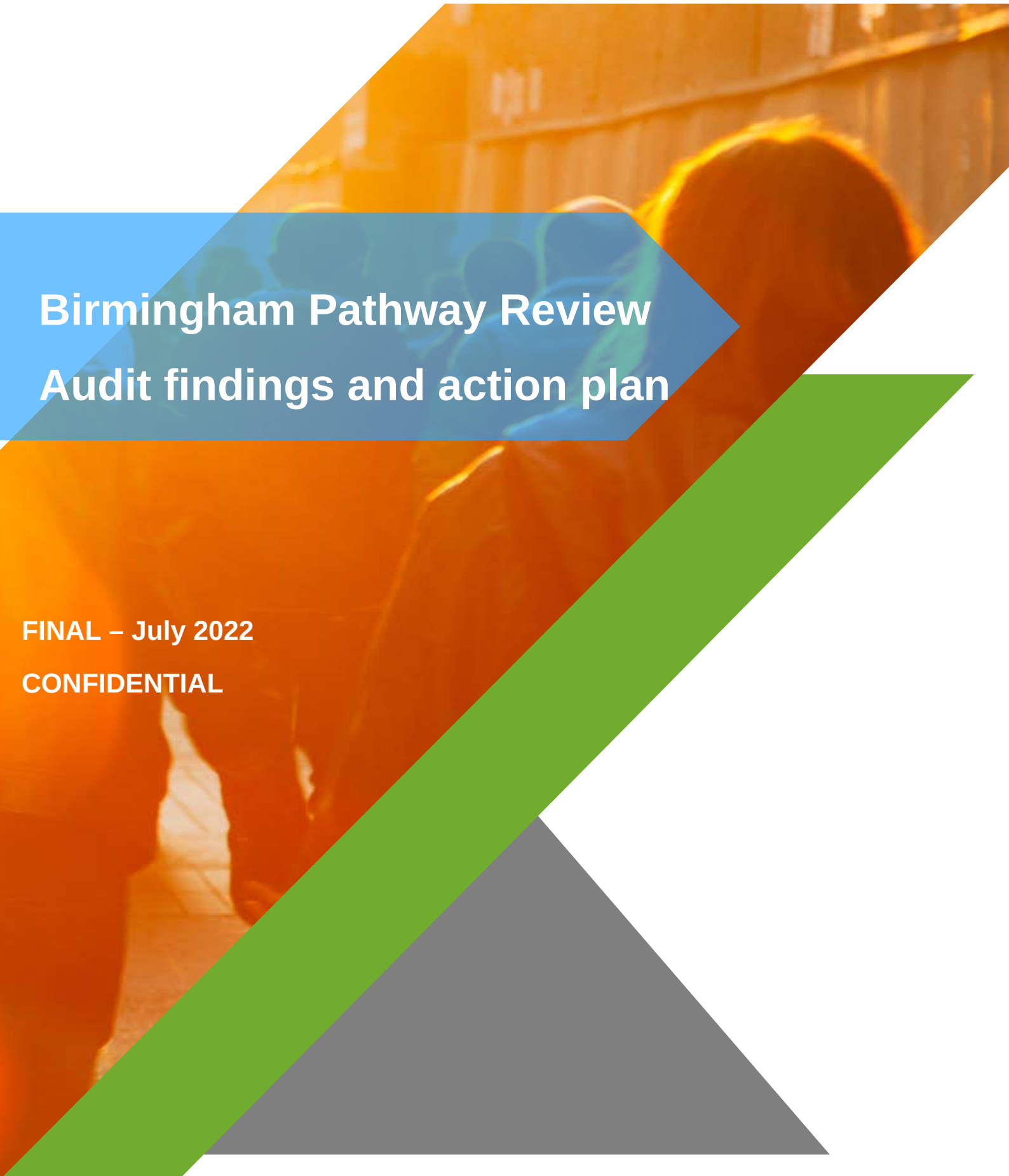


Birmingham Pathway Review
Audit findings and action plan

FINAL – July 2022

CONFIDENTIAL

Contents

1 INTRODUCTION

1.1 Context

In 2011 and 2012 two mental health service users were involved in domestic homicides. Birmingham Safety Partnership published Domestic Homicide Reviews (DHRs) in both cases to establish what lessons could be learned. The findings and recommendations were translated into recommendations for Birmingham & Solihull Mental Health NHS Foundation Trust (BSMHFT), West Midlands Police (WMP) and Birmingham City Council (BCC). Since this time, Forward Thinking Birmingham (FTB) has been commissioned by Birmingham and Solihull Clinical Commissioning Group (BSCCG) to provide services for people up to 25 years old and early intervention services for people under 35 years of age.

We (Niche) were commissioned by NHS England (Midlands & East) to undertake a review to provide assurance of the completion of actions arising from these DHRs. This assurance review was published in 2018, and identified that, although progress had been made, further action was required to fully implement the recommendations and address the underlying problems identified by the DHRs. Key findings which needed further action were:

- Access to Approved Mental Health Professionals (AMHPs) to provide assessments under the Mental Health Act (MHA); and
- The need to make improvements in the management of access to mental health inpatient beds.

As a response to this assurance review, BSMHFT, FTB, BSCCG and BCC published action plans to address these findings.

In addition to the above, between May 2018 and July 2019 HM Coroner for Birmingham wrote ten 'Prevent Future Deaths' (PFD) letters to stakeholders across Birmingham, following the deaths of ten people. All the services identified in the Coroner's PFDs have responded to HM Coroner, describing the actions they will take to address the recommendations in the PFD letters received.

The coroner recommended services take action to improve the following:

- Handover and transfer of care information.
- Triage.
- Lack of beds and access to beds.
- Community mental health service capacity, specifically in relation to access to care co-ordinators in the Crisis & Home Treatment Team.
- Crisis response and responding to carers' concerns.
- Interagency communication.
- Access to AMHPs.

In early 2021, Niche Health and Social Care Consulting were appointed by NHS England to conduct a review of the Birmingham Pathway to determine: ***"If a service user accessed services today with a similar history/problem what would be different about the service they receive?"***

As the basis for answering this question, a case note audit of a sample of 100 case notes was conducted between July and September 2021.

1.2 Structure of report

Following this introduction, this report is structured as follows:

Section 2 explains the method which was used to carry out an audit of a sample of case notes.
Section 3 contains the findings of our case note audit.
Section 4 contains the action plans prepared in response to the audit findings

2 METHOD

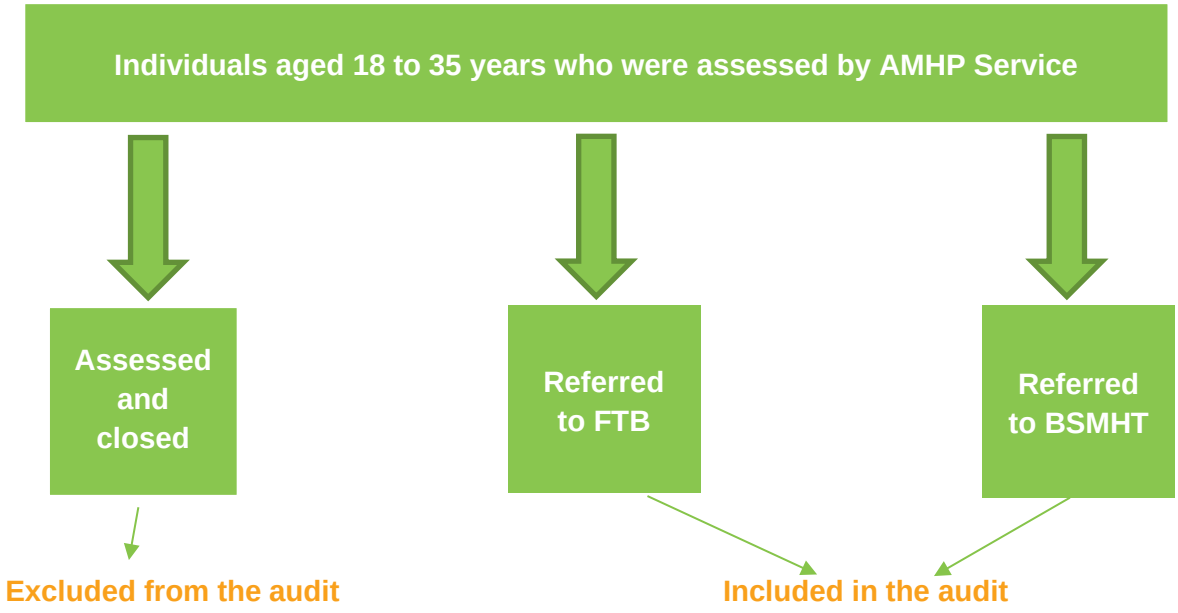
2.1. Case note audit

Following detailed review of the cases underlying this audit, a template was agreed between Niche and project partners in Birmingham, to audit the case notes against. This template is attached as Appendix One.

A Data Processing Agreement was developed by Niche and signed and approved by:

- John Williams, Assistant Director of Adult Social Care behalf of Birmingham City Council.
- Marion Harris, Chief Nurse & Caldicott Guardian on behalf of Birmingham Women's & Children's NHS Trust (on behalf of Forward Thinking Birmingham).
- Hilary Grant, Executive Medical Director on behalf of Birmingham & Solihull Mental Health NHS Foundation Trust.

The time period for the data sample was the first six months of 2021. The criteria for inclusion in the audit were:



The follow-through audit included an audit of individual BSMHFT or FTB case notes if the individual was assessed by the AMHP Service and was then:

- Admitted to an inpatient service under Section 2/3 Mental Health Act.
- Referred to and accepted informally by inpatient services.
- Referred to and assessed and/or accepted by a Crisis Resolution & Home Treatment Team.
- Referred to or continued under the care of a Community Mental Health Team (CMHT).

If the AMHP service assessed a Birmingham resident and then the person was placed in a bed or service outside Birmingham, the case was included in the sample. However, the audit did not attempt to track patient records with providers beyond BSMHFT or FTB.

A maximum of 20 minutes was allocated to audit each set of case notes; we are conscious that information which is very difficult to retrieve is much less clinically useful.

A small number of cases in the sample provided did not fully meet the criteria set out above. Specifically:

a) Out of area patients and Birmingham patients placed out of area

The intention was to exclude individuals from the sample where the AMHP service assessed a non-Birmingham resident and then referred the case back to their local services outside Birmingham. However, there were two cases where it was unclear whether the patient was from outside Birmingham or not.

There were three cases where the individual was out of area and assessed by the Birmingham AMHP service. In one case we were unclear whether they were referred and transferred to their local services or admitted to a Birmingham bed. In another case, the individual had no Birmingham address, and it was unclear what the outcome of the assessment was. The third individual was an inpatient who was under Section 2 and had been referred for a Mental Health Act assessment under Section 3.

These cases have been retained in the audit findings, as they appear realistically representative of the types of practice arising within the services under consideration.

b) Age range

The intention was to focus on individuals aged 17 to 35. There were six patients who were aged slightly over 35 years (36/37 years) at the time of assessment. We have included these in the audit findings, as they do not significantly change its focus.

The structure of records maintained by Birmingham City Council did not permit ready access to some important supporting documents. These were retrieved and supplied separately to Niche, following the main audit visits.

2.2 Action planning

The audit findings were shared with the three local agencies on 19th October 2021. At that meeting, it was agreed that each agency should review and respond to the findings via its own internal governance processes. Niche prepared a template for action plans to be prepared in response, and this forms the basis of section 4 of this document.

A draft combined report and action plan was circulated to all three agencies on 13th December and signed off at a final project meeting on 21st December 2021.

3 FINDINGS

The definitions of “good” and “acceptable” used here are set out in Appendix One.

3.1 Birmingham City Council

Table 1: Audit results for the AMHP’s records at Birmingham City Council by audit question. Raw sample numbers used.

Audit question	Good	Acceptable	No	Not applicable	Total (applicable)	Total
The individual was assessed within 4 hours of a referral to the AMHP service for an MHA assessment.	13	1	43	43	57	100
There is evidence that referrals have been triaged.	70	28	2	0	100	100
There is evidence of the AMHP involving family/ carers in the assessment process.	48	18	34	0	97	100
Where an individual was previously known, there is evidence that their previous history including risk management was taken into consideration during the assessment process.	71	23	6	0	100	100

In relation to the “Not Applicable” category for question 1, this related mainly to patients who were already inpatients. A request had been made for a Mental Health Act assessment as their Section 2 was expiring. There was no need for them to be assessed within 4 hours.

Chart 1: % of records classified as 'Good', 'Acceptable' and 'No' for question 1 of the audit of AMHP's records at Birmingham City Council.

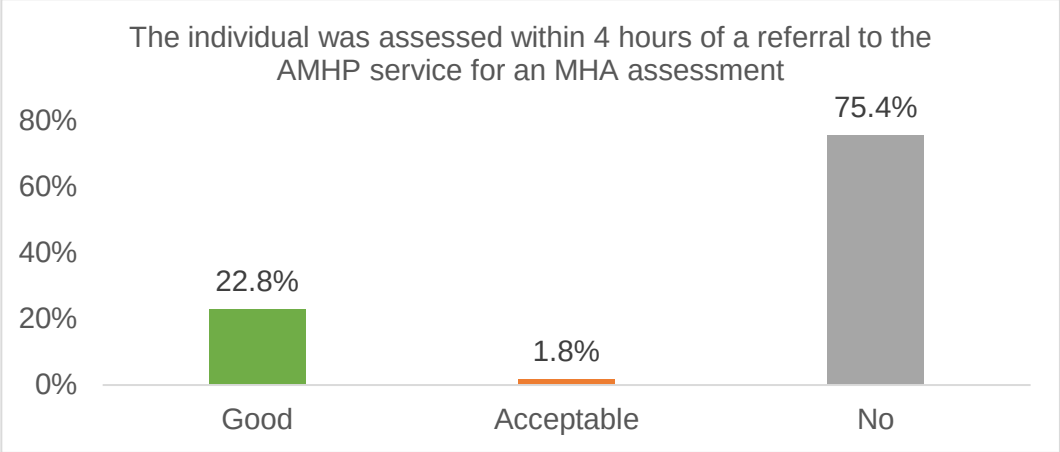
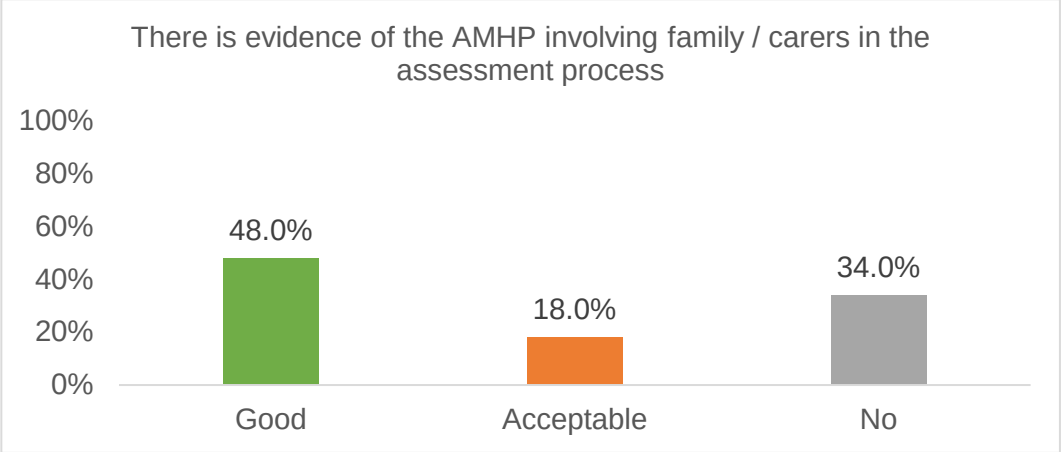


Chart 1 shows that just over 75% of individuals were not assessed within 4 hours of a referral being made to the AMHP service for a Mental Health Act Assessment.

Chart 2: % of records classified as 'Good', 'Acceptable' and 'No' for question 2 of the audit of AMHP's records at Birmingham City Council.

Chart 2 shows that in almost all cases referrals were triaged. The 2% refers to two cases.

Chart 3: % of records classified as 'Good', 'Acceptable' and 'No' for question 3 of the audit of AMHP's records at Birmingham City Council.



There was evidence of the AMHP involving family members/carers in the assessment process in almost 70% of cases. Where the response was "No" there was a range of reasons for this including being unable to identify the next of kin, being unable to contact the next of kin, the next of kin being abroad, the individual not having any contact with their family/carer. In one case there was a Barring Order in place. In over half of the cases where "No" was the finding, there were reasons in the case notes describing why contact had not been possible.

Chart 4: % of records classified as 'Good', 'Acceptable' and 'No' for question 4 of the audit of AMHP's records at Birmingham City Council.

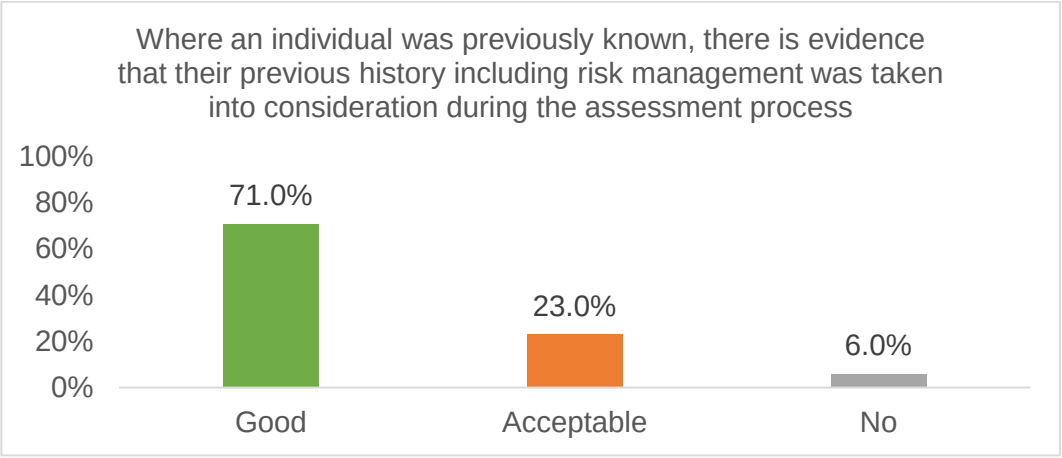


Chart 4 shows that in almost all cases there was evidence of the individual's previous history and risk management having been taken into consideration during the assessment process where relevant.

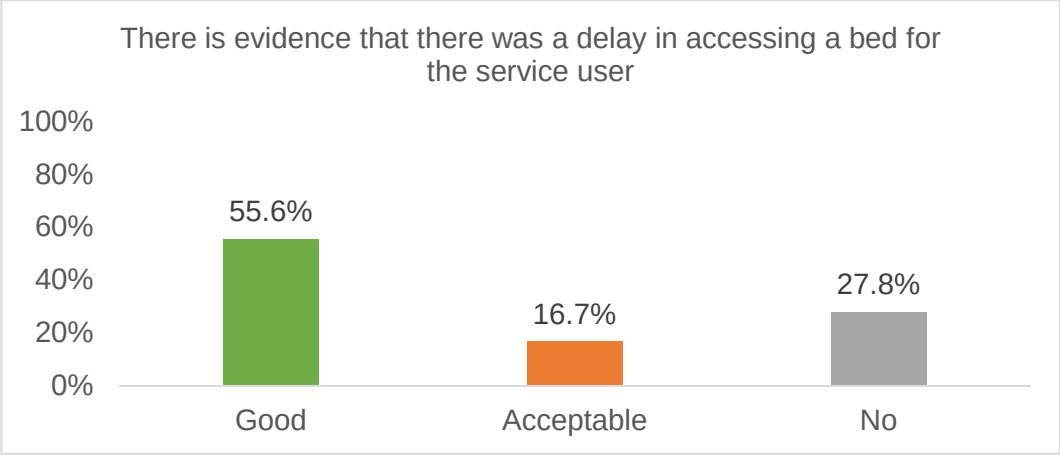
3.2 Forward Thinking Birmingham and Birmingham Women's and Children's NHS Foundation Trust

Table 2: Audit results for the provider records at Birmingham Women's and Children's Trust by audit question. Raw sample numbers used.

Audit question	Good	Acceptable	No	Not applicable	Total (applicable)	Total
There is evidence that there was a delay in accessing a bed for the service user.	10	3	5	11	18	29
There is a current risk formulation and management plan in the case notes.	11	5	13	0	29	29
There is evidence that staff have checked whether a carer's assessment has been completed in the last year or there is evidence of family members/carers being made aware they are entitled to a carer's assessment.	0	0	29	0	29	29
There is evidence that a carer's assessment has been completed.	0	0	29	0	29	29
There is clear evidence of the nature of any concerns that family members/carers have raised.	11	5	13	0	29	29
There is evidence of family/carer concerns being taken into consideration in managing risk.	9	6	14	0	29	29
There is evidence of interagency communication.	9	17	3	0	29	29
There is evidence of service users with drug and alcohol problems being referred to substance misuse services.	0	1	20	8	21	29
There is evidence that a handover meeting took place to plan the handover of any service user being transferred to another team.	7	10	4	8	21	29
There is evidence of effective management of delays in discharging the service user (could relate to inpatient transfers, care	0	0	19	10	19	29

Audit question	Good	Acceptable	No	Not applicable	Total (applicable)	Total
coordination, funding, accommodation, amongst other reasons).						
Applied to service users where poor medication compliance is documented. Poor concordance of medication compliance is documented in the risk management plan.	8	2	2	17	12	29
Applied to service users where psychological therapies have been used. There is evidence that the service user was able to access psychological therapies whilst under the care of the Home Treatment Team.	0	0	0	29	0	29
Where relevant, there is evidence of communication between the CMHT and the Home Treatment Team.	1	1	0	27	2	29

Chart 5: % of records classified as 'Good', 'Acceptable' and 'No' for question 1 of the audit of provider records at Birmingham Women's and Children's Trust.



In over 44.8% (n=13) of cases there was evidence of a delay in accessing a bed. "Good" means that there was good evidence documented that there had been a delay in accessing a bed and there was a documented timeline and explanation for the delay and any attempts to escalate the challenges were also documented. "Acceptable" means that any delay in accessing a bed was recorded and the reasons and alternative means of managing the individual are recorded. "No" means that there was no documentation regarding a delay in accessing a bed. In 37.9% (n=11) this question was recorded as "Not Relevant" as the patient was already an inpatient. This group is not shown in Chart 5.

Chart 6: % of records classified as 'Good', 'Acceptable' and 'No' for question 2 of the audit of provider records at Birmingham Women's and Children's Trust.

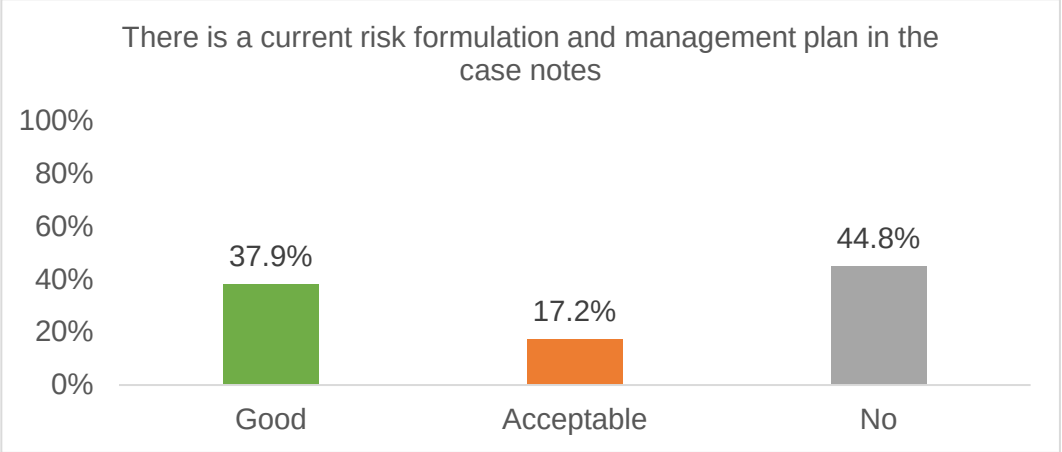
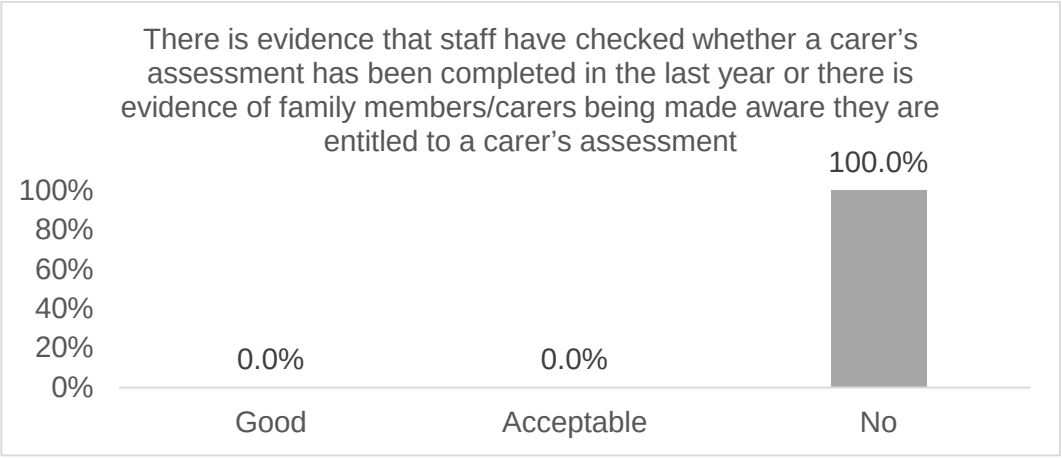


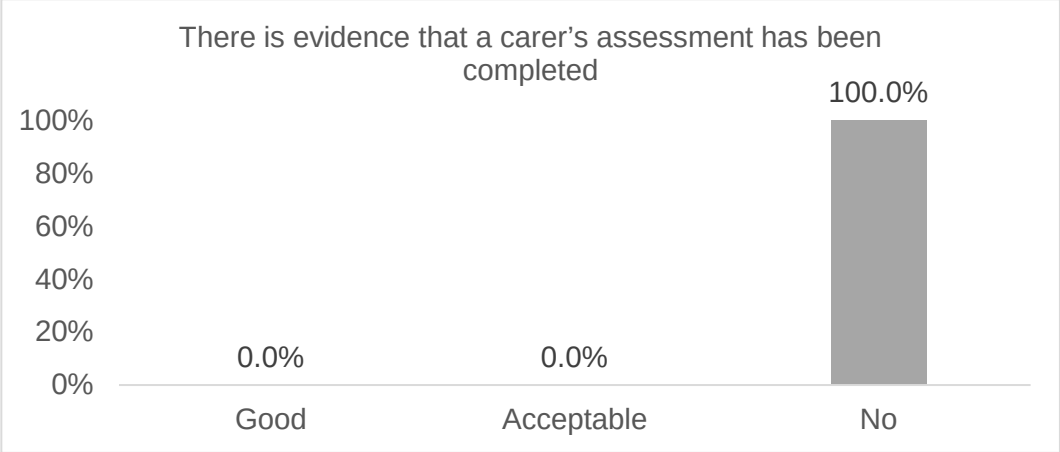
Chart 6 shows that overall, there was a current formulation and management plan in the case notes in 55.1% of cases. In 44.8% of cases there was no current formulation and risk management plan related to the episode of care being audited. Sometimes the risk management plan in the case records related to a previous care episode the previous year. This was therefore counted as a "No" as it was not current and relating to the present episode of care.

Chart 7: % of records classified as 'Good', 'Acceptable' and 'No' for question 3 of the audit of provider records at Birmingham Women's and Children's Trust.



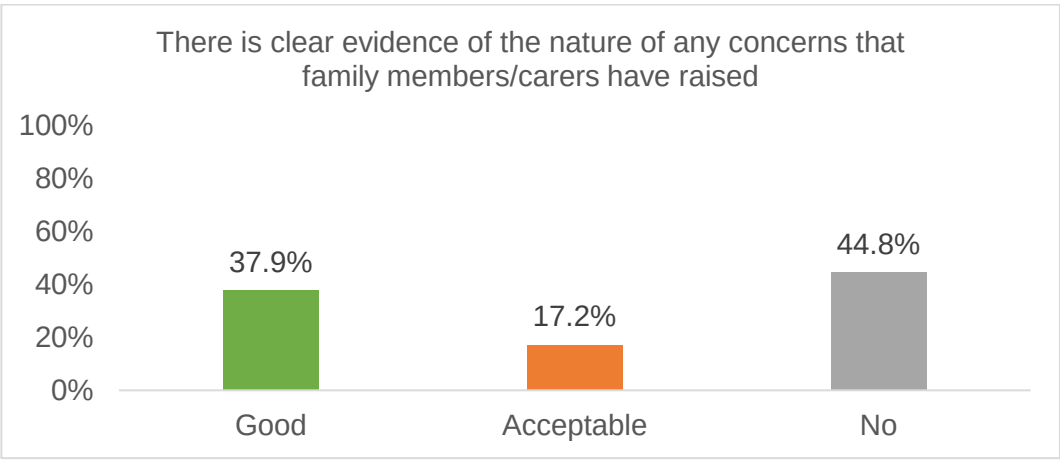
When auditing the case notes at FTB we could not initially find completed carer's assessments in any of the case notes we were auditing. We liaised with two senior members of staff who explained that all carers are screened to see whether they require a carer's assessment or not. If it is thought a carer's assessment is required and the carer consents to one being undertaken, then one is completed. We were also able to clarify where within the electronic case notes we would expect to find a completed carer's screening tool and a completed carer's assessment if one had been completed. We found no completed carer's screening forms from the last year.

Chart 8: % of records classified as 'Good', 'Acceptable' and 'No' for question 4 of the audit of provider records at Birmingham Women's and Children's Trust.



We found no completed carer's assessments in the current FTB case notes. In both the records relating to the previous year and the current records we found one example of a carer's screening tool having been started but not completed. We found two cases where a carer had been offered a carer's assessment and they had declined. In five sets of case notes the cases have since been closed. We were advised that we were not able to view this information as a result. In two of the cases recorded under "No" we were able to ascertain from the records that family members/carers lived abroad.

Chart 9: % of records classified as 'Good', 'Acceptable' and 'No' for question 5 of the audit of provider records at Birmingham Women's and Children's Trust.

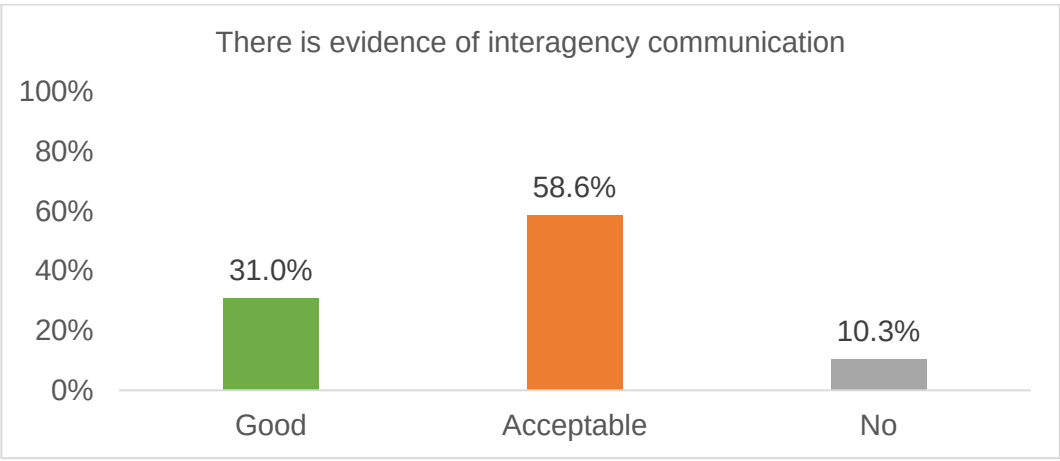


There was evidence of concerns family/carers had raised in over 50% of cases (n=16). In over 40% of cases (n=13) there was no evidence this was the case. The reasons behind why no concerns were varied. In one case the carer had no concerns. In another, the individual was an asylum seeker who was concerned about his family, but no information was documented in relation to his family's concerns about him. In one case a Barring Order was proposed and in two cases the individual had no contact with their family/carer. In some instances, the AMHP had tried but been unsuccessful in contacting family/carers.

Chart 10: % of records classified as 'Good', 'Acceptable' and 'No' for question 6 of the audit of provider records at Birmingham Women's and Children's Trust.

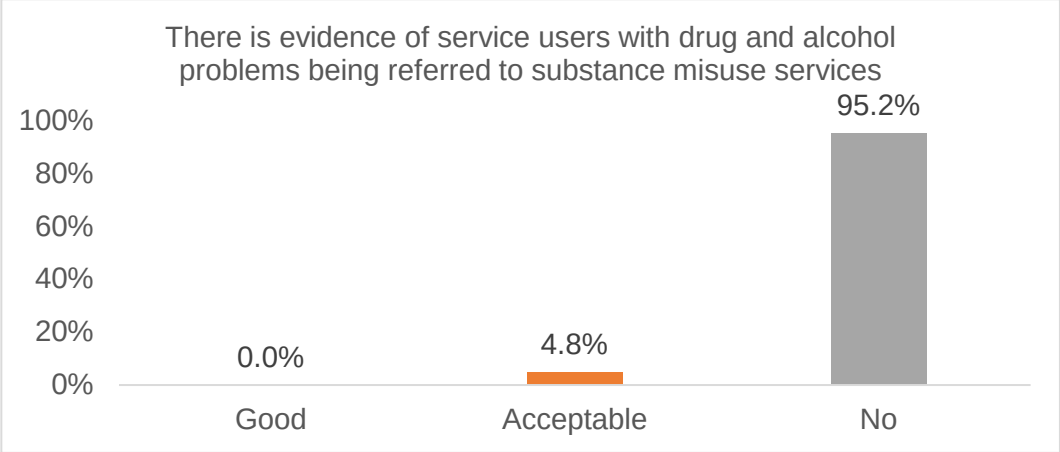
The reasons for allocating "No" are variable. There were no actions documented in two cases in relation to the proposed actions in response to concerns family/carers had raised. The risk assessment and management plan were not up to date in two cases. As with Chart 9 there were examples where we have recorded "No" as it was not possible to view this information as the case had since been closed. One family raised no concerns. No related actions were therefore documented. One individual was recoded as an asylum seeker and no contact was recorded with his family in relation to their concerns.

Chart 11: % of records classified as 'Good', 'Acceptable' and 'No' for question 7 of the audit of provider records at Birmingham Women's and Children's Trust.



There was evidence of interagency communication to various degrees in the majority of the case notes audited.

Chart 12: % of records classified as 'Good', 'Acceptable' and 'No' for question 8 of the audit of provider records at Birmingham Women's and Children's Trust.



We identified one instance where an individual had been referred to a substance misuse service and one instance where an individual was going to be referred. We found 28.5% (n=6) of individuals had stated they were currently using drugs and alcohol and no evidence of a referral to substance misuse services. We categorised these in the "No" category. 28.5% (n=6) stated they had previously used drugs and alcohol which we also categorised under "No". There were also instances where there was no record of drug and alcohol use which were also recorded in the "No" category.

Chart 13: % of records classified as 'Good', 'Acceptable' and 'No' for question 9 of the audit of provider records at Birmingham Women's and Children's Trust.

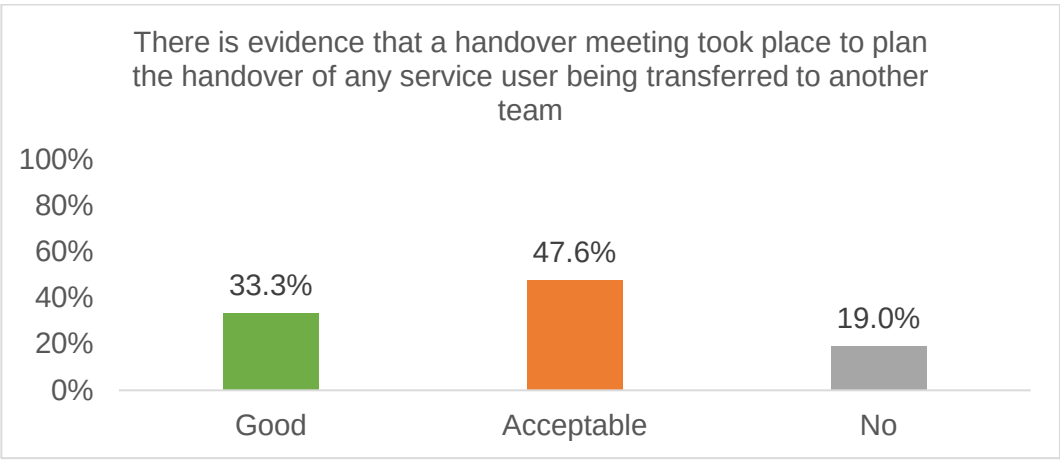
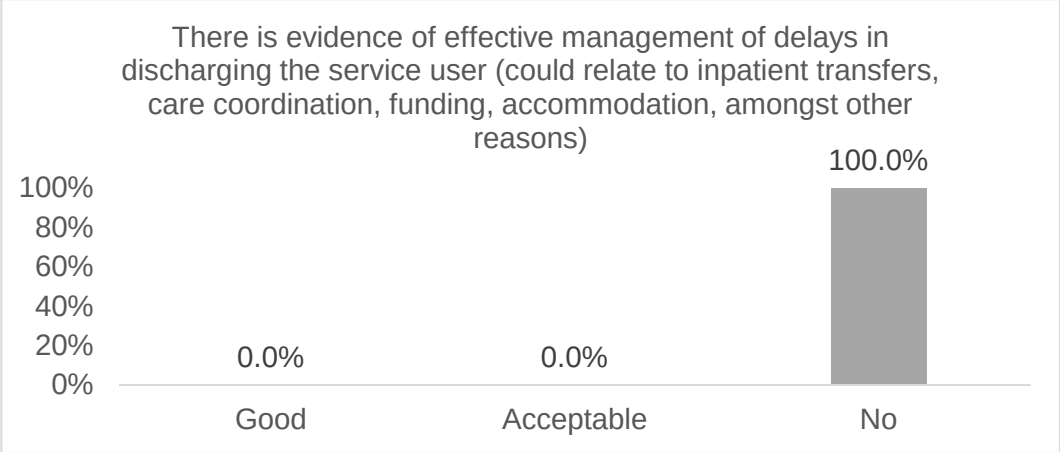


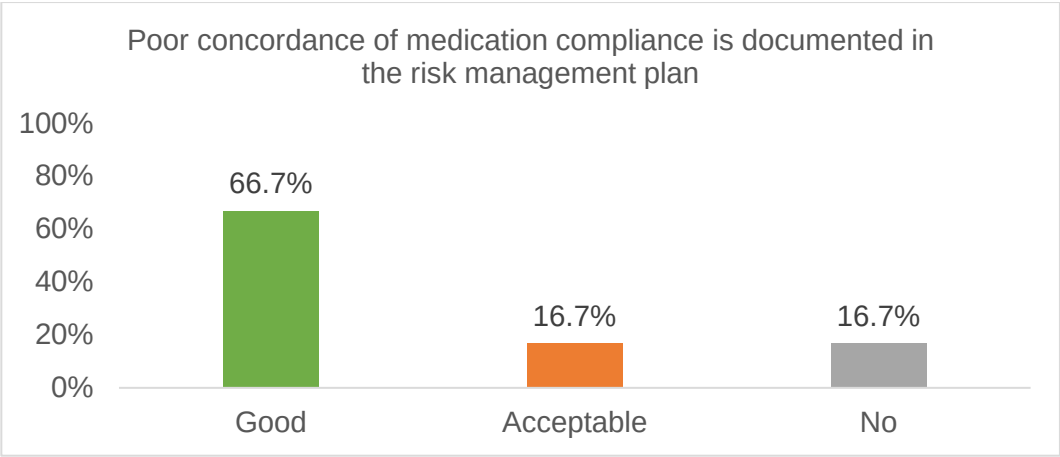
Chart 13 shows that in most instances, some form of a handover had taken place.

Chart 14: % of records classified as 'Good', 'Acceptable' and 'No' for question 10 of the audit of provider records at Birmingham Women's and Children's Trust.



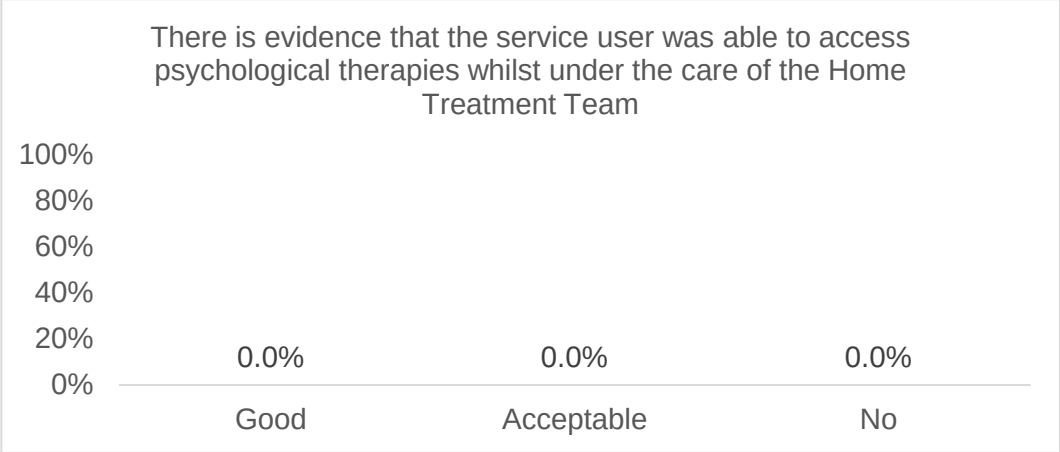
There was no evidence at all in the FTB case notes of any delays to patient discharge.

Chart 15: % of records classified as 'Good', 'Acceptable' and 'No' for question 11 of the audit of provider records at Birmingham Women's and Children's Trust.



There were instances where poor compliance was documented as part of risk management. The "No" category refers to individuals where there was evidence that they were compliant with medication which relates to just under 20% of the sample. There was also one case where the individual was not on any medication.

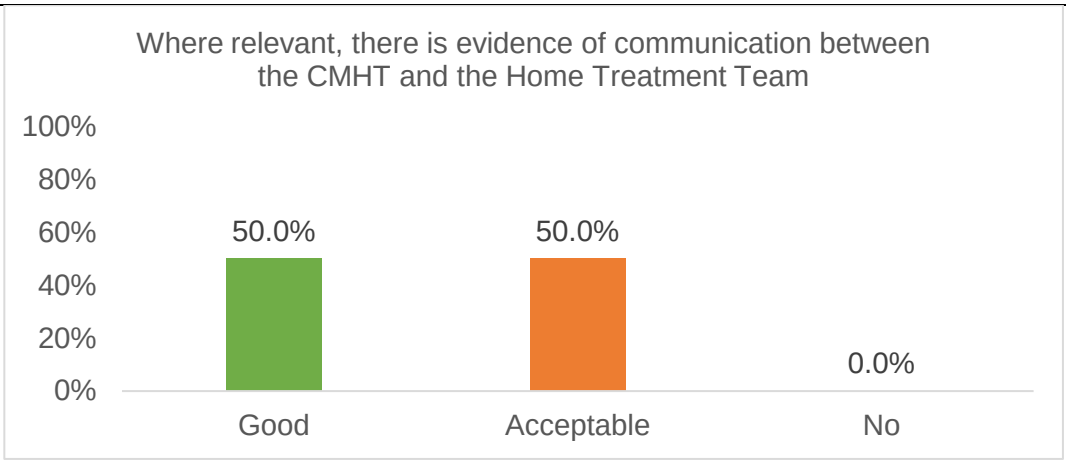
Chart 16: % of records classified as 'Good', 'Acceptable' and 'No' for question 12 of the audit of provider records at Birmingham Women's and Children's Trust.



There were no instances in the FTB case notes which referred to access to psychological therapies whilst under the care of the Home Treatment Service.

Chart 17: % of records classified as 'Good', 'Acceptable' and 'No' for question 13 of the audit of provider records at Birmingham Women's and Children's Trust.

When reviewing Chart 17, please note that the sample size in this case was very small involving two patients in total.



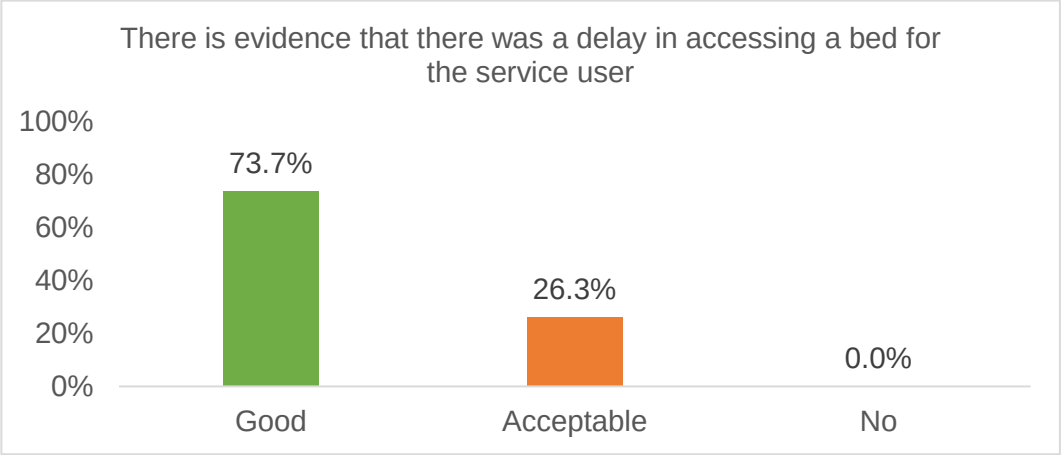
3.3 Birmingham and Solihull Mental Health NHS Foundation Trust

Table 3: Audit results for the provider records at Birmingham and Solihull Mental Health NHS Foundation Trust by audit question. Raw sample numbers used.

Audit question	Good	Acceptable	No	Not applicable	Total (applicable)	Total
There is evidence that there was a delay in accessing a bed for the service user.	14	5	0	40	19	59
There is a current risk formulation and management plan in the case notes.	46	9	1	3	56	59
There is evidence that staff have checked whether a carer's assessment has been completed in the last year or there is evidence of family members/carers being made aware they are entitled to a carer's assessment.	6	2	43	8	51	59
There is evidence that a carer's assessment has been completed.	2	5	44	8	51	59
There is clear evidence of the nature of any concerns that family members/carers have raised.	30	19	5	5	54	59
There is evidence of family/carer concerns being taken into consideration in managing risk.	27	20	7	5	54	59
There is evidence of interagency communication.	39	16	1	3	56	59
There is evidence of service users with drug and alcohol problems being referred to substance misuse services.	14	9	9	27	32	59
There is evidence that a handover meeting took place to plan the handover of any service user being transferred to another team.	29	21	2	7	52	59
There is evidence of effective management of delays in discharging the service user (could relate to inpatient transfers, care coordination, funding,	15	12	1	31	28	59

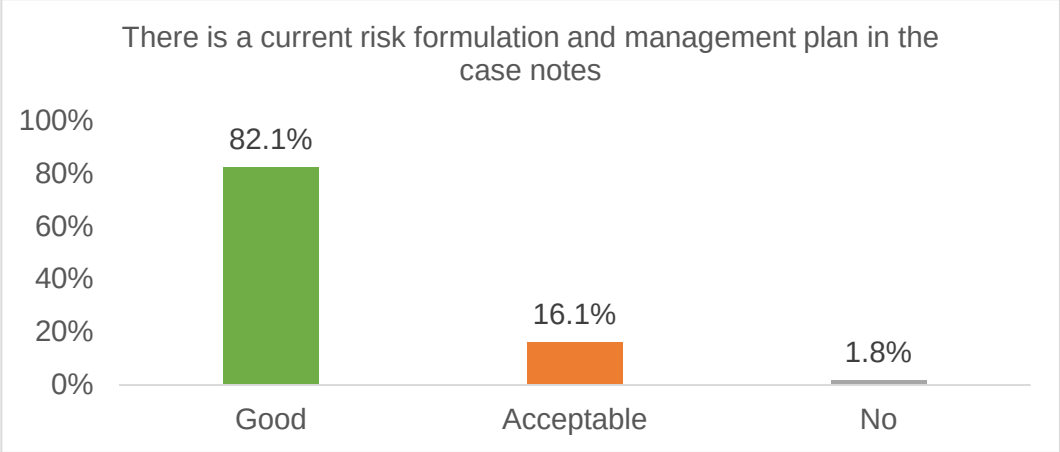
Audit question	Good	Acceptable	No	Not applicable	Total (applicable)	Total
accommodation, amongst other reasons).						
Applied to service users where poor medication compliance is documented. Poor concordance of medication compliance is documented in the risk management plan.	35	0	7	17	42	59
Applied to service users where psychological therapies have been used. There is evidence that the service user was able to access psychological therapies whilst under the care of the Home Treatment Team.	27	12	3	17	42	59
Where relevant, there is evidence of communication between the CMHT and the Home Treatment Team.	19	6	0	34	25	59

Chart 18: % of records classified as 'Good', 'Acceptable' and 'No' for question 1 of the audit of provider records at Birmingham and Solihull Mental Health NHS Foundation Trust.



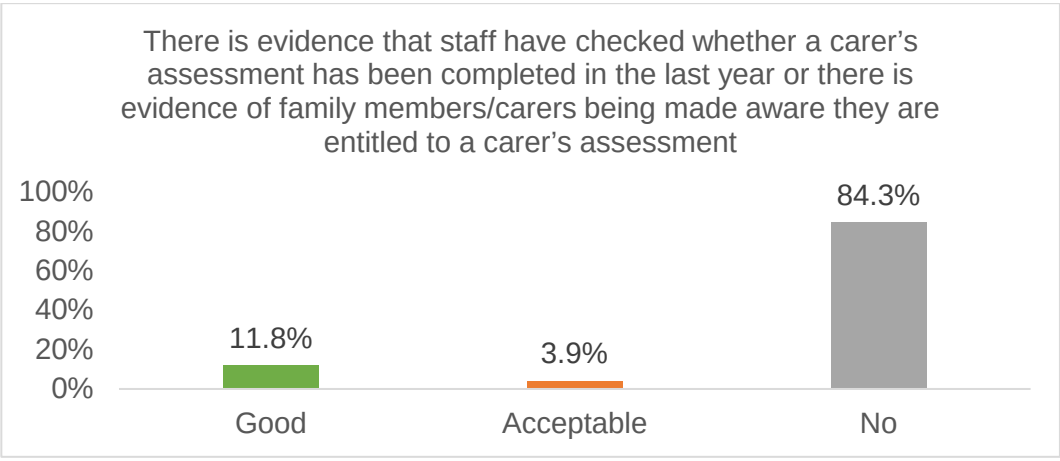
In 19 of 59 cases audited there was evidence of a delay in accessing a bed for a service user (32%). Chart 18 shows that in over 70% of cases where there was evidence of a delay in accessing a bed for a service user there was a good record of the time between decision to admit and admission to a bed. The reason/s for the delay in accessing a bed and any attempts to escalate the matter were also recorded in these cases. There were no cases where the reasons for a delay in accessing a bed were not documented.

Chart 19: % of records classified as 'Good', 'Acceptable' and 'No' for question 2 of the audit of provider records at Birmingham and Solihull Mental Health NHS Foundation Trust.



There was a current risk formulation and management plan in almost all the case records audited in BSMHT. There was one case where there was not one in place.

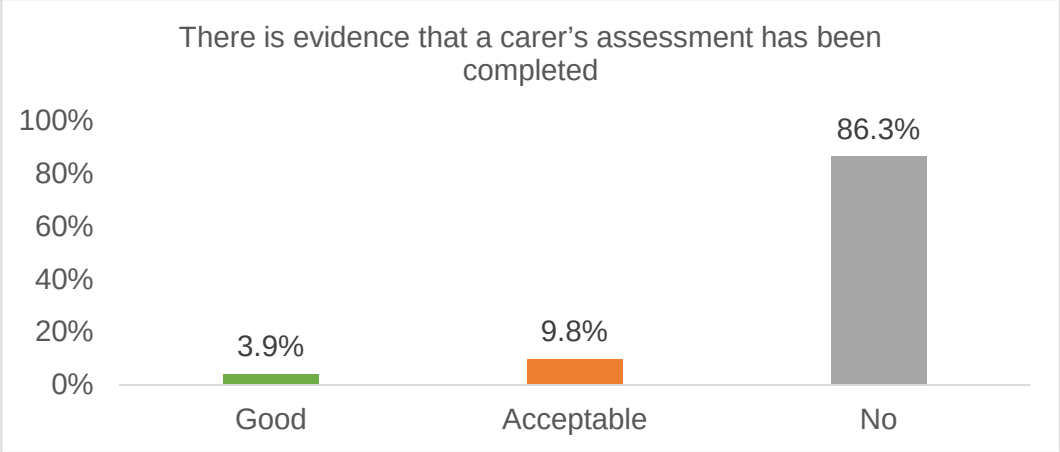
Chart 20: % of records classified as 'Good', 'Acceptable' and 'No' for question 3 of the audit of provider records at Birmingham and Solihull Mental Health NHS Foundation Trust.



It was challenging in the BSMHT case notes to locate carer's assessments or any record of communication with carers. We attempted to clarify where they would be in the case notes by asking two staff members, but they were unsure.

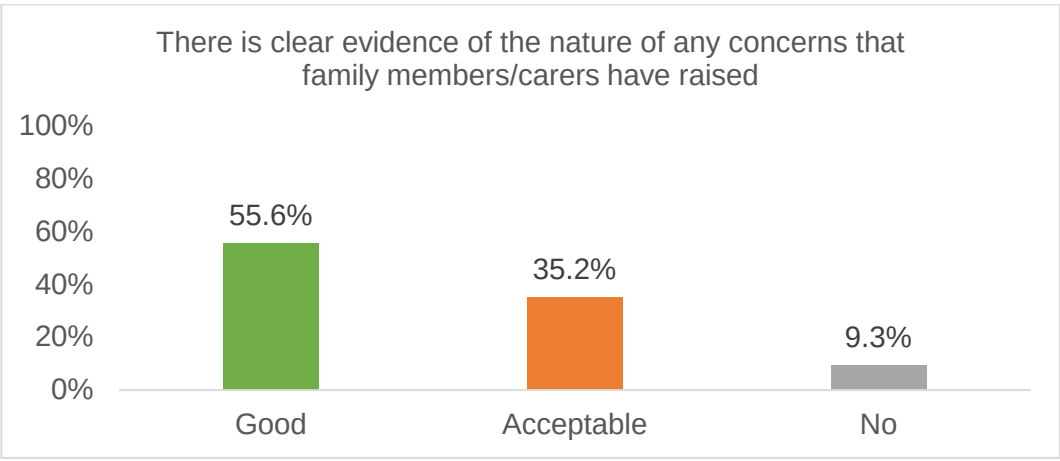
In most cases, we found no documented evidence that staff had checked whether a carer's assessment had been completed in the last year or evidence that family members/carers had been made aware of the fact that they could have a carer's assessment.

Chart 21: % of records classified as 'Good', 'Acceptable' and 'No' for question 4 of the audit of provider records at Birmingham and Solihull Mental Health NHS Foundation Trust.



In most cases (86.3%) there was no documented evidence that a carer's assessment had been completed. We attempted to locate any evidence within the case notes, but were unable to do so. There did not appear to be an allocated place in the electronic case notes for this information to be stored.

Chart 22: % of records classified as 'Good', 'Acceptable' and 'No' for question 5 of the audit of provider records at Birmingham and Solihull Mental Health NHS Foundation Trust.



In just over 90% of the case notes audited we found evidence of the nature of concerns raised by family members/carers.

Chart 23: % of records classified as 'Good', 'Acceptable' and 'No' for question 6 of the audit of provider records at Birmingham and Solihull Mental Health NHS Foundation Trust.

Chart 23 shows that in 50% of cases audited we found good evidence that concerns raised by family members/carers had been taken into consideration when managing risk. Acceptable evidence was found in 37%. However, we found no evidence that concerns raised by family members/carers was being taken into consideration in 13% (n=7).

Chart 24: % of records classified as 'Good', 'Acceptable' and 'No' for question 7 of the audit of provider records at Birmingham and Solihull Mental Health NHS Foundation Trust.

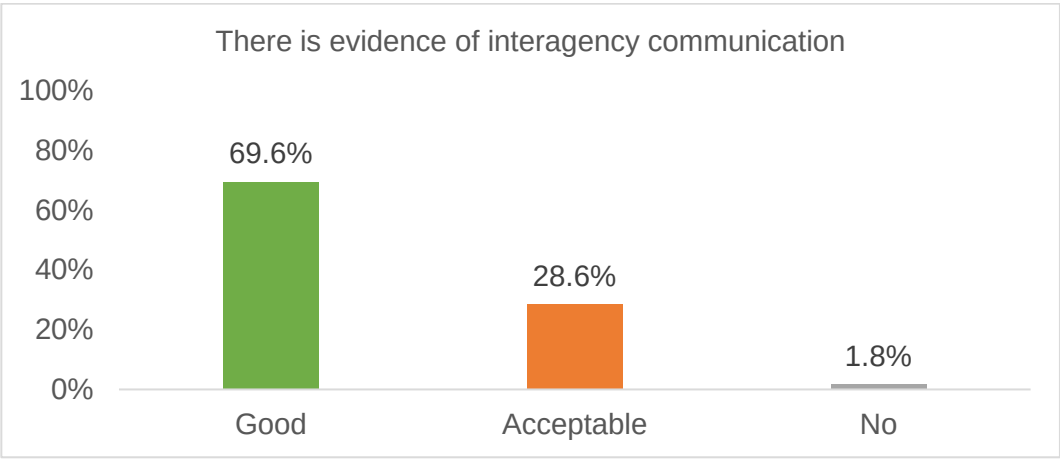
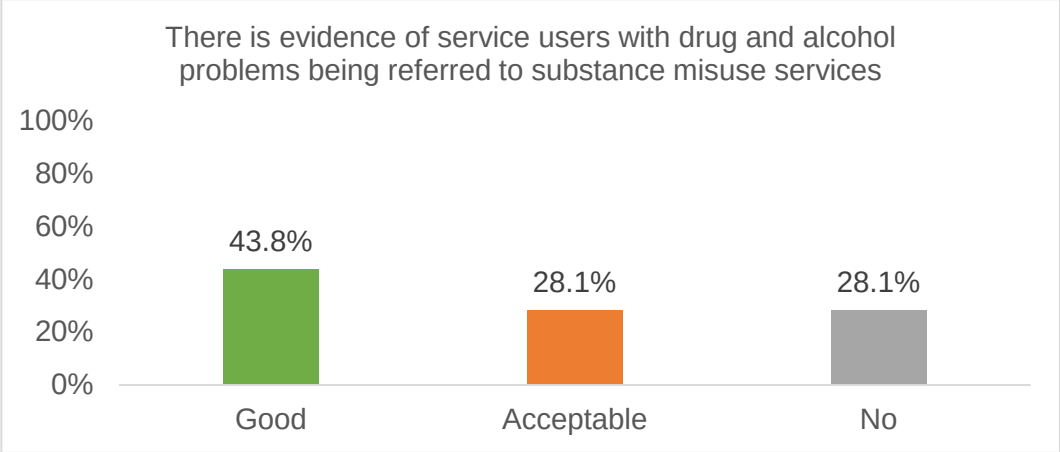


Chart 24 shows that there was good evidence of interagency communication in almost 70% of cases and acceptable evidence in almost 30%. There was no evidence of interagency communication in 1.8% (n=1).

Chart 25: % of records classified as 'Good', 'Acceptable' and 'No' for question 8 of the audit of provider records at Birmingham and Solihull Mental Health NHS Foundation Trust.



In 32 of the 59 cases audited there was evidence that the service user involved had drug and/or alcohol problems (54%). Chart 25 shows there was evidence in over 70% of these 32 cases that service users with drug and alcohol problems were referred to substance misuse services. In under a third of cases (n=9) there was no evidence this was the case.

Chart 26: % of records classified as 'Good', 'Acceptable' and 'No' for question 9 of the audit of provider records at Birmingham and Solihull Mental Health NHS Foundation Trust

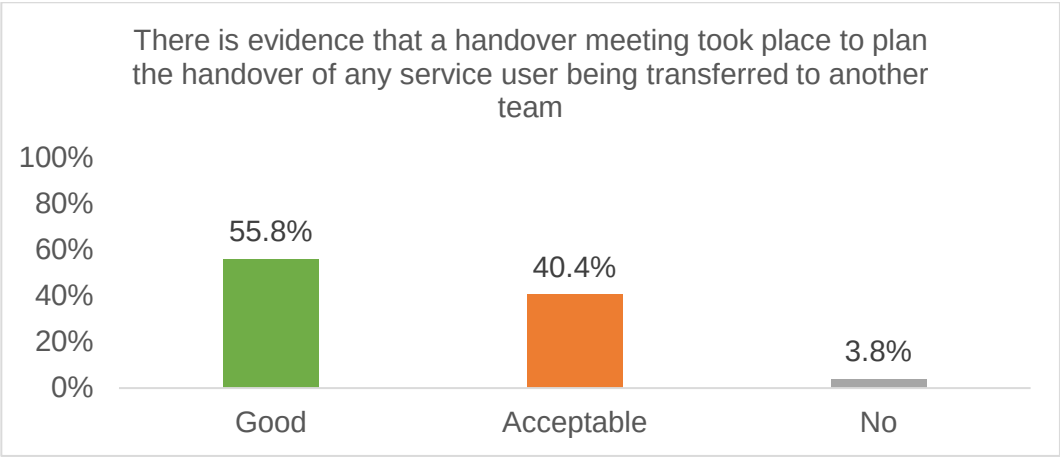
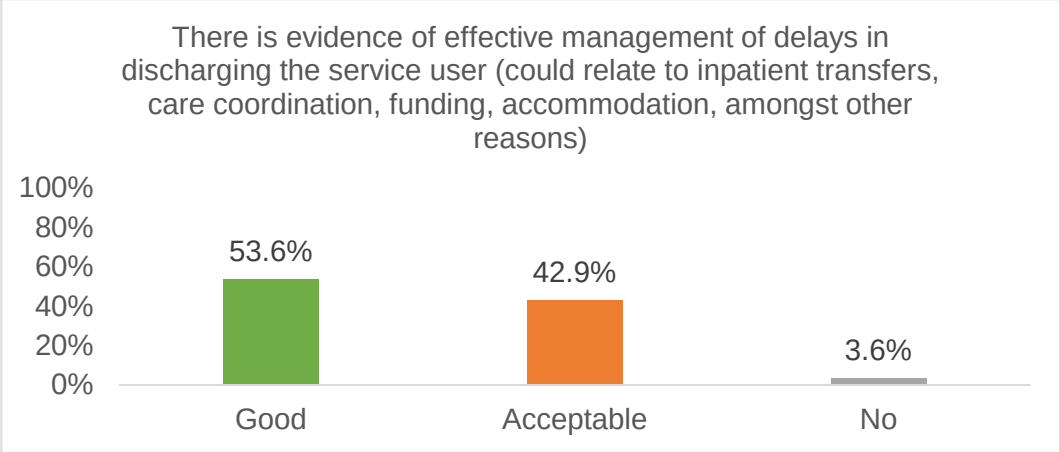


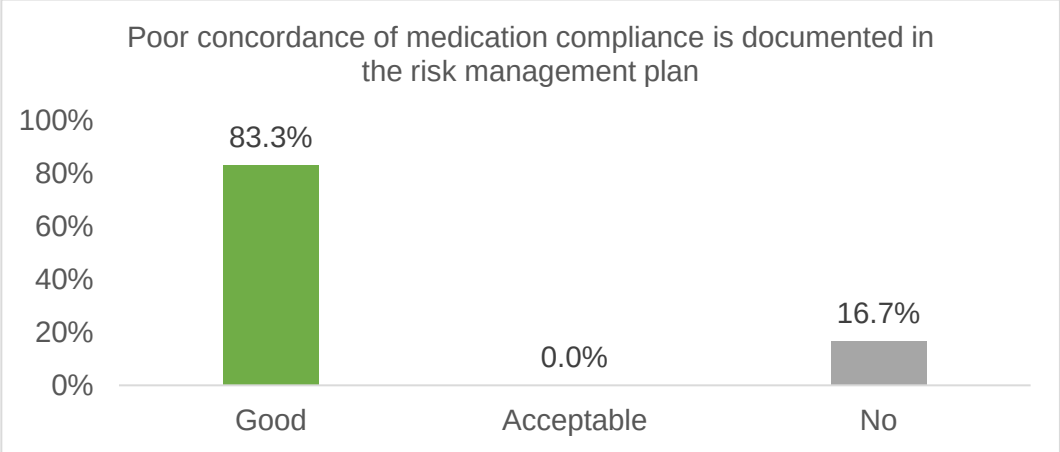
Chart 26 shows that a handover meeting took place to plan the handover of any service users being transferred to another team in most cases. There was no evidence of a handover meeting having taken place in 3.8% (n=2) of cases.

Chart 27: % of records classified as 'Good', 'Acceptable' and 'No' for question 10 of the audit of provider records at Birmingham and Solihull Mental Health NHS Foundation Trust.



There were delays in the discharge of the service user in 31 of the 59 cases audited (53%). Chart 27 shows that delayed discharges were being managed effectively in most of these 31 cases. In 3.6% (n=1) this was not the case.

Chart 28: % of records classified as 'Good', 'Acceptable' and 'No' for question 11 of the audit of provider records at Birmingham and Solihull Mental Health NHS Foundation Trust.



42 of the 59 cases audited documented that the service users had or could have poor medication compliance (71%). Chart 28 shows that for these 42 cases, poor concordance of medication compliance was documented in the risk management plan in over 80% of cases. It was not documented in 16.7% of cases (n=7). There was no 'Acceptable' standard for this audit question.

Chart 29: % of records classified as 'Good', 'Acceptable' and 'No' for question 12 of the audit of provider records at Birmingham and Solihull Mental Health NHS Foundation Trust.

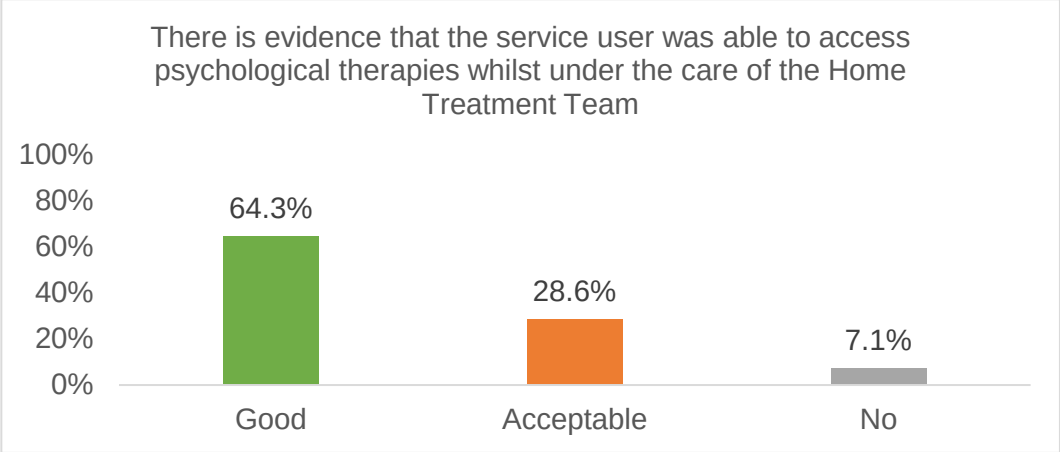


Chart 29 shows that over 60% of service users had been referred for psychological therapies whilst under the care of the Home Treatment Team: a referral was in the case notes and there was documented evidence that the individual had commenced therapy or documented evidence about why the individual had not commenced therapy. In almost 30% there was evidence that a referral for psychological therapies had been made and a delay had also been documented. In 7% of cases (n=3) there was no evidence of a referral having been made.

Chart 30: % of records classified as 'Good', 'Acceptable' and 'No' for question 13 of the audit of provider records at Birmingham and Solihull Mental Health NHS Foundation Trust.

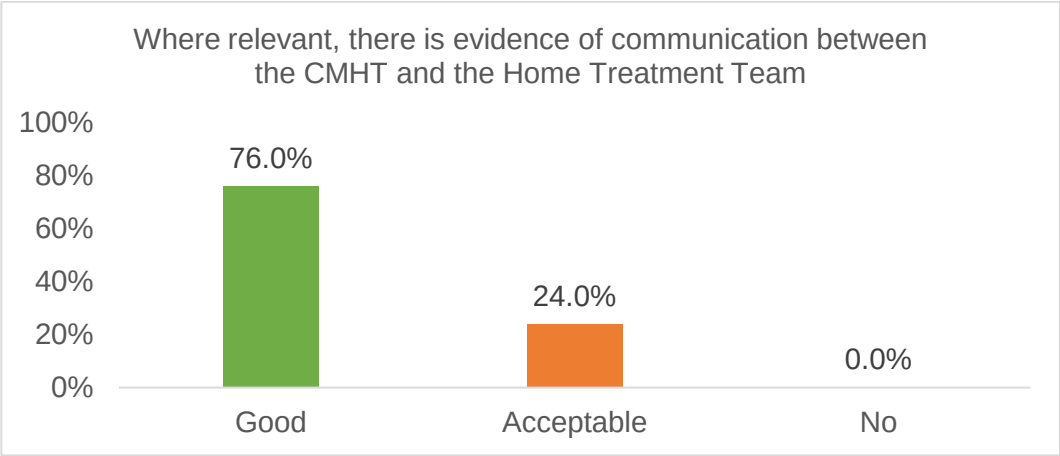


Chart 30 shows that where relevant there was evidence of communication between the CMHT and the Home Treatment Team in all cases.

4 ACTION PLANS

This section contains the action plans prepared by agencies in Birmingham in response to the findings of this audit.

4.1. AMHPs audit - Birmingham City Council

Audit question	Results				Observations	Action(s)	Lead for action(s)	Completed by date
	Good	Acceptable	No	Not applicable				
The individual was assessed within 4 hours of a referral to the AMHP service for an MHA assessment.	13	1	43	43	4 hours timeframe is a Royal College of Psychiatry response timeframe for ideal practice, no-where in statute that gives a timescale for the completion of MHA Assessment requests – Code of Practice to the Act indicates as soon as possible. There will be many mitigating factors for not completing the assessment within 4 hours of the referral and this is an unrealistic timeframe. Examples of mitigating factors: S12 Doctor availability, need to have both assessing Doctors present as the same time, s136 states 24 hours timeframe for completion of the assessment, s135 same. Patient may not be medically fit, need to arrange for police attendance, the assessment request may come from an out of area location so we may need time to travel etc.	BCC to set their own realistic timeframes for assessment responses taking into consideration the mitigating factors detailed in observations and share with partners for information. This will form part of our ongoing AMHP Business case. BCC to review appropriate timeframes for completing MHA Assessments and benchmark this with comparators. BCC are following agreed consultation frameworks to complete the formal statutory AMHP Business Case Consultation under section 188 Trade Unions and Labour Relations Act 1992 which will be followed by a review and then inform the proposed timeframe for completing MHAAQ's. The above is to be discussed with AMHPs and an AMHP specific set of Key Performance Indicators to be introduced in line with Eclipse roll out for reporting purposes. Eclipse is being implemented in early 2022 and	Joanne Lowe	April 2022 April 2022 subject to review

Audit question	Results				Observations	Action(s)	Lead for action(s)	Completed by date
	Good	Acceptable	No	Not applicable				
						the KPI indicators will be developed within the Eclipse implementation. Agree/Share the above KPIs with partners at the Joint Strategic Operational Group or Urgent Care Meeting chaired by senior managers across the CCG and Birmingham and Solihull Mental Health Foundation Trust and FTB		January 2022 subject to review
There is evidence that referrals have been triaged.	70	28	2	0	Triage is the process of screening referral requests to determine any additional risk factors, any timescales that should ideally be adhered to, to determine is a s135(1) s135(2) warrant is required. To check if there are children at the property who will need to be cared for. Are there any pets that need to be accommodated? Is this an out of area request? If so will the host LA complete this on our behalf etc. Evidence will be recorded within the observations and sometimes within the referral form itself. Joanne Lowe AMHP Lead and Lavern Newell Team Manager Out of Hours modified the referral and request forms in April 2021 to include a detailed risk assessment	All actions completed AMHP Lead to work with Senior Practitioners and AMHPs undertaking Triage to ensure recording follows a set of guiding principles. Introduce internal audit of triage which is important as we move into the new AMHP Model – quarterly audit of a random sample of 25 cases per quarter	Joanne Lowe	April 2021

Audit question	Results				Observations	Action(s)	Lead for action(s)	Completed by date
	Good	Acceptable	No	Not applicable				
					and date of last contact by Consultant to inform the triage process. Work has been undertaken by the AMHP Lead to request all AMHPs support triage and to develop the Senior Practitioners recording and evidence of triage. The change in forms from April 2021 may account for a lack of 100% triage in the sample. Only 2 cases were identified as lacking evidence of triage and no distinction is given between day and out of hours services in the audit.			
There is evidence of the AMHP involving family/ carers in the assessment process.	48	18	34	0	This information would be most prevalent within the AMHP report. The AMHP reports were not all available during the audit and many had to be downloaded and forwarded outside of the set timeframe for the audit due to issues with recording systems. In 27 of the cases the AMHP reports had not been uploaded onto Erecords which may account for the reason why this overall figure is quite low. Staff previously had support from Business Support to upload the AMHP reports and hard copies were collated and scanned. The pandemic has prevented this and not all agency staff and AMHPs have access to recording systems.	Make the uploading of AMHP reports mandatory. This will be supported by Eclipse as documents can be uploaded as word documents instantly within the client record. Include the uploading of AMHP reports in the above audit. Include the evidence of social circumstances report as a KPI as in 1 above. As above this is dependent on the implement of the revised AMHP Business Case and MHA HUB which is currently subject to statutory consultation. This will be reviewed	Joanne Lowe	January 2022 – April 2022

Audit question	Results				Observations	Action(s)	Lead for action(s)	Completed by date
	Good	Acceptable	No	Not applicable				
					It is a mandatory requirement for all AMHPs to leave a social circumstances report for the client as soon as possible after the assessment is completed.	according to the above timeframes – April 2022.		
Where an individual was previously known, there is evidence that their previous history including risk management was taken into consideration during the assessment process.	71	23	6	0	This is a good outcome as it shows we have recorded risk in 94 cases, although this should be 100% We have made changes to the referral form to include a comprehensive risk assessment so it is positive that risk is now being explicitly recorded in the referral and triage process.	Completed as point 1 above this was managed through the changes to the referral form. We need to work with our Business Support colleagues both in and out of hours to ensure we have a consistent approach to recording risk and quality assure the referral information. We will achieve this though holding a briefing with colleagues and doing a workshop around referral information and recording.	Joanne Lowe	Completed

4.2. Forward Thinking Birmingham and Birmingham Women's and Children's NHS Foundation Trust

Audit question	Results				Observations	Action(s)	Lead for action(s)	Completed by date	Action update
	Good	Acceptable	No	Not applicable					
There is evidence that there was a delay in accessing a bed for the service user.	10	3	5	11	In 2021 additional commissioned beds have gone into the system for BSOL. The arrangements for accessing BSOL beds are associated with an established bed management clinical priority process that has been agreed with the BSOL system. There has been a reciprocal commitment and actions in place to ensure that the patient with the highest clinical need in the system is a priority for a bed. In any working day there are two meetings urgent care pathway flow meeting and a further meeting with senior leads to look at all patients delayed waiting for a bed. This includes care planning and risk assessing for the patient if they are delayed and are waiting to be admitted. There is a third escalation meeting for the wider system. All of the information captured relating to the meetings is recorded in minutes, and email update to the city system At 1.30 the city wide system call has minutes and shared widely with the system. Any delay for a patient in the system will be recorded as part of that operational sit rep process, bed managers and senior leaders.	We will develop an Audit template for the system to measure the success and effectiveness of the system process for BSOL MOU's	Lisa McGowan	31/01/2022	This audit, which assessed understanding across FTB, BCC and BSMHFT has been completed and presented at Joint Commissioning Operational Group. The audit has highlighted that further work is required to ensure that we are practicing in line with the MOUs. We need to develop our Mental Health Act training to ensure that all staff are aware of the MOUs and how they are expected to practice. MOU's require updating so that action expected when a patient is not sectioning in a timely manner is clear to staff. We also need to carry out further recruitment as a system, across the providers to maximise timely access to beds. The mental health needs of the city have changed in the last 2 years compared to previously, we need to carry out further work to understand

Audit question	Results				Observations	Action(s)	Lead for action(s)	Completed by date	Action update
	Good	Acceptable	No	Not applicable					
									the development of the mental health profile across the city and how we best arrange our services to match current requirements.
There is a current risk formulation and management plan in the case notes.	11	5	13	0	Our monthly MHCQI's, which audit the presence of risk assessments and management plans in the case notes suggest a higher level of compliance with this standard. In response to this finding we are revisiting our MHCQI's to ensure we have sufficient scrutiny upon the currency and timely review of the risk assessment and care plans.	Review and develop monitoring mechanism to ensure that we are monitoring that risk assessments and care plans are current for that episode of care.	Nina Barbosa (Governance Lead)	31/01/2022	MHCQIs have been reviewed and the indicators in place cover sufficient detail to ensure that the quality and timeliness of the care plans is assessed. We will continue to monitor this closely. Current results indicate that we have a high level of risk assessment and care plan completion, and that these are typically of a good quality and are clinically useful. We will continue to review how we monitor the completion of risk assessments and care plans.
There is evidence that staff have checked whether a carer's assessment has been completed in the last year or there is evidence of family members/carers being made aware they are entitled to a carer's assessment.	0	0	29	0	Our approach to supporting carers and family has widened and in partnership with the carer forum we are ensuring family members have a place to raise their concerns about all aspects of care including care of the family. We wanted to avoid isolating carers and leaving them with their burden of raising issues alone which was a reported systemic issue – the support from the forum ensures the service and other carers can respond and the carer can receive both tailored support from the service whilst maximising the potential peer support from the carer forum. We are developing a framework of audit to	From January 2022 we will also include this in the Mental Health Care Quality indicators. We will develop training for our community and inpatient teams raising the profile of services that carers can be signposted to, and on how to complete the screening tool.	Tim Newbold (Head of Nursing)	30/05/2022	While trying to address how we improve recording that a carer has been referred for a Carer's Assessment, we have established that there are challenges with where staff record that a carer has been referred for a Carer's Assessment. As a result of this, we have refocused our action from training staff to developing how our documentation is arranged so that the prompt to document that someone has been referred for a Carer's

Audit question	Results				Observations	Action(s)	Lead for action(s)	Completed by date	Action update
	Good	Acceptable	No	Not applicable					
					support the findings that relate to care feedback on staff training, values and behaviour as well as practice. Homegroup Mental Health Carers Support Service Here is some details on what they offer: Homegroup provides a range of high quality information, advice, one to one and group/peer support to carers of adults with mental health needs across the city of Birmingham. Carers can be of any age including young carers (those aged 4 – 17 years old). The cared for individual will be need to be registered with a Birmingham GP (NHS Birmingham West and Sandwell, NHS Birmingham Crosscity, NHS Birmingham South and Central). The service provides person-centred support based on needs identified by the carer. These may include: • health and wellbeing support • advice and support to engage with clinicians and services • support to access respite • information about mental health issues • support around social issues including employment, housing and finances • supported access to opportunities for social engagement • Birmingham carers can also offer an overarching family	We will also review what feedback we can receive confirming that a carer's assessment has been completed, and assess how this can be documented in our CareNotes system.			Assessment is much more accessible.
There is evidence that a carer's assessment has been completed.	0	0	29	0					
There is clear evidence of the nature of any concerns that family members/carers have raised.	11	5	13	0					

Audit question	Results				Observations	Action(s)	Lead for action(s)	Completed by date	Action update
	Good	Acceptable	No	Not applicable					
					support plan that underpins an entire family unit and their support needs. This audit has highlighted that there is significant work to be done ensuring that we document that carer's assessments are required and have been requested; and to understand how we can monitor that they have been completed on our behalf. The report noted that the reasons for not recording concerns that the family members have raised is variable. 3 specific examples are given of different reasons seen.				
There is evidence of family/carer concerns being taken into consideration in managing risk.	9	6	14	0	The report notes the reason why there is no documentation of family/carer concerns being documented is variable, including that they have not raised concerns. It is noted that in 2 cases the risk assessments and care plans were not in date. Our action above to monitor this more closely will address that issue.		Tim Newbold	31/01/22	Consent from adult patients is a requirement when clinicians are looking to liaise with families and carers. In order to ensure that we are acting in best interests of patients and family units we will include consent has been sought and clearly documented (there is a front page platform on care notes to display this action) into our MHCQI monitoring tool. This will support and drive forward improvements around our liaison with families and carers and where subject to further audit in the future – we will be able to demonstrate more clearly

Audit question	Results				Observations	Action(s)	Lead for action(s)	Completed by date	Action update
	Good	Acceptable	No	Not applicable					
									relational aspects of patient care and treatment.
There is evidence of interagency communication.	9	17	3	0	Demonstrates reasonable level of compliance				
There is evidence of service users with drug and alcohol problems being referred to substance misuse services.	0	1	20	8	We have had significant difficulties gaining consent from our service users to refer them to drug and alcohol services. Without this consent we are unable to refer them. It is preferable for the service user to choose to actively seek this support, and self-refer, for a good recovery outcome. We are developing training to ensure that staff are correctly identifying young people who require drug and alcohol support; and that they are referring them correctly. We are however, setting up motivational interview training with staff so that they are better able to encourage young people to engage with activities to benefit their lifestyle, such as engagement with drug and alcohol services.	Finish developing training to ensure that staff are correctly identifying young people who require referral to drug and alcohol services. Develop skills in motivational interviewing as a means to begin the work with young people to address their use of substances.	Sarah-Jayne Alleyne & Peter Delaney Sarah-Jayne Alleyne	31/01/2022 31/12/2021	We are reviewing our care note record system and build prompts into Risk Assessment template that leads staff when exploring addiction and dependency that we seek to support patients with referrals and or secure consent for them to do on their behalf. We are also revieing building similar prompts int our CHOICE assessment system. Motivational Interviewing training has been developed and a pilot and first wave of roll out is occurring within our Early Intervention pathway. Post this initial phase we will review evaluation and feedback papers and adjust content and delivery accordingly.
There is evidence that a handover meeting took place to plan the handover of any service user being transferred to another team.	7	10	4	8	Demonstrates reasonable level of compliance				
There is evidence of effective management of	0	0	19	10	Our approach to managing the delays to discharge are evidenced via the high		Lisa McGowan	31/01/2022	This action is complete. The situational report has been

Audit question	Results				Observations	Action(s)	Lead for action(s)	Completed by date	Action update
	Good	Acceptable	No	Not applicable					
delays in discharging the service user.					quality situation reps which is a collection of tools used by the clinical team to report, monitor and escalate delays around discharge and admission – this process was introduced to support effective system management delays in discharge that are not clinically relevant would not be in a care record. You will find this Sit rep resource is distributed twice daily and evidence effective management and prioritisation of cases.		and Annie Cheatham		arranged in such a manner that it provides high and defined level of detail to oversee flow and throughput. The sit rep is circulated three times a day as opposed twice. This sit rep also underpins a number of forums that are in place around bed management, escalations and early detection of high priority cases.
Poor concordance of medication compliance is documented in the risk management plan.	8	2	2	17	Demonstrates reasonable level of compliance				
There is evidence that the service user was able to access psychological therapies whilst under the care of the Home Treatment Team.	0	0	0	29	At the time of the audit the Home Treatment Team did not have access to psychological therapies assessment and formulation process. We have subsequently recruited a Senior Psychologist and they are in post creating a pathway within urgent care and HTT for Psychological Therapy whilst under the care of the urgent care FTB services.			Completed	The Psychologist post has now been appointed to and is in position within the Urgent Care Pathway.
Where relevant, there is evidence of communication between the CMHT and the Home Treatment Team.	1	1	0	27	Demonstrates reasonable level of compliance				

4.3. Birmingham and Solihull Mental Health NHS Foundation Trust

No.	Audit question	Results				Observations	Action(s)	Lead for action(s)	Completed by date
		Good	Acceptable	No	Not applicable				
1	There is evidence that there was a delay in accessing a bed for the service user.	14	5	0	40	There is a good level of compliance. The Trust has an established bed management process including on-call support where required.	The Trust has a dedicated 24-hour bed management service. Following the PFD the Trust went through a systematic review of the bed management policy for BSMHFT. The Trust has subsequently developed standard operating procedures. A section 140 (MHA) policy has also been developed and agreed with partners. A daily bed management meeting now occurs at 10am (working days) and is followed by an 11am grand safety huddle. This enables senior clinical managers to discuss clinical prioritisation of resources including access to beds to mitigate clinical risk. An additional 22 beds (acute and acute PICU) have now been commissioned through local private providers. A bed locality model has been re-introduced to the	Kerry Webb	Complete Evaluation October 2021

No.	Audit question	Results				Observations	Action(s)	Lead for action(s)	Completed by date
		Good	Acceptable	No	Not applicable				
							organisation. This allies local wards to local home treatment teams and CMHTs. This not only improves collaborative and integrative working but also enable HTT and ward to work locally to create a bed through local discharge where safe to do so. There is a 9.30pm daily on-call huddle and a 10am on-call huddle every weekend/bank-holiday meeting.		
2	There is a current risk formulation and management plan in the case notes.	46	9	1	3	Compliance level adequate. The Trust has monitoring processes in place including local review and audit. There are current initiatives to strengthen knowledge and practice of risk assessment and management underway across the Trust.	Home treatment risk assessments and care plans are monitored for completion and for quality. There are now regular matron led quality audits in place and these are reported through local clinical governance and FPP. A care planning group completed a piece of work with acute care that has improved care planning tools on the electronic patient records system. Regular audits are in place to review the standards of care plans in place.	Quality Governance Team	Audit to be undertaken with review on an ongoing basis and results discussed in multi disciplinary team meeting and local clinical governance committees

No.	Audit question	Results				Observations	Action(s)	Lead for action(s)	Completed by date
		Good	Acceptable	No	Not applicable				
3	There is evidence that staff have checked whether a carer's assessment has been completed in the last year or there is evidence of family members/carers being made aware they are entitled to a carer's assessment.	6	2	43	8	It is important to distinguish between statutory carers assessment which is the responsibility of the LA, and a carers assessment to support a service user involved in our services. We have taken this definition to mean the latter: An assessment of carer need in order to understand a collective approach to supporting a service user engaged with mental health services provided by the Trust.	The Trust has been working with the Meriden Family Programme to develop a comprehensive approach to identifying family and carers and completing a family and carers assessment to support effective engagement. Whilst there is a programme of roll out of training for this, it is recognised that some services where the episode is likely to be brief and intense (such as Acute and Urgent Care mental health services) it is neither possible nor appropriate to engage in a full carer assessment using the existing approach. It is therefore important that we develop something targeted at recording a more concise assessment of carer need focused on this type of episode. To develop a short form (concise) family and carer assessment for use in	Group: Family and Carer Pathway Collaborative Group Lead: Jane Clark, Associate Director for Allied Health Professions and Recovery	Carer assessment form in place to be evaluated on an ongoing basis.

No.	Audit question	Results				Observations	Action(s)	Lead for action(s)	Completed by date
		Good	Acceptable	No	Not applicable				
							shorter episode services (such as CRHTT)		
4	There is evidence that a carer's assessment has been completed.	2	5	44	8	Please see 3 above. It is important to recognise the results of questions 5 and 6 below, demonstrating that HTTs are engaging carers in supporting service users through their crisis period.	A restructure has been implemented that has resulted in each directorate having a lead for patient and carer experience and engagement. Audit arrangements are in place to review care plans and provide evidence that carer's assessments are in place. Quarterly report to come through local Clinical Governance Committee for assurance	Home treatment family and carer lead	September 2022 and quarterly thereafter
5	There is clear evidence of the nature of any concerns that family members/carers have raised.	30	19	5	5	This demonstrates a good level of carer engagement.	Home treatment have appointed a dedicated family worker that supports the engagement of collaborative family working through individual cases and education to teams. Quarterly report to come through local Clinical Governance Committee. .Issues raised formally are reviewed in allotted timescales with monthly reports provided through governance forums to address themes.	Home treatment family and carer lead	September 2022 and quarterly thereafter

No.	Audit question	Results				Observations	Action(s)	Lead for action(s)	Completed by date
		Good	Acceptable	No	Not applicable				
6	There is evidence of family/carer concerns being taken into consideration in managing risk.	27	20	7	5	This shows that the formulation of risk involves the views of those who know the service user best.	Family and carer engagement collaborative in place Qualitative piece of work with families has been agreed through local Clinical Governance Committee	Home treatment family and carer lead	September 2022 and quarterly thereafter
7	There is evidence of interagency communication.	39	16	1	3	Adequate assurance	Home treatment and CMHT pathway interface meeting to continue on a monthly basis. The JSOG will continue to oversee and address any issues across organisations through the formal monthly meetings.	Elaine Murray	
8	There is evidence of service users with drug and alcohol problems being referred to substance misuse services.	14	9	9	27	Further information is required to determine whether the 28% of service users who were not referred for support with drug and alcohol issues were either already involved with addiction services, refused a referral, or that this was not completed by the HTT.	There is a Trust wide Task and finish group current in place looking at issues relating to safe and effective management, treatment and signposting of service users with an alcohol or drug problem. Acute care will undertake a review of A&D pathways from HTT to address the uncertainty of the 28%, ensuring that clarity of actions and recording is clear going forward. This will be managed through the quality audit cycle and will also be incorporated into the task and finish action plan. This local	Clinical nurse manager for HTTs	Ongoing

No.	Audit question	Results				Observations	Action(s)	Lead for action(s)	Completed by date
		Good	Acceptable	No	Not applicable				
							team action will be led by the team manager. Safeguarding strategic committee taking a multi-agency approach to implementation of drug and alcohol strategy. Programmes have been implemented to develop the workforce with the creation of 10 new teaching posts, the expansion pf physician associate roles and international recruitment.		
9	There is evidence that a handover meeting took place to plan the handover of any service user being transferred to another team.	29	21	2	7	Adequate compliance. The Trust has carried out a themed review of transition and recognises the need to continue to ensure that transitions in care are recognised as risk periods.	All of the acute and urgent care SOPs have been revised in 2021/22. They each cover referral and pathway process to other core services. There is an ongoing monthly CMHT/HTT pathway interface meeting attended by clinical managers. This meeting enables any local interface issues to be identified and addressed swiftly and with regularity. There is a joint strategic operational group meeting (JSOG) that meets on a monthly basis and is attended by all local providers including mental	Clinical Governance team to audit processes	December 2022

No.	Audit question	Results				Observations	Action(s)	Lead for action(s)	Completed by date
		Good	Acceptable	No	Not applicable				
							health, local authority, police and addictions services. This picks up new or unresolved interface issues.		
10	There is evidence of effective management of delays in discharging the service user.	15	12	1	31	Adequate assurance	A weekly bed meeting to address delayed transfer of care is led by the associate director of acute / urgent care with attendance from FTB, commissioners and local authority		
11	Poor concordance of medication compliance is documented in the risk management plan.	35	0	7	17	17% of service users in this sample (n=7) did not have concordance issues within their risk management plan. HTT's will be reminded of this important requirement.	Remind HTT staff of the importance of recording issues of medication concordance within the risk management plan. This will include concordance being discussed as part of the MDT. Treatment concordance will also now be incorporated into the factors considered in the risk huddles led by local home treatment psychologists	CNM for HTT Head of nursing to work with lead psychologist	Complete September 2022
12	There is evidence that the service user was able to access psychological therapies whilst under the care of the Home Treatment Team.	27	12	3	17	The Trust has recognised the need for a strengthened MDT approach in HTTs. There is now regular input from Psychology within the services.	Clinical psychology posts are now funded substantively and psychology provision is delivered through 1-1 clinical input, supervision to clinicians, MDT discussion and risk	Multi-disciplinary team	

No.	Audit question	Results				Observations	Action(s)	Lead for action(s)	Completed by date
		Good	Acceptable	No	Not applicable				
							formulation and weekly case risk huddles on complex cases.		
13	Where relevant, there is evidence of communication between the CMHT and the Home Treatment Team.	19	6	0	34	The Trust operates a geographical model of delivery, this enables the fostering of communication and working relationships between HTT and CMHT.	The bed locality bed was initiated in August 2021. All home treatment teams now have dedicated inpatient beds on locally identified male and female wards. This ensures that both HTTs and wards are liaising with a smaller and dedicated partner pathway rather than across 9 HTTs and 16 wards. It enables more effective in-reach and cooperative working and more effective use of resources. All HTTs link directly with their local wards for MDT discussions / discharge planning and all patients discharged are seen within 3-days of discharge face to face as a minimum.	Locality Governance Committee	October 2022

GLOSSARY	
AMHPs	Approved Mental Health Professionals
BCC	Birmingham City Council
BSCCG	Birmingham & Solihull Clinical Commissioning Group
BSMHFT	Birmingham & Solihull Mental Health NHS Foundation Trust
CMHT	Community Mental Health Team
DHR	Domestic Homicide Review
FTB	Forward Thinking Birmingham
MHA	Mental Health Act
PFDs	Prevent Future Deaths
PICU	Psychiatric Intensive Care Unit
WMP	West Midlands Police

5 APPENDIX ONE: AUDIT TEMPLATE

Date of audit.	
Hospital / community base / service	
Ward (if applicable).	
Name of lead contact for the service and contact details.	
Has the Information Governance lead for the service given written permission via email for the case note audit to proceed?	
Name of Niche staff member conducting the audit.	
Niche assigned patient number (not NHS number).	

AMHP Service			
Key issue being audited		**Good evidence**	**Acceptable evidence**
1	The individual was assessed within 4 hours of a referral to the AMHP service for an MHA assessment.	The assessment took place within 4 hours of referral	The assessment was initiated but not completed within 4 hours of referral
2	There is evidence that referrals have been triaged.	The assessment documents a clear statement of risks to self or others, and a planned response	The assessment documents only one of a statement of risks to self or others; and a planned response
3	There is evidence of the AMHP involving family / carers in the assessment process.	The assessment includes a description of communication with family members/carers. Information about the individual's past history, the current situation as they see it and views around risk are documented. Carers' views in relation to what support the individual and they require are documented.	• Evidence of involvement but no detail given. • There is evidence that contact was attempted with a family member/carer but they were uncontactable. • It is documented that contact was made with a family member/carer but they did not wish to engage with the assessment process. • It is documented that the AMHP was unable to

			engage a family member/carer in the assessment process as there were no contact details available for them.
4	Where an individual was previously known, there is evidence that their previous history including risk management was taken into consideration during the assessment process.	A summary of past mental health and physical social care history and provision is documented. There is information from previous risk management plans documented	The records refer to the individual's past mental health and physical needs and how health and social care met them in the past.

Inpatient Services / Crisis Resolution and Home Treatment Teams / CMHTs			
Key issue being audited		**Good evidence**	**Acceptable evidence**
Bed management			
1	There is evidence that there was a delay in accessing a bed for the service user.	There is a record which shows the length of time between the decision to admit to a bed and the time the individual was admitted to a bed. The reason/s for any delay in accessing a bed are documented. Any attempts to escalate the challenges in identifying a bed are recorded.	Any delay in accessing a bed is recorded and the reasons outlined. Alternative means of caring for the individual (such as referral to the CRHT) are outlined.
Risk assessment and management			
2	There is a current risk formulation and management plan in the case notes.	There is an up-to-date risk formulation and management plan in the case notes.	There is a risk assessment in the case notes relating to this episode of care. There is a risk management plan recorded.
Family and/or carer involvement			
3	There is evidence that staff have checked whether a carer's assessment has been completed in the last year or there is evidence of	The records refer to carer's assessments and demonstrate that staff have either checked whether one has been conducted in the	The records indicate that staff have considered carer's assessments and are going to clarify whether one has been undertaken in the last

	family members/carers being made aware they are entitled to a carer's assessment.	last year or made carers aware that they can have an assessment undertaken.	year and pursue this with the carers if not.
4	There is evidence that a carer's assessment has been completed.	• The records indicate that a carer's assessment has been completed. A care plan has been completed following completion of a carer's assessment. • The records state that the carers were offered an assessment but declined.	There is a record that the team have been unable to identify a family member/carer despite their attempts to do so.
5	There is clear evidence of the nature of any concerns that family members/carers have raised.	There is a record of communication (via calls/emails/face to face discussions) of instances when the family have raised concerns. The concerns are detailed in the case notes.	There is a record of communication from family members about their contact with the service and a brief summary of any concerns raised.
6	There is evidence of family/carer concerns being taken into consideration in managing risk.	There is a risk management plan. It states the concerns raised by the family and actions to be taken to manage risk and any other issue is detailed.	A record of the family/carer concerns raised is documented in the notes and the actions planned to manage these.
Evidence of interagency communication			
7	There is evidence of interagency communication.	There are detailed notes describing staff from different organisations sharing relevant information about the individual when required. These notes enable a comprehensive understanding of needs, including housing and employment issues.	There is some evidence of interagency communication, but limited evidence as to comprehensive needs assessment
Meeting the needs of service users with dual diagnosis			
8	There is evidence of service users with drug and alcohol problems being referred to substance misuse services.	• Consideration has been given to whether the individual may have dual diagnosis. The	There is a record of staff making contact with the alcohol and substance misuse team.

		assessment process explored use of alcohol and substances. Individuals who are identified as having alcohol and/or substance misuse problems are referred to addiction services. • There is evidence that a member of the alcohol and substance misuse team is attending ward rounds to ascertain if there are any patients who require assessment and support.	
Discharge planning			
9	There is evidence that a handover meeting took place to plan the handover of any service user being transferred to another team.	There is a record that a handover meeting was held prior to transferring an individual to another service. There are notes which outline what was discussed at the meeting.	There is a record that a handover meeting took place.
Delayed discharges			
10	There is evidence of effective management of delays in discharging the service user. (could relate to inpatient transfers, care coordination, funding, accommodation, amongst other reasons)	Any delays in discharging the individual are documented along with the reasons. There is evidence that delays are escalated on a regular basis. Progress made in trying to resolve the delays is documented.	The reason(s) for any delays is/are documented.
Medication management			
11	*Applied to service users where poor medication compliance is documented.* Poor concordance of medication compliance is documented in the risk management plan.	Poor medication concordance is documented in the risk assessment and risk management plan. The plan sets out how the risks will be managed.	

Access to psychological therapies in the Home Treatment Team			
12	*Applied to service users where psychological therapies have been used.* There is evidence that the service user was able to access psychological therapies whilst under the care of the Home Treatment Team.	A referral for psychological therapies is documented in the case notes. There is a record in the case notes that the individual has commenced therapy or there is a record why the individual has not commenced therapy.	A referral for psychological therapies is documented in the case notes. Any delay in accessing therapy is documented.
Communication between community teams			
13	Where relevant, there is evidence of communication between the CMHT and the Home Treatment Team.	There is a record of meetings/communication between both teams via telephone/emails/video calls/meetings. The actions arising from the meeting/s are documented.	There is a record of meeting/communication between the team, but no record of actions.

Niche Health & Social Care Consulting
4th Floor
Trafford House
Chester Road
Old Trafford
Manchester
M32 0RS

Tel: 0161 785 1000

Read more about us at: www.nicheconsult.co.uk