Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Community Mental Health Team Inspection (Announced)

Swansea North Community Mental Health Team, Swansea Bay University Health Board

Inspection date: 15 and 16 July 2025
Publication date: 16 October 2025

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

Communications Manager
Healthcare Inspectorate Wales
Welsh Government
Rhydycar Business Park
Merthyr Tydfil
CF48 1UZ

Or via

Phone: 0300 062 8163
Email: hiw@gov.wales
Website: www.hiw.org.uk

Digital ISBN 978-1-80633-577-0

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

Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people

Our values

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

- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and diversity through our work
- Proportionate - we are agile and we carry out our work where it matters most

Our goal

To be a trusted voice which influences and drives improvement in healthcare

Our priorities

- We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety
- We will work collaboratively to drive system and service improvement within healthcare
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities.

Contents

1. What we did 5

2. Summary of inspection 6

3. What we found 10

- Quality of Patient Experience 10
- Delivery of Safe and Effective Care 16
- Quality of Management and Leadership 22

4. Next steps 26

Appendix A – Summary of concerns resolved during the inspection 27

Appendix B – Immediate improvement plan 27

Appendix C – Improvement plan ..... **Error! Bookmark not defined.**

1. 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) completed an announced inspection of Swansea North Community Mental Health Team within Swansea Bay University Health Board on 15 and 16 July 2025.

Our team, for the inspection comprised of two HIW healthcare inspectors, two CIW inspectors, three clinical peer reviewers, one of which was a Mental Health Act reviewer.

During the inspection we invited service users or their carers to complete a questionnaire to tell us about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of 11 questionnaires were completed by service or their carers and nine were completed by staff. Feedback and some of the comments we received appear throughout the report.

Where present, quotes in this publication may have been translated from their original language.

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

2. Summary of inspection

Quality of Patient Experience

Overall summary:
Only a small number of service users who completed the questionnaire said that staff provided them with sufficient time to discuss their needs and treatment, and even fewer felt that staff listened to them attentively during their meetings. Although advocacy services were made available, less than half of respondents reported being offered advocacy support.

There was evidence through discussion and observation that the staff team supported service users' rights to dignity and respect, demonstrating a commitment to upholding rights and equality. Capacity assessments for decision-making were conducted where necessary, yet outcomes were not consistently documented within care records.

Access to services could be gained through the NHS 111 option 2 service, enabling people of all ages to contact a mental health professional at any time, day or night, seven days a week.

There was a central Single Point of Access (SPOA) service in place, which as the name suggests, enables service users and their carers to access support and advice in a timely and effective way without the inconvenience of being re-directed. However, service users told us that it was difficult to access support when they needed it, and that they did not know who to contact in a crisis.

This is what we recommend the service can improve:

- Ensure that the physical health service it is effective in meeting the needs of all service users and that communication between staff and service users is improved
- Ensure that all service users and their carers are aware of how to access support and advice outside of normal office opening hours
- Consider ways of better managing ADHD referrals to ensure that service users receive timely and effective intervention and to reduce the pressure on other aspects of the service
- The health board must ensure that service users have timely access to psychiatry and psychology services
- Ensure that service users are offered the option of receiving service through the medium of Welsh and that this is consistently recorded within care records
- The health board and local authority must ensure that service users are given enough time to discuss their needs and treatment.

This is what the service did well:

- Single point of access to services
- Service user involvement in the assessment and care planning process.

Delivery of Safe and Effective Care

Overall summary:
The inspection found that care records relating to the Mental Health Act were generally well maintained. In each record, Community Treatment Orders (CTOs) were deemed legally valid, with conditions clearly articulated and all supporting documentation completed correctly.

An effective system was established to ensure all aspects of CTO administration functioned efficiently, as evidenced through documentation, timely notifications to professionals, clear correspondence with patients and relatives, and the provision of information regarding patient rights and advocacy services. However, care documentation did not always reflect the person centred and empowering approach to care planning and provision.

The care records reflected all domains of the Mental Health (Wales) Measure, encompassing emotional, psychological, and physical health needs. Emphasis was placed on enabling service users to take ownership of their care, with relative involvement where appropriate. However, the service users' voice and preferences were not consistently recorded within care and treatment plans, and there was limited evidence of planned therapeutic interventions, which impeded the capacity to deliver proactive, person-centred support.

Although care and treatment plans were reviewed by practitioners in most records, the documentation of these reviews was not consistently informative, timely, or well-co-ordinated. Formal reviews tended to be logged as case notes by the care coordinator, with limited evidence of input from the broader multidisciplinary team. Additionally, review records did not reference outcomes from care and treatment plans. It is therefore essential that the health board and local authority ensure that all records are comprehensive, promptly maintained, well-coordinated, and accurately reflect the outcomes specified in the care and treatment plan.

Immediate assurances:

- Medication storage refrigerator and room temperatures were not consistently recorded daily.
- There were no notices attached to the door of the duty room indicating that an oxygen cylinder was stored there.

- Staff working at the service had not received training on the safe administration of oxygen in the event of an emergency.

This is what we recommend the service can improve:

- Some aspects of risk management
- Ensure that the person centred and empowering approach to the provision of care and support is fully embedded across the service and that care documentation consistently reflects service users' views on how they wish to be cared for
- Ensure that the service user's wishes are always reflected in the care and support documentation
- Review the administrative support available
- Ensure that care and treatment plans and ongoing support arrangements are reviewed within specified timeframes and that all relevant professionals are involved.

This is what the service did well:

- Multidisciplinary approach to the provision of care
- Mental Health Act administration
- Infection prevention and control
- Pharmacy support.

Quality of Management and Leadership

Overall summary:
Health and social care staff were integrated and co-located. This enhanced joint working and day to day communication between the health board staff and local authority team members. Staff were striving to provide a seamless service and overall, there were good, informal and formal working relationships between the local authority and health board staff.

The inspection found ongoing efforts towards learning, improvement, and research within the service, highlighting quality improvement activities and partnership development. Audit processes were in place for care records, but were not regular, though joint digital care plan audits are in development. Team Managers participate in meetings where quality-related issues and themes are escalated and reviewed, ensuring that any actions or learning are communicated to staff.

A whole-systems approach was demonstrated through partnership working, with timely interventions helping to avoid hospital admissions, smooth transfers of care between teams, and collaboration with third sector agencies and local GPs supporting service users.

Overall, staff views on the culture of the CMHT were generally positive, with most staff telling us that they were generally satisfied with the working environment and conditions.

This is what we recommend the service can improve:

- Remain focused on staff recruitment and retention to establish a permanent staff team and ensure continuity of care
- Review the roles and responsibilities of reception staff to ensure that they are employed in sufficient numbers, are treated fairly and that lone working risks are properly managed
- Undertake a comprehensive staff training needs analysis to identify any gaps in current provision and to support staff development by ensuring that staff have time to complete training
- The health board must develop a more robust general auditing and reporting framework for quality assurance and to facilitate service development.

This is what the service did well:

- Staff striving to provide a seamless service
- Good staff support, supervision and appraisal processes in place
- Mandatory training completion rates.

Details of the concerns for patient's safety and the immediate improvements and remedial action required are provided in Appendix B.

3. What we found

Quality of Patient Experience

Patient feedback

HIW issued online and paper questionnaires to obtain service user views on Swansea North CMHT. In total, we received 11 responses. Not all respondents completed every question, and responses were generally critical of the service.

Service users told us that they were generally dissatisfied with the care and support they received, that staff did not listen to them, and that their views and wishes were not always considered during the care planning process.

Service users also reported that they experience problems accessing the service and encountered delays in contacting the service over the phone with calls often going unanswered.

Service user comments included:

> *"My experience at Ty Einon was deeply distressing and left me feeling invalidated and unheard. I had high hopes when I first reached out for support, but unfortunately, the care I received was far below an acceptable standard".*
>
> *"Ty Einon is honestly a massive failure to the community. I first dealt with Ty Einon when I was 18 and been with them and [Doctor] since. I have practically begged to speak to [Doctor] because I really don't like the physical and mental effects of the controlled stimulant he has prescribed me."*
>
> *"I often go months without seeing anybody. I get told they will do things for me but then I never hear from them again about it. e.g. I asked for therapy sessions. Instead of helping me book them my nurse told me he could do them himself. Then I never heard back about that until he moved jobs and the next person in charge actually progressed my request and got me on the waiting list."*

The health board and local authority must reflect on the comments made by service users and take steps to address the issues raised.

Person centred

Health promotion

Staff supported service users to maintain their physical health, and health promotion material was available.

Service users had access to a physical health clinic. However, the service did not extend to home visits, neither was a system in place to follow up on patients who do not attend. Communication from the physical health team was described as very poor.

The health board must review the physical health provision to ensure that it is effective in meeting the needs of all service users, and that communication between staff and service users is improved.

The physical health clinic room was reasonably well equipped and contained equipment, such as to obtain patient blood samples, pulse oximetry, Oxygen cannisters and an anaphylaxis kit. It was the duty nurse's responsibility to check these monthly. However, there was no equipment checklist available to ensure what and when the checks were completed.

The health board must produce a checklist for the equipment stored within the physical health treatment room, and ensure it is checked regularly.

Dignified and respectful care

Consultations and confidential discussions with service users were seen to take place in private.

Individualised care

Service users who completed the electronic survey said that they did not feel listened to, and that their views and wishes were not always considered during the care planning process. They also reported poor experiences when accessing services.

The care documentation seen did not always reflect the person centred and empowering approach to care planning and provision. Service users' views were not consistently recorded within care and treatment plans. In several cases, the assessments lacked clear evidence of the individual's voice, preferences, or lived experiences. This limits the ability of the risk assessment to inform meaningful, person-centred planning and may reduce its effectiveness in supporting proactive and preventative approaches to care. Strengthening the use of reflective, strengths-based language and ensuring co-production with the individual would enhance the quality and impact of risk management planning.

The health board and local authority must ensure that the person centred and empowering approach to the provision of care and support is fully embedded across the service, and that care documentation consistently reflects service users' views on how they wish to be cared for.

Communication methods varied depending on the individual's preferences, needs and risks. Some preferred to visit Ty Einon, others preferred home visits and combinations of phone calls or text messages.

Family members were included in communication arrangements, where consent is provided, and could be a useful source of information where service user engagement fluctuates.

Timely

Timely care

We were told that service users could access the CMHT through NHS Wales 111 Option 2 service. This service enables people of all ages to contact a mental health professional in their area at any time day or night, seven days a week.

In addition, the central Single Point of Access (SPOA) service, as the name suggests, enables service users and their carers to access support and advice in a timely and effective way without the inconvenience of being re-directed. The team also accepts some direct referrals which they triage internally, on a daily basis.

However, half of the service users who completed the questionnaire told us that it was difficult to access support when they needed it, and that they did not know who to contact when in a crisis. Only two service users told us that they were able to access right healthcare at the right time.

Service user comments included:

> *"The waiting lists are huge. I don't see them very often. I used to see them once a week. Now I see them maybe once every 3 months which has coincided with my MH declining significantly to the point where I'm now so bad my parents are struggling to look after me and I've had interactions with the Police."*

> *"Even when actually talking to someone who is qualified to help, they don't really have anything to offer. A lot of waiting in hopes the patient sorts themselves out it seems. Crisis line is just the reception team who don't like answering the phones."*

> *"Crisis team do nothing. No one thinks of the longer picture, they just want you to go away and hopefully not die on their shift."*

The comments shared by service users are a concern, and the health board and local authority should consider these comments and make improvements as appropriate.

The health board and local authority must ensure that all service users and their carers are aware of how to access support and advice outside of normal office opening hours, and that they can access the right healthcare at the right time.

The prioritisation and provision of care and support was facilitated through assessment and triage of service user needs.

Half of the service users who completed the questionnaire felt the wait between referral and appointment was more than a month, and that the last time they saw someone from CMHT was within the last six months.

We were informed that there had been a substantial increase in referrals involving service users with a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD), with a waiting time of over four years for assessment. This has placed significant additional pressure on the service and has meant that psychiatrists are not always able to see the most complex cases in a timely way. We were told that there was a delay of up to four months in accessing psychiatry outpatient appointments.

The health board must promptly review the process in place for managing ADHD referrals, and ensure service users receive timely and effective assessment and intervention, and to reduce the pressure on other aspects of the CMHT service.

Concern was also expressed about the difficulties staff encountered when trying to access urgent consultant appointments, and we were told that this can take several weeks.

There was only one, part time psychologist working within the CMHT and we were told there was a 12 month wait for service users accessing psychology support.

The health board must ensure that service users have timely access to psychiatry and psychology services.

We were told that when service users are discharged from hospital, it is the Care Co-ordinator's responsibility to carry out the 72-hour review. However, discharge details have often not been received from the ward within 72 hours, resulting in review delays.

The health board must ensure that the CMHT is informed of any hospital discharges in a timely way, to ensure Care Co-ordinators can review service users following discharge within the 72-hour deadline.

Equitable

Communication and language

We were told that staff used a variety of communication methods, such as home visits, texts, and calls based on individual preferences and risk assessment.

Written information in the form of posters and leaflets were available in both Welsh and English.

We were told that staff are encouraged to complete a basic Welsh language course and there are opportunities to further develop Welsh language skills through the health board training department.

Some members of staff are bilingual (Welsh/English). However, the 'active offer' to receive services through the medium of Welsh was not consistently recorded within service users' care and treatment records.

The health board and local authority must ensure that service users are offered the option of receiving services through the medium of Welsh, and that this is consistently recorded within care records.

Translation services were also available to aid communication in other languages.

Only three service users who completed the questionnaire felt that staff gave them enough time to discuss their needs and treatment, and only four felt that staff listened to them carefully when they meet.

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

We were told that service users could access advocacy services. However, less than half of the questionnaire respondents said they were offered the support of an advocate.

The local authority and health board must ensure that all practitioners understand the importance of offering advocacy support to service users and must record this within individual care files.

Rights and equality

Discussions with service users and observations of staff interactions demonstrated that the team were supportive of service users' rights to be treated with dignity and respect.

Service users' capacity to make decisions was assessed when required. However, this was not consistently recorded within their care records.

The health board and local authority must ensure that the outcome of capacity assessments is consistently recorded within care records, using a clear and systematic format, demonstrating how the decision has been reached. As a matter of good practice, the criteria relating to patients' capacity to consent to treatment as outlined in the Mental Health Act Code of Practice, should be applied.

The premises were accessible with a ramp provided to enable wheelchair access into the building.

All service user accessible areas are located on the ground floor with service users escorted by staff due to the locked doors.

Delivery of Safe and Effective Care

Safe

Risk management
The environment was found to be generally free of any obvious risk to health and safety.

There was a comprehensive environmental ligature risk assessment in place that included the waiting area, and we were told that service users are never left unattended when at the clinic. We were told that there may be periods when service users could be unobserved whilst in the waiting area. Although there are reception staff and CCTV, there is limited observation of this area if individuals are occupied with other tasks. Patients are chaperoned once taken through from reception to the clinical rooms. However, the risk assessment mitigations did not specify that service users at risk should be reviewed jointly, in an appropriate and safe duty room, and that they would not be left unsupervised.

The health board and local authority must ensure that the ligature risk assessment mitigations specify that service users at risk should be reviewed jointly, in an appropriate and safe duty room, and that they must not be left unsupervised.

The waiting area is partially observed by the reception staff and is not always directly observed. In addition, not all chairs within the waiting area were secured to the floor, therefore, posing a risk to service user and staff safety.

The health board must ensure that all furniture within the waiting area is fixed to the floor to maintain service user and staff safety.

Close Circuit Television (CCTV) cameras were installed in various parts of the clinic. However, the cameras within the assessment rooms were not working. This has been identified as a risk during the Health & Safety Inspection conducted on 24 June 2025, and is awaiting action. In addition, emergency call alarms were not available in all consulting rooms.

The health board must ensure that all CCTV cameras are working, and that an emergency call bell is made available in all consulting rooms to maintain service user and staff safety.

There was a formal process in place for managing and reporting incidents. Staff explained that incidents are reported and that an assessment of level of harm is undertaken, and consideration given to the need for external notification to other

agencies. Where learning had been identified following incidents, this was fed back to staff through staff and Multidisciplinary Team (MDT) meetings.

From inspection of care records, we confirmed that service user risk assessments were completed and followed a MDT approach. It was positive to note that complex risks were escalated through professional forums, with multi-agency input where needed.

Discussions held with service users about risk management were recorded within care records. Consideration was being given to service users rights to take acceptable risks in accordance with the Mental Capacity Act 2005.

There were generally good infection prevention and control (IPC) measures in place, which were supported by comprehensive policies and procedures.

The environment was clean, tidy and well maintained. However, carpets were fitted within consultation rooms which should ideally be replaced with flooring that can be easily cleaned and decontaminated. The carpet on the stairs also required cleaning or replacing.

The health board should consider replacing the carpets within consulting rooms with flooring that can be effectively cleaned and decontaminated. The same consideration must be given to the carpet on the stairs.

The most recent IPC audit was conducted on 8 July 2025. The audit highlighted a 75% compliance with environmental standards, and 73% practice based assessments. We were told that this was the first IPC audit of this nature for the CMHT and that the intention is to undertake annual audits going forward.

Safeguarding of children and adults
There were clear procedures in places for staff to follow in the event of a safeguarding concern. The team also worked closely with other professionals and agencies to co-ordinate multi-agency responses to concerns raised, within established safeguarding processes. There were also systems in place to support both Multi Agency Risk Assessment Conference (MARAC), and Multi-agency Public Protection Arrangements (MAPPA).

Safeguarding arrangements within the local authority were generally robust. Practitioners spoken with demonstrated a good understanding of their responsibilities, and we saw evidence of appropriate action being taken in response to safeguarding concerns. However, where safeguarding concerns arose outside of the local authority, or within health services, outcomes were not always clearly communicated to the care co-ordinator. This can result in gaps in

understanding and delays in updating care and support plans, which may impact the continuity and effectiveness of support provided.

The health board and local authority must ensure that all safeguarding outcomes are clearly communicated to the care co-ordinators.

We confirmed appropriate safeguarding training had been provided to staff, and compliance with the mandatory training was good.

Medicines management
There was an appropriate medicines management system in place and staff were aware of the procedures to follow in respect of ordering medication.

We reviewed the medication storage arrangements in both the clinic room and duty room and found that medication storage refrigerator and room temperatures were not consistently recorded daily. **This issue was dealt with under HIW's immediate assurance process and are referred to in more detail within Appendix B of this report.**

The service was well supported by a pharmacist who attended the clinic four days a week. The pharmacist was able to prescribe medication and discuss medication matters with service users and their carers. In addition, a pharmacy technician attends the clinic on a Tuesday to assist with medication administration clinics, monitor the stock of depot (slow release) antipsychotic medication, and to manage medication stocks. They also audit the depot charts and ensure no doses have been missed, and that no staff signatures have been omitted.

We found that an oxygen cylinder was stored on the premises as part of the emergency resuscitation equipment. However, there were no warning signs on the door leading where the oxygen cylinder was stored. In addition, we found that staff working at the service had not received training on the safe administration of oxygen in the event of an emergency. **These issues were dealt with under HIW's immediate assurance process and are referred to in more detail within Appendix B of this report.**

Effective

Effective care
Service users were supported to remain safe, and work towards recovery.

Practitioners demonstrated a clear understanding of risk and safeguarding responsibilities, and we saw evidence of timely interventions and crisis planning. In several cases, individuals were supported through stable accommodation, regular contact with care co-ordinators, and access to good third sector services.

There were examples of thoughtful planning and testing of placements, including leave periods and family involvement, which support person-centred transitions. We reviewed care records of five service users on Community Treatment Orders (CTO) and nine supported by Care and Treatment Plans. The MDT approach to care and treatment planning was inconsistent, with reviews often unscheduled or poorly documented, and limited MDT input and reflective learning.

Most records had compliant care and treatment plans aligned with the Welsh Measure and showed MDT and service user involvement, although the voice of the service user was not always recorded. Assessments were jointly completed by nurse and social workers, however, some sections, such as consent to share information and social context, were incomplete.

The health board and local authority must ensure that there is consistency with MDT care and treatment planning and that all relevant section are complete. In addition, that the service users vice is always considered and recorded.

We also found evidence that psychiatric reviews were often conducted in isolation, and documentation lacked multi-disciplinary contributions. In addition, whilst there was strong collaboration within the social care team, there was a lack of social work presence through system in key teams, such as the Crisis Team. Furthermore, there was no evidence of risk formulation, including MDT representation, in the generic risk assessments.

The health board and local authority must ensure that Care and Treatment Plans and risk assessments are co-produced by the MDT and signed by all professionals involved.

There was a significant lack of administrative support for psychiatric appointments, which contributed to delays in treatment and placed additional burden on care co-ordinators. A significant backlog in managing correspondence and appointment planning was also noted.

The health board must ensure that there is adequate administrative support available to effectively manage correspondence and appointment scheduling.

The Approved Mental Health Practitioner (AMHP) service was also under pressure, with unclear quality assurance processes in place. This limits oversight and the ability to evaluate the consistency of decision-making.

The local authority must ensure that the AMHP service is adequately resourced, and that there are clear quality assurance processes in place to ensure effectiveness and consistency of decision making.

Patient records
The care records we reviewed were, in the main, well maintained. There was a joint, electronic recording system in use which facilitated effective information sharing between the health board and local authority staff. However, the electronic system was fragmented and not used by all parts of the wider service, such as psychiatry and inpatient services, which made accessing information difficult.

Staff explained that plans were in place to develop a new electronic records management system. However, this system would not be integrated across healthcare and social care teams. This therefore highlights that significant risks will remain with health and social care teams using separate case management systems, without clarity on how the separate systems will communicate with one another or shared promptly across teams.

The health board and local authority must ensure that there is consistency with MDT care and treatment planning and that all relevant section are complete. In addition, that the service users voice is always considered and recorded.

Mental Health Act monitoring
We found Mental Health Act administration records to be generally well maintained. In all cases, the CTOs were legally valid. Conditions were clear and relevant, with all supporting documentation correctly completed.

Our discussions with the Mental Health Act Administrator, demonstrated their good knowledge in relation to the application of, and compliance with the Mental Health Act, and associated Code of Practice. An effective operational system was in place to ensure all aspects of administering CTOs run smoothly. This was evidenced in relevant documentation, notifications to professionals, letters to patients and relatives, information on patient rights, and advocacy services.

Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision
There was good evidence of day-to-day communication with the local authority team and collaboration across the wider MDT, to support the delivery of care in line with the Mental Health Measure.

Service user records we reviewed reflected the domains of the Mental Health (Wales) Measure. This included service users emotional, psychological, and physical health needs. There was a focus on ensuring service users took ownership of their care, with the involvement of relatives where desired. However, the service user's voice and wishes were not always reflected in all the care and

treatment plans viewed as highlighted earlier. In addition, there was limited evidence of planned or therapeutic interventions by the local authority staff. This restricted the ability to deliver proactive, person-centred support.

The local authority must ensure that service planned or therapeutic interventions are recorded.

We found evidence that care and treatment plans were reviewd in most care records. However, review documentation was not always informative, timely or well-co-ordinated. Formal reviews were generally documented as case notes by the care coordinator, with unclear input from the wider MDT. Review records often did not reference outcomes from care and treatment plans.

The health board and local authority must ensure that review records are comprehensive, promptly maintained, effectively co-ordinated, and accurately reflect the outcomes specified in the care and treatment plan.

Quality of Management and Leadership

Staff feedback

We held face-to-face discussions with staff during the inspection and invited staff to complete an online survey to reflect their views on the quality of the service and the support they received from the management team. We received nine responses.

Staff survey responses were mixed and are further highlighted within the following sections of this report.

Staff comments included:

> *" The management over the past few years has improved at team manager and service manager level."*
>
> *" My manager is always on hand if you need advice or support. She will always support you if you are required to attend meetings for patients."*
>
> *"The health team manager and service managers have helped make improvements over the last few years which is well received but medical input is a challenge as their clinics are so busy."*

Leadership

Governance and leadership

The health and social care staff were integrated and co-located. This enhanced day to day communication between the health board staff and local authority team members.

Staff were striving to provide a seamless service and there were generally good informal and formal working relationships in place between the local authority and health board staff.

Leadership within the Swansea North CMHT was described as being approachable, values-driven, and well-regarded by staff. The social care team manager fosters a collaborative and resilient culture, with regular supervision, open-door support, and strong morale reported across the workforce.

Workforce

Skilled and enabled workforce

Staff demonstrated strong collaboration and commitment to values, however, systemic pressures, particularly in psychiatry, psychology, administration, and AMHP cover hindered fully integrated, person-centred care. Strengthening reflective practice, cross-discipline communication, and workforce capacity is essential to improve outcomes. Vacancies limited service delivery, and timely preventative or therapeutic work.

The health board and local authority must remain focused on staff recruitment to establish a permanent staff team and ensure effective continuity of care.

Issues were identified in relation to reception staff numbers and responsibilities. We were told that reception staff had responsibility for opening and locking the building at the beginning and end of the day, and that on occasion this requires them to come in early and that they are not reimbursed for the extra hour they work. In addition, concerns were raised with regards to lone working when the staff member starts work early and leaves late.

The health board must review reception staff roles to ensure adequate staffing, fair treatment and appropriate lone working arrangements.

We reviewed a sample of staff files and saw there was a formal staff recruitment process in place, with all necessary pre-employment checks undertaken.

There were staff support, supervision and appraisal processes in place and most staff had received regular one-to-one meetings with their line managers. Staff told us that they generally felt supported in their roles, although there is limited opportunity for reflective practice within supervision sessions.

The health board and local authority must ensure that reflective practice discussions form part of staff supervision sessions.

We were told that access to training was generally good. However, operational demands often make it difficult for staff to find time to attend training events. Staff also report limited career progression opportunities compared to other areas of social services.

The health board and local authority must undertake a comprehensive staff training needs analysis to determine any gaps in current provision and to facilitate staff development, ensuring that staff have sufficient time to complete training.

Culture

People engagement, feedback and learning

There were Duty of Candour and the NHS Wales Putting Things Right policies in place. We were told that there were separate local authority and complaints recording systems in use. However, all complaints and incidents relating to Ty Einon were logged on the health board's Datix system regardless of source. Joint meetings were held to discuss the issues raised and formulate action plans. Learning is then shared with staff and any training needs identified.

Staff had received Duty of Candour training, and those spoken with were aware of their responsibilities and explained the process that would be followed on the receipt of a concern or following an incident.

There was a Feedback and Involvement Team in place who gathered service user feedback for Ty Einon. We were told that, over the past two years, 33 responses have been received from service users, with most responses being positive. However, a small number of respondents highlighted difficulties in accessing services over the telephone and calls not being returned. This is consistent with the service user comments in our questionnaire.

Information

Information governance and digital technology

Staff had received training on information governance and were aware of their responsibilities when dealing with confidential information.

Learning, improvement and research

Quality improvement activities

We were told that both the health board and local authority conduct audits on a regular basis, this included team manager and Lead Nurse quality assurance audits and joint CTP audits between Health Board and Local Authority. However, we found little documented evidence of regular joint audits taking place, although staff explained that joint digital care and treatment plan audits were being developed.

The health board and local authority must progress the plans to establish a more robust, joint general auditing and reporting framework for quality assurance, and to facilitate service development.

Team Managers attend meetings, where quality issues, themes and concerns are escalated and reviewed. Any actions or learning identified during these meetings

are fed back to staff through various internal processes, such as MDT meetings and staff emails.

Whole-systems approach

Partnership working and development
Care records showed timely interventions from the Assessment Home Treatment Team as an alternative to hospital admission. One record indicated a successful transfer of care to older person mental health service, with evidence of integrated support between teams for and effective transfer of care.

The team had established links with third sector agencies to help deliver some outcomes for service users, that the CMHT may find difficult to achieve on its own.

The team works closely with primary care services to include local General Practitioners (GPs).

4. 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 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 how the findings identified will be addressed
- 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
- Ensure required evidence against stated actions is provided to HIW within three months of the inspection.

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

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.			

Immediate improvement plan

Service: Swansea North Community Mental Health Team

Date of inspection: 15 and 16 July 2025

Findings

HIW was not assured that medication management processes are sufficiently robust and safe.
We looked at the medication storage arrangements in both the clinic room and duty room and found that medication storage refrigerator and room temperatures were not consistently recorded daily. This increases the risk of harm to patients.

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
The health board must ensure that measures are in place to ensure the medication refrigerator and medication storage room temperatures are monitored and recorded daily.	Delivery of Safe and Effective Care	• The rostered duty officer will record the medication refrigerator and medication storage room temperatures daily. • The duty officer checklist has been reviewed to ensure this is included as a daily mandatory task and this has been communicated with the team. • Weekly checks to be undertaken by the rostered pharmacy technician to ensure daily compliance is maintained and non-compliance will be raised to the CMHT Manager.	CMHT Team Manager	Complete

Findings

There were no notices attached to the door of the duty room indicating that an oxygen cylinder was stored there.

This meant that we could not be assured that the risks of harm were appropriately managed.

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
The health board must ensure that an appropriate notice is placed on the door to the duty room to indicate that an oxygen cylinder is stored there.	Delivery of Safe and Effective Care	• With immediate effect, the Health Board's Health & Safety team have provided a compliant interim safety sign which is now displayed. • Permanent oxygen warning signage, compliant with the Health & Safety Regulations, has been ordered and will be installed immediately upon delivery. Please note that the timescale recorded is an expected delivery date. • Concurrently, an assessment is being undertaken to establish whether oxygen is required for this unit.	Directorate Manager for Adult Mental Health	Complete 01.08.25 01.08.25

Findings

We found that staff working at the service had not received training on the safe administration of oxygen in the event of an emergency.

This meant that we could not be assured that the risks of harm to patients was appropriately managed.

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
The health board must ensure that staff receive appropriate training on the safe administration of oxygen in the event of an emergency.	Delivery of Safe and Effective Care	• A review of current staff training records has been undertaken to identify gaps in oxygen administration competences. • As such, Medical Gas Awareness Training sessions have been booked for delivery on 29.7.25 and 5.8.25 to all registered staff	Lead Nurse for Community Services Medical Devices Training Lead	Complete 29.07.25 - 05.08.25

		within the department who would use the equipment. • Further training sessions will be arranged to accommodate staff currently absent from work and new starters.		

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): **Michelle Forkings**

Job role: **Nurse Director for Mental Health and Learning Disabilities**

Date: **23/07/2025**

Improvement plan

Service: Swansea North Community Mental Health Team

Date of inspection: 15 and 16 July 2025

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.

Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1. Service users told us that they were generally dissatisfied with the care and support that they received and that staff did not listen to them and that their views and wishes were not always considered during the care planning process.	The health board and local authority must reflect on the comments made by service users and take steps to address the issues raised.	Person Centred	a) The service will review compliance with the *Collaborative Communication Approach to Practice* training, to include Local Authority colleagues and assess the need for refresher training to strengthen person-centred engagement and ensure service users 'voices are consistently heard and respected	Principal Officer, Swansea City & County Council and DMT	30.11.25

			b) The service will hold a reflective session to share and consider the feedback provided by service users during the inspection. The Learning & Development Team will review the feedback and identify how key themes can be incorporated into *Care and Treatment Planning* (CTP) training. This training which is available to both Health Board and Local Authority staff, will be updated to strengthen person-centred practice and ensure service users' views are embedded throughout the care planning process.	Ty-Einon CMHT Management Team and Learning and Development Team	30.11.25
			c) The Learning and Development Team will consider the inclusion of digital patient stories in the training for care and treatment planning.	Directorate Management Team and Learning & Development	30.11.25

			d) There is an expectation that all care coordinators attend the CTP training. The service has reviewed the compliance for Care and Treatment Planning Training and is developing a plan to improve the current position.	As above	30.10.25
1. (continued) Service users also reported that they experience problems accessing the service and encountered delays in contacting the service over the phone with calls often going unanswered.			e) The service will review the administrative establishment and identify the progress of recruitment to ensure vacancies are being progressed. f) The service will pilot a new telephone system. To improve access and streamline communication, the CMHT is introducing a telephone options system that directs callers to the most appropriate team member based on the nature of their enquiry. This ensures timely support, reduces misdirected calls, and helps	Directorate Manager Lead Nurse & Directorate Manager	30.10.25 Pilot will commence 1.11.25 and reviewed after 6-month period

			manage workload across the team more effectively. Evaluation of the pilot will be conducted within 6 months.		
2. The physical health service did not extend to home visits nor was there a system to follow up on patients who do not attend. Communication from the physical health team was described as very poor.	The health board must review the physical health provision to ensure that it is effective in meeting the needs of all service users and that communication between staff and service users is improved.		A Standard Operating Procedure (SOP) will be developed for the physical health clinic processes inclusive of home visits, Did Not Attend (DNA) and equipment checklists. This will be presented for sign off Policy Review Group and ratified in the Mental Health Quality and Safety Committee	Divisional Management Team	30.11.25 (Policy Review Group) and 16.12.25 (MH Quality & Safety Committee)
3. There was no checklist available to record equipment checks in the physical health clinic room.	The health board must produce a checklist for the equipment stored within the physical health treatment room, and ensure it is checked regularly.		As above the service will develop an SOP which will include an equipment checklist (16/12/25). In the interim, the service will develop a checklist to ensure the recording of equipment whilst awaiting the above.	Divisional Management Team	16.10.25

4. Care documentation did not always reflect the person centred and empowering approach to care planning and provision, and service users' views were not consistently recorded within care and treatment plans.	The health board and local authority must ensure that the person centred and empowering approach to the provision of care and support is fully embedded across the service, and that care documentation consistently reflects service users' views on how they wish to be cared for.		a) We will review the compliance for the collaborative communication approach to practice training for all Local Authority staff and consider the need for refresher training.	Principal Officer, Swansea City & County Council & DMT	30.11.25
			b) As highlighted in 1c) the Learning and Development Team will consider the inclusion of digital patient stories in the training for care and treatment planning.	Learning and Development Team & DMT	30.11.25

			c) There is an expectation that all care coordinators attend the CTP training. The service has reviewed the compliance for Care and Treatment Planning Training and is developing a plan to improve the current position.	Divisional Management Team	30.10.25
			d) The service has developed a digital CTP audit which will be conducted across the CMHTs. The audit does include a review as to whether the patient voice has been captured in an empowering approach.	Divisional Management Team	30.10.25
			e) The CTP audit process has been modernised to ensure that a multi-professional approach is used and completed digitally to allow for	Divisional Management Team & Learning & Development Team	In place. Reviewed in 2 stages: 1st review by end Q4 31.12.25

			efficiencies and easier thematic review of audits. These will be undertaken in the next 2 quarters, and this modernisation of the process will be evaluated.		
5. Service users told us that it was difficult to access support when they needed it, and that they did not know who to contact in a crisis.	The health board and local authority must ensure that all service users and their carers are aware of how to access support and advice outside of normal office opening hours and that they are able to access the right healthcare at the right time.	Timely Care	a) While care coordinators currently engage in discussions with service users regarding the crisis support services available to them, there is a recognised need to formalise this process. (subsequent actions listed para b – h below) b) To enhance clarity and consistency, the service will develop an information leaflet outlining the available crisis support options, in conjunction with the	Divisional Management Team & Mental Health and Learning Disabilities Feedback, Involvement and Improvement Team As above	31.12.25 31.12.25

			experts by experience within the Service Group.		
			c) Furthermore, the service will undertake a review of the current methods of communication to ensure that information regarding crisis support is conveyed in a clear, accessible, and standardised manner.	As above	31.12.25
			d) As highlighted under 4 e) a digital CTP audit will be conducted.	Divisional Management Team & Learning & Development Team	In place. Reviewed in 2 stages: 1st review by end Q4 31.12.25
			e) The service will ensure all service users who have had a CTP reviewed in the last 3 months will receive a further copy of their CTP which includes the crisis plan.	Ty Einon CMHT Management Team	30.11.25
			f) Ty Einon is currently in the second phase of a		

			pilot, whereby Person-Centred Safety Plans are being tested in a community setting, (In line with the All-Wales Patient Safety Program). This will allow us to understand the successes and challenges to support roll out to other community teams. The pilot will be evaluated and next steps identified.	Ty Einon CMHT Management Team & Care Coordinators	In place and for review by 31.12.25
			g) The service will develop a patient leaflet with the experts by experience as one of the communication methods.	Learning and Development Team / Quality Improvement Team	31.12.25
			h) As highlighted under 1f), the service will pilot a new telephone system. To improve access and streamline communication	Divisional Management Team	Pilot will commence 1.11.25 and reviewed after 6-month period

6. There had been a substantial increase in referrals involving service users with a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) with a waiting time of over four years for assessment. This has placed significant additional pressure on the service and has meant that psychiatrists are not always able to see the most complex cases in a timely way. We were told that there was a delay of up to four months in	The health board must promptly review the process in place for managing ADHD referrals, and ensure service users receive timely and effective assessment and intervention, and to reduce the pressure on other aspects of the CMHT service.	a) The service will analyse the demand and capacity modelling within outpatients across CMHTs to identify ways in which the waiting time can be reduced for psychiatric outpatient appointments. This will include reviewing the ADHD model and identifying improvements in order to better meet the demand and support of service users	Divisional Management Team	31.01.26
		b) The service will develop a process for urgent outpatient clinic slots so that those service users who require urgent review are able to be seen without delay. This will be monitored via the Mental Health Outpatient Improvement Group as part of its key performance indicators.	Divisional Management Team	31.10.25

	accessing psychiatry outpatient appointments.		c) The service will ensure the modernisation groups include a focus on access to ensure service users can access Mental Health support in a timely manner.	Divisional Management Team	Review by 31.12.25
7.	There were delays in accessing psychiatry and psychology services.	The health board must ensure that service users have timely access to psychiatry and psychology services.	a) The service will review outpatient's templates in line with RC Psychiatry guidelines to ensure they have urgent slots. This will be monitored via the Mental Health Outpatient Improvement Group as part of its key performance indicators.	Divisional Management Team	31.10.25
			b) The service has reviewed the psychology provision via a workplace plan. There is a 0.5 wte vacancy (preceptorship band 7/8a) at present due to reduction in hours. This post is currently going through	MH Psychology Lead	31.01.26

			the new recruitment process		
8. We were told that the CMHT are not informed of hospital discharges in a timely way so that Care Coordinators are able to review service users within the 72-hour deadline.	The health board must ensure that the CMHT is informed of any hospital discharges in a timely way, to ensure Care Coordinators can review service users following discharge within the 72hour deadline.		a) The service is reviewing current mechanisms in place that support discharge planning processes to ensure that there is seamless communication between inpatient and community staff. b) The service is reviewing the utilisation of SIGNAL for care coordinators in CMHTs so they are able to view the information of the service users whilst being an inpatient. *SIGNAL is a Swansea Bay University Health Board digital communication platform that holds patient admission information, including*	Divisional Management Team Divisional Management Team	31.10.25 31.10.25

			care and treatment plans and discharge planning.		
9. The 'active offer' to receive services through the medium of Welsh was not consistently recorded within service users' care and treatment records.	The health board and local authority must ensure that service users are offered the option of receiving services through the medium of Welsh and that this is consistently recorded within care records	Equitable Care	a) The active offer will continue to be provided to patients, however there is no formal recording mechanism currently in place. The service will review whether the new digital system, RIO which will replace WCCIS, can include the active offer as a Mandatory field on RIO. *To note, the go live date for RIO has been set for September 2026.*	Head of Operations	31.10.25
			b) The service will display posters in line with the active offer in Ty Einon's waiting room area. The service will encourage the uptake of Welsh language training	Ty-Einon Management Team	Complete

10. Some service users did not feel that staff gave them enough time to discuss their needs and treatment, and that staff did not listened to them carefully when they meet.	The health board and local authority must ensure that service users are given enough time to discuss their needs and treatment with staff.		a) The service will hold a reflective session to share the comments made by the service users from this inspection. The experts by experience will be involved in this session. b) The service will engage with the Mental Health Feedback, Involvement and Improvement team to increase the service user feedback.	Mental Health and Learning Disabilities Feedback, Involvement and Improvement Team / QI Team Mental Health and Learning Disabilities Feedback, Involvement and Improvement Team / QI Team	30.11.25 30.11.25
11. Service users are not always offered the support of an advocate.	The local authority and health board must ensure that all practitioners understand the importance of offering advocacy support to service users and must		a) The service will share information regarding advocacy service to all staff. The service will complete a CTP Audit which will review the evidence of whether advocacy is offered within the CTP.	Ty Einon CMHT Management Team	31.12.25

	record this within individual care files.		b) The service will display posters regarding advocacy in the Ty-Einon waiting rooms c) The service will invite the Advocacy service to present an information sharing session with the team to raise awareness.	Ty Einon CMHT Management Team Ty Einon CMHT Management Team	31.10.25 Invite to be sent by 31.10.25
12. Service users' capacity to make decisions was not consistently recorded within care records.	The health board and local authority must ensure that the outcome of capacity assessments is consistently recorded within care records, using a clear and systematic format, demonstrating how the decision has been reached. As a matter of good practice, the criteria relating to		a) The service has reviewed the compliance for MCA training which is currently 56.25%. Team leaders to promote refresher training where required to improve the % to 85%. b) Training dates have been provided to registered staff to book on via ESR, team manager to continuously monitor. As an interim, the service has shared information with the team regarding	Directorate Team, Ty Einon CMHT Management Team and MCA Lead. Directorate Team, Ty Einon CMHT Management Team and MCA Lead.	The Division has a trajectory to 85% by 31.1.26 and will monitor. Complete

	patients' capacity to consent to treatment as outlined in the Mental Health Act Code of Practice, should be applied		accessing e-learning resources. c) The service to review consent to treatment process with the Mental Health Act Team.	Directorate Team, Ty Einon CMHT Management Team and MCA Lead.	31.12.25
13. Risk assessments did not specify that service users at risk should be reviewed jointly, in an appropriate and safe duty room, and that they would not be left unsupervised.	The health board and local authority must ensure that the ligature risk assessment mitigations specify that service users at risk should be reviewed jointly, in an appropriate and safe duty room, and that they must not be left unsupervised	Safe care	The Environmental Ligature risk assessment to be updated to reflect the mitigating actions that should be taken to ensure a patient is chaperoned once within the clinical areas of Ty Einon Centre. This will be communicated out to all staff within the team.	Ty Einon CMHT Management Team	30.11.25
14. Not all chairs within the waiting area were secured to the floor.	The health board must ensure that all furniture within the waiting area is fixed to the floor to maintain service		The service has requested estates to fix chairs within the CMHT.	Ty Einon CMHT Management Team	31.10.25

	user and staff safety.			
15. The CCTV cameras within the assessment rooms were not working and emergency call alarms were not available in all consulting rooms.	The health board must ensure that all CCTV cameras are working, and that an emergency call bell is made available in all consulting rooms to maintain service user and staff safety	a) We will review the environmental Risk Assessment to ensure staff safety (share wider with staff) and review the use of hand held personal alarms to support clinical staff using non consulting rooms. This is also managed on a risk basis. b) The service has liaised with the Health Board's CCTV lead to identify issues and a solution.	Ty Einon CMHT Management Team Ty Einon CMHT Management Team	30.11.25 31.10.25
16. Carpets fitted within consultation rooms should be replaced with a floor covering that is easier to clean and the carpet on the stairs required	The health board should consider replacing the carpets within consulting rooms with flooring that can be effectively cleaned and decontaminated. The same	The service has liaised with estates to ascertain quotes to replace flooring in consultation rooms and to report back to Divisional Board for consideration and decision.	Ty Einon CMHT Management Team	30.11.25

cleaning or replacing.	consideration must be given to the carpet on the stairs.				
17. Outcomes of safeguarding concerns arising outside of the local authority or within health services, outcomes were not always clearly communicated to the care co-ordinator.	The health board and local authority must ensure that all safeguarding outcomes are clearly communicated to the care co-ordinators.		The current process is, the local authority reviews the referral, decide on threshold for strategy and feedback to the referrer. The service will review the current communication process with the Health Board's corporate safeguarding team as they receive all outcomes.	Directorate Team	30.11.25
18. Not all elements of service user assessments were completed.	The health board and local authority must ensure that there is consistency with MDT care and treatment planning and that all relevant section are complete. In addition, that the service users vice is	Effective Care	The service has developed a digital CTP audit which will be conducted across the CMHTs. The audit will ensure that all assessments are completed in their entirety. Audit findings will be shared with team managers and care coordinators to ensure identified improvements are completed	Directorate Team	30.11.25

	always considered and recorded.				
19. Care and treatment plans lacked evidence of being co-produced or signed by all professionals involved and the voice of the service user was not consistently evident. Psychiatric reviews were often conducted in isolation, and documentation lacked multi-disciplinary contributions. There was a lack of social work presence through system in key teams such as the Crisis Team.	The health board and local authority must ensure that Care and Treatment Plans and risk assessments are coproduced by the MDT and signed by all professionals involved.		a) Care and Treatment planning processes will be co-produced with service users and carers to ensure views and priorities are central to care. This work will begin ahead of the introduction of the new RIO clinical system, so that principles are embedded in practice prior to future system implementation *The digital platform RIO will enhance collaborative working and information sharing between health and local authority.* b) The service to request the new digital system (RIO) to link with the WPAS digital system so outpatient appointments	Ty Einon Management Team. Going forward; Head of Operations and Digital Services Head of Operations and Digital Services	30.11.25 review date and there will be regular monitoring leading into RIO implementation 30.11.25 review date and there will

In addition, there was no evidence of risk formulation, including MDT representation, in the generic risk assessments.		are visible on the same system.		be regular monitoring leading into RIO implementation
		c) The service to ensure the clinic list for outpatients is shared with the care coordinators so care coordinators are made aware of service user's outpatients' appointments to coordinate the co-production and signing of the CTP.	Ty-Einon Management Team	30.11.25
		d) Communication has been circulated with the expectation that all care coordinators attend the outpatient appointment.	Ty-Einon Management Team	Completed
		e) The service group have developed the safety planning framework which will enhance the way in which risk formulation is undertaken.	Directorate Management Team and Principal Officer Swansea City & County Council.	31.12.25

		f) The Directorate are currently implementing the framework across the community services.	Directorate Management Team & Ty Einon CMHT Management Team	31.12.25
20. There was a significant lack of administrative support for psychiatric appointments which contributed to delays in treatment and placed additional burden on care coordinators. A significant backlog in managing correspondence and appointment planning was noted.	The health board must ensure that there is adequate administrative support available to effectively manage correspondence and appointment scheduling	a) The service will review the establishment within the administrative support, identify the progress of recruitment to ensure vacancies are being progressed. b) As highlighted under 1f), the service will pilot a new telephone system. To improve access and streamline communication	Directorate Team & Ty Einon CMHT Management Team Directorate Team & Ty Einon CMHT Management Team	30.11.25 Pilot will commence 1.11.25 and reviewed after 6-month period
21. The Approved Mental Health Practitioner (AMHP) service was under	The local authority must ensure that the AMHP service is adequately	Swansea Council is solely responsible for the provision of the AMHP service. They are in the process of recruiting 2 extra AMHP to work solely on AMHP	Principal Officer, Swansea City & County Council	31.10.25

pressure, with unclear quality assurance processes in place.	resourced and that there are clear quality assurance processes in place to ensure effectiveness and consistency of decision making.		duty by day on a permanent basis. They will be supplemented by other AMHP in the service, making it a more robust service. The service will have another social worker join the daytime rota in September 2025.		
22. There were plans to develop a new electronic records management systems that would not be integrated.	The health board and local authority must ensure that there is consistency with MDT care and treatment planning and that all relevant section are complete. In addition, that the service users voice is always considered and recorded.		Whilst the RIO system which will replace WCCIS will enable digital integration across services, Service users feedback will be shared in a reflective session and incorporated into Care and Treatment Planning training. *See also R18*	Ty Einon Management Team, Head of Operations / Divisional Manager for Mental Health	30.11.25
23. Service users voice and wishes were not always reflected in all the care and treatment plans	The local authority must ensure that planned services or therapeutic interventions are recorded.	Monitoring the Mental Health (Wales) Measure 2010	a) To ensure that planned services and therapeutic interventions are recorded, the service undertakes quality assurance audits which	Directorate Team	31.10.25

viewed. In addition, there was limited evidence of planned or therapeutic interventions by the local authority staff			specifically reviews whether a plan is in place. b) The assurance findings are feedback to the team managers and wider staff	Directorate Team & Learning and Development Team	30.11.25
24. Records of reviews were not always informative, timely or well-coordinated and it was not always clear from those records how the wider MDT contributed to these reviews. The review records did not always refer to the outcomes identified in the care and treatment plans	The health board and local authority must ensure that review records are comprehensive, promptly maintained, effectively coordinated, and accurately reflect the outcomes specified in the care and treatment plan.		a) To ensure patient documentation is reflective of the patients care and treatment and outcomes, the service will develop a template to demonstrate what a good entry would need to include. This will be measured under an ongoing notes audit within the CMHT. b) We will review the MDT processes within the CMHT to ensure that it is patient focused and to consider the adoption of evidence-based models of care. This will be	Directorate Team & Learning and Development Team Service Group Nurse Director (Chair of Community Modernisation	30.11.25 31.12.25 (Incorporate into workstream)

			incorporated in the Modernisation workstream that in progress.	Group) & Directorate leads	
25. Systemic pressures, particularly in psychiatry, psychology, administration, and AMHP cover were impacting the team's ability to deliver fully integrated, person centred care.	The health board and local authority must remain focused on staff recruitment to establish a permanent staff team and ensure effective continuity of care.		The service will review the establishment and identify the progress of recruitment for outstanding posts to ensure vacancies are being progressed.	Directorate Management Team	30.11.25
26. Issues were identified in relation to reception staff numbers and responsibilities. In addition, concerns were raised with regards to lone working when the staff member	The health board must review reception staff roles to ensure adequate staffing, fair treatment and appropriate lone working arrangements.	Workforce	The service to review the lone working plan within the team. The service will develop a process to ensure the emergency alarms are tested to ensure they are operational.	Ty Einon CMHT Management Team	30.11.25

starts work early and leaves late.					
27. There was limited opportunity for reflective practice within staff supervision sessions.	The health board and local authority must ensure that reflective practice discussions form part of staff supervision sessions.		The service will commence reflective sessions with the team.	Ty Einon CMHT Management Team	30.10.25
28. Operational demands made it difficult for staff to find time to attend training events.	The health board and local authority must undertake a comprehensive staff training needs analysis to determine any gaps in current provision and to facilitate staff development, ensuring that staff have sufficient time to complete training.		a) The service will review the training needs & requests being made by staff members. Staff workloads will be discussed with the line manager during supervision and review if there are conflicting priorities due to operational demand. The Health Board has set that all services are to work within their training budget and this is not to be exceeded due to the financial position of the health board. Any issues	Ty Einon CMHT Management Team	31.12.25

			in this respect will be escalated to Service Group Management team.		
			b) August's statutory and mandatory training compliance % for Health Board staff is 91% (excluding those absent from work i.e. maternity leave) - with the employment of the new team manager, plan in development to ensure that training % increases for those training modules that are below target i.e. Paul Ridd and that the other training modules remains above target.	Ty Einon CMHT Management Team	31.12.25
			c) Local Authority staff indicate the need for training via supervision and annual appraisal. This is fed into the annual training	Principal Officer Swansea & City County Council, Directorate Team, Learning and	31.12.25

			department plan for training prioritisation in line with funding. d) Considerations regarding joint CMHT training and development will be considered as part of training process. e) The service will review the programme of audits that take place for the CMHT.	Development Team Principal Officer Swansea & City County Council, Directorate Team, Learning and Development Team Principal Officer Swansea & City County Council, Directorate Team, Learning and Development Team	31.12.25 31.12.25
29. There was little evidence of regular auditing and review of care documentation by the health board	The health board and local authority must progress the plans to establish a more robust, joint general auditing and reporting framework for quality	Learning, Improvement and Research	a) The CTP Audits were previously undertaken monthly, these were included within the preliminary information pack to HIW; however, the CTP audit has since been digitalised to allow	Directorate Management Team	31.01.26

although we were told that joint, digital care and treatment plan audits were being developed.	assurance, and to facilitate service development.		the service to collate thematic reviews, data and enables greater collaboration. These are being completed on a quarterly basis, whereby each team will audit 20 CTPs.		
			b) Audits findings will be analysed for thematic learning following the first two cycles to provided assurance against this recommendation.	Directorate Management Team	31.01.26
			c) The service continues to use the Quality Assurance Framework and report on Ty Einon's compliance with this through quality and safety forums.	Directorate Management Team	Complete

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): Dermot Nolan

Job role: Service Group Director MHLD

Date: 1.10.25