Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Inspection Summary Report

North Monmouthshire CMHT, Maindiff Court Hospital, Aneurin Bevan University Health Board

Inspection date: 15 and 16 November 2022

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This summary document provides an overview of the outcome of the inspection

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The CMHT provided patients an overall positive experience. We observed examples of person centred care and support which captured the voice, views and wishes of service users. This was supported by a breadth of positive comments received from service users relating to the care and support they receive from their care co-ordinators and the wider CMHT team.

We found that the CMHT provided service users with safe and effective care, treatment and support. Assessments, care plans and reviews were completed in a comprehensive manner, in line with the Mental Health (Wales) Measure and Social Services and Wellbeing Act.

We identified a small number of improvements relating to service access in order to strengthen CMHT capacity and provision for service users.

Overall, we found the service to be well led by passionate management and staff who put service users at the centre of the care they delivered.

We identified a small number of improvements and made recommendations in relation to joint working arrangements between the health board and local authority, and the equity of staff caseload arrangements amongst care co-ordinating staff.

What we did

Full details on how we inspect the NHS and regulate independent healthcare providers in Wales can be found on our website.

Healthcare Inspectorate Wales (HIW) and Care Inspectorate Wales (CIW) completed a joint announced community mental health inspection (CMHT) of North Monmouthshire Community Mental Health Team within Aneurin Bevan University Health Board and Monmouthshire County Council on 15 and 16 November 2022.

Our team for the inspection comprised of two HIW Healthcare Inspectors, a CIW local authority Inspector, two clinical peer reviewers (one of whom was the nominated Mental Health Act reviewer) and a patient experience reviewer. The inspection was led by a HIW Senior Healthcare Inspector.

This summary version of the report is designed for members of the public.

A full report which is designed for the setting and describes all findings relating to the provision of high quality, safe and reliable care that is centred on individual patients can be found on our website.

Quality of Patient Experience

Overall Summary

We found that the CMHT provided a positive experience. We observed examples of person centred care and support which captured the voice, views and wishes of service users. This was supported by a breadth of positive comments received from service users relating to the care and support they receive from their care co-ordinators and the wider CMHT team.

What we found this service did well

- Service users told us that they felt listened to and had enough time to discuss their care, support and treatment with CMHT staff
- Service users told us that they had timely access and communication with their allocated care worker and the right care provided at the right time
- The service had made some thoughtful improvements to the waiting areas.

Where the service could improve

- The health board / local authority must ensure that the availability of advocacy information is reminded to service users at appropriate intervals
- The health board / local authority must consider how one to one psychology waiting times can be reduced.

Patients told us:

"The CMHT has helped me maintain independence in the community"
"I now feel like I'm treated like a real person"
"The support I get is a safety net… it's a lifeline, when it gets difficult to cope"
"Inform me when we're due to meet"

Delivery of Safe and Effective Care

Overall Summary

We found that the CMHT provided service users with safe and effective care, treatment and support. Assessments, care plans and reviews were completed in a comprehensive manner, in line with the Mental Health (Wales) Measure and Social Services and Wellbeing Act.

We identified a small number of improvements relating to service access in order to strengthen CMHT capacity and provision for service users.

What we found this service did well

- Assessments, care plans and reviews captured the voice, views and wishes of the service user in line with the relevant legislation
- There was evidence of good discharge planning arrangements
- There were clear processes in place for the management and escalation of safeguarding and issues related to service user risk. Good risk assessment documentation was observed in social care files.

Where the service could improve

- The health board / local authority must continue to engage with GP practices where issues are identified and the health board is encouraged to provide support where required
- The health board / local authority must provide HIW with an update in relation to its ADHD/ASD pathway.

Quality of Management and Leadership

Overall Summary

We found the service to be overall well led by passionate management and staff who put service users at the centre of the care they delivered.

We identified a small number of improvements and made recommendations in relation to joint working arrangements between the health board and local authority, and the equity of staff caseload arrangements amongst care co-ordinating staff.

What we found this service did well

- We found passionate management, leadership, and staff who were committed to person centred care and support
- Staff overall commented positively on local management and the direction in which the service is developing.

Where the service could improve

- The health board and local authority must further explore and embed joint working arrangements
- The health board and local authority must engage with staff in the context of the staff comments provided.

Staff told us:

"The team has a great working relationship; they are very supportive to each other in the tough times. We always make sure we make time to help and support each other throughout the days and always there when someone needs to talk things through"

"I feel comfortable approaching anyone in the team if I had an issue and feel I can disclose things going on in my personal life that may affect my ability to work"

"There … needs to be services developed for Autism and a better transitions policy for young people coming into adult services"

Next steps

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the appendices of the full inspection report.

When we identify concerns that pose an immediate risk to patient safety we ask the health board to undertake urgent action. These concerns are outlined in the appendices and outline the action taken by the health board to protect patient safety and approved by us. We also provide a detailed table of improvements identified during the inspection where we require the service to tell us about the actions they are taking to address these areas and improve the quality and safety of healthcare services. In addition we outline concerns raised and acknowledge those resolved during the inspection.

At the appropriate time HIW asks the health board to confirm action has been taken in line with management responses documented in the improvement plan. We also ask health boards to provide documented evidence of action taken and/or progress made.