Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Inspection Summary Report

Welshpool CMHT, Bryntirion Mental Health Resource Centre, Victoria Memorial Hospital, Powys Teaching Health Board

Inspection date: 14 and 15 February 2023

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

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Service users were provided with a person centred and dignified experience. The feedback we received from service e users and their relatives/carers about the care they received was generally positive.

We found that the CMHT provided service users with 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 found the service to be well led with care and treatments being delivered by a professional and committed staff team. There was evidence of cohesive team working and staff, in general, told us that they were happy in their roles.

Note the inspection findings relate to the point in time that the inspection was undertaken.

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 Welshpool Community Mental Health Team based at Bryntirion Mental Health Resource Centre, Victoria Memorial Hospital, Welshpool on 14 and 15 February 2023. The service is delivered by Powys Teaching Health Board and Powys County Council

Our team for the inspection comprised of two HIW Healthcare Inspectors, 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

Service users were provided with a person centred and dignified experience. The feedback we received from service users and their relatives / carers was, overall, positive about the care they receive.

Where the service could improve

- Double booking of consulting room resulting in patients being turned away
- Confidentiality in reception

What we found this service did well

- Service users' wishes and views reflected in Care and Treatment Plans (CTP)
- Focus on achieving positive outcomes for service users
- Availability of advocacy services
- Links with third sector service providers.

Patients told us:

"All of the team have been very respectful when visiting my home - little things like taking their shoes off unprompted and asking where it would be best for them to sit. These small things are really important to me and I would see as being very good practice."

"My support worker has been like an angel that has saved me from the darkest place I've been, I'm incredibly lucky to be supported through the difficult times I'm facing."

"My CPN is really helpful, kind, caring and reacts quickly to any issues I have. Not every CPN is like that."

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.

Where the service could improve

- Review the duty arrangements in order to ensure that staff are able to fully meet the demands of their substantive roles
- Eliminate breaches of the 28 day target for reassessment under Part 3 of the Mental Health (Wales) Measure 2010
- Continue with their efforts to secure additional Section 12 doctors
- Review the use of clinic room which is not fit for purpose
- Develop integrated assessment and recording processes
- Ensure the availability of transport for timely and secure transfer of service users to hospitals
- Ensure that the Welsh Community Care Information System (WCCIS) is operating effectively and that staff have unhindered access to service users' care notes in order to effectively plan and deliver care and support
- Review the provision of ADHD services and ensure that service users are assessed in a timely fashion and appropriately supported
- Some aspects of MHA monitoring and documentation and no cover for MHA administrator when off on leave etc.

What we found this service did well

- Good joint working at local level
- Referrals to other agencies and third sector providers with focus on social integration
- Emphasis on prevention and early intervention
- Staff training
- Psychology and Psychiatry involvement in multidisciplinary meetings
- Physical health practitioner in post
- Medication management
- Risk assessments.

Patients told us:

"… finding out about my interests and things that could be encouraged to get me involved, inspired and engaged in positive activity was a golden thread through the support I was given; always solution focussed and positive."

"Sometimes I feel like I'm just being listened to but not listened to in any meaningful understanding way."

"No support as to how people should help me, no real guidance and just left waiting for appointments with no real outcome to how to deal with emotions etc especially in times of crisis."

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 team working and staff, in general, expressed enjoyment in their roles.

Where the service could improve

- Consider ways to further integrate the service and eliminate disparity higher up the management structure
- Continue with efforts to recruit into vacant posts.

What we found this service did well

- Staff support and supervision
- Visibility and accessibility of local management team
- Learning from incidents
- Auditing and reporting.

Staff told us:

"The team at Bryntirion are extremely supportive and it is a great place to work. My colleagues, the team lead and service manager are supportive and present, I feel appreciated by my team."

"My colleagues are caring and compassionate and responsive to service users' needs, I would be happy for anyone of them to support a friend or family member in service."

"I believe my manager and colleagues are exemplary but we are struggling as we are not at full capacity of staff and can only do so much. I feel we work very well together and use each other for peer feedback."

"Lack of staffing across the board which results in high workload and shorter time frames to see service users, the current staff go above and beyond to ensure they do the best they can. Many staff work over their allocated hours on a weekly basis."

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.