Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Community Mental Health Team Inspection (Announced)

Taff Ely Community Mental Health Team, Cwm Taf Morgannwg University Health Board

Inspection date: 13 and 14 January 2026
Publication date: 16 April 2026

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Digital ISBN 978-1-83745-498-3

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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.

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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) and Care Inspectorate Wales (CIW) completed a joint announced inspection of Taff Ely Community Mental Health Team within Cwm Taf Morgannwg University Health Board on 13 and 14 January 2026.

The joint team for the inspection comprised of two HIW senior healthcare inspectors, two CIW senior inspection managers and three clinical peer reviewers, one of whom was a Mental Health Act reviewer. When referring to the findings throughout the report, 'we' refers to the joint inspection team, unless otherwise specified.

During the inspection, we invited service users or their carers to complete a survey about their experience of using the service. We also invited staff to complete a survey to tell us their views on working for the service. A total of seven surveys were completed by service users, and three 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:
We found that the Taff Ely Community Mental Health Team (CMHT) delivered compassionate, individualised and attentive care. Staff demonstrated a consistently person-centred approach, showing strong awareness of social, cultural, language and diversity needs.

The service operated during core working hours, supported by established out-of-hours pathways. Referrals were accepted from multiple sources through a single point of access, with assessments offered as required.

The team's co-located and integrated structure was a notable strength, supporting continuity, coordinated care and shared responsibility for service user outcomes. Effective multidisciplinary team (MDT) working was evident, with staff from multiple professions accessible and able to respond to needs in a timely and coordinated way. The Care and Treatment Plans we reviewed generally reflected people's strengths and goals, with regular MDT discussions informing updates and reviews.

Service users who responded to our survey reported very positive experiences, describing staff as supportive, responsive and caring. They told us the team helped them feel understood, valued and treated as individuals.

However, we identified several areas for improvement. Although most survey respondents confirmed they had been offered advocacy support, advocacy was not routinely or clearly documented within care records, despite its importance in supporting informed choice and protecting service users' rights. Carers' assessments and associated documentation were also inconsistent, indicating that some carers' needs may not have been identified or supported.

We were informed of a substantial increase in referrals relating to Attention Deficit Hyperactivity Disorder (ADHD). Staff told us this created additional pressure on clinical and administrative capacity, impacting wider service delivery.

Additionally, we found that physical health monitoring and related documentation were not sufficiently robust in the records we reviewed, including for individuals assessed as being at higher risk. This posed a potential risk to service user safety.

This is what we recommend the service can improve:

- Ensure physical-health monitoring is consistently recorded and reviewed
- Strengthen support for carers and complete carers' assessments where applicable
- Review and improve the process for managing ADHD referrals to ensure timely assessment and reduce service pressures
- Ensure advocacy is routinely offered, actively supported, and clearly documented within care records.

This is what the service did well:

- Single point of access to services
- Good awareness of cultural, communication and neurodiversity needs
- Clear examples of compassionate, patient-focused care
- Co-located, integrated working that strengthened coordinated MDT care
- Positive feedback from service users about feeling supported, understood and valued.

Delivery of Safe and Effective Care

Overall summary:
Overall, staff demonstrated a strong commitment to providing safe and effective care. We saw clear evidence of multidisciplinary communication, regular meetings and structured clinical discussions that supported coordinated decision-making.

Care and Treatment Plans (CTPs) were generally aligned to the domains of the Mental Health (Wales) Measure and were detailed, structured and recovery-focused, with clear descriptions of assessed needs, planned interventions and review arrangements. However, we found variation in the consistency and quality of documentation. MDT discussions and key decisions were not always recorded, care plans were not consistently written in the first person, and evidence of active service user involvement in care planning was not always clear.

Mental Health Act (MHA) records were overall compliant, with statutory documentation completed appropriately and systems in place to uphold people's rights. Community Treatment Orders were lawfully applied, with conditions clearly articulated and all supporting documentation completed correctly. However, recurring inaccuracies in MHA documentation indicated a need for strengthened oversight and further training.

Staff understood safeguarding processes; however, trends in safeguarding practice were not consistently escalated to strategic forums, limiting opportunities for shared learning.

Clinical risk assessments completed by staff were generally comprehensive, and incident-reporting processes were used appropriately. However, we identified significant gaps in wider environmental and organisational safety systems. The CMHT was accessed through other areas of the hospital, and uncontrolled access meant that members of the public could enter CMHT clinical areas without restriction. These issues had remained on the organisational risk register for many years without resolution. We also found ligature risks within the CMHT and no formal ligature risk assessment in place, though this was initiated during the inspection. Additionally, routine fire-safety checks were not completed in line with required frequency.

Staff described challenges arising from multiple electronic record systems that did not communicate effectively, resulting in duplicated work, missed information and delays in sharing key updates between teams. These issues highlighted the need for stronger information-sharing processes, clearer escalation pathways and improved communication across professional groups.

Further concerns were raised about access to timely clinical advice during periods of crisis, with staff reporting limited availability of on-call medical support and Mental Health Act–approved clinicians. Workforce pressures across psychology, occupational therapy and administrative functions placed additional strain on the service, contributing to delays, reduced capacity and variable support for MDT activity.

Medicines management arrangements were also not sufficiently robust and required immediate assurance.

Immediate assurances:

- Inconsistent temperature monitoring of the medicines fridge and clinic room, with staff demonstrating limited awareness of temperature control requirements
- Incorrect depot medication intervals, including doses administered every four weeks instead of calendar-monthly
- Poor-quality and incomplete depot charts, with missing essential clinical information and depot medication administration recorded incorrectly
- Lack of pharmacy oversight, with no reliable audit processes in place to ensure safe storage, supply and prescribing of medicines.

Details of the concerns for service user’s safety and the immediate improvements and remedial action required are provided in Appendix B.

This is what we recommend the service can improve:

- Improve consistency and accuracy of care records, ensuring MDT discussions and key decisions are clearly captured
- Reduce errors in Mental Health Act documentation by strengthening oversight and providing additional staff training
- Ensure safeguarding themes and trends are consistently escalated and that learning is shared
- Strengthen security and environmental safety, including effective access-control, ligature risk management and timely fire-safety checks
- Address risks created by multiple electronic record systems to ensure timely, complete and accurate clinical information sharing
- Ensure timely access to clinical and medical advice during crises, including on-call and approved clinician support
- Stabilise workforce capacity across psychology, occupational therapy and administrative support to maintain safe and effective MDT care.

This is what the service did well:

- Staff demonstrated strong commitment to delivering safe and effective care
- Multidisciplinary working supported coordinated and timely decision-making
- Care and Treatment Plans were well-structured, recovery-focused and reviewed regularly with personalised dates
- Assessments were comprehensive and responsive, enabling timely support for service users
- Staff communicated proactively across disciplines to maintain continuity of care
- Staff adapted their approach to individual needs to support engagement.

Quality of Management and Leadership

Overall summary:
The co-location of health and social care staff strengthened day-to-day communication and supported timely professional dialogue. Staff described positive, collaborative relationships between teams, and leaders were viewed as visible, approachable and supportive.

Managers were receptive to feedback, promoted open communication and facilitated shared learning through structured meetings, incident-review discussions and escalation forums. A whole-systems approach was evident in operational partnerships with primary care, third-sector agencies and co-occurring specialist services. However, workforce pressures continued to affect service delivery, and staff also reported that support-worker capacity should be reviewed so practitioners can focus on core professional responsibilities.

Established systems were in place to support oversight, incident management, risk assessment and decision-making; however, oversight of some key clinical risks required strengthening, as existing governance arrangements did not provide sufficient scrutiny of environmental safety and medicines management.

There was evidence of good operational collaboration between health and social care teams, demonstrating a shared commitment to providing coordinated support. However, notable gaps were identified in strategic partnership working. Joint communication, engagement and information sharing between the health board and local authority were inconsistent, limiting coordinated decision-making.

Staff also reported that key strategic meetings and forums were not always attended or jointly owned by health and social care teams. As a result, decisions were sometimes made without full partnership involvement, limiting effective joint governance. Engagement between the health board and local authority was also limited in key service-planning activities, including the review of community services and associated third-sector arrangements.

Both organisations undertook routine audit and quality-improvement activity independently, but there was limited evidence of regular joint audit across the integrated CMHT. This indicated the need for a shared assurance framework to support collective accountability.

Mandatory training compliance was generally good; however, several health board modules required improvement, with resuscitation training noted as a particular area of concern due to limited course availability.

Supervision arrangements for healthcare staff were in place, but local authority supervision and reflective practice records were inconsistent, with some entries brief or absent. The local authority should embed clear expectations and consistent recording so that professional oversight is evident. This means showing the person’s journey through care and support, their lived experience, decisions made, actions agreed, and outcomes achieved.

This is what we recommend the service can improve:

- Strengthen joint communication, engagement and information sharing to support coordinated operational and strategic decision-making
- Prioritise recruitment, engage with staff on resource use and stabilise the workforce to maintain safe, high-quality care
- Ensure all outstanding mandatory training is completed and that sufficient training courses are available to maintain staff and service-user safety
- Ensure supervisions and reflective practice are consistently documented

- Establish a robust joint auditing and reporting framework so both agencies can fully participate in joint assurance processes and strengthen integrated governance arrangements.

This is what the service did well:

- Co-location of staff strengthened day-to-day communication and professional dialogue
- Leaders were visible, approachable and supportive, helping to create a positive team culture
- Teams demonstrated constructive relationships and worked together to provide consistent support
- Managers promoted open communication and shared learning through regular meetings, incident reviews and escalation forums
- Strong operational collaboration across disciplines
- Effective working relationships with primary care, third sector partners and co-occurring specialist services
- Clear processes in place to support incident management and operational oversight.

3. What we found

Quality of Patient Experience

Patient feedback

HIW issued online and paper surveys to gather service-user views on Taff Ely CMHT, alongside a review of how the quality of patient experience was reflected in care records. We received seven survey responses, all from current service users, who reported consistently positive experiences across all aspects of the service. All respondents rated the CMHT as “good” or “very good”, which aligned with the positive patient experience evidenced in clinical documentation reviewed during the inspection.

Access to the service was viewed favourably by the survey respondents, with all service users describing access as either “easy” or “very easy”; similarly, the majority felt they were seen the right number of times for their needs.

Strong levels of satisfaction were evident in therapeutic engagement: nearly all service users “strongly agreed” or “agreed” that CMHT staff gave them enough time, listened carefully, and involved them in the development of their care plan. All respondents confirmed they knew how to contact their care coordinator and crisis/out-of-hours services and felt they could access the right healthcare at the right time.

The survey responses highlighted exceptionally positive experiences with individual staff, with several service users expressing gratitude for the consistency, compassion, and proactive support received from CMHT staff.

While the feedback was overall positive, some responses reinforced areas for improvement which we identified during the inspection, including the need for more consistent access to specialist psychological input.

Service user comments included:

- *“My care coordinator and all the team at Dewi Sant really try their best to do all they can to help but they are limited when there is not enough psychologists on board or not retaining them long enough to help anyone. Please help figure this dire situation out.”*

- *"I would like to take the time to express how incredibly helpful my CMHT worker has been to me over the years. [STAFF MEMBER] consistently goes above and beyond to support me in ways that truly matter…*
  …I have been under many different services, and Dewi Sant CMHT has been by far the best.
  When [STAFF MEMBER] has been unavailable, [OTHERS] have stepped in, and they have been amazing.
  …It's clear that Dewi Sant CMHT has an outstanding team who genuinely care about the people they support.
  …[STAFF MEMBER] and the team have made me feel like a person — a human being — not just a case or a subject…For that reason, and for everything they have done, I am truly and forever thankful."

- *"My social worker went above and beyond in my care. Her communication was fantastic...her commitment to teach me coping techniques is the reason why I am still here today! From her continuous help, I know I no longer need the mental health team, and I hope they are able to help other patients the same.*
  I will be forever grateful for Dewi Sant's Community Mental Health Team! Even the receptionists went out of their way… My psychiatrist listened to me… So thank you to everyone who was involved in my treatment."

Person centred

Health promotion
We generally found evidence that service users were supported to meet their physical and mental health needs, including referrals to other services where appropriate. Service users had access to a weekly physical health clinic, delivered by a named nurse, supported by a healthcare support worker, with additional monitoring provided by General Practitioners (GPs).

The clinic room was spacious, clean, well-organised and well equipped to support physical health monitoring. However, we found this was inconsistently documented in some of the care records we reviewed. In two cases, service users assessed as being at risk of malnutrition had no recorded evidence of their weight being monitored. This created a risk that deterioration in their physical health may not be identified in a timely manner, particularly for those already recognised as being at increased risk.

The health board and local authority must ensure that physical health monitoring is consistently recorded, monitored and reviewed for all service users, and particularly those identified as being at increased risk.

Dignified and respectful care
We found strong evidence that service users were treated with dignity and respect. Staff demonstrated a compassionate and person-centred approach, and service users were supported to be involved in the planning and review of their care. Respondents to our survey consistently described being treated with dignity and respect, reporting that staff listened carefully, gave them enough time, and approached their care in a person-centred and compassionate way.

Individualised care
We found the team delivered individualised care that reflected service users' assessed needs, preferences and circumstances. Our review of Care and Treatment Plans (CTPs) found they were developed collaboratively with service users and reviewed regularly through multidisciplinary team (MDT) and informal case discussions. The plans identified personal outcomes and focused on service user recovery, rehabilitation and independence.

Care documentation demonstrated strong multi-agency working, with appropriate referrals and signposting to health, social care, third-sector and community-based services. Wider needs, including social circumstances, physical health and wellbeing, were considered as part of planning. We saw evidence of staff building supportive relationships with service users and carers and demonstrating person-centred practice, including recognising achievements and adapting plans to reflect what mattered to individuals.

However, we found some aspects of individualised care were not consistently documented. Evidence of carer identification and carers' assessments varied within the records, and we found examples where a formal carers assessment should have been considered but was not completed. Staff told us the local authority was updating its carers strategy and intended to strengthen support arrangements for carers.

The local authority should:

- **Offer and complete a carers' assessment where it appears a carer may have support needs, in line with the Social Services and Well-being (Wales) Act**
- **Record carers' assessments and outcomes clearly to demonstrate how carers' needs are identified and supported**
- **Strengthen support arrangements for carers and assure practice quality through routine oversight**
- **Consider whether individuals have difficulties engaging in assessment or decision-making and provide advocacy where required.**

Timely

Timely care

The service operated during core working hours and had established emergency procedures for out-of-hours support, including support from the Emergency Duty Team (EDT), to address urgent issues. Access to the CMHT was typically via referral from other mental health services, although referrals were accepted from a range of sources, including GPs, the NHS Wales 111 Option 2 service, inpatient units and Home Treatment Teams. All referrals were reviewed through a single point of access, with assessments offered where appropriate.

The co-location of the team positively supported accessibility and effective communication across health and social care. Clear referral, assessment and follow-up arrangements were in place. Regular meetings, including Single Point of Entry (SPE) meetings, MDT meetings and case discussions, enabled timely decision-making, risk review and coordination of care, and ensured prompt escalation when concerns were identified.

We were informed of a substantial increase in referrals relating to Attention Deficit Hyperactivity Disorder (ADHD). This created significant additional pressure on the service, affecting clinical capacity and generating additional administrative workload. Staff told us this had a considerable impact on overall service delivery, and that ADHD referrals should be managed through a separate pathway.

The health board must review and strengthen the process for managing ADHD referrals to ensure timely assessment and reduce pressure on wider CMHT functions.

We also identified workforce-related pressures affecting timeliness of access to psychology, occupational therapy (OT) and business support. Further findings on these issues are provided under the Effective Care section of this report.

Equitable

Communication and language

Communication with service users was generally clear, respectful and tailored to individual needs. We saw evidence that people were supported to understand their care, risks and options, enabling informed involvement in decision-making.

Communication and language needs were recorded in care records, and staff accessed interpreting services when required. Staff described routinely making the active offer of Welsh, with Welsh-speaking staff available. Written information,

including easy-read formats, was available in Welsh and English, with other languages provided on request.

Communication between staff was effective and supported coordinated care. Regular meetings enabled timely information-sharing, joint decision-making and escalation of concerns. Care documentation showed that staff communicated risk and care planning information clearly, including the use of visual tools such as red, amber, and green prioritisation (RAG ratings) to support shared understanding.

Rights and equality
We generally found appropriate arrangements in place to promote and protect service user rights, including high staff compliance with mandatory Equality, Diversity and Inclusion training. Policies supported equitable access and fair treatment.

Reasonable adjustments enabled individuals with protected characteristics to access services on an equal basis. The hospital environment supported this, with wide doorways, spacious corridors and lift access to service-user areas.

Service users' decision-making capacity was assessed when required and consistently recorded within care records. However, while advocacy services were available, records indicated that advocacy was not always consistently considered, offered or documented. We also found examples where individuals did not receive advocacy support when it may have been appropriate.

The health board and local authority must ensure:

- **Service users' entitlement to an advocate is routinely offered, and they are actively supported to make a referral if they accept**
- **Advocacy discussions, decisions and involvement are clearly documented in care records to ensure transparency and accessibility.**

Delivery of Safe and Effective Care

Safe

Risk management
The CMHT environment and the wider hospital were clean, tidy and well maintained throughout. Staff and service user areas were appropriately decorated, with observation windows, specialist chairs and panic alarms present in all consultation rooms. However, we identified several environmental, safety and security risks within both the CMHT areas and the wider hospital that compromised staff and service user safety.

We identified unaddressed risks related to ligature and broader harm within clinical settings. These included potential ligature points, unsecured fixtures, and objects that could present a risk of harm. Staff told us that service users would not usually be left unattended but confirmed this could not always be guaranteed, with reliance on alarms or reception staff if risks escalated.

Staff confirmed that a formal ligature audit had not been completed. Therefore, we were not assured that these risks had been sufficiently assessed or mitigated. We raised our concerns with senior managers, who subsequently prepared a draft ligature risk assessment during the inspection.

The health board must ensure that comprehensive ligature risk assessments are maintained and ensure mitigations are regularly reviewed to support service user safety.

While we found high staff compliance with mandatory fire safety awareness training, we also noted that routine monthly fire safety checks had not been completed since September 2025.

The health board must ensure that fire safety checks are completed and documented in line with required frequency.

We found the hospital-wide access and building security arrangements were not sufficiently robust and required urgent attention. The wider hospital site operated as an open-access environment, with the CMHT located beyond other treatment areas. Staff told us of previous incidents of assault on staff and members of the public entering CMHT areas unintentionally. The weaknesses in access control and site security increased the risks for staff and service users, while also limiting staff capacity to effectively manage escalating or unpredictable situations safely. Although the health board was aware of these risks and was seeking capital funding

to install CCTV, employ security officers, and introduce keypad-controlled entry systems, these concerns had remained on the risk register since 2021.

The health board must urgently review the hospital's security arrangements and ensure that effective access-control measures are implemented, supported by interim measures to reduce risks while longer-term solutions are implemented.

Incident-reporting arrangements were in place and managed appropriately by staff, with a formal process for recording and managing incidents via the DATIX system. Staff explained that incidents were assessed, and that serious or complex cases were escalated as required. The team evidenced that learning from incidents was routinely shared through staff meetings, supervision, and wider staff communications.

There was a clear framework for identifying, monitoring, and escalating risk, and staff described involving other agencies when incidents escalated or when multi-agency risk management was needed. From our inspection of care records, we confirmed that service-user risk assessments were completed and followed a multidisciplinary approach.

Safeguarding of children and adults
Healthcare staff confirmed they accessed up-to-date safeguarding policies and procedures through the health board's intranet, and we found clear processes in place to support the reporting and escalation of concerns. Staff demonstrated an understanding of appropriate safeguarding pathways and reported good links with the health board's safeguarding team. We confirmed that safeguarding training had been provided to staff and found an overall high compliance.

Safeguarding arrangements within the local authority were suitably robust. Practitioners demonstrated a good understanding of their responsibilities, and we saw evidence of appropriate action being taken in response to safeguarding concerns. Safeguarding and risk management were central to multidisciplinary discussions, and we noted timely information-sharing with the Multi-Agency Safeguarding Hub and the Emergency Duty Team to share and manage risks. However, we found that trends in practice and safeguarding themes were not always escalated to local and regional strategic forums.

The local authority should engage with staff to ensure safeguarding risks and emerging trends are consistently identified and escalated to the appropriate local and regional strategic forums, including the Regional Safeguarding Board.

Medicines management

We found some suitable arrangements in place to support the safe management of medications. The clinic room was clean and well equipped, providing an appropriate environment for medicines administration, with all equipment suitably calibrated within the last 12 months. Medicines were stored securely within locked cabinets and a dedicated medicines fridge, and the service had good systems in place for undertaking on-site blood tests, supporting timely and safe oversight of treatment.

However, we identified significant weaknesses in medicines management that posed a serious risk to service user safety and required urgent improvement. Medication refrigerator and room temperatures were not consistently recorded, and staff demonstrated limited awareness of temperature-monitoring requirements and the risks associated with non-compliance. There was a lack of pharmacy oversight, and no robust audit systems in place to ensure the safe storage and management of medicines. Our inspection of medication charts found repeated errors, including depot charts that were untidy, missing key information, and depot medication being administered at incorrect intervals.

These issues were dealt with under HIW's immediate assurance process and further detail is provided within Appendix B of this report.

Effective

Effective care

We found a stable and motivated workforce across both local authority and healthcare staff, supported by experienced team leaders. Co-location enabled timely professional discussions and a shared understanding of risk and need, contributing positively to coordinated care.

The CMHT delivered care that was well coordinated, person centred and supported by effective multidisciplinary working. Assessments were timely, detailed and comprehensive, incorporating mental health, psychosocial and risk-related information. Risk assessments provided a thorough understanding of potential harm, with structured tools used consistently to support understanding.

Referrals were triaged through a single point of access, after which people were offered an assessment of their needs. Where secondary mental health support was required, individuals were allocated a care coordinator by the team manager. Allocation arrangements were well established, with daily meetings supporting open multidisciplinary discussion to identify the most appropriate care coordinator.

Staff reported manageable caseloads and a team approach to redistributing work during staff absence, supporting continuity of care. Staff also described an open-door culture, effective links with onsite primary care and easy access to senior advice. They told us they were satisfied with their workload and felt their wellbeing was considered, through supervision and management support.

Staff generally reported effective coordination between health, social care and third-sector services. However, they described challenges arising from the use of separate IT systems that do not communicate effectively, leading to duplicated work, missing information and increased risk. Staff reported difficulties accessing key information and explained that important updates were not always shared or visible because records were split across systems. These communication gaps had, in some cases, heightened risks for people and contributed to escalations in need and avoidable hospital admissions, including occasions where service users were discharged without the CMHT being informed.

The health board and local authority must:

- **Strengthen information-sharing arrangements to ensure staff have timely access to complete and accurate records across all CMHT systems**
- **Ensure all staff understand and follow escalation processes when safety concerns arise**
- **Review and address the communication gaps that have resulted in missed information at key points and ensure learning is shared and embedded to prevent recurrence.**

Staff also described challenges relating to pathways into services, reporting that service users were sometimes passed between teams with delayed or unclear communication, including during periods of crisis. This created a risk of delayed or disjointed care, and of people not receiving timely support when their needs escalated. We were told that the health board was in the process of reviewing this matter as part of a wider review of community services, including pathways to care.

Some staff highlighted concerns regarding the clinical governance arrangements supporting crisis cover within the CMHT. They reported there was no on-call doctor available to provide timely medical advice or prescribing support, resulting in delays, additional pressure on clinicians, and increased risk when managing urgent situations. Staff also reported limited access to Mental Health Act approved doctors, leaving them at times without timely medical support for prescriptions or clinical decisions.

The health board and local authority must reflect on staff feedback about CMHT crisis cover and engage with staff to ensure timely access to medical advice.

During the inspection, we identified workforce gaps across key professional groups, which reduced capacity and placed additional pressure on the CMHT. Psychology provision was particularly affected, with the psychologist post vacant since November 2025, and the assistant psychologist post only recently recruited. This had created a significant backlog of people awaiting psychological support, with waiting times previously reaching up to three years. Although waits had begun to improve, they remained high at the time of inspection.

Staff reported that the lack of consistent psychology cover had a clear impact on service delivery. Care coordinators were holding complex and high-risk cases without timely specialist psychological input, leading to increased pressure, stress, and inappropriate caseload demands. We were informed that the health board had introduced several mitigating actions, including redirecting consultant psychologist time into the CMHT and increasing the hours of newly appointed psychology staff. Despite these measures, psychology capacity pressures and extended waiting times remained significant.

The health board must strengthen and stabilise the psychology workforce and ensure the CMHT has sufficient psychological support to:

- **Restore timely access to psychological therapies**
- **Prevent future backlogs and service pauses**
- **Support care coordinators managing complex and high-risk cases**
- **Provide consistent psychological leadership within the MDT.**

Workforce pressures were also identified in Occupational Therapy (OT). OT vacancies across the health board resulted in the dedicated CMHT OT being redeployed to cover other services, reducing capacity and limiting the level of OT support available.

The health board must strengthen Occupational Therapy (OT) capacity and ensure the CMHT has sufficient OT support to maintain safe, timely and effective care.

Administrative pressures were also significant. Although there were no direct administrative vacancies, one staff member was absent and existing administrative staff were frequently redeployed to cover wider vacancies, reducing consistent support for the CMHT. We were told there was no dedicated administrative support for monthly MDT meetings, risk-formulation meetings or professional forums. This

meant clinicians were responsible for producing notes and minutes, and some meeting records lacked clear documentation of key decisions.

The health board and local authority must review administrative staffing levels to ensure adequate support for essential CMHT functions.

Staff also reported that improved IT dictation software would support timely production of clinical letters and reduce administrative burdens. They also highlighted uncertainty around the use of AI-assisted tools, noting that clearer guidance from the health board would support safe and consistent practice.

The health board should engage with staff to ensure they have access to effective IT solutions, including appropriate dictation software, and provide clear guidance to support consistent practice.

Patient records

Records were generally electronic, with only minimal paper documentation retained in clinic files. The care records we reviewed were well maintained and securely stored, and the electronic systems used were password-protected. However, staff reported significant challenges caused by operating separate electronic record systems. A shared electronic recording system enabled information sharing between health board and local authority staff, but it was not used consistently across the wider service, resulting in duplicated documentation and difficulties accessing key information.

We were told that a new electronic records management system was due to be introduced; however, it would not be integrated across healthcare and social care teams. This posed a risk of ongoing challenges with timely and reliable information sharing between teams, which could impact on the delivery of safe and effective patient care.

The health board and local authority must address the risks created by multiple recording systems and ensure that key clinical information is recorded and shared consistently, to support timely, safe and effective care.

Mental Health Act monitoring

We found Mental Health Act (MHA) records to be well maintained and compliant with the requirements of the MHA. We reviewed the records of four service users subject to a Community Treatment Order (CTO) and found that all statutory documentation had been completed appropriately and updated as required. Good systems were in place to support service users' rights, with the provision of verbal and written information at suitable intervals. The Mental Health Act Team demonstrated effective governance oversight of statutory processes.

However, we found incorrect information repeatedly recorded within hospital managers' hearing minutes, where future extension dates were entered instead of the current extension dates being considered. While this did not impact the validity of any detentions, it resulted in inconsistencies and potential for confusion within the records. We discussed our findings with the Mental Health Act Team, who confirmed this was an administrative error and that robust action would be taken to address the issue.

The health board must:

- **Ensure hospital managers' hearing minutes are completed accurately, to avoid inconsistencies within records**
- **Provide additional training to MHA administrative staff to prevent future errors and maintain consistent, reliable documentation.**

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

We found that staff across both health and social care disciplines demonstrated a clear understanding of their responsibilities under the Mental Health (Wales) Measure. We reviewed several jointly completed Care and Treatment Plans (CTPs) that were detailed, structured and easy to navigate, with clear descriptions of assessed needs, planned interventions and review arrangements. Risk assessments clearly outlined identified risks along with specific plans to manage them.
We generally found person-centred plans that reflected people's strengths, preferences and goals, and evidence that service users were proactively involved in developing their plans. CTPs were regularly reviewed, with review dates personalised to individual needs. Routine MDT meetings provided opportunities for joint discussion and timely adjustment of plans.

We saw evidence of MDT input and coordinated working between health, social care and third-sector partners. However, across the records we reviewed, the documentation did not always evidence multidisciplinary discussions or decision making, and key updates were not consistently captured. General case recordings and MDT decisions were frequently absent, unclear or incomplete.

The health board and local authority must ensure multidisciplinary discussions, decision-making and key updates are consistently captured within service user records and are accessible to all relevant staff.

While there was strong evidence that service users had been involved in care planning, we found examples where records did not reflect the voice of the service user.

The health board and local authority must ensure that all records consistently use person-centred language that reflects the individual's voice and involvement in planning their care.

We were told that copies of the CTP were sent to service users with a request that they sign and return the plan if they agreed with the content. If no response was received, it was assumed the service user was satisfied. While this demonstrated an intention to involve individuals in reviewing their plans, reliance on non-response as implied agreement did not sufficiently evidence service users' involvement, as required under the Mental Health (Wales) Measure.

The health board and local authority must strengthen arrangements for evidencing service users' involvement in care planning, rather than relying on non-response as assumed agreement.

Quality of Management and Leadership

Staff feedback

During the inspection, we held extensive discussions with staff across both disciplines to understand their experiences of working within the CMHT and the support they receive from the management team. An online staff survey was also issued; however, with only three responses, the sample size was too small to draw reliable conclusions about the wider staff experience. The survey respondents nonetheless provided a positive view of the service, stating they would recommend it as a place to work and were satisfied with the quality of care they provide.

During our staff discussions, we received consistently positive feedback about the CMHT's culture. Staff described a supportive and collaborative environment where colleagues worked well together, communicated effectively and felt valued in their roles. Staff said they felt well supported through supervision, MDT meetings and regular communication with both health board and local authority leaders.

Staff reported that individual caseloads were generally manageable; however, system-level pressures continued to affect service delivery, including staffing capacity pressures and shortages in specialist areas, as well as delays linked to separate recording systems and limited access to IT platforms. Staff explained that these pressures sometimes affected the responsiveness and efficiency of care.

The health board and local authority should reflect on the staff feedback provided throughout this report and consider opportunities to strengthen the effectiveness and capacity of the service.

Leadership

Governance and leadership

Policies and guidance were available to support staff in their roles, and routine audit activity and structured meetings were in place to review incidents, findings and issues related to service user care. The governance structures generally supported oversight of risk, performance and incident management, with regular staff meetings to share feedback and discuss issues.

Staff described leaders across both the local authority and health board as visible, approachable and committed to patient care. Our staff discussions reflected consistently positive experiences of line management and senior leaders, with staff stating that their managers were supportive, provided clear feedback and involved them in decisions affecting their work.

Staff described positive working relationships and timely professional dialogue between local authority and health board colleagues. Communication between staff was generally reported to be effective, and we saw evidence of good operational working between local authority and health board staff. However, we identified notable gaps in strategic partnership working and information sharing that could impact the quality of decision making. Health-led morning huddles were not routinely attended by local authority staff, and staff told us the meeting would benefit from consistent local authority representation to support discussion of risks, updates and coordination decisions.

Although joint MDT forums were in place, we were told that other health board strategic forums made decisions in isolation, without local authority involvement. We were also informed that the health board had not meaningfully engaged the local authority in its planned review of community services, and that joint third-sector service level agreements had ended without consultation.

The health board and local authority must strengthen joint communication, engagement and information-sharing to support coordinated operational and strategic decision-making.

The health board should co-produce its review of community services and pathways to care with the local authority and service users, to ensure improvements are robust, informed and delivered in a timely way.

Workforce

Skilled and enabled workforce

Staff demonstrated strong collaboration and a clear commitment to shared values. However, workforce capacity pressures were evident, including vacancies within psychology, occupational therapy and business-support roles, as well as overstretched specialist co-occurring workers. Local authority staff also reported stretched capacity within Approved Mental Health Professional (AMHP) provision, delays in community Deprivation of Liberty Safeguards (DoLS) processes, and increasing pressure on neurodevelopmental services. Staff further told us that resources within the team could be used more effectively, with some describing carrying out tasks normally undertaken by support workers due to gaps in support-worker provision. Staff reported that these pressures affected service delivery and limited their ability to focus on their core professional responsibilities.

The health board and local authority must:

- **Undertake a review of staffing capacity across the CMHT and prioritise recruitment to vacant posts**
- **Engage with staff to discuss how the team's resources can be used more effectively**
- **Review support-worker capacity and provision to ensure that staff can focus on their core professional roles.**

Staff told us they had received appropriate training to undertake their roles. We found good systems in place to monitor mandatory training compliance, and overall compliance was generally good. However, some mandatory training modules for healthcare staff required improvement, which included Moving and handling, Resuscitation, Mental Capacity Act and Deprivation of Liberty Safeguards.

We alerted staff to these issues and were informed that staff were booked onto the next available training sessions wherever possible. However, resuscitation courses were fully booked across the health board, limiting immediate access.

The health board must ensure all outstanding mandatory training is completed and that sufficient training courses, particularly for resuscitation, are made available to support staff compliance and maintain staff and service user safety.

We found high staff compliance with annual appraisals and were told that health care staff received regular, documented supervision. However, our review of local authority records identified that supervision and reflective practice were not consistently recorded, and where records existed, they were often brief and lacked Specific, Measurable, Achievable, Relevant, Theme based (SMART) actions or documented follow-up. In several cases, no supervision notes were present, and senior managers agreed that recording of supervision and significant decisions was an area requiring improvement.

The local authority should ensure that supervisions and reflective practice are consistently recorded and documented to an appropriate standard.

Culture

People engagement, feedback and learning

We found clear arrangements in place for service users to raise concerns or make complaints, supported by the NHS Wales Putting Things Right (PTR) process. Service users could raise concerns in various ways, and all complaints were recorded onto DATIX and triaged by the complaints team. Formal complaints were recorded and investigated in line with PTR requirements.

Staff we spoke with during the inspection demonstrated clear understanding of Duty of Candour (DoC) requirements and we found high staff compliance with DoC training. Staff were able to describe the process that would be followed on receipt of a concern or following an incident.

Arrangements were in place to gather service user feedback, including surveys and feedback collected by the Patient Experience Team. Staff told us they sought feedback through routine engagement and annual quality-assurance activities, and that feedback was routinely analysed to identify and address key themes. We were told that Patient Reported Experience/Outcome Measures (PREMs/PROMS) were being implemented to strengthen feedback processes.

We were told how the CMHT had used service user feedback to improve the experience of neurodivergent service users, by redesigning appointment letters and introducing a video tour of the environment to reduce anxiety and support pre-appointment preparation.

Information

Information governance and digital technology
Staff compliance with mandatory information-governance training was high and staff were aware of their responsibilities when dealing with confidential information. However, during the inspection we found some paper records inappropriately stored in a meeting room, which did not comply with expected information-governance standards.

The health board and local authority must ensure that records are stored securely in accordance with information-governance requirements, and that staff remain vigilant in maintaining safe record-handling practices.

Learning, improvement and research

Quality improvement activities
The CMHT demonstrated a wide range of processes to monitor, review and improve the quality and safety of care. Staff described robust incident-management and monitoring arrangements, with a range of meeting processes in place to discuss service-user care. Senior managers demonstrated good oversight of priority areas for improvement.

We saw strong evidence that health board and local authority staff carried out suitable audits and quality-improvement activities independently. However, there was little documented evidence of regular joint audit activity across the integrated CMHT. We were told this resulted from the local authority and health board

operating different record systems, and that previous joint MDT audits had stopped when IT systems changed. The quality-assurance and risk-escalation documents we reviewed showed no local authority contribution.

The health board and local authority must work together to establish a robust joint auditing and reporting framework, ensuring both agencies can fully participate in joint assurance processes and strengthen integrated governance arrangements.

Whole-systems approach

Partnership working and development

Staff described good working relationships across the team and the wider system supporting the CMHT. They reported positive day-to-day collaboration with the mental health primary care team and the drug and alcohol service based within the same building. GP engagement was also described as supportive, with a practice also based on site.

Staff also described positive collaborative working within the co-occurring specialist service, where a working group had been established to review guidance and develop additional tools for practitioners, including service-user involvement in shaping resources.

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, CIW and the public with assurance that the findings identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW and CIW 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 organisations
- Provide HIW and CIW 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.

HIW will follow up on the progress of implementing improvements through its assurance processes, and CIW will follow up on local authority areas through its annual meeting with the Director of Social Services, and biannual meetings with the Heads of Adult Services (HoAS).

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
We found unassessed ligature and wider harm risks within clinical areas, including potential ligature points, unsecured fixtures, and items that could pose a risk of harm.	This posed a risk to staff and service user safety.	We raised our concerns with senior managers.	A draft ligature risk assessment was completed during the inspection.

Appendix B - Immediate improvement plan

Service: Taff Ely Community Mental Health Team

Date of inspection: 13 and 14 January 2026

HIW was not assured that medication management arrangements within the CMHT are sufficiently robust or safe. We reviewed the medication storage arrangements and found the following issues which pose a potential risk of serious harm to patients:

- Medication refrigerator and room temperatures were not consistently recorded daily
- Staff demonstrated limited awareness of temperature monitoring requirements and the risks associated with non-compliance.

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
The health board must: Ensure consistent monitoring and recording of medication refrigerator and medication storage room temperatures, with clear accountability for compliance	Delivery of Safe and Effective Care	1.1 A refrigerator and clinic room temperature checklist and process, which includes clear accountability for staff, have been developed and are in use daily.	Interim Senior Nurse RCT CMHTs	Complete 16/01/2026 See Appendix 1.1 + 1.2

Implement robust governance oversight and audit processes to ensure medications are safely stored		1.2 The daily refrigerator and clinic room temperature monitoring checklist includes a weekly team leader audit and a monthly senior nurse audit. This will be monitored through the monthly adult community mental health Quality, Safety, Risk and Experience meeting.	Interim Senior Nurse RCT CMHTs	Complete 16/01/2026 See Appendix 1.1
Provide staff with appropriate training, guidance and oversight to improve awareness and understanding of medicines storage and management processes.		1.3.1 The CTMUHB medication storage procedure has been re-shared by email and verbally with the team	Interim Senior Nurse RCT CMHTs	Complete 21/01/2026 See Appendix 1.3 + 1.3.1
		1.3.2 Pharmacy team will provide dedicated training to Taff Ely CMHT to ensure awareness of temperature monitoring requirements and the risks associated with non-compliance. Training is scheduled for 30/01/2026	Principal Mental Health Pharmacist	In Progress Estimated Date of Completion 30/01/2026

HIW was not assured that depot medication prescribing, and administration processes were safe or sufficiently robust. During the inspection we identified the following concerns:

- Three patients were receiving depot medication every four weeks instead of calendar monthly, resulting in 13 doses per year rather than 12. This creates a potential risk of medication accumulation and harm

- We found inconsistent terminology and confusion in records regarding the use of the terms ‘monthly’, ‘calendar monthly’, and ‘four-weekly’
- We saw examples of depot medication being prescribed in the incorrect section of prescription forms, creating a risk of error
- We found examples of poor-quality depot charts lacking essential clinical information (e.g., allergies, legal status, height, weight)
- We found a general lack of pharmacy support and guidance to the CMHT, resulting in insufficient oversight of safe medicines management practices.

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
The health board must: Ensure depot medication is prescribed and administered at the correct intervals	Delivery of Safe and Effective Care	2.1.1 The 3 depot charts highlighted have been reviewed and are now prescribed as per licence dosing.	Interim Lead Nurse	Complete 16/01/2026
		2.1.2 All depot charts in Taff Ely CMHT are under review to ensure that there are no other prescribing ambiguities. As there is no pharmacy resource within CMHTs, this will be undertaken by the medical team.	Consultant Psychiatrists	In Progress Estimated Date of Completion 30/01/2026

Introduce safeguards within the prescribing process so depot medication is always recorded correctly		2.2.1 A review of current processes for depot chart screening and supply of depot medication to CMHT to be undertaken by pharmacy dept	Head of Pharmacy: Quality and Safety	In Progress Estimated Date of Completion 30/01/2026
		2.2.2 A safe standardised approach to chart screening and supply is to be implemented HB-wide.	Head of Pharmacy Operational Services	Estimated Date of Completion 28/02/2026
		2.2.3 A wider depot service review will be undertaken by Meds Management MH Team.	Principal Mental Health Pharmacist	In Progress Estimated Date of Completion 31/03/2026
Standardise and improve depot charts, ensuring essential clinical details are consistently recorded		2.3.1 The CMHT is transitioning to the use of All Wales standardised inpatient mental health medication charts, as they contain a dedicated section for depot medications. All depot charts will be reviewed to ensure that they are written on the All Wales charts and include relevant clinical information.	Interim Senior Nurse RCT CMHTs	In Progress Estimated Date of Completion 30/03/2026

		2.3.2 An audit of the presence of relevant clinical information standards will be added to the existing CMHT depot audit (Appendix 2.3.2) and implemented on completion of the review of depot charts. This will be monitored through the monthly adult community mental health Quality, Safety, Risk and Experience meeting.	Interim Senior Nurse RCT CMHTs	In Progress Estimated Date of Completion 30/03/2026
Provide clear guidance and training to staff to remove ambiguity surrounding administration intervals and improve the accuracy of depot prescribing and documentation		2.4.1 Pharmacy team will provide dedicated training to Taff Ely CMHT to ensure awareness of prescribing and recording standards of all depot medications. Training is in place for 30/01/2026	Principal Mental Health Pharmacist	In Progress Estimated Date of Completion 30/01/2026
Strengthen pharmacy support to the CMHT, ensuring staff have access to timely advice, oversight and professional guidance relating to safe medicines management.		2.5.1 Contact details for the Medicines Management MH Team have been re-circulated to the wider MHLD team to support timely access to advice	Principal Mental Health Pharmacist	Completed 20/01/2026 See Appendix 2.5.1

		2.5.2 A review will be undertaken of high-risk prescribing areas within CMHT and resource allocation of Medication Management team with MHLD directorate.	Principal Mental Health Pharmacist	In Progress Estimated Date of Completion 31/04/2026

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): Tracey Larsen

Job role: Interim Lead Nurse

Date: 21/01/2026

Appendix C - Improvement plan

Service: Taff Ely Community Mental Health Team

Date of inspection: 13 and 14 January 2026

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.	Physical-health monitoring was inconsistently documented, including missing weight-monitoring records for service users at risk of malnutrition.	The health board and local authority must ensure that physical health monitoring is consistently recorded, monitored and reviewed for all service users, and particularly those identified as being at increased risk.	Health promotion			
2.	Carer identification and carers' assessments were inconsistently completed or recorded.	The local authority should:	Individualised care			

		• Offer and complete a carers' assessment where it appears a carer may have support needs, in line with the Social Services and Wellbeing (Wales) Act • Record carers' assessments and outcomes clearly to demonstrate how carers' needs are identified and supported • Strengthen support arrangements for carers and assure practice quality through routine oversight • Consider whether individuals have				

		difficulties engaging in assessment or decision making and provide advocacy where required.				
3.	A substantial increase in ADHD referrals created pressure on clinical and administrative capacity, impacting wider service delivery.	The health board must review and strengthen the process for managing ADHD referrals to ensure timely assessment and reduce pressure on wider CMHT functions.	Timely care			
4.	Advocacy was not consistently offered, documented, or acted upon, and some service users did not receive support where appropriate.	The health board and local authority must ensure: • Service users' entitlement to an advocate is routinely offered, and they are actively supported to make a referral if they accept	Rights and equality			

		• Advocacy discussions, decisions and involvement are clearly documented in care records to ensure transparency and accessibility.				
5.	A formal ligature audit had not been completed. Therefore, we were not assured that these risks had been sufficiently assessed or mitigated. Senior managers prepared a draft ligature risk assessment during the inspection.	The health board must ensure comprehensive ligature risk assessments are maintained and ensure mitigations are regularly reviewed to support service user safety.	Risk management			
6.	Monthly fire-safety checks had not been completed since September 2025.	The health board must ensure that fire safety checks are completed and documented in line with required frequency.	Risk management			
7.	The hospital-wide access and building security arrangements were not	The health board must urgently review the hospital's security	Risk management			

	sufficiently robust and required urgent attention to support staff and service users' safety.	arrangements and ensure that effective access-control measures are implemented, supported by interim measures to reduce risks while longer-term solutions are implemented.				
8.	Safeguarding themes, trends and patterns were not consistently escalated to local or regional strategic forums.	The local authority should engage with staff to ensure safeguarding risks and emerging trends are consistently identified and escalated to the appropriate local and regional strategic forums, including the Regional Safeguarding Board.	Safeguarding of children and adults			
9.	Staff described challenges in using multiple electronic record systems, resulting in duplicated work, missing information, and information gaps that in some cases were not	The health board and local authority must: • Strengthen information-sharing arrangements to ensure staff have timely access to	Effective care			

	escalated appropriately and contributed to avoidable hospital admissions.	complete and accurate records across all CMHT systems • Ensure all staff understand and follow escalation processes when safety concerns arise • Review and address the communication gaps that have resulted in missed information at key points and ensure learning is shared and embedded to prevent recurrence.				
10.	Staff highlighted concerns regarding the governance arrangements supporting crisis cover and also reported limited access to Mental Health Act approved doctors.	The health board and local authority must reflect on staff feedback about CMHT crisis cover and engage with staff to ensure timely access to medical advice.	Effective care			

11.	Significant psychology workforce gaps reduced capacity and increased caseload pressure.	The health board must strengthen and stabilise the psychology workforce and ensure the CMHT has sufficient psychological support to: • Restore timely access to psychological therapies • Prevent future backlogs and service pauses • Support care coordinators managing complex and high-risk cases • Provide consistent psychological leadership within the MDT.	Effective care			
12.	Wider Occupational Therapy vacancies resulted in the dedicated CMHT OT being redeployed to cover other	The health board must strengthen Occupational Therapy (OT) capacity and ensure the CMHT has sufficient OT support to	Effective care			

	services, reducing capacity and limiting the level of OT support available.	maintain safe, timely and effective care.				
13.	Administrative capacity was reduced due to sickness and redeployment, limiting governance support.	The health board and local authority must review administrative staffing levels to ensure adequate support for essential CMHT functions.	Effective care			
14.	Staff reported that improved IT dictation software would reduce administrative burdens. They also highlighted uncertainty around the use of AI-assisted tools, reporting that clearer guidance would support safe and consistent practice.	The health board should engage with staff to ensure they have access to effective IT solutions, including appropriate dictation software, and provide clear guidance to support consistent practice.	Effective care			
15.	Staff reported that the separate and incompatible record-keeping systems created risks, and a new system being introduced	The health board and local authority must address the risks created by multiple recording systems and ensure that key clinical information is	Patient records			

	will not be integrated across teams.	recorded and shared consistently, to support timely, safe and effective care.				
16.	Hospital managers' hearing minutes repeatedly contained incorrect extension dates, creating inaccuracies in statutory documentation.	The health board must: • Ensure hospital managers' hearing minutes are completed accurately, to avoid inconsistencies within service users' records • Provide additional training to MHA administrative staff to prevent future errors and maintain consistent, reliable documentation.	Mental Health Act monitoring			
17.	MDT discussions and decision-making were not consistently documented within service user records, with key updates, case recordings	The health board and local authority must ensure multidisciplinary discussions, decision-making and key updates are consistently	Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision			

	and MDT decisions frequently absent, unclear or incomplete.	captured within service user records and are accessible to all relevant staff.				
18.	Some records did not reflect the voice of the service user.	The health board and local authority must ensure that all records consistently use person-centred language that reflects the individual's voice and involvement in planning their care.	Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision			
19.	We found that non-response to CTP letters was being treated as implied agreement, which does not sufficiently evidence service users' involvement as required under the Mental Health (Wales) Measure.	The health board and local authority must strengthen arrangements for evidencing service users' involvement in care planning, rather than relying on non-response as assumed agreement.	Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision			
20.	Staff reported capacity shortages in specialist areas, as well as delays linked to separate	The health board and local authority should reflect on the staff feedback provided	Staff feedback			

	recording systems and limited access to IT platforms. Staff explained that these pressures sometimes affected the responsiveness and efficiency of care.	throughout this report and consider opportunities to strengthen the capacity and effectiveness of the service.				
21.	Although joint MDT forums were in place, other health board strategic forums were reported to make decisions in isolation, without local authority involvement.	The health board and local authority must strengthen joint communication, engagement and information-sharing to support coordinated operational and strategic decision-making.	Governance and leadership			
22.	We were informed that the health board had not meaningfully engaged the local authority in its planned review of community services, and that joint third-sector service level agreements had ended without consultation.	The health board should co-produce its review of community services and pathways to care with the local authority and service users, to ensure improvements are robust, informed and delivered in a timely way.	Governance and leadership			

23.	Workforce capacity pressures affected psychology, occupational therapy, administrative support and co-occurring roles. Local authority practitioners highlighted capacity pressures in Approved Mental Health Professionals (AMHPs), Community Deprivation of Liberty Safeguards (DoLS) and neurodevelopmental services, and reported undertaking support-worker tasks due to gaps in support-worker provision.	The health board and local authority must: • Undertake a review of staffing capacity across the CMHT and prioritise recruitment to vacant posts. • Engage with staff to discuss how the team's resources can be used more effectively • Review support-worker capacity within the CMHT to ensure that staff can focus on their core professional roles.	Skilled and enabled workforce			
24.	Some mandatory-training modules, including Moving and Handling, Resuscitation, and Mental Capacity Act/DoLS, required improvement.	The health board must ensure all outstanding mandatory training is completed and that sufficient training courses, particularly for	Skilled and enabled workforce			

	Resuscitation training was fully booked across the health board, limiting immediate access.	resuscitation, are made available to support staff compliance and maintain staff and service user safety.				
25.	Our review of local authority records identified that supervision and reflective-practice records were inconsistently documented.	The local authority should ensure that supervisions and reflective practice are consistently recorded and documented to an appropriate standard.	Skilled and enabled workforce			
26.	We found paper records were inappropriately stored in a meeting room, breaching information-governance standards.	The health board and local authority must ensure that records are stored securely in accordance with information-governance requirements, and that staff remain vigilant in maintaining safe record-handling practices	Information governance and digital technology			
27.	We found joint audit activity across the integrated CMHT was limited, with no	The health board and local authority must work together to establish a robust joint auditing and	Quality improvement activities			

	local-authority contribution to quality-assurance documents.	reporting framework, ensuring both agencies can fully participate in joint assurance processes and strengthen integrated governance arrangements.				

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):
Job role:
Date: