IMHA Relevant Issues Q1 April to June 2026

This report covers the first quarter of the year.

Team Information and Training:

This quarter we were able to implement the team changes that we discussed in a previous meeting.

There have been no changes in the Independent Mental Health Advocacy (IMHA) team during this time. We have had some sickness and annual leave during this quarter, but we have responded to and actioned all referrals received. With absence overlapping the quarter end some data is not yet on the database and reported. Everyone seeking advocacy support within a Managers' Hearing has received that support.

Team members continue to engage in a wide variety of training relevant to their roles and the All Wales IMHA Peer Support Group for advocates working in IMHA services across Wales. More recently, there has been training and briefing around the UK Supreme Court decision in relation to Deprivation of Liberty Safeguard (DoLS) guidance and we have developed our Equalities, Diversity and Inclusion Statement and Action Plan, and are currently undertaking the Social Care Wales Anti-Racist Wales five module training programme.

Natasha continues to engage in Hywel Dda University Health Board's Enabling Quality Improvement in Practice (EQIiP) programme led by Grace Elms, Advanced Nurse Practitioner / Independent Prescriber. We have also submitted our Quality Performance Mark re-accreditation and achieved the Cyber Essentials Plus annual accreditation.

We hold monthly Team meetings and Peer Supervision for advocates and advocates have monthly individual supervision around their role and casework.

Ongoing Service – Issues Raised:

All people referred to the service have been able to access advocacy within the time limits set by the contract during this quarter. All people requesting advocacy for Managers' Hearings have been able to access support. Within general ward settings we have met all needs to attend and or report into Best Interest processes on behalf of people lacking capacity around care and discharge needs.

The chart below shows a monthly breakdown of new referrals into the service and existing clients where there is ongoing support in each period. This has held up remarkably well given the staffing situation, which has now resolved:

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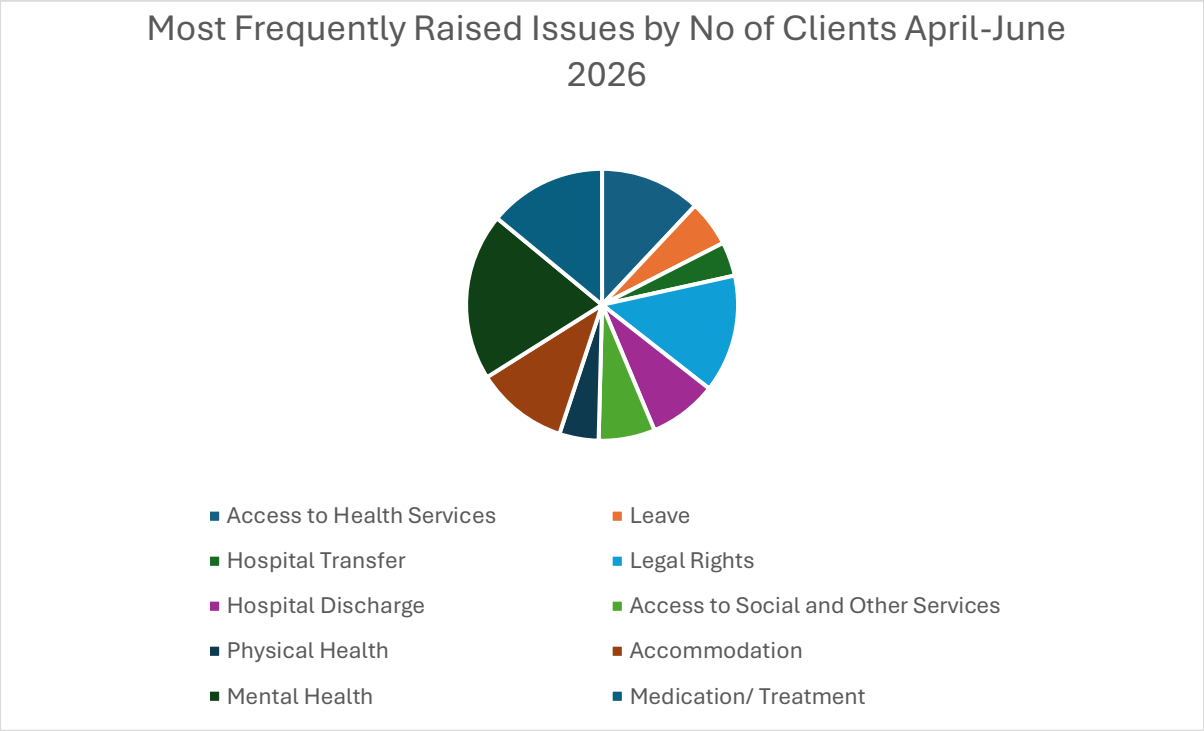
We know it will be disappointing for patients to see the Mental Health Review Tribunal for Wales (MHRTfW) reverting to online hearings while waiting for an emergency bill to be passed to allow not. We know that for many this will impede access to a hearing and participation in those. We have agreed within the All Wales IMHA Peer Group to monitor this and to provide evidence to the Tribunal about the impact of this on patients in due course and also inviting them to involve IMHA in the consultation process they say will follow the pilot.

The report contains some of the key themes about the care and treatment/period of time on the ward expressed by people seeking advocacy. Overall health service teams are positive in supporting people to access advocacy, and responding to concerns raised on behalf of people by advocates.

The chart below shows the main themes raised by people accessing the service during this period and is consistent entirely with the remit of the service:



Main concerns during this period expressed by clients of the service and reflected in discussion with advocates in peer and individual supervision:

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Referrals Generally: Most wards are referring appropriately into the service using the new referral form. There are always a number of self or advocate-initiated referrals so we can ultimately be confident that in so far as patients on mental health units is concerned, they are all having the opportunity to access advocacy. Sending in referrals is also important when the usual advocate is on annual leave or off sick so that cover can be provided.

The addition of a place on the form to identify the difference between someone on the ward informally or on DoLS is helpful, particularly as we need to monitor any changes coming as a result of the UK Supreme Court decision around DoLS. From time-to-time stray obsolete referral forms are used and we would ask that you ensure your teams are using the new referral form.

Reminder: For those with capacity to consent to a referral to IMHA, only those who do consent should be referred into the service. People can be followed up on wards where advocacy needs arise, or via interaction on the ward with the IMHA. It is always helpful to know of transferred patients to promote a smooth handover of advocacy for the person and to support the IMHA to provide a prompt response.

1. **Children and Adolescent Mental Health Services (CAMHS) patients –** children and young people have the same rights to information about and access to IMHA advocacy as any other person. We do not get direct referrals from CAMHS whether for young people on the Rainbow Suite or for the Morlais Children and Young People (CYP) bed. If referred, this is always by a member of the Morlais nursing team. We have done awareness raising with CAMHS leads, but this hasn't led to any direct referrals. If further awareness training is required, this can be arranged for any team.

2. **General wards** – We still get late referrals to support people with key decision-making meetings such as Best Interest Meetings, although there has been some improvement on this. In this time advocacy has consistently been able to support the person's views and wishes to ensure the person is kept at the centre of decision making. On general ward settings we tend to be asked to advocate in the more complex situations where family situations and conflicts risk the person not being at the centre of decision making about their care needs on discharge from hospital. People in this situation, lacking capacity around the key decisions under consideration, are particularly vulnerable. Sometimes no valid and applicable legal safeguards are around them such as DoLS. We have had a steady number of referrals on general wards in Carmarthenshire, these usually being generated by involvement of the MH Liaison Nurses – thank you! Referrals in Pembrokeshire wards tend to be made by Joint Discharge Team Social Workers or Ward

Managers/Sisters and in Ceredigion at Bronglais Hospital by nursing staff/Ward Managers/Sisters. We do also get a small number of referrals for patients detained on General Ward and these are usually highlighted appropriately to us by the Mental Health Act (MHA) Administration Department team.

3. **Meetings Generally:** there continue to be difficulties with meetings being arranged at short notice, often delayed or times changed with little notice on some wards (mainly the acute adult settings). This can lead to difficulty in clients securing advocacy involvement or having time to prepare for their meetings. Meeting arrangements on older adult wards, Psychiatric Intensive Care Unit (PICU) and Low Secure Unit (LSU) are more regular giving time for preparation and planning for both patients and advocates.

   Where difficulties remain, clients tell us that this uncertainty can negatively affect them. Limited time to prepare or involve advocacy can reduce their confidence in participating meaningfully in meetings and decisions about their care. Advocates are working with ward clerks and ward managers to address this, and we recognise that coordination with locality-based consultants adds complexity.

   A number of Bryngofal patients have expressed finding it difficult not seeing their Responsible Clinician (RC) in person when they are out of locality and struggling with Teams meetings where either internet connection or accessibility are issues during meeting times. As a theme patients' difficulty with remote meetings is ongoing.

4. **Out of County:** Several people have had to remain in hospitals outside their home county because of bed shortages, and issues relating to hospital transfer have been raised more frequently in recent months. This particularly affects people from Ceredigion, as there is no ward in their own county.

   Being placed further from home can affect access to support, the delivery of personal items from friends and family, and opportunities for home leave. Similar concerns arise where there is no suitable placement or interim placement available locally, meaning clients are placed out of county and away from their support networks.

   This can be especially difficult for older couples, particularly where the spouse or partner who is not in hospital, or is not moving into care, has no or limited access to transport. We recognise that this has been a consistent theme in our reports for many years, but it remains important for the service to continue raising the issue.

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5. **Staffing levels:** Patients and staff tell us that staffing levels are very low in many areas and patients feel this impacts their ability to access staff, support, the gym and leave.

   This continues to have an impact on those who have escorted leave, with clients reporting not being able to utilise their allocated leave, not being able to have home visits and other meaningful activity leave not being granted which they in turn consider can delay their progress.

   The issue of leave for smokers, particularly early in admission, continues to be raised. This especially impacts detained people without unescorted leave approved. However, we understand that the experience is varied.

6. **Delays in placements:** It has been highlighted that there have been significant delays in people leaving hospital, due to a lack of placements and care packages being available. This affects older adults and adults alike. Where delays in discharge lead to temporary placements, we will, where the need is clear, attempt to offer ongoing advocacy for the person until a settled placement is achieved. This does put additional demand on the service.

7. **Impact of Waiting Lists in Our Community Service:** We have observed a number of instances where people seeking access to our community service and on waiting lists for that service, have been admitted to the ward while on the waiting list. The waiting list exists owing to demand on the service and capacity issues. It is not entirely clear whether delayed advocacy is impacting access to services in the community and leading to admission or whether admission would have occurred in any event. However, anecdotally people do tell us that they feel our interventions in the community both prevent serious deterioration and admission. We are seeking to address this with additional triaging of people on the waiting list to be able to identify people in urgent need more closely. We will be feeding this information into our Community Service reviews also. People's advocacy needs are usually at their highest at the time they are referred in/seek our support and for our roles to have the greatest impact in supporting people, prompt access to the service is critical to fulfil the preventative element of our roles. The same applies when people leave the ward and seek community advocacy and we try to prioritise these referrals where people have clear ongoing advocacy needs. This is becoming increasingly difficult as demand and complexity within the community service increases.

8. **Use of DoLS:** There have been occasions where people lacking capacity to consent to an admission have been found to be on the ward informally without any legal

framework/safeguards and in those circumstances, we would highlight that for it to be addressed for the benefit of the patient and those caring for them. This is more of an issue on general ward. There remain delays in the standard DOLS assessments both on general wards and mental health units, and many patients fall way out of the required time frames. This means people are all too often illegally deprived of their liberty for extended periods. The DoLS Code of Practice is very clear on the fact that this leaves a person illegally deprived of their liberty. These concerns have been raised consistently. However, from July onwards the position regarding DoLS has been thrown into doubt following the UK Supreme Court decision and while guidance is awaited around this.

Awareness Raising re Advocacy:

If any of your teams would benefit from additional awareness around IMHA advocacy, please do let us know and sessions can be arranged with the advocates who habitually visit Health Board wards.

We have created some new guides in the form of infomercials for both clients and professionals and these are hosted on our You Tube channel and those can be accessed via the links below.

For clients:

A Guide to Independent Advocacy at AWW: https://youtu.be/XTfv5EkJzZo

A Guide to Independent Advocacy at AWW – Cymraeg: https://youtu.be/VjlPOvxZFVY

For you and your teams:

A Referrer's Guide to IMHA – 2026: https://youtu.be/xP7KQ5OfRIY

A Referrer's Guide to IMHA – 2026 – Cymraeg: https://youtu.be/xQH2Sp-tdVU

If you identify that a patient wants or may need advocacy at discharge from the acute settings, please do discuss with us about ongoing advocacy for the person as we have a range of community services available. In light of the above we do try to prioritise access to our community mental health advocacy service for people recently discharged from the hospital setting.

If you are unable to attend the meetings at which this report is discussed but would like to address any questions to the service the following options are available:

Advocacy West Wales
Eiriolaeth Gorllewin Cymru
A voice when you need it most
Llais pan fyddd ei angen arnoch fwyaf

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Direct questions via the minutes/meeting co-ordinator and the service will respond as soon as possible.

Contact Nia Williams or Natasha Fox directly on nia@advocacywestwales.org.uk or natasha@advocacywestwales.org.uk.

Natasha Fox, IMHA and Chief Officer, and Nia Williams, IMHA and Professional Lead, Advocacy West Wales-Eirolaeth Gorllewin Cymru, 31 July 2026.