**Ogic**<br/>h(W)Arolygiaeth Gofal lechyd CymruHealthcare Inspectorate Wales

# **Inspection Summary Report**

Bridgend North CMHT, Maesteg Community Hopsital, Cwm Taf University Health Board Inspection date: 13 and 14 December 2022 Publication date: 16 March 2023



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















Digital ISBN 978-1-80535-618-9 © Crown copyright 2023 The CMHT provided patients an overall positive experience. Service users were provided with a person centred and dignified care and treatment. The feedback we received from service users and their relatives / carers was overall positive about the care they receive from their care co-ordinators and the wider CMHT team.

We found that the CMHT provided service users with overall safe 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 provision and partnership working.

Overall, we found the service to be well led, with care and treatments delivered by professional and committed staff team. There was evidence of cohesive working team working and staff expressed enjoyment in their roles.



### What we did

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

Healthcare Inspectorate Wales (HIW) and Care Inspectorate Wales (CIW) completed a joint announced community mental health inspection (CMHT) of Bridgend North Community Mental Health Team based at Maesteg Community Hospital on 13 and 14 December 2022. This service is delivered by Cwm Taf Morgannwg University Health Board and Bridgend County Council

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 <u>website</u>.

## **Quality of Patient Experience**



#### **Overall Summary**

We found that the CMHT provided a positive experience. Service users were provided with a person centred and dignified care and treatment. The feedback we received from service users and their relatives / carers was overall positive about the care 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
- Staff felt empowered to try new ideas and initiatives to support the care and overall wellbeing of service users.

#### Where the service could improve

• The health board / local authority must ensure that the offer of, and decision making relating to, advocacy services is clearly documented.

#### Patients told us:

"We look forward to [name anonymised] coming. [Name anonymised] is being well looked after by the team. I ... find that [name anonymised] helps me to cope and anything that has to be done, we can count on [name anonymised] and team."

"The people on my care team are all absolute diamonds. They genuinely care about what they are doing and have gone above and beyond in showing their care and kindness for me."

"[Name anonymised] and the team have very good to me."

# Delivery of Safe and Effective Care



#### **Overall Summary**

We found that the CMHT provided service users with overall safe 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 provision and partnership working.

#### What we found this service did well

- Assessments, care plans and reviews demonstrated ownership by service users, which included forward looking and balance positive risk taking
- There was evidence of good physical health monitoring
- There were clear processes in place for the management and escalation of issues related to service user risk.

#### Where the service could improve

- The health board must ensure sufficient and timely access to one to one psychology sessions
- The health board and local authority must explore how pathways with local primary care services can be strengthened.

## Quality of Management and Leadership



### **Overall Summary**

We found the service to be overall well led, with care and treatments delivered by professional and committed staff team. There was evidence of cohesive working team working and staff expressed enjoyment in their roles.

### What we found this service did well

- Staff overall commented positively on the supported provided by local management
- There were good opportunities for learning and development.

#### Where the service could improve

• The health board and local authority should reflect on the staff feedback within this report.

#### Staff told us:

"Better IT systems to communicate between health and social services especially out of hours..."

"Additional appropriate offsite consultation room provision for service users who cannot get to Maesteg or Princess of Wales Hospital."

### 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.

