HIW & CIW: Joint Community Mental Health Team Inspection (Announced)

The Vale Locality Mental Health Team, Cardiff and Vale University Health Board and Vale of Glamorgan Council

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

Our purpose

To check that people in Wales receive good quality healthcare

Our values

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

- **Independent**
- **Objective**
- **Caring**
- **Collaborative**
- **Authoritative**

Our priorities

Through our work we aim to:

Provide assurance:	**Provide an independent view on the quality of care**
Promote improvement:	**Encourage improvement through reporting and sharing of good practice**
Influence policy and standards:	**Use what we find to influence policy, standards and practice**

Care Inspectorate Wales (CIW)

Our purpose

To regulate, inspect and improve adult care, childcare and social services for people in Wales

Our values

Our Core values ensure people are at the heart of everything we do and aspire to be as an organisation.

- **Integrity: we are honest and trustworthy**
- **Respect: we listen, value and support others**
- **Caring: we are compassionate and approachable**
- **Fair: we are consistent, impartial and inclusive**

Our strategic priorities

We have identified four strategic priorities to provide us with our organisational direction the next three years. These are:

- **To consistently deliver a high quality service**
- **To be highly skilled, capable and responsive**
- **To be an expert voice to influence and drive improvement**
- **To effectively implement legislation**

1. What we did

Healthcare Inspectorate Wales (HIW) and Care Inspectorate Wales (CIW) completed a joint announced community mental health inspection (CMHT) of The Vale Locality Mental Health Team within Cardiff and Vale University Health Board and the Vale of Glamorgan Council on 4 and 5 December 2018.

Our team, for the inspection comprised of one HIW inspector, two clinical peer reviewers (one of whom was the nominated Mental Health Act reviewer) and a Care Inspectorate Wales (CIW) inspector. The inspection was led by a HIW inspection manager.

During this inspection, we reviewed documentation for patients detained under the Mental Health Act 1983 in order to assess compliance with the Act.

HIW and CIW explored how the service met the Health and Care Standards (2015) and the Social Services and Well-being (Wales) Act 2014. HIW also consider how services comply with the Mental Health Act 1983, Mental Health Measure (2010), Mental Capacity Act (2005).

Further details about how we conduct CMHT inspections can be found in Section 5.

2. Summary of our inspection

Overall, we found evidence that the service provided safe and effective care to its service users. However, we found some evidence that service was not fully compliant with all Health and Care Standards (2015) and the Social Services and Wellbeing (Wales) Act 2014.

The service was in a period of substantial change, having recently merged three CMHT's into one. This had an impact upon processes, procedures, meetings and management structures. This was having an impact upon the morale of staff at the time of the inspection. There was a need for clarification with regards to these issues.

The service was also in the process of being redesigned, with the implementation of a new model. This was at an early stage, however we found that there was a clear focus and positivity from management to change the service, which would ultimately benefit both staff and service users.

We found the quality of patient care and engagement with service users and their carers to be of a good standard. Service users spoke positively about the support they received from staff.

We found that access to the service had improved very recently, and service users were being seen in a more timely manner, however this was still in need of improvement.

The team were carrying psychiatry and psychology vacancies which were having a negative impact upon the care and treatment provided to service users.

We saw that the quality of record keeping was consistently of a good standard, including the Mental Health Act documentation.

We found that there was a good multidisciplinary approach with regards to service users assessments, care planning and reviews.

We found that care plans were strength based, recovery focussed and goal orientated. The team demonstrated a positive approach to working with third party organisations for the benefit of service users. We also found that the quality of care provided by the support team was of a very high standard.

This is what we found the service did well:

- Service user feedback was generally positive
- The environment was clean and tidy
- Robust management of medicines processes in place
- Provision of a support worker service that evidenced a positive and direct impact on service users
- Application of Mental Health Act and Mental Health Measure (2010) and legal documentation
- Identification of a vision for the future of the service supported by a passionate management team
- Strong integrated leadership model, supported at a senior management level.

This is what we recommend the service could improve:

- Recruitment into key roles, such as psychiatrists and psychologists
- Timeliness of transportation for services users to a place of safety and/or hospital
- Organisation of outpatient and medication clinics
- Completion of appropriate forms for service user capacity assessment by clinical staff
- Clarity for staff regarding new processes and procedures following the merge of three teams.

3. What we found

Background of the service

The Vale Locality Mental Health Team provides community mental health services at Barry Hospital, Colcot Road, Barry, CF62 8YH, within Cardiff and Vale University Health Board and the Vale of Glamorgan Council.

The team provides services to approximately 1,100 adults with mental health needs, and receives approximately 180 referrals each month, mainly from General Practitioners (GPs).

The staff team includes the CMHT integrated manager, two consultant psychiatrists, a psychiatrist, three psychologists, five social workers, thirteen community psychiatric nurses (CPN), four health care support workers, five social care support workers, four FORT[1] workers, plus a number of managerial and administrative team members across both the health and social care areas. At the time of inspection there were a number of long term vacancies carried by the team, namely psychiatrists and psychologists.

The team is supported by a Crisis and Home Treatment Team, which is based at Llandough Hospital.

Community mental health team services across the Vale of Glamorgan Council until September 2018 had been provided by three CMHTs. In a joint venture between Cardiff and Vale University Health Board and the Vale of Glamorgan Council, it was agreed to merge the three teams to create one team based at Barry Community Hospital.

[1] Focussed Outreach and Recovery Team

Quality of patient experience

We spoke with patients, their relatives, representatives and/or advocates (where appropriate) to ensure that the patients' perspective is at the centre of our approach to inspection.

Patient's comments were positive about the new environment, and the care and treatment they received by the team.

We observed professional and friendly interactions between staff and service users. In particular service users highlighted the helpfulness and support they received from reception staff.

We found that the quality of care provided by the team was of a good standard.

Consideration should be given to changing the timings of outpatient and medication clinic to ensure patients have a dignified and calm experience.

Recruitment of psychiatrists and psychologists into the service must be completed, to ensure service users have access to the care and treatment they require.

During our inspection we distributed HIW questionnaires to service users to obtain their views on the service provided at the practice. In total, we received 45 completed questionnaires.

Service user feedback in the questionnaires was generally positive. Some patients told us that the support they have received has made a big difference to their lives, and that the CMHT workers have been very helpful when arranging appointments.

However, one patient told us that they never get to see the same psychiatrist when they visit, which is causing them anxiety as it is hard for them to meet new people. This is explored later on in the report.

The CMHT had recently moved into new premises at Barry Hospital, and patients told us they were pleased with the new environment. Patients also told us that reception staff were kind and caring. We observed positive interactions between staff and service users, which were both professional and friendly.

Care, engagement and advocacy

We found the quality of care provided to service users to be of a good standard.

Almost all service users that completed a questionnaire felt that their CMHT worker usually gives them enough time to discuss their needs and treatment and listens to them carefully.

Almost all service users that completed a questionnaire felt that the CMHT had involved a member of their family, or someone close to them, as much as they would have liked.

A quarter of service users that completed a questionnaire said that they hadn't been offered the support of an advocate to potentially help them access information they may need, or to support them in situations where they didn't feel able to speak for themselves. Staff we spoke to told us that access to advocacy services was readily available. Based upon service user feedback in our questionnaires, the service must ensure that all service users are offered the support of an advocate. We also recommended that the wishes of a service user regarding advocacy is recorded in their records to demonstrate that this has been offered.

The majority of service users that completed a questionnaire told us that the service provided by the CMHT 'completely meets their needs' or 'meets most of their needs'.

Almost all service users that completed a questionnaire felt either very, or quite, involved in the development of their care plan. Just under two thirds of the service users that completed a questionnaire told us that they received a copy of their care plan. The service must ensure that all service users receive a copy of their care plan to ensure they have a comprehensive understanding.

The majority of service users that had been in contact with the CMHT for more than a year said that they have had a formal meeting or review with their care coordinator to discuss how their care is working, and that they felt involved in these meetings. Service users that completed a questionnaire also felt that they were given the opportunity to challenge any aspect of their care and treatment plan that they disagreed with during their formal meeting or review.

Two thirds of the service users that completed a questionnaire said that they had been given information (including written) by their CMHT.

The CMHT was based on the ground floor of Barry Community Hospital and was accessible to people with mobility problems. There were designated parking facilities for service users directly outside the building. Meeting rooms

and the clinical area were all located on the ground floor of the building and easily accessible. Toilet facilities were available by the waiting area.

Both staff and some patients we spoke to told us that the waiting area can become very busy and congested on certain days of the week. We were told that this is because there are often outpatient clinics and medication clinics arranged for the same time and day. Patients told us that this meant the waiting area was loud and busy and impacted on the quality of their experiences. One service user told us that they had often felt like leaving the building because of this. We recommended that the service reconsiders the arrangements and timings of all clinics to help ensure the patient experience is positive.

Improvement needed

The service must ensure that all service users are offered the support of an advocate and documented in service user records to show whether this has been accepted or declined.

The service must ensure that all service users receive a copy of their care plan.

The service should ensure that outpatient and medication clinics are arranged to suit service user needs.

Access to services

The range of time service users that completed a questionnaire had been in contact with the CMHT ranged from less than a year to more than 10 years. The majority of service users that completed a questionnaire had last seen someone from the CMHT in the last month.

The majority of service users that completed a questionnaire told us that they found it easy to access support from the CMHT when they needed it. The majority of service users that completed a questionnaire said that when thinking about their own needs, they had been seen by the CMHT about the right amount of times.

All but one of the service users that completed a questionnaire told us that they did know how to contact their care coordinator if they had a concern about their care.

The majority of service users that completed a questionnaire had been referred to the CMHT by their GP. From the responses in the questionnaire, service users had either been seen straight away after their referral (less than a week),

or it had taken much longer to be seen by the CMHT after their referral (about four weeks or longer).

We found that referrals were, in the main, received via GPs. However, referrals were also accepted from various sources such as other health or social care professionals or police. The CMHT also accepted self-referrals from individuals who had previously been service users of the team, through the Mental Health (Wales) Measure 2010[2].

We were told that following referral into the CMHT, service users were waiting on average around seven weeks for an assessment, the target being four weeks. We were told by the management team that the CMHT had worked very hard to reduce the waiting time, which prior to the merger of the three teams had been around sixteen weeks for some service users. The management team told us that they were working hard to reduce the waiting time, and were putting measures in place to address the issues. We saw that a referral screening meeting was being held twice a week, to consider the referrals received to ensure they were appropriate to the service. We were told that at this stage they would expedite any patients for referral where there were any serious issues of concern.

The management team also explained that a large proportion of referrals into the team were inappropriate and not suitable for secondary care services. Some referrals would be screened out at an early stage. However, we were told that there was a need to assess some service users to determine their suitability, with a large number not being appropriate for their care. In order to address this issue, the CMHT had a plan in place to work more closely with GP practices in the locality. This included encouraging practices to obtain advice from the duty team prior to making a referral, and from the consultant psychiatrist about medication issues, in an attempt to reduce the number of inappropriate referrals and therefore the need for as many assessments.

We were also told that the health board mental health directorate was planning on creating new primary care mental health positions. Mental health professionals would be based in GP practices in the locality to provide a mental health service, with the intention of helping to provide a better service for service users, and reduce the number of inappropriate referrals into the CMHT.

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[2] http://www.wales.nhs.uk/sitesplus/documents/861/100707mentalhealthfactsheeten.pdf

Urgent referrals were dealt with by the duty officer(s), of whom there were normally three on duty daily, with one senior lead to manage the service. Service users were usually seen on the same day by the duty officer(s). An end of day meeting was held to discuss the urgent referrals received and urgent assessments carried out that day. We received mixed feedback from staff about this, as the success of the meeting varied depending upon the availability of psychiatrists to attend the meeting. We were told that if they were unable to attend it meant that the information would need to be repeated and duplicated at the next multi-disciplinary team (MDT) meeting.

Referrals that required an assessment under the Mental Health Act were passed to one of the Approved Mental Health Professionals (AMHP) for action.

Where appropriate, and if service users did not meet the threshold for secondary health care, they were referred to other services better placed to meet their needs. A weekly multi agency referral meeting was held, where representatives from the CMHT, third sector agencies and primary care attend to consider the referrals received. Service users can be signposted onto third sector agencies that may be more appropriate to provide the relevant support to individuals.

The majority of service users that completed a questionnaire said that they knew how to contact the CMHT out of hours service, and all those service users that had contacted the service in the last 12 months said that they got the help they needed.

All but one of the service users that completed a questionnaire also said that they knew how to contact the CMHT if they had a crisis and almost all those who had contacted the CMHT in a crisis in the last 12 months told us that they did get the help they needed.

It was reported to us that there were often issues with transporting service users to hospital and/or a designated place of safety for assessment and/or treatment. The service was reliant upon the Welsh Ambulance Service for transportation. We were told that this often meant delays for service users accessing the care and treatment needed. This had the potential to impact directly on the service user experience, health and well-being. It also had the potential to directly impact upon staff accompanying service users, who would also be required to wait long periods of time.

Senior managers were aware of the above issues, and the impact delays of assessments and conveyancing have on service users and staff. We recommended that the service continues to explore alternatives for transporting service users to hospital and places of safety to ensure assessments and treatment are provided in a timely way.

We found that the service had difficulty in recruiting psychiatrists into the team, and was carrying a number of vacancies. The team were heavily reliant on locum doctors to fill posts. We found that this had an impact on the availability of appointments and continuity of care for service users. Staff told us that service user appointments were often cancelled and had resulted in a number of complaints to the management team as a consequence. The management team were actively trying to recruit into the vacancies on a full time basis, however recognised the difficulties in doing this and the negative impact on service users.

Staff and managers told us that there was a delay of approximately eighteen months to two years in service users being able access psychology services, after they were assessed as requiring them. The impact of this delay for service users was at best to hamper their recovery and could lead to service users' relapse. We saw that there were vacancies within the psychology team, and that the service was trying to recruit, however they acknowledged that to date they had been unsuccessful. The health board and local authority should review the availability of psychology and look at ways of reducing waiting times and how service users should be actively supported during the waiting period.

Improvement needed

The service must inform HIW how it will provide an assessment service to services users within the target timescale of 4 weeks.

The service must ensure that all appropriate staff attend the end of day meeting to ensure it meets the needs of both staff and service users.

The health board must continue to explore ways to ensure that psychiatry and psychology vacancies are recruited into.

The health board and local authority should review the availability of psychology support and look at ways of reducing waiting times and how service users should be actively supported during the waiting period.

The health board and local authority must ensure that transporting service users to a place of a safety and/or hospital is done in a timely way.

Delivery of safe and effective care

We considered the extent to which services provide high quality, safe and reliable care centred on individual patients.

Overall, we found that the service was providing safe and effective care to service users.

There was a multi-disciplinary, person centred approach to assessment, care planning and review. Service users were involved in the development of the care and treatment plans and we found them to be recovery focussed, strength based and goal orientated.

There were robust systems and processes in place for the management of medication.

There was a safeguarding of children and vulnerable adults policy in place, and staff had completed the relevant training.

There were a number of estates issues that were in need of attention and we found that ligature point risk assessments had not recently been carried out.

Discharge arrangements were generally satisfactory.

Record keeping was of a high standard and in accordance with the requirements of the Mental Health Act.

Managing risk and promoting health and safety

The CMHT was located in Barry Hospital. We found it to be clean, tidy and free from obvious hazards. We did, however, find that some of the rooms used for patient consultations did not have panic alarms in. We also found that the doors leading from the waiting room into the patient meeting room areas were not able to be locked. We were told that these issues had been reported to the estates management team and would be resolved quickly.

We saw that risk assessments were carried out and issues reported appropriately. However, we found that ligature point risk assessments were not being carried out.

Improvement needed

The service is required to confirm to HIW when the estates issues identified will be rectified.

Ligature point risk assessments must be undertaken and measures set in place to eliminate any risks identified.

Medicines Management

We found that the CMHT had robust and effective medicines management systems in place to help ensure the safe management and administration of medication.

The CMHT had a dedicated CPN who was responsible for clozapine management, an antipsychotic medication, with support and guidance from the directorate lead clozapine nurse.

The CMHT provided physical health monitoring alongside the depot clinic[3]. This was managed by a health care support worker, who was also able to provide healthy lifestyle information at the same time. We found this to be an area of good practice.

We observed that the clinic room was clean and tidy with all cupboards kept locked. Stocks were kept in good supply.

Assessment, care planning and review

Overall, we found that service user care records were of a good standard, and one in particular we looked at was of a very high standard. It was evident from the care documentation reviewed, and from discussions with service users, that their views and wishes were the main focus of the work conducted by the CMHT. We saw that the care and treatment plan were individualised, outcome focussed and goal orientated. We were able to see in the care documentation we looked at that relevant risk assessments had been carried out, and that medication reviews were in date.

[3] A clinic to provide injections of medication

Service users that completed a questionnaire were most likely to have their social and accommodation needs completely met by the services provided through the CMHT; service users were least likely to have their employment needs completely met by the services provided through the CMHT.

Where applicable, just under a quarter of service users that completed a questionnaire said that the option to receive direct payments to help meet their care and support needs had been discussed with them by the CMHT.

Patient discharge arrangements

We found that discharge arrangements were satisfactory. We looked at care records and could see appropriate discharge planning had been considered. However, staff discussions informed us there was an issue with discharging service users from doctor's caseloads, resulting in them having a large number of service users on their caseload. We discussed this with management who told us that work was currently being undertaken to address this. An active approach was described, where regular meetings were being held to consider the caseload of each doctor and actively discharge appropriate service users either into the care of other professionals and/or back out into primary care. We were told that this was at the beginning of the process and there was still work to be done to ensure service users were being discharged appropriately.

As part of the redesign of the service, we were told that the model would be outcome focussed for patients, and discharge arrangements considered at the initial care and treatment planning stage to ensure service users were receiving the most appropriate care in the most appropriate environment, i.e. in primary or secondary care.

Safeguarding

Staff we spoke to were clear about their responsibilities in relation to safeguarding adults and children. Staff described a clear process for reporting any safeguarding concerns.

Safeguarding training was mandatory for staff and we saw records to show that this had been completed.

Compliance with specific standards and regulations

Mental Health Act Monitoring

We reviewed the statutory documents of two service users who were the subject of Community Treatment Orders (CTO) being cared for by the CMHT. Overall, we found the record keeping was of a high standard, organised and

easy to navigate. We found the records to be fully compliant with the Mental Health Act and well documented.

There was evidence within the documentation of good MDT input into the decision making process. We found that written information showed good knowledge of the service users, and that relationships between staff and service users appeared to be well established.

Whilst information in relation to mental health capacity assessments was included in the documentation, it was not easy to find and could be easily missed by a person not familiar with the documentation and/or service user. We were told that there was a health board wide form for doctors to complete, however we did not find these had been used in the files we looked at. The service was reminded to ensure that appropriate forms are completed to record information succinctly in relation to mental health capacity assessments.

We spoke with staff from the Mental Health Act Administrator team who provided a comprehensive overview of the process and demonstrated a high level of knowledge and understanding of the legal requirements. We found that there was some innovative practice being developed by the team, with a plan to introduce a Mental Health Act weekly clinic for service users and their families/carers where they would be able to attend and raise any issues of concern and/or seek advice about any Mental Health Act issues. We would encourage the team to drive this forward for the benefit of their service users.

An issue was raised by the team with regards to the lack of medical staff, and the impact this had on patients and tribunal hearings. We were told that tribunal hearings had often had to be cancelled or rearranged due to the lack of medical staff able to provide reports and/or attend tribunal hearings. Potentially causing disruption and delay for service users.

Improvement needed

The service should ensure that doctors are completing the appropriate forms for mental health capacity assessments.

The service should continue to make every effort to ensure their recruitment and workload of Psychiatrists enables them sufficient availability to write psychiatric reports and attend Mental Health Review Tribunal hearings(a requirement of the MHA)

Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision

We found that the CMHT were using consistently appropriate tools to assess service users' needs, and found that this addressed the dimensions of life as set out in the Mental Health Measure and the domains set out in the Social Services and Well-being (Wales) Act.

Records clearly demonstrated that there was a multi-disciplinary, person centred approach to assessment, care planning and review. We saw clear evidence that service users had been involved in the development of the care and treatment plans, and where appropriate, family members or carers were also involved.

Overall, we found that the assessment of service users' needs was proportionate and appropriate, and that relevant risks were also well documented.

Care plans were well structured, detailed, and easy to navigate. They were person centred and reflected service users' emotional, psychological, general physical health and well-being needs. We found the plans to be recovery focussed and strength based and identified goals for service users to achieve along their recovery journey.

Entries within the case files were contemporaneous with all members of the team documenting their involvement/interventions within one file.

We found that the support provided by a team of support workers to be of a very high standard. It was clear that they were included in the care planning for service users and took an active role in delivering elements of the care and treatment package to aid service user recovery. We were able to see that the support workers had developed a number of social groups, such as a football team, which had proved to be very well received and a positive example of developing relationships and service user engagement. Social care support workers were also responsible for supporting service users moving into supported living accommodation. This is accommodation solely for the use of CMHT service users as a way of helping them to live independently, as a transition arrangement supported by these workers. We recognised this as an area of good practice.

Compliance with Social Services and Well-being Act

It was clearly evident from the care documentation seen, and from discussions with service users, that their views and wishes were the main focus of the work conducted by the CMHT. Service users told us, and we saw this documented that they felt involved, included and consulted in the planning of the support services.

During inspection the principles set out in the Social Services and Wellbeing (Wales) Act 2014, regarding voice and control and co-production were evidently being supported. This is because we saw written evidence in files and were told by service users that they were being supported to actively participate in their assessments and the design of their care and treatment plans.

Quality of management and leadership

We considered how services are managed and led and whether the workplace and organisational culture supports the provision of safe and effective care. We also considered how the service review and monitor their own performance against the Health and Care Standards and the Social Services and Well-being Act.

The CMHT had been restructured in the months leading up to the inspection, and we found that it was in period of substantial change. It was positive and encouraging to find that there was a vision for the future model of the service, which was being supported by both the health board and local authority.

A number of new processes, procedures, meetings and management structures were yet to be fully imbedded into the team. This requires attention by the management team and clarification provided to staff.

We also found that there were good links and communication between the management within the health board and local authority, with good overview of the service by both authorities.

Leadership, management and governance arrangements

The CMHT had experienced substantial change in the months leading up to the inspection. In September 2018, three CMHT's across the locality merged into one, becoming The Vale Locality Mental Health Team. We were told that this had impacted upon team processes, management structures, meeting arrangements and staff well-being during the bedding in period. It was clear from our discussions with both staff and management that the service was at the start of a change process and was in a state of flux. It was encouraging, however, that a vision for the future of the service was clearly demonstrated by the management team.

The team was managed by an integrated manager whose substantive post was within the local authority. We were told that the integrated manager would shortly be seconded over to the health board whilst the overarching management structure was confirmed and embedded into the service.

The CMHT demonstrated a strong integrated leadership model, supported at a senior management level. We saw that there was a vision for the future of the CMHT, which was to deliver a service driven by patient outcomes. We found that there was commitment and positivity from the management team to deliver this. However, the new model for the service was being project managed by one individual, and we were concerned to find that this post was due to come to an end in early 2019, prior to completion of the project. The redesign of the service and implementation of the new model was at an early stage, and we discussed with the management the importance of having appropriate personnel in place to drive forward the changes to ensure it is appropriately managed and embedded. We were told that extending the post was in the process of being considered, to help ensure the service redesign was successful.

We spoke with a number of available staff, the majority of whom were positive about working in the team. Concerns were raised however as a result of the merge from three to one teams, and the uncertainty and lack of clarity regarding some key areas of work and management structures. We were told that a number of new processes and meetings had been very recently introduced, and staff were unclear about the reason and purpose of some of these. An example being a new process for MDT had been introduced the week of the inspection. Other concerns raised included:

- Lack of clear management structure
- Clarity over meetings and their purpose(s)
- Unclear process regarding allocation of cases
- Role and remit of duty and the impact on individual case loads
- End of day meeting had the potential for duplication if a medic was unavailable (staff would need to present the same information again the following day and/or to MDT).

As a consequence, staff told us that morale was low, and they felt under pressure and uncertain about the plans for the service moving forward. Whilst we saw that regular meetings were being held with staff to discuss the service redesign, staff felt that communication was poor and they did not feel involved in any decision making. We saw that respective professional meetings, i.e. nurse and social worker only meetings, were held on a regular basis, however the team did not have an all staff meeting where such issues could potentially be discussed as a team. We suggested to the management team that they consider alternative ways of communicating with staff, such as all staff team meetings, to help ensure that all staff receive the same information and messages.

Formal recruitment processes were in place and managed centrally by both the health board and local authority. Employment checks, such as qualifications, professional registration and disclosure and barring checks were undertaken respectively by the relevant teams.

We saw that staff had access to supervision, however feedback was varied about the quality and purpose of the meetings. We were told that some staff had access to good quality supervision, which was professionally driven and allowed for reflective practice. Other staff told us however that supervision was predominately about case management, and did not always allow for a wider discussion. The service must ensure that staff supervision is conducted in a robust way, ensuring that all staff have access to meaningful, professional discussions. Staff told us however that the management team were very supportive and there was an open door policy, and they were able to obtain advice as and when they required.

We saw that there were formal annual appraisals in place, managed under respective health board or local authority systems.

There was a formal complaints procedure in place (for the NHS) which was compliant with Putting Things Right[4], and a poster was displayed in the reception area for service users to easily see. We were, however, unable to see that information relating to the local authority's complaint process was displayed. This information must be displayed for service users to enable them to make a complaint.

We were told that complaints received into the CMHT would be managed by the integrated manager, and delegated onto the relevant professional lead to investigate i.e. a lead nurse would manage a health concern and a social work lead would manage a social services concern. Where a complaint implied both involvement from health and the local authority, the integrated manager would investigate. We saw examples of where process had been followed and service users concerns managed in line with the policy. We were also told that where appropriate, information would be shared with the wider health board and local

[4] Putting Things Right is a process for dealing with Complaints, Claims and Incidents which are collectively termed “Concerns”. This represents a significant culture change for the NHS in Wales in the way in which it deals with things that go wrong, introducing a single and consistent method for grading and investigating concerns, as well as more openness and involvement of the person raising the concern.

authority complaints teams to ensure that learning is disseminated appropriately. Staff told us that serious untoward incidents and concerns were recorded on the Datix[5] system and they were encouraged to do this. Staff however told us that they rarely received feedback on any concerns or issues raised. The service must ensure that feedback is provided to staff to support learning, development and to help prevent reoccurring issues.

At the time of our inspection, there were a number of vacancies in the team and some long term staff sickness. We were also told that there were some plans in place to create some additional positions to strengthen the team in support of the new service model, these additional positions had not yet been advertised. Some staff told us that they felt it would be beneficial to have a better balance of staff working in the team, meaning more social workers, as they felt this would increase the skill set and create a more holistic environment for both staff and service users.

A concern raised by staff, management and service users was with regards to the lack of continuity and availability of psychiatrists. We were told that the team had been holding vacancies for a significant period of time, and had been heavily reliant on locum doctors. The management team were very much aware of the issue and were actively trying to fill the vacancy on a permanent basis.

As mentioned previously in the report, it was also of concern that the team had significant and long term vacancies in the psychology team. This meant that service users were waiting significant periods of time for appropriate support, care and treatment. Again, the management team were very much aware of the issue and were again trying to fill the vacancy on a permanent basis.

We saw that there were good working partnerships with other agencies, such as MIND[6] and EDAS[7]. We saw examples where staff had referred to this service for support whilst on waiting lists for some psychology services, to help support them during this period of time. MIND and EDAS staff were regularly present in the CMHT and attended some multidisciplinary meetings, and appeared to have good working relationships with the team.

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[5] NHS wide electronic incident reporting system

[6] https://www.mind.org.uk/about-us/mind-cymru/

[7] http://www.e-das.wales.nhs.uk/home

Improvement needed

The service must ensure that new process, procedures, management structures, meeting structures and purposes as a result of the merge of CMHT's are clearly defined to all staff.

The local authority must ensure that information regarding complaints and the process to follow is displayed for service users to have ease of access to, to help empower them to raise a complaint.

The service must explore alternative ways of communication with all staff to ensure that they have access to the same information.

The service must ensure that all staff receive feedback following the submission of a complaint or concern.

4. What next?

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 when and how the findings identified will be addressed, including timescales
- 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.

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.

5. How we inspect community mental health teams

Our inspections of community mental health teams are announced. The service receives up to 12 weeks notice of the inspection.

Feedback is made available to service representatives at the end of the inspection, in a way which supports learning, development and improvement at both operational and strategic levels.

We check how CMHTs are meeting the Health and Care Standards 2015, Social Services and Well-being Act (Wales) 2014 comply with the Mental Health Act 1983 and Mental Capacity Act 2005. We consider other professional standards and guidance as applicable.

These inspections capture a snapshot of the standards of care within community mental health teams.

Further detail about how HIW inspects mental health and the NHS can be found on our website.

Appendix A – Summary of concerns resolved during the inspection

The table below summaries 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
No immediate concerns were identified on this inspection.			

Appendix B – Immediate improvement plan

Service: The Vale Locality Mental Health Team

Date of inspection: 4 - 5 December 2018

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.

Immediate improvement needed	Standard	Service action	Health/Social Services Lead	Responsible officer	Timescale
No immediate assurance issues were identified during this inspection.					

Appendix C – Improvement plan

Service: The Vale Locality Mental Health Team

Date of inspection: 4 - 5 December 2018

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.

Improvement needed	Standard	Service action	Health/Social Services Lead	Responsible officer	Timescale
Quality of the patient experience					
The service should ensure that outpatient and medication clinics are arranged to suit service user needs.	4.1 Dignified Care	The Acting Clinical Director has redesigned the Job Plans for the Medical Team within the Locality Team. This is designed to better reflect the needs of the service-users and to provide senior leadership support to ensure our most senior, most qualified practitioners meet the highest clinical needs. Within the job plans, the clinics and ward cover are spread more evenly across the week. Patient	Health Board Lead	Clinical Director/ SNM Community	Complete

Improvement needed	Standard	Service action	Health/Social Services Lead	Responsible officer	Timescale
		Surveys are completed and these can be used to monitor this action			
The service must ensure that all service users receive a copy of their care plan.	4.2 Patient Information SSWBA Code of Practice 3	This is standard practice, and all staff will be reminded to do so, ensuring that the CTPs are not only completed collaboratively but also with increased quality. Six monthly audits will be undertaken to review CTPs and sharing with service users.	Health Board and Social Services Leads	Clinical Director/ SNM Community	Immediate
The service must ensure that all appropriate staff attend the end of day meeting to ensure it meets the needs of both staff and service users.	3.2 Communicating effectively	The redesigned Psychiatrists' job plans are designed to ensure that there is medical cover on a daily basis for unscheduled care. This includes attendance at the end of day meetings to provide leadership and decision-making support for the clinical team.	Health Board Lead		Complete
The service must ensure that all service users are offered the	5.1 Timely access;	Fully compliant with part 4 3rd sector clinics at the locality	Health Board and Social Services	SNM Community/	Complete

Improvement needed	Standard	Service action	Health/Social Services Lead	Responsible officer	Timescale
support of an advocate and documented in service user records to show whether this has been accepted or declined.	SSWBA Code of Practice 10	team on a weekly basis provide advocacy support and signposting for service-users and their carers. The team have ensured posters providing people's rights and how to access advocacy and lodge a complaint are visible in the waiting area. Service users can be referred for Independent Professional Advocacy via the Cardiff and Vale Advocacy Gateway - http://cvag.cymru/ - if a person requires assistance to engage in any stage of the assessment process. The VLMHT will be adding this information to appointment letters.	Leads	Directorate Manager/ Clinical Board Director of Operations	
The service must inform HIW how	5.1 Timely access;	Waiting times have reduced since the amalgamation and			

Improvement needed	Standard	Service action	Health/Social Services Lead	Responsible officer	Timescale
it will provide an assessment service to services users within the target timescale of 4 weeks.	SSWBA Code of Practice 3	assessments are now provided within 4 weeks			Complete
The health board and local authority must ensure that transporting service users to a place of a safety and/or hospital is done in a timely way.	5.1 Timely access; SSWBA Code of Practice 3	Transport provision is currently being explored by the Clinical Board in partnership with the Local Authority to resolve the transportation issues for service-users requiring transport to a place of safety. A paper has been presented to the legislative committee and will be extended to the Chief operating officer to seek funding. Progress will be fed back at the next transformation meeting			August 2019
The health board and local authority should review the	6.1 Planning Care to	There is a national shortage of psychologists	Health Board and Social Services	Head of Psychology	April 2019

Improvement needed	Standard	Service action	Health/Social Services Lead	Responsible officer	Timescale
availability of psychology support and look at ways of reducing waiting times and how service users should be actively supported during the waiting period.	promote independence SSWBA Code of Practice 8	To mitigate, the use of high intensity psychological approaches by trained non psychology qualified staff is currently being explored – nurse therapist starting April 1st for 6 months and Band 7 Psychologist starting October 1st.	Leads		
The local authority must ensure that information regarding complaints and the process to follow is displayed for service users to have ease of access to, to help empower them to raise a complaint.	SSWBA Code of Practice 2	Posters providing information on how to raise a complaint are visible all of the waiting areas	Social Services Lead	SNM Community/ Directorate Manager	Complete
Delivery of safe and effective care					
The service is required to confirm to HIW when the estates issues identified will be rectified.	2.1 Managing risk and promoting	Since the inspection a room booking system has been introduced to ensure that rooms with panic buttons are	Health Board Lead	Senior Nurse Manager, Adult Mental Health	Complete

Improvement needed	Standard	Service action	Health/Social Services Lead	Responsible officer	Timescale
	health and safety	always available and are booked as required			
		The rooms are only ever used for double handed assessments and all patients are risk assessed before the room is used.	Health Board Lead	Senior Nurse Manager, Adult Mental Health	Complete and embedded as part of routine practice
		Doors leading from the waiting area to the clinical rooms now have TDSI access control installed and the necessary magnets have been ordered and will be activated as soon as they are received and installed.	Health Board Lead	Senior Nurse Manager, Adult Mental Health	Review end April 2019
Ligature point risk assessments must be undertaken and measures set in place to eliminate any risks identified.		Ligature risk assessment completed on 5/12/18. This will be reviewed yearly	Health Board Lead	Health and Safety Department	Complete
The service should ensure that doctors are completing the appropriate forms for mental	Application of the Mental	Update training in MCA, in line with the UHB actions will be delivered. Staff will be	Health Board Lead	Clinical Board Director	July 2019

Improvement needed	Standard	Service action	Health/Social Services Lead	Responsible officer	Timescale
health capacity assessments. The service should continue to make every effort to ensure their recruitment and workload of Psychiatrists enables them sufficient availability to write psychiatric reports and attend Mental Health Review Tribunal hearings(a requirement of the MHA)	Health Act	reminded of the forms – which sit neatly on PARIS – for easy use. A medical staffing plan has been agreed –with a provisional weekly timetable, demonstrating daily availability for meetings spread across the medical staff. The weekly timetable allows some flexibility to schedule both tribunal and managers hearings work for patients.			
Quality of management and leadership					
The service must ensure that new process, procedures, management structures, meeting structures and purposes as a result of the merge of CMHT's are clearly defined to all staff. The service must explore alternative ways of	Governance , Leadership and Accountability; SSWBA Code of Practice 8	A sub-group is exploring new managerial models that integrate better within existing services and ensure clinical leadership within the patient pathway across different tiers of the service within the locality. This aims to ensure greater continuity for service-	Health Board and Social Services Leads	SNM Community/ Directorate Manager/ Clinical Board Director of Operations	July 2019

Improvement needed	Standard	Service action	Health/Social Services Lead	Responsible officer	Timescale
communication with all staff to ensure that they have access to the same information. The service must ensure that all staff receive feedback following the submission of a complaint or concern.		users. For the service, it will involve changes across directorates and initiation of the Organisational Change policy. On a local level, leadership and MDT meeting structures have been revisiting to include 'Panel' style MDT meetings for staff to escalate clinical issues to the most senior clinicians in the team. An ongoing review of caseloads by senior clinicians of the junior staff's caseloads is currently being undertaken to ensure a greater adherence to evidence-based, outcome focused care.			
The health board must continue to explore ways to ensure that psychiatry vacancies are recruited into.	7.1 Workforce	Following a review of existing job plans to to make the Western Vale consultant post equitable, all medical vacancies have now been posted to recruitment.	Health Board Lead	Clinical Director	July 2019

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): **Phillip Ball**

Job role: **Senior Nurse Manager, Adult Mental Health Directorate**

Date: **11-03-19**