Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Community Mental Health Team Inspection (Announced)

Ystradgynlais Community Mental Health Team, Powys Teaching Health Board

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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

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 Ystradgynlais Community Mental Health Team within Powys Teaching Health Board on 16 and 17 September 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 patients 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 six questionnaires were completed by patients or their carers and six 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.

This (full) report is designed for the service and describes all findings relating to the provision of high quality, safe and reliable care that is centred on individual patients.

2. Summary of inspection

Quality of Patient Experience

Overall summary:
Service users were generally satisfied with the care and support they received. They felt listened to and that their views and wishes were considered during the care planning process. Service users reported generally satisfactory experiences when accessing services and that they were involved in the assessment and care planning process. However, some reported difficulties contacting the service by phone, and care plans were not always written in the individual's own words and were not strengths based. Personal outcomes and priorities were not always clearly captured and the monitoring and review documentation lacked detail about progress, outstanding or unmet needs. In addition, family and support networks were not always actively involved in assessments, planning and reviews, which can limit holistic care and engagement.

We were told that timely access to services had improved since the implementation of the NHS 111 option 2 service and the Single Point of Access (SPOA) service. However, the availability of local in-patient beds for emergency admissions was an issue with service users often having to be placed in services outside of Powys. This added complexity and made it more difficult to coordinate care and maintain regular contact with service users.

In addition, there were persistent problems arranging transport for timely and secure transfer of service users to hospitals. It is concerning that these issues have been highlighted as areas for improvement during other CMHT inspections in Powys. We were also told there was no formal policy in place around secure transfer of service users. More must be done by the health board to improve on this.

This is what we recommend the service can improve:

- Ensure that there is sufficient space for staff to undertake their duties effectively and with due consideration to service user confidentiality
- Ensure that physical health interventions are recorded in detail within care documentation
- Ensure that care plans and all assessment documentation is available on file and written in the individual's own words and strengths based with personal outcomes and priorities clearly captured
- Ensure that monitoring and review documentation is detailed and clearly reflects progress and outstanding or unmet needs

- Ensure that family and support networks are actively involved in assessments, planning and reviews
- Review the availability of in-patient beds for emergency admission, to ensure that the current arrangements are sufficient to meet local demand and to help avoid service users having to be placed outside of the county
- Formulate a secure transfer/conveyancing policy and ensure that there are suitable transport arrangements in place for the safe and timely transfer of service users to hospital.

This is what the service did well:

- Single point of access to services
- Service users involvement in the assessment and care planning process
- Physical health monitoring.

Delivery of Safe and Effective Care

Overall summary:
We found generally positive evidence that assessment, care planning and review processes were focused on the individual needs of service users, and a collaborative approach was taken towards care and treatment planning in most of the cases that we looked at. However, some sections of the care documentation, such as consent to share information and social context, were incomplete.

Staff expressed concerns about the availability of transport for timely and secure transfer of service users to hospitals. This issue has been highlighted as areas for improvement during other CMHT inspections in Powys.

We found the Mental Health Act administration process to be effective and robust with accurate record keeping. However, as has been highlighted during other CMHT inspections in Powys, the lack of administrative support to the mental Health Act Administrator requires addressing.

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. However, we found that some Section 17 leave of absence forms had not been signed by the service user.

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.

Documentation reflected the person centred and empowering approach to care planning and provision.

Emphasis was placed on enabling service users to take ownership of their care, with relative involvement where appropriate. However, not all the care records reflected all domains of the Mental Health (Wales) Measure, encompassing emotional, psychological and physical health needs.

Immediate assurances:

- Medication storage room temperatures were not consistently recorded daily.

This is what we recommend the service can improve:

- Review the use of the corridor as a waiting area and ensure that there is appropriate oversight of service users
- Ensure that all furniture within the corridor waiting area is fixed to the floor to maintain service user and staff safety
- 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
- Ensure that effective transport arrangements are in place for timely and secure transfer of service users to hospitals
- Review the administrative support available to the Mental Health Act Administrator
- Ensure that the Approved Mental Health Practitioner (AMHP) service is adequately resourced
- Continue with efforts to improve availability and access to Section 12 Approved doctors.

This is what the service did well:

- Multidisciplinary approach to the provision of care
- Responsiveness of service
- Mental Health Act administration
- Auditing and reporting
- Management overview and support.

Quality of Management and Leadership

Overall summary:
Health and social care staff were integrated and co-located, enhancing joint working and day to day communication. 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 and improvement within the service, highlighting quality improvement activities and partnership development. Audit processes were in place for care records and 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 long term planning and staff recruitment and retention to establish a permanent staff team and ensure effective continuity of care
- 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
- Ensure that there is a system in place to review and reflect on feedback about the service and that an effective system of reflective practice is embedded in order to promote service development.

This is what the service did well:

- Culture
- 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 Ystradgynlais CMHT. In total, we received six responses, all of which were generally positive. Not all respondents completed every question.

Service users told us that they were generally satisfied with the care and support they received and that their views and wishes were considered during the care planning process.

However, service users reported that they sometimes experienced difficulty contacting the service over the phone, with calls often going unanswered.

Service user comments included:

> *"Feels like my CMHT is understaffed and/or overworked. Most of the time it's difficult to have someone answer the phone, don't always see somebody in the reception when I go there etc."*

> *"They're pretty much always good to me in my opinion but I know that there's been times where it's been difficult to get the help I needed. I'm lucky to have my family around me however."*

> *"Having been in a very bad place for a while, I don't know where I would be without the help, support and just being there for me."*

Person centred

Health Promotion
Health promotion material was available in various areas of the clinic.

Staff supported service users to maintain their physical health. An Associate Physician had recently been employed who undertook physical checks on service users to include conducting anti-psychotic clinics and lithium levels monitoring. However, physical health interventions were not always recorded in detail within patient care documentation.

The health board must ensure that physical health interventions are recorded in detail within care documentation.

The team took a proactive approach to supporting individuals, routinely using referrals and signposting to community services to promote holistic well-being, prevent relapse and maintain motivation for recovery.

Regular contact and facilitation of advocacy and support networks were evident. Consistency of care coordinator was valued, and arrangements were in place to address geographical challenges and ensure continuity of care.

Staff consistently reported a positive team culture and supportive management. There was a strong value base, with staff invested in and committed to their local community.

Dignified and Respectful Care
Consultations and confidential discussions with service users were seen to take place in private. However, we were told that limited clinical space and lack of consulting rooms often impacted on confidentiality and the ability to provide optimal care.

The health board and local authority must ensure that there is sufficient space for staff to undertake their duties effectively and with due consideration to service user confidentiality.

Individualised Care
Service users who completed the electronic survey said that they felt listened to and that their views and wishes were considered during the care planning process. However, care plans were not always written in the individual's own words and were not strengths based. Personal outcomes and priorities were not always clearly captured and the monitoring and review documentation lacked detail about progress, outstanding or unmet needs. In addition, family and support networks were not always actively involved in assessments, planning and reviews, which can limit holistic care and engagement.

The health board and local authority must ensure that care plans and all assessment documentation are available on file, written in the individual's own words, and strengths based, with personal outcomes and priorities clearly captured.

The health board and local authority must ensure that monitoring and review documentation is detailed and clearly reflects progress and outstanding or unmet needs.

The health board and local authority must ensure that family and support networks are actively involved in assessments, planning and reviews.

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.

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

Staff expressed concerns about the availability of local in-patient beds for emergency admissions with service users often having to be placed in services outside of Powys. This added complexity and made it more difficult to coordinate care and maintain regular contact with service users.

In addition, there were persistent problems arranging transport for timely and secure transfer of service users to hospitals. It is concerning that these issues have been highlighted as areas for improvement during other CMHT inspections in Powys. We were also told there was no formal policy in place around secure transfer of service users. More must be done by the health board to improve on this.

Addressing these challenges will require ongoing collaboration with health partners, commissioners and transport providers, as well as a strategic focus on workforce planning and the development of local resources to reduce reliance on out-of-county placements.

The health board must review the availability of in-patient beds for emergency admission, to ensure that the current arrangements are sufficient to meet local demand and to help avoid service users having to be placed outside of the county.

The health board and local authority must formulate a secure transfer/conveyancing policy and ensure that there are suitable transport

arrangements in place for the safe and timely transfer of service users to hospital.

Equitable

Communication and Language
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.

Some members of staff are bilingual (Welsh/English) with service user language preference identified on assessment and recorded.

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.

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.

The premises were accessible with good wheelchair access into the building.

All service user accessible areas were 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 premises were reasonably well maintained, but not purpose built to provide mental health services. Consequently, there were multiple ligature risks within the building. These risks had been assessed and mitigated by ensuring that service users were not left unattended whilst in the building. However, service users were having to wait on chairs in the corridor area once greeted by reception staff. This area was not directly observed by staff and there was no working CCTV within the corridor area nor in the consulting rooms. In addition, chairs within the waiting area were not secured to the floor, therefore, posing a risk to service user and staff safety and there was no emergency call alarms within consulting rooms.

The health board and local authority must review the use of the corridor as a waiting area and ensure that there is appropriate oversight of service users.

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

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.

Lone worker monitoring was not sufficiently robust both within the building and when staff are visiting service users in the community. This was particularly an issue for the Approved Mental Health Practitioners (AMHP) who often work alone in isolated and rural areas out of normal office working hours.

The local authority must ensure that there are robust arrangements in place to support staff when they are working alone.

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 an 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.

Infection, Prevention, Control and Decontamination
The environment was clean, tidy and well maintained and there were generally good infection prevention and control (IPC) measures in place, which were supported by comprehensive policies and procedures.

The most recent IPC audit was conducted on 8 July 2025, highlighted 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 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).

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 and found that 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 supported by a pharmacist based at Neville Hall hospital 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 attended the service 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 reviewed a sample of medication administration charts and found that some lacked detail such as the service user legal status, height, weight and allergies.

The health board must ensure that medication administration charts are fully completed.

Effective

Effective Care

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

We found evidence of good multi-agency working, with regular collaboration and information sharing between health colleagues, advocacy services and third sector organisations. This ensured care was coordinated and responsive to changing needs.

Staff strived to engage with service users as frequently as outlined in individual care and treatment plans and the small catchment area allowed for more personalised and responsive care.

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 supported person-centred transitions.

We reviewed care records of six service users on Community Treatment Orders (CTO) and ten supported by Care and Treatment Plans.

Most records had compliant care and treatment plans aligned with the Welsh Measure and showed MDT and service user involvement, although, as previously mentioned, 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 sections are complete.

The AMHP service was under pressure due to a significant increase in demand, national difficulty of recruiting and maintaining the AMHP workforce, the large geographical area covered and the need to regularly conduct assessments of service users placed out of the area.

The local authority must ensure that the AMHP service is adequately resourced.

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 they have arrangements in place to mitigate against the risk of having separate electronic case management systems in place and to ensure that information is shared promptly across teams.

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. However, we found that some Section 17 leave of absence forms had not been signed by the service user.

The health board must ensure that Section 17 leave of absence forms are signed by the service user.

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. However, there

were some delays reported in receiving information relating to service users placed outside of Powys.

The Mental Health Act Administrator covered the whole of Powys, and was expected to attend Mental Health Act Review Panels across the county, in addition to completing audits and delivering training for staff. We were told that meeting the demands of the job could be difficult at times as there was limited administrative support available. This issue has been highlighted during previous inspections of other CMHTs in Powys and it is concerning to note that it remains unresolved.

The health board must promptly review the administrative support available to the Mental Health Act Administrator.

There were significant challenges in arranging timely Mental Health Act assessments due to limited availability of Section 12 approved doctors, resulting in delays for urgent assessment and intervention.

The health board must continue with efforts to improve availability of, and access to, Section 12 approved doctors.

Monitoring the Mental Health (Wales) Measure 2010: Care Planning and Provision

Statutory duties and CTP compliance were generally well managed, with high compliance rates.

The team jointly maintained and reviewed the Section 117 aftercare list, ensuring compliance with the Mental Health (Wales) Measure and timely reviews.
There was good evidence of day-to-day communication between staff and collaboration across the wider MDT, to support the delivery of care.

Most, but not all of the 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.

The health board and local authority must ensure that care and support is provided in line with the domains set out in the Mental Health (Wales) Measure and that all service user records reflect this.

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 six responses.

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

Staff comments included:

> ***"The CMHT are doing their best but there are consistent difficulties that do not get addressed by Senior Management. This causes frustration and an inability to improve the service."***

> ***"There have been great difficulties with poor staffing levels within the team for several years. The team themselves are dedicated and hardworking, however no matter how dedicated, leaving only one or two qualified staff on duty at any time will have an impact on the standard of care that can be offered. This had been raised repeatedly to senior staff who have (after several years) finally addressed the issue. The CMHT is a small team, so sickness/Annual leave/urgent referrals have a huge impact on the staff available."***

> ***"Ystradgynlais CMHT is a nice place to work. There has been issues with staff retention in the past, however there is good levels of staff currently. We have good relationships with other services and disciplines. Colleagues are supportive. We provide a good level of support and care to individuals."***

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.

Staff described the leadership team as responsive and supportive, with open channels for raising concerns and a focus on solutions rather than blame.

There was active succession planning in place and investment in leadership development, including coaching and compassionate leadership courses.

Workforce

Skilled and Enabled Workforce
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.

Staff demonstrated strong collaboration and commitment to values, However, systemic pressures, particularly in occupational therapy, 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.

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

Despite staffing pressures, staff wellbeing was supported through wellbeing days, occupational health and a stable team structure. The management team was responsive and supportive of staff.

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.

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 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 was 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.

Staff consistently reported a positive team culture and supportive management. There was a strong value base, with staff invested in and committed to their local communities.

Staff told us that this is a nice service to work for. They feel that there has been a significant improvement in the last eight months or so and that the workload is now better managed.

The team demonstrated a strong commitment to multidisciplinary working, with regular MDT meetings and shared responsibilities across health and social care. Staff were flexible, supportive and willing to cover multiple roles as needed.

Staff were clear that their managers were highly supportive in this context and there was recognition that the team adapted and responded well to complex cases and crises. However, this often came at the expense of service development and reflective practice.

The health board and local authority must ensure that there is a system in place to review and reflect on feedback about the service and that an effective system of reflective practice is embedded in order to promote service development.

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
The health board and local authority conducted 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.

Team Managers attended 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 system approach

Partnership Working and Development
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.

Staff worked closely with the local inpatient unit and attended ward reviews and Mental Health Act Tribunals.

The team had a good working relationship 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 highlighted during this inspection.			

Appendix B – Immediate improvement plan

Service: Ystradgynlais Community Mental Health Team

Date of inspection: 16 and 17 September 2025

Findings

HIW was not assured that medication management processes are sufficiently robust and safe.

We looked at the medication storage arrangements and found that the temperature of the room where medication was stored was not checked and recorded on a daily basis.

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

1. Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
The health board must ensure that the temperature of the room where medication is stored is monitored and recorded on a daily basis.	Delivery of Safe and Effective Care	Clarification from medicines management around the policy for ambient room temperature held. Policy number MMP001. Policy and recording template shared with all team leads across Powys. Dual thermometers have been ordered for 5 sites across Powys to implement process urgently.	Service Manager Service Manager Service Manager	Completed. Completed Completed.

		Audit to take place week commencing 06th October 2025 to ensure compliance across all of the Community Mental Health Team sites in Powys.	Service Manager	Due week commencing 06th October 2025.

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: **Bethan Gwalchmai**

Name (print): Bethan Gwalchmai

Job role: **Interim Service Manager Powys CMHT**

Date: **29th September 2025**

Appendix C - Improvement plan

Service: Ystradgynlais Community Mental Health Team

Date of inspection: 16 and 17 September 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	Service action	Responsible officer	Timescale
1. Physical health interventions were not always recorded in detail within patient care documentation.	The health board must ensure that physical health interventions are recorded in detail within care documentation.	Physical Health Monitoring Standard Operating Procedure (SOP) has been developed and will be implemented across service and recorded in Patient Electronic Record with particular focus on the roles and responsibilities of Physicians Associates.	Service Manager GP/MH Liaison medical lead. Locality Consultants	April 2026
2. Limited clinical space and lack of consulting rooms often impacted on confidentiality and the ability to provide optimal care.	The health board and local authority must ensure that there is sufficient space for staff to undertake their duties effectively and with due consideration to service user confidentiality.	A review of the area and an Environmental Risk Assessment has been carried out. Recommendations have been made to increase capacity and rooms available as clinical space. Some staff and service movements are	PTHB Head of Operations PCC Team Manager South	March 2026

		required to complete these changes.		
3. Care plans were not always written in the individual's own words and were not strengths based. Personal outcomes and priorities were not always clearly captured.	The health board and local authority must ensure that care plans and all assessment documentation are available on file, written in the individual's own words, and strengths based, with personal outcomes and priorities clearly captured.	**Powys Teaching Health Board (PTHB)** – All staff responsible for care and treatment planning have attended care and treatment planning training over the past 2 months held at Maindiff Court hospital. Additional Care & Treatment Plan Training is being rolled out across Mental Health Services in collaboration with the Recovery College. Care and Treatment Plan (CTP) Audit in December 2025 will monitor improvements to this and feedback into Senior Management Team Meeting to ensure this remains an ongoing priority. **Powys County Council (PCC)** - All PCC staff are provided with 'strength-based' training	Team Lead CTP Lead Quality & Safety Lead Team Manager South & Senior Practitioner	Completed December 2025

		and refresher courses are available. All staff will be reminded of this training and where applicable discussions will be held during formal supervision. PCC will continue to monitor the improvement via its monthly audits.		
4. Review documentation lacked detail about progress, outstanding or unmet needs.	The health board and local authority must ensure that monitoring and review documentation is detailed and clearly reflects progress and outstanding or unmet needs.	**PTHB** – Review of s117 Aftercare Policy and CTP Policy has been completed, Implementation Plan is under development, associated training will be rolled out to ensure all staff are aware and understand responsibilities. Regular monitoring through twice yearly CTP audit. Unmet Needs process has been reviewed, and governance process has been strengthened to ensure SMT oversight and review. Divisional Risk Register will be used to ensure all unmet	CTP Lead Quality & Safety Lead Head of Operations	April 2026 January 2026

		needs are recorded and progressed. **PCC** – Staff will be reminded during team meetings and supervision sessions of the importance of recording progress and any outstanding or unmet need.	Team Manager South & Senior Practitioner	
5. Family and support networks were not always actively involved in assessments, planning and reviews.	The health board and local authority must ensure that family and support networks are actively involved in assessments, planning and reviews.	**PTHB** - As previously discussed, reviewed of CTP Policy has highlighted need for co-production and involvement of personal support network for all service users within CTP forums, compliance around this is monitored through CTP audit. PTHB is actively engaging with National initiatives to put family and carer involvement as a priority for delivery across the division. **PCC** – Staff will be reminded during team meetings and supervision sessions of the	CTP Lead Quality & Safety Lead Team Manager South & Senior Practitioner	April 2026

		importance of family and support network involvement where the necessary consent has been given. This would also be picked up within the 'Strength-based' training and any refresher of this course.		
6. There is a lack of local in-patient beds for emergency admissions with service users often having to be placed in services outside of Powys.	The health board must review the availability of in-patient beds for emergency admission, to ensure that the current arrangements are sufficient to meet local demand and to help avoid service users having to be placed outside of the county.	PTHB is in a process of Transformation, number and configuration of inpatient beds is central to this. A scheme to develop an addition 5 inpatient beds off Felindre Ward (Defynnog) is being implemented, this is at options appraisal stage and contractors are in place, scheme to be delivered by end of financial year. Consideration being given to block purchase of additional beds to ensure clinical safety, quality and accessibility.	Head of Operations	March 2026
7. There were persistent problems arranging transport for timely and	The health board and local authority must formulate a secure transfer/conveyancing policy and	Lack of Operational Policy for Secure Transport has been acknowledged and scheduled	Head of Operations	April 2026

secure transfer of service users to hospitals and there was no formal policy in place around secure transfer of service users.	ensure that there are suitable transport arrangements in place for the safe and timely transfer of service users to hospital.	for completion via Clinical Policy Advisory Group (CPAG). Further work is being done around commissioning of alternative transport providers to ensure increased accessibility, patient safety and financial prudence.	Business & Performance Manager	
8. The corridor was being used as a service user waiting area and was not directly observed by staff.	The health board and local authority must review the use of the corridor as a waiting area and ensure that there is appropriate oversight of service users.	A review of the area and an Environmental Risk Assessment has been carried out. Recommendations have been made to increase capacity and rooms available as clinical space which will allow Waiting Room to be reinstated.	Health & Safety Advisor Team Lead Service Manager	January 2026
9. There was no working CCTV within the corridor area nor in the consulting rooms.	The health board must ensure that all CCTV cameras are working.	A review of the area and an Environmental Risk Assessment has been carried out. Recommendations have been made to increase capacity and rooms available as clinical space and once complete a review of CCTV and alarm call system	Head of Operations Health & Safety Advisor Team Lead Service Manager	February 2026

		coverage of these areas and potential change of usage will be carried out to ensure adequate operational coverage of CCTV.		
10. There were no emergency call bells fitted within the consulting rooms.	The health board must ensure that an emergency call bell is made available in all consulting.	A review of the area and an Environmental Risk Assessment has been carried out. Recommendations have been made to increase capacity and rooms available as clinical space and once complete a review of CCTV and alarm call system coverage of these areas and potential change of usage will be carried out to ensure adequate operational coverage of CCTV.	Health & Safety Advisor Team Lead Service Manager	February 2026
11. Chairs within the waiting area were not secured to the floor, therefore, posing a risk to service user and staff safety.	The health board must ensure that all furniture within the corridor waiting area is fixed to the floor.	A review of the area and an Environmental Risk Assessment has been carried out. Recommendations have been made to increase capacity and rooms available as clinical space and will allow reinstate of Waiting	Health & Safety Advisor Team Lead Service Manager	February 2026

		Area with appropriate furniture and fixtures for this purpose.		
12. Lone worker monitoring was not sufficiently robust both within the building and when staff are visiting service users in the community. This was particularly an issue for the Approved Mental Health Practitioners (AMHP) who often work alone in isolated and rural areas out of normal office working hours.	The health board and local authority must ensure that there are robust arrangements in place to support staff when they are working alone.	**PTHB** - PTHB has a Lone Worker Policy, this includes signing in/signing out procedures and operational policies to ensure that staff working in the community have clear arrangements in place to their safety. This policy has been recirculated to staff and signing in/out procedures have been strengthened to ensure awareness and compliance. **PCC** have an effective corporate lone working system, which staff often supplement with an informal 'buddy' system. We continue to have discussions with our corporate Health & Safety colleagues on ways to improve safety especially for those out of office hours.	Team Lead Senior Manager Learning Disabilities and Mental Health	Completed

13. Some medication administration charts lacked detail such as the service user legal status, height, weight and allergies.	The health board must ensure that medication administration charts are fully completed.	Medication Management Policy has been recirculated to relevant staff and compliance will be monitored via monthly audit.	Team Lead Service Manager	Completed
14. Assessment documentation was not fully completed.	The health board and local authority must ensure that there is consistency with MDT care and treatment planning and that all relevant assessment documentation is fully complete.	**PTHB** - Additional Care & Treatment Plan Training is being rolled out across Mental Health Services in collaboration with the Recovery College. CTP Audit in December 2025 will monitor improvements to this and feedback into Senior Management Team Meeting to ensure this remains an ongoing priority. Monitoring of this is embedded in audit cycle. **PCC** staff will be reminded to complete all relevant documentation in a timely manner. The team have access to an AI tool to support in the completion of documentation.	CTP Lead Quality & Safety Lead Team Manager South & Senior Practitioner	December 2025

15. The AMHP service was under pressure due to due to a significant increase in demand, national difficulty of recruiting and maintaining the AMHP workforce, the large geographical area covered and the need to regularly conduct assessments of service users placed out of the area.	The local authority must ensure that the AMHP service is adequately resourced.	Following the pilot of our AMHP hub trial, PCC have committed to recruiting a further two permanent AMHP social worker posts to help ease the pressure. These posts will have a specific role to undertake MH Act Assessments alone and will not hold a caseload.	Team Manager North & Team Manager South	01/04/2026 – 31/07/2026
16. 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	The health board and local authority must ensure that they have arrangements in place to mitigate against the risk of having separate electronic case management systems in place and to ensure that information is shared promptly across teams.	**PTHB** The Health Board continues to engage in National Digital Transformation work which includes exploration of Shared Care Records. Locally tendering arrangements are in place for replacement digital system and system requirements include recognition of need for mutual access to records. Robust Information Governance arrangements will	Head of Operations	From March 2026

another or shared promptly across teams.		need to be implemented to ensure safe sharing of information across both organisations. **PCC** continue to have discussions with PTHB around the future of the CMHT service and how information and risks are shared in a prompt and safe manner. We are also liaising with other local authorities who are already on separate systems to their health colleagues to learn lessons on how they operate.	Team Manager North, Team Manager South & Quality Assurance and Improvement Manager.	On implementation of new database for social care, currently scheduled for late Spring/ early summer 2026.
17. Some Section 17 leave of absence forms had not been signed by the service user.	The health board must ensure that Section 17 leave of absence forms are signed by the service user.	Responsibility for ensuring this lies with MHA Administration and processes held in Bronllys Hospital rather than the CMHT in Ystradgynlais, we have however reviewed these processes, ensured this element is part of the checklist and processes. We have also issued reminders to		

		Responsible Clinicians that this is a requirement that must be met. We are currently developing an audit tool which will monitor compliance with this requirement going forwards.		
18. The Mental Health Act Administrator covered the whole of Powys and was expected to attend Mental Health Act Review Panels across the county, in addition to completing audits and delivering training for staff. We were told that meeting the demands of the job could be difficult at times as there was no additional administrative support available. This issue has been highlighted during previous inspections of other CMHTs in Powys and it is concerning to note that it remains unresolved.	The health board must promptly review the administrative support available to the Mental Health Act Administrator.	Attempts to recruit to this post have been delayed by Vacancy Freeze Process, this role has now been authorised by Executive Team and is out to advert.	Head of Operations	Completed

19. There were significant challenges in arranging timely Mental Health Act assessments due to limited availability of Section 12 Approved doctors, resulting in delays for urgent assessment and intervention.	The health board must continue with efforts to improve availability of, and access to, Section 12 Approved doctors.	**PTHB** This is an issue raised by our social care colleagues. Up to this point we have not been using the incident management framework. If there are issues in future the senior practitioner from PCC will contact the PTHB team leader and Datix will be submitted to enable the situation to be reviewed and inform service improvement We have however reviewed all our MHA related policies and are in the process of developing a new pathway for identification of daytime s12 doctors. **PCC** will continue to provide PTHB with statistical information on MHAA delays in order to inform service improvement.	Clinical Director	March 2026

20. Not all of the service user records we reviewed reflected the domains of the Mental Health (Wales) Measure.	The health board and local authority must ensure that care and support is provided in line with the domains set out in the Mental Health (Wales) Measure and that all service user records reflect this.	PCC and PTHB teams will work with all CMHT employees to make sure all domains are completed. This will be monitored through on-going training, supervision and case file audits. The recent care and treatment planning training was in line with the MHM Wales Measure and all staff responsible for care and treatment planning in the team have attended. Supervision continues to address quality audit of CTPs to ensure that all domains are considered.	Team Lead Team Manager (PCC)	Completed.
21. Systemic pressures, particularly in occupational therapy, psychiatry, psychology, administration, and AMHP cover hindered fully integrated, person-centred care.	The health board and local authority must remain focused on long term planning and staff recruitment and retention to establish a permanent staff team and ensure effective continuity of care.	**PTHB -** Staff morale and retention in Ystradgynlais have improved. Staff are being encouraged to and are utilising staff benefits, including wellbeing breaks. The full-time administration post will be	Team Lead Service Manager	Completed

		going out in the new year which will relieve pressure on current administrator (subject to current Vacancy Freeze). Through Better Together, Transformation Project future planning is considering how teams can be brought to together to strengthen and improve capacity across disciplines. As Noted Above **PCC** have committed to enhancing the number of AMHP qualified social workers on a permanent basis following the success of the AMHP hub. Since April 2025, PCC have increased the 'AMHP Lead' role from one individual to two individuals to increase availability of support and supervision to the wider team/ service. We currently only have one social worker/ Adult Menal Health Practitioner (AMHP)	Senior Manager Learning Disability & Mental Health, team Manager South & Team Manager North	PCC – AMHP posts to be effective from 01/04/2026

		vacancy across the Mental Health service countywide. PCC recognise that we currently have several non-AMHP social workers within the service however we have plans to schedule the appropriate AMHP training for these workers. PCC also recognise there is work to do in promoting the AMHP role across other areas of social care such as Children's services or our Older Person teams.		
22. Operational demands were often making 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.	**PTHB** – Staff availability to attend training has considerably improved due to almost being at full complement of staffing. Mandatory training compliance has improved, and staff have had the opportunity to attend other training such as brief solution focussed therapy, CBT and nurse supervisor/assessor.	Team Lead	Completed

		PCC complete an annual training needs analysis across the whole service; this incorporates the PCC staff working within the CMHT's. PCC CMHT staff have access to specialist training alongside all other social care training. We will encourage staff to attend training and have increased the numbers of permanent staffing to help ease pressure on the teams so staff feel they can attend training. For AMHP's we provide specific training alongside our partner with Cheshire East to enable their continued development.	Team Manager South & Team Manager North	
23. Staff were clear that their managers were highly supportive in this context, and there was recognition that the team adapted and responded well to complex	The health board and local authority must ensure that there is a system in place to review and reflect on feedback about the service and that an effective system of reflective	**PTHB** – Team Lead is focussing on reflective practice in supervision and is looking to set up group supervision to bring complex cases for	Team Lead Service Manager	March 2026

cases and crises. However, this often came at the expense of service development and reflective practice.	practice is embedded in order to promote service development.	discussion and to make time for reflection. Development of 3 monthly team meetings for feedback of any service developments, information regarding transformation and team service improvements is in progress. Staff will have the opportunity to feedback on if this initiative has been supportive of improvements to working practices. **PCC** offer reflective practice sessions for all staff, our monthly supervisions and team meetings offer opportunity for reflective practice this will continue. All AMHP's are invited to attend an 'AMHP forum' on a bi-monthly basis, this invite is extended to practitioners within our Emergency Duty Team.	Team Manager South, Team Manager North & Senior Practitioners	

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): Lauraine Hamer

Job role: Interim Head of Mental Health Operations

Date: 11th December, 2025