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

The Links Community Mental Health Team (CMHT), Cardiff and Vale University Health Board/Cardiff 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 W

Our values

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

- **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 The Links Community Mental Health Team (CMHT)

HIW and CIW completed a joint announced inspection of adult community mental health services at The Links CMHT within Cardiff and Vale University Health Board and Cardiff Local Authority on 2 and 3 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 twelve service user case files in total. This included a review of care and treatment plans (CTP's) and documentation for three patients on Community Treatment Orders (CTO's) who were subject to the application of the Mental Health Act (MHA) 1983. We also interviewed CMHT staff and managers and talked to a small number of service 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 Social Care Standards (2015). Where appropriate, HIW and CIW also considered how well services comply with the Mental Health Act (MHA) 1983, Mental Health Wales Measure (2010), Mental Capacity Act (MCA) 2005 and the Social Services and Well-being (Wales) Act.

Initial feedback was provided to the CMHT and to representatives from Cardiff and Vale University Health Board and Cardiff Local Authority 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 Links CMHT. A summary of our findings are outlined within this report.

Background of The Links CMHT

The Links CMHT is the oldest and largest of the eight CMHTs that provide multidisciplinary community mental healthcare and social services within the area of Cardiff and the Vale of Glamorgan.

The Links provides secondary mental health and social care services to the communities of Splott, Adamstown, Tremorfa and Roath within an area that includes a University, HMP Cardiff and an Asylum Seeker Dispersal Centre.

As part of the health board and local authority's community mental health ongoing 'all system review of provision', it has been identified that there are significant variations in the levels of deprivation, (a key indicator of psychiatric morbidity) between the CMHTs and this has established that The Links catchment area reflects the highest levels of deprivation.

At the time of the inspection the caseload of The Links was 520 open and active cases, which had significantly reduced since 2014. This reduction was

achieved through a concerted effort by staff at the CMHT, working closely with their GP colleagues, combined with a proactive case load management system, adopted by the CMHT manager, Community Psychiatric Nurse (CPN) lead and the Social Work manager. The work on reducing caseloads at The Links had been carried out as a result of HIW's homicide review in 2014[2].

Patients within primary care can be referred to the CMHT through their GPs, or they can self-refer, which initiates an integrated screening and assessment process.

The CMHT includes a range of disciplines including psychiatry, psychology, physiotherapy, dietetics, nursing, health care support workers, social work and occupational therapy. The team also includes a number of administration and reception staff. The team is able to signpost referrals to other agencies where the presenting problem is not a core focus or remit of the CMHT. This includes, for example, referrals for primary care, counselling and drug and alcohol problems.

[2] Report of a review in respect of: Mr L and the provision of Mental Health Services, following a Homicide committed in October 2012

http://hiw.org.uk/docs/hiw/reports/140925mrlhomicidereporten.pdf

2. Summary of our inspection

Overall we found evidence that The Links CMHT provides safe and effective care and that service user satisfaction was high.

We have also identified some areas for improvement. The most notable area for improvement is the environment, which is run down, with actions identified within environmental risk assessments requiring implementation to ensure all risks are being appropriately managed.

Service users told us they were pleased with the service they received. The CMHT staff members we spoke with were professional, committed and highly motivated in the care of their service user group and this was reflected in what service users told us during the inspection.

There were systems in place to promote safe and effective care, from referral, assessment, care and treatment planning, through to discharge. We found a number of proactive initiatives being developed to help improve service users' experience of services. Generally record keeping was also of a good standard. However, aspects of record keeping, medicines management, safeguarding practice and integration of advocacy services required improvement.

Overall we found management and leadership to be effective and staff told us they felt supported. There were good opportunities for more specialist training and staff had access to supervision and performance reviews. Aspects of mandatory training requirements, volume of psychiatrists' caseload and arrangements for service user feedback required improvement.

This is what we found the service did well

- Service users we spoke with were extremely positive about staff and the service they provided. Interactions we observed between staff and service users were kind and respectful
- Staff were committed, service user centred and passionate about their work

- Members of the CMHT worked collaboratively and effectively as a multidisciplinary team and there was evidence of good working relationships with other services and agencies

- CMHT staff across a range of disciplines are involved in improvement initiatives and projects that are being trialled with the aim of improving service users' experiences of services

- Regular referral and multidisciplinary team (MDT) meetings promote good communications within the team

- There was evidence of supportive leadership within the CMHT

- Good access to more specialist training and development opportunities for staff.

This is what we recommend the service could improve

- The environment is run down and a number of health and safety, fire, security and environmental actions have been identified in the service's own health and safety risk assessments. Actions identified in these assessments require implementation to ensure risks are being appropriately managed and to ensure the building is fit for purpose. Sustainable plans for the CMHT being run in an appropriate environment, must be put in place

- Information must be provided in accessible formats to meet service users' needs

- Advocacy services should be more integral to the care and treatment planning process

- Case reviews should be planned in a more systematic way to ensure timeliness

- Carers' assessments should be routinely offered and their response recorded

- Aspects of medicines management require improvement

- Safeguarding checks must be consistently carried out and recorded

- Psychiatrists' caseloads must be safe and manageable, particularly given HIW's findings following the Mr L homicide in 2014

- Staff must be brought up to date with all mandatory training topics

- Ensuring all service users and their carers are empowered to provide feedback on services on an ongoing basis, with results being used in a meaningful way, to improve standards.

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 the service users' perspective are at the centre of our approach to inspection.

Service users we spoke with during the inspection spoke highly of the care and support they received at The Links. They felt the CMHT was accessible, they could come to The Links any time and they knew how to contact members of the team when they needed to.

We saw staff engaging with service users in respectful and helpful ways and there were a number of proactive initiatives that were being run by passionate and dedicated staff to promote service user engagement.

Improvements are required to ensure that advocacy services are embedded into the service, that information is made available in accessible formats, and to ensure referral meetings run as effectively as possible.

During the inspection we spoke with a number of service users attending the CMHT to obtain their views on the services provided as well as service users from the football team, run by members of the CMHT. We also offered service users the opportunity to complete questionnaires to provide their views. Comments included the following:

> *"I am feeling better, I don't see my CPN now, but I know how to contact him if I need him and I come here to see people"*
>
> *"My Support Worker is marvellous and always sorts things out for me when I have problems"*
>
> *"I am really grateful for the out of hours services, it's great knowing there's someone there for me at the weekends when I tend to feel a bit down"*

"The team go above and beyond, my care worker visits every other week, I feel supported, I get advice about my medication, my consultant is accessible if I need to see him"

"The setting for the appointments is dismal, today the outside entrance of the CMHT smells of urine"

"…The reception staff always treat me with respect and courtesy and go out of their way to help and if I phone I always get help or directed to the most appropriate health professional".

Care and engagement

Overall, the evidence from reviewing case records, discussions with service users, staff and observations of staff and service user interactions indicated that care and engagement was of a high standard. There were well established relationships between service users and staff. Service users were treated with dignity and we saw that engagement between CMHT members and service users was respectful and professional.

We observed a warm welcome from the reception staff for all service users. They were offered a hot or cold drink and reassurance where needed. They were quickly put in touch with the staff member they needed to see. There was a wide range of up to date information on display about The Links, local help groups, appropriate health promotional resources, advocacy details and community activities and support. Health promotion boards were rotated so that service users had access to a variety of information on an ongoing basis.

Although there was a wide range of information on display, there was a lack of information available in different languages and formats. Information was also not fully compliant with the Welsh Language Act. Information and signage was not bilingual, the telephone was not always answered bilingually and written information was not routinely provided in Welsh (or other languages). Staff used interpreting services where needed. However, we found that there were sometimes difficulties in accessing interpreters of certain languages, e.g. Albanian, which was made more difficult when interpreters were required at short notice.

We saw excellent multidisciplinary working, to ensure the care and treatment offered to service users was coordinated and the most appropriate form of intervention.

There were a number of proactive initiatives that supported service user engagement and wellbeing running at the CMHT, led by core CMHT staff, such as, for example, a football team. Some of these initiatives are detailed further in

the report below. This was an area of noteworthy practice in terms of how the CMHT promoted care and engagement both formally, and informally, with service users.

Access to services and advocacy

The majority of referrals to the CMHT come from primary care services, usually the GP, although self referrals are also accepted. We saw that an improved referral framework between the CMHT, GPs and practice managers had been developed and was improving the quality and timeliness of GP referrals. Referrals were collated to ensure compliance with the Mental Health (Wales) Measure. The team provides a telephone advisory service about the best way to access assessments.

Overall we found evidence of an effective and systematic referral management process. All referrals are considered on a daily basis by a member of the CMHT and are systematically prioritised for initial screening and subsequent assessment by the MDT. Following the initial referral, (urgent cases are screened on the same day) the case is then discussed by the MDT for a team decision regarding next steps. We saw that outcomes of referral discussions are provided to both the service user and the referrer with detailed feedback. Sometimes this included further advice and/or signposting to other services.

We observed an MDT referral meeting and overall we found it to be an effective forum for information sharing and decision making, with good prioritisation. However, we noted that in a small minority of cases, limited contextual information was provided in the meeting which meant that there was a delay in reaching a decision/outcome on the case and therefore a delay in service provision. It would be beneficial for all staff members to bring full and detailed research and background information to these meetings to avoid delays.

Arrangements were in place to ensure the service ran consistently if staff members were on annual leave. The CMHT have a well organised holiday cover rota, with identified members of the team being allocated to their colleague's case load well in advance of the leave.

There were also arrangements in place to provide service cover over weekends. There is a weekend clinic that runs from 9 – 12:30 Saturday and Sunday, which is run by two members of the CMHT, alongside the crisis service. Staff make needs assessments and provide advice and support. They may make arrangements for a home visit, or contact with other services. This is in addition to the standard crises/emergency service provision. Service users told us they valued this service.

In the revised Mental Health Act Code of Practice (2016) informal service users (not detained under the MHA) as well as those under the MHA are now eligible to access advocacy services. We found that service users are provided with advocacy information leaflets when they initially access services. However we saw that advocacy is not always routinely offered to service users as part of their first contact information e.g. for screening assessments or ongoing care and treatment. Service users who are informal are not routinely signposted to an advocate for general support. We saw that service users on a Care and Treatment Order (CTO) are more likely to be referred to the advocacy services to support them (if they wish) for a Mental Health Review Tribunal[3] (MHRT) or a Hospital Managers Panel[4].

What the service does well

- Service users gave very positive feedback about the service
- Service users were treated with dignity and respect and there were well established relationships between staff and service users
- The service ran a number of proactive initiatives to support engagement with service users e.g. football team
- There was an effective and systematic referral management system in place
- There was good service cover during annual leave and at weekends.

Improvement needed

- Information displays and signage must be compliant with the Welsh

[3] A Mental Health Review Tribunal is an independent judicial body, whose main purpose is to review the cases of detained patients, conditionally discharged patients, or those subject to Community Treatment Orders (CTO's)

[4] Hospital Managers (meaning the organisation or individual in charge of the hospital/service, or responsible for CTO administration in the community) must either consider discharge of patients for which they are responsible themselves, or arrange for the power of discharge to be delegated to a hospital managers discharge panel. The discharge panel may consist of three or more people who may be non-executive directors of the LHB and must not be employees of the LHB concerned.

Language Act. Information must be available in a range of languages and formats to meet service users' needs

- The health board and local authority must ensure that staff are able to access interpreting services for all languages in a timely way
- All staff taking part in referral meetings should ensure that key research and information is available for discussion at the meetings to inform actions and outcomes in a more effective and timely way
- Staff must review the ways in which they signpost all service users to advocacy and the service must ensure that advocacy is integral to service user experience.

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.

Overall, we found care and treatment to be safe and effective, with some areas requiring improvement. There were a number of proactive initiatives being implemented as a way to improve service users' care and treatment including around assessment and understanding of diagnosis, through to goal/outcome planning and more effective discharge.

We found that service user records were generally completed to a good standard and reflected an integrated multidisciplinary approach. However, a small minority assessments reviewed did not contain sufficient detail. We also found some areas within service user records that required improvement, to ensure all required information had been accurately and comprehensively recorded. Overall, where the Mental Health Act was applicable, the service user records we reviewed were compliant with just several minor improvements identified.

Appropriate safeguarding arrangements were in place, however, there was a need to ensure child safeguarding checks were consistently carried out and recorded. We identified that aspects of medicines management at the CMHT also required improvement.

The environment was run down and provided extreme challenges both to staff working within the environment, and in terms of reflecting to service users that they were valued. It was notable that the rest of the site had been refurbished, except for mental health and substance misuse services. The health board must ensure that actions from recent environmental risk assessments are implemented and sustainable plans for the future are in place.

Managing risk and promoting health and safety

The Links is a three storey building at the rear of the newly refurbished Cardiff Royal Infirmary (CRI). On approaching the building it looks run down and derelict; many of the windows are broken or have been bricked up or covered with stone proof grills. The top two storeys are not in use, the skylights have been broken and the gutters have not been maintained, causing the brickwork to be saturated and ceilings and floors to flood during heavy rain. Just prior to our inspection, water had been running through the ceiling on to the main computer server in reception and had been repaired by installing a makeshift plastic cover.

We saw that the work environment was challenging for staff in the following ways:

- One of the windows was secured by tying three windows together with wire and although preventing anyone from outside opening the window, it also prevents staff from opening the window in warm weather
- The manager's office overlooks a small courtyard containing rubbish, dead birds and other items that fall, or are thrown into the yard and because of the dysfunctional guttering and blocked drainage, there are pools of stagnant water
- Kitchen facilities were minimal for 30 staff members and comprised of a small galley kitchen, one small kettle and fridge
- There is a shortage of desk space and some staff have their desks in areas used as thoroughfares to other areas of the building, which made working conditions challenging
- There are no cleaners available for non-service user areas, so some members of the team currently undertake cleaning duties, vacuuming offices, corridors and cleaning the kitchen and staff toilets.

In terms of facilities for service users we found a number of areas requiring improvement:

- Patient toilets have not been renovated since they were installed. There was one accessible patient toilet available; the other toilets involved access down a small flight of steps. On the day of the visit, there was no hand wash gel in the male toilet
- There is limited space in clinical rooms and only one treatment room to facilitate service users attending The Links for depot injections and other physical healthcare checks

- There are interview rooms, but these are few, for the number of service users attending the centre. Some of these rooms are small and have no windows; one has an extractor fan with the volume so loud, voices have to be raised, making communication difficult and compromising the confidentiality of the interview as the rooms are not sound proof

- The entrance to The Links does not enable wheelchair users' independent access. There is a ramp, but the external buzzer is located too high for wheelchair users to reach, to alert staff of their arrival

- Staff told us the outside part of the centre was often used as somewhere to urinate and this caused an unpleasant odour in the entrance.

In terms of security:

- Storage for records is limited and some cupboards and filing cabinets for service users' records are unable to be locked, or are within a locked room but not secured in a locked cupboard

- Most interview rooms had safety alarms; however, one therapy room was highlighted in a recent risk assessment as not having one

There was a current lone worker policy in place and all members of staff were issued with a personal alarm which aimed to protect staff to some extent.

Health and safety risk assessments were carried out on an ongoing basis. We reviewed the most recent risk assessments post our inspection visit. The health and safety risk assessments identified a number of concerning areas, particularly in relation to fire safety and lone worker safety. HIW requires the service to take urgent action around the areas identified. It was clear that the building was being maintained to the bare minimum to allow it to continue to function, with a number of temporary repairs, as outlined above. This is a situation that cannot be sustained in the longer term. Aside from the functionality, the environment appeared uncared for with an unpleasant and neglected atmosphere both outside and within the building.

The reception area of the centre is, however, an excellent resource, providing a comfortable, pleasant and open space. Notice boards created by staff provided eye catching and helpful visual aids and information. Children's' toys and magazines were also available.

What the service does well

- Welcoming reception room

Improvement needed

- Urgent action must be taken in order to mitigate the risks that are outlined in the service's own health and safety risk assessments dated from June – August 2017 and in this inspection report
- The health board and local authority must urgently carry out requisite improvements to the environment to ensure the building as a whole is fit for purpose. The health board and local authority must ensure that building maintenance and current repairs are appropriate and satisfactory
- The health board and local authority must ensure that sustainable plans are in place for the ongoing and future provision of services
- The health board and local authority must ensure all areas of the building are regularly cleaned to a satisfactory standard
- All service user records must be securely stored at all times
- Safety alarms must be available for staff in all rooms where there is an assessed level of risk.

Medicines management

We found medication management overall, to be safe. We found that medication reviews were undertaken regularly and there was therapeutic monitoring of those on clozapine (an antipsychotic medication).

However, we identified the following areas for improvement:

- The management of depot injections[5] was not adequately recorded. The senior nurse responded in a prompt and professional manner to address this issue

- Medication and medication transport policies/guidelines were not available in the clinical room

- Some medication charts did not contain all service user details, such as MHA status, or name of GP

- There is not a named pharmacist attached to the CMHT and pharmacy input and support is limited, for example in attending meetings, ensuring effective stock management, and in undertaking independent medication chart audits. A medication chart and clozapine (antipsychotic drug) audit is however carried out by the nurse lead. In the clinical room, space is extremely limited. We found the general tidiness and storage facilities to be poor. We were however informed by nursing staff that there was a cleaning and reorganisation of the clinical room planned. At present, there is no cleaner available for general cleaning of the clinical area

- The fridge temperature was not recorded consistently

- The temperature in the clinic is not monitored to ensure medicines continue to be stored within a safe range.

What the service does well

- Regular medication reviews

- Therapeutic monitoring of service users taking clozapine

Improvement needed

- The management of depot injections must be adequately recorded

- Medication and medication transport policies should be available in the

[5] A **depot injection** is a special preparation of the patient's medication, which is given by injection. The medication is slowly released into the body over a number of weeks.

clinical room

- All medication charts must be fully complete and details such as MHA status and GP must be consistently recorded
- The health board must ensure there is adequate input and access to pharmacy support
- The clinical room must be organised, clean and tidy
- Fridge temperature must be recorded consistently
- Staff must ensure the room temperature in the treatment room is kept at an appropriate and comfortable level.

Quality of care and treatment

Assessment, Care and treatment planning and review

The inspection team reviewed a sample of twelve case records in total, including three patients who were on Community Treatment Orders (CTOs) and subject to the application of the Mental Health Act. The case files we reviewed held information about service users' assessments, care and treatment plans, risk assessments, review and discharge arrangements.

There was a shared electronic case management system (PARIS) used by both health and local authority staff which ensured that all staff had access to one overall source of information when working with service users. However, paper records were also still used by some medical staff. This meant that, in reality, there was a need to consult both electronic and paper records for a fully comprehensive view of service user's care and treatment.

MDT meetings were held weekly where screening assessments are discussed and actions prioritised and other information is shared. We found that records of the meetings were clearly recorded including the decision making process and accountability for actions. We saw that appropriate ongoing referrals had been made as a result of these meetings. However, there were some instances where required interventions arising from assessed needs could not be implemented in a timely way, for example eating disorders and psychology, as services in these areas are extremely limited.

In the majority of cases we found up to date, comprehensive assessments of service users' needs and there was good multidisciplinary input. In most cases we found that clear objectives and outcomes had been set, which made the

treatment plan and goals of the assessment clear. In a minority (two cases), we found there was less detail in current assessments and some conflicting information about current needs. In these cases, we found a reliance on historical information, lack of clarity over current risks, incorrect recording of one person's native language and some missing information. Generally we found risk assessments to be clear and comprehensive.

In relation to the assessment of physical health needs, some records indicated a very good evidence based approach. Other records were not reflective of effective ongoing and routine monitoring. We were informed however that a lead physical health nurse has recently been appointed and a weekly physical health clinic has been established. Staff told us they were introducing a more systematic approach to the assessment and monitoring of service users on the CMHT caseload, including a structured monitoring process for those patients on depot injections and clozapine.

We found that carers were not always offered a carers assessment, which is essential when drawing up a carers support plan, as outlined in the Social Service and Well Being (Wales) Act 2014 (SSWBA). A worker had been appointed to focus on carers support through a partnership project with Hafal (a Welsh mental health charity, supporting people with serious mental illness and their carers).

From assessment through to care and treatment planning and review, there was evidence of strong multidisciplinary collaboration and needs, goals and outcomes were often clearly identified. All case notes examined clearly recorded an appointed care coordinator, responsible for the service user's care and aftercare pathway, which is compliant with the Mental Health (Wales) Measure 2010. We saw specific examples of the provision of care and treatment to service users, which highlighted that the focus of care was on recovery with the promotion of service users' rights, dignity and independence.

Care and treatment plans showed that the team worked closely with GPs, practice managers and had well established links with other agencies and services including local housing, police, the university and local care and residential homes to ensure service users had a fully integrated care and after care pathway.

There were also a number of proactive initiatives being implemented with the aim of improving service users' care and treatment planning, access to services, their pathway through mental health services and overall experience of services. These included the following:

- The lead nurse is championing an evidence based recovery model for service users, helping people to become independent and to make their own decisions about how they rebuild their lives

- A specific person has been appointed to lead on a small group initiative *My Diagnosis and Me* which provides support and breaks down diagnosis into simple, understandable terms and helps people to understand and manage their diagnosis

- An OT led project (Occupational Formulation) is being implemented, incorporating joint goal planning and measurable outcomes with service users, improving life skills and through the identification of people's strengths and weaknesses demonstrating improved patient outcomes

- The Links has seconded an Approved Mental Health Professional (AMHP) to HMP Cardiff to determine need for health and well-being assessments within the prison population

- A number of groups and activities were available for service users, for example a football group which was very popular, a walking group, a health and wellbeing group and a relapse prevention group. This facilitated opportunities to engage with service users about their support needs both formally and informally.

Overall, the care and treatment plans we reviewed were of a good standard. However, we found some details were incomplete across some service users' records. This included:

- Service users' first language

- Service users' agreement to the CTP. In one case we were informed that the service user had agreed, but this had not been recorded

- Confirmation that advocacy had been routinely offered, (a requirement of the Mental Health (Wales) Measure) or family/carers involvement recorded

- Although PARIS documentation includes prompts and mandatory fields that remind staff of their responsibility to identifying carers and offering them assessments, it was not always recorded whether this had been done or not.

In some instances we also found that case reviews/evaluations were not planned in a systematic way, some were not held within identified timescales and it was noted that the PARIS system did not flag up review dates.

In order to monitor the quality of CTPs we saw that a clinical audit of CTPs was regularly carried out, by the team, on randomly selected CTPs using the All Wales Audit tool. Overall, findings from the most recent audit reflected a good standard of the application of the CTP and feedback given to individuals and within the CMHT group focused on improving specific areas of the CTP. Audit outcomes are also shared with senior management and an analysis over twelve months helps focus on themes and trends that needed to be addressed, in order to continually improve their quality.

Safeguarding

All Wales child protection and adult at risk procedures were in place and referrals were made to the Multi-agency Safeguarding Hub (MASH) for consideration, where necessary. We saw that safeguarding issues were raised at MDT meetings and staff were confident that any safeguarding issues would be clearly identified.

However we saw one record where potential child safety concerns had apparently not been recorded and as a consequence there was no written evidence that relevant checks had been carried out, nor an assessment of whether further action/risk management was indicated. We also saw in one case in the referrals meeting, some hesitancy by staff in making enquires with children's services. This was in relation to a case where there were potential indicators that safeguarding could be an issue. We brought this to the attention of staff in both cases to ensure relevant checks had taken place (in the case of the record), and would take place (in the case from the referral meeting). We were subsequently assured by the actions taken by staff in these cases. Staff must ensure that lateral checks with partners are consistently undertaken when relevant and that responses are recorded. Training records also indicated that there was some improvement required to ensure all staff were brought up to date with mandatory safeguarding training.

Discharge arrangements

All service users have an identified care coordinator who works with them and the CMHT, actively coordinating their discharge and aftercare. We saw that staff supported service users to consider and implement discharge plans. Regular outpatient reviews for those patients subject to a CTO are also held.

In practice, we saw that there were challenges in ensuring discharge happened in a timely way. Some of the reasons for delays in discharge were due to delays in carrying out reviews and challenges in the transitional arrangements when service users move between The Links, private hospital sector, Children and Adolescence Mental Health Services (CAMHS) and older persons mental

health services. We saw that there was work ongoing to try to improve the experience of transitioning between services and working groups with CAMHS and older persons services were in place.

The team told us about several positive initiatives that had been implemented at the CMHT level to support service users with discharge. These included:

- Service users are helped to prepare for discharge through the 'Stepping Out leavers group'. The group is an eight week programme which aims to proactively prepare service users for graduation from secondary care back to primary care and also rehearses signs and symptoms of relapse, crises plans and helps them understand their rights and the process for self-referral

- A support social worker has taken on the role as the liaison person between the CMHT and inpatient services. They attend the MDT case reviews at the hospital and take a proactive approach to addressing housing, finance and benefits needs, child protection and setting plans in place early on in the discharge and after care planning process.

Monitoring the Mental Health Act

We reviewed three CTO's and found all to be fully compliant with the Mental Health Act (MHA) and Code of Practice and all were of a good standard.

CTO records reviewed were well organised and MHA record keeping was of a good standard. CTO's are reviewed by staff appropriately and a link person has responsibility to liaise with the inpatient services (as necessary) and MHA team to coordinate CTP reviews and any legal requirements of the CTO.

One patient, whose file we reviewed, had been recalled (this means the patient was re-admitted to hospital temporarily for assessment). However, the CTO did not record whether the notice of recall had been given to the patient by hand or post - this should be noted.

Records indicated that all patients had received information relating to their legal rights under the MHA, and there were advocacy leaflets available. However, access to advocacy services did not seem integral to the CMHT service provision and this has been detailed earlier in the report.

The MHA team are viewed as approachable and very helpful. The MHA administrator is a member of the All Wales MHA Administrators Forum. This provides a regular opportunity for sharing good practice and updated case law. One of the administrators has also completed a diploma in mental health law. This meant that the MHA team were able to take a well informed approach to practice and training for staff.

Every effort is made to ensure the Hospital Managers Discharge Panels reflect a diversity of ethnic backgrounds and that those appointments reflect the ethnicity of the local communities the CMHT serve.

Regular MHA training is provided for all staff as part of their induction, but it is not a mandatory training area and therefore staff are not updated regularly. It would be beneficial for staff to receive refresher training on an ongoing basis.

Regular scrutiny of documents and MHA audits are carried out to enable improvements in the application of the MHA and a flow chart provides a robust system for medication and consent requirements for those patients subject to a CTO.

What the service does well

- Effective MDT meetings with detailed records held, leading to good MDT working through the processes of assessment and care planning
- Overall, we found a good standard of assessment
- Clear records of service users' goals and outcomes
- CTP audits completed as a way to improve quality
- A number of pilot projects and other initiatives were run by staff with the aim to improve service users' care and treatment
- Good standard of MHA recording.

Improvement needed

- Staff must ensure that all assessments are based on current information which is accurate and captured without gaps; and that risks in all cases are made clear
- All carers must be offered a carers assessment and this must be recorded
- Staff must ensure that service user records are fully complete and should ensure that first language, service user consent to the assessment, information about advocacy and the offering of carers' assessments are all routinely completed
- Reviews should be completed within specified timescales and there should be a system in place that supports planning reviews
- Staff must ensure that child care safeguarding checks are consistently carried out, whenever these are deemed necessary. These must be recorded
- The reasons for delays in discharge, where these occur, should be reviewed and actions identified to support discharge at a local level should be identified and implemented
- Mandatory MHA training to be considered for all staff and regular update training to be available
- Format of notice of recall should be recorded on MHA records.

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 Links CMHT is an integrated Multidisciplinary Team (MDT). There was evidence of strong and supportive leadership and a collaborative and effective staff team.

Overall, there were systems in place to ensure staff received supervision and performance development reviews (PDRs). Staff told us they felt supported and had access to supervision.

A lot of work had been done to reduce caseloads over the last few years, as a result of HIW's review of a homicide committed by Mr L in 2014. However, psychiatrists' caseloads remained high, which had been a concern of the homicide review, and in some cases administrative support for medical staff was limited.

There was good access to training opportunities that were relevant to staff roles. However, staff were not up to date with mandatory training across a number of topics and this requires improvement.

There was an audit programme in place that was being further developed. There was some evidence of service user feedback into the service, however, these systems required review to ensure they were systematic, accessible and used in a meaningful way to improve services.

Leadership, management and governance arrangements

We spoke with a number of management and frontline staff over the two days. The CMHT comprises of 39 staff including two vacancies and a number of staff who are part time. The CMHT integrated manager, by consent of the local authority and the health board, represents the joint management of the CMHT and has responsibility for the recovery pathway for all service users.

There was a commitment to joint working and both management and frontline staff expressed a clear sense of pride about the team and the work they were doing. All staff we spoke with were very positive, highly motivated and enthusiastic. Staff demonstrated compassion and care for their patient group and there was a strong sense of team spirit. We also saw that the health care support worker role was highly valued and used across a number of areas in effective ways.

CMHT staff members spoke of being able to raise/escalate concerns and there being an open and honest culture, which encourages discussion about aspects of care and treatment, attitudes and appropriate interventions. A staff counselling service was also available.

Staff indicated that they had access to supervision and annual Performance Development Reviews (PDR) which provide opportunities for support, discussion about enhanced skills development and training. Staff spoke of approachable managers and good peer support within the team. A structured approach to supervision is in place for social workers within the CMHT and as part of the City of Cardiff Council Social Services policy, each member of staff has a contractual agreement to receive supervision every six weeks. Clinical supervision was available for CPNs within the CMHT, and although uptake was low, staff were able to access this when required.

Every patient has a named psychiatrist and there are four within the team. With over five hundred cases, each psychiatrist has a case load at the absolute limit of the Royal College of Psychiatrists recommendation for a safe case load[6]. Although caseloads had reduced since HIW's homicide review in 2014, further work is required to ensure psychiatrists' caseloads are safe and manageable. The CMHT are working on a local protocol with GPs whereby patients who only have depot medication or who are stabilised on long term medication, can be transferred back to the care of their GPs. This is with the aim of reducing the case load for each psychiatrist, whilst reflecting a strong message of recovery and stability and limiting the stigmatising effect for those people remaining long term on the CMHT list.

Medical members of the CMHT had actively contributed to the newly developed referral framework with their GP colleagues; however they had limited

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[6] "Safe patients and high-quality services: a guide to job descriptions and job plans for consultant psychiatrists" 2012 https://www.rcpsych.ac.uk/pdf/REVAL2013%2014%20CR174.pdf

administrative support, which impacted on the timeliness of reports and general organisation and quality of the records and administrative requirements for service users.

The CPN case load averages at just fewer than 30 cases. This is higher than the normal average in the team, due to two significant vacancies. However, at the time of the inspection one CPN had already been recruited and the plan is to reduce the average case load back down to around 25 cases for each qualified CPN when both posts are filled. CPNs' caseloads were another aspect of concern when HIW undertook the homicide review of Mr L in 2014. Management staff must therefore ensure caseloads remain safe and manageable on an ongoing basis. The Social Worker (SW) case load is around 15 cases per whole time equivalent. A great deal of effort had been made to reduce caseloads overall over the last few years and this was very apparent.

There were a number of other disciplines making up the team including a lead occupational therapist (OT), an OT and an OT technician, (shared with another CMHT), a part time psychologist and a part time art therapist who at the time of the inspection had a student art therapist on placement. There was some physiotherapy input, although this was limited and subsequently was not always integral to the team planning process. Integral to the team are a number of support workers.

Overall, we found there was a commitment to supporting staff with continuing professional development and training. For example, Cognitive Behavioural Therapy (CBT), Dialectical Behavioural Therapy (DBT) and skills based training was available. A Cardiff and the Vale UHB Leadership programme has been completed by senior members of the CMHT and is made available to other team members as part of their professional development programme. CMHT staff also regularly attend a Leadership in Public Safety course and have brought back learning and ideas for improvements to the team. For example, the physical health monitoring programme developed from staff attending this course. This was a good example of how staff were committed to implementing improvements and developing service delivery.

Although there was good access to skills based and specialist training, compliance with mandatory training topics was variable. Some staff also reported limited access to training, due to their workloads. Training records indicated that staff compliance with mandatory training across a number of areas was variable, for example, we saw gaps in safeguarding adults, fire safety, resuscitation and the Mental Capacity Act. We also found that Mental Health Act training is not mandatory for all staff.

We saw that there was an audit programme in place, which was being further developed, to monitor the quality of care and treatment provided. This included a monthly team performance checklist, patient safety and quality indicators, management and staffing indicators, mandatory training, and professional standards and regulation. The CMHT manager also completed audits and monthly quality and safety managers' meetings incorporated a focus on audit activity across CMHTs. This meant there was a system in place for monitoring the performance of the service, with a view to making improvements.

We reviewed a sample of complaints and found that actions had been taken within specified timescales, as outlined in All Wales guidelines, to take action to resolve concerns and complaints. At present, informal feedback/concerns given by service users and families is not recorded or considered and we suggested the service consider this, as a way to further improve the service. There is a Directorate wide approach to the management of serious incidents and 'Lessons Learnt' meetings are held for senior staff/managers, following a serious incident or complaint.

There was a system for collecting service user feedback, through service user questionnaires which were completed by service users on an adhoc basis, when they attended the CMHT. It was not clear what changes had been made as a result of this feedback at CMHT level. Service user feedback channels therefore required improvement to ensure systems for gaining feedback were made known and accessible to all service users and their carers, and results were reviewed and considered at a local level.

What the service does well

- Well integrated MDT working across health and social care staff
- Staff were passionate about their work within mental health services
- Staff felt supported by management and able to raise concerns
- Good access to specialist and professional development training and opportunities
- An audit programme was in place that was being further developed to ensure that the quality of services was monitored with a view to making improvements.

Improvement needed

- Staff must be supported to stay up to date with mandatory training topics on an ongoing basis, by both the health board and local authority

- CPN caseloads must remain within safe and manageable limits on an ongoing basis. The health board must provide an update regarding CPN vacancies and the planned adjustments to caseloads as a result
- Psychiatrists' case loads must be safe and manageable. Psychiatrists must have access to sufficient administrative support
- The service must provide a way for service users and their carers to provide feedback in an empowered, systematic and accessible way. The service should be able to demonstrate that feedback received is used to improve services.

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 the HIW and CIW 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
The management of depot injections was not adequately recorded.	This meant there was a higher risk of errors and lack of audit trail to support appropriate medicines management.	Inspectors raised this with the senior nurse.	The senior nurse responded in a prompt and professional manner to address this issue.

Appendix B – Immediate improvement plan

Service: The Links CMHT

(Cardiff and Vale University Health Board & Cardiff Council)

Date of inspection: 2 & 3 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 improvements				

Appendix C – Improvement plan

Service: The Links CMHT

(Cardiff and Vale University Health Board & Cardiff Council)

Date of inspection: 2 & 3 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 patient experience				
Information displays and signage must be compliant with the Welsh Language Act. Information must be available in a range of languages and formats to meet service users' needs	Health and Care Standards; 4.2 Patient Information. Local Authority Quality Standards (LAQS) 1a; 6d.	A plan will be developed along with the UHB Welsh Language Officer to ensure that the department becomes fully compliant with the Welsh Language Act. A review of the range of information available for all service users will be undertaken.	Integrated Manager Integrated Manager	End April 2018 and quarterly review thereafter End April 2018 and quarterly review

Improvement needed	Standard	Service action	Responsible officer	Timescale
				thereafter
The health board and local authority must ensure that staff are able to access interpreting services for all languages in a timely way	Health and Care Standards; 3.2 Communicating Effectively. LAQS 1a; 6d.	The Integrated Team have a robust system for identifying the need for Interpreters. A Cardiff and Vale UHB contract exists with W.I.T.S for planned appointments as identified. Unscheduled care is managed through a telephone request via Language Line. This was a unique situation given the language requirement of the individual and the fact that there is only one available interpreter, who was not available on this occasion. Since the time of the review, all staff have been reminded of the process. Medical secretaries now ensure that a translator is available when an invite for an appointment is sent out to a service user.	Integrated Manager Admin Manager	Complete
All staff taking part in referral meetings should ensure that key research and information is available for discussion at the meetings, for the cases they are responsible for, to inform actions and outcomes in a more effective and timely	Health and Care Standards; 5.1 Timely Access. LAQS 1b.	All referrals are screened by a clinician for clinical risk, urgency and appropriateness on the day that they are received. This initial screening should also involve the gathering of pertinent	Integrated Manager	Complete

Improvement needed	Standard	Service action	Responsible officer	Timescale
way.		information to help inform the care pathway. A wider more in depth weekly meeting reviews the referrals along with already gathered pertinent information from the electronic record along with relevant contacts from other agencies, (e.g. Children's services, police). All efforts are made to request comments from clinicians and consultations are carried out with the PARIS electronic record open. The Clinical Board will liaise with Primary Care Services to remind them of the necessary standards for good quality referrals.		End April 2018
Staff must review the ways in which they signpost all service users to advocacy and the service must ensure that advocacy is integral to	Health and Care Standards; 6.1 Planning Care to	Local Advocacy Service are regularly invited to the staff training forums within the CMHT to help refresh the CMHT's		April 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
service user experience.	Promote Independence. LAQS 1g.	understanding of the access arrangements. Information leaflets and posters will be readily available across the patient and staff areas of the CMHT. The Clinical Board will work with all Community Mental Health Teams to put in a system to ensure that a leaflet is sent out to everyone invited to a first assessment. This will outline to the service user their entitlement to receive advocacy via Advocacy Cymru. A review of the signage in the reception area of all the CMHTs will be undertaken to ensure that there is information on advocacy support clearly available for service users.		End April 2018 End April 2018
Delivery of safe and effective care				
• Urgent action must be taken in order to mitigate the risks that are outlined in the service's own health and safety risk assessments dated from June – August 2017 and in this inspection report.	Health and Care Standards; 2.1 Managing Risk and Promoting Health and Safety, 2.4 Infection	Cardiff and Vale UHB will review the progress against the Health and Safety report and address the urgent measures. A fire risk assessment re-inspection will be carried out.	Estates Directorate Manager Fire Service Officer	April 2018 End Feb 2018 End Feb 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
• The health board and local authority must urgently carry out requisite improvements to the environment to ensure the building as a whole is fit for purpose. The health board and local authority must ensure that building maintenance and current repairs are appropriate and satisfactory. • The health board and local authority must ensure that sustainable plans are in place for the ongoing and future provision of services. • The health board and local authority must ensure all areas of the building are regularly cleaned to a satisfactory standard. • All service user records must be securely stored at all times.	Prevention and Control (IPC) and Decontamination, 3.5 Record Keeping. Data Protection Act 1998.	A further health and safety review to audit the current risk assessments and provide further support for identified issues will be undertaken. Project team to be established by health board Capital Planning Team to plan for replacement facilities in 2018. There is currently an outline business case with Welsh Government to secure investment for an enhanced Primary Care centred model. Cleaning contract to be established and where necessary, reviewed with supplier There is controlled access to the building and all records are securely stored in lockable cabinets in a locked and dedicated room within the CMHT. All staff will be reminded of the need to ensure that all cupboards containing	Health & Safety Team MH Clinical Board and Local Authority Directorate Manager I.M and CMHT Lead Administrator	End Feb 2018 Summer 2018 March 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
• Safety alarms must be available for staff in all rooms where there is an assessed level of risk.		records are kept locked at all times. All rooms with the exception of the room used by the Art Therapist have panic alarm strips. Each session is risk assessed, this room is next to the reception area that is always staffed, and it is never used for initial assessments or to assess any patient who is unknown to the service. The risk therefore is minimal and managed before it is used. A request for this area to be alarmed has been submitted to the Estates Department.	I.M.	Review June 2018
• The management of depot injections must be adequately recorded.	Health and Care Standards; 2.6 Medicines Management	Depot medication records were updated and improved immediately as noted in the report. All Depot administration is against a valid prescription and is recorded in the patient's prescription chart. The UHB	Lead CMHN	Complete

Improvement needed	Standard	Service action	Responsible officer	Timescale
		has considered this recommendation and advice sought from the Medicines Management Specialist Nurse with regards to the recording of Depot injections. As there is no statutory obligation to treat this particular medication as a controlled drug the UHB is satisfied with the current recording arrangements.	Lead CMHN C&V Pharmacy	Complete
		All Depot stock is ordered via an e-system WOREC and this can provide an audit trail of the amounts of Depot used.	Lead	Complete
		Any incidents involving depot and its administration are recorded on Datix and this again can provide an auditable trail.		
		Annual audit will be undertaken as part of further assurance process.	Pharmacy	Embedded as part of routine practice
• Medication and medication transport policies should be available in the clinical room.		Relevant Policies are now stored in the Treatment room and relevant staff are aware of their presence		Complete

Improvement needed	Standard	Service action	Responsible officer	Timescale
• All medication charts must be fully complete and details such as MHA status and GP must be consistently recorded. • The health board must ensure there is adequate input and access to pharmacy support.		GP details are not recorded on the All Wales medication charts. All relevant policies in relation to community treatment orders will be stored along with treatment charts. Plans will be put in place to audit compliance.	Lead CMHN	End April 2018
		The Clinical Board will be reviewing the pharmacy input within the context of the wider community services review	Director of Operations	End June 2018
• The clinical room must be organised, clean and tidy.		The clinic has benefited from a deep clean and reorganisation within the limits of the available space and requirements. The cleaning services have now been contracted to clean the floor twice a week.	Integrated Manager	Complete
• Fridge temperature must be recorded consistently.		All staff will be reminded of the need to record fridge temperatures in line with patient safety notice (PSN015) The storage of medicines; Refrigerators. A system of regular monitoring will be	Integrated Manager	End April 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
• Staff must ensure the room temperature in the treatment room is kept at an appropriate and comfortable level.		put in place. Additional electric heating and ventilation is available when required. A thermometer will be ordered.	Integrated Manager	End Feb 2018
• Staff must ensure that all assessments are based on current information which is accurate and captured without gaps; and that risks in all cases are made clear.	Health and Care Standards; 3.5 Record Keeping, 5.1 Timely Access. LAQS 5d; 1c; 1h;	All mental health assessments undertaken by the CMHT follow a standardised comprehensive format and this is governed by the Mental Health Measure. Further specialist assessments are undertaken depending upon identified need. Compliance is addressed through audit, and caseload supervision and sampling to ensure consistent practice. The UHB will participate in and respond to the findings of the National Delivery Audit of Care and Treatment Plans which is scheduled to take place in February.	Team Leaders, I.M. I.M. HAFAL, Cardiff Local Authority	Continue to review and respond to results of monthly compliance audits 26 Feb 2018 review June 2018
• All carers must be offered a carers assessment and this must be recorded.		All carer's are offered a carer's assessment. At all Care and Treatment Plan reviews, the carer's views are integrated into the process. The CMHT	Integrated Manager	Complete

Improvement needed	Standard	Service action	Responsible officer	Timescale
• Staff must ensure that service user records are fully complete and should ensure that first language, service user consent to the assessment, information about advocacy and the offering of carers' assessments are all routinely completed.		has within its establishment a dedicated third sector (Hafal) link worker –joint funded by the Local Authority and the UHB specifically to oversee the coordination and implementation of outcomes of Carer's assessments. The Local Authority have also engaged one full time member of staff to conduct assessments. All staff have been reminded of the requirement for accurate record keeping in relation to this matter. The standardised format of the Secondary Care assessment and review process includes prompts to record this information. The UHB will participate in and respond to the findings of the National Delivery Audit of Care and Treatment Plans which is scheduled to take place in February.	All	Complete 26th Feb 2018 review June 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
• Reviews should be completed within specified timescales and there should be a system in place that supports planning reviews.		There is a statutory obligation, at least annually, to convene a multi-disciplinary Care and Treatment Planning Review for each allocated patient under the care of the CMHT. Measures are in place to audit and ensure a high compliance with this. These measures include, individual caseload management, CMHT management performance reporting and review along with external and peer led audit. The Clinical Board is currently exploring a range of options to improve performance with this. These include: • Future development of the electronic system to introduce triggers for review; • An improvement in current administrative systems which is already underway and has already dramatically increased compliance	Director of operations, Clinical Board	Review June 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
Staff must ensure that child care safeguarding checks are consistently carried out whenever these are deemed necessary. These must be recorded.	Health and Care Standards; 2.7 Safeguarding Children and Safeguarding Adults at Risk. LAQS 5.	Within the standardised assessment tool (Form 1), a mandatory field requires information relating to known contacts with children and prompts for any safeguarding issues to be recorded and highlighted. Additionally, staff have been reminded of and supported in the use of the safeguarding module in the electronic records to ensure that this information can be more effectively disclosed and audited	All	Complete and embedded as part of routine practice
The reasons for delays in discharge, where these occur, should be reviewed and actions identified to support discharge at a local level should be identified and implemented.	Health and Care Standards; 5.1 Timely Access, 6.1 Planning Care to Promote Independence. LAQS 1c.	The team had single figure incidences of a delayed discharge from inpatient care in the last 12 months the reasons for which were examined and considered by health and social services departments through a formal standing mechanism. Alongside this, the CMHT Care Coordinators remain fully engaged with all inpatients during their admission and through joint working can help assist with any identified barriers to discharge To further improve the UHB will identify any apparent delays in discharges from	Clinical Board Director of Nursing Integrated Manager	Complete Annual review

Improvement needed	Standard	Service action	Responsible officer	Timescale
		the service as part of established annual reviews. The UHB is currently contributing to the development of an All Wales policy in relation to the transition of service users from CAMHS to adult services.	Clinical Board Director/Director of Nursing	Review June 2018
• Mandatory MHA training to be considered for all staff and regular update training to be available. • Format of notice of recall should be recorded on MHA records.	Mental Health Act 1983 Health and Care Standards; 7.1 Workforce	Administration staff, along with health and social care staff have been trained in MHA awareness. Update training for all staff is available through the ongoing in house training at the Links and through the UHB Learning and Education Department. Training is also available via the Local Authority training department. The Directorate will consider whether MHA training is made a mandatory requirement A legal document (CP5) is completed for every recall. This is stored within the MHA Office and also uploaded onto the patient electronic recording system	I.M. Director of Nursing, Clinical Board	Ongoing Review June 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
		(PARIS). The Responsible Clinician and/or Care Coordinator, is additionally required to record the recall within a medical case note on the patient's records. The team acknowledges that this was an oversight and there have been discussions with all relevant staff to ensure that this does not happen again.	Integrated Manager	Complete
Quality of Management and Leadership				
• Staff must be supported to stay up to date with mandatory training topics on an ongoing basis, by both the health board and local authority	Health and Care Standards; 7.1 Workforce, 6.3 Listening and Learning from Feedback. Social Services and Well-being Act 2014	The Staff improvements in Record (ESR) the Electronic dashboard has recorded the mandatory training compliance in a much more accurate and accessible way for staff and supervisors and a review of this is accessible easily in supervision. The ESR system also incorporates a direct portal into e-learning modules. Additionally, The Learning and Education Department offer regular comprehensive and varied training sessions to all UHB employees.	I.M. and CMHT Leads IM	Complete Review June 2018 Complete

Improvement needed	Standard	Service action	Responsible officer	Timescale
• CPN caseloads must remain within safe and manageable limits on an ongoing basis. The health board must provide an update regarding CPN vacancies and the planned adjustments to caseloads as a result. • Psychiatrists' case loads must be safe and manageable. Psychiatrists must have access to sufficient administrative support		The Directorate will explore all possible Options to further support staff in achieving all mandatory training within prescribed timescales. As noted in the report, two full time CMHN vacancies impacted upon CMHN case loads within the CMHT. Both posts are now filled and we have now achieved equitable CMHN team case load numbers as a result. Psychiatrist caseloads are being reviewed as part of the ongoing wider review of Community MH Services. The Links CMHT is recruiting an additional team secretary 3 days per week to further support the administration of this process	Lead CMHN I.M and Admin Manager	Complete Review April 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
• The service must provide a way for service users and their carers to provide feedback in an empowered, systematic and accessible way. The service should be able to demonstrate that feedback received is used to improve services.		There is an established process in place whereby service users and their carers can feedback their experiences. This process involves the allocation of a number of patient satisfaction surveys to each CMHT every month. It is the responsibility of the Integrated Manager to ensure these are completed and submitted within specified deadlines. The I.M. is expected to review each survey prior to submission and act upon any issues where possible –informing the patient, if requested. There is a recognition that within the Mental Health client group, it may be necessary to consider and design a more bespoke approach to gathering this information. A specific workshop between CMHT staff, I.M.'s and the Patient Experience Team will take place in April 2018.	Patient Experience Team	Ongoing- embedded into practice

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): **Carol Evans**

Job role: **Assistant Director Patient Safety and Quality**

Date: **14-02-18**