HIW & CIW: Joint Community Mental Health Team Inspection (Announced)

Wrexham Community Mental Health Team, Betsi Cadwaladr University Health Board and Wrexham County Borough Council

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Contents

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that people in Wales receive good quality healthcare

Our values

We place patients at the heart of what we do. We are:

- **Independent**
- **Objective**
- **Caring**
- **Collaborative**
- **Authoritative**

Our priorities

Through our work we aim to:

Provide assurance:	**Provide an independent view on the quality of care**
Promote improvement:	**Encourage improvement through reporting and sharing of good practice**
Influence policy and standards:	**Use what we find to influence policy, standards and practice**

Care Inspectorate Wales (CIW)

Our purpose

To regulate, inspect and improve adult care, childcare and social services for people in Wales

Our values

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

- **Integrity: we are honest and trustworthy**
- **Respect: we listen, value and support others**
- **Caring: we are compassionate and approachable**
- **Fair: we are consistent, impartial and inclusive**

Our strategic priorities

We have identified four strategic priorities to provide us with our organisational direction the next three years. These are:

- **To consistently deliver a high quality service**
- **To be highly skilled, capable and responsive**
- **To be an expert voice to influence and drive improvement**
- **To effectively implement legislation**

1. What we did

Healthcare Inspectorate Wales (HIW) and Care Inspectorate Wales (CIW) completed a joint announced community mental health team inspection (CMHT) of Wrexham CMHT within Betsi Cadwaladr University Health Board and Wrexham County Borough Council on 15 and 16 October 2019.

Our team, for the inspection comprised of two HIW inspectors, two clinical peer reviewers (one of whom was the nominated Mental Health Act reviewer) and two Care Inspectorate Wales (CIW) inspectors. The CIW inspectors were only present for the first day of the inspection. The inspection was led by a HIW inspection manager.

During this inspection, we reviewed documentation for patients detained under the Mental Health Act 1983 in order to assess compliance with the Act.

HIW and CIW explored how the service met the Health and Care Standards (2015) and the Social Services and Well-being (Wales) Act 2014. HIW also consider how services comply with the Mental Health Act 1983, Mental Health Measure (2010), Mental Capacity Act (2005).

Further details about how we conduct CMHT inspections can be found in Section 5.

2. Summary of our inspection

Overall, we found evidence that the service provided safe and effective care. However, we found some evidence that the service was not fully compliant with all Health and Care Standards (2015), Mental Health Act 1983 and the Social Services and Well-being (Wales) Act 2014.

We found the quality of service user care and engagement to be generally good and service users were mainly positive about the support they received.

All referrals received by the team are screened through the Single Point of Access (SPoA) process. We found that information shared between professionals was responded to in a timely manner.

We found that a multidisciplinary, person centred approach was in place for the assessment, care planning and review and that service users and their families were involved, where appropriate, in the process.

We found discharge arrangements to be satisfactory, in general, and tailored to the wishes and needs of service users.

Staff feedback in relation to workload and the quality of management and leadership was mixed, and this requires further exploration by the management team.

This is what we found the service did well:

- Staff engagement
- Information for patients and carers
- Physical environment was clean and welcoming
- Person centred care planning and provision
- Multidisciplinary approach to provision of care

- General record keeping
- Medication management
- Physical health overview for patients
- Management overview and governance
- Auditing, reporting and review
- Support and supervision for staff.

This is what we recommend the service could improve:

- Update risk assessments and link to care plans
- Mental Health Act Administration
- Access to psychology, occupational therapy and healthcare assistants
- Duty arrangements
- Ligature risk assessment
- Some aspects of staff training
- Staff involvement in decision making.

3. What we found

Background of the service

Wrexham Community Mental Health Team (CMHT) provides community mental health services at Ty Derbyn, Wrexham Maelor Hospital, Croesnewydd Road, Wrexham, LL13 7TD, within Betsi Cadwaladr University Health Board and Wrexham County Borough Council.

Wrexham CMHT provides community and recovery focussed mental health and social care in line with the statutory Welsh Government legislative framework led by the Welsh Mental Health Measure. Services within Wrexham are principally primary care (Tier 1), and the CMHT (Tier 2). The joint service providers are Betsi Cadwaladr University Health Board (BCUHB) and Wrexham County Borough Council Local Authority (LA). The team currently operates during daytime core hours of nine to five, from Ty Derbyn which is located on the site of Wrexham Maelor Hospital.

The team deals with a high referral rate of over 5,500 referrals per annum.

Services are community and recovery focused for adults with mental health needs, providing evidence based care within defined localities. There is full integration of nurses, social workers, support workers, psychiatrists, psychologists and occupational therapists. Although psychology and occupational therapy are line managed separately, they are co-located and work across the county. The line management for psychology is through to the Director of Psychological Therapies within the Mental Health & Learning Disabilities (MHLD) Division, BCUHB. The line management for Occupational Therapy (OT) is through to the Therapies Division, at BCUHB but there is close working across BCUHB. Ty Derbyn houses Local Primary Mental Health Support Services, psychological therapies, community mental health teams and Caniad[1], alongside accompanying administration support. The team has established links with local services such as home treatment, liaison team, and acute care services. All services attend, and play an active part in the weekly multi-disciplinary team meeting. Local authority staff, in the Initial Response Team, also work alongside

[1] https://caniad.org.uk/wrexham/

the team to share appropriate information regarding concerns received from North Wales Police and/or other social care agencies.

The team operates within the confines of the Welsh Mental Health Measure (WMHM) alongside the Social Services Well-being Act (SSWBA).

A county based approach for service delivery was in operation, with Tier 1 services, also based at Ty Derbyn, integrated within the whole county team. This has resulted in an expansion of the service to include new staff and a redistribution of the skill mix into front line Local Primary Care Mental Health Support Services. Medical support is also a key factor of the service, and Ty Derbyn has been instrumental in piloting a different model of working to allocate planned medical sessions to deliver accessible, direct comprehensive mental health services at the earliest point of referral. This was in the process of being evaluated to ensure that staff are supported appropriately to work alongside primary care services to offer a high standard of client care at the nearest point of entry to services in line with Part 1a and 1b of the WMHM.

Quality of patient experience

We spoke with patients, their relatives, representatives and/or advocates (where appropriate) to ensure that the patients' perspective is at the centre of our approach to inspection.

Overall, we found evidence that the service provided safe and effective care. However, we found some evidence that the service was not fully compliant with all standards in all areas.

The service users who contributed to the inspection were generally positive about the services they received. Service users, in the main, felt included and respected by the choices they were given.

During the inspection we distributed HIW questionnaires to service users to obtain their views on the standard of care provided by the CMHT. A total of 39 questionnaires were completed.

Most of the service users who completed the questionnaire rated the service provided by the CMHT as either excellent or very good, and nearly all said that staff treat them with dignity and respect.

Care, engagement and advocacy

Based on the service users' responses to the questionnaire, we determined the quality of care and engagement to be adequate.

Nearly all service users who completed a questionnaire said that their preferred language was English, and that they were always able to speak to staff in their preferred language.

Most respondents said that staff usually give them enough time to discuss their needs and treatment and few said they did not. Most respondents said that staff usually listen to them carefully when they meet.

We were told that service users were able to access Independent Mental Capacity Advocates (IMCA) and Independent Mental Health Advocates (IMHA). Around half of the service users who completed a questionnaire said they had been offered the support of an advocate. Most respondents said they knew how to contact this person if they have a concern about their care.

The majority of service users who completed a questionnaire said the service provided completely met their needs.

Improvement needed

The health board and local authority must ensure that all service users are afforded enough time to discuss their needs and treatment with staff.

Access to services

Ty Derbyn was accessible to people with mobility problems, with limited, designated disabled parking spaces located near the main entrance, and lowered curbs leading to the electronically operated door at the main entrance. There were adapted toilet facilities available within the waiting area.

The whole of the accommodation was in a good state of repair both externally and internally. The furniture and fixtures throughout the building were also in a good state of repair.

The waiting area and consulting rooms were clean and tidy. Health promotion leaflets and posters were available within the waiting area together with magazines for people to read whilst waiting to be seen.

We found access to the service and the referral process to be adequate. Referrals were, in the main, dealt with appropriately. However, staff told us that they often struggled to limit delays in addressing service users' needs due to the high demand.

We found that referrals were, in the main, received via general practitioners (GPs). However, referrals were also accepted from various sources such as other health or social care professionals or police.

A majority of respondents said they were referred to the CMHT by their GP, a few referred themselves following discharge from an inpatient ward, and around a quarter said that they were referred to the service by other means.

Around a quarter of respondents said it took them up to two weeks to be seen by the CMHT following their referral, around half said it took three to four weeks, and around a quarter said that they did not know or could not remember how they were referred. Comments included:

> *"I have been asking for help since 2016, but I feel I only started to get the correct help, help I needed since 2019, under the treatment of Doctor. Why does a person have to get to crisis point to get the help they need. Doctor and his team have been superb".*

"It takes too long to get help when there is a person in crisis who doesn't recognise or accept that they are suffering from mental ill health. Only when the crisis reaches a dangerous level and families are strong enough to fight the system to face CMHT to help is it put in place."

All referrals to the team are screened through the Single Point of Access process (SPoA). There was a very high demand on the service with up to 30 referrals being considered at SPoA meetings each day. Multi-disciplinary meetings, held to review referrals, were taking place regularly and were attended by members of the multidisciplinary team. We observed these meetings during the inspection and found that information was shared and responded to within the constraints of the pressures on the service.

Urgent referrals are dealt with through the duty system. Service users were usually seen on the same day by a duty officer. If, after relevant enquiries, the referral was not judged to be as urgent as first thought, then the service user would be offered an appointment, within 28 days with the primary mental health care team as required under the Mental Health Measure. There was high demand on the duty system and we were told that demand often outweighs capacity. This was being reviewed at the time of the inspection. Service users expressed mixed experiences of the duty system with some telling us that they had received a prompt response whilst one service user told us that they had to wait for four hours to be seen. Some staff also expressed concerns about the duty system stating that arrangements were not always well planned and that there was not always adequate cover in place. Comments included:

"Inefficiency in planning rotas - often on duty and clinic at same time. Numbers are priority not complexity and man hours spent. No reward for hard work and development of good practices."

"Duty system needs to be looked at, however, I am aware that this is in place."

"Some days on duty there is only one member of staff on the rota due to shortages. It is a regular occurrence not having anything to eat or drink when on duty as it is so busy."

"One duty system work is a free for all that severely impacts on duty and CMHT clients."

"Duty arrangements in our team have made the duty system unsafe, and unworkable. Managers have not come up with any sensible solution to this."

Referrals that require an assessment under the Mental Health Act are passed to one of the Approved Mental Health Professionals (AMHP) for action. The AMHP provide a designated service and do not act as care co-ordinators and are therefore able to respond to referrals in a timely way.

Where appropriate, and if service users do not meet the threshold for secondary health care, they are referred to other services better placed to meet their needs.

Where appropriate, people with caring responsibilities were offered carer assessments under the requirements of the Social Service Well-being (Wales) Act and were referred to Hafal[2], for additional support and advice.

Staff and managers told us that there was a delay of up to four years in service users being able access psychology and psychotherapy services after they were assessed as requiring them. The impact of this delay for service users was at best to hamper their recovery and could lead to service users' relapse. The health board should review the availability of psychology and psychotherapy support and look at ways of reducing waiting times, and how service users should be actively supported during the waiting period. It is concerning that the delay in accessing psychology support was highlighted as an area for improvement during inspections of other CMHT managed by the health board. There were also some delays in accessing Occupational Therapy and Health Care Support Worker services.

The team was experiencing some challenges with allocation of care co-ordinators due to the volume of referrals. However, staff told us that every effort was being made to ensure that this was being managed appropriately, with the most appropriate team member being allocated to work with particular service users.

All clinical staff had access to the BCUHB based IT network. Work was under way to develop a joint electronic case management system across Wales.

Out of hours emergency access to mental health services was provided by Wrexham Local Authority Emergency Duty Team (EDT). EDT consisted of AMHP provision, for assessments under the Mental Health Act. There was clear

[2] Hafal is a charitable organisation managed by the people they support: individuals whose lives have been affected by serious mental illness.

guidance in place to ensure safe and effective hand over of work from daytime to out of hours.

In addition, the Psychiatric Liaison Team offered access to 24 hour services for mental health assessments via the emergency department at Wrexham Maelor Hospital. We were told that there was good communication and joint working between the CMHT and the Psychiatric Liaison Team.

The majority of service users who completed a questionnaire said they knew how to contact the CMHT out of hours service, although nearly a third said they did not. Of those who said they had felt the need to contact the CMHT out of hours service in the last 12 months, around half said they got the help they needed.

Most respondents said they knew who to contact in the CMHT if they have a crisis, although a quarter said they did not. Of those who needed to contact the CMHT in a crisis in the last 12 months, around half said they got the help they needed.

Improvement needed

The health board and local authority must ensure that:

- Delays, from point of referral to when service users are assessed, are reduced
- The current duty system is reviewed, and that adequate staff cover is secured
- Sufficient resources are secured in order to improve access to psychology, psychotherapy, Occupational Therapy and healthcare support workers' services
- All service users are aware of how to contact the CMHT out of hours service
- All service users are aware of who to contact in the CMHT if they have a crisis and that they receive timely support.

Delivery of safe and effective care

We considered the extent to which services provide high quality, safe and reliable care centred on individual patients.

There was a multi-disciplinary, person centred approach to assessment, care planning and review. From the care files inspected, we found that service users were involved in the development of the care and treatment plans and relevant people such as family members or carers were also involved where appropriate.

The service had a system in place to enable patients to raise concerns/complaints and the service was able to demonstrate that they considered patient feedback to improve services.

The medication management processes were safe and robust.

We found the ligature point risk assessment required reviewing and updating in order to reflect all risks and to highlight actions to be taken.

Record keeping was generally good and care notes were easy to navigate. However, action is required to ensure that the service is compliant with the requirements of the Mental Health Act 1983.

Managing risk and promoting health and safety

The environment was found to be free of any obvious risk to health and safety. However, a service user spoken with during the inspection told us that they sometimes feel vulnerable when sitting in the waiting area, particularly when there are other, sometimes distressed service users waiting to be seen by staff.

General and more specific environmental risk assessments were undertaken and any areas identified as requiring attention were actioned. There was a ligature point risk assessment in place. However, we found that this required reviewing and updating in order to reflect all risks and to highlight actions to be taken.

From inspection of care files, we found that individual service users' risk assessments had been undertaken. However, these were not always being reviewed and updated in line with specified timescales.

Quarterly health and safety meetings were being held at Ty Derbyn to review any concerns and risks which are then escalated to the East area health and safety meeting and the Mental Health and Learning Disability divisional meeting. Key information relating to risk was shared with all staff electronically and at team meetings.

Staff told us that positive risk management was part of service planning and delivery. All staff are trained in the Wales Applied Risk Research Network (WARRN)[3] risk management framework. This training was considered mandatory for all clinical staff.

Staff told us that the weekly multidisciplinary meetings afforded them the opportunity to discuss and escalate any concerns. In addition, regular discussions between consultant medical staff and care coordinators promoted the escalation and documented of identified risks. Monthly supervision sessions, led by the team managers also enabled discussions around risk and escalation if required.

Improvement needed

The health board and local authority must ensure that:

- The ligature point risk assessment is reviewed and updated in order to reflect all risks and to highlight actions to be taken to reduce risks
- Individual service users' risk assessments are reviewed and updated in line with specified timescales.

Medicines Management

We found the management processes to be safe and robust.

We observed that the clinic room was clean and tidy with all cupboards kept locked. Stocks were kept in good supply.

Ty Derbyn had a high volume of clients who need ongoing support with their medication. Clozapine was monitored and depot injections were administered

[3] http://www.warrn.co.uk/

through the nurse led clinic service which also provided physical health care monitoring.

Assessment, care planning and review

There was a multi-disciplinary, person centred approach to assessment, care planning and review. From the care files inspected, we found that service users were involved in the development of the care and treatment plans and relevant people such as family members or carers were also involved where appropriate.

The care files we viewed were generally well managed and easy to navigate. However, some care plans had not been reviewed and updated to reflect the changes in service users' condition, as highlighted in the progress notes which were generally comprehensive.

Most service users who completed a questionnaire said that they were seen by the CMHT staff about the right amount of times, though nearly a quarter of respondents said they were not seen enough when needed.

Most service users who completed a questionnaire told us that they felt involved in the development of their care plan and that they received, or were given an opportunity, to have a copy of their care plan.

Around half of the service users who completed a questionnaire said that they had a formal meeting or review with their care coordinator to discuss their care in the last 12 months, with most adding that they felt involved in the discussions and decisions made about their care and support during their formal meeting or review.

A majority of respondents said they were given the opportunity to challenge any aspect of their care and treatment plan that they disagreed with during their formal meeting or review.

The majority of service users who completed a questionnaire said it was easy to access support from the CMHT when they need it, a few said it was not very easy. Comments included:

> *"Telephone numbers to communicate with them not through Ty Derbyn. Reception desk which has not good service at all. Too much anxiety by waiting on line every time, then you leave a message and no one comes back to you".*

> *"Very understanding people".*

We found that there were good systems in place to manage service users' physical health with monthly wellness, drop in clinics being held at Ty Derbyn.

This is open to all service users, whether open or closed to the CMHT. This enables third sector agencies to come together, to offer advice and support, in one location, and includes welfare rights, housing and voluntary agencies.

A quarter of service users who completed a questionnaire said they had needed support for physical health needs in the last 12 months, and most confirmed that they had received help.

Improvement needed

The health board and local authority must ensure that:

- Care plans are regularly reviewed and updated to reflect the changes in service users' condition
- All service users are able to access support from the CMHT when they need it.

Patient discharge arrangements

Following our inspection of case files, and discussions with staff, we found discharge arrangements to be generally satisfactory. This is because the process, in the main, was service user-led and managed in accordance with service users' requirements.

The majority of service users who completed a questionnaire said their accommodation needs have been met and around half said that their employment needs have been met by the services provided through the CMHT.

Around half of respondents said that their education needs have been met by the services provided through the CMHT.

The majority of respondents said that their social needs (such as being able to go out when they want), have been met by the services provided through the CMHT.

Around a third said that the option to receive direct payments to help meet their care and support needs had been discussed with them, around a third said it had not and a further third didn't know or couldn't remember.

Around half of the service users who completed the questionnaire said that the CMHT involved a member of their family, or someone else close to them, as much as they would have liked.

Around two thirds of respondents said they had been given information about other support services (including written) by the CMHT, and around a quarter said they had not. The remainder said they did not want any information.

Safeguarding

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

There were clear policies and procedures in place for staff to follow and the training information provided confirmed that staff had received adult and child safeguarding training.

The team has key link workers for both Multi Agency Risk Assessment Conference (MARAC)[4], and multi-agency public protection arrangements (MAPPA)[5] within the safeguarding arrangements.

Compliance with specific standards and regulations

Mental Health Act Monitoring

We reviewed the statutory documents of six service users who were the subject of Community Treatment Orders (CTO)[6] being cared for by Wrexham CMHT, and spoke with members of the Mental Health Act Administration team. We highlighted a number of areas for improvement in respect of documentation relating to the detention of patients under the Mental Health Act. Issues highlighted included:

[4] A Multi Agency Risk Assessment Conference (MARAC) is a local, multi agency victim-focused meeting where information is shared on the highest risk cases of domestic violence and abuse between different statutory and voluntary sector agencies.

[5] MAPPA stands for Multi-Agency Public Protection Arrangements and it is the process through which various agencies such as the police, the Prison Service and Probation work together to protect the public by managing the risks posed by violent and sexual offenders living in the community.

[6] Patients who have been detained in hospital under the Mental Health Act, may be discharged on to a community treatment order (CTO). A CTO is an order made by a responsible clinician to enable supervised treatment in the community.

- Non-compliance with Section 11 of the Act, in that medical examinations were not reviewed within the required five day time frame. This invalidated the Section 3 order and also the Community Treatment Order.

- A date on Part 3 of Form CP3 on one file had been altered from a 12 to a 13. This may have invalidated the detention.

- Form CO8, to authorise treatment for mental disorder on one file was completed before the commencement of the Community Treatment Order which is not reflective of Chapter 25.42 of the Code of Practice.

- Form CP2, variation of conditions under section 17(B)(2), on one file, did not evidence that the patient, or nearest relative, had been informed of a change, or that the patient had received a copy of Form CP2 in accordance with chapter 4.11 and 29.29 of the Code of Practice.

- Form CO6 for ECT treatment, on one file, did not contain any evidence of statutory consultation with the Second Opinion Appointed Doctor (SOAD)[7], in accordance with Chapter 25.62 of the Code of Practice, or a record that the responsible clinician has communicated the results of the SOAD visit, in accordance with Chapter 25.69 of the Code of Practice.

- On one file inspected there was no evidence that the responsible clinician had shared the SOAD decision with the patient following the completion of Form CO7, in accordance with chapter 25.69 of the Code of Practice.

- Old treatment certificates, which were no longer in force, and no longer authorise treatment, were not clearly marked as such, in accordance with chapter 25.87 of the Code of Practice.

- Statutory consultee records were not always completed following a visit by the SOAD, in accordance with chapter 25.62 of the Code of Practice.

[7] The SOAD service safeguards the rights of patients detained under the Mental Health Act who either refuse the treatment prescribed to them or are deemed incapable of consenting.

- There was no evidence on any files inspected of the non-statutory form being used to record that the patients has been explained their rights under section 132A of the Act in accordance with Chapter 4.3 of the Code of Practice, which states that patients should be informed of their rights both verbally and in writing.

- Some correspondence still referring to SCT (supervised community treatment), this term is no longer to be used effective from the Revised Code of Practice in October 2016.

- Expired Section 17[8] leave forms were not clearly marked as no longer valid, in accordance with chapter 27.17 of the Code of Practice.

Improvement needed

The health board must ensure that services are provided in line with the requirements of the Mental Health Act, and that all supporting documentation is accurately completed.

Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision

We reviewed the Care and Treatment Plans (CTP) of a total of 11 service users.

We found some consistency in the tool used to assess service users' needs and found this addressed the dimensions of life as set out in the Mental Health Measure and the domains set out in the Social Services and Well-being (Wales) Act, in most cases.

Overall, we found that the assessment of service users' needs was proportionate and appropriate.

[8] Section 17 leave can be used in respect of patients who have been treated in hospital under the Mental Health Act, and are being discharged or allowed out of the hospital on short-term leave, and may be put under a Community Treatment Order (CTO). Under Section 17 of the Act, patients can be recalled to hospital if, for example, they stop taking required medication or their condition gets worse.

Care plans were generally well structured and person centred and reflected service users' emotional, psychological and general health and well-being needs.

Entries within the case files were contemporaneous with all members of the team documenting their involvement/interventions within one file. However, as previously mentioned, care plans did not always reflect changes in service users' care needs which were reported in the progress notes.

We found the process of identifying, assessing and managing risk to be adequate with some files demonstrating a higher calibre of recording than others. We found that risk assessments mostly informed the interventions identified in the service user's care plan. However, as previously mentioned, these were not being reviewed and updated in line with specified timescales.

Compliance with Social Services and Well-being Act

It was evident from the care documentation seen, and from service users' responses to the questionnaire, that their views and wishes were the main focus of the work conducted by the CMHT. Service users told us that they felt involved, included and consulted in the planning of the support services. We saw examples where some service users had positively engaged in 'what matters'[9] conversations.

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

Quality of management and leadership

We considered how services are managed and led and whether the workplace and organisational culture supports the provision of safe and effective care. We also considered how the service review and monitor their own performance against the Health and Care Standards and the Social Services and Well-being Act.

We found that there were adequate links and communication between the management within the health board and local authority, with adequate overview of the service by both authorities.

Staff gave mixed comments in relation to management and leadership and suggested communication between managers and staff could be improved. This requires further exploration by the management team.

Leadership, management and governance arrangements

The integrated working of Health Staff and Local Authority Staff, within the CMHT, has been in place for over 15 years. The team was based in BCUHB accommodation. The team was managed by a county manager, whose substantive post was within the health board.

There was a partnership agreement in place to ensure appropriate integration of both local authority and health board functions. BCUHB and Wrexham LA hold budgets separately. The Community Service Manager has a responsibility and delegated accountability for both, working closely with Wrexham Local Authority Head of Service.

Weekly performance reports were being presented to the local authority and health board senior managers.

Team meetings were taking place on a weekly basis. These meetings were minuted and copies shared with team members. The senior leadership team also met on a regular basis and make themselves available to team members through visits to the office.

We were told that there have been some early discussions between BCUHB and Wrexham LA relating to the governance and management arrangements for social care staff. Wrexham LA is looking to strengthen social care roles and ensure the implementation of the Social Services and Well-being Act (Wales

2014), within mental health, whilst maintaining the level of integrated working delivered by the current arrangement.

There was a formal complaints procedure in place which was compliant with Putting Things Right[10] and the local authority's formal complaint process. Information about how to make a complaint was posted in the reception area.

Staff told us that emphasis was placed on dealing with complaints at the source in order for matters to be resolved as quickly as possible, as well as to avoid any further discomfort to the complainant and any need for escalation. All complaints are brought to the attention of the county manager who addresses them in line with relevant local authority and health board policy. Although there were two separate complaints processes in place, there was evidence of joint complaint investigation and reporting. Staff also told us that serious untoward incidents and concerns were recorded on the Datix[11] system, and discussed at weekly meetings and any learning disseminated to the team through the health board's quality, safety and experience group.

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

We reviewed a sample of eight staff files (four employed by the health board and four employed by the local authority). We saw that there was a formal staff recruitment process in place with all necessary pre-employment checks undertaken. We saw that there was a formal staff support and supervision process in place with regular one to one meetings being held between staff and

[10] Putting Things Right is a process for dealing with Complaints, Claims and Incidents which are collectively termed "Concerns". This represents a significant culture change for the NHS in Wales in the way in which it deals with things that go wrong, introducing a single and consistent method for grading and investigating concerns, as well as more openness and involvement of the person raising the concern.

[11] Datix is a web-based incident reporting and risk management software for healthcare and social care organizations.

their line managers. In addition to one-to-one meetings, staff told us that they received day to day, informal support from their line managers who were reported as being very accessible.

There were formal annual appraisals in place, managed under respective health board or local authority systems.

Professional support and supervision was accessible, both individually and as part of groups with staff able to access training from both the health board and local authority although there are challenges around electronic recording of training due to being employed by separate agencies. Staff also have separate electronic recording systems for annual leave and time sheets. However, local processes had been set up to keep this to a minimum with managers working across both governance arrangements to ensuring that training and staff ratios were actively managed.

Staff we spoke with told us that they were able to access mandatory and other service specific training and the training record we viewed confirmed this. Mandatory training completion figures were at 80% for clinical staff which is slightly below the target of 85%.

We distributed HIW questionnaires to staff during the inspection to obtain their views on the standard of care and working conditions. We received 22 completed questionnaires from a full range of staff. Respondents said they had been in their current role from two to over 30 years. The majority of respondents had been in post six years or more.

All staff who completed a questionnaire said that they had undertaken training in Health and Safety, the Mental Capacity Act 2005, Mental Health Act 1983, Deprivation of Liberty Safeguards, the Mental Health (Wales) Measure 2010, safeguarding adults and fire safety. Most said they had undertaken training in risk assessment and management and in safeguarding children.

A minority of staff said that they had undertaken training in Cognitive Behavioural Therapy (CBT)[12] and Dialectical Behaviour Therapy (DBT)[13], and most had received it more than 12 months ago.

Very few staff members who competed a questionnaire said that they had undertaken training in Family Therapy, with half saying that they had received other training relating to specialist care provided in their area of work.

Most staff members who completed a questionnaire said training, or learning and development helped them to do their job more effectively and said that it helped them to stay up to date with professional requirements. A majority said the training helped them to deliver a better experience for service users.

Half of the staff who completed a questionnaire said they had undertaken joint social services / health board training in the last 12 months.

Nearly all staff who completed a questionnaire told us that they had an appraisal, annual review or development review of their work in the last 12 months, and that their learning and development needs were identified.

Half of the staff who completed a questionnaire told us that they are often unable to meet all the conflicting demands on their time at work with around half saying that there was never enough staff within the CMHT to enable them to do their job properly. Comments from staff included:

> *"Whilst I always try to give my job 100%, it is becoming increasingly difficult due to poor management and staff shortages. It is unsafe to work due to lack of staff and no support from senior management."*

[12] Cognitive behavioural therapy (CBT) is a talking therapy that can help service users manage problems by changing the way they think and behave. It's most commonly used to treat anxiety and depression, but can be useful for other mental and physical health problems.

[13] Dialectical behavior therapy (DBT) is a type of talking treatment. It's based on cognitive behavioral therapy (CBT), but has been adapted to help people who experience emotions very intensely.

“Staff shortages has put added pressure on remaining staff - support very lacking.”

“Not enough time, resources to give the service user the care they need, and as I have been in this team for many years this saddens me. Although I attempted to give my best care this is not always possible and I have to be the bearer of bad news and be open and honest with the patient about lack of resources”.

A minority of respondents said they were able to make suggestions to improve the work of their CMHT with around half saying that they never felt involved in deciding on changes introduced that affect their work.

The majority of staff members who completed a questionnaire told us that were satisfied with the quality of care they are able to give to service users and service users informed and involved in decisions about their care.

Nearly half the staff who completed a questionnaire told us that the organisation encourages teamwork.

A minority of staff told us that there was, generally, a culture of openness and learning with the organisation that supports staff to identify and solve problems.

Around half the staff said that partnership working with other organisations was effective.

The majority of staff said that they were able to access the electronic records management system and databases in order to support the provision of good care and support for service users.

The majority of staff members who completed a questionnaire told us that that their manager encourages them to work as a team and that they could be counted on to help them with a difficult task at work. Comments included:

“Easily accessible and approachable.”

“Despite change in management, I still feel that we are very much supported”.

The majority of staff who completed a questionnaire told us that they know who the senior managers were and that there is generally effective communication between senior management and staff.

Around half agreed that their immediate manager takes a positive interest in their health and well-being and a minority disagreed. Around half did not agree their manager takes positive action on health and well-being. Around half agreed that

their current working pattern/off duty allows for a good work life balance and few disagreed.

> *"Managers do not listen to the staff, there have been a few serious incidents in the team, including a member of the team violently attacked. Managers have not made any changes since and staff are still at risk of being attacked."*

> *"Although I do know my senior management, I do not feel supported by them. I find they ignore staff concerns around safe staffing levels and lack of services available to patients."*

> *"Due to low staff levels, and not being supported after a serious incident this led to myself and other members of the team having to take a period of on work related stress."*

> *"I was off work with work related stress - I was harassed so much by a manager that I ended up even more stressed - and nothing got done."*

> *"Staff feel not supported by managers if an error, near incidents, feel they are blamed. Staff member was treated badly over a [recent incident.]"*

A minority of staff who completed the questionnaire said that they had seen errors, near misses or incidents in the last month that could have hurt staff or service users. Most staff who had seen an error said they had reported it.

Around half of respondents did not agree that the CMHT treats staff who are involved in an error, near miss or incident fairly, with a minority of respondents stating that the CMHT encourages them to report errors, near misses or incidents.

A minority of respondents agreed that the CMHT would treat reports of an error, near miss or incident confidentially and slightly more disagreed.

Half of respondents stated that the organisation would blame or punish the people who are involved in such incidents. Around half disagreed that action would be taken on incidents identified.

> *"Culture of blame rather than support."*

> *"There is a culture of blame within the service."*

> *"Manager are too easy to blame staff and do not treat staff fairly."*

"Staff have been seriously injured nothing has been done."

Around half of the staff members who completed the questionnaire said that they were not always informed about errors, near misses and incidents that happen in the team and a minority said they were given feedback about changes made in response to reported errors, near misses and incidents.

Most of the staff who completed a questionnaire said that if they were concerned about unsafe clinical practice they would know how to report it. Around half said they would feel secure raising concerns about unsafe clinical practice. However around 40% of respondent would not. Around half were not confident their organisation would address their concerns once reported.

"There have been numerous, all reported. Yet again, managers or health and safety officer do nothing about it."

Around half of respondents said that management did not act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age.

A few staff reported having personally experienced discrimination by service users, their relatives or other members of the public. Nearly a third of respondents said they had personally experienced discrimination by a manager / team leader or other colleagues. Those who reported discrimination said it had been on grounds of gender, sexual orientation, age and "other" grounds. Comments included:

"We have issues on a weekly basis with patients/families being verbally aggressive towards staff."

Improvement needed

The health board and local authority must ensure that:

- All staff complete all aspects of mandatory training and are familiar with the requirements of the Social Services and Well Being (Wales) Act 2014
- Relevant staff receive CBT and DBT training
- Staff are able to meet all the conflicting demands on their time
- Staff are able to make suggestions to improve the work of the team and that they are involved in deciding on changes introduced that affect their work
- A culture of openness and learning is encouraged and supported with the team
- Positive action is taken in respect of staff health and well-being
- All errors, near misses and incidents are treated confidentially
- Staff involved in errors, near misses and incidences are treated fairly
- Appropriate action is taken as a result of errors, near misses and incidences and staff are kept informed about changes made in response to reported errors, near misses and incidents
- Staff feel secure in raising concerns about unsafe clinical practice and that they feel confident that management would address their concerns once reported
- Staff are not subjected to discrimination.

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, measurable, 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 HIW's website.

5. How we inspect community mental health teams

Our inspections of community mental health teams are announced. The service receives up to 12 weeks' notice of the inspection.

Feedback is made available to service representatives at the end of the inspection, in a way which supports learning, development and improvement at both operational and strategic levels.

We check how CMHTs are meeting the Health and Care Standards 2015, Social Services and Well-being Act (Wales) 2014 comply with the Mental Health Act 1983 and Mental Capacity Act 2005. We consider other professional standards and guidance as applicable.

These inspections capture a snapshot of the standards of care within community mental health teams.

Further detail about how HIW inspects mental health and the NHS can be found on our website.

Appendix A – Summary of concerns resolved during the inspection

The table below summarises the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
No immediate concerns were identified on this inspection.			

Appendix B – Immediate improvement plan

Service: Wrexham Community Mental Health Team

Date of inspection: 15 and 16 October 2019

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	Health/Social Services Lead	Responsible officer	Timescale
No immediate assurance issues were highlighted during this inspection.					

Appendix C – Improvement plan

Service: Wrexham Community Mental Health Team

Date of inspection: 15 and 16 October 2019

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	Health/Social Services Lead	Responsible officer	Timescale
Quality of the patient experience					
The health board and local authority must ensure that all service users are afforded enough time to discuss their needs and treatment with staff.	3.2 Communicating effectively Social Services and Well Being Act (Wales) 2014 Part 3 Code of Practice (assessing the needs of individuals) points 16, 17, 18, 23.	Review the Duty system to ensure that there is a more robust process in place for unscheduled care patients so that patients are seen by their Care Coordinator or the relevant Team and not the Duty Officers.	Community Service Manager	Head of Operations & Service Delivery (BCUHB) & Service Manager Initial Response & Mental Health (WCBC)	April 2020
The health board and local authority must ensure that delays,	5.1 Timely access; Well-being priority 1	Review the Duty system to ensure that there is a more robust process in	Community Service Manager	Head of Operations & Service Delivery	April 2020

Improvement needed	Standard	Service action	Health/Social Services Lead	Responsible officer	Timescale
from point of referral to when service users are assessed, are reduced.	Social Services and Well Being (Wales) Act 2014 Part 4 Code of Practice (Meeting Needs) point 20 Social Services and Well Being (Wales) Act 2014 Part 8 Code of Practice on the Role of the Director of Social Services (social services functions)	place for unscheduled care patients so that patients are seen by their Care Coordinator or the relevant Team and not the Duty Officers.		(BCUHB) & Service Manager Initial Response & Mental Health (WCBC)	
The health board and local authority must ensure that the current duty system is reviewed, and that adequate staff cover is secured.		Review the Duty system to ensure that there is a more robust process in place for unscheduled care patients so that patients are seen by their Care Coordinator or the relevant Team and not the Duty Officers.	Community Service Manager	Head of Operations & Service Delivery (BCUHB) & Service Manager Initial Response & Mental Health (WCBC)	April 2020
The health board and local authority must ensure that sufficient resources are secured		Internal processes are to be reviewed to	Head of Occupational Therapy	Assistant Director of Therapies	March 2020

Improvement needed	Standard	Service action	Health/Social Services Lead	Responsible officer	Timescale
in order to improve access to psychology, psychotherapy, Occupational Therapy and healthcare support workers' services.		improve access to Occupational Therapy. Business case to be developed for additional Psychological Therapies staff which will explore the opportunity to introduce Band 4 Assistant Psychologists to the teams. Review the current Health Care Support Worker provision allocated to the teams based on demand and if there is a need for additional support, review what resource is available that can be moved to support the team on a	Consultant Clinical Psychologist Community Service Manager	Director of Clinical Psychology & Psychological Therapies Head of Operations & Service Delivery (BCUHB) & Service Manager Initial Response & Mental Health (WCBC)	July 2020 July 2020

Improvement needed	Standard	Service action	Health/Social Services Lead	Responsible officer	Timescale
		short/medium/long term basis.			
The health board and local authority must ensure that all service users are aware of how to contact the CMHT out of hours service.		All Service Users are to receive a copy of their Care & Treatment Plan which includes details of contact details out of hours. Develop posters for within the waiting area and clinic rooms which clearly display out of hours contact numbers and details. Develop wallet-sized cards, to be available on reception, with emergency contact details for patients to take away.	Community Service Manager	Head of Operations & Service Delivery (BCUHB) & Service Manager Initial Response & Mental Health (WCBC)	March 2020
The health board and local authority must ensure that all		All Service Users are to receive a copy of their	Community Service Manager	Head of Operations &	March 2020

Improvement needed	Standard	Service action	Health/Social Services Lead	Responsible officer	Timescale
service users are aware of who to contact in the CMHT if they have a crisis and that they receive timely support.		Care & Treatment Plan which includes details of contact details out of hours. Develop posters for within the waiting area and clinic rooms which clearly display out of hours contact numbers and details. Develop wallet-sized cards, to be available on reception, with emergency contact details for patients to take away.		Service Delivery (BCUHB) & Service Manager Initial Response & Mental Health (WCBC)	
Delivery of safe and effective care					

Improvement needed	Standard	Service action	Health/Social Services Lead	Responsible officer	Timescale
The health board and local authority must ensure that the ligature point risk assessment is reviewed and updated in order to reflect all risks and to highlight actions to be taken to reduce risks.	2.1 Managing risk and promoting health and safety Social Services and Well Being Act (Wales) 2014 Part 3 Code of Practice (assessing the needs of individuals) Point 53, 63, 64 Social Services and Well Being (Wales) Act 2014 Part 4 Code of Practice (Meeting Needs)	Review anti-ligature assessments, update current risks and ensure these are included at the Local Health & Safety Group Meeting for review. Agree routine reviews of the risk assessments.	Community Service Manager	Head of Operations & Service Delivery (BCUHB) & Service Manager Initial Response & Mental Health (WCBC)	February 2020
The health board and local authority must ensure that individual service users' risk assessments are reviewed and updated in line with specified timescales.		Raise staff awareness through an immediate memo and Team Meetings. Carry out an audit of case notes as part of Supervision and discuss with staff the	Community Service Manager	Head of Operations & Service Delivery (BCUHB) & Service Manager Initial Response & Mental Health (WCBC)	February 2020 May 2020

Improvement needed	Standard	Service action	Health/Social Services Lead	Responsible officer	Timescale
		importance of timely reviews and to update paperwork accordingly.			
The health board and local authority must ensure that care plans are regularly reviewed and updated to reflect the changes in service users' condition. The health board and local authority must ensure that all service users are able to access support from the CMHT when they need it.	3.1 Safe and Clinically Effective care Social Services and Well Being (Wales) Act 2014 Part 4 Code of Practice (Meeting Needs) points point 113, 114, 120, 121	Raise staff awareness through an immediate memo and Team Meetings. Carry out an audit of case notes as part of Supervision and discuss with staff the importance of timely reviews and to update paperwork accordingly. Develop posters for within the waiting area and clinic rooms which clearly display out of	Community Service Manager Community Service Manager	Head of Operations & Service Delivery (BCUHB) & Service Manager Initial Response & Mental Health (WCBC) Head of Operations and Service Delivery Head of Operations & Service Delivery (BCUHB) & Service	February 2020 June 2020 February 2020

Improvement needed	Standard	Service action	Health/Social Services Lead	Responsible officer	Timescale
		hours contact numbers and details. Develop wallet-sized cards, to be available on reception, with emergency contact details for patients to take away.		Manager Initial Response & Mental Health (WCBC)	
The health board must ensure that services are provided in line with the requirements of the Mental Health Act, and that all supporting documentation is accurately completed.	Application of the Mental Health Act	Ensure that the process in place to scrutinise and check Mental Health Act papers is followed. Ensure that all staff are up to date with their Mental Health Act mandatory training.	MHA Manager Community Service Manager	Head of Governance Head of Operations and Service Delivery Head of Operations & Service Delivery (BCUHB) & Service Manager Initial Response & Mental Health (WCBC)	February 2020 March 2020

Improvement needed	Standard	Service action	Health/Social Services Lead	Responsible officer	Timescale
		Ensure that staff utilise the expertise of the Approved Mental Health Practitioner Team that is co-located in the CMHT and also that of the Mental Health Act Team.	Community Service Manager	Head of Operations & Service Delivery (BCUHB) & Service Manager Initial Response & Mental Health (WCBC)	February 2020
Quality of management and leadership					
The health board and local authority must ensure that all staff complete all aspects of mandatory training. Also, that all staff are familiar with the requirements of the Social Services and Well Being (Wales) Act 2014.	Health and Care Standards - Governance, Leadership and Accountability; Social Services and Well-being (Wales) Act - Part 8	Review mandatory training during supervision to ensure compliance of all staff. Ensure that there is specific focus around the Social Services and Well Being (Wales) Act within Team Meetings and share guidance with all staff.	Community Service Manager Community Service Manager	Head of Operations & Service Delivery (BCUHB) & Service Manager Initial Response & Mental Health (WCBC)	April 2020 February 2020

Improvement needed	Standard	Service action	Health/Social Services Lead	Responsible officer	Timescale
		Training and Development Officer to meet with Local Authority Staff to ensure that staff know how to access the learning hub and community care inform. Training opportunities to be shared with staff by Team Managers.	Local Authority Team Manager Team Managers		March 2020 February 2020
The health board and local authority must ensure that relevant staff receive CBT and DBT training.		Review staff training and development needs through supervision and Performance Appraisal Development Review (PADR) and encourage staff to apply for CBT/DBT training if this is relevant to their role.	Community Service Manager	Head of Operations & Service Delivery (BCUHB) & Service Manager Initial Response & Mental Health (WCBC)	March 2020

Improvement needed	Standard	Service action	Health/Social Services Lead	Responsible officer	Timescale
The health board and local authority must ensure that staff are able to meet all the conflicting demands on their time.		Ensure that discussions are held in supervision and team meetings and clearly documented and that staff are encouraged to manage their time appropriately.	Community Service Manager	Head of Operations & Service Delivery (BCUHB) & Service Manager Initial Response & Mental Health (WCBC)	March 2020
The health board and local authority must ensure that staff are able to make suggestions to improve the work of the team and that they are involved in deciding on changes introduced that affect their work.		Senior Leadership Team to attend regular Team Meetings to share developments and receive suggestions for service improvements. Staff to be encouraged to be involved in local communication programmes such as Listening Leads or the Be Proud campaign.	Community Service Manager	Head of Operations & Service Delivery (BCUHB) & Service Manager Initial Response & Mental Health (WCBC)	April 2020
The health board and local authority must ensure that a culture of openness and learning		Staff are to be encouraged to attend and participate in local	Community Service Manager	Head of Operations & Service Delivery	February 2020

Improvement needed	Standard	Service action	Health/Social Services Lead	Responsible officer	Timescale
is encouraged and supported with the team.		meetings and feed back to their teams the learning from such meetings. Continue to share the Strategy, Service & Re-Design (SSRD) Monthly Update with Teams and ensure this is being discussed in Team Meetings. Ensure that learning from Serious Untoward Incidents are shared with the Teams.	Community Service Manager Community Service Manager	(BCUHB) & Service Manager Initial Response & Mental Health (WCBC)	February 2020 March 2020
The health board and local authority must ensure that positive action is taken in respect of staff health and well-being.		Staff are to be encouraged to complete Wellbeing Action Plans as part of their supervision. Managers to discuss individual staff requirements during supervision and make any reasonable	Community Service Manager Community Service Manager	Head of Operations & Service Delivery (BCUHB) & Service Manager Initial Response & Mental Health (WCBC)	March 2020 March 2020

Improvement needed	Standard	Service action	Health/Social Services Lead	Responsible officer	Timescale
		adjustments to support individuals.		Head of Operations & Service Delivery	
The health board and local authority must ensure that all errors, near misses and incidents are treated confidentially.		Staff are to be encouraged to attend local Today We Can and Quality, Safety, Experience, Effectiveness and Leadership Meetings to understand how incidents, etc. are reported, discussed and managed to assure staff that these are treated confidentially.	Community Service Manager	Head of Operations & Service Delivery (BCUHB) & Service Manager Initial Response & Mental Health (WCBC)	March 2020
The health board and local authority must ensure that staff involved in errors, near misses and incidences are treated fairly.		Staff are to be encouraged to attend local Today We Can and Quality, Safety, Experience, Effectiveness and Leadership Meetings to	Community Service Manager	Head of Operations & Service Delivery (BCUHB) & Service Manager Initial Response &	March 2020

Improvement needed	Standard	Service action	Health/Social Services Lead	Responsible officer	Timescale
		understand how incidents, etc. are reported, discussed and managed and individual staff involved in such incidents, etc. are supported by Managers utilising the systems and services that are in place. Set up a peer support system for staff.	Community Service Manager	Mental Health (WCBC)	March 2020
The health board and local authority must ensure that appropriate action is taken as a result of errors, near misses and incidences and staff are kept informed about changes made in response to reported errors, near misses and incidents.		Staff are to be encouraged to attend local Today We Can and Quality, Safety, Experience, Effectiveness and Leadership Meetings to understand how incidents, etc. are reported, discussed and managed. Share Lessons Learned Bulletin and ensure this	Community Service Manager Community Service Manager	Head of Operations & Service Delivery (BCUHB) & Service Manager Initial Response & Mental Health (WCBC)	March 2020 March 2020

Improvement needed	Standard	Service action	Health/Social Services Lead	Responsible officer	Timescale
		is clearly displayed and discussed within Team Meetings.			
The health board and local authority must ensure that staff feel secure in raising concerns about unsafe clinical practice and that they feel confident that management would address their concerns once reported.		Ensure that raising concerns is a standing item at Team Meetings and that staff are encouraged to raise concerns as this is the process for learning and improving our service. Ensure that staff are aware of how to raise concerns through their Line Management and Senior Managers. Ensure that staff are aware of the Safe Haven process.	Community Service Manager Community Service Manager Community Service Manager	Head of Operations & Service Delivery (BCUHB) & Service Manager Initial Response & Mental Health (WCBC) Head of Operations & Service Delivery (BCUHB) & Service Manager Initial Response & Mental Health (WCBC)	February 2020 February 2020 February 2020
The health board and local authority must ensure that staff		Staff are to be made aware of the process for raising concerns if they	Community Service Manager	Head of Operations & Service Delivery	February 2020

Improvement needed	Standard	Service action	Health/Social Services Lead	Responsible officer	Timescale
are not subjected to discrimination.		feel discriminated against. Staff to attend Equalities Training and Dignity at Work Training. Signage to be developed in the waiting area in relation to there being a zero tolerance for discriminatory abuse on staff.	Community Service Manager	(BCUHB) & Service Manager Initial Response & Mental Health (WCBC)	February 2020

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): Hilary Owen

Job role: Head Of Governance and Compliance, Mental Health & Learning Disabilities

Date: 4th February 2020