Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Joint HIW & CIW National Review of Mental Health Services Inspection visit to (announced):

Welshpool Community Mental Health Team, Powys Teaching Health Board/Powys Local Authority

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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 are receiving good care.

Our values

- **Patient-centred: we place patients, service users and public experience at the heart of what we do**
- **Integrity: we are open and honest in the way we operate**
- **Independent: we act and make objective judgements based on what we see**
- **Collaborative: we build effective partnerships internally and externally**
- **Professional: we act efficiently, effectively and proportionately in our approach.**

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 and focus over 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. About our review

Healthcare Inspectorate Wales (HIW) and Care Inspectorate Wales (CIW) decided to undertake a thematic review relating to mental health in the community during 2017/18. The review is primarily a response to the issues identified in community mental health services as part of the homicide reviews[1] undertaken by HIW. This review focusses on community adult mental health services (people between the ages of 18-65), looking at Community Mental Health Teams (CMHTs) and consists of inspection visits to one CMHT in each Health Board area.

As part of the overall review and in addition to the individual CMHT inspections, HIW and CIW will listen to the views of service users and carers across Wales in relation to the mental health care, support and treatment they have received in the community. Discussions will also be undertaken with representatives from stakeholder mental health organisations.

HIW and CIW will also interview senior management staff from each health board and relevant local authority. This will assist the evaluation of the extent to which leadership and management arrangements effectively support the delivery of the community mental health services that promote positive outcomes for service users and carers.

Each inspection visit will result in an individual report. A single all-Wales joint report will also be produced in spring 2018 which will detail the main national themes and recommendations identified during the course of the review.

Inspection visit to Welshpool CMHT

HIW and CIW completed a joint announced CMHT inspection of Welshpool CMHT within Powys Teaching Health Board and Powys Local Authority on 7 & 8 September 2017.

[1] See: http://hiw.org.uk/reports/special/homicide/?lang=en

The inspection team was led by a HIW inspection manager and comprised two HIW clinical peer reviewers (one of whom was the nominated Mental Health Act reviewer) and two CIW inspectors.

During the inspection visit, we reviewed a sample of ten service user case files, including a review of documentation for four patients detained under the Mental Health Act. We also interviewed CMHT staff and managers and talked to a small number of services users and/or carers and families.

HIW and CIW reviewed relevant policy documentation in advance of the inspection visit and during the visit we explored how the service met Health and Care Standards (2015). Where appropriate, HIW and CIW also considered how well the service was compliant with the Mental Health Act 1983, Mental Health Measure (2010), Mental Capacity Act (2005) and Social Service Well-being (Wales) Act (2014).

Initial feedback was provided to the CMHT and to representatives from the Powys Teaching Health Board at the end of the inspection visit, in a way that supported learning, development and improvement.

This inspection visit captured a snapshot of the experience of service users and carers/families, and of the quality of care delivered by the Welshpool CMHT. A summary of our findings are outlined within this report.

Background of the Welshpool CMHT

The Welshpool CMHT is a co-located rather than a fully integrated team. Powys Teaching Health Board and Powys Social Services provide community mental health services at Bryntirion Mental Health Resource Centre. The site provides a base for health and social services personnel as well as facilities for service user consultations, for minimal invasive procedures, and a location for meetings to be held.

From a health perspective the CMHT staff team included an area manager who also had responsibility for the crisis resolution team, home treatment teams and Welshpool and Newtown offices. Additional health employees included, community mental health nurses, support workers, occupational therapist, psychiatrists and a range of administrative support staff were available on-site. Social services staff based at Welshpool included a mental health team manager, approved mental health senior practitioners, social workers, support workers, and administrative support personnel. Psychological services are not located within the Bryntirion Resource Centre.

The referral process used by the CMHT enabled cases to be discussed at a central multidisciplinary team meeting (the hub) twice weekly. Following evaluation, and if appropriate, service users would receive an initial assessment. Following the initial assessment the case would then be brought back to the referral and assessment team for a multi-disciplinary decision regarding ongoing care/treatment.

Presently there are two electronic case management systems in operation between health and social services as well as shared paper records. There is an intention to migrate all information onto one integrated system. This migration was presently being undertaken, with the intention of reducing duplication and improving the effectiveness of the information sharing between health and social care practitioners.

2. Summary of our inspection

Overall, we found evidence of an effective and timely duty and referral management process, with good service user engagement and frontline management support. For example, multi-disciplinary meetings were held twice a week with cases referred back for initial assessment by duty workers. The results of these initial assessments were then referred back to the referral and allocation meeting which was held once a week.

Service users and carers we spoke to provided positive feedback of their experience of the service. However, we found some evidence that the service was not fully compliant with all Health and Care Standards (2015) and Local Authority Social Services Quality Standards (2015)[2]. There is a need for increased outcome focussed assessment and care planning, recognition of the importance of advocacy, of carers assessment and support and greater consistency in the completion of assessment and care planning documentation.

Welshpool CMHT has seen considerable changes since December 2015 with all mental health services now being solely delivered under the auspices of Powys Teaching Health Board and Powys Local Authority. Previously the mental health service provision was delivered by three separate health boards. This has resulted in changes in management structures in both health and social services. In addition management structures within the local authority currently include a number of interim posts. Policies and procedures reflecting the new organisational structure are not yet

[2] Contained in Code of practice in relation to measuring social services performance: issued under section 145 of the Social Services and Well-being (Wales) Act

complete and some senior management roles are not clearly understood within the CMHT.

We identified that difficulties had been encountered in relation to the recruitment of staff and this had subsequently impacted on the caseloads of current staff.

This is what we found the service did well:

- Working relationships between health and social services staff at team level
- Service users spoken with were very happy with the services and support provided
- Good cooperative working between CMHT and third sector organisations
- Peri-natal initiatives and joint working
- Effective, flexible mental health support worker service.
- Health staff felt enabled to raise concerns in an open manner with senior staff

This is what we recommend the service could improve:

- Staffing levels and evaluations of caseloads
- Completion of Mental Health Act documentation
- The quality of community treatment plans (CTP), reviews and risk assessments
- Increased focus on carers assessment and services
- Medication management

3. What we found

Quality of Service User experience

We spoke with service users, their relatives and carers and/or advocates (where appropriate) to ensure that their perspective was at the centre of our approach to inspection.

Service users we spoke to reported the location of the CMHT to be accessible and responsive to their needs. Overall patients were very appreciative of the help and support provided. This was evidenced by the significant effort service users and people made to meet with members of the inspection team in order to provide information regarding their experience of the services provided.

Service users we spoke to were positive in their feedback. They referred to the welcoming and accepting attitude of staff at all levels and the fact that they have felt central to the assessment and care management process.

There are effective processes in place to receive and respond to referrals to the CMHT Single Point Of Access (SPOA) referred to as the HUB. Although the service in general is responsive, there are waiting lists for occupational therapy and very long waiting times to receive a service from psychology services. Eligibility criteria for access to other teams providing a service for mental health service users, such as those with a learning difficulty or problems with substance misuse sometimes impacts negatively upon efficient access to those services.

Service users are not always provided with advocacy at the first opportunity and whilst carers and family members are involved in the care planning process, carers are not always offered an assessment. This may limit their access to carer support services and negatively impact upon their ability to continue to provide care.

During the inspection we spoke to four service users to obtain views on the services provided. Comments included the following:

Everyone is so welcoming

They have always been here for me, when I need them… and at times when I don't want them but do need them

I always feel central to the care planning

Without this service I would not be here

All staff go above the call of duty

Considering the lack of money, resources and cut backs, they work so hard and always respectful

Care and engagement

Overall the evidence from case file reviews and discussions with service users and staff indicated that care and engagement with service users and carers is good. In many cases the continuity of health staff in particular has supported the building of strong trusting relationships between staff and service users.

Service users interviewed commented on the warmth of the reception they have received there, from staff at all levels.

The reception area includes a comfortable waiting area and there were information leaflets provided. Most leaflets were bilingual although in some cases there was a shortage of material in Welsh. The mental health support work teams provide support to assist people to engage in community activities.

We identified good practice in relation to peri-natal service provision. We viewed protocols and held a discussion with a psychiatrist, which identified that the new protocols, policies and procedures promoted joint working between the CMHT, midwives and health visitors. The collaboration between all professionals was said to provide expectant mothers with an improved holistic service for people receiving a CMHT service.

Access to services and advocacy

The majority of referrals for secondary mental health service are sent directly to the HUB. It is recognised that some referrals also arrive at Powys Peoples Direct which is the County Council Single Point of Access. Managers were confident that information, advice and sign-posting to other services is provided effectively by duty officers, as required by the Social Services and Well-being (Wales) Act. However, processes to measure the effectiveness and accessibility of mental health services for the public are not currently in place.

Discussions at the HUB indicated that a proportion of referrals accepted by the CMHT as meeting the threshold for initial assessment, results in appointments not being taken up service users. This sometimes happens repeatedly for the same individual without any subsequent follow up by the service. This suggests that consideration needs to be given, in association with GP's and primary care services, about the way in which service users are introduced to the service and provided with encouragement to take up first appointments.

The duty team in the Welshpool CMHT is staffed by a CPN and a social worker on a daily rota basis. There are CPN link workers and counsellors operating in GP surgeries to respond to primary mental health care need. Staff and managers report there to be close liaison between primary care and the CMHT although in some cases the quality of referrals has contained inadequate information to enable effective decision making.

The HUB is attended by a varying group of staff depending on availability, and there is a rolling chair. In the session observed, there was attendance from health staff from primary care, from the older people's team, a health manager and it was chaired by a consultant psychiatrist. No social services staff were present on this occasion. A consensual atmosphere to decision making was apparent in the HUB meeting. This may mitigate against robust analysis and evaluation of the needs and requirements of service users. Senior managers should seek to encourage a culture which enables inter-professional challenge between the members of the CMHT and others in order to ensure that the holistic needs of individuals are considered with multidisciplinary input.

We identified that several referrals were not fully comprehensible due to them being completed in hand written format. We noted that some 'guess work' was observed and in addition we identified that the meeting utilised the use of acronyms. It was apparent that some staff were not fully conversant with these. As a consequence potentially, significant issues were not fully considered during the meeting due to the lack of clarity and understanding. We recommend that the use of acronyms is avoided in order to reduce possible misunderstanding and that the need for improving the quality of referral documentation is feedback to referrers.

We heard that whilst cases where there were potential safeguarding issues were referred for assessment during the HUB meeting, not all safeguarding matters were discussed in sufficient detail to ensure sound decision making. More explicit reference to potential safeguarding issues when they arise would ensure that this issue is at the forefront of practitioners' thoughts when considering the needs of vulnerable people and their families.

The CMHT operates within a complex network with other services or teams including for example: the crisis resolution team; psychology services; substance misuse services; learning disability services; primary health services and other social service departments such as housing. In some instances effective work is hampered by the impact of waiting lists, for example in the case of psychology and to a lesser extent occupational therapy. There is also a lack of shared understanding of operational practices and priorities for example with the Learning Disability Service.

The CMHT provides access to formal advocacy services in relation to the Mental Health Act and also commission's advocacy services from a third sector organisation. Evidence from case files suggested that advocacy is not offered as routinely as it should be, particularly at the initial assessment stage.

Service users interviewed stated they felt closely engaged with the assessment and care planning process and well supported to express their views. This was not always clearly illustrated by the records where there was limited evidence on some files of care plans being signed or service users being provided with copies of their assessment or care plan.

What the service does well

- Welcoming responsive reception to people accessing the resource centre.
- Provides a responsive duty service involving health and social services team members.
- Positive working relationships between primary health care services and the CMHT providing improved referral information to support efficient decision making at the hub.

Improvement needed

- Attendance at the HUB decision making meeting to ensure multidisciplinary consideration of referrals.
- Referral pathways to the learning disability service.

- Evaluation of the numbers of people not attending for appointments following referral.
- Safeguarding to be more formally considered at all hub meetings.
- Referral to advocacy to be given greater consideration at referral stage.
- Feedback to be given to referrers systematically with a view to improving the quality of referrals.

Delivery of safe and effective care

We considered the extent to which services provide high quality, safe and reliable care centred on individual service users and their carers.

Assessments were undertaken in a timely way and through a collaborative approach with service users.

Records sometimes contained very limited detail and require a greater outcome focus. Similarly whilst reviews were usually completed on time, they did not always demonstrate an analytical or evaluative approach.

Risk assessments were routinely completed. However they varied in quality and this has been identified as a development area by management. There is a need for risk assessment documentation to address risks to others more explicitly, as well as risks to service users more comprehensively.

Our evaluation of medicines management identified that there was no designated clozapine policy and procedure in operation. Nor was the environment conducive to performing clinical procedures.

Whilst mandatory safeguarding training is undertaken by all multi-disciplinary staff there is a need for staff to continuously develop their awareness of safeguarding matters in practice.

Care planning documentation was of an inconsistent standard. For example we saw limited evidence of detail around articulating desired outcomes and social, cultural and occupational aspirations. However, we also viewed strengths within the service. We heard that the service is responsive to need and provides options for service users. The support worker service is valued and provides a supportive link with community facilities and third sector services.

There is evidence that carers' needs are identified but this does not always lead to carers assessments being undertaken or services

provided in a systematic way.

There is a clear process for discharge following Multi Disciplinary Team (MDT) decisions and testimony of service users indicated that this and transfer between workers or teams was effective. Documentation to evidence the decision making process and the involvement of MDT members needs to be clearer.

Managing risk and promoting health and safety

Our evaluation of medication management identified areas requiring improvement. Presently the controlled drugs (CD) book being used was not specifically designed for that purpose. We recommend that a designated CD book is utilised to record controlled drugs in a systematic and appropriate format. We also identified, in records viewed, that daily stock checks of the controlled drugs were not undertaken in a timely manner. The All Wales Medication Administration Records (MAR) were not utilised by the CMHT. MAR charts viewed were of an inconsistent standard. Specifically we identified that NHS numbers, allergies and duration of medication were not consistently documented. We were advised that at present no formal clozapine policy, procedure/protocols were in operation. We recommend that the health board evaluate this aspect of patient medication management and introduce systems which ensure patients taking this medication are monitored and cared for in a consistent manner.

We were informed by staff that on regular occasions due to space constraints, patients would receive their medications in the counselling rooms. We saw that these rooms were not appropriate for undertaking clinical activities. In particular there was no hand washing facilities and no couches available for patients to lie on if feeling unwell.

Improvement needed

- Medication management systems must be reviewed and evaluated to include the utilisation of a designated appropriate controlled drugs book, daily monitoring of the controlled drugs and comprehensive completion of all medication administration records.

- A designated clozapine policy must be developed and implemented accordingly.

- Clinical procedures must be undertaken in designated rooms that can provide a safe environment for both staff and patients.

- Clinical procedures to be undertaken in designated rooms with appropriate hand washing and drying facilities.

Quality of care and treatment:

Assessment, Care and treatment planning and review

Case files reviewed by inspectors and interviews with staff and service users indicated that once a referral is accepted, assessments are generally undertaken promptly and include service users in a collaborative way. The quality of assessment and care plan records was variable, with some being comprehensive but others including only limited detail, particularly in relation to social care needs. Some care and treatment plans also lacked an outcome focus. Our review of case files indicated that assessments need to more explicitly identify potential safeguarding issues concerning children with whom service users have contact.

Carers

Whilst there was evidence of carers' involvement in the assessment process and reference to carers' assessments being offered in some cases, there was little evidence of carers' assessments having been completed within the documentation. Evidence was available of carer's assessments having been undertaken by a specialist worker in the past; however this practice has now been discontinued. Further development of the skills required to identify carers' needs by the wider integrated team is needed to ensure that carers receive timely and appropriate services when required.

Requests for services for carers go to a management resource panel for consideration. There are various resources from which carers' services may be derived but these are not well known, raising the question whether support for carers to continue in their caring role is always as accessible as it should be. Carers' champions have been identified in the CMHT and there is a county

wide carers' forum[3], but staff informed us that links between the forum and the CMHT are not yet well developed.

Risk assessments

Risk assessment using a specified risk tool is included routinely as part of the assessment, however our review of case files revealed that the quality of risk assessment was inconsistent.

We saw some examples of risk assessments that were comprehensive and included details about triggers and relevant mitigating actions. Some service users reported their experience of risk assessment and management as being effective and enabling them to 'feel safe'. However we also saw examples of risk assessments that lacked sufficient detail about contingency arrangements in response to risk. One risk assessment document we saw did not fully consider the possible risks to children. This variability has been recognised by CMHT management as an area for further skill development. Managers told us that there are positive links between Multi Agency Public Protection Agency (MAPPA) and Multi Agency Risk Assessment Conference (MARAC) which form part of the co-ordinated community response to address domestic violence and individuals that may present a risk to others.

Care Planning

Case file reviews evidenced that some service users were being supported to access social and leisure community activities and to develop confidence and skills through voluntary work. However, in other care plans reviewed, the recording of desired outcomes identified by service users in relation to housing, work and occupation, leisure and social involvement and the identified actions to achieve these varied in quality. Unmet needs were not being routinely recorded; this has a negative impact on the organisation's ability to identify where services need to develop.

Records and service user testimony indicated that care provision was sensitive to changes in the service user's circumstances and needs. Care plans reviewed recorded the range of services offered and accepted by service users including

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[3] The carers' engagement Forum has been set up to give carers and service users a chance to inform and enhance the work of commissioners and service providers. The forum takes part in discussions where their views and experiences are respected and valued.

one-to-one and group support, talking therapies, psychology services as well as medication treatments. Service users commented on the fact that they were provided with choice about the range of services available. The involvement of mental health support workers is a valued service and enables a range of support activity to be provided outside of office hours.

There are, however, long waiting lists (of up to 2 years in some cases) for psychology input resulting in some people not receiving the most appropriate service for them at the desired time.

Housing

Whilst there are extra care housing facilities in Newtown which can be accessed by Welshpool service users, supportive housing facilities in Welshpool as well as local resources to provide an alternative to hospital, is limited.

Reviews

Reviews of service users are, in general carried out on time and include a review of the risk assessments in addition to the care plan. In some cases we reviewed we noted additional reviews had taken place in response to changes in circumstances or because of complexity or risk. However, some of the reviews we saw were largely descriptive and lacked analytical or evaluative rigour. They frequently included the care coordinator and service user only, with input from other multidisciplinary team members not always clear. Annual reviews are recorded on the same documentation as initial assessments and this sometimes results in a lack of contemporary analysis and some duplication. Redesign of the review documentation template would provide an opportunity to encourage the inclusion of more critical analysis and a reduction in repetition.

Safeguarding

Managers told us that since the introduction of the SS&WBA, safeguarding practice and procedures have been strengthened. A dedicated safeguarding team is now in place with three permanent designated lead managers providing consistency within the CMHT. Managers were confident that mandatory training is undertaken and that staff know and understand information sharing processes. We were informed that Safeguarding is a regular topic in team meetings but there is always a need to reinforce implementation of policies and process. The reporting of safeguarding concerns is usually undertaken by Approved Mental Health Professional (AMHP).

In one case reviewed, specific risks were identified to the service user but potential risks to a relevant child were not explicitly highlighted. Similarly the

emotional well-being of the child was not sufficiently considered in the risk record. No record of referral or discussion with the safeguarding team was seen by reviewers during our inspection visit. However on further discussion with the team manager we were assured that relevant discussions and referrals had been undertaken and these had been documented accordingly.

We reviewed a record which made reference to inappropriate behaviour by an adult; however the information available within the record was not sufficiently comprehensive to provide assurances that appropriate action had been undertaken. The CMHT must ensure that all references to inappropriate behaviour are evaluated and referred in a timely manner. In addition comprehensive documentation of such incidents must be recorded. We were subsequently assured by the team manager that this matter was dealt with appropriately.

The Mid and West Wales Regional Adults Safeguarding Board[4] was described by a manager within the CMHT as a developing forum which does not yet have clear links down to the operational teams, enabling it to provide an effective lead regarding training. This means that opportunities for the professional development of safeguarding practice consistently across the region and local authority may not be fully utilised.

The lead for Mental Capacity Act and Deprivation of Liberty Safeguards[5] is taken by the safeguarding team. We were told that Independent Mental Health Advocates (IMHA) and Independent Mental Capacity Assessors (IMCA) were being used effectively by the CMHT, but that there was a backlog for assessments pending. The health board needs to evaluate the requirement for additional resources, in order to minimise this backlog.

Discharge arrangements

The process of discharge from the CMHT is dependent upon multidisciplinary team discussion and a review when required. We identified that the recording to document the discharge process, including who was involved in the closure

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[4] Regional arrangements were established to meet the requirements of the Social Services and Well-being (Wales) Act

[5] The Mental Capacity Act (2005) Deprivation of Liberty Safeguards provides a legal framework to protect vulnerable adults, who may become, or are being deprived of their liberty

decision, was not always as explicit as it could be. Evidence was seen of discharge decisions being followed up with letters to the GP and to the service user informing them of their rights to re-refer themselves to the team.

One service user told us that during a recent transfer of their care from one team to another, time was taken to enable joint working and they had 'felt safe' throughout the process. Another service user informed us that they'd had three different doctors but that the handover each time was 'seamless' and the service user felt they were always given time and attention.

What the service does well

- Service users are provided with choice about a range of services available to them.
- The support worker service is flexible to need and valued by service users.
- Service user records demonstrate the ability of the service to respond appropriately to changes in individuals' needs.
- Discharge from the CMHT or transfer of case responsibility between workers is dealt with well providing reassurance to service users.

Improvement needed

- Risk assessment documentation to include information and decision making concerning risk to others, in addition to risks for the service user, more explicitly.
- Reviews to be more analytical / evaluative.
- Increased focus on outcomes in assessment and care planning.
- Increased focus on carers needs, assessment and services.
- Increased provision of psychology service to improve access.

Monitoring the Mental Health Act

We reviewed the statutory detention documents of three patients being cared for by Welshpool CMHT.

Overall we identified that improvements were necessary in order to make patient records easier to use. Some patient records were extremely cumbersome and challenging to navigate; and there was an inconsistent filing process evident. We identified that there were numerous duplicates of documents within patient's records. Expired treatment forms were not marked as cancelled, which could potentially be confusing and risk inaccurate information being gleaned from the records. Finding relevant documentation was difficult and arduous; this would be challenging for anyone providing care to a service user with whom they were not familiar, such as a new member of staff or duty workers, carrying potential implications for service user care and safety. We recommend that regular auditing of service user records is introduced in order to improve their effectiveness.

The service user records we reviewed clearly evidenced that Community Treatment Orders had been appropriately authorised by the service users' responsible clinician. Also, grounds for opinion of the CTO (CP1 form) were appropriate and clinicians had clearly specified any further conditions. Treatment forms (Form CO8) under Part 4A Mental Health Act were evidenced as being regularly reviewed by the responsible clinician.

We viewed evidence in patient's documents of clinicians referring to supervisory community treatment (SCT), which is now outdated and does not reflect the amendments made in the Code of Practice for Wales revised 2016. SCT's should now be identified as Community Treatment Orders (CTO)

The health board must undertake an evaluation on the validity of a CTO's as we identified instances of Part 3 of the forms being signed and dated before the date completed by the AMHP at Part 2.

During our visit we were unable to confirm that relevant patients had been made aware of their legal rights as we were unable to find any documented evidence. However, following the inspection we were notified that two out of the three patients did have written evidence on file that demonstrated they were made aware of their rights. The health board are advised to evaluate this area of practice to ensure all patients are fully aware of their legal rights as identified in Section 132A of the Mental Health Act 1983 at commencement of CTO and this is documented accordingly.

We identified that there was insufficient evaluation of the use guardianship[6] within the team. We recommend that CTO and guardianship be fundamental components to be considered for use in appropriate circumstances. The development of core policies and procedures in relation to guardianship would provide additional options.

What the service does well

- Treatment forms under Part 4A were regularly reviewed by the responsible clinicians.
- Patients were provided with information about advocacy services on commencement of a CTO and extension and this was confirmed during discussions with the mental health administrator.
- Patients are kept involved in discussions relation to the extending their CTO.

Improvement needed

- Arrangements need to be undertaken to review patient's records and ensure that expired treatment plan forms are identified and clearly marked as cancelled.
- The auditing of patients records needs to be implemented and monitored in order to ensure that they are structured and maintained to a satisfactory standard.
- Patients' records must incorporate up to date guidance as identified in the Code of Practice for Wales Revised 2016.
- The health board must ensure that all patients have been informed of their rights as identified in Section 132A of the MHA (1983) and that this is documented accordingly in the patient's records.

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[6] Appointment of a guardian under the Mental Health Act 1983 to help and supervise patients in the community for their own welfare or for the protection of other people.

- Legal advice must be sought as section 20A(9) of the Act was not complied with by the responsible clinician, as the signing sequence evidenced that Part 3 was completed before Part 2 on the Form CP3 - Section 20A report extending the community treatment period.

Quality of management and leadership

We considered how the CMHT is managed and led and whether the workplace and organisational culture supports the provision of safe and effective care.

The Welshpool CMHT has undergone considerable change within the last two years due to the reorganisation of health care provision. The provision of community mental health services is now being delivered by the Powys Teaching Health Board instead of three separate health boards. Although senior managers feel this has enabled some important improvements to the service the process of developing an integrated health and social services organisation is still underway. In addition there have been a number of senior management posts within social services that have remained filled on only an interim basis over a significant period. More stability through permanent appointments to these posts would provide for greater continuity and would support service development.

There are reporting mechanisms to highlight serious incidents and arrangements are in place for the supervision and appraisal of staff. Audits of the teams' activity and practice are carried out. Limited evidence of how this performance management activity had been used to improve practice or service delivery was evidenced.

The CMHT demonstrates a commitment to training and development of staff but some opportunities for more joint and integrated training remain.

Leadership, management and governance arrangements

Staff and managers within the Welshpool CMHT stated that team members work well together with good cooperation and communication. There are different arrangements for the funding, employment terms & conditions and day to day management of health and social services staff; these were not always clear to the staff and managers we interviewed. Furthermore the roles of some senior staff within Social Services were not fully understood by staff.

There has been an extended period of change affecting the CMHT since December 2015. These changes have included the repatriation of health services back to PTHB from three separate health boards and delays encountered in making permanent appointments to key senior social services management posts. The uncertaintly created by these changes has had an adverse effect on staff morale.

Although some policies and procedures are in place and understood by staff, the rewriting of others is still outstanding since the reorganisation in December 2015. It is not clear to CMHT staff or managers who has the lead responsibility for this work or if a timesacle for its completion is in place. This leads to on-going uncertaintly and excacerbates poor staff morale.

The CMHT experiences difficulty in the recruitment of AMHPs to the extent that there has not been a full complement of permanent AMHPs over an extended period. Due to the fact that staffing levels are below their full complement, there is no contingency for dealing with the pressures when there is sickness or vacancy. Possible reasons given for difficullites in recrutiment/retention include the rurality of the area and what are percieved to be uncompetitive pay rates compared with neighbouring areas.

The service does not have an allocation waiting list. As a consequence, although described as manageable, social workers and CPNs caseloads were described as heavy and at times stressful. The workload of operational managers within the social services element of the team was described as high and stressful.

Staff reported having regular supervision and said that they feel supported by their line managers. An annual appraisal scheme was in place and managers have access to an Institute of Leadership and Management (ILM) management development programme. Our scrutiny of a small sample of staff supervision notes, supported staff observations and also reflected some of the staffing and caseload issues they identified. The notes reviewed suggested that supervision tends to concentrate on caseload management rather than clinical discussion or personal development.

A regular audit process of casefiles was in place but it was not made clear to inspectors that analysis of the audits and actions identified to address any issues was being undertaken effectively.

The CMHT demonstrated a commitment to training and development of managers through the ILM development programme. Managers were confident that manadatory safeguarding training is carried out as required by staff. To date only social services staff have undertaken SS&WBA training and in some

cases staff had not had training relating to carers. Extension of further joint training would support the team to operate as an integrated unit.

What the service does well

- Front line staff feel supported by their line managers.
- Good communication and mutual support within the operational team.

Improvement needed

- Stability of senior management roles in social services.
- Actions to address the recruitment difficulties.
- Extension of training in the SS&WBA and carers legislation.
- Comprehensive completion of all policies and procedures following the return of mental health services under the control of the health board.

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, measureable, 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.

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: **Welshpool CMHT (Powys THB & Powys Local Authority)**

Date of inspection: **7 & 8 September 2017**

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	Responsible officer	Timescale
No immediate assurance issues were identified on this inspection				

Appendix C – Improvement plan

Service: Welshpool CMHT (Powys THB & Powys Local Authority)

Date of inspection: 7 & 8 September 2017

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	Responsible officer	Timescale
Quality of the patient experience				
Attendance at the HUB decision making meeting to ensure multidisciplinary consideration of referrals.	3.2 Communicating effectively Local Authority Quality Standards (LAQS) 1h)Suitable arrangements for assessing and determining need	Consistent service representation at the HUB is key to its effective working. The Service Manager for Adult MH (PTHB) and the Senior Manager for MH (Social Service) will ensure consistent representation from the MH specialities across the agencies.	Service Manager for Adult Mental Health (PTHB) Senior Manager for Disabilities & Mental Health (PCC)	December 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
	and eligibility			
Referral pathways to the learning disability service. Referral to advocacy to be given greater consideration at referral stage.	5.1 Timely access LAQS1b) Provide services to prevent or delay people's need for care and support LAQS1g) Arrange independent advocate	A new referral pathway will be developed for clients/patients moving between Mental Health and Learning Disability Services (in respect of both, including where services are jointly delivered between NHS, Social Services and 3rd Sector partners). Practitioners will be reminded (and where required provided with further training) to ensure that where appropriate all clients who would benefit from advocacy are made aware of this service and asked whether they wish to accept advocacy services. All clients will be provided with advocacy information at point of referral.	Head of Learning Disabilities (PTHB) Senior Manager for Disabilities & Mental Health (PCC) Service Manager for Adult Mental Health (PTHB) Senior Manager for Disabilities & Mental Health (PCC) Service Manager for Adult Mental Health (PTHB)	Workshops will commence in January 2018 and the full pathway will be in place March 2018. December 2017

Improvement needed	Standard	Service action	Responsible officer	Timescale
Feedback to be given to referrers systematically with a view to improving the quality of referrals.	LAQS1a) work with partners to ensure access to clear and understandable information, advice and assistance to support people to actively manage their well-being and make informed decisions.	Outcome of Hub to be communicated back to referrer and include comments on quality of information provided generally on the date of the Hub, but within 7 working days.	Senior Manager for Disabilities & Mental Health (PCC)	January 2018
	LAQS1h) have in place suitable arrangements for assessing and determining need and eligibility.	Referrals that do not meet service access criteria are returned with feedback and recommendations for more appropriate support.	Service Manager for Older Adult Mental Health (PTHB)	February 2018
		A review will be undertaken to assess the frequency of unsatisfactory referrals. Service criteria to be developed and disseminated to partners.	Service Manager for Adult Mental Health (PTHB)	March 2017
Reviews to be more analytical/evaluative.	6.1 Planning Care to promote	Staff training in CTP will be delivered 2018 and has been included within the	Head of Clinical	March 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
	independence	Clinical Education plan. This will include a focus on person centred and outcome based care planning. All Wales Part 2 Leads Advisory Group has prepared a presentation to be implemented across Wales.	Education Head of MH Nursing & Clinical Governance Senior Manager for Disabilities & Mental Health (PCC)	
	LAQS 3a) Respond effectively to changing circumstances and regularly review achievement of personal well-being outcomes	A new Audit process will be developed along with a quality assurance process.	Service Manager for Older Adult Mental Health (PTHB)	March 2018
Increased focus on outcomes in assessment and care planning.	LAQS 4a) Support people to do the things that matter to them, to achieve their personal well-being outcomes.	As above		
	LAQS 5d) Take the views of carers into	Increase staff knowledge on services for Carers by working in partnership with Credu arranging attendance at Team Meeting and link to SS & WB Act	Service Manager for Adult Mental Health (PTHB	January 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
Increased focus on carers needs, assessment and services.	consideration when assessing care and support needs. Quality criteria; All carers who appear to have support needs are offered an assessment in their own right	Training. An evaluation will be undertaken prior to training and again after training has been completed. As part of involvement in the Parts 2 and 3 CTP Advisory Group, staff guidance on writing up SMART Goals within the CTP is currently being developed	Senior Manager Disabilities & MH Service Managers for Adults and Older Adults	February 2018
Increased provision of psychology service to improve access.	LAQS 2a)Jointly develop with partners and people the means to promote and support people to maintain a healthy lifestyle 2b) support people to access services which enable them to maintain a good	Deliver the Psychology improvement plan to reduce waiting times (in line with RTT) for access to Psychology and Psychological therapies.	Head of Psychology	Commenced in October 2017

Improvement needed	Standard	Service action	Responsible officer	Timescale
	level of mental health and emotional well-being.			
Delivery of safe and effective care				
Review of the attendance at the Hub decision making meeting to ensure multidisciplinary consideration of referrals.	2.1 Managing risk and promoting health and safety LAQS 2b) Support people to access services	Undertake a review of attendance at the HUB decision-making meeting. Adult Social Care to ensure representation of Senior Practitioner or Social Worker at all Hub Meetings within available capacity	Senior Manager for Disabilities & Mental Health (PCC) Service Manager for Older Adult Mental Health (PTHB)	January 2018
Evaluation of the numbers of people not attending for appointments following referral.		Analysis of patients DNA and development of action plan to improve performance.	Service Manager for Adult Mental Health (PTHB)	March 2018
Clinical procedures must be undertaken in designated rooms which can provide a safe environment for both staff and patients.	LAQS 3c) develop suitable arrangements for people who put their safety or that	Remedial works request has been escalated to the Estates Department for inclusion in the capital work plan.	Head of Estates	TBC following funding commitment.

Improvement needed	Standard	Service action	Responsible officer	Timescale
Risk assessment documentation to include information and decision making concerning risk to others, in addition to risks for the service user, more explicitly.	of others at risk to prevent abuse and neglect. 3e) manage risk in ways which empower people to feel in control of their lives consistent with safeguarding needs	WARRN Training has been undertaken among Practitioners and the new risk assessment form integrated into WCCIS. An Audit into the quality of WARRN will be conducted.	Complete Service Manager for Older Adult Mental Health (PTHB) Service Manager for Adult Mental Health (PTHB)	Complete April 2018
Clinical procedures to be undertaken in designated rooms with appropriate hand washing and drying facilities.	2.4 Infection Prevention and Control (IPC) and Decontamination	Remedial works request has been escalated to the Estates Department for inclusion in the capital work plan.	Head of Estates	March 2018
Medication management systems must be reviewed and evaluated to include the utilisation of a designated appropriate controlled drugs book, daily monitoring of the controlled drugs and comprehensive completion of all medication administration records.	2.6 Medicines Management	An appropriate controlled drugs ordering record book is in place Refresher training to be delivered to clinicians and an audit tool to monitor compliance to be reviewed with team	Service Pharmacist. Service Manager for Older Adult Mental Health	Complete March 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
		manager.	(PTHB) Service Manager for Adult Mental Health (PTHB)	
A designated clozapine policy must be developed and implemented accordingly.		Clozapine Policy developed and clinicians provided with training on its implementation.	Service Pharmacist	April 2018
Safeguarding to be more formally considered at all hub meetings.	2.7 Safeguarding children and adults at risk LAQS 3c) Develop suitable arrangements for people who out their own safety or that of others at risk to prevent abuse and neglect and 1k)Work with other professionals, including	All safeguarding concerns are to be considered at the HUB and followed up immediately with the referrer. Amend process to include record of risks considered in evaluation of the referral. Share safeguarding flow chart and process with hub members.	Service Manager for Older Adult Mental Health (PTHB) Service Manager for Adult Mental Health (PTHB) Safeguarding Manager (PCC)	December 2017

Improvement needed	Standard	Service action	Responsible officer	Timescale
	providers to facilitate and lead a multidisciplinary plan for care and support			
Arrangements to be undertaken to review patient's records and ensure that expired treatment plan forms are identified and clearly marked as cancelled. Auditing of patients records to be implemented and monitored in order to ensure that they are structured and maintained to a satisfactory standard. Patients records must incorporate up to date guidance as identified in the Code of Practice for Wales Revised 2016. All patients have been informed of their rights as identified in Section 132A of the MHA (1983) and that this is documented accordingly in the patient's records. Legal advice must be sought as section 20A(9) of the Act was not complied with by the responsible clinician, as the signing sequence	Application of the Mental Health Act	A full audit and review of Patients Rights Forms and Awareness of Advocacy Services was undertaken in September 2017. Learning from the audit has been implemented. A system of monitoring completion of 'Patients Rights Form' and that patient is aware of Advocacy Services has been put in place to evidence accurate administration of PTHB responsibilities in relation to the Act Legal advice has been provided on this issue. PTHB advised that although it would be usual to anticipate Part 3 of	Head of MH Operations. Head of Complex Care and MHA Administration Head of Complex Care and MHA Administration	Completed September 2017 Completed N/A

Improvement needed	Standard	Service action	Responsible officer	Timescale
evidences Part 3 is completed before Part 2 on the Form CP3 - Section 20A report extending the community treatment period.		Form CP3 to be completed before Part 2, a failure to follow this sequence does not render the applications fundamentally defective and therefore potentially unlawful. This view is based on the fact that the patient's rights under both the MHA and the ECHR have not been prejudiced in that both the RC and an AMHP has confirmed that the criteria for the extension is met and that it is appropriate to extend the CTO period. It is also the case that regulation 17 of the Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008, which is concerned with the extension of community treatment periods, makes no reference to the sequence of the RC's and AMHP's statements and reports on Form CP3.		

Improvement needed	Standard	Service action	Responsible officer	Timescale
Quality of management and leadership				
Stability of senior management roles in social services and HB. Actions to address the recruitment difficulties. Extension of training in the SS&WBA and carers legislation. Completion of rewriting of policies and procedures following organisational change.	Governance, Leadership and Accountability CIW Local Authority Core Inspection Programme Evaluation Criteria. Dimension 5: Leadership, Management & Governance Social Services and Well-being (Wales) Act 2014	A full permanent Senior Management Team are in place for Mental Health within PTHB. This includes; Assistant Director, Head of MH Nursing, Head of MH Operations and the wider senior team. A new Team Manager commenced work on 4/12/17. PCC ASC currently developing a "Workforce Plan Future Approach" for the service including MH staffing. The shorter term pressures on the service are being developed as part of the "Current Workforce Plan" including baseline staffing structure including a review of staffing structure. (Linked to PCC ASC Service Improvement Plan.) A PTHB Mental Health Policy and Documentation Group was established in January 2016. Essential policies have been prioritised and ratified. Pan Powys policies and procedures to be completed by	Joy Garfitt Assistant Director Interim Head of Operational Adult Social Care Head of MH Nursing and Clinical Governance	Complete in respect of PTHB. Ongoing in respect of PCC. February 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
		February 2018.		

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): Ruth Derrick

Job role: Head of Mental Health Operational Services

Date: 22 December 2017