Review of compliance

South West Yorkshire Partnership NHS Foundation Trust Fieldhead Hospital	
Region:	Yorkshire & Humberside
Location address:	Ouchthorpe Lane Wakefield West Yorkshire WF1 3SP
Type of service:	Community healthcare service Hospice services Community based services for people with a learning disability Long term conditions services Community based services for people with mental health needs Hospital services for people with mental health needs, learning disabilities and problems with substance misuse

	Rehabilitation services Community based services for people who misuse substances
Date of Publication:	April 2012
Overview of the service:	Fieldhead is a hospital site that delivers in-patient and specialist services and is owned by South West Yorkshire Partnership NHS Foundation Trust. The Trust also provides community, services to people in Barnsley, Calderdale, Kirklees and Wakefield. The Kirklees Intensive Home Based Treatment (IHBT) team is based in Huddersfield and provides rapid and intensive interventions as close to home as possible, for individuals experiencing acute, severe mental health difficulties across Kirklees.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

Fieldhead Hospital was not meeting one or more essential standards. Improvements are needed.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review because concerns were identified in relation to:

Outcome 01 - Respecting and involving people who use services
Outcome 04 - Care and welfare of people who use services
Outcome 06 - Cooperating with other providers
Outcome 14 - Supporting staff
Outcome 16 - Assessing and monitoring the quality of service provision

How we carried out this review

We reviewed all the information we hold about this provider and carried out a visit on 6 January 2012.

What people told us

Within this report CQC refer to the term 'perinatal metal health problems.' Perinatal Psychiatry includes not only postnatal mental illness such as post natal depression, but also the problems faced by women with pre-existing mental health problems who become pregnant. It includes the effects of the mental illness and their treatment on the unborn and developing child.

Because of the nature of the Intensive Home Based Treatment service, we were unable to speak directly with people who use the service.

We carried out our visit on 6 January 2012 to look at progress that has been made following recommendations that were made from an independent review of perinatal services within Kirklees. The review was instigated after the unexpected death of a person with post natal depression who was using the service. Our inspection team included a specialist practitioner who is a consultant psychiatrist with expertise in treating people with perinatal mood disorders. The specialist practitioner did not visit the Trust but held a telephone conference with key personnel from The Trust.

What we found about the standards we reviewed and how well Fieldhead Hospital was meeting them

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

People using the service are provided with appropriate information to help them to understand the care, treatment and support choices available to them. Their views are taken into account in the way the service is provided and delivered.

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

Overall people receive care, treatment and support that meets their needs.

Because of the lack of information within some care records, it was unclear whether the person's relatives had been involved in and agreed with the care being provided.

Individual care records need to be clearer and more specific in saying at which point a person's presentation would indicate a need for their care to be reviewed so that prompt actions can be taken to prevent further relapse and distress for the individual.

We have minor concerns with this outcome area and an improvement plan is requested to show how compliance will be maintained.

Outcome 06: People should get safe and coordinated care when they move between different services

The care pathway information lacks detail about previous and potential risks to the mother, child and others as a result of the person's illness, and actions to be taken where risks are identified. Because of this referrals may not be made to the appropriate agencies so that measures can be taken to safeguard people from possible harm.

We have minor concerns with this outcome area and an improvement plan is requested to show how compliance will be maintained.

Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Because the planned training in relation to perinatal mental health disorders is insufficient and is being delivered by trainers who lack expertise in this area of work, there are risks that the Trust's staff will not be sufficiently equipped to safely meet the needs of this specific service user group.

We have moderate concerns with this outcome area and a compliance action has been made to ensure that compliance with this outcome is achieved.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Overall, patients benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

Actions we have asked the service to take

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 01:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Understand the care, treatment and support choices available to them.
* Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
* Have their privacy, dignity and independence respected.
* Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement

The provider is compliant with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
Because of the nature of the Intensive Home Based Treatment service, we were unable to speak directly with people who use the service.

Other evidence
The independent review team made recommendations that the Intensive Home Based Treatment (IHBT) team need to provide more written information to people who use their service and their carers. They identified that this information should include information about the role and aims of the IHBT. It was also recommended that staff from the IHBT document clearly that they have had discussions with the person using the service about whether the IHBT or hospital is best placed to meet the person's needs at that specific time. The rationale for the decisions made also needed to be recorded. The investigation found there was a lack of written evidence to show that staff held discussions and gave explanations to people using the service about any changes to their medication.

When CQC visited we found that referrals are made to the Intensive Home Based Treatment (IHBT) team via the Single Point of Access (SPA) service or through internal sources such as in-patient services or Community Mental Health Teams (CMHTs). A practitioner from the team will then carry out an assessment of the person's needs in

the most suitable location. This is to gather more information about the crisis the person is experiencing. At the end of this assessment the practitioner talks to the person and/or their relative (with the person's permission) to discuss and agree a plan of care. The plan of care may lead to involvement from the IHBT but could alternatively result in referral to another suitable service or admission into hospital.

When people are referred to the IHBT they are given an information leaflet about the purpose of the service and the staff team. Carers' are also provided with a leaflet that tells them what to expect from the team. Other useful contact numbers are included within this information so that carers can also access support through other services.

People who use the service and their carers are provided with details about customer services and what to do if they want to make any comments or raise any concerns or complaints about the trust's services. This information is also available in other formats such as Braille, large print, audio and in other languages.

The IHBT hold electronic records on each referral to their service. We looked at a sample of these records and found that staff had recorded when they had given written information to the person using the service and their carer. Assessments were thorough and identified peoples' individual needs and any risks associated with this.

We saw evidence that staff had involved people in decision making about their care, treatment and support. For example, one person had been identified as being at risk of overdosing on medication. The records showed that the IHBT practitioner had discussed these risks with the person, especially about the person keeping all their prescribed medication at their home. As a result of this the person and practitioner came to a joint agreement that IHBT would deliver and administer the medication in the interim period until any risks of harm to the person were minimised.

There was also written evidence that staff had actively engaged people in decision-making about whether home treatment or hospital was the most suitable place to receive the care, support and treatment needed. Staff documented the agreed decision and the reasons for this. Where risk assessments identified unacceptable levels of risk, people were admitted into an in-patient facility for their own health and safety.

Information leaflets are going to be provided to people using the service and carers about post natal depression, to give people a better understanding of the illness and care, treatment and support

The IHBT provide a service between 8am and 10.30pm. People are also given contact details if they require support out of hours via the SPA team.

Our judgement
People using the service are provided with appropriate information to help them to understand the care, treatment and support choices available to them. Their views are taken into account in the way the service is provided and delivered.

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

There are minor concerns with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
Because of the nature of the Intensive Home Based Treatment service, we were unable to speak directly with people who use the service.

Other evidence
The independent review team found that care records lacked written evidence to show that people who use the service and carers were fully involved in decision making about their care. There was also little information about the carer's role in the care plan and their ability or willingness to provide this. The investigation team said that it was also unclear from peoples' care records, as to at which stage of a person's relapse is there a need for a review of their care. Risk assessment tools did not include any risks to women either before, during or after pregnancy, including known risk factors relating to suicide.

We looked at the electronic care records of three people who use the service. The care records are well organised, informative and easy to follow. Each person's needs had been assessed and care plans detailed how the person's assessed needs were to be met by staff. We were told that within the first 72 hours of a person's referral to the service, at least two visits will be made to see the person. This helps in determining the level of input and type of support the person requires. If a decision is taken for the IHBT to work with the person, then an individual care plan is developed at this stage.

A number of assessments are in place to assess any risks to the person or others. Where potential risk had been identified, a management plan was in place to minimise

the possible risks from occurring. The risk assessment tools currently used by IBHT contain little reference to pregnant women who may be specifically at risk from developing mental illness (see outcome 6).

Every input from a member of the IHBT is recorded within the progress notes in the person's care records. These were informative and up to date. Progress notes include records from clinical review meetings. They also refer to comments made by the person using the service. The records showed how decisions had been made although it was not always clear whether the person using the service was in agreement with the decisions made.

In one person's care records we saw that the person's family have a lot of involvement with the person receiving the service. However, there is a lack of evidence within the records to show how they are involved in supporting the care plan. This was discussed with a member of staff who has involvement in the case. They explained that the family had not been willing to support the care plan and this had made it difficult to effectively engage with the person using service. This needed to be recorded to evidence that attempts had been made to involve the family, even though these attempts had been unsuccessful.

We saw evidence that the team works proactively to support people in a person centred way. For example, one person was suffering distress from a recent bereavement and this put the person at increased risk from self-harm. Staff had accompanied the person to attend their relative's funeral and had carried out intensive follow-up work. Counselling had been organised for the person and staff had supported them to engage with community support groups.

Clinical reviews are regularly held between multi-disciplinary team members. This enables discussion to take place about peoples' progress and any concerns so that staffing resources can be prioritised.

Staff told us that the team ask for an up to date care plan to be provided with any person who is referred to the service. Within the care plan there is information about individual risks to the person and others. There is also detail about relapse signs that may indicate the person is becoming unwell, and contingency plans if this was to happen. These were clearly set out and easy to follow. However, it was not fully clear from people's individual records as to at which point a review is triggered due to increased levels of risk and concern.

The specialist practitioner who formed part of our inspection team held discussions via a telephone conference with senior members and clinicians from the Trust. Some of these people were members of the Kirklees perinatal group that was set up to look at ways of improving perinatal mental health services within the Trust.

We were informed that the trust is intending to develop additional assessment tools that are more detailed in assessing risks specifically relating to women experiencing mental health problems during the perinatal period. When we asked about the specific details of these assessment tools, it became clear that the Trust was planning to make adaptations to existing tools for its own use. There are potential legal implications from using this approach and the trust members were signposted as to which other avenues they could explore for advice.

Our judgement
Overall people receive care, treatment and support that meets their needs.

Because of the lack of information within some care records, it was unclear whether the person's relatives had been involved in and agreed with the care being provided.

Individual care records need to be clearer and more specific in saying at which point a person's presentation would indicate a need for their care to be reviewed so that prompt actions can be taken to prevent further relapse and distress for the individual.

We have minor concerns with this outcome area and an improvement plan is requested to show how compliance will be maintained.

Outcome 06:
Cooperating with other providers

What the outcome says

This is what people who use services should expect.

People who use services:
* Receive safe and coordinated care, treatment and support where more than one provider is involved, or they are moved between services.

What we found

Our judgement

There are minor concerns with Outcome 06: Cooperating with other providers

Our findings

What people who use the service experienced and told us
Because of the nature of the Intensive Home Based Treatment service, we were unable to speak directly with people who use the service.

Other evidence
The serious incident review findings highlighted the need for the IHBT team to have better communications with GPs' and for the Trust to develop perinatal care pathways so that people are referred to and receive care and treatment from the most appropriate service, and there is a clear pathway in and out of the service.

When we looked at peoples' care records we saw how staff from the IHBT communicated with other professionals to make sure information was shared to encourage safe and consistent care. The team has close links with the SPA team, in-patient and community services. GPs' are notified about changes to a person's medication plan and are sent discharge letters when people no longer require IHBT services so they are up to date with the person's treatment and care plan.

Within peoples' care records we saw that when a person has been referred from or is being discharged to community services, a member of the IHBT team often does joint visits with a member of the relevant community team so they can become familiar with the person and their needs. Staff also attend CMHT allocation meetings so that they can gather more information about people who may need to be referred to their service and likewise provide feedback about people who have been discharged and referred to the CMHT. This encourages good communication to ensure peoples' needs are

understood and met within the appropriate service.

The Trust is not a sole provider of perinatal services but is commissioned to provide the community mental health element as part of the whole care pathway process for people with perinatal mental health problems.

The Trust has set up a perinatal group which provides input into the Kirklees multi-agency perinatal strategy group. One of the Trust group's main roles is to develop care pathways for people with perinatal mental health problems. As a result of this, the Trust has developed a document called the 'Kirklees Perinatal Mental Health Pathway'. This provides good information and describes the format (in accordance with National Institute of Clinical Excellence (NICE) guidelines) for delivering perinatal mental health support within the Kirklees area. This includes identifying people who may be at risk from mental health problems during the perinatal period and raising staff awareness about how to recognise this so that referrals can be made to specialist services.

The Trust perinatal group has also worked alongside other providers such as the local Primary Care Trust (PCT) and Kirklees Infant and Perinatal Strategy Group which included representatives from NHS Kirklees, and health visitors and midwives from Kirklees and Calderdale. The aim of this was to look at service provision and to agree shared approaches in managing people with perinatal mental illness.

We were told that the Trust has a consultant psychiatrist with some experience and interest in supporting people with perinatal mood disorders. Where a person is assessed and requires a specialist consultant, a referral is made to the appropriate out of area specialist service. In cases where a decision is made to admit the person, admission would be arranged with the Mother and Baby Unit within Leeds NHS services, unless there was a specific reason why mother and baby should not be together and needed to be in separate units.

We looked at the draft version of the care pathway documentation and found that it contained detailed information and considered the risk assessment process. However, where there is identified risk to the mother because of her past or present mental health problems, there was little information about the potential risks to others because of this, especially to the child or other children involved. We were told that it is the responsibility of clinicians to make decisions about whether the family needs to be assessed.

When we discussed the planned service changes in relation to care pathways, risk assessment tools and training plans with the representatives from the Trust, it was explained that there is no one in the Trust with expertise in perinatal mental health disorders. This lack of expertise potentially has an impact in areas such as assessment of risk, clinical care, treatment and support, timely referrals to other services and training. We discuss this in more detail within this report under outcome 14. We were also told that psychiatrists do not have designated sessions solely for people experiencing perinatal mental illness.

Our judgement
The care pathway information lacks detail about previous and potential risks to the mother, child and others as a result of the person's illness, and actions to be taken where risks are identified. Because of this referrals may not be made to the appropriate agencies so that measures can be taken to safeguard people from possible harm.

We have minor concerns with this outcome area and an improvement plan is requested to show how compliance will be maintained.

Outcome 14:
Supporting staff

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by competent staff.

What we found

Our judgement

There are moderate concerns with Outcome 14: Supporting staff

Our findings

What people who use the service experienced and told us
Because of the nature of the Intensive Home Based Treatment service, we were unable to speak directly with people who use the service.

Other evidence
The independent review team had concerns about the lack of perinatal mental health training for staff working in crisis situations.

When we visited we saw that the IHBT consists of a very experienced team of qualified nursing staff, social workers, psychiatrists, approved mental practitioners and support workers. During our visit we spoke with staff that had a good understanding of peoples' needs and the aims of the service.

Trust representatives explained that specific training is going to be given to all staff about perinatal mood disorders. Additional training is planned for all staff so that they are fully aware and understand about the care pathways process and can use perinatal risk assessment tools. Staff told us that the development of the care pathways will formalise their care practices to ensure that people are referred to the appropriate services in a timely manner.

When we questioned representatives of the trust about the content of the training, we were told that this will be about increasing staff awareness. The training plan is for all teams to have powerpoint demonstrations delivered to them along with information about the care pathways. We saw the content of the powerpoint demonstrations about pregnancy and mental health and illness. These provided good information and are

likely to have a positive impact in raising staff awareness.

As yet, only one of six CMHT's has actually received the awareness training. Senior clinicians and managers from the Trust had attended a perinatal network event. We were told that some of the Trust's medical staff had attended a medical education event on perinatal psychiatry but had no formal training. This level of learning is inadequate, and does not equip the majority of staff with sufficient knowledge and skills to safely meet the needs of people who are referred to services with perinatal mental illness.

The plan is for nominated staff to attend the training days and then for them to train colleagues. Again, because the service does not have a specialist in perinatal disorders, we have concerns about how effective the planned training would be. We were informed that the Trust had put together care pathway and associated training materials, linking with an external specialist perinatal service with the intention they would scrutinise the documents and provide further advice regarding suitability.

We did have concerns that given that the large majority of staff who have had no previous training at all about the subject matter, one staff awareness session is unlikely to provide staff with the necessary knowledge and skills to develop their competencies in caring for to women with perinatal related illnesses. It is also unlikely to provide assurances that people who are referred will receive the appropriate care and treatment from the most appropriate service.

We stressed the importance of staff having training from people with an expertise in perinatal mood disorders and provided guidance on how representatives from the Trust could explore and access external perinatal training resources.

Our judgement
Because the planned training in relation to perinatal mental health disorders is insufficient and is being delivered by trainers who lack expertise in this area of work, there are risks that the Trust's staff will not be sufficiently equipped to safely meet the needs of this specific service user group.

We have moderate concerns with this outcome area and a compliance action has been made to ensure that compliance with this outcome is achieved.

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

The provider is compliant with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
Because of the nature of the Intensive Home Based Treatment service, we were unable to speak directly with people who use the service.

Other evidence
The findings from the independent review recommended that the service has better communication with families of people who are using the service following serious incidents.

The manager of the IHBT carries out monthly audits of the care plan records. Where there are areas for improvement, staff are asked to amend and update the care plan. We were told that any individual staffing shortfalls are addressed within the staff supervision process. Staff told us reviews following serious incidents had reinforced the importance to them of recording all information and maintaining accurate and up to date records.

Staff receive regular supervision to discuss caseloads, care practices and to identify any training needs.

There are details within information leaflets that are given to people who use the service and their carers about how to raise concerns and make complaints. The trust has a complaints procedure outlining the process and timescales for investigation.

Risks to people are considered. Staff carry out individual risk assessments on each

person who uses the service. As previously mentioned in outcome 6, risk assessment tools need to be developed more extensively in relation to people with perinatal mental illness. Carers are also offered an assessment. The trust has policies and procedures that help maintain the safety of the staff. We saw in peoples' care records that where there was an identified risk to a member of staff from visiting the person alone, staff carried out the visit in pairs.

Staff explained that following a serious incident, the manager always contacts the carers to offer support and to provide any advice. Serious incident reviews are held to reflect on incidents and to look at what could have been done differently to change the outcomes for people.

Some improvements remain outstanding following recommendations made from the independent review, as detailed earlier in this report under outcomes 6 and 14.

When we discussed all of our concerns with representatives from the Trust, we were encouraged that they acknowledged these shortfalls and showed commitment to taking any necessary actions to improve the service. In order to make the changes necessary, representatives from the Trust may need to consider consulting with a perinatal specialist to review the pathway the Trust is currently providing.

Our judgement
Overall, patients benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

Action
we have asked the provider to take

Improvement actions

The table below shows where improvements should be made so that the service provider **maintains** compliance with the essential standards of quality and safety.

Regulated activity	Regulation	Outcome
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	Why we have concerns: Because of the lack of information within some care records, it was unclear whether the person's relatives had been involved in and agreed with the care being provided. Individual care records need to be clearer and more specific in saying at which point a person's presentation would indicate a need for their care to be reviewed so that prompt actions can be taken to prevent further relapse and distress for the individual.	
Diagnostic and screening procedures	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	Why we have concerns: Because of the lack of information within some care records, it was unclear whether the person's relatives had been involved in and agreed with the care being provided. Individual care records need to be clearer and more specific in saying at which point a person's presentation would indicate a need for their care to be reviewed so that prompt actions can be taken to prevent further relapse and distress for the individual.	
Nursing care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations	Outcome 04: Care and welfare of people who use services

	2010	
	Why we have concerns: Because of the lack of information within some care records, it was unclear whether the person's relatives had been involved in and agreed with the care being provided. Individual care records need to be clearer and more specific in saying at which point a person's presentation would indicate a need for their care to be reviewed so that prompt actions can be taken to prevent further relapse and distress for the individual.	
Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	Why we have concerns: Because of the lack of information within some care records, it was unclear whether the person's relatives had been involved in and agreed with the care being provided. Individual care records need to be clearer and more specific in saying at which point a person's presentation would indicate a need for their care to be reviewed so that prompt actions can be taken to prevent further relapse and distress for the individual.	
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 24 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 06: Cooperating with other providers
	Why we have concerns: The care pathway information lacks detail about previous and potential risks to the mother, child and others as a result of the person's illness, and actions to be taken where risks are identified. Because of this referrals may not be made to the appropriate agencies so that measures can be taken to safeguard people from possible harm.	
Diagnostic and screening procedures	Regulation 24 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 06: Cooperating with other providers
	Why we have concerns:	

	The care pathway information lacks detail about previous and potential risks to the mother, child and others as a result of the person's illness, and actions to be taken where risks are identified. Because of this referrals may not be made to the appropriate agencies so that measures can be taken to safeguard people from possible harm.	
Nursing care	Regulation 24 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 06: Cooperating with other providers
	Why we have concerns: The care pathway information lacks detail about previous and potential risks to the mother, child and others as a result of the person's illness, and actions to be taken where risks are identified. Because of this referrals may not be made to the appropriate agencies so that measures can be taken to safeguard people from possible harm.	
Treatment of disease, disorder or injury	Regulation 24 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 06: Cooperating with other providers
	Why we have concerns: The care pathway information lacks detail about previous and potential risks to the mother, child and others as a result of the person's illness, and actions to be taken where risks are identified. Because of this referrals may not be made to the appropriate agencies so that measures can be taken to safeguard people from possible harm.	

The provider must send CQC a report about how they are going to maintain compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 14 days of the date that the final review of compliance report is sent to them.

CQC should be informed in writing when these improvement actions are complete.

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 14: Supporting staff
	How the regulation is not being met: Because the planned training in relation to perinatal mental health disorders is insufficient and is being delivered by trainers who lack expertise in this area of work, there are risks that the Trust's staff will not be sufficiently equipped to safely meet the needs of this specific service user group.	
Diagnostic and screening procedures	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 14: Supporting staff
	How the regulation is not being met: Because the planned training in relation to perinatal mental health disorders is insufficient and is being delivered by trainers who lack expertise in this area of work, there are risks that the Trust's staff will not be sufficiently equipped to safely meet the needs of this specific service user group.	
Nursing care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 14: Supporting staff
	How the regulation is not being met: Because the planned training in relation to perinatal mental health disorders is insufficient and is being delivered by trainers who lack expertise in this area of work, there	

	are risks that the Trust's staff will not be sufficiently equipped to safely meet the needs of this specific service user group.	
Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 14: Supporting staff
	How the regulation is not being met: Because the planned training in relation to perinatal mental health disorders is insufficient and is being delivered by trainers who lack expertise in this area of work, there are risks that the Trust's staff will not be sufficiently equipped to safely meet the needs of this specific service user group.	

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 14 days of the date that the final review of compliance report is sent to them.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

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