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

Cynon Community Mental Health Team, Cwm Taf University Health Board/ Rhondda Cynon Taf County 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 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 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 Cynon Community Mental Health Team

HIW and CIW completed a joint announced inspection of Cynon Community Mental Health Team, within Cwm Taf University Health Board and Rhondda Cynon Taf Council, on 23 and 24 August 2017.

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

The inspection team was led by a HIW inspection manager and comprised of two 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 eleven service user case files, including a review of documentation for patients receiving care 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 who were accessing the service.

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 Social 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 Act (2014).

Initial feedback was provided to the Cynon Community Mental Health Team and to representatives from the Cwm Taf University Health Board and the Rhondda Cynon Taf local authority at the end of the inspection visit, in a way that supports 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 Cynon Community Mental Health Team. A summary of our findings is outlined within this report.

Background of the Cynon Community Mental Health Team

Cynon Community Mental Health Team provides community mental health services from Cwm Cynon Hospital. Cynon CMHT is jointly managed by Cwm Taf University Health Board and Rhondda Cynon Taf local authority.

The team is jointly managed by a senior nurse employed by the health board and the head of assessment who is employed by the local authority. Operationally, the social work staff are managed by a social work manager and the health staff are managed by a team leader who is a community psychiatric nurse.

At the time of the review, the team consisted of:

- Two consultants and one staff grade psychiatrist
- Occupational therapist
- Psychologist

- Part time forensic practitioner working across North Cwm Taf (Merthyr and Cynon)
- Social work manager
- Community Psychiatric Nurse Team Leader
- Senior social worker
- Five social workers
- Six CPN (band 6)
- Substance misuse worker
- Community care worker (social care)
- Three support workers (health)

The team also has the support of an Independent Living Team hosted by the local authority that promotes recovery.

The total team caseload was approximately 286 and the team receive between 40 – 80 referrals per month.

The team provides a wide range of services/clinics which included:

- Psychosis provision
- Depot, Clozapine and Lithium clinics
- Physical health service
- Attention Deficit Hyperactivity Disorder clinic
- Mindfulness programme
- Dialectical Behaviour therapy

2. Summary of our inspection

Overall, we found evidence that the service provided safe and effective care. 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].

The service users we spoke with were positive about the services they received. They described the accessibility of the people who work within the team. Service users told us that they felt included and respected by the choices they were given and valued the consistency in the support they received.

Overall, there were good internal communication systems in place. However, the sharing of information could be improved through a more integrated records management system.

There was a multidisciplinary, person centred approach to assessment, care planning and review. There was documented evidence to show that service users were involved, to various extents, in the development of the care and treatment plans. Relevant people such as family members or carers were also involved where appropriate.

We found a disproportionately high number of service users detained under Section 4[3] (admission for assessment in cases of emergency) of the Mental Health Act which appeared to be linked to the limited availability of Section 12 doctors[4].

Overall, we found good management and leadership with staff generally

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[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 2014

[3] Section 4 of the Mental Health Act allows emergency detainment for the purpose of assessment for a duration of up to 72 hours.

[4] A medically qualified doctor who has been recognised under section 12(2) of the UK's Mental Health Act 1983 (amended in 1995, 2007), who has specific expertise in mental disorders and has received training in application of the Act

commenting positively on the support that they received from their line managers.

This is what we found the service did well:

- Person centred approach with service user involvement in the planning and delivery of care
- Staff committed to providing a good service
- Good team working
- Good access to social, employment and educational services

This is what we recommend the service could improve:

- The consistency of care documentation
- Ensure that 'What matters'[5] conversations take place and these are recorded in case files
- Ensure care and treatment plans are shared with service users in a consistently timely fashion
- Engagement with service users, carers and families to get feedback on the quality of service needs to take place more frequently and systematically
- Ensure that the workload of medical staff allows them sufficient time and capacity to carry out the care co-ordinator role fully
- Develop a more integrated IT and records management system
- Ensure that Disengagement Policy is aligned with the Mental Health Act requirements

[5] A structured conversation between professionals and service users to determine what they value most and how they wish to be cared for.

3. What we found

Quality of service users' experience

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

The service users we spoke with were positive about the services they received. They described the accessibility of the staff who work within the team. They said they were provided with choice and that they valued the consistency of the support they received.

Service users told us that they were treated with dignity and respect by staff. The service had a system in place to enable service users to raise concerns/complaints and the service was able to demonstrate that they considered feedback to improve services.

Service users made positive comments, particularly about the relationships they had with staff.

During the inspection we spoke to service users and carers to obtain views on the services provided. People's comments included the following:

'Staff go out of their way to provide support'

'Felt treated as a friend rather than a service user'

Care and engagement

Overall, we found the quality of service user care and engagement to be very good.

Throughout the duration of the inspection we were available to speak with service users, their relatives, carers and/or representatives all of whom spoke positively of the service and support provided by the CMHT. Service users confirmed that contact numbers have been provided to them and that they knew who to contact for support out of office hours.

Service users spoke highly of the professionals who work within the team and added that there was always someone to speak to even when their named care

co-ordinator was not available. This included good support from the 'out of hours' Crisis Resolution Team.

The CMHT building was accessible to people with mobility problems. The waiting area was clean and tidy and well maintained. The consulting rooms were fit for purpose, well maintained and adequately furnished and decorated.

We saw that there were health promotion leaflets and posters available within the waiting area together with magazines for people to read whilst waiting to be seen.

There were good records on file about service user's language needs and we were told by managers that staff make an 'Active Offer' for service users to receive information in a language of their choice. Staff said that that provision for services through the medium of Welsh was being met, but the demand was low. One staff member within the team was Welsh speaking and translation services were available for any person wishing to communicate in languages other than English.

There was evidence on files reviewed that service users were involved in the development of their care plans with statements phrased in service users' words. There were also file recordings that decisions were being made jointly by service users and professionals.

The team had held engagement events with service users and carers in 2015 and 2016. The attendance at the event in May 2016 had been low (7 people), but managers said that it provided useful feedback.

Access to services and advocacy

We found access to the service and the referral process to be good.

The team has a duty system in place where a duty officer receives and manages calls from a number of different sources such as other health or social care professionals or police. 'Relevant patients'[6] can also refer themselves

[6] Patients who have previously been under the care/treatment of the CMHT.

directly to the service. However, in the main, referrals were received via general practitioners.

Referrals are reviewed at weekly Single Point of Entry Meetings which are usually attended by a combination of team managers, duty officers, members of the older people community mental health team, substance misuse service, psychiatrist and psychologist. We observed one of these meetings during the inspection and found that information was shared and considered in an appropriate way which meant that service users received timely care.

We were informed that referrals that require an assessment under the Mental Health Act were passed to the duty Approved Mental Health Professionals (AMPH) for action and are dealt with in a timely way.

When appropriate, and where referrals did not meet the threshold for secondary care, then service users are referred by the duty officer to other services better placed to meet their needs.

We found that the team had good links with the crisis team and outreach and recovery team. Also, we were told that these teams often worked together to support service users.

Staff members spoken with told us that people with caring responsibilities are identified and offered a formal assessment of their needs as directed by the Social Services and Wellbeing Act. However, in the individual care files examined there was often a lack of written evidence that a carer had been clearly identified or that a carer's assessment had been offered. There was no clear prompt on the assessment forms to encourage the recording of this information.

One of the social workers within the team was designated as a 'carers' champion' who promoted good practice on supporting carers within the team.

We were told by staff that access to Independent Mental Capacity Advocates (IMCA) and Independent Mental Health Advocates (IMHA) was generally good. We were informed by staff that there was little demand for more general advocacy services although this service was being offered and arranged where needed. However, the information on the case files we reviewed did not support that this service was being offered.

Staff members we spoke to informed us that the allocation of workload to care co-ordinators was effectively managed. The team is jointly managed and cases are allocated to care coordinators on the basis of the most appropriate person to work with a particular service user who is available. However, we found

some instances of medical staff taking on a care co-ordination role, but who were not able to fully carry out their responsibilities as care co-ordinators due to other work pressures and high caseloads.

What the service does well

Service users, their relatives, carers and/or representatives spoke positively of the services and support provided

Good access to service with responsive referral process

Good multi-disciplinary working at the Single Point of Entry meetings

Good links and joint working with the crisis team and outreach and recovery team

Improvement needed

Need to record on case files where there are people with caring responsibilities and that a carer's assessment has been offered, and include a prompt on the assessment forms to encourage the recording of this information

Need to record on case files that advocacy has been offered. Advocacy needs to be proactively offered and a record of this offer recorded

Ensure that the workload of medical staff allows them sufficient time and capacity to carry out the care co-ordinator role fully

There should be regular engagement events with service users and their families to provide feedback about the services provided by the team

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.

The sample of service user records we reviewed were well set out and easy to navigate. However, we identified gaps in the information and some inconsistencies in the way that some staff were completing records.

Our review of records highlighted that information about physical health checks was sporadic.

Evidence was found in the files that care coordinators review cases on a yearly or more frequent basis if required.

Case files are monitored through case file audits which are carried out jointly. Cases were found to be reviewed appropriately on a yearly or more frequent basis.

Overall, there were good internal communication systems in place. However, the sharing of information could be improved through a more integrated records management system.

There was a safeguarding of children and vulnerable adults' policy in place and staff had completed training in this subject.

Risk assessments were generally comprehensive and included details about triggers and relevant mitigating actions. However, we also saw examples of risk assessments that lacked sufficient detail about contingency arrangements in response to identified risks.

General and more specific risk assessments were undertaken in most cases and any areas identified as requiring attention were actioned.

Managing risk and promoting health and safety

There were policies and procedures in place to minimise risks to members of staff. There was a lone working policy in place which had been jointly signed off, and we were told that the team operated an 'end of day' procedure for staff to report in when they had completed their shift.

Quality of care and treatment

Assessment

The assessment format has been standardised to cover the eight domains of the Mental Health Measure. Overall, we found that the assessment of service users' needs was, in the most part, proportionate and appropriate. In some cases, the assessment document was completed in more detail than others. This was also the case for the document used for the assessment of risk.

We reviewed a sample of eleven case files and found the quality of record keeping to be variable with some inconsistencies, particularly around the detail of some care and treatment plans, risk assessments, record of advocacy being offered, carer assessments and lack of service user signatures.

There was a multidisciplinary, person centred approach to assessment, care planning and review. There was documented evidence to show that service users were involved, to various extent, in the development of the care and treatment plans and relevant people such as family members or carers were also involved where appropriate. However, there was no evidence on a minority of the files seen of a 'what matters' conversation having taken place.

Most of the case files reviewed contained documented evidence to show that 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, were being considered as part of the assessment and care planning process.

Risk assessments, using a specified risk tool, were included routinely as part of the general assessment process. 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. However, we also saw examples of risk assessments that lacked sufficient detail about contingency arrangements in response to identified risks.

Care and treatment planning and review

We found the plans to be generally well structured and person centred and reflected service users' emotional, psychological and general health and wellbeing needs. The paper case files reviewed were relatively easy to navigate. However, unmet needs were not routinely recorded.

We saw evidence on the care files inspected to show that service users were supported to access a range of external services including social and leisure community activities, housing support and help accessing benefits, and to develop confidence and skills through voluntary work.

Records viewed and discussions with service users indicated that care provision was sensitive to changes in the service user's circumstances and needs. Care plans we saw recorded the range of services offered and accepted by service users as well as medication treatments. Service users told us that they were given a choice of services and that the team's response to changing needs was timely and effective.

Statutory reviews, in general, were carried out on time. In some cases we noted additional reviews were seen to take place in response to changes in circumstances or because of complexity or risk.

We identified some delays in copies of care and treatment plans being sent out to service users. In the two longest delays we found, in one case there was a delay of 2 months and in another case a delay of 4 months.

Safeguarding

Staff that we spoke with were clear about their responsibilities in relation to safeguarding adults and children. They were also able to describe the reporting processes.

The training information viewed during the inspection evidenced that staff had received adult and children safeguarding training.

Managers told us that a dedicated safeguarding team, referred to as the 'hub' was now in place to manage and process safeguarding referrals. This arrangement was reported to be working well.

Discharge arrangements

From examination of case files and discussions with staff we found evidence that discharge arrangements were generally satisfactory with some detailed discharge care plans in place. In some cases, the patient themselves instigated discharge and this was undertaken in collaboration with the multidisciplinary team. However, we did find examples where the care and treatment plan and risk assessment had not been updated prior to discharge with potential consequences for engagement issues with the service user following their discharge.

We were told that where discharge is being considered, all cases are brought to a multi-disciplinary meeting held each Thursday to review the appropriateness of discharge. Clear processes are in place around the discharge and section 117[7] aftercare so that service users are aware of their rights.

We saw evidence that the service users were advised of their right to re-refer into the service following their discharge.

What the service does well

Multidisciplinary, person centred approach to assessment, care planning and review

The care provision was sensitive to changes in the service user's circumstances and needs

Improvement needed

Ensure consistency of information entered on assessment documentation and risk assessments

[7] Aftercare is the help service users get in the community after they leave hospital. This can cover all kinds of things like healthcare, social care and supported accommodation.

Ensure that the 'what matters' conversation takes place and that this is noted on individual care files

Ensure that the dimensions of life, as set out in the Mental Health Measure and the domains set out in the Social Services and Well-being Act, are being considered as part of the assessment and care planning process in every case

Ensure that copies of the Care and Treatment plans are forwarded to service users in a timely fashion

Ensure that care and treatment plan and risk assessment are updated prior to discharge

Monitoring the Mental Health Act

We were told by staff that there were very few community treatment orders (CTO)[8] in place at the time of the inspection and that, where CTOs had been used, they had been effective in managing service users' care needs.

We looked at case files relating to seven service users whose care had been managed through Community Treatment Orders.

We found the record keeping to be generally good and in accordance with the requirements of the Mental Health Act. There was evidence within the documentation of appropriate consultation with the service user, their carer (where appropriate) and other professionals. There was also clear documentation relating to reviews of the CTO and clear recording of circumstances where service users, under their CTO, were issued with recall notices within appropriate time scales and their CTO was revoked after period of assessment.

We saw evidence of service users being discharged from their CTO when their condition had improved, which further demonstrated least restrictive approach.

[8] A Community Treatment Order (CTO) is a legal order made by the Mental Health Review Tribunal or by a Magistrate. It sets out the terms under which a person must accept medication and therapy, counselling, management, rehabilitation and other services while living in the community.

We also saw examples of when CTOs had been revoked due to the service user not engaging and not complying with the conditions as set out within their CTO. However, we identified that on these occasions, service user risk assessments were not always being reviewed at the point where CTOs had been revoked.

We were shown a copy of the service's procedure for the management of service users who disengage from Care and Treatment Planning and considered that this needs to be reviewed to ensure that it is fully aligned with the requirements of the Mental Health Act in respect of entitlement to aftercare.

There was evidence to show that members of the team who were approved mental health professionals (AMHP) were involved in assessments and in drawing up the terms of CTOs and in the review and revoking process.

We found reference within some case notes to stipulate whether or not the service user was self-advocating. However, there was no record of independent advocacy support being offered or used. We did find documented evidence on one service user file which showed that they had been supported at CTO reviews by their solicitor and an advocate.

We spoke with the Mental Health Act Administrator who told us that there were formal systems in place for the effective distribution of documentation to the Community Mental Health Team. The Mental Act Administrator provided up-to-date information around numbers of service users detained under the Mental Health Act. However, there appeared to be a disproportionate number of service users detained under section 4. On speaking with an approved mental health professional and senior managers, there appeared to be a correlation between limited numbers of Section 12 doctors and the elevated number of assessment where the use of Section 4 detentions were used.

What the service does well

AMHPs are always invited to review CTOs

Improvement needed

Ensure that risk assessments are reviewed at the point when CTOs are revoked

Review and amend the procedure for management of service users who disengage from Care and Treatment Planning to ensure that it is fully aligned with the requirements of the Mental Health Act

Reduce the number of Section 4 admissions as a consequence of the unavailability of Section 12 doctors

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.

Overall, we found good management and leadership with staff generally commenting positively on the support that they received from their line managers.

Staff told us that they were treated fairly at work and that they felt that an open and supportive culture existed. Staff also told us that they were aware of the senior management structure within the organisation and that the communication between senior management and staff was generally effective.

We found that there were good links and communication between the management within the health board and local authority as well as good overview of the service by both authorities. However, we found that a number of organisational documents provided to us covering protocols, policies and process, had not been reviewed recently and within the given timeframe.

Leadership, management and governance arrangements

Throughout the inspection we spoke with members of the management team and available staff, the majority of whom were very positive and upbeat about working in the team. They said they felt well supported by line managers and their peers.

The team management was not integrated, but run through good partnership working. This appears to work well due to the positive working relationships between the individual managers. It was noted that all the senior staff have been in post for many years, and this contributed to the stability of the team.

Staff members told us that the management arrangements were working well at team level. However, more integration was required at senior management level particularly around the joint policies and procedures, finance and complaints management. Many of the organisational policies had not been reviewed within their stated timescales, some by several years.

We confirmed that there was a formal staff recruitment process in place with evidence of required background checks being undertaken. The staff interviewing process was competency based with record of the interview retained on staff files. Formal contracts and job descriptions were issued to staff by the health board or the local authority respectively.

We spoke with a recently appointed member of staff who told us that there was a formal induction process in place and that they were well supported by more experienced colleagues and their line manager.

We looked at a sample of seven staff supervision files (six employed by the health board and one employed by the local authority). We saw that there was a formal staff support and supervision process in place with regular one to one meetings being held between staff and their line managers. In addition to one to one meetings, staff told us that they received day to day, informal support from their line managers who were reported as being very accessible. We found that there was a formal annual appraisal process in place managed under respective health board or local authority systems.

Sickness levels and turnover of staff within the team was low with any absences being managed by the other team members absorbing the additional workload. Staff felt that this was the best option, in the short term, as it allowed for a degree of continuity of care enabling service users to receive services from staff that they were familiar although bank staff cover was available if needed. Staff members also told us that the workload had increased recently. Team managers said that the social work caseloads, in particular, were rapidly increasing to appoint where they were near maximum capacity. It was unclear whether this information had been communicated as an issue to senior management.

It was observed that AMHPs from the team were having to carry out assessments elsewhere in the local authority area because of a lack of Section 12 doctors being available. This had a knock on effect on the workload of other staff in the team. The health board and local authority should monitor staffing levels and take action to limit the pressure on staff ensuring that the quality of service offered to service users is not compromised. A whole system view should be taken of staff requirements.

Staff we spoke with told us that they were able to access mandatory and other service specific training.

There were formal governance arrangements in place with monthly area team meetings. These meetings are minuted, copies of which are shared with team members. The senior leadership team also meet on a regular basis and made themselves available to team members through visits to the office.

There was a formal complaints procedure in place which was compliant with 'Putting Things Right'[9] and the local authority's formal complaint process. Information about how to make a complaint was posted in the reception/waiting area.

Emphasis was placed on dealing with complaints at source in order for matters to be resolved as quickly as possible and to avoid any further discomfort or distress to the complainant as well as any need for escalation. All complaints are recorded whether received verbally or in writing. All complaints are brought to the attention of the team managers who deal with them in line with the respective health board or local authority policy. We found that more could be done to integrate the complaints handling policy to avoid duplication of process.

We were informed that serious untoward incidents (SUIs) and concerns were discussed at a weekly joint agency meetings and any learning disseminated to the team through the team managers.

Audits of care files were being undertaken on a regular basis by the team managers as a quality assurance and clinical governance measure.

We found the internal communication systems to be good with joint overview and governance by both the local authority and health board senior management teams. However, we identified that a number of organisational

[9] 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.

documents provided to us covering protocols, policies and process, had not been reviewed recently and within the given timeframe; this could result in staff not being provided with clear up to date guidance.

What the service does well

Good management overview of the service

Good formal and informal staff support and supervision processes

Good access to mandatory and service specific training

Improvement needed

More integration is required at senior management level particularly around the development of joint policies and procedures, finance and complaints management

There needs to be clear systems in place to ensure that senior managers are kept fully updated on the workload pressure being experienced by staff.

A whole system review of staffing requirements should be undertaken, particularly around the requirements for section 12 doctors and AMHPs to ensure that the quality of service offered is not compromised.

Organisational policies need to be reviewed to ensure that up to date integrated guidance is provided to staff

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, CIW 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 and CIW 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 and CIW's websites.

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 during this inspection.			

Appendix B – Immediate improvement plan

Service: Cynon Community Mental Health Team

Cwm Taf University Health Board & Rhondda Cynon Taf County Council

Date of inspection: 23 and 24 August 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 during this inspection.				

Appendix C – Improvement plan

Service: Cynon Community Mental Health Team

Cwm Taf University Health Board & Rhondda Cynon Taf County Council

Date of inspection: 23 and 24 August 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 service user's experience				
Ensure that copies of the Care and Treatment plans are shared with service users in a consistently timely fashion.	3.2 Communicating effectively LAQS 2c Encourage and empower	1. To be raised and enforced at all team meetings with staff 2. Review the training package and reinstate the training programme with CTP lead 3. Review impact of training and policy review / implementation through audit in line with that undertaken by Delivery Unit	Team Manager/Senior Nurse/LA Team Managers CTP Lead/ Senior |Nurses/LA Team Managers	Immediate Training package to be delivered from April 2018 Sept 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
Ensure that the 'what matters' conversation takes place and that this is noted on individual case files.	6.1 Planning Care to promote independence LAQS 1c Work with people to undertake assessments in a timely manner	1. To be raised and enforced at all team meetings with staff 2. Review the training package and reinstate the training programme with CTP lead 3. Review impact of training and policy review / implementation through audit in line with that undertaken by Delivery Unit	Team Manager/Senior Nurse/LA Team Managers CTP Lead/ Senior |Nurses/LA Team Managers	Immediate Training package to be delivered from April 2018 Sept 2018
Advocacy to be proactively offered and recorded on case files.	6.2 Peoples rights LAQS 1g Arrange independent advocate	1. Ensure all information regarding accessing Advocacy is available to staff 2. To be raised and enforced at all team meetings with staff 3. Review the training package and reinstate the training programme with CTP lead	Senior Nurse/LA Managers Team Manager/Senior Nurse/LA Team Managers CTP Lead/ Senior |Nurses/LA Team Managers	Immediate Immediate Training package to be delivered from April 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
		4. Review impact of training and policy review / implementation through audit in line with that undertaken by Delivery Unit		Sept 2018
Establish regular engagement events with service users and their families to provide feedback about the services provided by the team.	6.3 Listening and Learning from feedback LAQS 2c Encourage and empower	1. Issue on the agenda for CTP Delivery group 2. Included in the IMTP as a priority for the coming year.	Team Managers LA and Health. Service user involvement forum	Already in planning phase with delivery April 2018
Delivery of safe and effective care				
Review use of medical staff as care co-ordinators to ensure that their caseload is manageable and allows them sufficient time and capacity to carry out the care co-ordinator role fully. Ensure that the dimensions of life, as set out in the Mental Health Measure and the domains set out in the Social Services and Well-being Act, are being considered as part of the assessment	1 Safe and Clinically Effective care LAQS 1h Suitable arrangements for assessing and determining need and eligibility LAQS 3a	1. The Directorate and LA are planning to review CMHT model fully commencing 2018 and are committed to reviewing the delivery of all services including the roles & functions of Care Co-ordination 2. Reinstate CTP training with CTP lead	Directorate Management Team/LA Senior Managers CTP Lead	April 2019 April 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
and care planning process in every case. Ensure that care and treatment plan and risk assessment are updated prior to discharge.	Professionals respond effectively to changing circumstances and regularly review achievement of personal well-being outcomes	3. To be raised and enforced at all team meetings with staff 4. Review the training package and reinstate the training programme with CTP lead 5. Review of documentation particularly in line with WCCIS All Wales Documentation 6. Review impact of training and policy review / implementation through audit in line with that undertaken by Delivery Unit	CTP Lead/ Senior |Nurses/LA Team Managers	April 2018 Sept 2018
Develop a more integrated IT and records management system. Ensure that the IT system is robust and consistently available to staff.	3.4 Information Governance and Communications Technology	1. Cwm Taff is committed to signing deployment order for WCCIS once relevant assurances in place. RCT and Merthyr Local Authorities already signed. 2. Project lead in place to support he delivery of WCCIS as a consistent system across Cwm Taf footprint	ADO/Director	September 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
Case files to reflect people with caring responsibilities and that a carer's assessment has been offered and include a prompt on the assessment forms to encourage the recording of this information. Ensure consistency of information entered on assessment documentation and risk assessments.	3.5 Record keeping QSLA 5d Take views of people's carers into consideration	1. To be raised and enforced at all team meetings with staff. Business process in place for this and staff to be reminded 2. Review the training package and reinstate the training programme with CTP lead 3. Review of documentation particularly in line with WCCIS All Wales Documentation 4. Review and re-deliver up-dated risk assessment training 5. Review impact of training and policy review / implementation through audit in line with that undertaken by Delivery Unit	Senior Nurse/LA Managers/CTP Lead Team Manager/Senior Nurse/LA Team Managers	April 2018 Sept 2018
Risk assessments to be reviewed at the point when CTOs are revoked. Review and amend the procedure for management of service users who disengage from Care and Treatment Planning to ensure	Application of the Mental Health Act	1. Review and re-deliver up-dated risk assessment training 2. Review of disengagement Policy 3. Review impact of training and policy review / implementation	Associate Clinical Director	April 2018 Sept 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
that it is fully aligned with the requirements of the Mental Health Act.		through audit in line with that undertaken by Delivery Unit		
Quality of management and leadership				
Explore integration at senior management level particularly around the development of joint policies and procedures, finance and complaints management. Organisational policies need to be reviewed to ensure that up to date integrated guidance is provided to staff.	Governance, Leadership and Accountability	1. Directorate Management Team to work with Local Authorities to consider joint policies around finance and complaints management 2. Review Policies and procedures and up-date where necessary	HoN Directorate Manager	April 2018 June 2018
Ensure that clear systems are in place to communicate information about workload pressures between the team managers and senior managers. Undertake a whole system review of staffing requirements with particular regard to the number of Section 12 doctors and AMHPs and how they are deployed to ensure that the quality of service offered is not compromised.	7.1 Workforce	1. Case load weighting system to go live in early 2018 to help support the demand capacity between the services 2. Local Authority have committed 3 extra places for AMPH training for September 2018 and are committed to a minimum of two training places per year 3. Review of CMHT to look at the use section 12 doctors	HoN senior Nurse/LA Team Manager	April 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
		4. Review of Psychology and psychological therapies commenced and medical review will commence following appointment of CD		

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): Philip Lewis

Job role: Head of Mental Health Nursing

Date: 20.12.17