a range of needs-based assessments, focused and individualised therapeutic input, and a structured approach to each day.

Physical health needs were assessed, monitored and acted upon. This included smoking cessation advice and the offer of nicotine replacement therapy. Despite efforts, smoking outside the unit was prevalent and the health board should consider the proximity of the smoking area to the main unit building, in line with Welsh Government smoke-free legalisation.

The health board must review the proximity of the smoking area to the main unit building in line with smoke-free legislation.

It was positive to see that blanket restrictions were limited and that there was a positive risk-taking approach adopted, underpinned by individual risk assessments and care planning. One example was the consumption of energy drinks on the unit,

whereby a health promotion and educative approach was favoured, with information boards displayed and verbal advice offered to patients.

There were a range of meaningful activities on the unit for the patients to access, with a good focus on accessing the community to aid independence and re-integration. Whilst engagement reportedly fluctuates, staff were knowledgeable of the individual needs and preferences in how patients choose to engage and spend their time. To support uptake and engagement with the structured approach of timetabled activities, we recommend that roles, responsibilities and ownership of these activities are more clearly defined.

The health board should ensure that roles, responsibilities and ownership of structured activities is strengthened.

Dignified and respectful care

We observed positive interactions between staff and patients. This included knowledgeable, respectful and calm conversations, with staff taking the time to engage meaningfully with patients.

Staff were seen to knock on patient doors before entering. All patients had access to their own bedrooms, which they could lock and personalise, if desired. There were two bathrooms, both of which were communal spaces. However, bedroom doors did not have vision panels, which meant that staff were required to open patient doors at least hourly during the night, dependent upon each patient's observation level. This affects good sleep hygiene, which is an important aspect of rehabilitation care.

The health board must explore if vision panels can be installed to improve sleep hygiene.

We noted that available rooms and space on the unit were extremely limited. This meant that there was limited space for MDT meetings, visiting, and one-to-one work with patients. This resulted in patients having restricted space at times, including inappropriate spaces sometimes being used for meetings which would benefit from a private space.

The health board must explore if a room on the site can be made available to the Unit on a more consistent, if not permanent, basis.

Individualised care

Staff demonstrated a good knowledge of the patients on the unit, which was reflected in care planning documentation and day-to-day engagement between staff and patients.

Patients were supported according to their needs, preferences and goals. This included skills development, such as kitchen assessments. One patient that we spoke with commented positively about the skills he had learnt in this respect, noting that they had moved from eating ready meals each day to now cooking their own meals.

Patients were encouraged to take responsibility for their own everyday tasks, such as laundry and accessing services within the community. Staff provided encouragement to empower patients to make decisions for themselves and with a decreasing degree of supervision and support from staff, in line with the rehabilitation mode of care.

For patients who were detained, leave from the unit was balanced against wishes, individual risks, and was generally well facilitated by staff. This was reviewed in weekly ward rounds to ensure its on-going appropriateness.

Patients were able to keep their own devices, such as mobile phones and tablets, on the unit. Wi-Fi was available to encourage patients to stay in touch with friends and family.

Timely

Timely care

In the lead up to, and throughout the inspection, staffing numbers and skill mix was stable. We confirmed that staffing could be adjusted to meet patient needs and acuity, including increased observation levels, when necessary. The need for this, however, was reportedly limited due to the designation of the unit. Use of regular bank staff was favoured, where available, to ensure familiarity with patients and their needs.

The unit and patients benefitted from a well-functioning MDT, which included a consultant psychiatrist, registered mental health nurses, an occupational therapist and technician, healthcare support workers and a psychologist and psychology assistant. Whilst some roles, such as the psychiatrist and psychology team were not based on the unit full-time, we found this to not inhibit professional dialogue or timely patient care and input.

Equitable

Communication and language

Language preferences and communication needs were recorded in each patients care and treatment plan, and we observed staff being mindful of these needs when engaging with patients.

Whilst most patients were able to advocate for themselves, use of advocacy services were available, with regular attendance by the service to the unit. However, we would recommend recording of the offer and uptake or decline of advocacy services could be strengthened. Unit staff may wish to include this in patient notes at the pre-ward round check-in for consistency. It was positive to see clear record of wishes regarding patient instructed involvement of relatives and carers, as desired.

The health board should strengthen the recording of advocacy offer and uptake or decline.

Rights and equality
We confirmed that patient's rights in relation to the Mental Health Act were being upheld. Patients were provided with, or had the offer of, written material to explain their rights. Where desired, access to advocacy and / or family and carer involvement was noted.

There was evidence of patient engagement relating to their care and treatment, including invitations to attend weekly ward round meetings and pre-ward round check in's completed by their named nurse. We found engagement from patients to be generally good.

It was positive to see daily morning meetings taking place on the unit, which facilitated a conversation between staff and patients on a range of topics, including daily activities and feedback. These were well attended, and patients were empowered to speak up. We would recommend that monthly community meetings are undertaken on the ward, as a further means of encouraging wider feedback on the unit and in support of maintaining a therapeutic environment.

The health board should seek to introduce community meetings to supplement daily morning meetings.

Delivery of Safe and Effective Care

Safe

Risk management
The unit operates an unlocked rehabilitation model of care. This was underpinned by appropriately evidenced individual risk assessments and strong relational security between staff and patients.

Admission processes were carefully managed, but there remains an inherent degree of risk for the unit due to its layout, relative isolation, registered nurse staffing by night, and other factors which were provided in the verbal feedback session. We recommend the health board uses this inspection as an opportunity to underline the importance of continuing to stringently assess patient moves and admissions, as far as possible and despite health board wide bed pressures. This is to ensure staff and existing patient safety and wellbeing, on what was found to be an otherwise settled and well-functioning unit.

The health board must continue to stringently assess patient moves and admissions, as far as possible and despite known bed pressures, to ensure staff and existing patient safety and wellbeing.

Positively, there was a low number of incidences of challenging behaviours that required escalation, and the unit worked well collectively to minimise the risk of behaviours escalating. There is, however, potential for behaviours to unexpectedly challenge staff who are not frequently exposed to these events. PMVA (Prevention and Management of Violence and Aggression) training was provided to staff, with good compliance, and is a training area that we would advise continues to promote staff and patient safety and wellbeing.

The environment has not benefitted from an anti-ligature programme of works, but was subject to general and individual risk assessments, as required. We confirmed that any patient with active suicidal ideation would not be admitted to the unit and care would be stepped up accordingly.

Other aspects of estate issues and ward maintenance were reported by staff and reviewed by the health board's estates department in a generally timely manner. However, remedial works were reportedly not always carried out in a consistently timely way. Whilst certain areas of the environment had been improved, such as the recently renovated kitchen, the overall indoor and outdoor environment would benefit from improvement to ensure patients can benefit from a therapeutic environment, as far as reasonably possible.

The health board should ensure that estates issues affecting the unit are given sufficient attention and priority to maintain a therapeutic environment.

Infection, prevention and control and decontamination

The unit was generally well organised and clean throughout the inspection, against the backdrop of an aging building and generally high footfall on and off and the unit.

Domestic staff were found to be working diligently, and cleaning schedules were comprehensive and up-to-date. However, we would recommend that high level cleaning is included onto these schedules, and a storage solution is found for the patient laundry room.

The health board should ensure that high level cleaning is included in cleaning schedules and that a storage solution is found for the patient laundry room.

Staff compliance with mandatory training was good and there were processes in place to check and maintain effective IPC, which included regular nursing audits, by a nominated nurse with responsibility for IPC.

Safeguarding of children and adults

There were appropriate processes in place to safeguard vulnerable adults. This included a robust recording and understanding of patient histories and associated risk factors. The unit worked to established health board processes and procedures, and there was good compliance with staff training according to their roles and responsibilities.

The overall number of safeguarding incidents on the unit were low, but staff were able to articulate examples of safeguarding concerns and an appropriate set of actions that would be taken in response.

Oversight of safeguarding incidents was monitored within senior nursing and operational governance meetings. Staff confirmed that support and oversight from health board safeguarding teams is provided.

Medicines management

There were good arrangements in place to appropriately manage medication on the unit. The clinic was locked at all times, with keys being held by a registered member of staff.

Medication charts were found to be well completed, with prescribing and administration of medications found to be appropriate. However, there were some

omissions in ensuring that the legal status of patients was consistently completed on the front sheet.

The health board must ensure that patient's legal status is included on medication charts.

The unit benefitted from pharmacy input on a weekly basis, with evidence of pharmacist-led stock checks and audits being undertaken.

Emergency equipment and drugs were readily accessible and routine checks were completed. Fridge temperature checks also consistently recorded to ensure medication efficacy.

Effective

Effective care

The unit MDT comprised of a wide range of healthcare professionals. There was a consensus amongst staff that they felt listened to and had their professional views respected during ward rounds and other MDT forums. Staff commented positively on the fresh direction taken by the consultant psychiatrist who had been in post for several months. Patients shared a similar view that they were consistently invited to ward round meetings, received information about their care and treatment, and felt involved in their care. This included the involvement of families and carers, as desired.

It was positive to note that the patients received dedicated occupational therapy input, together with psychology input-based patient needs. This included individual, group and intensive support, as required. Staff commented that patients are generally able to receive therapeutic support in a timely manner, which was confirmed in the records that we reviewed.

Relational security on the ward was good, which contributed towards a calm atmosphere, with a low number of incidents. It was positive to note that all seven respondents to our patient survey indicated that they felt safe on the unit.

Nutrition and hydration

Patients had access to two kitchens to prepare meals. One kitchen had recently undergone a refurbishment, providing patients with a pleasant environment to prepare and eat meals. Given the rehabilitation designation of the unit and its relative isolation, patients were provided with a weekly allowance to complete food shopping. Essential food supplies, such as bead, cereals and hot drinks, were provided for patients by the service.

Patients were supported to use the kitchen, and assessments were undertaken by a dedicated occupational therapy team. One patient positively expressed that they had only ever eaten microwave meals prior to their admission, and that they are now able to cook their own meals.

Nutrition and hydration needs were appropriately assessed using the All-Wales Nutritional Risk Screening Tool (WASSP). Where required, appropriate follow-up actions had been taken.

Patient records and Monitoring the Mental Health (Wales) Measure 2010: care planning and provision

Care planning was well aligned with the Mental Health (Wales) Measure. This included comprehensive care and treatment plans that reflected the domains of the Welsh Measure and were regularly reviewed. However, care and treatment plan review minutes were not always uploaded onto the electronic records system in a timely manner. All patients had access to a named nurse, who assumed the role of care co-ordinator.

The health board should ensure that Care and Treatment Plan review minutes are uploaded onto WCCIS in a timely manner.

The unit used individualised, evidence-based risk assessments for assessing and managing clinical risk in patients. These were reviewed at regular intervals and when necessary.

Physical health needs were met in several ways. This included new and existing arrangements with a local GP practice, although staff noted that GP access can sometimes present challenges and is an area being explored by the service. Ward based nursing and medical input was also provided, and we noted referrals to other healthcare professionals were made in a timely manner. Patients were encouraged to access other services, such as optometry and dentistry, in the local community.

Mental Health Act monitoring
We reviewed the records of all patients who were detained under the Mental Health Act 1983 and found all legal documentation related to their admission to be compliant with the Act. There was documented evidence that patient rights were being upheld in line with the Act, and patients were regularly presented with their rights, and provided with written information to this effect.

Detention documentation could be navigated with ease, and it was positive to identify improvements had been sustained since the last inspection. However, we

recommend that previous Section 17 leave and consent to treatment certificates are clearly marked with 'no longer valid' to ensure that staff refer to the most recent document.

We found mental capacity to be assessed and recorded in patients ward round notes, alongside careful consideration of patient views and wishes. However, we recommend that the unit utilises the health board wide corporate checklist for assessments to ensure that there is consistency in approach and remains in line with the code of practice.

The health board should ensure that aspects of Mental Health Act documentation are strengthened, as set out in the body of this report.

Quality of Management and Leadership

Staff feedback

We invited staff to complete a survey about their experience working on Ty Skirrid Unit, as well as for the wider organisation. In total, we received 13 responses.

A representative sample of staff comments included:

> *" The ward team work well together to improve patient experience. The HCSW's have recently been shortlisted for the HCSW Team of the Year within the Health board which they are pleased with."*

> *" Another space/room for interventions/activities and MDT meetings to allow patients usual use of the ward."*

> *"The only concern I have is the night shift qualified. There is only one qualified by night where they cannot have a break or leave the ward and leaves a lot of responsibility to the one nurse."*

> *"I think the ward could improve by employing an activities co-ordinator to work aside the OT s and ward staff to support social interaction with some of the patients who struggle and then work on their strengths and weaknesses…"*

> *"The ward manager is very supportive, friendly, approachable, knowledgeable, very professional and a really good role model for junior members of staff. In all of my roles in and outside of the NHS this manager is the best one I have had by far!"*

The health board should consider the staff feedback regarding only on registered nurse on duty by, which impacts on their ability to take a break or leave the ward. This must include mitigations for any risks, such as appropriate level of skill mix on duty, a two-nurse checks for certain medications, and they needs for the registered nurse to leave the ward.

Leadership

Governance and leadership
Governance and oversight processes appeared to work well, enabling a flow of information between the unit, senior nursing, and divisional level meetings.

Matters raised in these meetings involved patient care, workforce, quality and safety.

We found evidence of good management and leadership on the unit. All staff on the ward appeared to work well together throughout the inspection. Positive feedback was provided about the ward manager, and the senior nurse was visible and actively engaged with patients in a knowledgeable manner during the inspection.

All staff who responded to the staff survey confirmed that their immediate manager can be counted on to help them with a difficult task at work. All but one agreed that they are given clear feedback and slightly fewer agreed that they are asked for their opinion before decisions are made that affect their work

In relation to senior managers, most staff members agreed that senior managers are visible and that communication is effective, and all agreed that they are committed to patient care.

Several policies and procedures were in the process of being updated. We recommend that review and ratification of policies and procedures are prioritised, according to their level of clinical risk. This must include the policy relating to patient restraint, which was due for review in 2019.

The health board must ensure that policies and procedures are reviewed and ratified in a timely manner. These should be prioritised according to their level of clinical risk.

Workforce

Skilled and enabled workforce

It was positive to find a generally stable workforce, with a committed team of staff, several of whom had worked on the unit for several years. There was a degree of bank usage on the unit, but staff confirmed that they make every effort to ensure regular bank staff are used to help ensure patients are familiar with the staff who are providing their care and treatment.

There was evidence of good medical leadership on the unit, with staff and patients complementing the care provided by the consultant psychiatrist. Staff and patients were also complementary of the therapeutic offer available to patients.

When asked in our survey if there are enough staff to do their job properly, two staff disagreed. This is reflective of comments received and set out earlier in this

report relation to nurse staffing by night. However, all staff responded that they can meet conflicting demands on their time at work.

Positively, mandatory training and annual appraisal completion rates were maintained to an overall good level, except for basic life support (BLS) and Mental Health Act training. However, we confirmed that there were imminent plans in place to resolve this.

Several staff were supported to undertake additional learning, development and training relevant to their roles, responsibilities and future career intentions. This included formal management, vocational and nursing training.

Culture

People engagement, feedback and learning
There were opportunities for patients, relatives and carers to provide feedback, complements and complaints. Patients were provided with a booklet upon admission, which encourages patients to speak with the ward manager. We confirmed that the ward manager has an open-door policy.

Patients could attend morning meetings to resolve any minor worries or concerns and could also speak with their named nurse. We have recommended earlier in this report that the unit should explore re-instating community meetings to ensure that wider feedback and concerns can be captured and responded to.

There were a low number of formal complaints, however, we confirmed that patients wishing to make a formal complaint would be directed to the appropriate NHS Wales Putting Things Rights process and with the support of an advocate, if required.

Information

Information governance and digital technology
Patient records were found to be securely stored on the unit. This included paper and digital records. The patient status board was always kept out of view, to maintain patient privacy and confidentiality.

Learning, improvement and research

Quality improvement activities
There were several nursing led audits undertaken on the unit. Some of these included audits in infection prevention and control, the environment, and patient records. The audits were generally well scored, using a health board audit

template and system, ensuring consistency in completion and reporting. Audits were monitored by ward management, senior nurse and fed into divisional quality, performance and safety meetings to ensure senior oversight.

Whole-systems approach

Partnership working and development
The unit works closely with other mental health services within the health board. This helps to ensure that wards and units and can share a professional dialogue in a timely manner, including highlighting and resolving concerns, and to aid patients in accessing the right level of care and in a timely manner.

The unit and divisional team maintained close working relationships with the local authority and supported living providers to help identify suitable placements for patients to aid timely discharge planning. Whilst there were some delays experienced in this regard, discharge planning was a prominent feature of patients care on the unit and regular meetings take place to monitor progress.

4. Next steps

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

The improvement plans should:

- Clearly state how the findings identified will be addressed
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the inspection.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

Appendix A – Summary of concerns resolved during the inspection

The table below summarises the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns Identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
One recently outdated palperidone injection was found in the clinic	Outdated medication can affect its efficacy	This was flagged to the nurse in charge	We confirmed that routine checks are undertaken by the pharmacy department, who attend the ward on a weekly basis. Ward staff confirmed that this would be flagged for their attention.

Appendix B - Immediate improvement plan

Service:

Date of inspection:

The table below includes any immediate concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.	Not applicable					
2.						
3.						
4.						

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative:

Appendix C - Improvement plan

Service: Ty Skirrid Unit, Maindiff Court Hospital

Date of inspection: 6-8 October 2025

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.	Page 11	The health board should ensure that roles, responsibilities and ownership of structured activities is strengthened.	Health and Care Quality Standards 2023 Person-centred / Effective	1. Ward to update activities timetable to reflect role of staff to undertake each activity.	Ward manager/ Occupational Therapist	1/12/2025
				2. Activity timetable is on display on main ward and individualised available in each patient bedrooms		Complete
2.	Page 11	The health board must explore if vision panels can be installed to improve sleep hygiene.	Person-centred / Effective	3. Minor Works costings to be obtained to determine next steps.	Service Improvement Manager	April 2026 due to Health Boards minor works procedures

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
				4. To be added to the Mental Health Capital Priorities register for funding.		Complete
3.	Page 11	The health board must explore if a room on the site can be made available to the Unit on a more consistent, if not permanent, basis.	Person-centred / Effective / Workforce	5. Ward Manager to re-explore availability of a room on site to use on a regular basis with the Senior Nurse	Ward manager	Meeting with Senior Nurse 5/12/2025 to discuss options
4.	Page 13	The health board should strengthen the recording of advocacy offer and uptake / decline.	Person-centred / Effective	6. Discuss and offer advocacy in patients' 3-weekly ward rounds.	Ward Manager	4/12/2025 (1st Patient Ward Round)
				7. Document advocacy discussions and outcomes in the ward round entry.	Ward Manager	4/12/2025 (1st Patient Ward Round)
5.	Page 13	The health board should seek to introduce community meetings to supplement daily morning meetings.	Person-centred / Effective	8. Meetings are now in place on a monthly basis	Ward Manager	Complete
6.	Page 14	The health board must continue to stringently assess patient moves and admissions, as far as	Effective / Safe / Leadership	9. Maintain established process for rehab referrals, overseen by the Responsible Clinician and agreed via MDT.	Clinical Director for Adult Mental Health	Complete and continue to monitor

	Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
		possible and despite known bed pressures, to ensure staff and existing patient safety and wellbeing.		10. Any patients transferred outside of this process are agreed with the locality responsible clinician.		Complete and continue to monitor
7	Page 15	The health board should ensure that estates issues affecting the unit are given sufficient attention and priority to maintain a therapeutic environment.	Person-centred / Effective / Safe	11. Outstanding maintenance lists to be reviewed weekly by dedicated housekeeper and escalations sent to the directorate Service Improvement manager to escalate appropriately.	Ward Manager	Complete and continue to monitor
				12. Escalate issues to the directorate Service Improvement Manager as needed.		Complete and continue to monitor
8.	Page 15	The health board should ensure that: • High level cleaning is included in cleaning schedules • A storage solution is found for the	Person-centred / Safe	13. Meeting scheduled for the facilities manager to address these issues.	Ward Manager/ Facilities Manager	Meeting scheduled 12/12/25
				14. All Patients' belongings have now been returned to bedrooms and areas decluttered.		Complete and continue to monitor

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
		patient laundry room.				
9.	Page 16	The health board must ensure that patient's legal status is included on medication charts.	Effective / Safe	15. Continue weekly checks of medication charts to ensure patient legal status is included.	Pharmacist/ SHO/Responsible Clinician	Complete
10.	Page 17	The health board should ensure that Care and Treatment Plan review minutes are uploaded onto WCCIS in a timely manner.	Effective / Safe	16. Remind all staff of the correct procedure for uploading review minutes onto WCCIS.	Ward Manager/ Senior Nurse	Complete and continue to monitor via AMAT and Divisional Audit processes
				17. Monthly audit of compliance with WCCIS		January 2026
11.	Page 18	The health board should ensure that aspects of Mental Health Act documentation are strengthened, as set out in the body of this report.	Effective / Safe	18. Capacity Checklist for Mental Health Act is now in place to ensure there is consistency in approach and remains in line with the code of practice.	Responsible Clinician/ Mental Health Act Admin Manager to	Complete and continue to monitor via Clinical Director

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
				19. Monthly audit of MHA documentation	provide oversight	Complete and continue to monitor via Clinical Director
12.	Page 19	The health board should consider the staff feedback regarding only on registered nurse on duty by, which impacts on their ability to take a break or leave the ward. This must include mitigations for any risks, such as appropriate level of skill mix on duty, a two-nurse checks for certain medications, and they needs for the registered nurse to leave the ward.	Workforce	20. Ward is currently undergoing an establishment review to consider options or alternatives to address the staffing levels	Lead Nurse	Establishment reviews to be completed by January 2026
				21. Options Appraisal has been developed to address immediate safety concerns on site.		Options appraisal complete. Awaiting discussions – to take place in December 2025
				22. The future of Maindiff Court site is currently under review as part of the wider health board Mental Health		Ongoing

	Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
				& Learning Disability & estates strategy		
12.	Page 20	The health board must ensure that policies and procedures are reviewed and ratified in a timely manner. These should be prioritised according to their level of clinical risk.	Effective / Safe / Leadership	23. Ensure all policies and procedures are reviewed in the Divisional Policy Group and prioritized by clinical risk.	Divisional Policy Group	Ongoing

Oversight and monitoring of the improvement plan will be undertaken by the following groups: -

- Action Plan meeting
- Directorate Quality Patient Safety Meeting
- Divisional Quality Patient Safety Meeting
- Senior Management Team
- Quality Management Group
- Quality Patient Safety Outcomes Committee

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

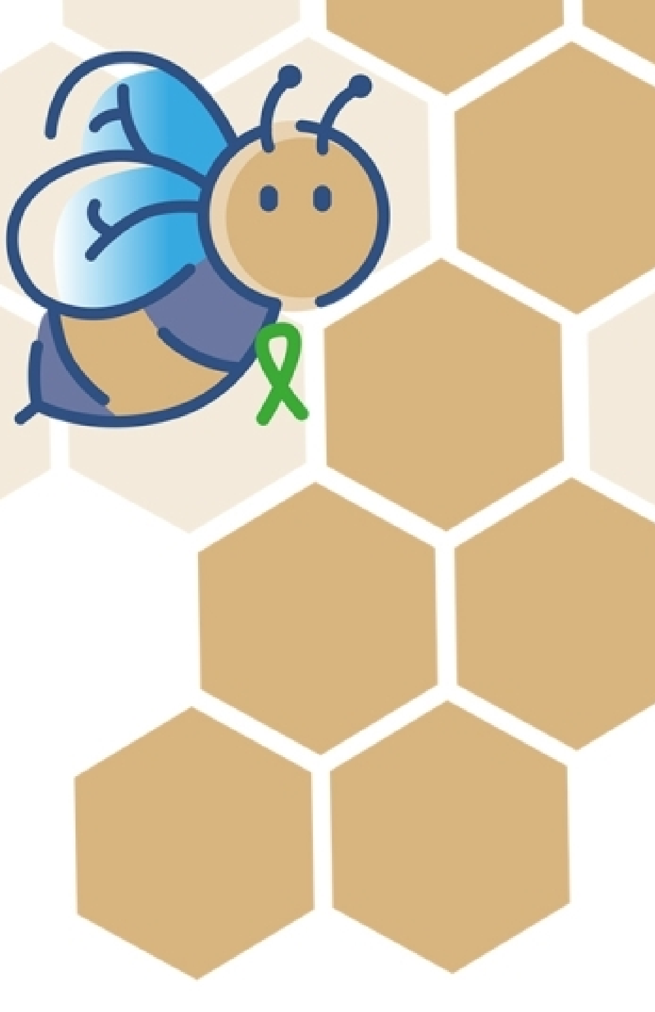
Service representative

Name (print): Nadine Gould

Job role: Divisional Nurse

Date: 27/11/25

Mental Health & Learning Disabilities Committee



24th March 2025

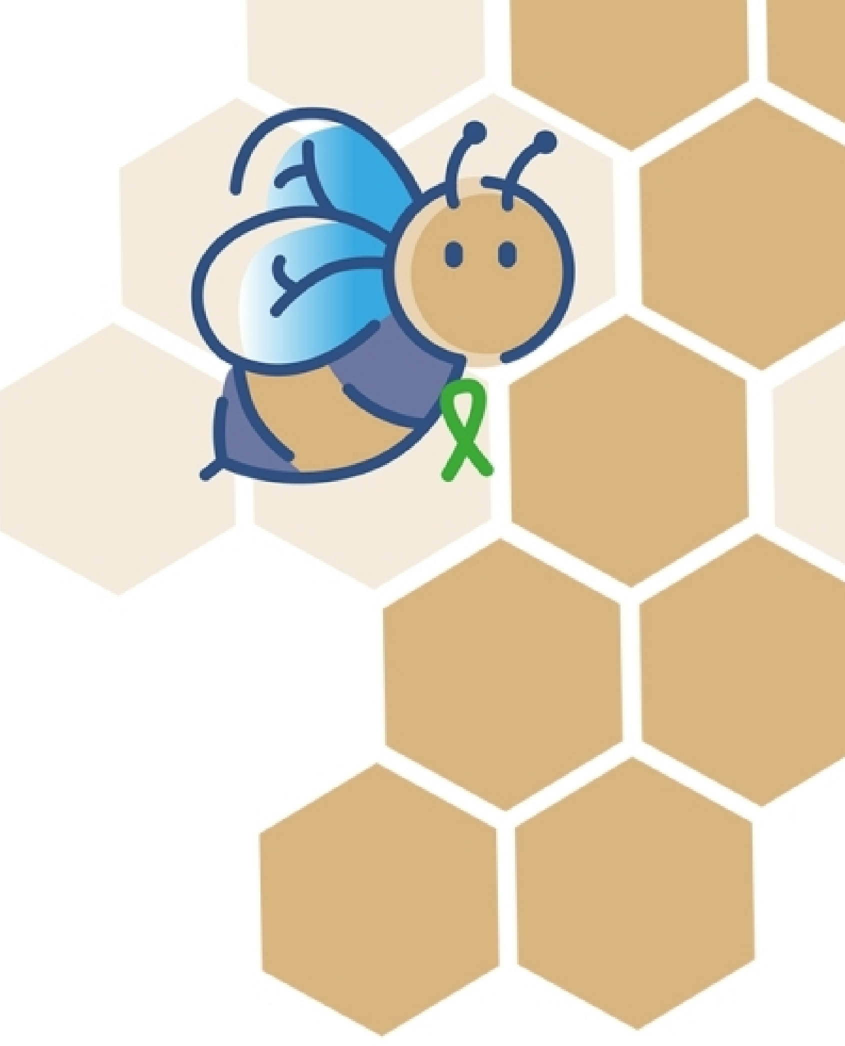
Progress of the Bill

- Nov 2024 – 1st reading in the House of Lords
- Late Nov 2024 – 2nd reading
- April 2025 – 3rd reading
- June 2025 – House of Commons Scrutiny
- November 2025 – Bill returns to the House of Lords for amendment
- Received Royal Assent on the 18/12/2025

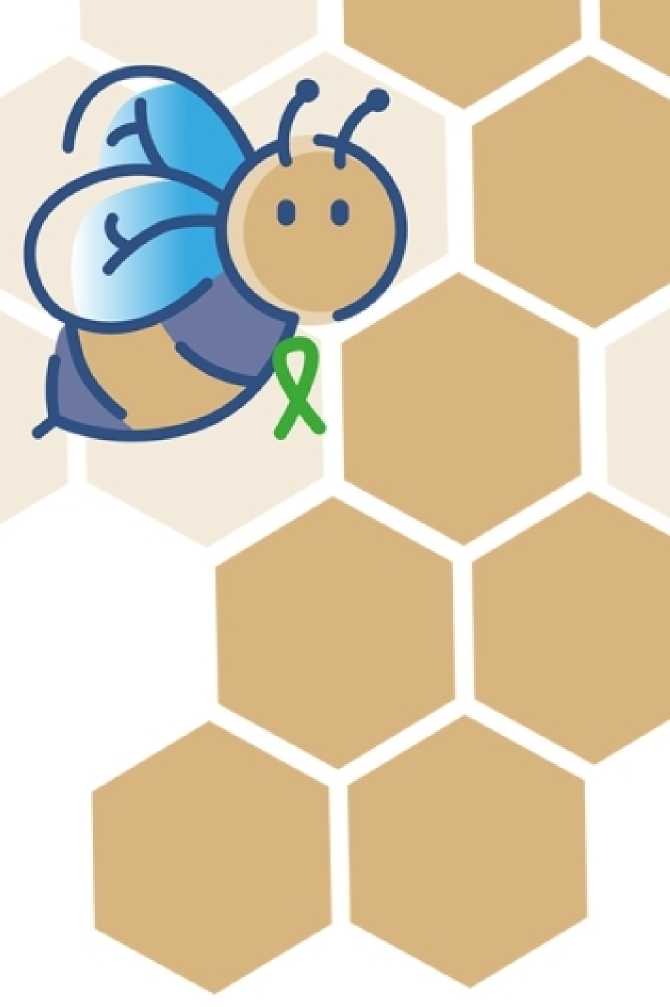
Legislative Consent Process

- The MHA Bill passed six consent stages in Wales
- Senedd approval in October 2025

The Bill Received Royal Assent on the 18/12/2025



Wales Phased Implementation plan



December 2025

- Welsh Government begin roadmap planning

February 2026 - 2027

- Code of Practice - Formal consultation begins on existing Code of Practice
- MHRT – change of criteria to retain and employ more medical members to cope with increased Tribunals, recruitment drive for of extra administration staff
- Phased commencement – Care providers begin training for staff and upgrade systems
- 2027 + - Full roll out of changes - Monitor compliance and quality.

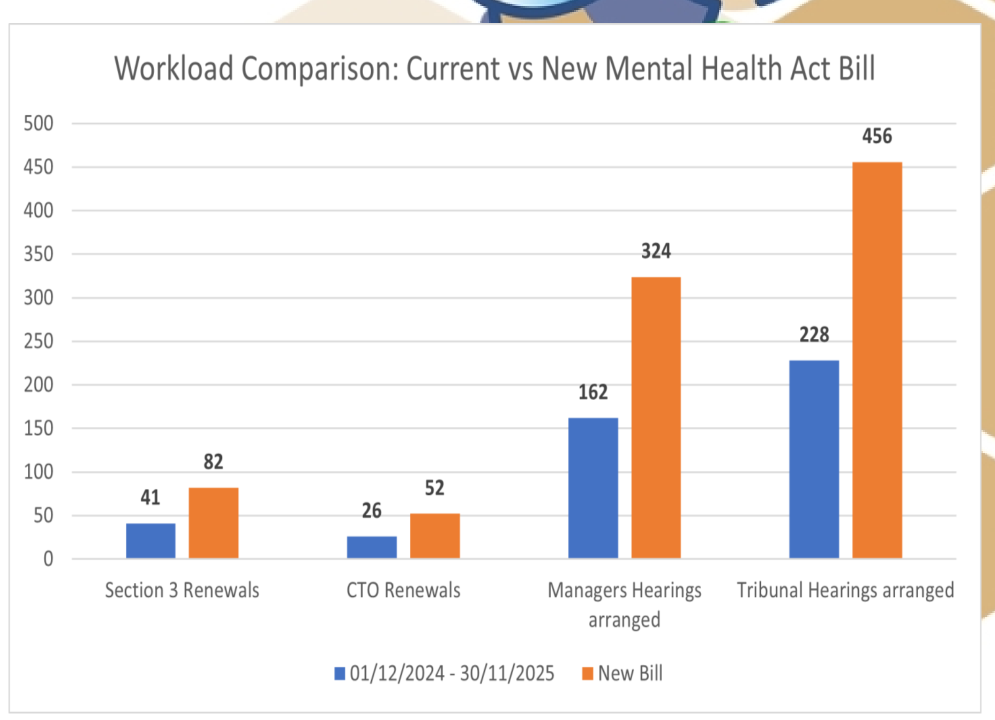
Iechyd Meddwl ac Anableddau Dysgu Gwent
Mental Health & Learning Disabilities Gwent
Cyflwyno Gofal sy'n Canolbwyntio ar yr Unigolyn a Thosturiol
Delivering Person Centred & Compassionate Care

Challenges for the MH&LD Division

1. Workload Increase

- Section 3/37/CTO renewals will be every 3 months, currently 6 months.
- Tribunal referrals and Manager reviews every 3 months (currently 1 in first 6 months of detention and yearly thereafter) plus patients will still have a right to appeal
- In addition to the above, there will be an increase in consent to treatment, patient rights and detention papers to process.

The additional workload will require a staffing uplift to administer the new process.

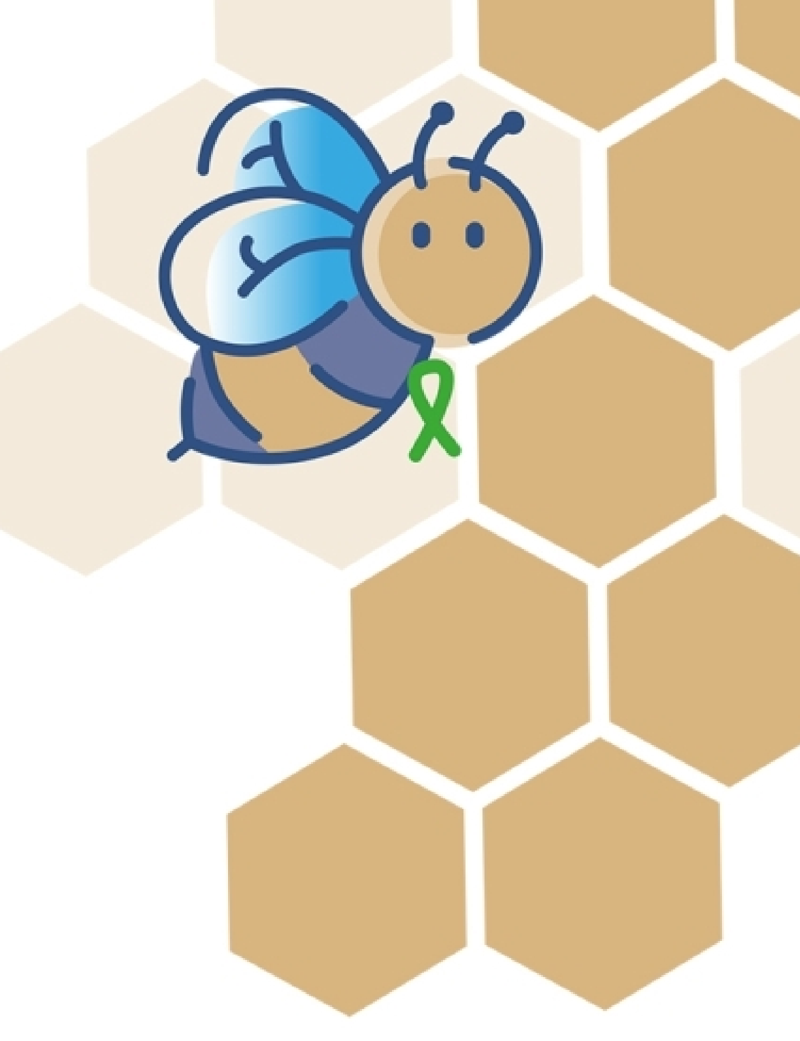


2. Training resources

- The changes will also impact on training as staff will need additional MHA training to meet its legal obligations under the Mental Health Act Bill.

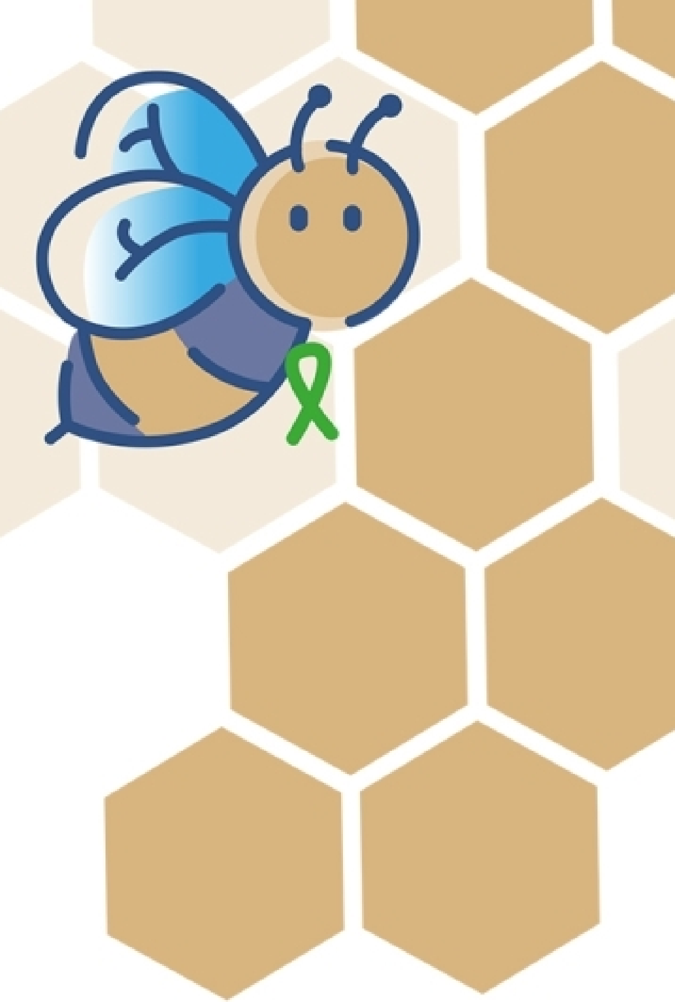
Financial impact

- **Admin staff -** Additional admin staff will be required to administer the additional tribunal and managers hearings, current estimate is that 2 x Band 3, 2 x Band 4 administrators, and 1 Band 5 manager will be required.
- **Medical time -** Additional medical time to attend tribunals
- **Managers hearings -** Additional hearings, recruitment of additional associate hospital managers
- **IMHA -** Additional IMHA staff as automatic right to advocacy



ABUHB Current Preparatory Measures

- The MHA team are attending regular **MHA forums collaborating with colleagues** across Wales to share best practices, building an All-Wales unified approach to the Bill.
- The senior Mental Health Act administrators have **completed University certificates in Mental Health Act Law**, in line with other Health Boards in Wales to prepare for the changes
- The MHA team have been **attending HIW training days** to stay aligned with Welsh Government requirements and legislative changes that will be required when the roll out of the bill commences.
- Our current training programme has been tailored to **alert current staff of impending changes to the Mental Health Act** and the predicted first implementation
- The MHA Team are currently **developing additional training material** in preparation for implementation
- The MHA team is actively **reviewing and streamlining existing processes** to maximise the efficiency of current resources. This will provide a clear understanding of capacity and forecast of the additional resources required to implement the changes



Agenda Item:

	CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: DATE OF MEETING:	24 March 2026
CYFARFOD O: MEETING OF:	Mental Health Act Monitoring Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Mental Health Maturity Assessment
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Paul Solloway, Director of Digital
SWYDDOG ADRODD: REPORTING OFFICER:	Paul Solloway, Director of Digital

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Gwybodaeth/For Information

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The first national Digital Maturity Assessment for Mental Health services in Wales has recently been completed, providing an evidence-based baseline of digital capabilities and readiness across all Health Boards. This assessment comes at a pivotal time, as digital transformation underpins the Welsh Government's Mental Health & Wellbeing Strategy and is essential for delivering safe, consistent, and modern mental health services.

The assessment was undertaken collaboratively by Directors of Digital and Mental Health Executive Leads in each Health Board, with specific focus on five domains:

- Governance and Leadership
- People and Culture
- Electronic Patient Record (EPR)
- Digital Services
- Digital Processes

The findings will directly inform the upcoming two-year National Digital and Data Delivery Plan for Mental Health and are intended to complement and align with broader Electronic Health Record (EHR) maturity work led by the National Digital Data & Technology (DDaT) Leadership Board.

Cefndir / Background

Digital maturity in healthcare, as assessed by frameworks such as the Healthcare Information & Management Systems Society (HIMSS) Electronic Medical Record Adoption Model (EMRAM), remains low in Wales, with all Health Boards at level 1 – indicating limited clinical automation, siloed systems, and ongoing reliance on paper-based processes.

The Welsh Government's "A Healthier Wales" vision and the Digital Architecture Review (DAR) have long emphasised the need for open architecture, interoperability, and a national approach to digital transformation. Mental health services, in particular, have faced challenges with fragmented systems, inconsistent adoption of digital tools, variation in workforce capability and know challenges with the Welsh Community Clinical Information System (WCCIS).

Locally, the Aneurin Bevan University Health Board has completed its own Digital Maturity Self-Assessment, confirming similar themes: informal and reactive governance (level 2), developing digital culture and workforce capability, early-stage integration of the Digital Capability Framework (DCF), and a strong likelihood of meeting the 2028 EPR target given the Health Board has awarded a contract to the Access Group for the RIO mental health system and implementation activities has started.

Asesiad / Assessment

The national assessment reveals significant variation in digital maturity across Health Boards, with the greatest gaps in workforce capability and digital processes. Governance scores range from 2.0 (informal/reactive) to 3.5 (transitional/mature), and while EPR readiness is generally progressing, the adoption of digital services and processes is uneven, particularly in community and CAMHS pathways. The Health Board demonstrates good foundational capability—video and telephone consultations are widely used, and procurement for a Mental Health EPR is complete with implementation expected by March 2027. However, digital tools such as mobile apps and remote monitoring remain in pilot phases, and digital processes like asset/resource management and shared care records are at minimal maturity (level 1). Across Wales, universal weaknesses include remote monitoring, inconsistent data quality, and fragmented records. Risks identified include funding and resource capacity, interoperability challenges, slow DCF adoption, and persistent paper-based duplication.

Alignment with National EHR Strategy

The findings from the Digital Maturity Assessment strongly align with the principles and strategic direction set by the National DDaT Leadership Board for EHR maturity. The Board is advocating for a "Once for Wales" approach, clear investment priorities, and the use of the HIMSS EMRAM framework to guide progress towards fully integrated, interoperable EHR systems by 2035. Both national and ABUHB assessments highlight the need for standardisation, coordinated capability-building, and targeted investment in digital infrastructure and workforce skills.

Recommendation

Based on the analysis, the following recommendations are proposed:

- Accelerate Governance and Workforce Capability: Health Boards should prioritise structured digital leadership and comprehensive workforce development plans, embedding DCF pathways and digital literacy into routine staff development and appraisal processes.
- Standardise Digital Processes: should be focus on addressing universal weaknesses, particularly remote monitoring, shared care records, and asset/resource management, leveraging proven solutions and cross-organisational learning.
- Ensure EPR Delivery and Interoperability: Maintain momentum on EPR procurement and implementation, ensuring alignment with national technical standards and securing sustainable funding. ABUHB and other Boards should provide clear delivery plans and monitor progress against the 2028 target.
- Embed Data Quality Improvement: Address data quality, duplication, and fragmented records through the mandated Mental Health Core Dataset and outcomes measurement frameworks.
- Align with National EHR Strategy: Health Boards should actively participate in the EHR needs assessment, ensuring mental health priorities are fully represented in national planning and the transition towards HIMSS EMRAM level 7 by 2035.

Overall, the Digital Maturity Assessment highlights the urgent need for coordinated national action, investment in digital foundations, and consistent capability-building across Wales. By addressing these priorities, Wales will be better positioned to deliver modern, efficient, and patient-centred mental health services, in line with national digital ambitions.

Argymhelliad / Recommendation

The committee is asked to **NOTE** the outputs of the Digital Maturity Assessment alongside the next steps and recommendations.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	Not Applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3.4 Information Governance and Communications Technology Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Not Applicable Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Digital, Data, Intelligence

Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	 2025-08-13%20National%20DDaT%20Lead DDAT Leadership Board Paper Digital%20Maturity%20Assessment%20Ana Summary of NHS Wales Findings ABUHB%20Self%20Assessment.xlsx Aneurin Bevan's Self-Assessment
Rhestr Termau: Glossary of Terms:	CAMHS – Child & Adolescent Mental Health Servies DDaT – Digital Data & Technology EHR – Electronic Health Record EMRAM – Electronic Medical Record Adoption Model EPR – Electronic Patient Record DAR – Digital Architecture Review DCF – Digital Capability Framework HIMSS – Healthcare & Information Management Systems Society WCCIS – Welsh Community Care Information System
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Not Applicable

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive

	Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• **Workforce**	Not Applicable
• **Service Activity & Performance**	Not Applicable
• **Financial**	Not Applicable
Asesiad Effaith Cydraddoldeb **Equality Impact Assessment** (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Not Applicable Choose an item.

Name of Programme: Electronic Health Record
Lead Organisation: Welsh Government

Submitted By:

Submitted By: Digital and Data Team
Presented at Leadership Board by: Steve Probert
Date of Leadership Board: 13 August 2025

Objective

We are asking the National DDaT Leadership Board to review the guiding principles in this paper for an EHR, provide feedback by end of August, and support the development of a market specification for the needs assessment for approval in September.

Submission Purpose.

Report submitted for: Decision

1. Sponsor a national approach to closing the long standing EHR maturity gap in Wales, that involves consideration of commercial EHRs as a direction and consider initial governance for that.

2. Review the principles in this paper and agree a final set for submission to Ministers for approval by end of August.

3. Support the development of a consultancy specification for an initial needs assessment from Health Boards and Trusts for approval in September 2025, procurement in October 2025, and execution by year end with a report delivered to the National DDaT Leadership Board and Ministers in January 2026.

Summary

This paper sets out a high-level assessment of the development of Electronic Health Record (EHR) solutions in Wales over the past 20 years. It proposes an approach to closing the long-standing gaps in maturity of these systems based on agreed principles, and an initial assessment of the most pressing needs of the system.

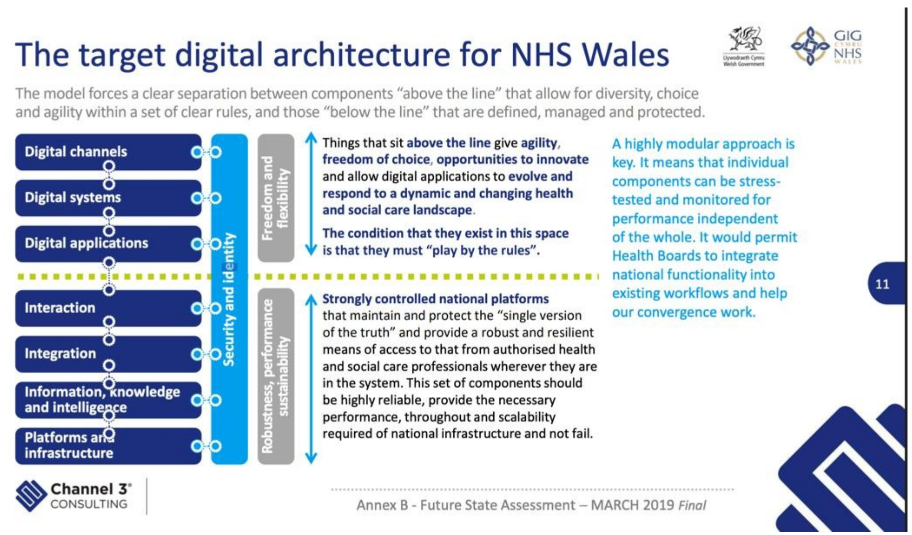
Background

The Welsh Government's "A Healthier Wales 2018" vision, reinforced the focus on digital technology as a key enabler of transformational change and set out a vision of making better use of digital, data, and communication technologies to enhance the quality and value of health and social care services in Wales.

Building on a Healthier Wales, the 2019 Digital Architecture Review (DAR) by Channel 3 Consulting Ltd. considered the current configuration and capability of digital systems, in Wales including the electronic patient record, and their ability to meet the ambitions set out in A Healthier Wales. The DAR noted a highly complex and fractured clinical system estate which currently stands at approx.: 2981 systems in use, 132 of which are nationally supported.

The review recommended a target 'open architecture' model based on common standards and prioritised steps to transition systems and services from current to future state. It suggested a 3-year time horizon (i.e. to 2022) for significant improvement in the overall capability. Crucially, the DAR set out a target architecture that separated infrastructure technologies ("below the line") required to provide stability and security of health and care systems against standards, and applications built on this layer ("above the line") where there would be more freedom and flexibility as to the specific products and solutions including EHRs deployed based on need within the standards framework. This included commercial solutions as well as those developed in Wales.

This is illustrated below:



Whilst the DAR is currently being implemented (National Target Architecture Project), the fundamental principles are not expected to change.

Current Position

The vision set out in A Healthier Wales in 2018, reinforced in the Digital and data strategy for health and social care in Wales 2023 and refreshed AHW actions in 2024 remains valid, but it is still a long way off from being realised. The state of digital clinical systems as experienced by the Health Boards in Wales remains at a low level of maturity.

The Healthcare Information and Management Systems Society (HIMSS) Electronic Medical Record Adoption Model (EMRAM) is a de-facto international standard

framework designed to assess the level of digital maturity in healthcare organisations in terms of capabilities used by clinicians to deliver front line care. The model consists of eight stages (0-7) that measure the adoption and utilisation of EHRs and other digital health technologies. It is vendor and product agnostic and is used globally as a measure of digital capabilities at the level of care settings and notably in acute care. HIMSS level 7 is highest level of digital maturity, where the organisation has a fully integrated EHR system that is capable of advanced data analytics, interoperability, and continuous improvement through the use of health information technology.

The HIMSS assessment conducted across NHS Wales Health Boards in early 2023, concluded that most of NHS Wales still only reaches EMRAM level 1. In other words, Health Boards still, in the round, have some clinical automation, but it is limited to ancillary departments such as laboratory, pharmacy, and radiology.

The NHS in Wales still currently relies on a number of disparate systems that present multiple challenges, including data silos, duplication of effort, and a lack of a single patient view. These issues are exacerbated by varying standards, inconsistent architectures, and multiple "versions of the truth". This means that the population we serve in Wales is not benefiting from the best that digital has to offer front line clinicians, and that we have a significant level of "technical debt" that is fractured, unreliable and costly to maintain. There are direct impacts on patient care and safety, but also potentially indirect impacts on Wales, such as attracting clinical talent and research investment.

In the same timeframe, the commercial EHR market has matured considerably. There are several offerings across the acute care settings of systems that are robust, secure and interoperable, and increasing maturity in the systems that support other care settings such as community care, mental health, and social care. These solutions are proven, meet recognised standards, and provide a range of commercial options without the need for development and support of locally developed capabilities.

Proposed Way Forward

Our progress on digital maturity has demonstrated that this is a hard problem to solve, and that it will need a coherent national approach to strategy deployment. We also have the opportunity to access a mature commercial market and to avoid the costs, lead times and support overheads associated with locally developed solutions. One of the recommendations from the Ministerial Advisory Group (MAG) on NHS Wales Performance and Productivity report includes the development of a roadmap for EHR in Wales.

There are two key steps to making a start:

1. A set of agreed principles to guide the development of our approach that will require agreement by Ministers.
2. Undertake a short needs assessment at Health Board level to identify the most pressing needs for EHR technologies.

Principles

The following principles are suggested for guiding our national approach to closing our EHR maturity gap in Wales:

1. Our approach will align with the vision set out in A Healthier Wales (2018), the recommendations of the Digital Architecture Review (2019), the 2024 AHW refreshed actions and the MAG recommendation.
2. We will adopt a Once for Wales approach in terms of the standards and approach we adopt to addressing the gap in our EHR technologies. This needs to be aligned with the recently agreed categories 1 to 3 proposed to the National DDaT Leadership Board in May 2025:
   - 1. Base Tier: Compliance with National Architecture,
   - 2. Middle Tier: Service Standardisation,
   - 3. Highest Tier: One Common System
3. We will use the HIMSS EMRAM framework as a way of setting goals and measuring progress. For EHRs we will aim nationally in acute care settings (where solutions are most mature) to be at HIMMS EMRAM level 7 for all health boards by 2035.
4. We will set clear investment priorities and envelopes and work to rolling 3year time horizons with clear measurable outcomes
5. We will adopt a phased approach based on investment available, and the benefits required and create a national rolling programme of change to achieve our ambitions.
6. We start by investing against the most pressing Health Board priorities for delivering health and social care locally.

We are asking the National DDaT Leadership Board to review and agree a set of principles for approval by Ministers.

Once the principles above are agreed, we are seeking approval to commission a short consultancy study by the end of 2025, and building on the HIMSS assessments of 2023 to seek the views of the Executive Teams and digital leaders of the Health Boards, and Trusts to assess:

1. Their current assessment of their digital maturity and major gaps by care setting.
2. Their local ambitions and strategies for digital systems.
3. Their funding and resource gaps in achieving their needs.
4. Their current assessment of their most pressing EHR needs at a specific level (which care settings, which hospitals etc.)

The principal output of the work would be high level map of the EHR needs by Health Board / Trust and care setting, and an assessment of the most pressing needs to guide the development of a longer-term approach and further engagement.

We would target a maximum of 4 - 6 weeks for execution with a specific request that the suppliers use senior people to conduct the discussions with stakeholders and report to the National DDaT Leadership Board by the year end. We would complete

this study on a national consultancy framework and are targeting a maximum budget of £50K for external support for a focussed strategic report.

NHS Wales
Digital Maturity Assessment - Summary Findings

January 2026

Purpose

As the first assessment of its kind for Mental Health services in Wales, this work establishes a national and local baseline and creates a foundation for consistent, evidence-based digital transformation.

Why this matters:

Digital maturity underpins the Mental Health & Wellbeing Strategy and is essential for delivering consistent, safe, modern mental health services.

What We Did:

We asked all Health Boards in Wales to complete a Mental Health Digital Maturity Assessment. This is the first national picture specifically focused on Mental Health digital capability.

Assessments were jointly completed by Directors of Digital and Mental Health Executive Leads to ensure clinical and digital perspectives. All Health Boards have submitted their returns.

Each Health Board assessed themselves across five domains:

- Governance and Leadership,
- People and Culture,
- Electronic Patient Record (EPR),
- Digital Services,
- Digital Processes,

Next Steps:

These insights will help shape and inform the 2-year National Digital and Data Delivery Plan for Mental Health, supporting commitments within the Mental Health and Wellbeing Strategy.

Please note: We are aware of Steve Probert's letter (attached), which focuses on understanding the digital maturity of Electronic Health Records (EHR) within each Health Board. The Mental Health Digital Maturity Assessment focuses specifically on mental health services, while the EHR strategy addresses system-wide core clinical systems. Both initiatives complement each other and should align, with the mental health assessment informing broader EHR needs.

Strategic Ambitions (Welsh Government 3-Year Delivery Plan)

Digital & Data Priorities Supporting the Mental Health & Wellbeing Strategy

National Deliverables

- Establish a Data, Digital & Outcomes Group to provide oversight of system-wide work ✔ Completed
- Develop a national Digital & Data Plan for Mental Health, including a detailed two-year implementation plan, covering:
  - Mandated Mental Health Core Dataset for all MH services– To be implemented by end of Year 1
  - Clear outcomes and experience measures across all services– To be in place and reported by end of Year 3
  - Electronic Patient Record (EPR) for Mental Health across Wales– To be delivered by end of Year 3

Overall Executive Summary of Findings

Digital maturity varies significantly across Health Boards.

Governance and workforce capability show the greatest variation.

EPR readiness is generally progressing, but timelines/funding create risk.

Digital services are unevenly adopted, especially in community and CAMHS.

Digital processes show universal weaknesses, particularly remote monitoring.

Executive Summary: Governance, People & Digital Capability

Key Finding:

Governance and workforce capability show wide variation, creating inconsistent digital readiness.

Governance & Leadership

- Governance maturity varies widely (**2.0–3.5**).
- **BCUHB** strongest (3.5); **ABUHB** and **HDUHB** lowest (2.0).
- Several Boards (e.g., **CAVUHB**) show solid operational maturity but **lack a clear MH digital strategy** or alignment with national solutions.
- **CTMUHB** and **PTHB** show developing but inconsistent governance.

People & Culture

- Workforce digital maturity sits between **1.5-3.0**.
- **BCUHB, CTMUHB,** and **SBUHB** show stronger cultural readiness (3.0).
- **HDUHB** lowest (1.5), **ABUHB** at (2.0), **PTHB** and **CAVUHB** mid-level (2.5).
- Most Boards **lack structured plans** to build MH digital capability.

Digital Capability Framework (DCF) Integration

- DCF integration is **immature** nationally (**1.5–2.5**).
- **PTHB** and **HDUHB** lowest (1.5).
- **ABUHB, BCUHB, CTMUHB** at 2.0 → early stage, not embedded.
- **SBUHB** highest (2.5).
- **CAVUHB** – no documented DCF score.

Executive Summary: Electronic Patient Record (EPR) Readiness, Digital Services & Digital Processes

Key Finding:

Most Health Boards are on track for EPR 2028, but Digital Services and Digital Processes lag behind.

EPR Readiness (Target: 2028)	Digital Services	Digital Processes
Very Likely (A): ABUHB, CAVUHB, CTMUHB, PTHB — all have clear procurement and implementation paths. **Somewhat Likely (B):** BCUHB, HDUHB, SBUHB — progress underway, but rollout timelines and funding dependencies pose risks.	CAVUHB & SBUHB (inpatients) are most digitally enabled (76–100%). ABUHB, BCUHB, CTMUHB, HDUHB show mixed or early-stage digitisation, with many services still partially or not digital. PTHB progressing but reporting incomplete.	Strengths in Infrastructure, BI, and Shared Care Record in some Boards. Universal weaknesses in Remote Monitoring (Level 1 everywhere). Inconsistent Asset & Resource Management and Medicines Management. MH services frequently lag the wider Board's digital systems, reflecting adoption and integration challenges rather than a lack of technology.

What Stands Out (Comparative Analysis)

Key Finding:

Variation is greatest in workforce capability and digital processes.

A. Governance & leadership

- BCUHB (3.5) and SBUHB/CAVUHB (3.0) report more mature governance.
- ABUHB and HDUHB are earlier on the journey (2.0),
- PTHB/CTMUHB sit in the mid-tier (2.5)

B. Workforce/DCF

- DCF adoption is the main drawback: Even where culture is “3”, DCF integration lags at 1.5–2.5, and several Boards call out a lack of coordinated digital skills provision beyond system-specific training. (HDUHB 1.5; PTHB 1.5; CTMUHB 2; BCUHB 2 with generic capability training “in development”.)

C. EPR trajectory to 2028

- On track, but funding & integration risks:
  - On/near track: ABUHB (procurement completed; MH EPR by 2027); CAVUHB (long-standing EPR use, replacing Paris); PTHB (contract award Jan-26; full by 2028).
  - HDUHB will continue to maximise the functionality available within WPAS and CarePartner to support current Mental Health service needs.
  - Dependency risks: SBUHB (MVP in 26/27; full rollout hinges on planning & funding to 28/29), BCUHB/CTMUHB (joint procurement; dependency on national interoperability/standards).

D. Digital delivery

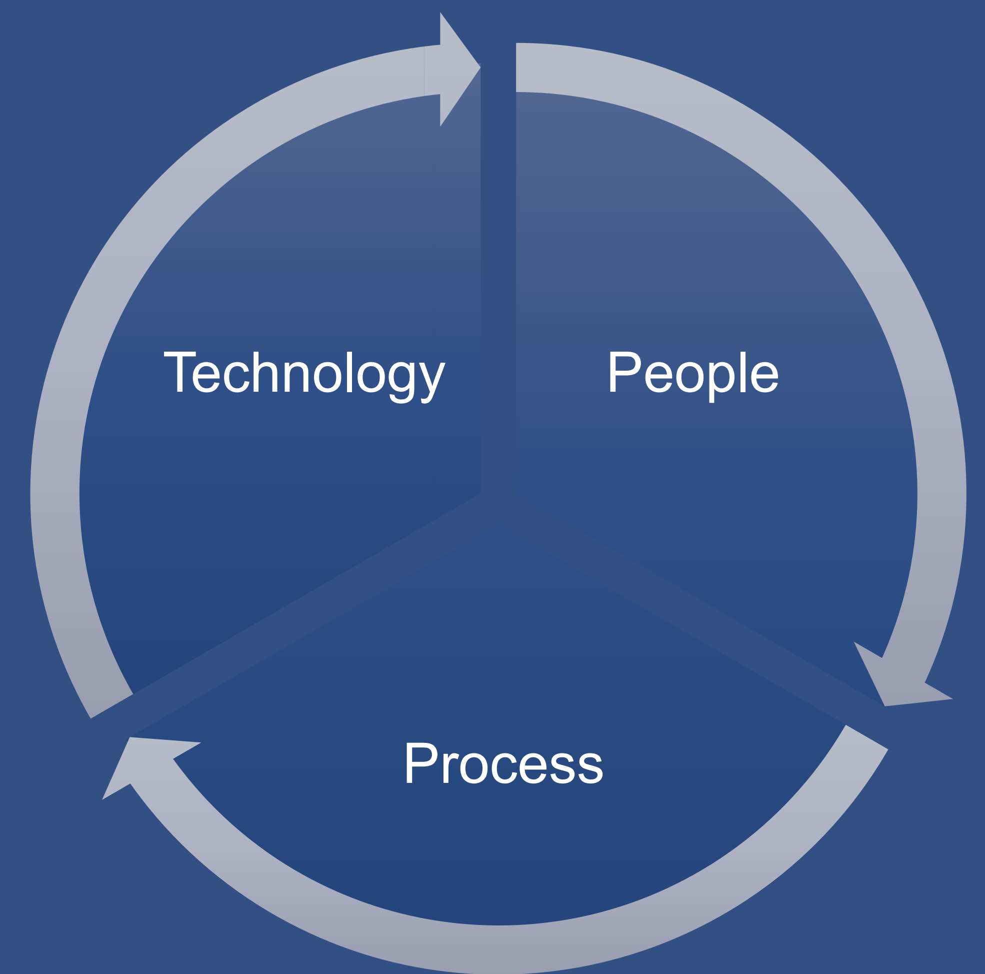
- Most Boards report partial digitisation in community & CAMHS; CAV reports the broadest “fully digital” coverage across adult services, though some notes (e.g., legal constraints on S136) mean “recorded digitally but done in person”.
- Tooling reuse potential is real: Reuse candidates mentioned include Power Apps/BI (CAVUHB), FACE/SMS (CTMUHB), HEMPA/Signal/DMS (SBUHB), and My Medical Record (ABUHB). These could be fast followers for MH services once governance and IG patterns are templated.

E. Digital processes

- Remote monitoring = level 1 almost everywhere except for HDUHB (level 2); pilots exist but are not integrated with EPR.
- Records management remains mixed with pockets of paper reliance (e.g., SBUHB and HDUHB for MH=1).
- Business & Clinical Intelligence: Several Boards cite Power BI growth, but clinical decision support is still basic (allergy alerts/operational views rather than clinical pathway embedded information).

Evidence-Informed Areas for Discussion to Help Shape the 2-Year Delivery Plan

The assessment highlights several national priorities that should shape the 2-year delivery plan, including governance consistency, workforce capability, interoperability foundations and EPR readiness.



Key Insights From the Digital Maturity Assessment (Suggested Areas of Need)

Emerging Themes Across Health Boards	What the Findings Suggest	Potential Benefits if Addressed
Significant **variation in digital maturity**, especially in workforce capability, digital processes, and interoperability.	A need for greater **standardisation and "Once for Wales" approaches** to accelerate maturity.	Improved **data quality** and reduced duplication.
Inconsistent adoption of digital tools across inpatient, community and CAMHS pathways.	Stronger **governance structures** and clearer Mental Health digital leadership across Boards.	More efficient **patient flow** and operational visibility.
Data quality challenges caused by mixed paper/digital records, duplication and fragmented systems.	Prioritisation of **digital foundations** (infrastructure, asset/resource management, remote monitoring).	Better **patient and staff experience** through consistent pathways.
EPR readiness varies, with Mental Health pathways not consistently represented in Health Board system roadmaps.	Consistent **capability-building** and more coherent digital adoption across all services.	Strong foundations for **outcomes measurement** and improvement.

Opportunity: Standardise, align and build capability across all Health Boards.

Alignment With National Expectations

Findings align strongly with national expectations, particularly around data quality, capability and EPR.

SC2.0 TRANSFORMATION PILLARS	HEIW — DIGITAL CAPABILITY FRAMEWORK (DCF)	OSR (ONCE FOR WALES / SHARED RECORD)	WELSH GOVERNMENT MENTAL HEALTH & WELLBEING STRATEGY
Alignment Summary: Clear mapping to all four pillars: Digital Services (citizen-facing tools) Digital Foundations (interoperability, infrastructure) Digital Capability (workforce skills) Inclusion (accessible routes) **Status: Strong alignment**	**Alignment Summary:** Need for more structured, role-based capability pathways. Adoption of DCF is **inconsistent** across Health Boards. **Status: Partial alignment (gap)**	**Alignment Summary:** Inconsistent usage across Mental Health services. Opportunities to improve interoperability, information flow, and continuity of care. **Status: Partial alignment (gap)**	**Alignment Summary:** Strong alignment with WG expectations around: • Developing a national **digital & data plan** • Creating a **Mental Health Core Dataset** • Improving **outcomes measurement** • Delivering a **MH EPR** **Status: Strong alignment**

IGDC • DHCW

Suggested Areas for Discussion (Future Priorities to Explore, Informed by National Expectations Including WG MH & Wellbeing Strategy Assessment findings highlight several areas requiring further discussion in relation to WG's digital ambitions:

Digital & Data Overarching Plan + a Two-Year Detailed Implementation Plan

Findings suggest where national prioritisation and consistent approaches may be needed across HBs (e.g., foundations, interoperability, capability).

Mandated Mental Health Core Dataset — End of Year 1

Data quality issues, duplication and fragmented processes suggest strong alignment to this requirement.

Outcomes & Experience Measures Across All Services — End of Year 3

Variation in analytics maturity and limited real-time data reinforce the need for national outcomes reporting frameworks.

Mental Health EPR — End of Year 3

Readiness varies significantly; findings indicate the need for coordinated national approaches, MH-specific functionality, and alignment with procurement timelines.

The assessment evaluates maturity across six domains:

Governance & Leadership

Self-assessed Maturity Levels

Governance maturity varies from 2.0–3.5 across Wales.

- ABUHB **2.0** (Lowest)
- BCUHB **3.5** (Highest)
- CAVUHB **3.0** (good operational maturity; service lacks a digital strategic plan and has no interface with national solutions.)
- CTMUHB **2.5** (“needs completion” in places)
- HDUHB **2.0** (Lowest - the fundamental structures, committees, and policies are in place, but digital is not yet consistently embedded or operating with the reliability expected of a higher maturity level.)
- PTHB **2.5** (governance improved post digitisation; Consistent data recording and reporting remains challenging due to current systems, double recording issues)
- SBUHB **3.0** (HB wide feedback noted)

Governance & Leadership Maturity Level (Self- Assessed)

Health Board	Maturity Level
ABUHB	2
BCUHB	3.5
CAVUHB	3
CTMUHB	2.5
HDUHB	2
PTHB	2.5
SBUHB	3

People & Culture

Self-assessed Maturity Levels

Workforce capability lags behind governance in most Health Boards

- ABUHB 2.0
- BCUHB 3.0
- CAVUHB 2.5 (good maturity but lacks a plan)
- CTMUHB 3.0
- HDUHB 1.5 (Lowest - the foundations exist, but they are not yet mature, measurable, or widespread enough to demonstrate a fully developing digital culture)
- PTHB 2.5
- SBUHB 3.0 (Were not clear whether they had to go vertically or horizontally in terms of assessment.)

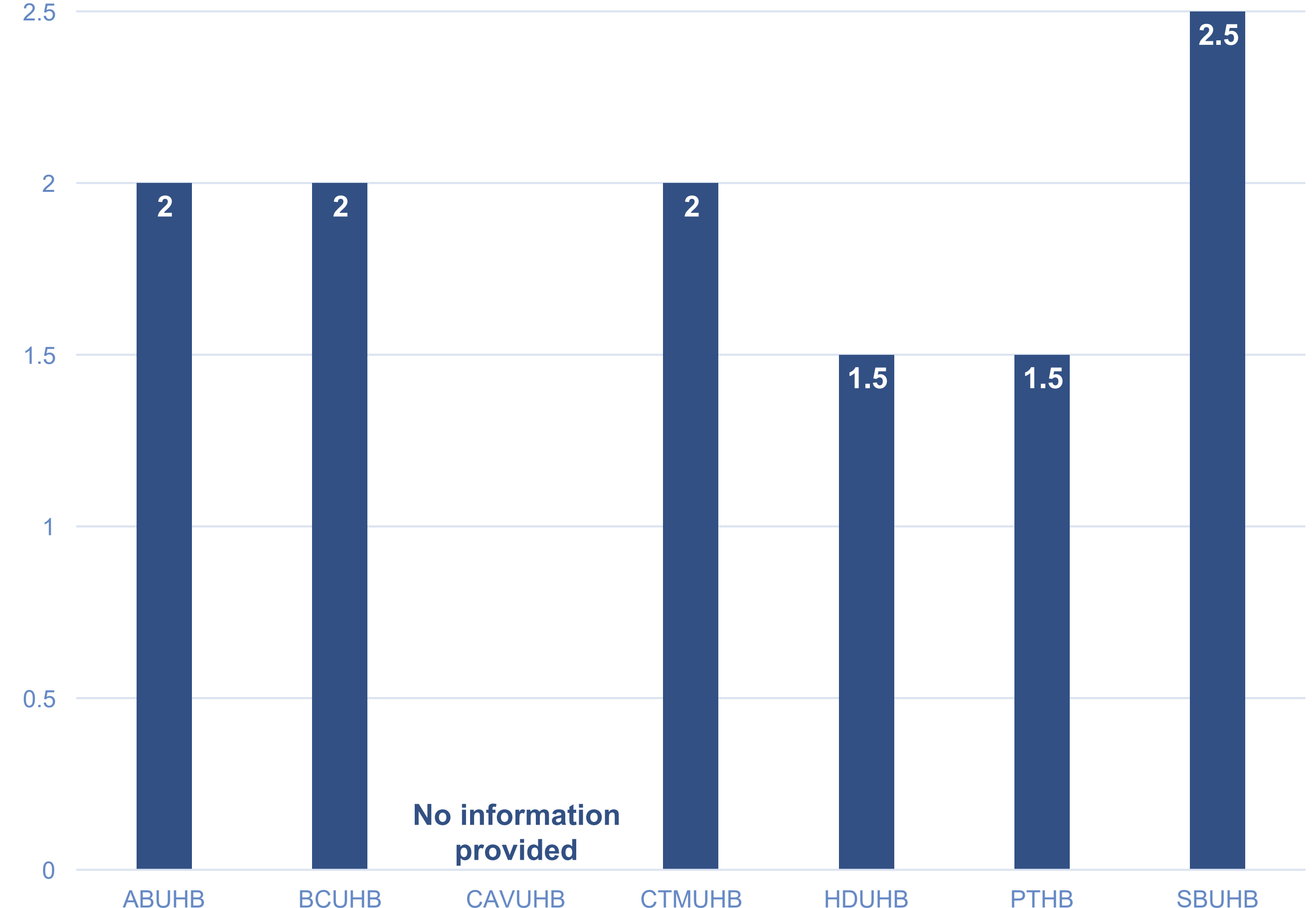
ABUHB	BCUHB	CAVUHB	CTMUHB	HDUHB	PTHB	SBUHB
2	3	2.5	3	1.5	2.5	3

Digital Capability Framework (DCF) integration

Self-assessed Maturity Levels

DCF is the least developed domain nationally.

- ABUHB 2.0
- BCUHB 2.0 (system training exists, general digital capability training in development)
- CAVUHB (no explicit DCF overall score was recorded)
- CTMUHB 2.0
- HDUHB 1.5 (DCF integration is emerging but not yet systematic, measurable, or embedded enough)
- PTHB 1.5 (Digital literacy audits on wards; wider DCF not embedded)
- SBUHB 2.5



Electronic Patient Record (EPR) readiness (Likelihood of meeting 2028 target)

- **Very likely (A)**:
  - ABUHB - Procurement completed and business case approved by the Board. Awaiting Welsh Government sign-off.
  - CAVUHB - CAV migrating off Paris as it is now end of life. Currently exploring options for replacement.
  - CTMUHB - Procurement Outcome Report being produced by BCUHB to be presented at the CTMUHB Board at the end of January 2026, followed by WG approval in February, enabling contract award.
  - PTHB - Combined Mental Health and Community procurement. The contract will be awarded in January 2026, with implementation of a new EPR to be completed by 2028
- **Somewhat likely (B)**:
  - BCUHB - Min viable product in 26/27. Deliver the system to all services by the end of FY 28/29. Welsh government funding is aligned with this.
  - HDUHB – Will continue to maximise the functionality available within WPAS and CarePartner to support current Mental Health service needs; however, recognise that progressing toward a full Mental Health EPR will require significant redesign and standardisation of its clinical and administrative processes.
  - SBUHB - Implementing by the end of March 2026 in 20 teams and across integrated teams by Oct 2026. Further rollout dependent on funding, procurement and business case.

Overall Message

Most Health Boards are **well positioned** to meet the 2028 EPR target, but **BCUHB** and **SBUHB face risks** due to timeline stretch, funding dependencies, or phased deployment approaches. **HDUHB** continue to maximise the functionality available within their existing systems to support current Mental Health service needs.

Digital Services

ABUHB - All services/teams across MH&LD have 'ticked' Video Consultation & Telephone due to the confirmed roll-out and utilisation of Office 365 products. There are varying degrees of adoption across the division, and there are isolated examples of pilot activities - where additional digital 'tools' are used to support/enhance clinical activity - e.g. patient comms. There are however, very few examples of these solutions being mature in their use or development. My Medical Record – A Mobile app based service - Scoping underway.

BCUHB – Digital delivery status is mainly Partially Digital. Digital Implementation is largely 1–25% and 26–50% across CAMHS and adult community; several inpatient/community categories "Not digital" or NA; indicates baseline digitisation is still developing.

CAVUHB - Digital delivery status is mainly Fully Digital and Partially Digital. Digital Implementation is largely 76–100% across many adult/older adult community and inpatient services.

CTMUHB - Digital delivery status shows many "Not digital" or partially digital services. The mode of delivery is mainly telephone and web-based.

HDUHB - Digital delivery status shows mostly "Partially digital" services. The mode of delivery is mainly telephone and video consultation. They have also highlighted that several MH services in scope are marked as "service not available."

PTHB - Digital delivery status is not provided. Digital Implementation ranges up to 75% for most services.

SBUHB - Digital delivery status predominantly partially digital with Digital Implementation (1–50%) across the community; inpatients show 76–100% Digital Implementation.

Digital Services - Summary Key Findings by Health Board

ABUHB	BCUHB	CAVUHB	CTMUHB	HDUHB	PTHB	SBUHB
Shows good foundational digital capability but limited maturity • All MH&LD teams use **video and telephone consultation** via Office 365. • **Digital tools exist but are not consistently adopted**, and pilots remain isolated. • Very few solutions are fully embedded or mature in routine practice. • Early scoping underway for *My Medical Record* mobile app. **Message:** Good foundations, but digital innovations are still emerging and not fully embedded.	**Is still building baseline digitisation** • Many services marked **"Partially Digital" or "Not Digital"**. • Most digital implementation is only **1–50% complete** across CAMHS and adult community. **Message:** BCUHB remains in an early stage of digital transformation with substantial work needed.	**Is among the most digitally mature** • Majority of services are **Fully Digital or Partially Digital**. • Many adult/older adult community and inpatient services show **76–100% digital implementation**. **Message:** One of the highest adopters of digital MH systems across Wales.	**Shows mixed progress with many services still not digital** • Large number of services classified as **"Not digital" or partially digital**. • Digital delivery mostly relies on **telephone and web-based** solutions. **Message:** Digital uptake is variable; many services are still early-stage or lacking digital enablement.	**Shows partial digital adoption across most services** • Majority of services are classified as **Partially Digital (26–50%)**. • Digital delivery is primarily through **video consultations and telephone**, with limited use of more advanced digital solutions. • Similar levels of digital adoption are observed across **community, inpatient, and specialist services**. • Many services are currently **in scope** and are **not marked as "Service not available"**, indicating ongoing or planned implementation rather than absence of provision. **Message:** HDUHB demonstrates partial and consistent digital adoption across service settings, largely reliant on video and telephone delivery, with further development required to progress beyond mid-level implementation.	**Shows moderate progress but limited data available** • Digital delivery status **not fully reported**. • Where data exists, implementation is **up to 75%** for most services. **Message:** Progress is occurring, but insight is limited due to incomplete reporting.	**Shows partial adoption with stronger progress in inpatient settings** • Community services largely **Partially Digital (1–50%)**. • Inpatient services significantly more advanced (76–100%). **Message:** Digital maturity is higher in inpatient settings, with community services lagging.

Overall Summary

Mental Health digital service delivery across Wales is **inconsistent**, with notable variation in how digital tools are implemented and adopted.
CAVUHB and SBUHB (inpatients) show the strongest maturity, while **BCUHB, CTMUHB, and parts of ABUHB** still rely heavily on non-digital or partially digital systems.
This creates **uneven access, efficiency, and patient experience**, highlighting the need for a more coordinated national approach.

Digital Processes

Digital maturity in Mental Health (MH) services across Wales varies significantly between Health Boards and generally trails wider organisational digital capability. While some Boards demonstrate high maturity in specific domains, widespread gaps.

ABUHB reports an overall average digital maturity score of 2.25 across its digital processes, providing Mental Health Services. The highest maturity level (Level 4) is observed in Remote & Assistive Support, Business & Clinical Intelligence, and Infrastructure & Standards. In contrast, the lowest maturity (Level 1) is recorded in Remote Monitoring, Shared Care Record, and Asset & Resource Management, indicating areas requiring targeted development and investment.

BCUHB reports an overall average digital maturity score of 1.7 across digital processes supporting Mental Health Services, compared with a higher Health Board–wide average of 2.25. The highest maturity (Level 3) is observed in Diagnostics Management, while the lowest maturity (Level 1) is evident in Remote Monitoring, Shared Care Record, and Business & Clinical Intelligence, highlighting key gaps relative to wider organisational capability.

CAVUHB reports an overall average digital maturity score of 2.25 across digital processes supporting Mental Health Services, compared with a lower Health Board-wide average of 1.75. The highest maturity (Level 4) is observed in Shared Care Record and Transfer of Care, while the lowest maturity is evident in Remote Monitoring, Diagnostics Management, and Asset & Resource Management, highlighting areas for targeted improvement.

CTMUHB reports a higher overall Health Board digital maturity score of 3.17, compared with a lower average of 2.08 across digital processes supporting Mental Health Services. The highest maturity (Level 3) is observed in Transfer of Care, Diagnostics Management, and Infrastructure & Standards, while the lowest maturity is evident in Remote Monitoring, Medicines Management, and Decision Support, indicating priority areas for improvement within Mental Health services.

HDUHB reports a digital maturity score of 1.42 for Mental Health services, compared with an overall Health Board average of 3.08. The highest maturity (Level 2) is observed in Remote Monitoring, Shared Care Record, Diagnostics Management, and Infrastructure & Standards. The lowest maturity (Level 1) is evident in Records Management, Medicines Management, Asset & Resource Management, and Business & Clinical Intelligence, highlighting significant gaps in core digital enablement. HDUHB has also identified that other digital processes used elsewhere within the Health Board could be leveraged and adapted for Mental Health services, presenting opportunities for cross-organisational learning and targeted improvement.

PTHB reports a digital maturity score of 2.08 for Mental Health services, compared with an overall Health Board average of 1.58. The highest maturity (Level 4) is observed in Infrastructure & Standards, followed by Records Management and Business & Clinical Intelligence at Level 3. The lowest maturity (Level 1) is evident in Remote Monitoring, Medicines Management, and related areas, highlighting key opportunities for targeted improvement.

SBUHB reports a digital maturity score of 2.3 for Mental Health services, compared with an overall Health Board average of 2.58. The highest maturity (Level 4) is observed in Shared Care Record and Business & Clinical Intelligence, while the lowest maturity (Level 1) is evident in Remote Monitoring, Records Management, and Asset & Resource Management, highlighting areas for further development.

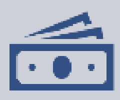
Digital Process – Summary Key Findings by Health Board

ABUHB	BCUHB	CAVUHB	CTMUHB	HDUHB	PTHB	SBUHB
Strengths (Level 4): Remote & Assistive Support, Business & Clinical Intelligence (BI), Infrastructure & Standards **Weaknesses** (Level 1): Remote Monitoring, Shared Care Record, Asset & Resource Management **Insight:** Strong foundations but interoperability and operational enablers need improvement.	**Strength** (Level 3): Diagnostics Management **Weaknesses** (Level 1): Remote Monitoring, Shared Care Record, BI **Insight**: MH significantly lags broader Board capability, particularly in data-driven functions.	**Strengths** (Level 4): Shared Care Record, Transfer of Care **Weaknesses:** Remote Monitoring, Diagnostics Management, Asset & Resource Management **Insight**: MH outperforms the wider Board but struggles with diagnostics and resource visibility.	**Strengths** (Level 3): Transfer of Care, Diagnostics Management, Infrastructure & Standards **Weaknesses:** Remote Monitoring, Medicines Management, and Decision Support. **Insight**: Largest maturity gap between MH and overall Board systems—suggesting adoption, workflow, and integration gaps rather than technological limitations.	**Strengths** (Level 2): Infrastructure & Standards, Shared Care Record, Diagnostics Management, Remote Monitoring **Weaknesses:** Records Management, Medicines Management, Asset & Resource Management, Business & Clinical Intelligence (Level 1) **Insight:** Early digital capability is evident in core infrastructure and selected clinical enablers; however, significant gaps remain in information management, medicines, and operational intelligence. Opportunities exist to accelerate Mental Health digitisation by adapting and scaling proven digital processes already in use elsewhere within the Health Board, supporting more consistent and sustainable digital maturity.	**Strengths:** Infrastructure & Standards (Level 4), Records Management and BI (Level 3) **Weaknesses**: Remote Monitoring, Medicines Management **Insight**: Good technical foundation; biggest gaps in remote care and core clinical safety functions.	**Strengths** (Level 4): Shared Care Record, BI **Weaknesses**: Remote Monitoring, Records Management, Asset & Resource Management. **Insight**: Strong data and interoperability foundations, but weak operational digitisation. Cross-Wales Themes Common Strengths High maturity in Infrastructure & Standards, BI, and Shared Care Record in exemplar sites. Several Boards demonstrate the capability to lead national “adopt and spread” programmes.

Common Weaknesses

- **Remote Monitoring is Level 1 in ALL Boards except HDUHB,** highlighting a universal gap that requires a coordinated national strategy
- **Shared Care Record -** systems for sharing key clinical information across services remain inconsistent in Mental Health, limiting continuity and safety of care.
- **Asset & Resource Management** – digital tools for managing beds, staff, rooms, equipment, and capacity are used unevenly across Wales.
  This leads to variations in efficiency, visibility of capacity, and patient flow between Health Boards.
- **MH services often lag wider Board-wide digital capabilities**, indicating adoption gaps.
  This is not due to a lack of available technology, but challenges with integration, workflow alignment, configuration, and the extent to which MH services have been supported to adopt existing systems.

Key Risks



Funding and resource capacity: Multiple returns flag national funding timing and business change/training capacity as risks to EPR and skills adoption (e.g., HDUHB, PTHB, SBUHB).

Interoperability & standards: Several indicate dependence on national technical/data standards and NDR/shared care record evolution; risks to timelines if standards or national services lag.

DCF under adoption: Without Personal Development Plan embedding and Learning Management System linked pathways, Digital capability uplift will trail EPR deployments, lowering benefits realisation.

Paper & duplication: Double recording (e.g., WPAS/WCCIS) and reliance on paper in some areas will impede data quality and analytics gains.

Next Steps

Each Health Board to provide their 2026/27 Digital & Data Delivery Plan for Mental Health Services, including:

- alignment to national priorities
- local actions, dependencies and resource requirements
- timelines across governance, capability, digital services and EPR readiness

Each Health Board to present their updates at the next meeting on 31st March 2026.

Diolch

Let's discuss

Digital Maturity Assessment Tool
NHS Health Board Mental Health Services

Digital Maturity Self-Assessment – Health Board Mental Health Services

Welsh Government and NHS Wales recognise that digital transformation is critical to delivering sustainable, high-quality mental health services. Building a shared understanding of current digital capabilities and capacity will enable the effective use of digital and data solutions across all aspects of service delivery. The Digital Maturity Self-Assessment is a survey tool designed to help Health Boards Mental Health Services evaluate their level of digital maturity. This assessment provides insight at both local and national levels, supporting strategic planning and improvement.

Submission Requirement

Each Health Board's Director of Mental Health and Director of Digital are asked to jointly complete and submit one self-assessment that reflects the areas below within their Health Board Mental Health services. All sections to be completed.

Digital Maturity areas

The tool is structured around six core areas:
- Governance and Leadership
- People and Culture
- Electronic Patient Record
- Digital Tools
- Digital Processes

The form should be completed and returned to **nitin.baby@wales.nhs.uk** by **Friday, 9th January 2026.**

Details of Person Completing this Assessment	
NAME:	**Paul Solloway**
JOB TITLE:	**Director of Digital**
ORGANISATION:	**Aneurin Bevan Health Board**
EMAIL:	paul.solloway@wales.nhs.uk

Details of Person Completing this Assessment	
NAME:	**Leanne Watkins**
JOB TITLE:	**Chief Operating Officer**
ORGANISATION:	**Aneurin Bevan Health Board**
EMAIL:	leanne.watkins2@wales.nhs.uk

Digital Maturity Assessment - Governance and Leadership

This assessment is designed to help you evaluate your Health Board's Mental Health services' current governance and leadership structures that support the implementation of digital ways of working in Health Board Mental Health services. This includes executive support, authorisation processes, reporting structures, and defined roles and responsibilities.

Digital Governance and Leadership Maturity Levels

Review the five levels of maturity:

Level 1 – Minimal: Little or no digital engagement or awareness.
Level 2 – Informal and Reactive: Early, ad-hoc digital initiatives with limited staff involvement.
Level 3 – Transitional: Digital strategy is emerging, and staff are beginning to engage.
Level 4 – People & Professionals Driven: Digital culture embedded, staff actively driving change.
Level 5 – Transformed: Digital-first mindset across the organisation; continuous improvement.

What you need to do

1. Tick all boxes that apply to your Health Board/Mental Health Service.
2. Once all statements are reviewed, use the drop-down option to select your self-assessed overall maturity level rating (e.g., 3.5 if you are between Levels 3 and 4) in the blue section below.

Level 1 Minimal		Level 2 Informal and reactive		Level 3 Transitional		Level 4 People & Professionals driven		Level 5 Transformed		Comments
FALSE	little buy-in from the executive team	TRUE	value proposition of digital is starting to be acknowledged by the executive team	FALSE	digital strategy in place	FALSE	digital strategy integrated into the mental health planning process and influences overall organisational strategy and direction	FALSE	digital strategy is embedded in, and indistinguishable from, the organisational vision and strategy	
FALSE	there is no departmental digital strategy	TRUE	exploring the impact of innovation and emerging technologies on the Health Board/ Mental Health services	FALSE	roles and responsibilities for delivering the digital strategy are clear and understood	FALSE	benefits of having a digital strategy are well-defined, understood and drive all digital activity	FALSE	executives understand and fully embrace digital channels and lead by example	
FALSE	digital value propositions are not understood or developed	TRUE	some one-off collaboration with other departments regarding digital service delivery	FALSE	benefits of having a digital strategy are well-defined and understood	FALSE	KPIs and benefits for the Partners, Health Boards, and individuals are clearly defined, monitored, and reported.	FALSE	new services and products are born digital	
FALSE	digital opportunities are not understood or defined	TRUE	social media channels are monitored, but social media is seen more as a risk than an opportunity	FALSE	strategic digital partnerships with other departments	FALSE	seamless patients/individuals experience across all mental services/channels – digital and non-digital	FALSE	non-digital services and products are reengineered, joined up and re-born as digital	
FALSE	ad hoc digital projects initiated by individual Mental Health services and individuals			FALSE	focussed on people who need Mental Health services, meeting their needs using emerging technologies	FALSE	strategic collaboration with other departments, utilising multiple channels	FALSE	digital services and channels drive the organisational structure and reporting	
FALSE	a social media presence or engagement with patients/individuals has not been permitted by the executive			FALSE	pro-active engagement with people who need services across all digital channels					
				FALSE	benefits of social media are understood and drive social media activity					

(Select your rating from drop down)

Please put your Overall Maturity Level Rating *(Self Assessed)*	2

Comments: *Please provide your rationale for the overall self assessed Maturity level score.*

Digital Maturity Assessment - People and Culture

This assessment is designed to help you evaluate your Health Board's Mental Health services' current level of digital culture and workforce capability. The purpose is to identify the maturity of digital culture within Mental Health services, supporting strategic planning, workforce development, and alignment with the All-Wales Digital Capabilities Framework.

Section 1: Digital Culture Maturity Levels

Review the five levels of maturity:

Level 1 – Minimal: Little or no digital engagement or awareness.
Level 2 – Informal and Reactive: Early, ad-hoc digital initiatives with limited staff involvement.
Level 3 – Transitional: Digital strategy is emerging, and staff are beginning to engage.
Level 4 – People & Professionals Driven: Digital culture embedded, staff actively driving change.
Level 5 – Transformed: Digital-first mindset across the organisation; continuous improvement.

The assessment is divided into **two sections**, as outlined below. ***(Please scroll down below for section 2)***

What you need to do

1. Tick all boxes that apply to your Health Board/Mental Health Service.
2. Once all statements are reviewed, use the drop-down option to select your self-assessed overall maturity level rating (e.g., 3.5 if you are between Levels 3 and 4) in the blue section below.

Level 1 Minimal		Level 2 Informal and reactive		Level 3 Transitional		Level 4 People & Professionals driven		Level 5 Transformed		Comments
FALSE	bottom-up drive by staff for embracing digital culture	TRUE	small number of staff engaged in digital projects	FALSE	digital strategy developed and embraced by staff	FALSE	all staff fully embrace the digital strategy and are driving cultural change	FALSE	all staff are digitally savvy and aware; having a defined 'digital team' becomes obsolete	
FALSE	little or no appetite in the organisation for digital service delivery	TRUE	some cross-organisation awareness of digital opportunities	FALSE	digital team embedded in organisational structure	FALSE	strong patients/individuals focused culture adopted and continually improved	FALSE	digital culture is embedded into the overall corporate culture and constantly monitored, improved and refined	
TRUE	risk-averse and resistant to change	FALSE	risk-aversion inhibiting change	FALSE	staff understand the benefits and opportunities for them and patients/individuals from the digital strategy	FALSE	staff organised in teams around patients/individuals rather than the organisation's services and products	FALSE	feedback from patients/individuals and staff is encouraged, made public, and lessons learned are applied	
FALSE	limited or no attempt to understand staff needs/requirements	TRUE	social media engagement is restricted to listening	FALSE	focus is on patients/individuals and how digital can meet their needs	FALSE	staff seek to redefine their roles and personal KPIs in line with the digital strategy and organisational KPIs	FALSE	staff proactively generate and explore ways to improve digital service delivery and internal productivity via digital solutions	
TRUE	fear of risk of engagement with social media and of staff use of social media	TRUE	change management strategy developing	FALSE	digital transformation change management plan implemented					
		TRUE	starting to break down internal silos and collaborative practices are emerging							

(Select your rating from drop down)

Please put your Overall Maturity Level Rating *(Self Assessed)*	2

Comments: *Please provide your rationale for the overall self assessed Maturity level score.*

Section 2 - Digital Capabilities Framework (DCF) Integration

This section focuses on how well the All-Wales Digital Capabilities Framework is embedded in your organisation.

Categories include:

- Awareness and Promotion of the DCF
- Assessment of Skills
- Learning Resources and Access
- Integration and Use

For each category, review the descriptions under Levels 1–5:

- Level 1 – Minimal: No awareness or structured approach.
- Level 2 – Informal and Reactive: Early, inconsistent efforts.
- Level 3 – Transitional: Structured processes emerging.
- Level 4 – Advanced: DCF embedded in workforce planning and development.
- Level 5 – Optimised: Digital-first mindset fully integrated.

What you need to do

1. Select the statements that best describe your Health Board/Mental Health Service's current position.
2. Once all statements are reviewed, use the drop-down option to select your self assessed Overall Maturity Level Rating for DCF integration (e.g., 3.5 if you are between Levels 3 and 4) in the blue section below.

Category	Level 1 Minimal		Level 2 Informal and reactive		Level 3 Transitional		Level 4 Advanced		Level 5 Optimised		Comments
Awareness and Promotion of the All-Wales DCF	FALSE	Limited or no awareness of the Digital Capabilities Framework (DCF). Not referenced in staff development.	TRUE	Some staff are aware of the DCF but are not consistently promoted. Awareness grows through ad-hoc initiatives.	FALSE	DCF is referenced in some development discussions and staff communications. Awareness exists but varies across teams.	FALSE	DCF is actively promoted and embedded in PDPs and workforce planning. Clear leadership support.	FALSE	DCF is fully embedded in organisational culture. Staff are advocates and continuously evolve their capabilities.	
Assessment of Skills	FALSE	No structured approach to assessing digital or data literacy. Minimal understanding of workforce capability.	TRUE	Early assessments in isolated areas, such as informal audits or small-scale surveys. Limited reporting.	FALSE	Workforce capability is assessed using recognised tools (e.g., DCF self-assessment, internal audits). Engagement data available.	FALSE	Comprehensive and routine digital and data skills assessments informing workforce planning and development priorities.	FALSE	Capability insights are used strategically. Continuous improvement based on assessment data and evaluation of outcomes.	
Learning Resources and Access	FALSE	No clear digital learning provision. Staff are unaware of available resources.	FALSE	Local or basic training is made available but not well-coordinated or measured.	TRUE	Staff have structured access to training (e.g., LMS modules, local materials, EHR-related training). Evidence of uptake exists.	FALSE	Training provision aligned to DCF and role requirements. Data literacy and digital skills support service improvement.	FALSE	Learning content is continuously expanded, evaluated, and integrated into daily practice. Staff proactively develop skills.	
Integration and Use	FALSE	Digital and data skills are not recognised in Personal Development Plans (PDP), induction or mandatory processes. Development is ad-hoc.	TRUE	Some staff include digital skills within PDPs, but they are inconsistent and not centrally monitored.	FALSE	Digital skills are routinely included within PDPs and induction standards. Growing organisational expectations.	FALSE	Digital and data capability embedded in performance expectations, improvement plans, and workforce design.	FALSE	A digital-first mindset is embedded across all roles. Digital and data capability is a defining expectation for all professionals.	

(Select your rating from drop down)

Please put your Overall Maturity Level Rating *(Self Assessed)*	2

Comments: *Please provide your rationale for the overall self assessed Maturity level score.*

Electronic Patient Record (EPR)

In the absence of an agreed All-Wales definition for an Electronic Patient Record (EPR), for the purpose of this assessment we are defining the EPR as:

Electronic Patient Record (EPR)

An Electronic Patient Record (EPR) is a digital system designed to store, manage, and share clinical and administrative information. It offers a centralised, secure, and accessible repository of health data that supports more coordinated and efficient patient care. This includes functionality for:
- Clinical documentation,
- Risk assessments,
- Care planning,
- Multi-disciplinary team (MDT) coordination,
- Referrals and Discharge processes.

Purpose of this Assessment

This assessment is designed to help us understand the current level of EPR adoption and readiness within Mental Health services across Health Boards in Wales. Your input will contribute to building a national picture of progress and identify areas where support or coordination may be needed to meet the 2028 target.

What you need to do

-Select the drop-down value that best reflects the current position of your Health Board's Mental Health services regarding EPR implementation.
-Could you confirm the current Health Board status for EPR.
- Confirm whether you have a plan in place to meet the required criteria by 2028.

If helpful, you may add comments or context in the section provided.
Your responses will help ensure that Mental Health services are aligned with national digital transformation goals and that any gaps in readiness can be addressed collaboratively.

Criteria	Description	Will it be met by 2028? *(Please select a suitable option from the drop down)*	What is your plan (if applicable) to meet the criteria by 2028?	Comments
System Implementation	EPR system for mental health is procured, deployed, and implemented and will be live by 2028 across all services of Mental Health.	**A - Very likely**	Implementation of Mental Health EPR will be completed by March 2027	Procurement completed and business case approved by the Board. Awaiting Welsh Government sign-off
Clinical Usability	The health and care workforce actively uses the system for documentation, care planning, MDT coordination, referrals and discharge processes, etc.	**A - Very likely**	Deployment plan developed and programme and service resources in place	
Interoperability	EPR can share data with other systems and adheres to national technical and data standards.	**A - Very likely**	Procurement mandated to comply with local architectural principles which are broadly in line with national architecture with data sharing via the NDR and national shared care record when available	
Mobile and Community Access	The system supports mobile working and access in community settings.	**A - Very likely**	System has a mobile app and all laptops have been prcurred with 4G/5G connectivity	
Workforce Readiness	Staff are trained, and the system is embedded into workflows with governance and support.	**A - Very likely**	Training and business change resources embedded in the product team which will operate the platform for its entire lifecycle	

Current Health Board Status for EPR (Based on available Information to us)

- Issued your own ITT to procure a Mental Health system to replace CareDirector.
- Evaluation has taken place, and the chosen supplier is due to be announced soon.
- Funding via the Connecting Care programme.
- ABUHB is not looking to procure a Community Health system at the current time.

	(Please select a suitable option from the drop down)	**Comments**
Are the above-mentioned details up to date for your Health Board with respect to an EPR procurement?	**No**	All procurement activities completed (in standstill), funding is a combition of national funding for 25/26 and local funding for 26/27 onwards with anticipation further national support will be become available. Assessment on community solutions will comence in 2026 with initial gap analysis against Mental Health EPR.

Digital Maturity Assessment - Digital Tools

This assessment is designed to help us identify which mental health services in your Health Board use digital technologies to deliver services (apps, portals, video consultations, remote monitoring, etc.).

Modes of Digital Delivery:

- **Video Consultation**: Real-time virtual appointment via secure video platform.
- **Telephone Consultation**: Clinical/support interaction over the phone.
- **Web-Based Platform**: Online tool accessed through a browser for care, self-management, or communication.
- **Mobile App:** Smartphone/tablet app for symptom tracking, therapy, or clinician communication.
- **Remote Monitoring**: Collect and review patient data (mood, activity, medication) remotely.
- **Text-Based Support**: SMS or secure chat for mental health support.

What you need to do

Section 1: Mode of digital Delivery in your mental Health Services
1. Select the drop-down value that best reflects the Digital Delivery Status and Digital Implementation % for your Health Board Mental Health Services.
2. Tick the boxes for applicable Modes of Digital Delivery.

Section 2: What Digital Tools are currently being used in your Health Board for other services that could also be used in mental health services?
1. Are there any other Digital Tools used elsewhere in your Health Board that could be applied in Mental Health? *(Please select a suitable option from the drop down value)*
2. Details of Digital Tool Use (Name of the Digital tools used, Speciality/Services it's been used, etc.)

The assessment is divided into **two sections**, as outlined below. ***(Please scroll down below for section 2.)***

Section 1: Mode of digital Delivery in your mental Health Services

Mental Health Services	Digital Delivery Status *(Please select a suitable option from the drop down)*	Mode of Digital Delivery												% Digital Implementation *(Please select a suitable option from the drop down)*	Comments
CYP Specialist CAMHS service Community Mental Health Team (CMHT)		TRUE	Video consultation	TRUE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support		All services/teams across MH&LD have 'ticked' Video Consultation & Telephone due to the confirmed roll-out and utilisation of O365 products. There are varying degrees of adoption across the division and there are isolated examples of pilot activities - where additional digital 'tools' are used to support/enhance clinical activity - e.g. patient comms. There are however very few examples of these solutions being mature in their use or development.
CYP Crisis teams		TRUE	Video consultation	TRUE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support		
CYP Liaison service		TRUE	Video consultation	TRUE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support		
WCat1d: CYP Sanctuaries		TRUE	Video consultation	TRUE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support		
Under 18 Local Primary Mental Health Support Services		TRUE	Video consultation	TRUE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support		
CAMHS Specialist Drug & Alcohol Team		TRUE	Video consultation	TRUE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support		
CYP inpatient		TRUE	Video consultation	TRUE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support		
CYP S136 suite		TRUE	Video consultation	TRUE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support		
Youth justice		TRUE	Video consultation	TRUE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support		
Any other CYP MH services not listed above		TRUE	Video consultation	TRUE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support		
CYP Eating Disorders (Community)		TRUE	Video consultation	TRUE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support		
CYP Eating Disorders (inpatient)		TRUE	Video consultation	TRUE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support		
CAMHS Schools In-reach		TRUE	Video consultation	TRUE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support		
Local Primary Care Mental Health Support Service (LPMHSS) Adult		TRUE	Video consultation	TRUE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support		
Psychiatric Liaison service Adults (18-64)		TRUE	Video consultation	TRUE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support		
Liaison service Older Adults (65+)		TRUE	Video consultation	TRUE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support		
Early Intervention in Psychosis team (EIP)		TRUE	Video consultation	TRUE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support		
Crisis Resolution Home Treatment Teams (CRHTT) (Adult age 18-64)		TRUE	Video consultation	TRUE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support		
Crisis Resolution Home Treatment Teams (CRHTT) (Older Adult age 65+)		TRUE	Video consultation	TRUE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support		
Crisis House (All adults 18+)		TRUE	Video consultation	TRUE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support		
Sanctuary (all adults 18+)		TRUE	Video consultation	TRUE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support		
Shared Lives		TRUE	Video consultation	TRUE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support		
Acute Day services		TRUE	Video consultation	TRUE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support		
Section 136 suite (age 18+)		TRUE	Video consultation	TRUE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support		
Any other Crisis provision not noted above?		TRUE	Video consultation	TRUE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support		
Adult Community Mental Health Teams (Adult CMHT)		TRUE	Video consultation	TRUE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support		
Older Adult Community Mental Health Teams (OACMHT)		TRUE	Video consultation	TRUE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support		
Assertive Outreach Teams (AOT)		TRUE	Video consultation	TRUE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support		
Community Teams for people with complex emotional needs		TRUE	Video consultation	TRUE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support		
Recovery Colleges		TRUE	Video consultation	TRUE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support		
Veterans Service		TRUE	Video consultation	TRUE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support		
Criminal Justice Liaison Service (CJLS)		TRUE	Video consultation	TRUE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support		
Forensic Community Teams		TRUE	Video consultation	TRUE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support		
Specialist Community Drug & Alcohol Teams		TRUE	Video consultation	TRUE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support		
Speciaist Eating Disorder Service		TRUE	Video consultation	TRUE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support		
Specialist community service for people with complex emotional needs		TRUE	Video consultation	TRUE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support		
Community trauma services		TRUE	Video consultation	TRUE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support		
Any other community based services not already included for adults/older adults		TRUE	Video consultation	TRUE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support		
MH Supported Housing		TRUE	Video consultation	TRUE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support		
Inpatient: Adult Acute wards/units		TRUE	Video consultation	TRUE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support		
Inpatient: Older Adult Acute wards/units		TRUE	Video consultation	TRUE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support		
Inpatient: Psychiatric Intensive Care Unit (PICU)		TRUE	Video consultation	TRUE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support		
Inpatient: High Dependency Unit (HDU)		TRUE	Video consultation	TRUE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support		
Inpatient: Open rehabilitation/recovery		TRUE	Video consultation	TRUE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support		
Inpatient: Locked rehabiliation/recovery		TRUE	Video consultation	TRUE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support		
Inpatient: Low Secure Unit		TRUE	Video consultation	TRUE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support		
Inpatient:Medium Secure Unit		TRUE	Video consultation	TRUE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support		
Inpatient: High secure		TRUE	Video consultation	TRUE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support		
Inpatient: Eating disorder		TRUE	Video consultation	TRUE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support		
Inpatient: Neuropsychiatry		TRUE	Video consultation	TRUE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support		
Inpatient: Alcohol/ substance use		TRUE	Video consultation	TRUE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support		
Inpatient: Complex emotional needs		TRUE	Video consultation	TRUE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support		
Inpatient: Continuing care		TRUE	Video consultation	TRUE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support		
Perinatal Mental Health (community)		TRUE	Video consultation	TRUE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support		
Perinatal Mental Health (inpatient)		TRUE	Video consultation	TRUE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support		
Dementia inpatient services		TRUE	Video consultation	TRUE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support		
Memory Assessment Services (MAS)		TRUE	Video consultation	TRUE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support		
NHS 111#2		TRUE	Video consultation	TRUE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support		

Any other MH inpatient services not listed above?		TRUE	Video consultation	TRUE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support	

Section 2: What Digital Tools are currently being used in your Health Board for other services that could also be used in mental health services?

Are there any other Digital Tools used elsewhere in your Health Board that could be applied in Mental Health? *(Please select a suitable option from the drop down)*	**Details of Digital Tool Use** *(Name of the Digital tools used, Speciality/Services it's been used, etc.)*	**Mode of Digital Delivery**												**Comments**
Yes	My Medical Record	FALSE	Video consultation	FALSE	Telephone	FALSE	Web based	FALSE	Mobile App based	TRUE	Remote monitoring	FALSE	Text-based support	Scoping underway.
		FALSE	Video consultation	FALSE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support	
		FALSE	Video consultation	FALSE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support	
		FALSE	Video consultation	FALSE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support	
		FALSE	Video consultation	FALSE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support	
		FALSE	Video consultation	FALSE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support	
		FALSE	Video consultation	FALSE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support	
		FALSE	Video consultation	FALSE	Telephone	FALSE	Web based	FALSE	Mobile App based	FALSE	Remote monitoring	FALSE	Text-based support	

Current Digital Process Capabilities in your Health Board Mental Health Services

Digital Processes

Digital processes are technology-enabled workflows that support how care is accessed, delivered, and coordinated.
In NHS Wales, these refer to digitally enabled methods, workflows, and systems used to plan, deliver, record, share, and improve health and care services electronically. They involve the use of technology, data, and automation to make service delivery more efficient, integrated, safe, and patient-centred, supporting clinicians, administrators, and patients throughout the care pathway.

Examples include:
- Patient-facing processes: referrals, discharge, remote monitoring, virtual consultations, access to records, etc.
- Staff-facing processes: digital handover, decision support, scheduling, clinical documentation, data dashboards, etc.

Purpose of this Assessment

This assessment is designed to help us identify the use of digital processes to deliver mental health services in your Health Board.

What you need to do

1. Review the Domains and Definitions: Each row represents a digital capability area (e.g., Remote Monitoring, Shared Care Record). Definitions and maturity criteria are provided for reference.
2. Assign Digital Maturity Levels: Use the drop-down (1–5) in the columns: Health Board Level – Overall maturity across all services. Mental Health Level – Maturity within Mental Health services.
   Refer to the Maturity Level Criteria column for guidance:
   - 1 = No digital capability
   - 5 = Fully embedded with advanced features (e.g., predictive analytics)

3. Identify Other Digital Processes: Are there any other digital processes used elsewhere in your Health Board that could be applied in Mental Health?
   - Select Yes or No from the drop-down.
   - If Yes, provide details in "Details of Other Use" (e.g., Virtual consultation).

4. Add Comments: Use the Comments column for any additional notes.

Domain	Definition	Maturity Level	Criteria	All Services Example	What is the Digital Maturity Level in your Health Board *(Please select a suitable option from the drop down)*	What is the Digital Maturity Level in your Mental Health Services *(Please select a suitable option from the drop down)*	Are there any other Digital Process used elsewhere in your Health Board that could be applied in MH. *(Please select a suitable option from the drop down)*	Details of Other Use *(Name of the Digital tools used, Speciality/Services Its been used etc.)*	Comments
Remote Monitoring	Use of digital processes to monitor patients outside traditional clinical settings, such as at home or in virtual consultation.	1	No remote monitoring	Patients self-report symptoms on paper or during appointments.		1			
		2	Pilot projects	Virtual consultation pilot. E.g Using Blood Pressure cuffs and pulse oximeters to monitor patients.					
		3	Partial integration	patients use home devices linked to EPR					
		4	Embedded in pathways	Service pathway includes remote monitoring with alerts					
		5	Predictive analytics	AI flags deterioration risk from wearable data					
Shared Care Record	An integrated digital record accessible across health and care settings to support coordinated care.	1	No shared record	GP and hospital systems are separate		1			
		2	Read-only access	Staff can view GP records via portal					
		3	Bidirectional sharing	Community teams update shared record					
		4	Real-time updates	One Health and Social Care record across partners					
		5	Population health	Shared record supports risk stratification and planning					
	Systems and processes for	1	Paper-based	Notes stored in physical folders					
		2	Basic EPR	Electronic Patient Record used across inpatient and outpatient					

Records Management	creating, storing, accessing, and securing patient records digitally.	3	Broad EPR use	Electronic Patient Record used all services		**3**			
		4	Mobile/cloud access	Clinicians access records via tablets; cloud backup					
		5	Seamless access	Single sign-on across settings; full audit trail					
Transfer of Care	Digital processes and workflows that support safe and efficient handover of patient care between services.	1	Manual discharge	Faxed summaries to various services		**2**			
		2	Inconsistent digital use	Some wards use electronic discharge summaries					
		3	Digital handover tools	Transfer of care app is used in the service pathway					
		4	Real-time integration	Discharge info sent instantly to community teams					
		5	Predictive planning	System flags patients ready for discharge					
Diagnostics Management	Digital processes for ordering, processing, and accessing diagnostic tests and results.	1	Paper-based	Diagnostic requests and results are handled manually.		**2**			
		2	Electronic ordering	Requests are made digitally but may not be integrated.					
		3	Integrated systems	Diagnostic systems link with patient records.					
		4	Real-time access	Results available instantly with alerts					
		5	AI-assisted diagnostics	AI flags abnormal scans for review					
Medicine Management	Electronic systems for prescribing, administering, and monitoring medications to ensure safety and efficiency.	1	Paper prescriptions	Handwritten drug charts		**2**			
		2	EPMA pilot	Electronic Prescribing and Medicines Administration (EPMA) used in					
		3	Wide EPMA use	EPMA is used across multiple inpatient areas.					
		4	Automated alerts	System provides safety alerts during prescribing.					
		5	Closed-loop system	Professional can scan patient wristbands and medication barcodes; analytics track prescribing trends and adherence.					
Decision Support	Digital processes that assist clinicians in making informed decisions, including alerts, guidelines, and predictive analytics.	1	No support tools	Clinicians rely on memory/guidelines		**2**			
		2	Basic alerts	Allergy alerts in the prescribing system					
		3	Embedded guidelines	Clinical pathways integrated into digital systems.					
		4	AI tools	AI supports clinical decision-making.					
		5	Predictive support	Real-time decision support using analytics.					
Remote & Assistive Support	Digital processes that enable remote consultations and support patients with assistive needs.	1	No remote support	All care is delivered face-to-face		**4**			
		2	Occasional video consults	Limited use of virtual consultations.					
		3	Embedded remote support	Remote care is part of routine service delivery.					
		4	Assistive tech used	Technology supports patients with additional needs.					
		5	Personalised remote care	Integrated remote monitoring and virtual consultations tailored to patient needs					
Asset & Resource Management	Digital tracking and scheduling of physical assets and human resources to optimise operations.	1	Manual tracking	Equipment logged on spreadsheets		**1**			
		2	Digital inventory	Barcode system for asset tracking					
		3	Real-time tracking	RFID tags on beds and wheelchairs					
		4	Automated scheduling	Theatre scheduling system linked to staffing					
		5	Predictive planning	AI forecasts bed demand and allocates resources					
Business & Clinical Intelligence	Use of data analytics and digital processes to support strategic and clinical decision-making.	1	Manual reporting	Monthly reports compiled in Excel		**4**			
		2	Basic dashboards	Use of tools to visualise KPIs; dashboards are available but not deeply embedded in workflows.					
		3	Routine use	Clinical teams use dashboards for daily huddles					
		4	Planning and improvement	Data used to redesign outpatient/community flow					
		5	Predictive analytics	Advanced analytics, like machine learning used to predict outcomes (e.g., readmission risk).					
Infrastructure & Standards	The underlying IT systems, networks, and compliance frameworks that support digital processes.	1	Legacy systems	Outdated hardware/software (e.g., Windows XP), poor connectivity.		**4**			
		2	Basic infrastructure	Wi-Fi available in clinical areas; device refresh in progress.					
		3	Upgraded systems	Cybersecurity tools and modern devices					
		4	Cloud readiness	Migration to cloud-based Electronic Patient Records (EPR) is underway.					
		5	Scalable infrastructure	Supports advanced capabilities like AI, remote care, and innovation projects.					
Access & Communications	Digital channels and processes that facilitate communication and access for patients and staff.	1	No digital access	Patients receive paper letters only; no online interaction.		**1**			
		2	Basic portals	Patients can view appointments online via a portal.					
		3	Mobile apps	Patients use apps for booking appointments and viewing results.					
		4	Inclusive design	Services offer accessible formats and translation tools to meet diverse needs.					
		5	Personalised access	Patients choose the communication method; feedback loop is embedded					

Mental Health & Learning Disabilities Committee
24th March 2026

Engagement with Stakeholders

The Integrated Planning Group has engaged with services through a **structured, multi-layered approach**, including:

- **Direct engagement with Divisions and Integrated Networks** by launching *draft planning parameters, timelines and priorities* for discussion and refinement through divisional days, SLG sessions and integrated networks.
- **Cross-divisional triangulation sessions** where services, finance, workforce and planning colleagues jointly review activity, workforce, financial positions, risks and opportunities to ensure aligned and realistic plans.
- **Regular IMTP project planning and feedback loops**, enabling divisions and enabling functions (digital, estates, workforce, finance) to shape and validate their elements of the plan and highlight gaps, risks and required enablers
- **Use of the Divisional Integrated Framework**, supporting each service to develop delivery plans, assess workforce and finance impacts, and articulate risks, interdependencies and enabler requirements in a standardised format.
- **Iterative review through fortnightly IPG meetings**, where service leads and enabler teams bring updates, challenge assumptions, refine priorities, and confirm deliverables ahead of scrutiny and Board submission.

Summary Plan

Models of Care

Developing Services Supporting the Mental Health and Wellbeing Strategy

Inpatient Services

Q1	Q2	Q3	Q4
• Evaluate learning from Ty Lafant reduction in beds • Progress Business Case for Co-location of Older Adults Wards • Consider use of Adult Rehab ward at Maindiff Court as we move to Community Model • Agree strategic estate direction to support inpatient Models of Care	• Further plans for Adult Rehab ward at Maindiff Court as we move to Community Model		
	• Develop high-level estate options and planning assumptions	• Confirm preferred estate approach and phasing aligned to service and workforce change	• Develop detailed Inpatient services plans • Progress the co-location of Older Adults wards • Reflect inpatient estate requirements within IMTP and capital planning processes

Community Services

Q1	Q2	Q3	Q4
• Develop Business Case for Adult Community Rehab Service • Agree estate principles to support community- based Models of Care	• Identify community estate requirements and potential options	• Progress Adult Community Rehab Service	
		• Confirm priority community estate changes and dependencies	• Incorporate community estate requirements into IMTP delivery plans

Open Access

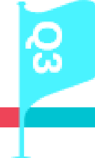
• Progress plan in line with the Open Access Steering group and direction from Welsh Government in respect of the Mental Health and Wellbeing Strategy

Risk: Welsh Government Directive with no additional monies to support the change – Action within current financial envelope

Alternative Accommodation Options

Q1	Q2	Q3	Q4
• Complete Assessment of needs for LD patients	• Complete Assessment of needs for Adult Mental Health Services		
Risk: Ability to deliver outcomes is based on ability for all patients to be reviewed.			

Q2



Quality Improvement

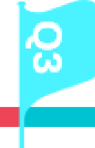
Ward Accreditation and engagement with the National Safety Programme

Q1	Q2	Q3	Q4
Ward Accreditation			
• Complete Older Adults Ward Accreditation		• Complete ward accreditation across Adults and LD	• Complete community accreditation
Patient Safety Programme			
• Implement safe discharge standards	• Implementation of person-centred safety planning as per National Guidance	• Engage in individual workstreams as led by the NHS Wales Performance and Improvement team	

Ministerial Priorities

Meeting ministerial targets and measures

Q1	Q2	Q3	Q4
Mental Health Measure			
• Maintain Part 1a and 1b ministerial priorities			
Memory Assessment Targets			
• Commence implementation of agreed changes	• Ongoing implementation of plan	• Changes fully embedded in operational delivery	• Evaluation of changes
Psychological Therapies			
• Complete WL/pathway data accuracy work	• Complete joint PCMHSS/ Psychology pathway work	• Implement changes	• Evaluation of changes



Digital

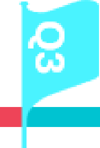
Digital Opportunities and new systems

• Replacement Electronic patient record preparation for installation			
• Exploring option for robotic automation across all areas to support early triage and screening, with signposting to appropriate support			
• Wi-Fi Installation			

Workforce Sustainability

Culture and workforce models

Culture Programme
• Culture program has commenced, currently identifying teams for support
Workforce Models
• Work force planning has commenced for Psychology and Medical staffing



Partnerships

Strategy and national delivery plans, co-production and partnership with Third Sectors

Mental Health and Wellbeing Strategy

Q1	Q2–Q3	Q4
• Develop local action plan, including stakeholder mapping based on National Delivery Plan and implement governance arrangements to support these	• Review progress of action plan	• Implementation of 2026/27 delivery plan

Risk: Engagement of partners- will engage though Regional Leadership group

Suicide and self-harm National Delivery Plan

Q1	Q2–Q3	Q4
• Develop local action plan, including stakeholder mapping based on National Delivery Plan and implement governance arrangements to support these	• Review progress of action plan	• Implementation of 2026/27 delivery plan

Risk: Engagement of partners- will engage though regional leadership group

Power of Discharge Sub-Committee Meeting

Tuesday 24th February 2026
14:00 – 15:30

Virtually via Microsoft Teams

Present:

Paul Deneen – Chair, Independent Board Member
Perry Attwell – Associate Hospital Manager
Simon Evans – Associate Hospital Manager
Kolade Gamel – Service Group Manager: Mental Health Learning Disabilities
Pamela Haylings – Associate Hospital Manager
Beverley Hopkins – Mental Health Act and Divisional Admin Manager
Sandra Mason – Assistant Director: Mental Health Learning Disabilities
Elaine Phillips – Associate Hospital Manager
Carol Smith – Associate Hospital Manager
Peter Walters – Associate Hospital Manager
Amelia James – Mental Health Act Implementation Support Officer *(Minutes)*

Apologies:

Keith Dunn – Associate Hospital Manager

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Agenda Item	Key Discussion points /Updates	Action	Who
1. Welcome, Introductions & Apologies	Paul welcomed everybody to the meeting. Paul shared the news that Carol Morgan – Associate Hospital Manager sadly passed away on 3rd February 2026. Paul has written to Janine, Carol's stepdaughter to offer the groups condolences and sympathies and to express that Carol was an incredibly valued member of the team who had given so much service to the community and to others. A minute's silence was held to remember Carol. Apologies were received from Keith Dunn.		
2. Matters Arising and Minutes from previous Meeting	**<u>Associate Hospital Manager's Pre-meeting discussions</u>** Pam and Elaine said they found the Associate Hospital Manager's (AHM'S) pre-meeting discussions helpful. Carol mentioned that there are times when the managers are having their pre-meeting discussion and members of the care team join the link early and the managers then have to		

	stop the discussion. Carol asked whether it would be possible for a lobby to be set up so that the discussion can be held and then the care team could be let in. Amelia said that she has been looking at setting up the hearings with breakout rooms so that managers can have a separate discussion around their decision without asking the care team to leave and re-join the meeting so she will also look at setting up a lobby for future. Amelia mentioned that this would not be possible for the next couple of hearings as they had been set up by Holly who is currently off work on medical leave and she does not have administrative permissions. **Training for Doctors** Bev said that Alun Jennings will be doing some training with the doctors around what their responsibilities are for managers reviews and tribunal hearings once the dates have been finalised. The minutes and action points from 11th November 2025 were reviewed and agreed.	Amelia to set up hearings with breakout rooms and a lobby going forward Amelia to update minutes with apologies from Pete	**AJames** **AJames**
3. Items for Decision	No items for Decision.		
4. Items for Discussion	**Feedback from AHM's** I. Chairmanship Pete raised the question of whether there would be more people taking on the role of chair in order to share the burden of report writing. Simon said that he had been asked by Bev if was interested in being a chair, however would need a bit more training around being a chair and in the writing up of the paperwork because these are legal documents.		

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	Elaine also expressed interested in doing training on chairing and would like to have further information. Paul said that there would be people who could mentor and offer support to anyone underdoing training to become a chair. Paul asked Bev to look at a programme of training for those interested in become chairs. Paul also said that it would be useful to look at what other health boards are doing in regards to chairmanship training and whether they already have training materials around this. II. <u>Allocation of hearings</u> Pete said that he was once in correspondence with the MHA admin office and within an hour 12 spaces had been allocated of which he only received one because he was told it was done on a first come, first serve basis. Pete queried whether managers hearing panel spaces are allocated on a first come, first serve basis or if there is policy that includes sharing of hearings. Bev explained that she was in the office at the time with this member of staff and that she didn't know why they had said this. The process is that once the dates have been sent out the AHM's have 24 hours to respond and then it should be allocated fairly. Bev confirmed that she had spoken to the staff member and she is now fully aware of what needs to be done going forward. III. <u>Panel Report written by Chair - update</u> Pete discussed that in terms of report writing it is fascinating to see the practise of different organisations. He said that within ABUHB the AHM's were once trained to keep their reports to around 30-40 words in order	Bev to review chairmanship training.	**BHopkins**

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	to be succinct, however there are others that do 2-3 pages of A4. There are no clear guidelines as to how to write a report. Carol agreed with Pete and said that there are differences between reports because different chairs have different backgrounds and experiences. Carol said that for her writing the report is all about making sure the criteria is identified and that the role of the manager is to determine whether the person meets the legal framework for detention or not. IV. <u>AHM's hearing – what happens if any complaints are received from relatives about the patient's treatment?</u> Carol shared an incident that had taken place when she was on the panel for a face-to-face hearing with a different organisation. One of the nearest relatives turned up to the hearing with a dossier of papers that they wanted the panel to read at the meeting to help make their decision. The panel members scanned the document at the end and it turned out to be complaints about the treatment of the patient in hospital. The patient hadn't seen the document so it was unable to be submitted because nobody else had had access to it. The nearest relatives were very unhappy with the panel's decision and wanted to challenge it. There was no understanding of the lay role of the AHM, that whilst there are instructed from the MHA office, they are not part of the office. Carol explained that during this particular hearing the Responsible Clinician who a lot of the complaints were about would not respond and sat looking at their feet. Carol said that she wanted to raise the issue in case something like this came up in ABUHB.		

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	Sandra asked Carol whether the information that had been provided should have been a complaint and whether they were advised to put it through the Putting Things Right (PTR) process. Carol confirmed that they had but only because there were members of the panel that were ex-health board members. Sandra asked Bev to ensure that the AHM's are aware of the PTR process and how to access it. Information around this can be found at [Complaints & Concerns - Aneurin Bevan University Health Board] Bev raised the idea of putting together a pack to distribute to the AHM's with information for any scenario that might come up. V. <u>Independent Mental Health Advocate (IMHA) Representation</u> Carol discussed a recent hearing in which AHM'S had been given the impression that the patient wanted IMHA representation. When the hearing started the patient did not attend and there was no IMHA in attendance. The administrators in the MHA office had to chase what was going on and it turned out that the patient had refused to discuss with the IMHA and had not given them instructions so they therefore felt unable to join the meeting. At the same time when the AHM's asked the ward to check with the patient again the then decided they were going to contest. VI. Carol asked that in the future this is documented either by the RC, Care Coordinator or ward team as this resulted in a wasted meeting that needed to be rescheduled. Amelia explained that in this instance the MHA office had received a clearly documented email from the IMHA that	Bev to collate an information pack	**BHopkins**

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	they had tried to engage the patient 3 times in person and once on the telephone and the patient had declined to share information and declined advocacy representation. Amelia clarified that the person administering the hearing had taken it over last minute due to sickness and that the confusion had come from the MHA office on this occasion. VII. <u>Hearing Links</u> Carol mentioned that sometimes the clinicians struggle to find the link for the hearing as the emails have been sent out a few weeks before and they have not been sent out as a calendar invite. **<u>Training Update</u>** It was agreed that Bev should be contacted by the AHM's if they have any individual training requests. Bev will be rolling out chairmanship training	Amelia to review and conduct training with MHA team Bev to roll out chairmanship training	**AJames** **BHopkins**
5. Items for Information	**<u>Mental Health Act Update Report, Q2 July – September 2025 prepared for meeting of MHLD Committee in January 2026</u>** Sandra explained that there was nothing exceptional to report and discussed that the good news is that the backlog of AHM hearings has been cleared. The other things to note were in terms of paperwork – compliance, training, slip of the pen errors etc. The team have been asked to do some work around this for the next report so an action plan has been put in place. Paul noted that it was an incredibly helpful and comprehensive report and that it was important for the AHM's to see because it gives a holistic picture. Paul also mentioned that there is a very good glossary included at the end of the report that is helpful in understanding all of the different sections. Paul expressed the boards gratitude for the help of the AHM's in clearing the significant backlog of hearings and thanked them for their		

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	support and contribution. **MHA Admin Staff Update** Bev updated the group that the MHA admin team are working well together and that she is really happy with them. Bev explained that the department is extremely busy as the number of people being detained under the MHA is increasing and there are the usual challenges of sickness and people taking leave. **Mental Health Act 2025 - Update** Paul thanked Amelia for sending out information on the updated Mental Health Act proposals. Bev explained that the bill achieved Royal Assent in December but it will be introduced gradually over a period of around 10 years. In the meantime, there is nothing to do but wait for further information. Paul discussed that there is a significant amount of money required for the implementation of the changes. The question is when will it be signed off? Pete asked what the impact will be on the staffing levels in the office. Sandra responded that from a senior perspective nothing official has been received around increasing staff or expectations. There is currently no impetus to change because ABUHB hasn't been asked to change anything at this moment in time. When the time does come there will be plenty of notice given. It was decided to put this on the agenda for the next meeting so that we can have a review of the progress and assess where we are at with it.	Amelia to include Mental Health Act 2025 Update as an agenda item for the next meeting	**AJames**
6. Any Other Business	Bev said that she would arrange a day for the AHM's to meet as soon as possible. She explained that she was hoping to hold this at St. Cadoc's but there is currently a lot of building work taking place so it's very noisy and disruptive at the moment.	Bev to arrange AHM's training day as soon as it is possible to do so.	**BHopkins**

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	Paul thanked the group for their contribution to today's meeting. Paul also thanked Kola, Sandra, Bev, Amelia and the MHA team for all the work they are doing to support what's been happening locally with ABUHB. Paul thanked Perry, Pam, Elaine, Simon, Pete and Carol for their efforts.		
Date of next meetings: Tuesday 2nd June 2026 at 09:30 **Tuesday 11th August 2026 at 09:30** **Tuesday 10th November 2026 at 09:30**			

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	CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN **ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING**

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	24 March 2026
CYFARFOD O: **MEETING OF:**	Mental Health and Learning Disabilities Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Mental Health and Learning Disabilities Committee – Review of Committee Forward Work Plan 2025/26
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Governance Support Officer

Pwrpas yr Adroddiad **Purpose of the Report**
Er Gwybodaeth/For Information

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Mental Health and Learning Disabilities Committee is asked to review the agreed Committee Forward Work Plan appended to this report as **Appendix A.**

The Forward Work Plan has been developed with due regard to recommendations from the Committee Self-Assessment 2024/25 and to enable the Committee to: -

- Fulfil its Terms of Reference;
- Seek assurance and provide scrutiny on behalf of the Board, in relation to those items identified within the Committees terms of reference, and,
- Seek assurance that governance, risk, and assurance arrangements are in place and working well.

Cefndir / Background

In line with good governance practice, the Mental Health and Learning Disabilities Committee has a Forward Work Plan that has been developed to ensure statutory requirements for items of Committee business are scheduled in across the

year. The Forward Work Plan can therefore be utilised as a tool for informing and pre-empting committee business and support the agenda setting process.

The Committee will support the Health Board in discharging its accountabilities and responsibilities for the achievement of the Health Board's objectives and organisational requirements in accordance with the standards of good governance determined for the NHS in Wales.

As appropriate, the Committee will advise the Board and the Accountable Officer (Chief Executive) on where and how its system of governance and assurance may be strengthened and further developed.

Where required, the Committee will provide accurate, evidence based (where possible) and timely advice to the Board in respect of citizen experience and the quality and safety of directly provided and commissioned services.

During the period the following requests and/or changes to the forward work plan have been included.

Deferred item on the Forward Work Programme:

- Mental Health Estates Strategy – This item has been rescheduled for June's Committee.

- Assurance in respect of CAMHS & Mental Health Services Performance – These two items have now been combined to form part of the main Performance update for the Committee.

These changes have been reflected on the updated Forward Work Programme.

Additional item on the Forward Work Programme:

There have been two additions to the Forward Work Programme namely

- Maindiff Court Mental Health Inspection report following a recent HIW inspection.

- Mental Health Maturity Assessment which is a shared item between the Chief Operating Officer and the Director of Digital.

Argymhelliad / Recommendation

The Committee is requested to **NOTE** the updated Mental Health and Learning Disabilities Committee Forward Work Plan as provided in **Appendix A.**

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:	The monitoring and reporting of committee business is a key element of the Health Boards assurance framework

Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. The Committee Forward Programme monitors delivery of objectives.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item. Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	N/A
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	N/A

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk

Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Choose an item. Choose an item. Not applicable to this report

Annual Programme of Business for 2025-26

Mental Health and Learning Disabilities Committee

This Annual Programme of Business has been developed with reference to:

- Aneurin Bevan University Health Board's Standing Orders;
- The Health Board's Integrated Medium-Term Plan and related Annual Delivery Plan;
- The outcomes of the Committee's self-assessment for 2024/25
- The Board's Strategic Risk Register; and
- Key statutory, national and best practice requirements and reporting arrangements.

Area of Focus as per Standing Orders:
The Mental Health and Learning Disabilities Committee will focus on all aspects of the Health Board's activities to contribute to the agreement of a strategic direction for mental health, learning disabilities and child and adolescent mental health services (CAMHS) in the areas of Gwent. The Committee's purpose is to monitor the effectiveness and efficiency of service delivery for mental health, learning disabilities and CAMHS services and identify areas for improvement; and monitor the appropriate delivery of the functions of Hospital Managers in response to Chapter 11 of the Mental Health Act 1983 (co-ordinated on behalf of the Committee by the Mental Health Act Managers Group). In respect of the achievement of the Boards' strategic aims, objectives and priorities, the Committee will seek assurance regarding: • arrangements for discharging its functions and meeting its responsibilities regarding mental health, learning disabilities and CAMHS issues and especially the Health Board's compliance with the Mental Health Act 1983, Mental Capacity Act 2005, Equality Act 2010 (where relevant) and associated legislative and statutory frameworks • arrangements for responding to the above legislation that this is being undertaken appropriately in accordance with its stated objectives and the requirements and standards determined for the NHS in Wales. In undertaking this work the Committee will have close liaison with other committees of the Board, especially the Patient Quality, Safety and Outcomes Committee • implementation of the National Dementia Standards within the health board.

MATTERS TO BE CONSIDERED (Report Title)	Lead	Frequency of Report	Schedule of Meetings			
			QTR 1 Apr to June 17/06/25	QTR 2 July to Sept 09/09/25	QTR 3 Oct to Dec 09/12/25	QTR 4 Jan to Mar 24/03/26
Preliminary Matters						
Attendance and Apologies	Chair	**SI**	✓	✓	✓	✓
Declarations of Interest	Chair	**SI**	✓	✓	✓	✓
Minutes of the Previous Meeting	Chair	**SI**	✓	✓	✓	✓
Action Log and Matters Arising	Chair	**SI**	✓	✓	✓	✓
Committee Governance						
Development of Committee Annual Programme of Business 2025/265	Chair DoCG	**AN**	✓			
Review of Committee Programme of Business 2025/26	Chair DoCG	**SI**	✓	✓	✓	✓
Annual Review of Committee Terms of Reference	DoCG	**AN**				✓
Annual Review of Committee Effectiveness 2025/26	Chair DOCG	**AN**				✓
Outcome of Annual Review of Committee Effectiveness 2025/26	Chair DoCG	**AN**				
Committee Annual Report 2025/26	Chair DoCG	**AN**				Q1, 2026/27
Committee Risk Report	DoCG	**SI**	✓	✓	✓ D	✓

Committee Core Business						
Mental Health Act Compliance Report • Engage with other Welsh Health Boards and obtain data on their implementation and use of the Mental Health Act for comparison (Action for December's meeting **MHLD/0909/03.2)** • Ensure duplicate patients, who are detained more than once in a quarter, are highlighted in the data to ensure accurate reporting (Action for December's meeting **MHLD/0909/03.2)**	COO	**SI**	✓	✓	✓	✓
Power of Discharge (PoD) sub-Committee Update	PoD Chair	**SI**	✓	✓	✓	✓
Annual Benchmarking Report	COO	**AN**				✓
Right Care Right Person Presentation Update	COO	**AN**	✓			
Mental Health Services related Performance and Outcomes,	COO	**SI**	✓	✓	✓	✓

4

including Quality, Safety and Activity						
111 Press 2 Performance and Outcomes	COO	**AN**	✓			
Assurance in respect of Mental Capacity Act and DOLS	DON	**Bi-Annual**	✓		✓	
Mental Health Estates Strategy	COO	**Bi-Annual**		✓		✓
MH&LD Division: Staff Wellbeing & Engagement	COO	**Annual**			✓	
Staff Security, including Violence and Aggression, specific to MH&LD Services staff	COO	**AN**			✓ D	✓
Assurance in respect of CAMHS Services	COO	**Bi-Annual**		✓		✓
Assurance in respect of Dementia Standards	DoN	**Bi-Annual**		✓		✓
MH&LD Divisional Risk Report	COO/ DoCG	**Bi-Annual**		✓		✓
Maindiff Court Mental Health Inspection report	DoN					✓
Restrictive practice and associated process Report **MHLD/1706/06**	COO	**Action**			✓	
Right Care Right Person report to include the progress of phase 3 and anonymised case studies.	COO	**Action**		✓		

MHLD/1706/07						
Report on the impact of Robotic Process Automation (RPA) with detail on implementation **MHLD/1706/08**	COO	**Action**		✓		
The Mental Health Bill update on the impact on Wales **MHLD/1706/10**	COO	**Action**		✓		
Restrictive Practice and Associated process Report **MHLD/0909/03.5**	COO	**Action**			✓	
Mental Health Act Bill Update **MHLD 2201/5.2**	Committee Secretariat	**Action**				✓
Mental Health Act Compliance Deep Dive on documentation errors, including themes, causes, and training needs (especially relating to locum/agency staff) **MHLD 2201/3.2**	COO	**Action**				✓
Mental Health Act Compliance monitor and report back on Section 136 trends and the impact of the *Right Care, Right Person* approach **MHLD 2201/3.2**	COO	**Action**				✓
Mental Health Act Compliance bring forward an update on training programme	COO	**Action**				✓

effectiveness to reduce unlawful and rectifiable errors **MHLD 2201/3.2**						
Mental Health Services Performance provide the Committee with further updates on: Neurodevelopmental (ND) service pressures, needs-based pathways progress and Waiting list recovery work **MHLD 2201/3.3**	COO	**Action**				✓
Mental Health Services Performance develop quarterly reporting with triangulated data to strengthen oversight of Restrictive practices **MHLD 2201/3.3**	COO	**Action**				✓
Mental Health Services Performance ensure a more detailed update on inpatient safety work and related national metrics is brought to a future meeting. **MHLD 2201/3.3**	COO	**Action**				✓
Mental Health Maturity Assessment	COO (Paul Solloway to support)					✓
MENTAL HEALTH & LD DIVISION: IMTP Priorities						

Models of Care	COO	**Annual**		✓		
Partnerships	COO	**Annual**				✓
Quality Improvement	COO	**Annual**		✓		
Workforce	COO	**Annual**			✓ D	✓
Digital Transformation	COO	**Annual**				✓

Lead Officer	
Key	
CEO	Chief Executive
DoCG	Director of Corporate Governance
DoF&P	Director of Finance & Procurement
DoSP&P	Director of Strategy, Planning & Partnerships
COO	Chief Operating Officer
DPH	Director of Public Health
DoT&HS	Director of Therapies & Health Science
DoW&OD	Director of Workforce & Organisational Development
DoN	Director of Nursing
MD	Medical Director
DOD	Director of Digital
HoQI	Head of Quality Improvement for MHLD
Chair	Chair

Frequency of Inclusion
Narrative of Reason why Included in the FWP – other reasons to be developed as part of FWP discussions

SI	Standing Item
An	Annual
1/4ly	Quarterly
BI	1/2 yearly
Schedule of Meetings	
√	Scheduled agenda item in FWP
D	Deferred from this agenda
√D	Deferred Scheduled agenda item
W	Withdrawn from FWP
T	Transferred to another Committee
IC	Matter discussed In Committee