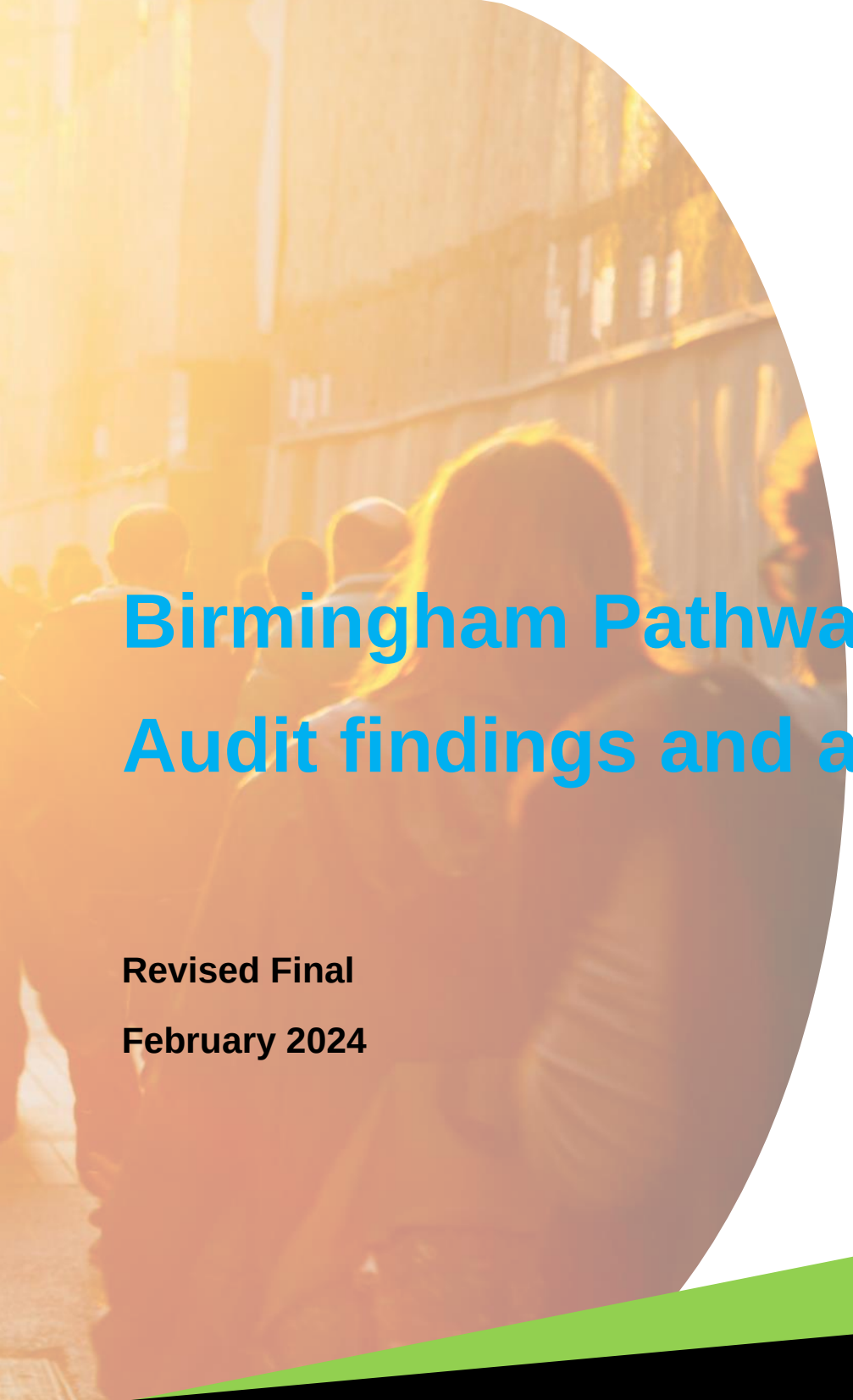

Birmingham Pathway Review
Audit findings and action plan

Revised Final

February 2024

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1. Introduction

1.1 Context

In 2014 two mental health service users were involved in domestic homicides. Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT) completed internal reviews of care and treatment for both service users, in line with the requirements of the NHS Serious Incident Framework (March 2013). These resulted in findings and recommendations for BSMHFT. Birmingham Community Safety Partnership commissioned a Domestic Homicide Review (DHR) to be carried out in both cases to establish what lessons could be learned. These DHRs were completed, and reports were written and shared with stakeholders, but they were not published. Although both incidents met the threshold for commissioning an independent mental health homicide investigation, they were not commissioned at that time. In 2021 the NHS England Midlands & East (NHSE) Regional Investigations Review Group decided it would be proportionate to commission a review of how the current systems might respond to a similar situation.

We (Niche) were commissioned by NHSE to complete an examination of the present-day situation to answer one fundamental question:

"If a service user accessed services today with a similar history/problem – what would change/be different"?

As the basis for answering this question, we agreed to:

- Identify the issues arising from these cases and carry out a review of the current pathway with reference to these issues.
- Review and assess compliance with local policies, national guidance, and statutory obligations in so far as these policies and guidance are relevant to the specific issues arising from these two cases.
- Via the review, identify areas of good practice, opportunities for learning and areas where improvements to service may be required.

1.2 Common characteristics

We identified that the perpetrators of the two homicides shared a number of common characteristics. These characteristics were then used to identify the cohort of interest for the review, as set out in the method section below.

1.3 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 our commentary on the policies used to complete the audit.

Section 5 comments on the present-day service provision governance and quality systems, arrangements for identifying and escalating risks and opportunities for improving the quality of services.

Section 6 contains an overview of our findings and action focused recommendations.

Section 7 is the action plan.

2. Method

2.1 Case note audit

Following detailed review of the cases underlying this audit, a template was agreed between Niche and BSMHFT, to audit the case notes. This audit template is attached as appendix two.

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

- Dr Dinesh Maganty, Medical Director on behalf of Birmingham and Solihull Mental Health NHS Foundation Trust.

We completed a case note audit of a sample of 48 case notes, across the BSMHFT assertive outreach team and the FIRST service to determine how the current pathway would manage service users with a similar profile.

The time period for the data sample was the first six months of 2022. However, it should be noted that in order to reach a judgement we had to refer to case records which were older than six months. Examples of where we referred to case records which were older than six months include care plans and risk plans.

The criteria for inclusion in the audit were that the service user should be under the care of the BSMHFT assertive outreach service or FIRST, and additionally met the following:

Essential

- Male
- Aged 28 – 50
- Under the care of Trust services for five years or more
- Has previously been subject to a Community Treatment Order (CTO)
- Named carer

Desirable

- Has previously had a history of non-compliance with prescribed medication
- Currently prescribed clozapine
- Has a known history of violence
- Has an identified partner

Exclusion criteria

Service users placed in mental health services out of area or with a private provider.

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.

Several of the records provided by BSMHFT did not fully meet the criteria set out above, and this is discussed in Section 3 of this report.

2.2 Development of an audit template

We developed an audit template consisting of standards, each of which fell under one of the following themes.

Table 1: Audit template –themes

No.	Theme
1	Management of service users detained under Section 3 Mental Health Act (MHA)
2	Use of Community Treatment Orders (CTOs)
3	Care planning – compliance with the policy
4	Risk assessment and management
5	Family and/or carer involvement
6	Evidence of interagency communication (including supported housing provider)
7	Meeting the needs of service users with dual diagnosis

For each of the standards audited, we described what information would need to be seen via the clinical audit in order to be considered 'good' or 'acceptable' evidence. The definitions for 'good' and 'acceptable' and the standards are presented in appendix two. We also included a category 'N/A' or 'not applicable' to indicate that the question being audited was not relevant to that particular case.

The clinical audit was conducted by two members of the Niche project team who worked closely together to ensure consistency when using the audit template. The audit was undertaken on site at the Uffculme Centre, Birmingham. Whilst auditing the case notes a qualified member of staff from the assertive outreach team provided support to the members of Niche staff conducting the audit. She identified the correct set of case notes and supported Niche staff to locate the information they were seeking in order to complete the audit. A further staff member from FIRST provided support with regards to completing the audit in relation to case notes from their team.

2.3 Action planning

The audit findings were shared with BSMHFT on 2 February 2023. At the meeting it was agreed that the Trust would review and respond to the findings via its internal governance process. Niche prepared a template for the Trust action plan, and this forms the basis of Section 7 of this report.

A draft of this report and action plan was agreed with BSMHFT on 11 June 2023.

3. Audit findings

Assertive outreach team and forensic intensive recovery support team

From the list provided by BSMHFT of service users under the care of the assertive outreach team who met the essential criteria for the audit, we randomly selected 105 service users. We completed a full audit of the clinical record for 44 of these service users. We excluded 61 service users from the full audit because:

- the patient was under the care of a non-Trust service at the time of the audit (19)
- there was no carer identifiable in the clinical record (33)
- the patient was under the care of inpatient services (5)
- other (4)

From the list provided by the Trust of patients under the care of the FIRST, who met the criteria for the audit, we randomly selected 10 service users. We completed a full audit of the clinical records for four of these service users. We excluded six service users from the full audit because:

- The service user was under the care of a non-Trust service at the time of the audit (2)
- There was no carer identified in the clinical record (4)

The audit findings for both services are combined and summarised in the tables below. We have combined the data from both teams because the sample size for FIRST was small. However, we have made narrative comments about any findings specific to the service.

3.1 Management of service users detained under the Mental Health Act

Table 2: Management of service users detained under the Mental Health Act. Raw sample numbers used

Audit question	N/A	Good	Acceptable	No	Total (applicable)	Total
Date of detention.	35	12	0	0	12	47
The care team is planning for re-assessment or rescinding the section throughout the service user's admission.	36	9	0	2	11	47
Where a Section has ended there is evidence that this was an assessed and planned decision.	45	2	0	0	2	47
Where a Section has lapsed the care team has taken immediate action to assess the service user.	47	0	0	0	0	47

Chart 1: % of records classified as 'good' or 'acceptable' for question 1 of the audit of management of service users detained under Section 3 MHA

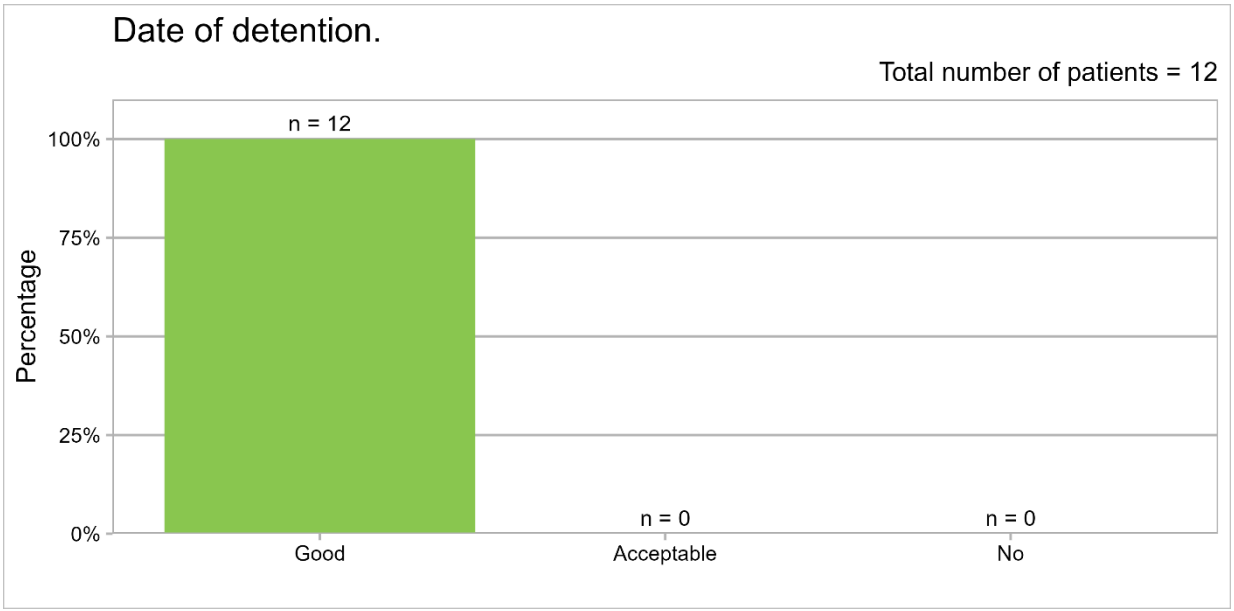


Chart 1 shows that the date of detention was available in 100% of cases.

Chart 2: % of records classified as 'good' or 'acceptable' for question 2 of the audit of management of service users detained under Section 3 MHA

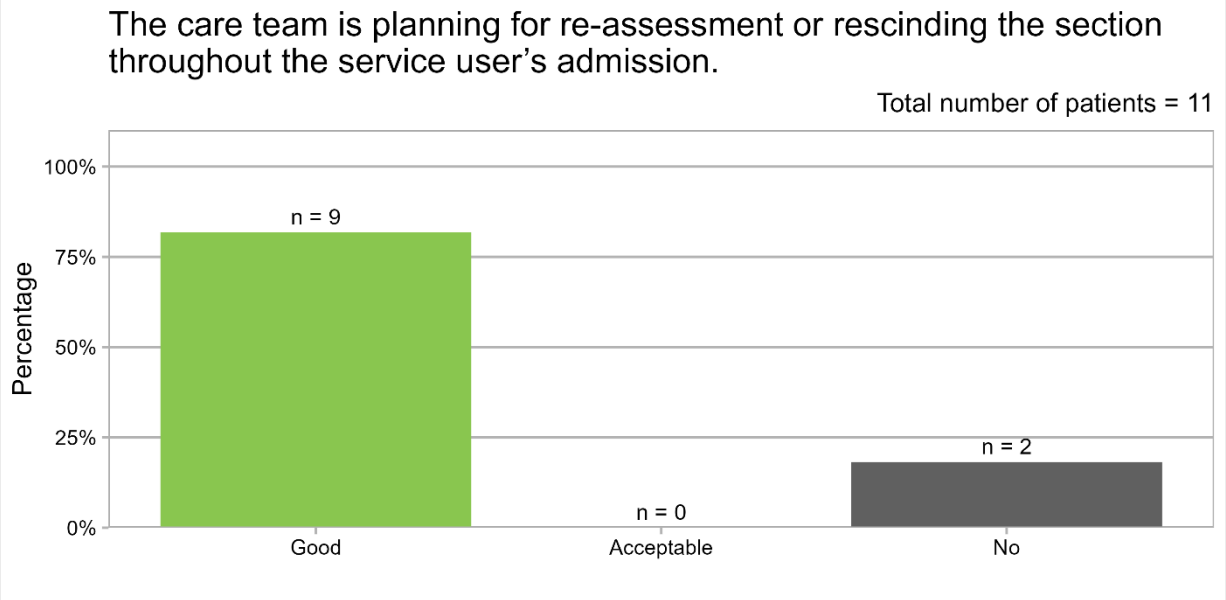


Chart 2 shows for 82% of service users there was planning for re-assessment or rescinding the Section during the service user's admission. Where there was no planning, we determined that this was appropriate because they were not at a point in their care pathway where this type of planning was required.

Chart 3: % of records classified as 'good' or 'acceptable' for question 3 of the audit of management of service users detained under Section 3 MHA

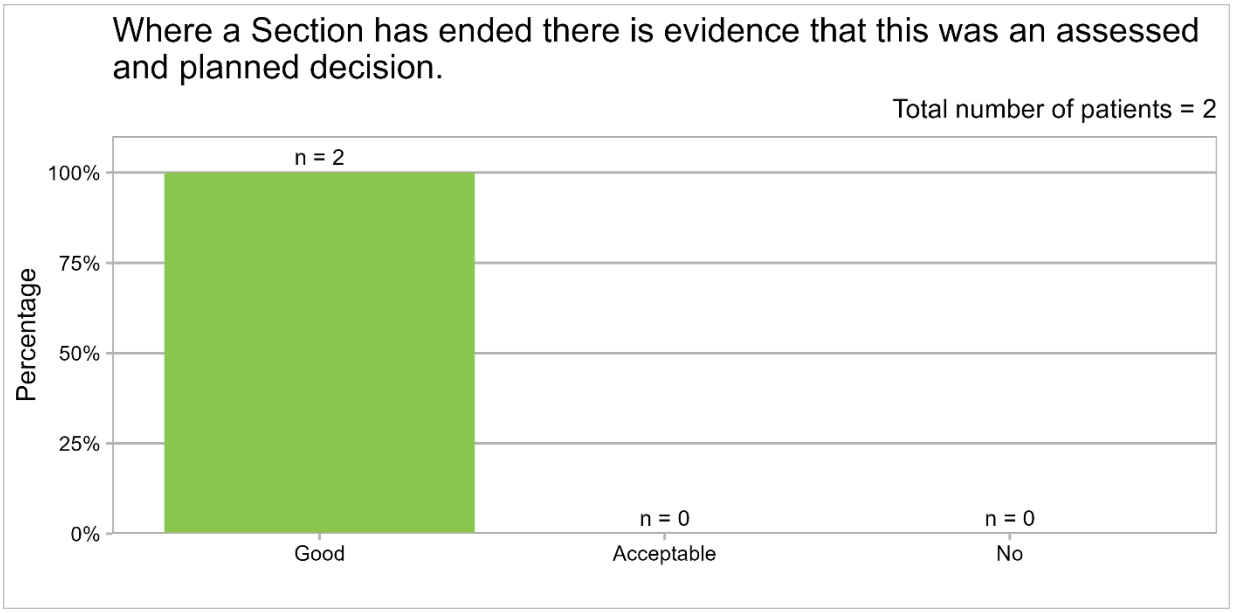


Chart 3 shows that it was an assessed and planned decision to end a Section for all of the service users in the sample. However, it is important to remember that this was a very small sample.

Chart 4: % of records classified as 'good' or 'acceptable' for question 4 of the audit of management of service users detained under Section 3 MHA

Chart 4 shows that there were no service users in the sample whose Section had been allowed to lapse.

3.2 Use of Community Treatment Orders

Table 3: Audit results for the provider records for the management of service users under Community Treatment Orders (CTO) by audit question. Raw sample numbers used

Audit question	N/A	Good	Acceptable	No	Total (applicable)	Total
The CTO is developed, discussed, and agreed with the service user.	35	12	0	0	12	47
When developing the CTO there are discussions with the family, carers, and others in line with the Trust Mental Health Act policy and the Code of Practice.	37	5	2	3	10	47
The required conditions of the CTO are clearly documented.	32	9	1	5	15	47
a. The requirements of the CTO are in keeping with legal requirements and the service users identified needs and are not generic in nature.	32	12	2	1	15	47
b. The licence requirements are capable of being monitored.	32	13	1	1	15	47
The requirements of the CTO are monitored and discussed with the service user on a regular basis.	32	11	3	1	15	47
a. When a service user has been recalled to hospital, they are *correctly informed about their legal status*.	44	1	0	2	3	47
b. When a service user has been recalled to hospital, they are *given a copy of the CTO3*[1]*.*	43	1	0	3	4	47

[1] CTO3 forms are notice of recall forms. https://www.gov.uk/government/publications/community-treatment-order-cto-forms-for-use-under-the-mental-health-act

Chart 5: % of records classified as 'good', 'acceptable' and 'no' for question 1 of the audit of management of service users subject to CTO

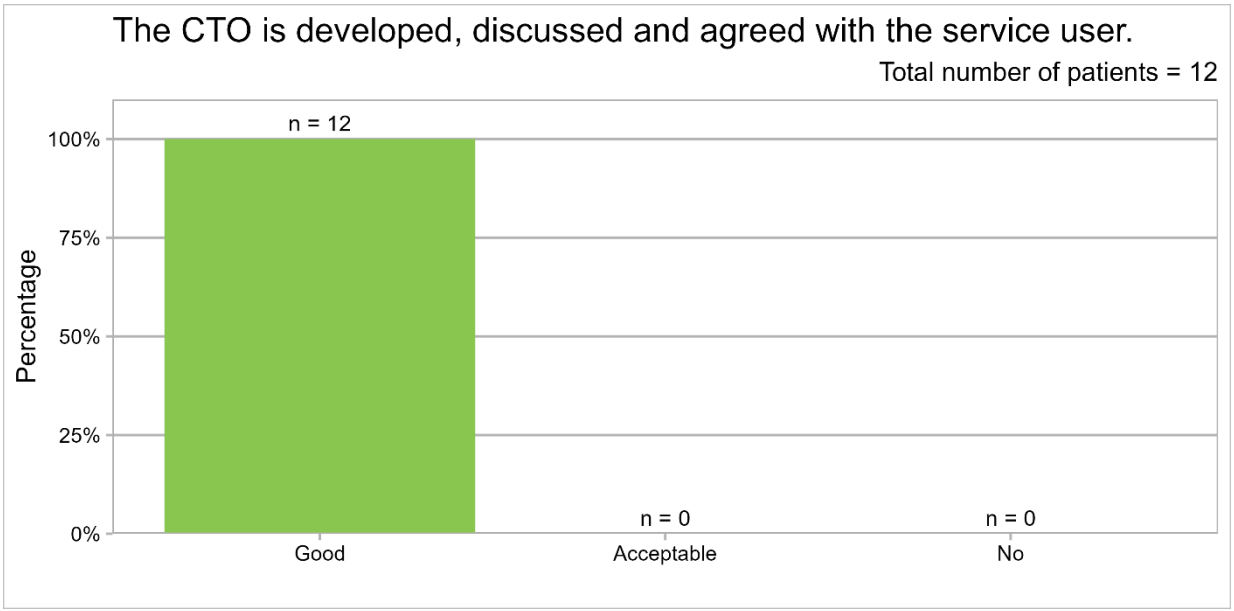


Chart 5 shows that 100% of service users were involved in the development of their CTO; and that it was discussed and agreed with them.

Chart 6: % of records classified as 'good', 'acceptable' and 'no' for question 2 of the audit of management of service users subject to CTO

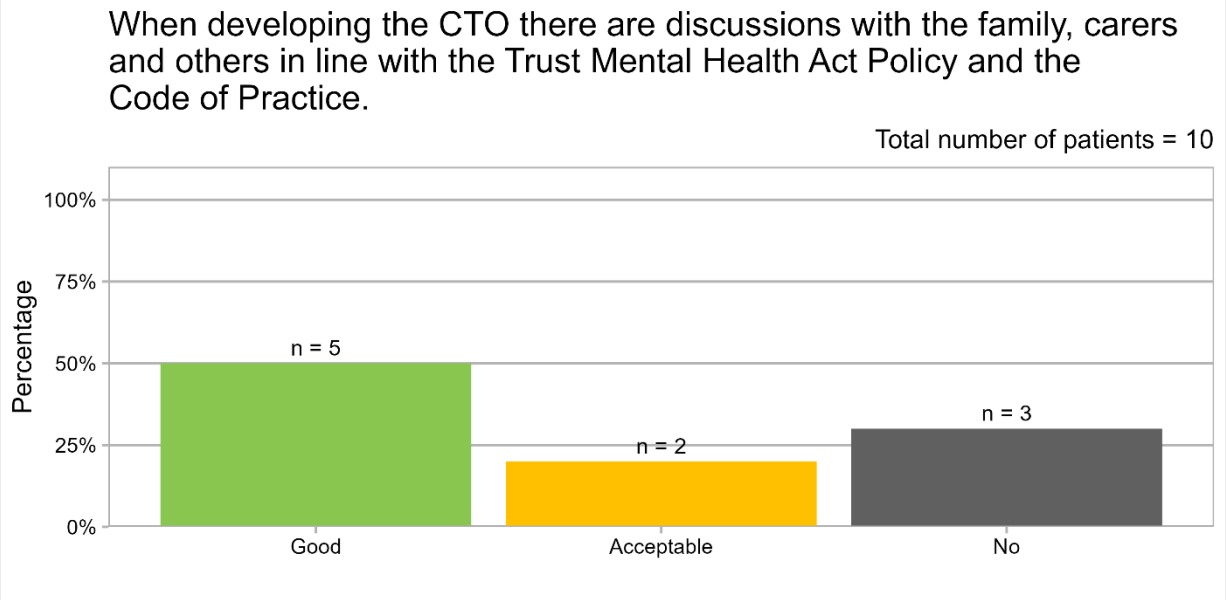


Chart 6 shows that 50% of family, carers and others had good involvement in discussions about the service user's CTO; whilst a further 20% had acceptable involvement. The key difference between scoring 'good' versus 'acceptable' on this question was whether or not there was evidence that where decisions had been taken contrary to the wishes of the family, carers, or others this was explained to them and documented in the case notes. 20% of carers were not involved in discussions about service users, although there is the possibility that the service user requested that they were not involved.

Chart 7: % of records classified as 'good', 'acceptable' and 'no' for question 3 of the audit of management of service users subject to CTO

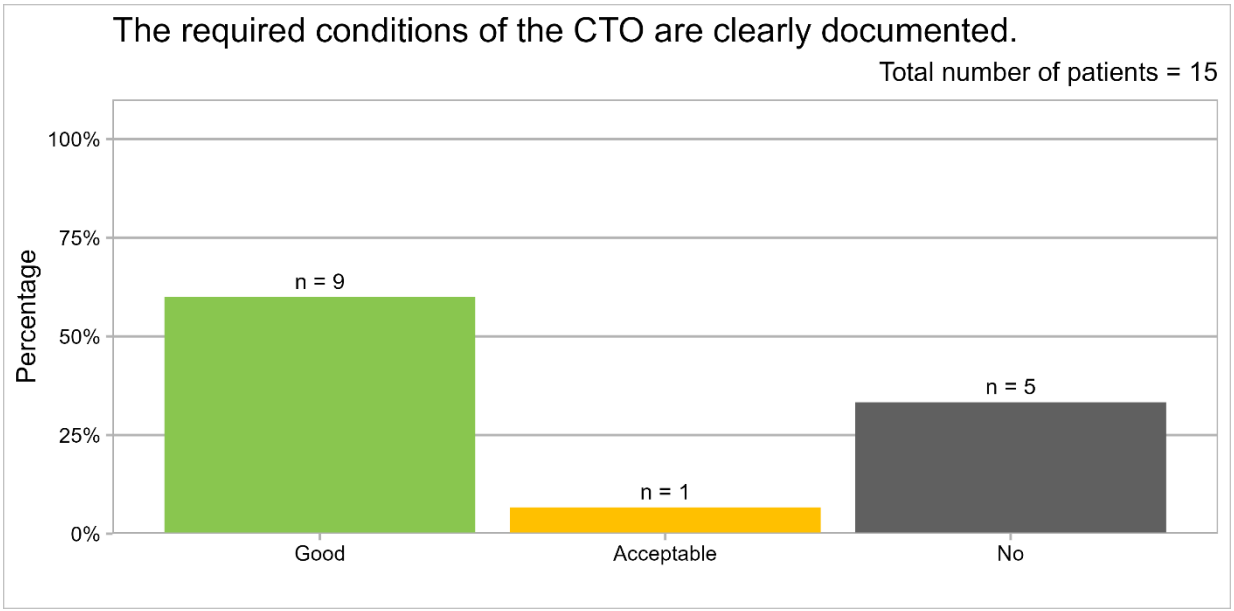


Chart 7 shows that the required conditions of the CTO were clearly documented in the clinical notes for 60% of service users, whilst the CTO conditions were acceptably documented for a further 7%. In over 30% of service users the CTO conditions were not clearly documented.

Chart 8: % of records classified as 'good', 'acceptable' and 'no' for question 4a of the audit of management of service users subject to CTO

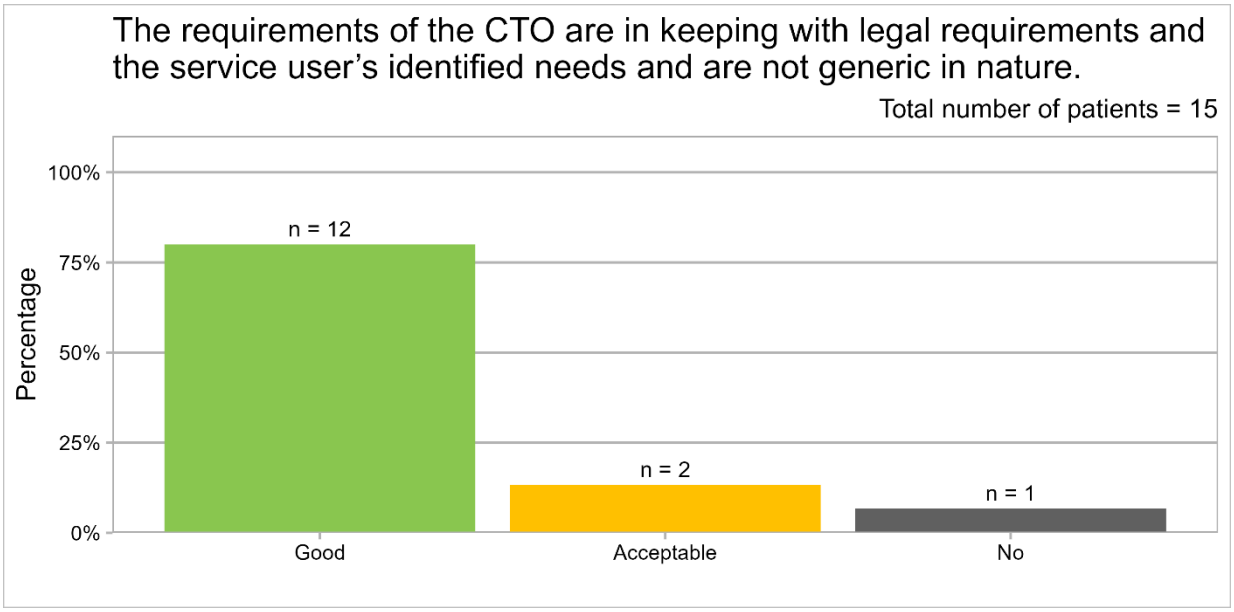


Chart 8 shows that the requirements for 80% of the service user CTOs were in keeping with the service user's needs and not generic in nature. In 13% of cases, the requirements of the CTO were recorded in an acceptable manner.

Chart 9: % of records classified as 'good', 'acceptable' and 'no' for question 4b of the audit of management of service users subject to CTO

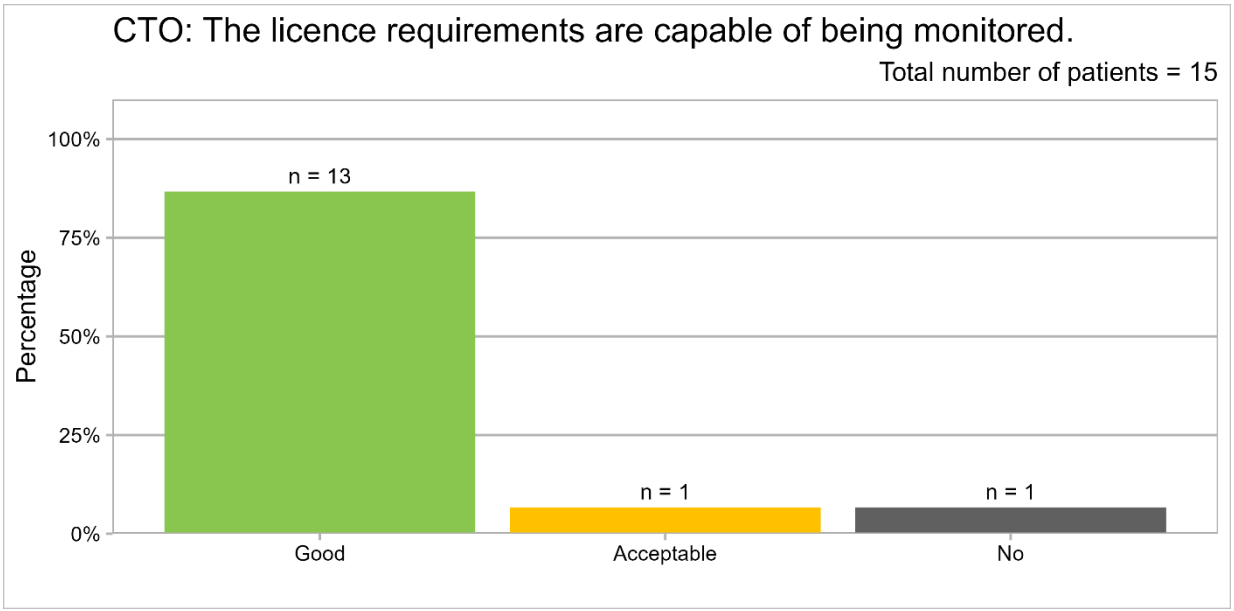


Chart 9 shows that 87% of the CTO licence requirements were capable of being monitored. Examples of licence requirements included the requirement to live in supported accommodation and complete regular drug screens. In 7% of cases the requirements met an acceptable standard.

Chart 10: % of records classified as 'good', 'acceptable' and 'no' for question 5 of the audit of management of service users subject to CTO

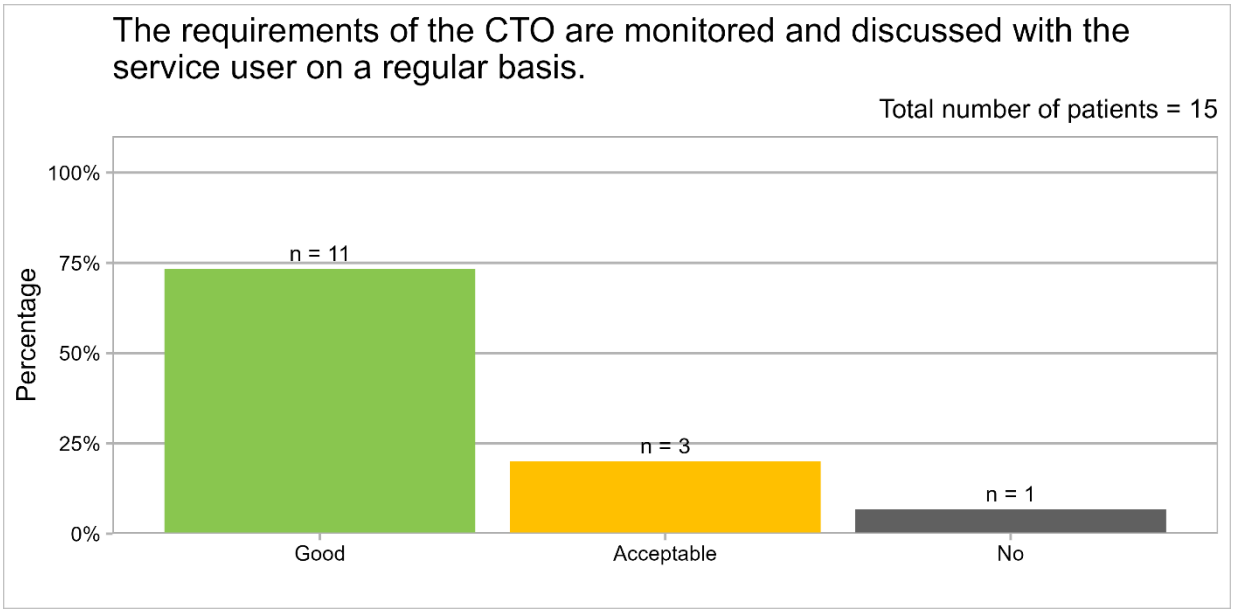


Chart 10 shows that the requirements of the CTO were monitored and discussed on a regular basis with 73% of service users. A further 20% had the requirements of their CTO monitored and discussed with them on a regular basis. There was a record of a discussion having taken place in these cases, but the discussion lacked detail.

Chart 11: % of records classified as 'good', 'acceptable' and 'no' for question 6a of the audit of management of service users subject to CTO

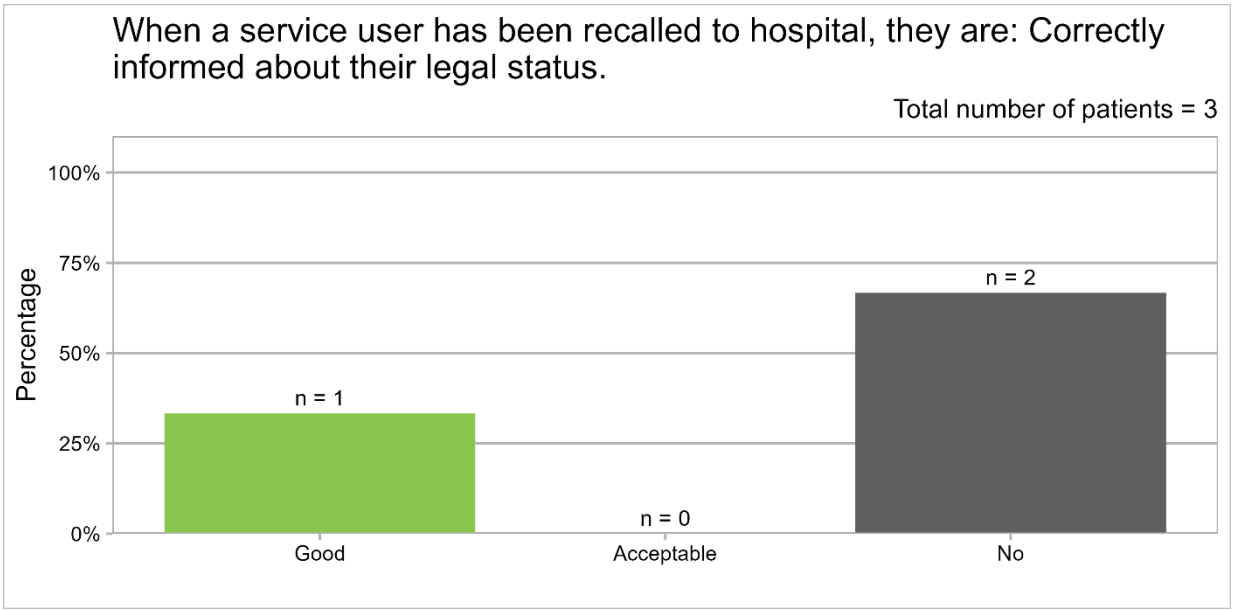


Chart 11 shows that 67% of service users were not correctly informed of their legal status when they were recalled to hospital. 33% of service users were correctly informed about their legal status.

Chart 12: % of records classified as 'good', 'acceptable' and 'no' for question 6b of the audit of management of service users subject to CTO

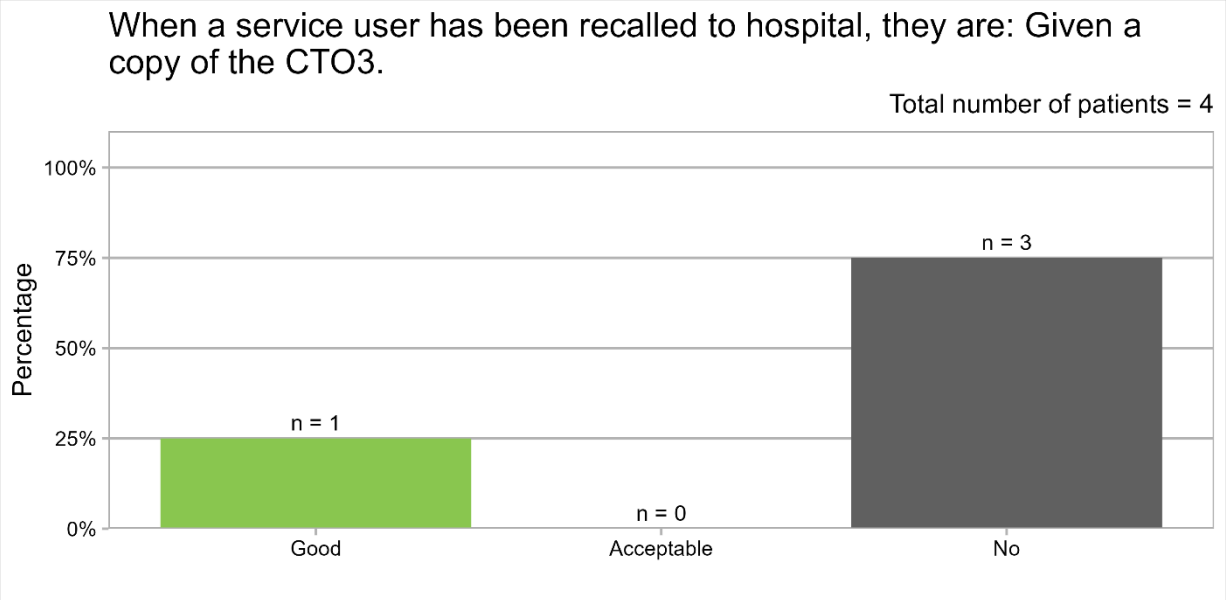


Chart 12 shows that 75% of service users recalled to hospital were not given a copy of the CTO3. 25% of service users were provided with a copy of the CTO3.

3.3 Care planning and management of risk

Table 4: Audit results for the provider records for care planning and management of risk by audit question. Raw sample numbers used

Audit question	N/A	Good	Acceptable	No	Total (applicable)	Total
There is an up-to-date Care Programme Approach (CPA) care plan in the patient records.	0	18	9	20	47	47
There is a current risk assessment in the case notes.	0	30	7	10	47	47
There is a current management plan in the case notes.	0	21	10	16	47	47
There is a current crisis and relapse plan in the case notes.	0	31	8	8	47	47
There is evidence that, where there is a risk to others, especially where the carer is identified as having their own vulnerabilities, this has been assessed and is documented in the risk plan. This would include consideration of domestic abuse issues.	3	25	8	11	44	47

Chart 13: % of records classified as 'good', 'acceptable' and 'no' for question 1 of the audit of care planning

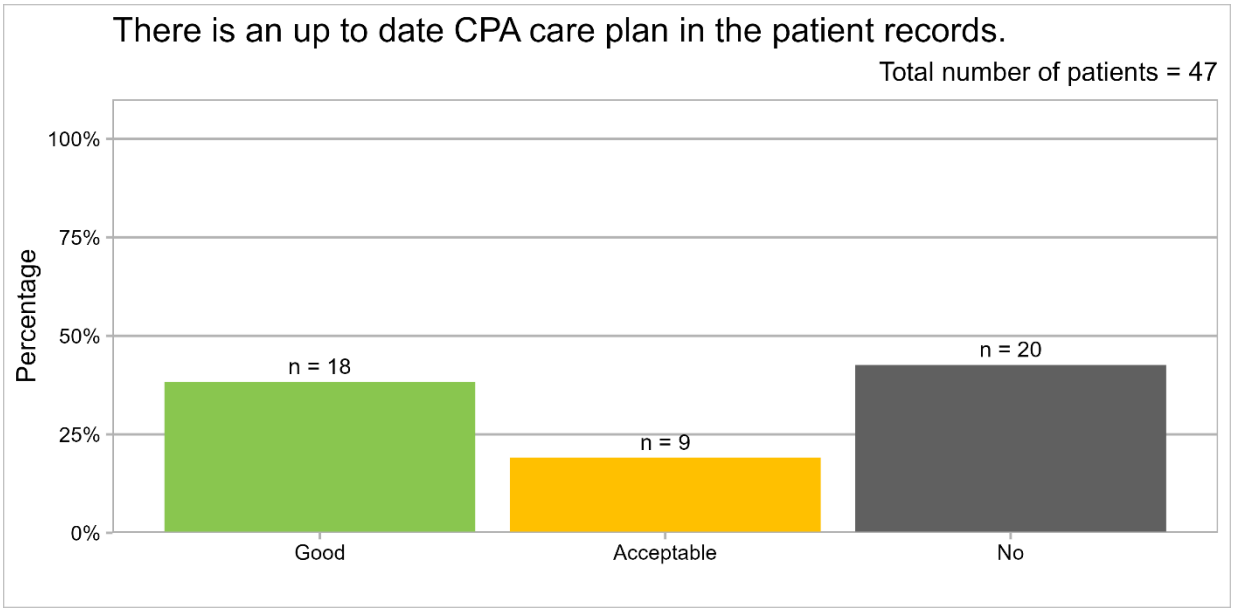


Chart 13 shows that 42% of the service users did not have an up-to-date CPA care plan (in line with minimum policy expectations every 12 months) in their clinical record. Whilst 40% did have a CPA care plan in their clinical record, there was evidence of acceptable care planning for the remaining 18%.

Chart 14: % of records classified as 'good', 'acceptable' and 'no' for question 1 of the audit of management of risk

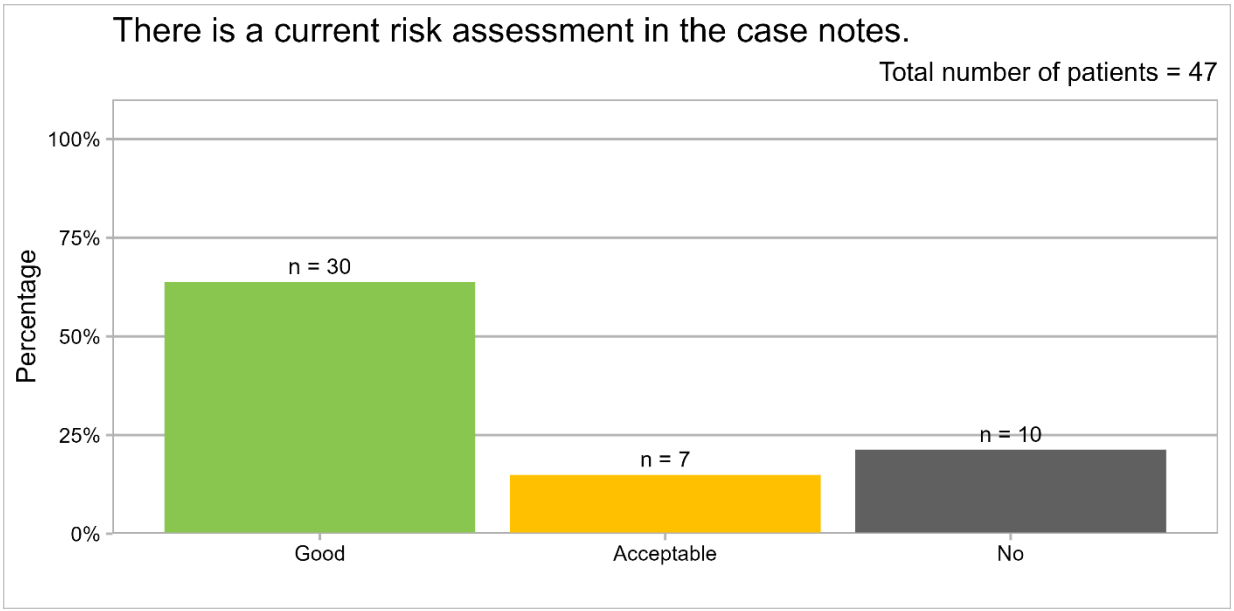


Chart 14 shows that 65% of service users had a risk assessment in their clinical notes that meets the Trust policy requirements; while 14% had an acceptable risk assessment in their clinical notes. However, 21% of service users did not have an up-to-date risk assessment (within policy expectations minimum 12 months) in their clinical record. The Trust risk assessments 'pull through' the information from previous assessments. This ensures that risk information is not lost. However, there were occasions when the risk assessments we reviewed did not contain any current risk information and it was not possible for the reviewer to determine if the risk assessment had been reviewed covering all risk areas concerned or if the practitioner had simply changed the date on the assessment.

Chart 15: % of records classified as 'good', 'acceptable' and 'no' for question 2 of the audit of management of risk

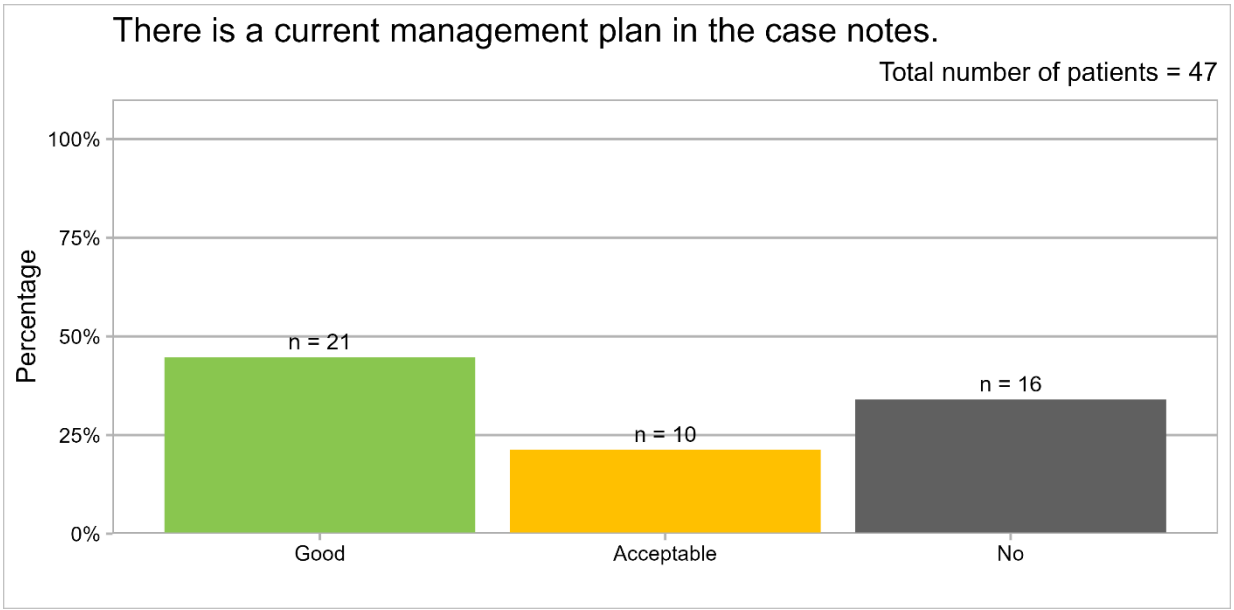


Chart 15 shows that 46% of the service users reviewed had a good risk management plan in their clinical records and a further 21% had an acceptable current (within 12 months) plan. However, 33% of service users did not have a risk management plan in their clinical record.

Chart 16: % of records classified as 'good', 'acceptable' and 'no' for question 3 of the audit of management of risk

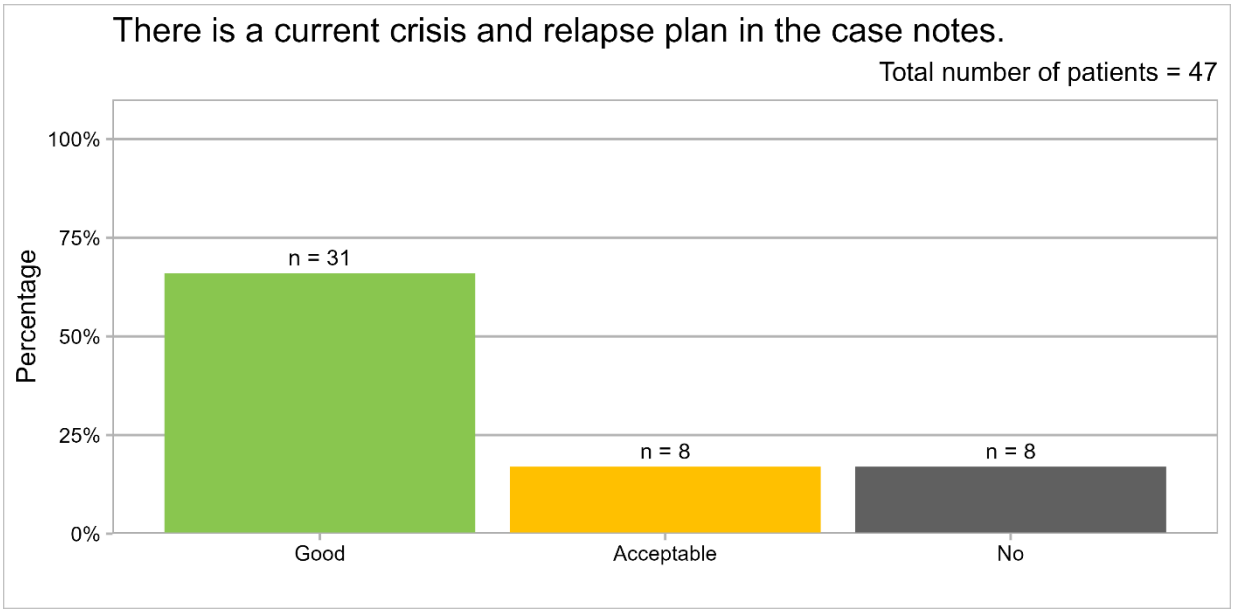


Chart 16 shows that 67% of service users had a good current crisis and relapse plan in their clinical notes and 17% had acceptable current crisis and relapse plans. However, 17% of service users did not have a current crisis and relapse plan in place.

Chart 17: % of records classified as 'good', 'acceptable' and 'no' for question 4 of the management of risk

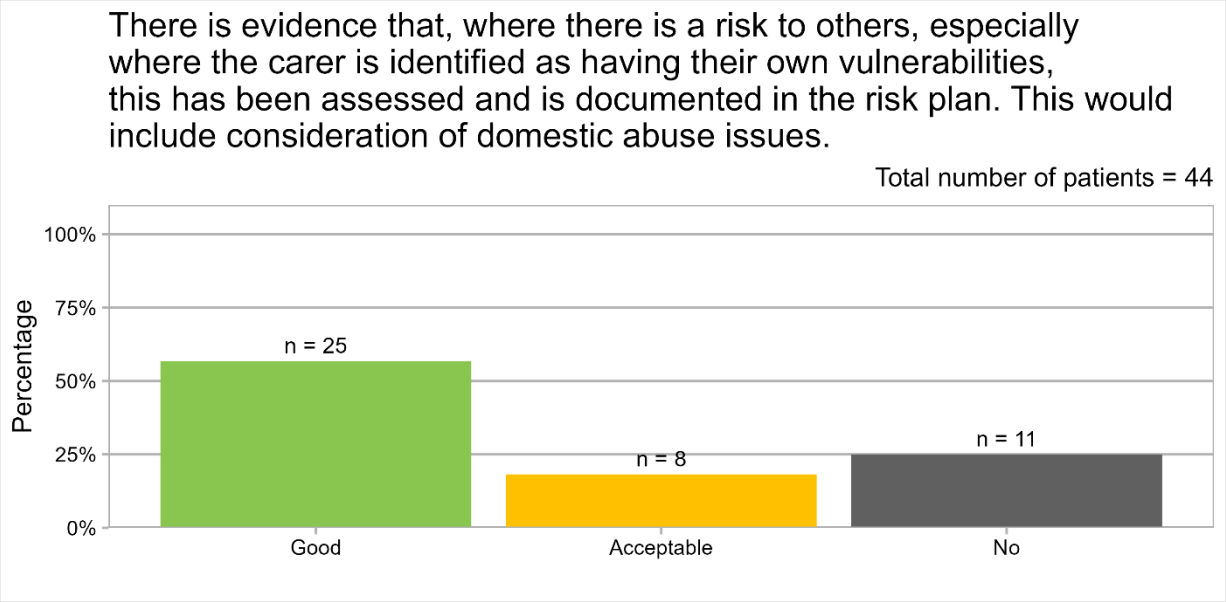


Chart 17 shows that risk to others is identified in the risk assessments to a good standard for 59% of service users and 18% have this information identified to an acceptable standard; whilst 24% of service users do not have risk to others identified in their risk assessments. We noted that, on more than one occasion, risk to violence to family members when the service user was mentally unwell was identified in their risk assessment. However, there was no documented plan to keep family members safe in the event of the service user becoming unwell. The focus was on keeping the service user safe.

3.4 Family and/or carer involvement

Table 5: Audit results for the provider records for the support of family and/or carers. Raw sample numbers used

Audit question	N/A	Good	Acceptable	No	Total (applicable)	Total
There is evidence that staff have checked whether: (a) A carer's assessment has been completed in the last year OR (b) There is evidence of family members/carers being made aware they are entitled to a carer's assessment.	1	11	6	29	46	47
There is clear evidence of the nature of any concerns that family members/carers have raised.	8	26	7	6	39	47
There is evidence of family/carer concerns being taken into consideration in managing risk.	10	24	4	9	37	47

Chart 18: % of records classified as 'good', 'acceptable' and 'no' for question 1 of the audit about family and/or carer involvement

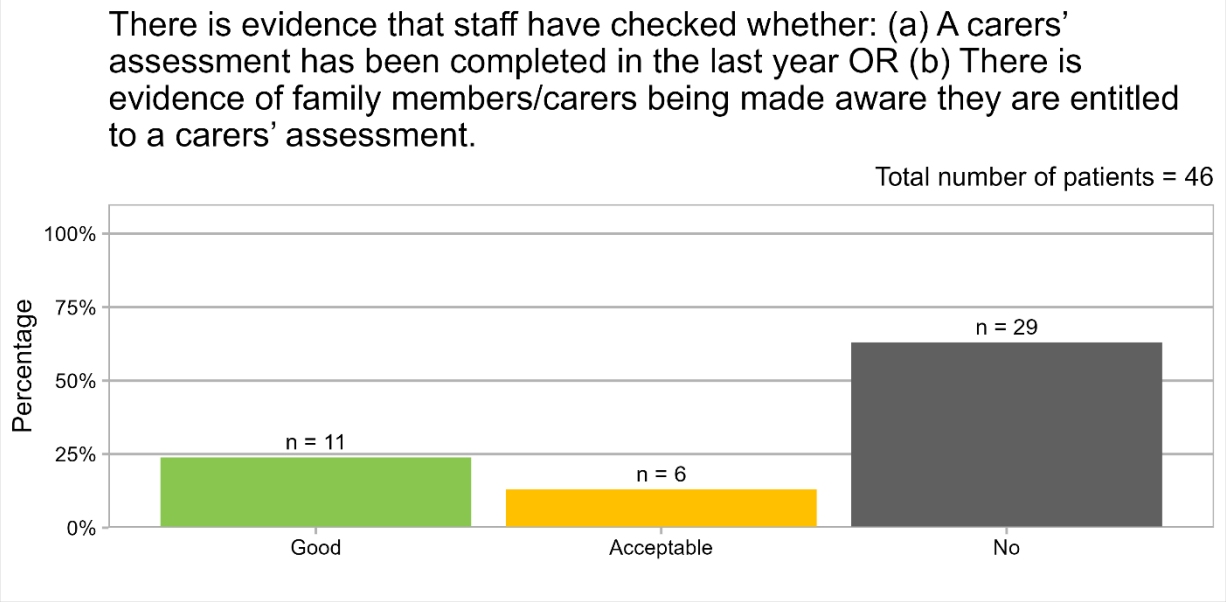


Chart 18 shows that there was no evidence available that either a carer's assessment had been offered to or completed for 52% of carers in the clinical records reviewed. 25% of carers had had a carer's assessment completed in the last year and 13% had been given acceptable information about a carer's assessment. It should be noted that it was not easy to find information about carers and carers' assessments on RiO[2].

[2] Electronic clinical record system

Chart 19: % of records classified as 'good', 'acceptable' and 'no' for question 2 of the audit about family and/or carer involvement

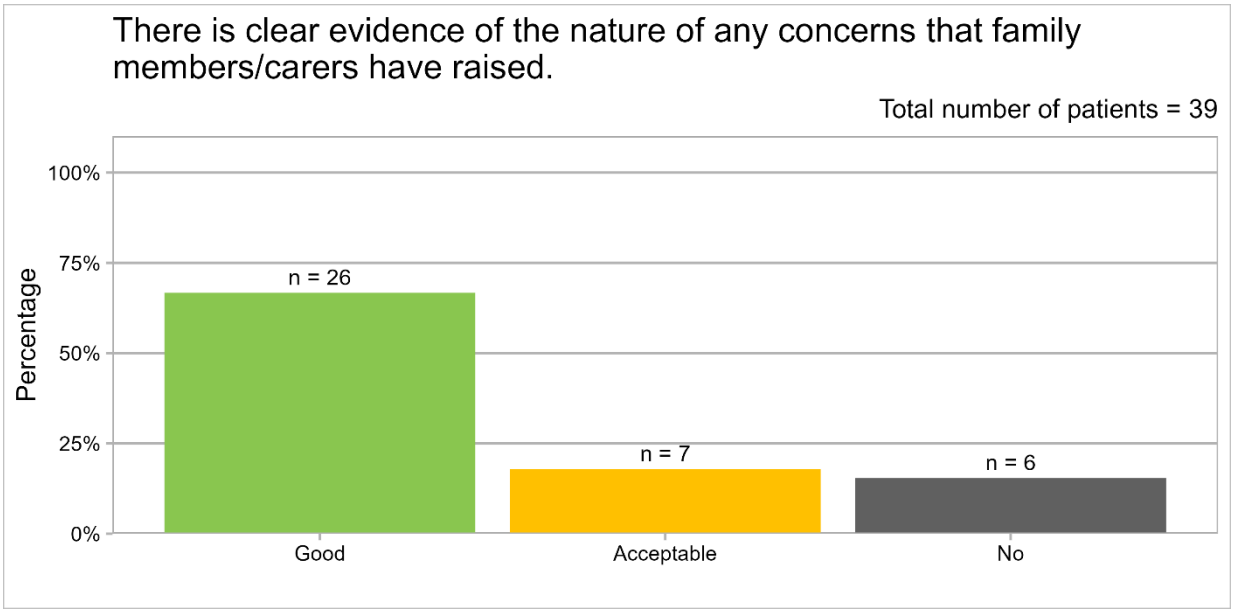


Chart 19 shows that there was good evidence about the nature of any concerns raised by family members/carers for 64% of the service users and to an acceptable standard for 72%. There was no clear evidence of the nature of any concerns raised by 18% of family members/carers. However, they may not have raised any concerns with the care team.

Chart 20: % of records classified as 'good', 'acceptable' and 'no' for question 3 of the audit about family and/or carer involvement

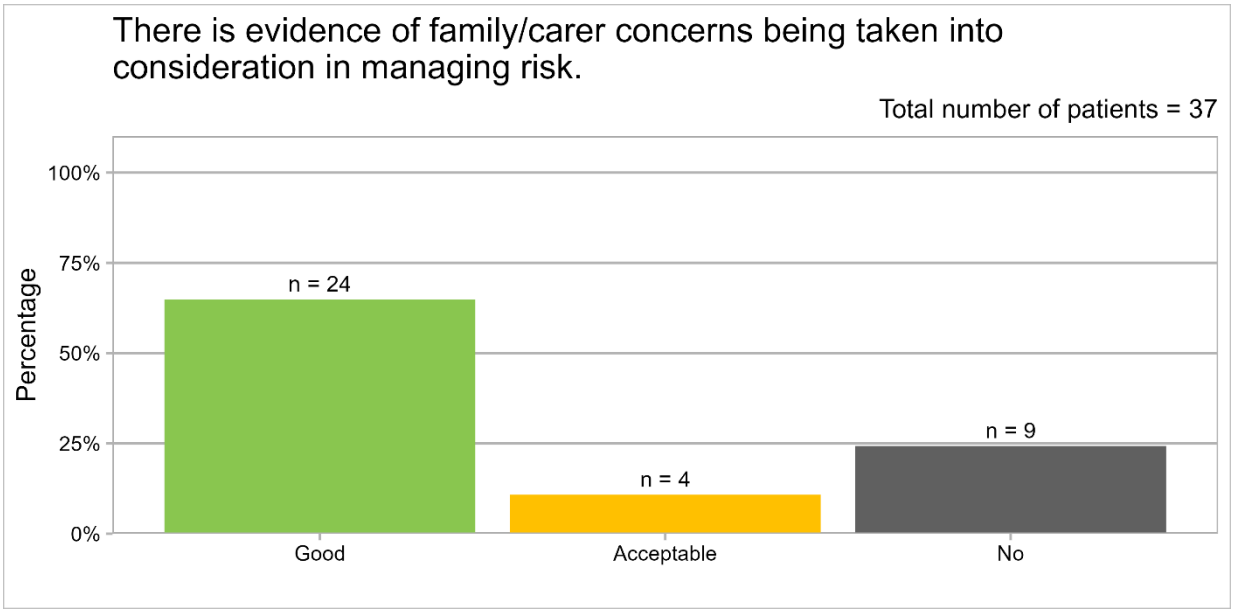


Chart 20 shows that there was good evidence that family/carer concerns were taken into consideration when managing risk and acceptable consideration was given in 75% of the clinical records. However, for 25% of family/carers their concerns were not taken into consideration when managing risk.

3.5 Evidence of interagency communication (including supported housing provider)

Table 6: Audit results for the provider record: Evidence of interagency communication. Raw sample numbers used

Audit question	N/A	Good	Acceptable	No	Total (applicable)	Total
Where the service user is living in supported accommodation there is clear evidence of joint working with the accommodation provider.	32	10	3	2	15	47
Where the service user is living in supported accommodation there is evidence of the Trust care team being responsive to any concerns they raise.	37	8	1	1	10	47
Where the service user is under the supervision of criminal justice services there is evidence of information sharing between the services.	40	1	1	5	7	47

Chart 21: % of records classified as 'good', 'acceptable' and 'no' for question 1 of the audit about interagency communication

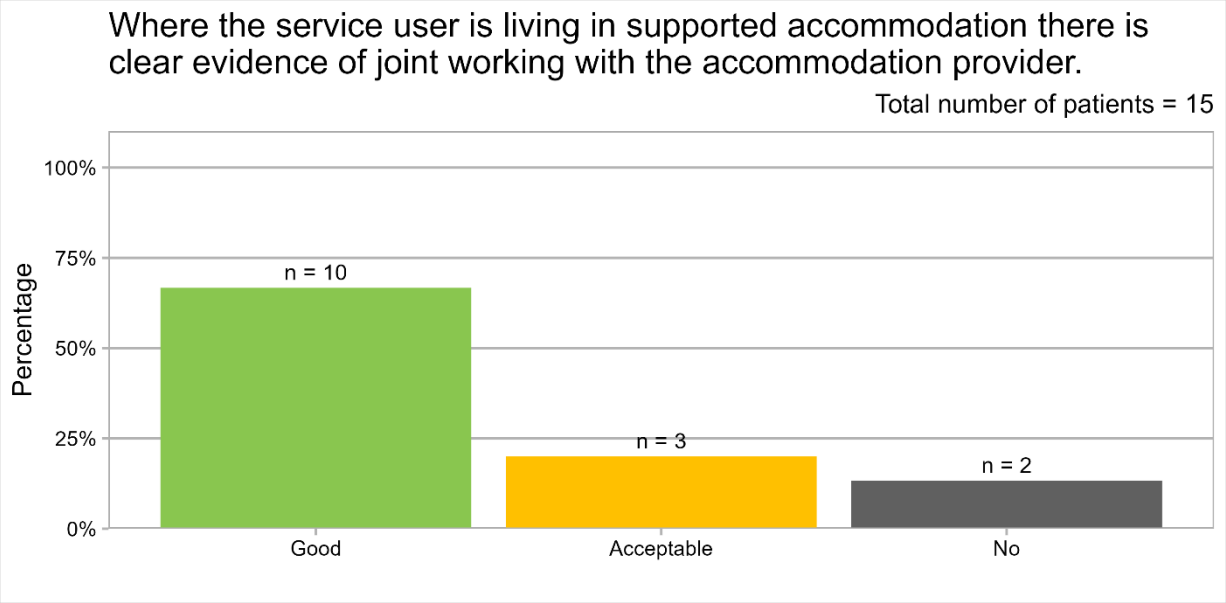


Chart 21 shows that there was clear evidence of joint working with the accommodation provider for 69% of service users living in supported accommodation and there was acceptable evidence of joint working with accommodation providers for 19% of service users. However, there was no evidence of joint working with accommodation providers for 12% of service users living in supported accommodation.

Chart 22: % of records classified as 'good', 'acceptable' and 'no' for question 2 of the audit about interagency communication

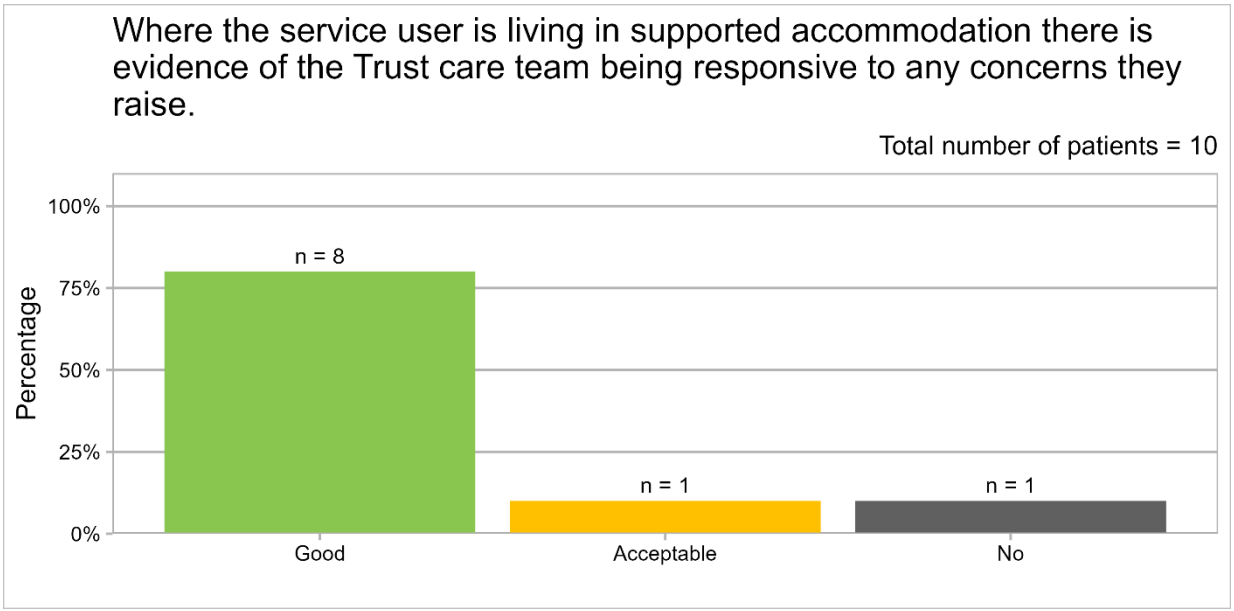


Chart 22 shows a good standard of response from Trust care services in 82% of cases when a concern had been raised by the accommodation provider. There was an acceptable response to 9% of concerns raised and no response to the remaining 9% of concerns raised.

Chart 23: % of records classified as 'good', 'acceptable' and 'no' for question 3 of the audit about interagency communication

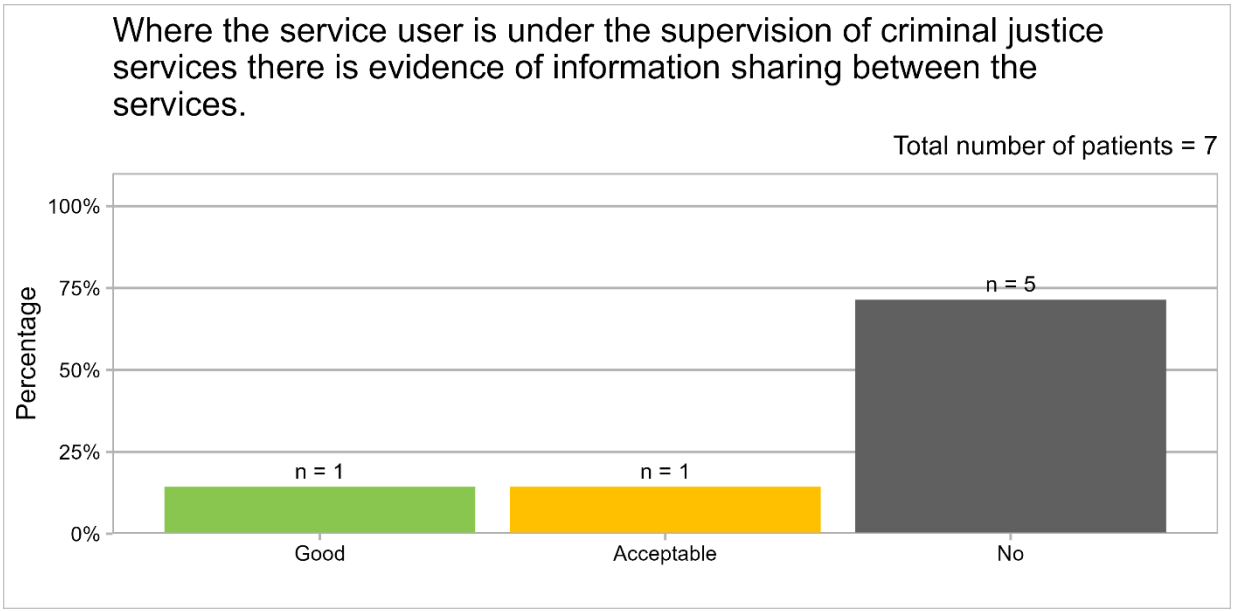


Chart 23 shows that there was no information sharing with criminal justice services for 72% of the service users known to the service. There was a good level of sharing between Trust services for 14% of service users and no information sharing for the remaining 14%.

3.6 Meeting the needs of service users with dual diagnosis

Table 7: Audit results for the provider records: Meeting the needs of service users with dual diagnosis. Raw sample numbers used

Audit question	N/A	Good	Acceptable	No	Total (applicable)	Total
There is evidence of a referral to substance misuse services for service users with drug and alcohol problems.	14	20	5	8	33	47

Chart 24 % of records classified as 'good', 'acceptable' and 'no' for question 3 of the audit about meeting the needs of service user with dual diagnosis.

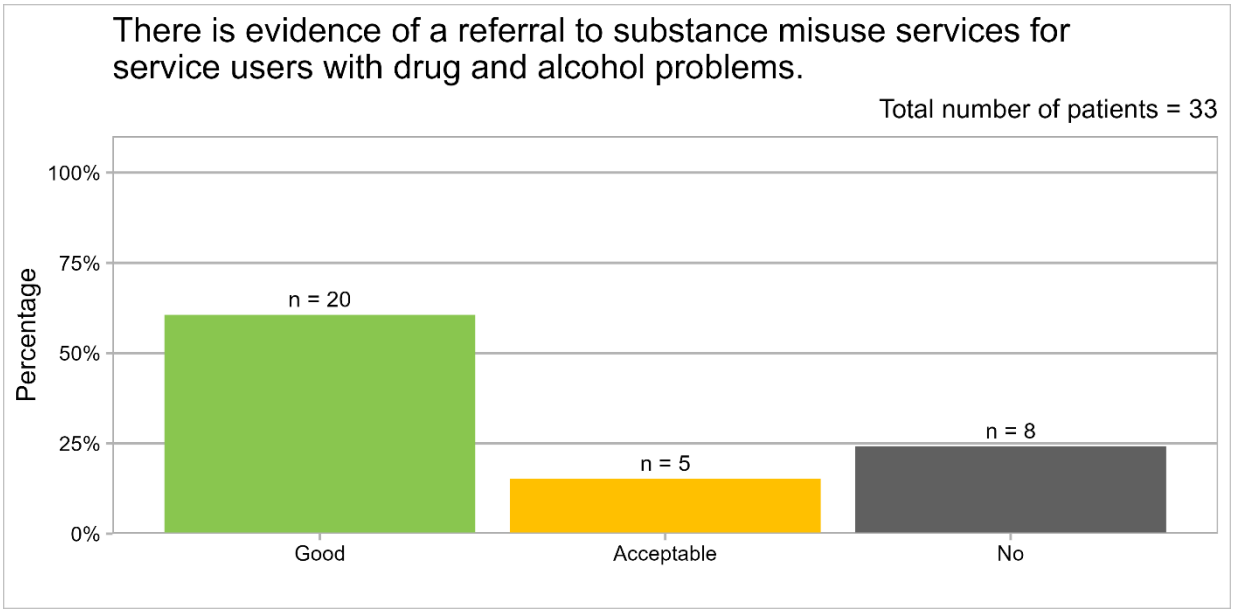


Chart 24 shows that there were good appropriate referrals to substance misuse services for service users with drug and alcohol problems for 59% of the service users and there was an acceptable referral for 15%. However, there was no evidence of referral for 26% of these service users. It is possible they were already known to substance misuse services, and thus that no new referral was required.

3.7 Medication compliance

Table 8: Audit results for the provider records: Medication compliance. Raw sample numbers used

Audit question	N/A	Good	Acceptable	No	Total (applicable)	Total
There is a plan in place to monitor medication compliance that has been agreed with the service user.	2	37	5	3	45	47
There is documented evidence regarding whether the plan is being adhered to.	2	36	4	5	45	47
The service user's mental state is assessed regularly.	0	38	8	1	47	47

Chart 25: % of records classified as 'good', 'acceptable' and 'no' for question 1 of the audit about medication compliance

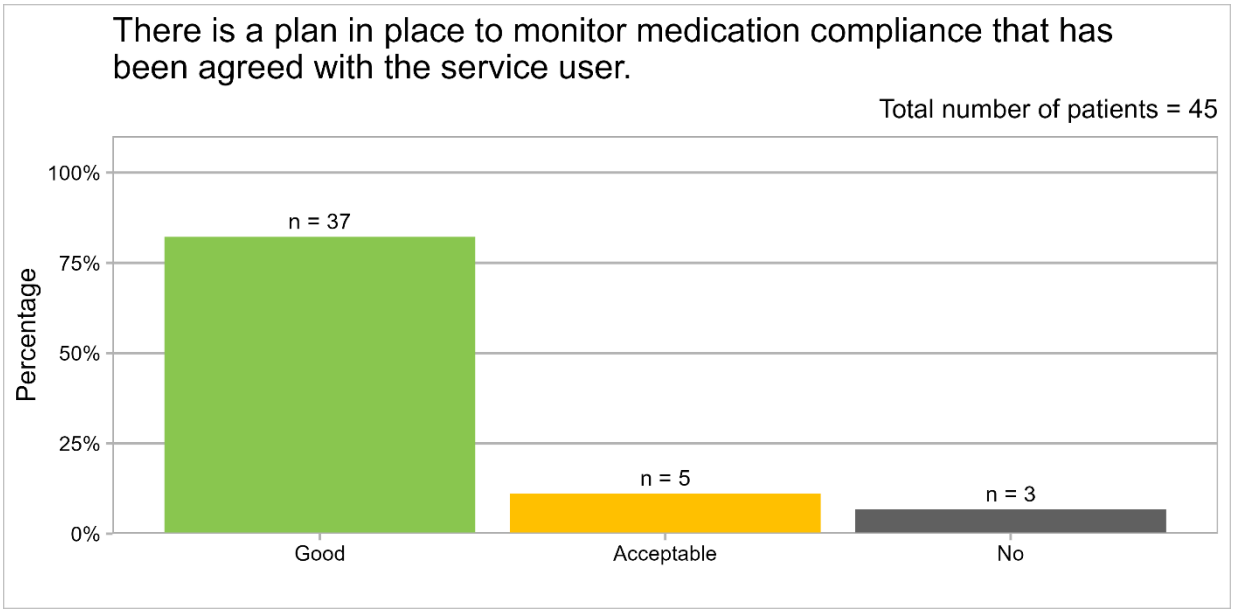
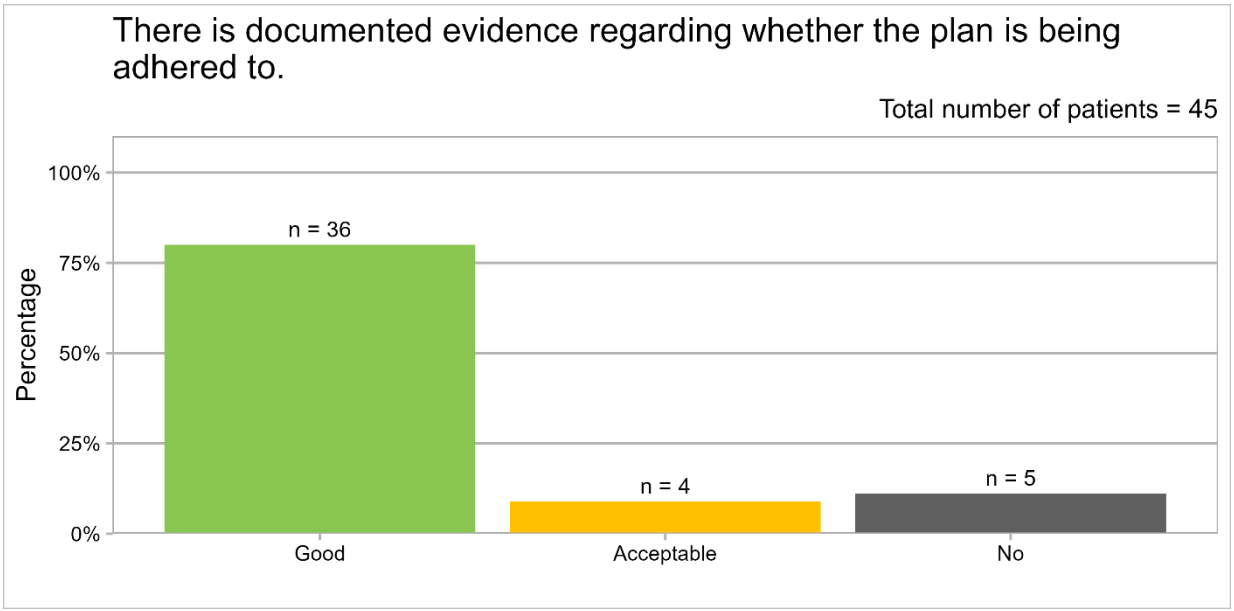


Chart 25 shows that medication compliance was monitored in line with a plan agreed with the service user to a good standard for 82% of cases 11% of service users had their medication compliance monitored to an acceptable standard. However, 7% of service users did not have their medication monitored in line with the plan agreed with them.

Chart 26: % of records classified as 'good', 'acceptable' and 'no' for question 2 of the audit about medication compliance



We audited Trust staff compliance in relation to the medication plan (as opposed to the service user's compliance). Chart 26 shows that where there was an agreed plan in place to monitor the service user's compliance with medication there was good adherence to it for 80% of cases. There was acceptable compliance with the plan for 9% of the service users. Agreed plans were not adhered to for 9% of service users.

Chart 27: % of records classified as 'good', 'acceptable' and 'no' for question 3 of the audit about medication compliance

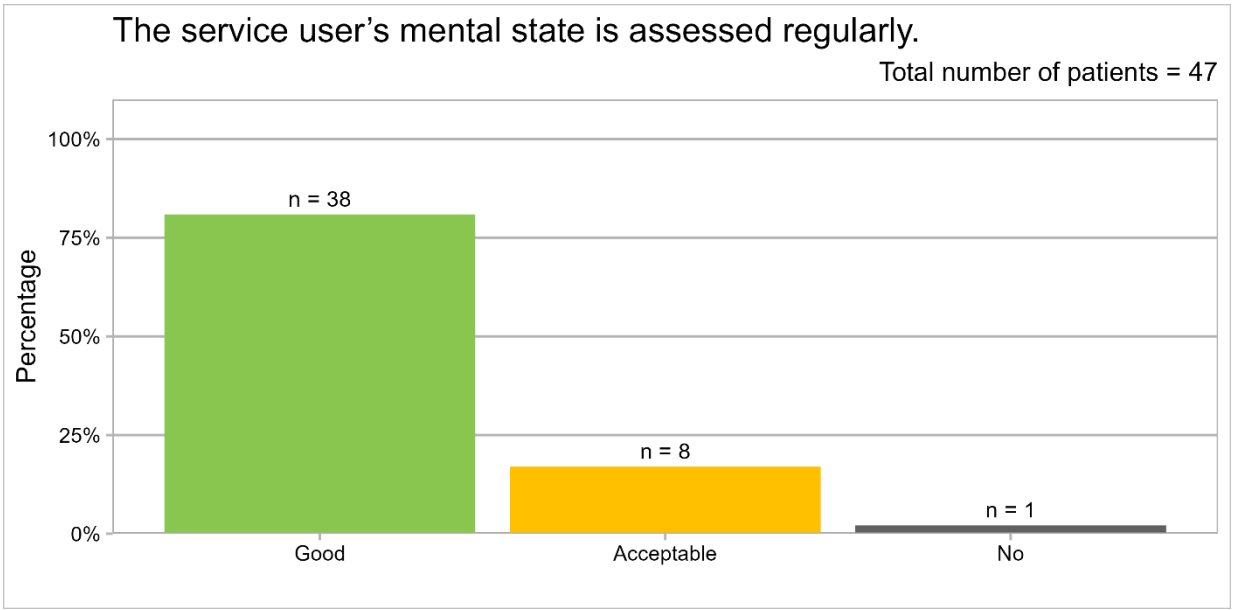


Chart 27 shows that 81% of records included mental state assessments which were completed to a good standard and 17% to an acceptable standard. 2% of service users did not have their mental state assessed regularly.

3.8 Record keeping

Table 9: Audit results for the provider records: Record keeping. Raw sample numbers used

Audit question	N/A	Good	Acceptable	No	Total (applicable)	Total
Where there is a treatment plan agreed with the service user, this is adhered to by the care team.	4	34	4	5	43	47
There is evidence that the treatment plan was communicated with the service user.	3	37	3	4	44	47
There is evidence that the care team has adhered to the treatment plan.	1	38	4	4	46	47
The care team has a consistent approach to documentation of the service user's clinical presentation.	2	34	9	2	45	47

Chart 28: % of records classified as 'good', 'acceptable' and 'no' for question 1 of the audit about record keeping

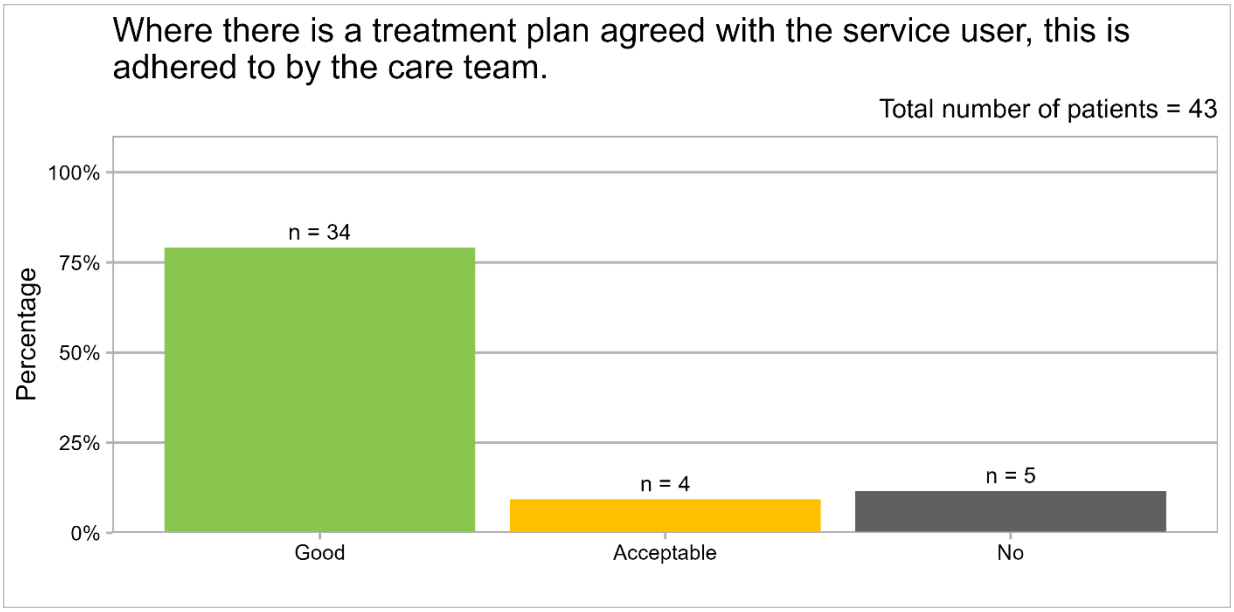


Chart 28 shows that 79% of the time agreed care plans were adhered to by the care team to a good standard and 10% to an acceptable standard. In 11% of cases the agreed care plan was not adhered to by the care team, for example, a plan for a face to face visit once a fortnight was not adhered to.

Chart 29: % of records classified as 'good', 'acceptable' and 'no' for question 2 of the audit about record keeping

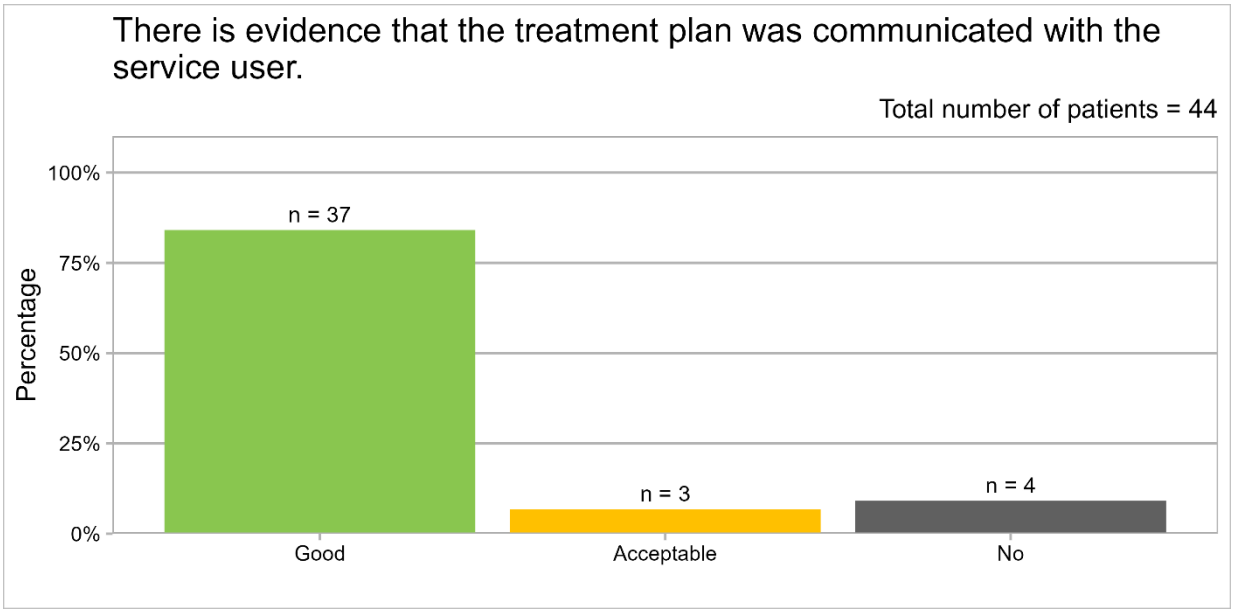


Chart 29 shows that for 84% of service users their care plan was communicated with them to a good standard and 7% to an acceptable standard. 9% of the service users did not have their care plan communicated with them by the care team.

Chart 30: % of records classified as 'good', 'acceptable' and 'no' for question 3 of the audit about record keeping

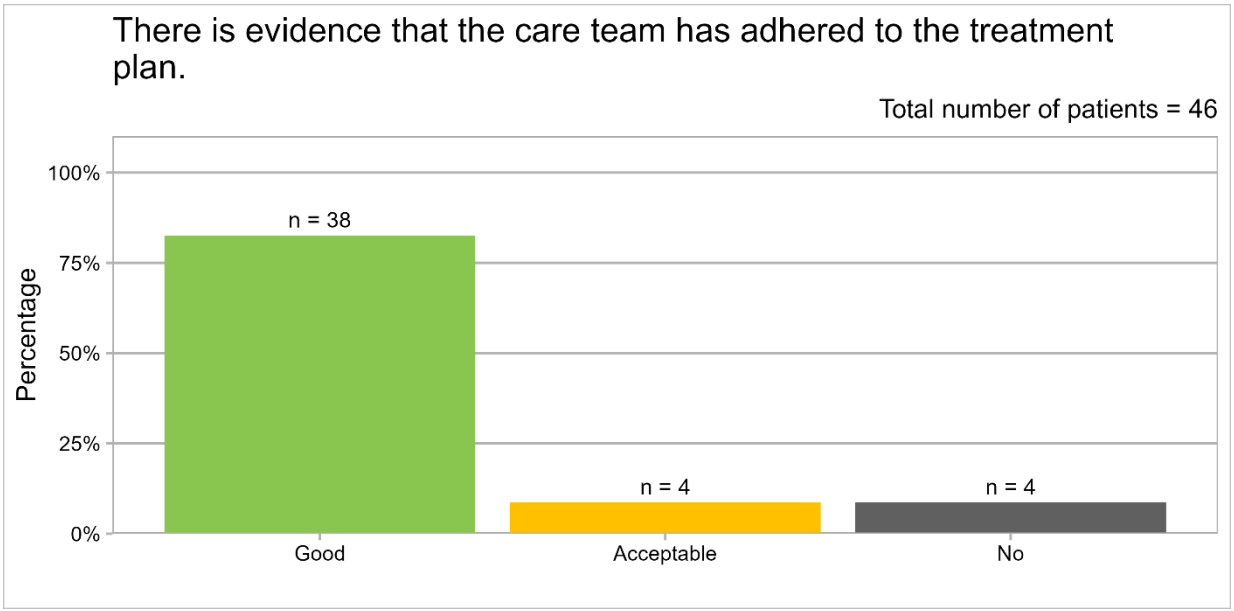


Chart 30 shows that for 83% of service users there was evidence that their day to day treatment plan was adhered to at a good standard by the care team and for 8% they were adhered to at an acceptable standard. 9% of service users did not have their agreed treatment plan adhered to by their care team, for example, in one case the patient was disengaging, and there was no clear treatment plan.

Chart 31: % of records classified as 'good', 'acceptable' and 'no' for question 4 of the audit about record keeping

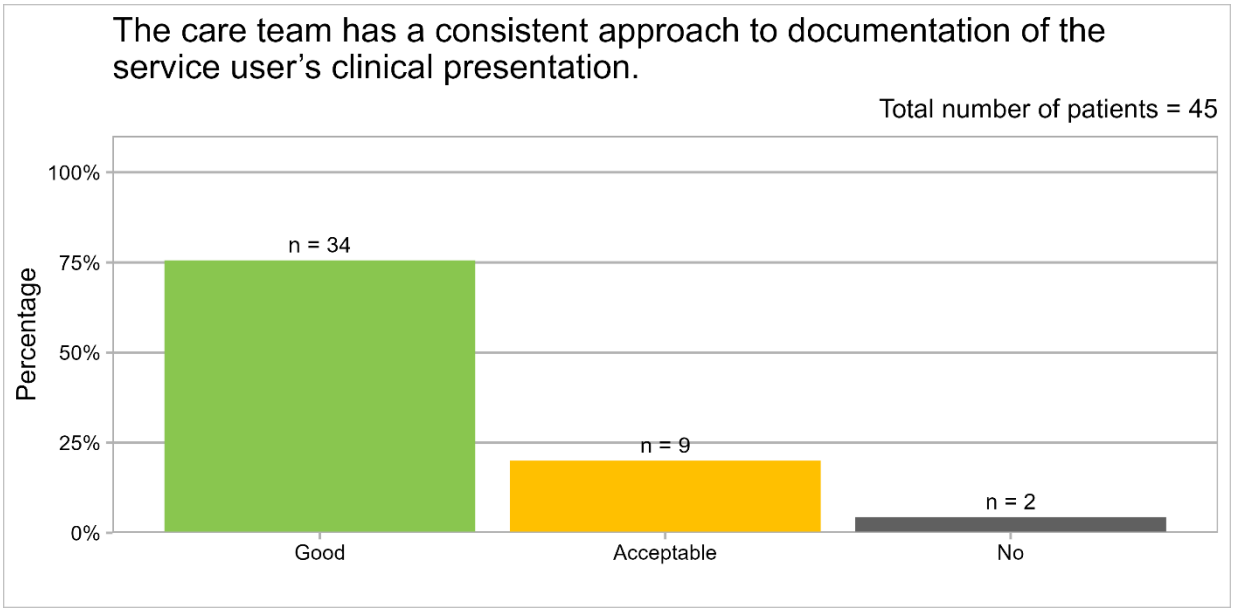


Chart 31 shows that in 75% of the clinical records audited there was a good consistent approach to the documentation of the service user's presentation. In 20% of the clinical records, it was acceptable. For 4% of the clinical records audited, the care team did not have a consistent approach to the documentation of the service user's presentation. Some examples of this are: there is no template for clozapine clinic entries, overuse of the word 'settled', and absence of comment on mood for a service user with a diagnosis of bipolar disorder.

4. Compliance with Trust Policies

When we designed the audit tool, we identified good and acceptable practice by considering the following Trust policies, along with national guidance and good practice.

Key issue being audited	Policy/national guidance/good practice
Management of service users detained under Section 3 Mental Health Act	Mental Health Act Policy
Use of Community Treatment Orders	Mental Health Act Policy
Care planning	Care Programme Approach and Care Support Policy
Risk assessment and management	Clinical Risk Assessment Policy
Family/carer involvement	Care Programme Approach and Care Support Policy
Evidence of interagency communication (including with a supported accommodation provider)	Care Programme Approach and Care Support Policy
Meeting the needs of service users with dual diagnosis	Dual Diagnosis Policy
Medication compliance	Medicines Code – policy and procedures
Record keeping	Care Programme Approach and Care Support Policy

Mental Health Act Policy

The Mental Health Act Policy references in detail the Mental Health Act Code of Practice and we tested compliance with this.

We established that 100% of the service users had their date of detention entered in the clinical record.

When a service user is detained under the Mental Health Act it is good practice for the care planning process to include decisions about rescinding or renewing MHA Sections. We found that 82% of the sample had been involved in planning for re-assessment or the rescinding of their Section at the time of the audit. We consider that was too early in the detention for the remaining 18% for this type of planning to have commenced. This was borne out by the finding that there had been a planned and assessed ending for 100% of the service users in the sample whose Section had ended.

Community Treatment Orders

Policy requirement: “Clearly, the patient does not have to explicitly agree to being placed on a CTO, however, for it to have a chance of being successful, the patient would need to understand what is being asked of them and would need to share the Responsible Clinician’s (RC) wish for the CTO to work.”

We found that in 100% of the service user CTO records audited, the service user had been involved in the development of the CTO, and it had been discussed and agreed with them.

Policy requirement: “The views of families, carers and others, if appropriate, should be considered when taking decisions, where decisions are taken which are contradictory to views expressed, professionals should explain the reasons for this.”

In 50% of the service user records audited we found good engagement with the family/carer about the use of a CTO and in 20% there was acceptable engagement. Whilst we acknowledge that the service user might not have wanted family/carer involvement in the development of their CTO in the remaining

30% of cases. The Trust might want to consider a more in-depth audit into the involvement of family/carers in the development of CTOs.

Policy requirement: There are two mandatory conditions that apply to all CTOs and an option for the RC to identify additional conditions. “There must, however, be necessary or appropriate help to ensure that the patient receives their treatment, prevent risk of harm to the patient’s health or safety or to protect other people.”

During the audit we considered if CTO conditions met this policy requirement. We determined that 93% of the CTOs we reviewed were either good or acceptable. However, with regard to the documentation of the CTO requirements, over 30% were not adequately documented.

In addition to this, CTO requirements must be capable of monitoring, and we concluded that the requirements of 95% of the CTO’s we reviewed were capable of good or acceptable monitoring, and that 93% were monitored to a good or acceptable standard.

Policy requirement: When a service user is subject to recall to hospital the MHA Code of Practice requires that the service user is made aware of their legal status and “the CTO3 should be given to the patient in person wherever possible, if this is not possible then served to the patient’s last known address.”

Of the service users in the audit subject to recall to hospital 67% were not informed of their legal status and 74% were not provided with a copy of the CTO3.

Learning Point One: In the sample we found, care teams were not always discussing the decision to recall service users subject to CTO with them. Once the recall process had commenced, there was little evidence of informing the service user about their legal status and sharing the CTO3 with them.

Medicines Code – policy and procedures for managing clinical risks associated with medicines

In Appendix 14 of the Code the issue of medication adherence/concordance compliance is addressed. This guidance is intended to assist clinical staff in adopting a consistent and collaborative approach with service users and provides a number of strategies to maximise compliance.

The reader is referred to *NICE clinical guideline 76 - medicines adherence, issued January 2009*.[3] It also references a medication management module.

There is a requirement for concerns about service users not taking their medication to be recorded on their clinical record by the care coordinator and for this to be discussed at handover.

Additionally, the care plan should be revised to address the issues of non-compliance.

This review found that 82% of the service user records audited contained a plan to monitor medication. And 80% of the service user records audited contained good evidence that plans to monitor medication were being followed by the care team.

Furthermore, there was evidence of conversations with service users about their medication regime.

Care Management and CPA/Care Support Policy

The Trust policy aims to reinforce an integrated approach across the Trust to provide systematic assessment processes and effective care planning for service users. It reflected the national guidance in place at the time it was ratified and affirms the Trust’s commitment to the care programme approach.

[3] Medicines Adherence: involving patients in decisions about prescribed medicines and supporting adherence. https://www.nice.org.uk/guidance/cg76/evidence/full-guideline-242062957

The policy identifies that, “All service users will have their needs and care plan reviewed as determined by their changing needs and changing circumstances. The minimum standard is at least annually unless clinical presentation, the service user and/or carers, or operational service standards recommend more frequent review periods.”

The audit completed identified that 42% of the service users did not have an up-to-date care plan in place. From this we surmise that a care plan review was not completed for these service users in line with policy expectations.

We consider care planning and the recording of care planning under the title of ‘Record Keeping’ in the audit. The intention was for us to consider the day-to-day care management plans that can be found in a service user’s clinical record.

We found that in 90% or more of the records there was evidence of a good or acceptable treatment plan agreed and communicated with the service user. This compliance needs to be reflected in the completion of CPA. Planning, where we found the rate of completion to be 42%.

The policy states that care coordinators should facilitate access and support for service users from other agencies, including housing providers. The audit looked for evidence of joint working between care coordinators and housing providers. In 88% of the clinical records reviewed we noted good or acceptable communication between the care coordinator and the housing provider.

Learning Point Two: In the sample there is no evidence that more than 50% of service users under the care of the assertive outreach service and FIRST have an up-to-date care plan.

Clinical Risk Assessment Policy

“The Trust Board recognises that risk assessment and management, including positive risk taking is an integral part of good clinical practice and, to be effective, should be part of the culture of the Trust.”

The policy identifies the key points on the patient pathway when risk assessment and documentation should be completed.

Clinical indicators:

- When mental state or risk management appears to be deteriorating and the concerns of staff about the safety of the service user increase.
- When mental state or risk is resolving, and the current risk assessment management plan is no longer appropriate.
- When there is a change in the service user’s circumstances pertinent to risk formulation such as loss of job, breakdown of a relationship, changes in the ability of carers to provide care.
- When concerns are expressed by family, friends, or carers, external partners, or the general public about the safety of the service user.

Service transition indicators:

- On referral or re-referral into BSMHFT services within seven days of the first appointment attended.
- Prior to transitioning or transferring to any other team by the referring clinician or team, and again within seven days by the receiving team.
- At initial contact by urgent care services within 24 hours.
- On admission to an inpatient unit by the named nurse or inpatient responsible clinician within 24 hours of admission, and within seven days following admission and at each CPA review thereafter.
- When prescribing leave for a sectioned patient.

- Prior to leave and prior to discharge for all service users in an inpatient unit when considering step down from CPA to care support.
- At the annual review.
- Discharge from the Trust.

There is a requirement to review a risk assessment and risk management plan a minimum of every 12 months when the CPA review is completed.

The audit found that:

- 21% of the sample did not have a current risk plan.
- 33% did not have a risk management plan.
- 17% did not have a crisis and relapse plan.
- 24% did not have their risk to others identified or a plan to manage it.

The policy identifies how families, friends and carers should be identified and given the opportunity to be involved in the management of risk. The policy explains that relationships can change rapidly, and careful consideration should be given when identifying relationships as protective. It states that, “There are specific tools that may help to identify certain risks: Domestic violence and Domestic Abuse, Stalking, Harassment and Honour Based Violence Assessment (DASH). Service users may also present risks to those living with them or providing care for them, there are intrinsic considerations of a holistic risk assessment.”

The audit determined that in 75% of the records reviewed, 25% contained information about concerns raised by family/carers. And 72% of the records contained information about the nature of the concerns.

We would consider the Trust policy expectations regarding the involvement of family/carers in risk assessment has been met. This is because not all families/carers will have concerns about risk.

Audit observations

During the audit we saw two sets of records where a risk to family members when the service user was unwell was identified. However, neither of these identified the steps that the family could take to keep themselves safe should the service user experience a relapse in their mental health.

When staff complete a risk review, they pull through the information from the previous assessment. If no additional risks or change in risk is identified, they are not required to make an entry in the assessment. This results in risk reviews that look like a date change for a historic risk assessment.

Learning Point Three: In the sample, the assertive outreach team and FIRST are not compliant with Trust policy expectations regarding risk assessment and management.

Learning Point Four: In the sample, staff can pull through information from previous risk assessments when completing a review. If there has been no new risk identified during the review period, they are not required to make an entry in the risk assessment. Therefore, it is difficult to determine if a risk review has been completed or if it is simply a change of date.

Dual Diagnosis Policy

The Trust policy sets out the process for ensuring that service users with a dual diagnosis have access to effective services that respond to their complex needs. The Trust supports the recommendations in NICE Guidance NG58.[4]

It is to be noted that there are clinicians on the assertive outreach team who have been trained to work with service users with a dual diagnosis, and service users can be seen within the team to address both their mental health and substance use concurrently. However, service users can and should be referred to local drug and alcohol services after an assessment of need has been completed.

The audit found that 59% of service users presenting with a substance misuse problem had a good referral to a substance misuse service, whilst 15% had an acceptable referral. Given that a service user must agree to a referral to substance misuse services we consider this to be an acceptable level of compliance.

Domestic Violence Policy

Both of the incidents that resulted in the commissioning of this audit involved domestic violence. It was not possible for us to audit the Trust compliance with this policy, but we would like to make some observations about what we observed in the clinical records audited. We would also like to comment on the policy.

The policy is well-written and comprehensive. However, the policy focus is on intimate relationships, and there is little in the policy about risk to family members, including parents. Consideration needs to be given to the advice and guidance provided to staff where a risk to family members is a relapse indicator for a service user. Staff must ensure in risk assessments that there are plans in place to manage and mitigate any increase in risk both to the service user and family members.

Please see the audit observations for the Risk Assessment and Management Policy

Learning Point Five: We were unable to identify a Trust process that allows the risk of domestic abuse to be easily identifiable in the service user's clinical record.

Learning Point Six: We were unable to identify a clear process for developing 'keeping safe' plans for family members who may be at risk of domestic abuse.

Family and carer

The Care Act 2014 stipulates that identified carers have a right to an assessment of their needs. This is recognised in the Family and Carer Strategy 2019-2022.

This strategy describes the carer engagement tool which includes:

- Considering level of involvement.
- The care plan and risk assessment.
- Sharing of information.
- Signposting to support services and statutory carers assessment, if appropriate.

This should be reviewed a minimum of every 12 months.

The audit found that there was no evidence in 52% of the clinical records reviewed that the identified carer had been offered or completed a carer engagement tool.

[4] Coexisting severe mental illness and substance misuse: community health and social care services. https://www.nice.org.uk/guidance/ng58

Audit observation

During the audit we were told that the FIRST service acknowledged that the level of carer support and involvement in the service required improvement. To address this a 12-month temporary post has been created to promote carer support and involvement. We would expect that any evaluation of this temporary arrangement would use the offer/completion of the carer engagement tool as a key performance indicator.

Learning Point Seven: There is no evidence that 48% of carers were offered the opportunity to complete a carer engagement tool.

5. Quality and governance

The terms of reference required us to review the present-day service provision governance and quality systems, arrangements for identifying and escalating risks and opportunities for improving the quality of services.

There is a clear quality governance structure in place, from service level to the Trust Board, via the local and Trust-wide clinical governance committees (CGCs), reporting through to the integrated quality committee. We have seen evidence of recovery and secure care heads of nursing attending the Trust-wide CGC to represent their respective services, with detailed updates shown in the minutes reviewed. The CGC undertakes quarterly deep dives into areas of concern, as identified in the quality dashboard (a recent example in October being long-term seclusion). Feedback from the Trust-wide CGC is, in turn, provided back through the structure. These elements are all reflective of good practice.

We understand that this structure was reviewed in 2020 with various recommendations made relating to the CGCs, including the clarity of their workplans and contribution from medical staff. Workplans are now in place, although these are at a high level and relate to standing items only. It would be helpful to develop these to a more granular level of detail, including:

- subgroups are identified in their terms of reference, but these do not appear to report formally to the CGCs as per their current workplans, and
- quality improvement is referenced at length in terms of reference, but it is not clear how this is reported from the current work plans. There is an opportunity to be more prescriptive about this to ensure that the committees maintain a consistent focus in this area.

We were told that the structure and process for risk registers and their application are provided by the Trust centrally, and there had been discussions about working towards the risk register becoming a more dynamic process. There were some risks logged which were ongoing clinical issues rather than service risks, for example risk of serious self-harm by service users in the women's service.

At a service level, we have identified various elements of good practice. For example, the update from the Trust wide CGC to ensure a continuous feedback loop, open serious incident actions are discussed, audits are presented, and team managers can present their concerns and matters to escalate directly to the committees.

We have also identified the following areas to consider in terms of further improvement:

- While team managers do provide reports into their local CGC these are very high level. For example, some team managers' reports into the October 2022 Recovery CGC, reported just 'one death', 'some disagreements within the partnerships' with no sense of context or actions given and little additional detail in the minutes recorded.
- Some risks, particularly those which are not scored highly (or red rated) are only reviewed on a quarterly basis. There is insufficient detail on the risk register relating to the gaps in assurance (e.g., one entry just says 'managed through governance'). Articulating risks using the formula 'due to x, there is a risk that y, the impact of which is z' can be a helpful way of understanding the source and impact of a risk more clearly. We understand that discussions have started to use the risk register as a more active management tool.
- While some terms of reference include experts by experience in their membership, we have seen no evidence of this in the minutes reviewed, and we were advised in discussions that the CGC relies on secondary sources of evidence from service users. The terms of reference aspire to "ensuring that patients are at the heart of everything we do", but it was not clear how this was incorporated into the work of the CGC.

6. Conclusions

"If a service user accessed services today with a similar history/problem – what would change/be different?"

The learning points and audit results listed below relate to findings from the audit and from our review of policies. We would expect consideration of our findings to feed into future governance and policy processes, and have included an action plan template to assist with this.

Acceptable practice – what would be different:

- No MHA detentions were found to have been allowed to lapse.
- Where service users were detained under a CTO there was evidence in all cases that they had been involved in the development and discussion about their CTO.
- Conditions of the CTO were relevant to the individual service user and not generic. The conditions were also capable of being monitored.
- Where a service user was under CTO there was evidence of a discussion taking place on a regular basis about this.
- In the majority of cases the service user's mental state was regularly assessed.

Below acceptable practice

- The number of service users without an up-to-date CPA care plan.
- The number of service users without an up-to-date risk assessment.
- The number of service users without a risk management plan or with one which did not reflect their current circumstances and mental state. There was evidence that the date on the risk management plan had simply been changed.
- The number of service users without a crisis and relapse plan.
- It was difficult to find information about carers and carers' assessments.
- Staff adherence to medication plans was not 100%.

Learning points

Learning Point One: In the sample we found, care teams were not always discussing the decision to recall service users subject to CTO with them. Once the recall process had commenced, there was little evidence of informing the service user about their legal status and sharing the CTO3 with them.

Learning Point Two: In the sample there is no evidence that more than 50% of service users under the care of the assertive outreach service and FIRST have an up-to-date care plan.

Learning Point Three: In the sample, the assertive outreach team and FIRST are not compliant with Trust policy expectations regarding risk assessment and management.

Learning Point Four: In the sample, staff can pull through information from previous risk assessments when completing a review. If there has been no new risk identified during the review period, they are not required to make an entry in the risk assessment. Therefore, it is difficult to determine if a risk review has been completed or if it is simply a change of date.

Learning Point Five: We were unable to identify a Trust process that allows the risk of domestic abuse to be easily identifiable in the service user's clinical record.

Learning Point Six: We were unable to identify a clear process for developing 'keeping safe' plans for family members who may be at risk of domestic abuse.

Learning Point Seven: There is no evidence that 48% of carers were offered the opportunity to complete a carer engagement tool.

7. Action plan

Learning Point	Recommendation	Action	Responsible	Timeframe
Learning Point One: In the sample we found, care teams were not always discussing the decision to recall service users subject to CTO with them.	Add to the current CTO audit additional questions which look at CTO discussions taking place.	To add the question," Is *there evidence of the care team discussing the CTO recall if not is there evidence as to why they did not discuss* it?"	Head of MHA legislation	Complete
Once the recall process had commenced, there was little evidence of informing the service user about their legal status and sharing the CTO3 with them.	To continue with the monthly inpatient MHA audit which looks at patients being read their rights which is fed back through the local clinical governance committee with an appropriate action plan this is to be shared with the Trust wide governance committee.	To continue with the current audit.	Service area matron	On going monthly audit
Learning Point Two: In the sample there is no evidence that more than 50% of service users under the care of the assertive outreach service and FIRST have an up-to-date care plan.	Continue the current monthly care plan audit in place completed by the matron and fed back through local clinical governance committee.	To continue with the monthly audits which are fed back through CGC	Service area matron	On going monthly audit
Learning Point Three: In the sample, the assertive outreach team and FIRST are not compliant with Trust policy expectations regarding risk assessment and management.	To establish a Quality Improvement project to understand the issues surrounding the development and completion of risk assessments.	To identify an Executive sponsor and group members. Establish a methodology for the QI project and performance indicators.	Assertive Outreach Team Clinical Director	First meeting planned for July 2023
Learning Point Four: In the sample, staff can pull through information from previous risk assessments when completing a review. If there has been no new risk identified during the review period, they are not required to make an entry in the risk assessment. Therefore, it is difficult to determine if a risk review has been completed or if it is simply a change of date.	To review the Clinical Risk Assessment Management training. To ensure that there is clear guidance about what should and should not be included in a risk assessment.	A sample of a good, updated risk assessment will be included as part of the training and accessible as part of post course literature	Lead for Clinical Risk Training with the support of the Head of Patient Safety	July 2023

Learning Point	Recommendation	Action	Responsible	Timeframe
Learning Point Five: We were unable to identify a Trust process that allows the risk of domestic abuse to be easily identifiable in the service user's clinical record.	The Domestic Violence policy will include explicit guidance on the documentation of domestic abuse in the existing documents on RiO. To support this further we will incorporate it into our clinical system RiO training and Clinical Risk Assessment training too.	Policy to be approved which includes the guidance, together with assurance and monitoring timeframes RIO training to specify the purpose of each form	Lead for Domestic Violence Head of Patient Safety	August 2023
Learning Point Six: We were unable to identify a clear process for developing 'keeping safe' plans for family members who may be at risk of domestic abuse.	As per learning point 4 and 5 we will review our Clinical Risk Assessment Management training.	Good evidence would include Risk to others is clearly identified in the risk assessment, and the risk plan identifies how these risks will be managed. There is evidence that this risk assessment and risk plan have been shared with any individuals who are identified as being at risk. Acceptable evidence: The risks to others are evident within the care record and there is a plan to manage/mitigate risk This be considered as part of the training.	Lead for Clinical Risk Training with the support of the Head of Patient Safety	July 2023
Learning Point Seven: There is no evidence that 48% of carers were offered the opportunity to complete a carer engagement tool.	As an immediate response the service areas it is recommended that the service areas have a bespoke carers engagement session In addition, the carers engagement tool will be reviewed by the Family Engagement service. Following on from the work undertaken by the home treatment team we will look to see how the improvement work can be shared across the organisation.	Sessions organised with the teams There is a review of the engagement tool taking place on 23rd June 2023	Family engagement lead	September 2023 June 2023

Appendix One: Glossary

GLOSSARY	
BSMHFT	Birmingham and Solihull Mental Health NHS Foundation Trust
CGC	Clinical governance committee
CPA	Care Programme Approach
CTO	Community Treatment Order
DASH	Domestic Abuse, Stalking, Harassment and Honour Based Violence Assessment
DHR	Domestic Homicide Review
FIRST	Forensic Intensive Recovery Support Team
MHA	Mental Health Act
NHSE	NHS England
NICE	The National Institute for Health and Care Excellence
RC	Responsible clinician
RiO	Electronic clinical record system

Appendix Two: Audit template

Mental Health Act			
Key issue being audited		**Good evidence**	**Acceptable evidence**
1. Management of service users detained under Section 3 Mental Health Act (MHA)			
1.1	Date of detention.	Clearly visible in the clinical notes, e.g., on the opening page or on the service user demographic page.	Date of detention is elsewhere in the service users records, e.g., ward round notes or CPA.
1.2	The care team is planning for re-assessment or rescinding the section throughout the service users admission.	Evidence that the re-assessment date is discussed in multi-disciplinary team/CPA meetings/ward rounds and is being planned for.	References are made to the need for a re-assessment in relation to possible rescinding of the Section.
1.3	Where a Section has ended there is evidence that this was an assessed and planned decision.	Evidence that the re-assessment date is discussed in multi-disciplinary team/CPA meetings/ward rounds and is being planned for.	References are made to the need for a re-assessment in relation to possible rescinding of the Section.
1.4	Where a Section has lapsed the care team has taken immediate action to assess the service user.	Evidence the service user has been advised of a lapse of the Section (and their legal adviser if they are identified). Evidence this has been discussed with the multi-disciplinary team, service user and carer. Evidence that a further assessment was completed to determine if the service user required detention under the MHA.	Evidence that the service user has been advised that the Section has lapsed. Evidence of a mental state examination and assessment being completed once the lapse has been identified.
2. Use of Community Treatment Orders (CTO)			
2.1	The CTO is developed, discussed, and agreed with the service user.	Detailed discussions about CTO in ward rounds and meetings with the Responsible Clinician, care coordinator and service user are documented.	There is evidence that a discussion took place with the service user regarding the CTO.

2.2	When developing the CTO there are discussions with the family, carers, and others in line with the Trust Mental Health Act Policy and the Code of Practice.	Discussions about the CTO with family, carers and others are fully documented in the service users clinical record. Where decisions taken are contrary to the wishes of the family, carer, or others this is explained to them and there is a record of this in the clinical record.	There is evidence in the clinical record of discussions with the family, carer, and others about the CTO.
2.3	The required conditions of the CTO are clearly documented.	There is a copy of the CTO in the clinical record. The conditions of the CTO are reflected in the care plan.	Conditions of the CTO are clearly documented in the clinical records and in a care plan
2.4	a. The requirements of the CTO are in keeping with legal requirements and the service users identified needs and are not generic in nature. b. The licence requirements are capable of being monitored.	a. There is documented evidence which identify the reasoning behind the selected requirements. b. The licence requirements are described in a detailed way which enables them to be monitored.	
2.5	The requirements of the CTO are monitored and discussed with the service user on a regular basis.	There is a record of the discussion with the service user in their notes and the reader can see the outcome.	There is a record of the discussion with the service user, but it lacks detail
2.6	When a service user has been recalled to hospital, they are: a. Correctly informed about their legal status. b. Given a copy of the CTO3.	a. Evidence of a discussion with the service user about the recall and their legal status and rights once admitted. b. Evidence that the service user has been given a copy of the CTO3.	

Care planning and management of risk			
Key issue being audited		**Good evidence**	**Acceptable evidence**
3. Care planning – compliance with the policy			
3.1	There is an up-to-date CPA care plan in the patient records.	The CPA care plan reflects the service user areas of need documented in the records. There is evidence of all of: • regular review • service user involvement in development and review of the care plan • carer involvement in CPA development and CPA review • multi-agency involvement in the development and review of CPA • a copy of the CPA being shared with the service user, carer, and other agencies	There is an up-to-date care plan in place. There is evidence that it was shared with the service user, carer, and other agencies.
4. Risk assessment and management			
4.1	There is a current risk assessment in the case notes.	There is an up-to-date risk assessment detailing triggers, relapse indicators and early warning signs, completed in the agreed Trust risk template.	In the clinical record there is a narrative risk formulation, detailing triggers, relapse indicators and early warning signs.
4.2	There is a current management plan in the case notes	There is a risk management plan completed in the agreed Trust template that clearly articulates how identified risk will be managed.	In the clinical record there is a narrative risk management plan that articulates how the identified risk will be managed.
4.3	There is a current crisis and relapse plan in the case notes.	There is an up-to-date crisis and relapse plan which details the actions to be taken in the evident of the service user experiencing relapse indicators or going into crisis.	There is no plan but there is documented evidence of discussions with the service user and/or carer about the actions to be taken in the evident of relapse or crisis.

4.4	There is evidence that, where there is a risk to others, especially where the carer is identified as having their own vulnerabilities, this has been assessed and is documented in the risk plan. This would include consideration of domestic abuse issues.	Risks to others are clearly identified in the risk assessment, and the risk plan identifies how these risks will be managed. There is evidence that this risk assessment and plan have been shared with any individuals who are identified as being at risk.	The risks to others are evident within the care record and there is a plan to manage/mitigate the identified risk.
5. Family and/or carer involvement			
5.1	There is evidence that staff have checked whether a. A carers' assessment has been completed in the last year or b. There is evidence of family members/carers being made aware they are entitled to a carers' assessment.	The records refer to carers' assessments and demonstrate that staff have either checked whether one has been conducted in the last year or made carers aware that they can have an assessment undertaken.	There is evidence that staff have considered the carers' needs.
5.2	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 clinical record. If carers have no concerns this is documented.	There is a record of communication from family members about their contact with the service and a summary of any concerns raised.
5.3	There is evidence of family/carer concerns being taken into consideration in managing risk.	The risk management plan, completed in the agreed Trust format, identifies concerns and risks raised by the family and what actions will be taken to manage these concerns/risks.	There is a narrative in the clinical record about how family concerns/identified risks will be managed.

6. Evidence of interagency communication (including supported housing provider)			
6.1	Where the service user is living in supported accommodation there is clear evidence of joint working with the accommodation provider.	The care plan identifies the responsibilities of the care team and the supported housing with regard to the monitoring of all of the individual's behaviour, mental state, and compliance with medication.	There is evidence of joint planning and the sharing of information.
6.2	Where the service user is living in supported accommodation there is evidence of the Trust care team being responsive to any concerns they raise.	There is evidence of an agreement between the care team and the supported housing team about how concerns about the individual will be reported and responded to. When concerns are raised by housing they are acted on.	When concerns are raised by housing, they are acted on
6.3	Where the service user is under the supervision of criminal justice services there is evidence of information sharing between the services.	There is evidence of contact between the Trust care team and criminal justice services. The main contact for criminal justice services is clearly identified, along with their contact details in the clinical record.	There is evidence of contact between the Trust care team and criminal justice services.
7. Meeting the needs of service users with dual diagnosis			
7.1	There is evidence of a referral to substance misuse services for service users with drug and alcohol problems.	Individuals who are identified as having alcohol and/or substance misuse problems are provided with information about substance misuse services.	Consideration has been given to whether the individual may have dual diagnosis. The assessment process explored use of alcohol and substances.
8. Medication compliance			
8.1	There is a plan in place to monitor medication compliance that has been agreed with the service user.	There is evidence that the service user has been involved in the plan to monitor their compliance with medication. There is evidence that the patient has been provided with information about their prescribed medication.	There is a plan as to how medication compliance will be monitored.

8.2	There is documented evidence regarding whether the plan is being adhered to.	There is a record of the monitoring of the service users medication compliance against the plan.	There is a record of the monitoring of the service users medication compliance, without a reference to the detailed plan.
8.3	The service user mental state is assessed regularly.	There is evidence that the service users mental state is regularly assessed in a standardised manner by: • the care coordinator, and • at medical review	The service user mental state is regularly assessed by the team, and this is recorded in the clinical notes in a standardised manner.
9. Record keeping			
9.1	Where there is a treatment plan agreed with the service user, this is adhered to by the care team.	Treatment plans reflect discussion with the service user and are completed in the agreed Trust or team format.	There is a treatment plan available in the clinical record.
9.2	There is evidence that the treatment plan was communicated with the service user	There is evidence that a discussion has taken place with the service user about their treatment plan and their views are documented.	There is evidence in the clinical record of a discussion of the treatment plan with the service user.
9.3	There is evidence that the care team has adhered to the treatment plan.	There is a record in the clinical notes of the treatment provided referenced against the requirements of the treatment plan.	There is a record in the clinical notes of the treatment provided in the clinical record.
9.4	The care team has a consistent approach to documentation of the service user's clinical presentation.	There are detailed entries which illustrate the service users clinical presentation at that time.	Some details are documented which illustrate the service users clinical presentation at that time.

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