Good

Berkshire Healthcare NHS Foundation Trust

Mental health crisis services and health-based places of safety

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RWX51	Prospect Park Hospital	Crisis Resolution Home Treatment Team East Hub	SL1 6DQ
RWX51	Prospect Park Hospital	Crisis Resolution Home Treatment Team West Hub	RG30 4EJ
RWX51	Prospect Park Hospital	Health Based Places of Safety	RG30 4EJ

This report describes our judgement of the quality of care provided within this core service by Berkshire Healthcare NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Summary of findings

Where applicable, we have reported on each core service provided by Berkshire Healthcare NHS Foundation Trust and these are brought together to inform our overall judgement of Berkshire Healthcare NHS Foundation Trust.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for the service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

Summary of findings

Contents

Summary of findings

Overall summary

We rated mental health crisis services and health based places of safety as good because:

- The trust provided a robust and supportive induction programme for new staff working for the CRHTT. Staff felt supported by management and were encouraged to develop professionally. Staff were in the main qualified at band 5 and above and team leaders were band 7 with team managers being appointed on band 8b. Medical staff were actively involved in patient care.
- Our review of case notes showed that CRHTT staff assessed risk and needs thoroughly and created detailed care plans. Staff reviewed care plans and risk assessments on all home visits that we shadowed.
- The trust had responded to concerns about the CRHTT. Following an increase in demand, complaints from people using the service and an increase in whistleblowing, the trust had developed a robust action plan. Weekly meetings were taking place to update on progress and £1 million had been invested in these services. A robust recruitment programme was being implemented and 18 new members of staff had been recruited. The trust had introduced a governance lead across both CRHTTs and audits were starting to take place. Mandatory training was being given a priority and supervision sessions were being monitored. All staff were being trained in supervision skills in order to undertake supervision responsibilities for lower banded staff.
- HBPoS staff made timely and effective assessments.
- The trust had developed robust and thorough interagency protocols and operational policies for the health based places of safety (HBPoS) in line with the new Code of Practice.
- CRHTT staff developed supportive and caring relationships with their patients.
- CRHTT were improving the way they received feedback from carers and people using the service and this was showing positive results. The patient experience tracker was being used to capture feedback.
- CRHTT performed better than the England average in quarter one 2015-2016 for gatekeeping acute admissions. Admission rates were kept at a low level by treating people in the community.
- There were good secure systems for record keeping and good lone working policies for staff.
- Street triage had been introduced in the west of Berkshire. This had helped to reduce the number of S136 admissions detained in custody and reduced the overall number of S136 applications made in west Berkshire.
- CRHTT west had access to crisis beds to prevent acute hospital admission.
- CRHTT was in the process of accreditation with the Home Treatment Accreditation Scheme (ATAS). It had won three trust awards and was involved in local research studies.

However:

- Following a serious incident in HBPoS one and two in August 2015 a formal investigation was commissioned, following this a recommendation was made to review the environment. This review was not due for completion until January 2016 but remedial measures had been put in place to increase safety in the HBPoS in the interim.
- There was no environmental and no ligature risk assessment available for the HBPoS on the day of the inspection. New updated assessments were forwarded within a few days.
- HBPoS three had only a basic bolt on one side of the door separating the room from staff areas. This was a security issue and the trust agreed they would change this. Staff informed us that a review of HBPoS three was also due.
- Staff in CRHTT including management, recognised the need for a clear referral policy. CRHTT was perceived as having an open referral policy meaning it was difficult to decline inappropriate referrals. This was being implemented through the action plan.

Summary of findings

- Physical assessments were not robust and often relied on GPs or inpatient wards. The trust recognised this as an area needing improvement.

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

Good

We rated mental health crisis services and health based places of safety as good because:

- The trust had recognised problems within CRHTT and had invested £1million and increased staffing by 18 over the last few months. They had implemented a thorough action plan to address the issues.
- Medical cover was available when needed including four hours on Saturday and Sunday.
- We witnessed the implementation of a thorough mandatory training update programme to address training issues.
- We witnessed good lone working policies and procedures for staff.
- Risk was reviewed at each visit we shadowed.
- All staff were aware of safeguarding procedures.
- In HBPoS we saw clear staffing policies and PIT alarms were tested to good effect.

However:

- CRHTT west shared facilities with HBPoS three which meant that if the room was being used for a S136 there was no consulting room available for CRHTT.
- There was only a basic bolt separating HBPoS three from staff areas. This was inadequate and the trust agreed to change this.
- The HBPoS had no ligature risk assessment or environmental risk assessment available on the day of inspection. Blind spots were seen. New updated assessments were forwarded within a few days. HBPoS one and two had a serious incident in August 2015. Changes had been made to improve safety. However the environmental review was still outstanding as the trust wanted to include all stakeholders in this review. It was due for completion January 2016.

Are services effective?

Good

We rated mental health crisis services and health based places of safety as good because:

- Progress notes reviewed in the CRHTT showed good assessment of individual needs and planning of care.
- We witnessed regular and thorough handovers in both CRHTTs.
- The trust had developed robust induction programmes for new staff and staff told us they were supported and encouraged to develop in their roles.

Summary of findings

- There was a secure and effective recording system. All records were accessible from the electronic system.
- In HBPoS we observed two assessments under the Mental Health Act 1983 which were both completed within a few hours.
- There were good interagency polices and protocols and regular interagency meetings within HBPoS.
- Street triage had been introduced in the west of Berkshire. This had helped to reduce the number of S136 admissions detained in custody and reduced the overall number of S136 applications made in west Berkshire.

However:

- Care plans were not always recorded separately from the progress notes in CRHTT which may make them difficult to find.
- Physical health assessments did not happen as a standard requirement in CRHTT and relied on GPs or inpatient wards. We were told there was an action plan to improve this.
- Supervision levels were very low (under 50% in both teams) but again an action plan was being implemented to address this, and all staff were being trained in supervision skills in order to supervise lower banded grades. This would be completed by January 2016.

Are services caring?

Good

We rated mental health crisis services and health based places of safety as good because:

- On the visits we shadowed we witnessed thorough, supportive and patient centred care.
- We attended a carers group led by the crisis team which received good feedback.
- Care plans were reviewed on all home visits we shadowed.
- We saw evidence of improved collecting of information regarding patient and carer feedback using the patient experience tracker. Results from October 2015 were encouraging.
- We witnessed assessments where caring and respectful behaviour was observed throughout.

However:

- There had been many complaints about patients' experience of using CRHTT prior to our inspection.
- We saw the main entrance of the hospital being used to admit the S135 and S136 instead of the private side entrance. This compromised patient dignity and privacy.

Summary of findings

Are services responsive to people's needs?

Good

We rated mental health crisis services and health based places of safety as good because:

- In the CRHTT referrals were seen within trust target times and were face to face.
- The seven day discharge policy was thorough and above the national average for the whole of 2014/15.
- All patients knew how to complain and told us there was flexibility in appointment times and care.
- In response to negative feedback, the trust had invested £1 million into CRHTT and had implemented a robust action plan to address issues. Weekly meetings were taking place to review progress and staff were involved with this through listening in action events.
- In HBPoS the operational policy was up to date and thorough and there was a clear protocol for referrals and staffing.
- Street triage had been introduced in the west of Berkshire. This had helped to reduce the number of S136 admissions detained in custody and reduced the overall number of S136 applications made in west Berkshire.
- Audits were regularly undertaken in HBPoS and discussed in interagency meetings.

However:

- CRHTT staff told us that CRHTT had no clear criteria for referral. There appeared to be an open policy for referrals. All staff thought that the team should be split between home treatment and crisis. This was part of the action plan and we were told that this was to be piloted early in 2016.
- If HBPoS three was being used staff at CRHTT west had limited access to toilet and kitchen facilities.

Are services well-led?

Good

We rated mental health crisis services and health based places of safety as good because:

- The trust had recognised the problems within CRHTT and had implemented a robust action plan and invested money to deal with the issues.
- Staff felt listened to and supported by management.
- Managers we spoke with were enthusiastic and supportive.
- A robust recruitment plan was in place.
- Clinical governance had been introduced and audits were being planned on a regular basis.
- Plans were in place to increase the uptake of staff supervision.

Summary of findings

- In HBPoS we saw thorough and robust interagency policies and procedures.

However:

The review of the environment in the HBPoS was not due for completion until January 2016. The trust told us this was so that they could include all major stakeholders in the review. No environmental or ligature risk assessment was available on the day of the inspection and therefore could not be referred to by staff if needed.

Summary of findings

Information about the service

The crisis resolution and home treatment team (CRHTT) is a Berkshire wide service and is split into two hubs – east and west. Each hub is broken down into locality spokes. The east hub is based at Progress Business Centre, Slough and the west hub is based at Prospect Park Hospital, Reading. Berkshire east covers Bracknell, Windsor, Ascot and Maidenhead (WAM) and Slough. Berkshire west covers Newbury, Wokingham and Reading. The east hub also provides a psychiatric liaison service at Wexham Park Hospital in Slough.

The CRHTT is a specialist team of mental health professionals who provide short term support to people experiencing a mental health crisis. They aim to prevent admission to a psychiatric hospital by providing treatment in people's own homes. The service operates 24 hours a day, seven days a week.

The trust has two health-based places of safety (HBPoS) providing facilities for up to three people. These are all based at Prospect Park Hospital in Reading. HBPoS one and two are used for adults detained under section 136 Mental Health Act in order for a Mental Health Act Assessment to be undertaken. HBPoS three is used primarily for minors aged under 18 and is separate from the other two places of safety. A S136 is an emergency power which allows for the removal of a person from a public place to a place of safety for assessment, if it appears to the police officer that the person is suffering from a mental disorder.

Our inspection team

The overall team that inspected the trust was led by:

Chair: Dr Ify Okocha, medical director, Oxleas NHS Foundation Trust.

Head of Inspection: Natasha Sloman, Care Quality Commission.

Team leader: Louise Phillips, inspection manager, Care Quality Commission.

The team that inspected this core service comprised: two CQC inspectors, one Mental Health Act reviewer, one consultant psychiatrist and one occupational therapist.

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients using the service.

During the inspection visit, the inspection team:

- Visited all three health based places of safety and the two hubs of the crisis resolution and home treatment team, east and west.

Summary of findings

- Spoke with nine people who use the service.
- Observed four home visits to people who use the service.
- Reviewed 10 care records in the crisis resolution and home treatment teams and 10 S135 and S136 monitoring forms in the health based places of safety.
- Attended two handover meetings and observed a team debriefing.
- Observed a carers' group run by the crisis resolution and home treatment team.
- Checked 11 prescription charts
- Spoke with the service lead for the crisis resolution and home treatment service and the senior nurse for the health based places of safety.
- Spoke with two team leads of the crisis resolution and home treatment service.
- Spoke with 15 other staff including psychiatrists, qualified nurses, support workers, a pharmacist, psychologist, governance lead and two administrators.
- Tested the personal infrared transmitter (PIT) alarms in the health based places of safety.
- Witnessed two admissions to the health based places of safety.
- Visited the crisis beds available at Yew Tree Lodge.
- Looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

- Patients and carers who we spoke with were generally positive about CRHTT. People said they were treated with respect by staff and were given flexibility with appointment times. They knew how to complain. One service user reported that the service had improved greatly in the last 6 months.
- However, feedback provided by external agencies prior to the inspection had some negative themes. People who used the service had reported that the out of hours service was ineffective and some staff were accused of being rude and unsupportive. Some negative comments were also fed back from another inspector from a different core service in relation to CRHTT. The trust had listened to this feedback and had implemented a robust action plan to deal with the issues.

Good practice

- The CRHTT had set up a carers' group in both east and west which was well attended and generated positive comments.
- The west CRHTT had access to crisis beds at Yew Tree Lodge to prevent admission to a psychiatric ward.
- Street triage had been introduced in the west of Berkshire. This had helped to reduce the number of S136 admissions detained in custody and reduced the overall number of S136 applications made in west Berkshire.
- The HBPoS had strong links with external agencies and good interagency policies and procedures.

Areas for improvement

Action the provider SHOULD take to improve

- The trust should ensure that the improvement plan for CRHTT is implemented. The current policy needs updating to define clear referral criteria.
- The trust should ensure safeguarding referrals are recorded in patient notes.
- The trust should ensure that the Mental Capacity Act is being used within the wider context, not just in relation to consent to treatment.
- The trust should ensure that physical assessments are provided by CRHTT when needed and not rely on GPs and inpatient wards.

Summary of findings

- The trust should ensure that the environmental review of the HBPoS be completed and changes implemented.
- The trust should ensure that there is easy access to a resuscitation bag and defibrillator in the HBPoS.

The trust should ensure that the bolt on the door separating HBPoS three and CRHTT is changed to a double key lock. The trust should ensure that environmental and ligature risk assessments are always available in HBPoS.

Berkshire Healthcare NHS Foundation Trust

Mental health crisis services and health-based places of safety

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Crisis Resolution Home Treatment Team East Hub	Prospect Park Hospital
Crisis Resolution Home Treatment Team West Hub	Prospect Park Hospital
Health Based Places of Safety	Prospect Park Hospital

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

- The interagency policy for the HBPoS had been updated in the light of the new Code of Practice 2015 (Mental Health Act).
- We saw evidence of rights being given at regular intervals in the HBPoS and policies and reminders about this.
- Mental Health Act training was a mandatory requirement for all trust staff.
- Training had been provided to CRHTT staff on the new Code of Practice by a locality approved mental health professional.
- Staff had access to the locality approved mental health practitioners if an assessment was needed and contact details were available to all staff.

Mental Capacity Act and Deprivation of Liberty Safeguards

- The interagency policy for the HBPoS included the principles of the Mental Capacity Act.

Detailed findings

- The Mental Capacity Act was a mandatory training requirement for all trust staff. Evidence of capacity assessments in relation to consent to treatment were seen in the progress notes.

Good

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe and clean environment

- CRHTT east did not see people using the service at their premises. CRHTT west was based in Prospect Park Hospital and they had one room where they could interview people using the service. Most people using the services were seen in their own homes.
- The interview room was based next to the CRHTT west office. It was also used as HBPoS three if a young person was detained on a S136. If there was a S136 no consulting room was available, plus CRHTT staff would not have access to the kitchen or to the toilets which were shared with the HBPoS.
- The team offices at CRHTT west were cramped and could be overcrowded especially during handovers. We were told that a review was happening regarding the premises.
- We observed locked medicine cabinets in both CRHTTs with a temperature measure attached. Individual, named medication boxes were used for each patient.
- In CRHTT west we observed the emergency equipment trolley and the records were up to date. All staff were issued with a basic first aid kit which they carried with them on visits
- The premises that we observed were clean and tidy.

Safe staffing

- Staffing levels were adequate and had improved in recent months. Eighteen new members of staff had been employed across both teams in response to increased referrals and demand.
- In CRHTT west there were a minimum of 11 staff on the early shift and 11 staff on a late shift (hub and spokes). There were three staff on at night, two qualified and one support worker. In CRHTT east there were a minimum of 11 staff on an early shift and nine staff on a late shift. Three staff were based at the hub at night and extra staff were employed to cover accident and emergency psychiatric liaison at Wexham Park Hospital. Here there would be one member of staff on the early shift, one on the late shift, one team lead (9am-5pm) and one twilight (6pm – 2am).
- In CRHTT west, the team consisted of 22.2 qualified nurses (bands 5 and 6), 10 support workers, three team leads (band 7) and 0.5 clinical governance post. There were 32 consultant sessions and 11 speciality, associate specialist and staff grade sessions providing medical cover. Due to new recruitment, there were only 1.5 support worker vacancies. One nurse was on long term sick. Staff sickness was at 6.7% overall.
- In CRHTT east the team consisted of 20 qualified nurses (bands 5 and 6), 11.2 support workers, four team leads (band 7) and 0.5 clinical governance post. There were 31 consultant sessions and 11 speciality, associate specialist and staff grade sessions providing medical cover. There were eight qualified vacancies and one nurse and one support worker on long term sick. Staff sickness was at 4.3% overall.
- Staff reported there was always access to medical cover if needed and consultant cover had been commissioned at the weekends for four hours each day.
- There had been a reliance on bank and agency staff with 29% of shifts covered by agency staff overall. However this was reducing as more staff were employed. Where possible regular bank and agency staff would be used to provide continuity.
- Good mandatory training management had been implemented recently. We saw the mandatory training record for CRHTT west. All staff were listed alongside all mandatory training sessions and each session was colour coded to represent if training was up to date, due to expire or already expired. Out of 30 staff only one had outstanding risk assessment training and all staff had completed safeguarding adults and children levels one and two.
- Eight staff had expired medicines management training, eight staff needed care programme approach training and 19 staff had Prevent training outstanding. We were told that administrators had taken responsibility for reminding staff about training and that compliance was improving.
- All other mandatory training courses were mainly up to date or pre booked.

Good

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

Assessing and managing risk to patients and staff

- Risk was rated on a traffic light system and all staff we spoke to had knowledge of this. Risk of each person was reviewed at every handover and changes in risk rating were discussed at the multi disciplinary team meetings. All new referrals were graded on red which was the highest rating.
- Each referral had a full core assessment and risk assessment. The duty worker would contact the new referral as soon as possible and start to generate a care plan. Referrals were always screened by band 6 nurses or above and assessments always took place face to face.
- Risk was reviewed at every visit we shadowed.
- We reviewed ten care records across east and west and all had up to date and thorough risk assessments.
- Safeguarding training was mandatory and all staff were able to explain the process of referral. The safeguarding lead contacts were visible on staff noticeboards. Staff we spoke to were able to talk about different categories of abuse and advised that all safeguarding issues were discussed at the multi disciplinary meetings.
- We saw evidence in an audit of eight safeguarding referrals made to the local authority between June and November 2015 ranging from psychological and financial abuse, neglect and domestic violence. However we reviewed one care record that had been the subject of safeguarding and could find no evidence of the safeguarding referral in the progress notes. Staff were unable to show us where this referral was recorded in the notes.
- Lone working polices were good and the policy was available on the intranet. All trust staff had mobile phones and lone working devices. Home visits were risk assessed and staff mainly visited in pairs. One staff member raised a concern that agency staff did not have lone working devices.

Track record on safety

- Serious incidents were recorded and reviewed. Improvements were made as a result of learning.

Reporting incidents and learning from when things go wrong

- The CRHTT had been placed on the trust risk register due to concerns about pressure of demand on the service. Staff were feeling under pressure and patients were raising concerns with complaints about lack of continuity of care and staff attitude. Four recent whistleblowing complaints had been received recently about the service. Staff reported this was improving.
- We received a copy of a robust action plan to address these issues. A project group was set up and met weekly. £1 million had been invested to improve the service. This included increasing staff numbers, recruiting substantive leaders to higher bands, and holding listening in action events to include staff in the changes. The teams were getting better at capturing patient feedback and this was getting positive results.
- Staff reported that following serious incidents they were debriefed and supported, individually and as part of the team. Lessons learned were discussed at team meetings and information disseminated down from managers. We were told that the governance lead would produce a report of serious incidents that would be discussed at team meetings.
- We were told that staff had access to one to one psychology and the trust provided counselling.
- We witnessed the service line lead feeding back to the whole team following a recent death of a service user. The team had already been debriefed on this.
- We were told of another serious incident involving the death of an asian lady and her young son. As a result of this, the service line lead organised a Berkshire wide conference concentrating on south east asian women to raise awareness of forced marriage, domestic violence and other issues.

Health-based places of safety

Safe and clean environment

- HBPoS one and two were located within a separate suite next to Sorrel ward. There were two interview rooms, shared access to a wet room and a separate staff office. HBPoS three was based along the corridor next to the CRHTT (west) offices.
- The rooms in HBPoS one and two were generally clean and well maintained and clocks were visible from both rooms. Both had anti-barricade doors and viewing panels were present in all doors except the wet room.
- HBPoS three had only a basic bolt on one side of the door separating the room from staff areas. The trust agreed they would change this.

Good

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

- The shared wet room had a soap dispenser, toilet roll holder and paper towel holder which could potentially be removed and cause damage.
- Blind spots were identified in all places of safety and there was no CCTV. No ligature risk assessment was available at the time of the inspection but was provided at a later date.
- Furniture was slightly worn and could potentially be picked up and thrown. We were told that new, soft, modular furniture was on order and chairs could be moved to the staff office if there was a presenting risk.
- The duty senior nurse held the keys for the locked medicine cabinet.
- When not in use staff used the HBPoS one and two as a route to Sorrel ward. When in use staff were told not to use this route. However we witnessed staff attempting to access this route when the rooms were in use despite notices on the door. The HBPoS operational guidance clearly states this should not happen.
- Neither HBPoS one or two had easy access to a resuscitation bag or defibrillator equipment. This would have to be obtained from Sorrel ward and this would lead to delays. Staff could pull their alarms and this would be responded to but the responsive staff would have to return through the security doors to go and get the equipment.
- HBPoS three had inadequate bathroom locks. A coin or other piece of equipment would be needed to unlock the doors if needed.
- There was an inadequate lock between HBPoS three and the CRHTT. This could lead to security issues. This was raised with the trust and we were told that a double key lock would be fitted to this door to replace this bolt.
- All staff in the HBPoS carried alarms. At our request the manager set his off and eight staff arrived within one minute in response. A further staff member attended four minutes later and another six minutes later.

Safe staffing

- There was a clear policy around staffing for the HBPoS. A duty senior nurse would be responsible for the HBPoS at all times and would delegate staff as appropriate. Staffing was from the seven inpatient wards on a rotational basis. The staffing rota and the policy were clearly displayed on the wall of the office in HBPoS.
- If one person was brought into the HBPoS then a minimum of three staff would be deployed from the ward to support. If a second person required HBPoS a fourth staff member would be deployed and if the third HBPoS was required a further three staff would be deployed. The duty senior nurse was able to deploy further staff if needed.
- There would be at least one registered mental health nurse in the HBPoS at all times and at least one member of staff must be a regular member of staff.
- From 7.45pm – 7.15am there were three whole time equivalent bank staff available from the wards that were supernumerary.
- There could be difficulty in accessing S12 doctors out of hours resulting in patients being in the HBPoS longer than appropriate. Staff reported that approved mental health professionals may also not be readily available out of hours.

Assessing and managing risk to patients and staff

- On the day of the inspection there was no ligature risk assessment and no environmental risk assessment available. We raised this with the manger and within a few days we received up to date assessments.
- All permanent inpatient staff were trained in the Prevention and Management of Violence and Aggression (PMVA) and the trust required all staff involved in physical interventions to have received training in adult life support. However, bank staff may not have been trained in PMVA although where possible this would be requested.
- The duty senior nurse would ask for risk details at the point of referral, and the operational policy stated that a joint risk assessment be completed with the police on arrival at the HBPoS to determine whether it was safe for the police to leave. We witnessed the nurse looking up the history of the patient detained and discussing past and current risk factors with the police.

Good

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

- We were told that all staff were trained in de-escalation techniques and that the length of time of any restraint including prone restraint was captured and audited. Rapid tranquilisation was rarely used and seclusion was available on sorrel ward but again rarely used.
- Safeguarding adults and children was part of mandatory training. Datix was used to record any incidents.
- The duty senior nurse would check each shift as to which staff members were PMVA trained. The page holder would always be PMVA trained.
- Young people would use HBPoS three which is separate from HBPoS one and two.
- Protocols were in place if a doctor was needed for medical purposes prior to any mental health act assessment taking place.

Track record on safety

- We received figures of incidents for the last 12 months and noted 83 incidents were recorded broken down in to categories. Of these 15 were about capacity issues, 15 involved staff assault by patient and 12 involved the admission of a minor.
- August 2015 had the highest number of incidents recorded and was also the month when the most serious incident occurred resulting in substantial injuries to two members of staff. Following this serious incident there was a comprehensive review and recommendations were made. Staffing was increased, activities were made available for patients to use while in the HBPoS, and new access card points had been fitted to ensure patients could not gain access to the staff office where the incident occurred.
- The recommendations also included a full review of the HBPoS environment to take place to determine whether any additional safety features could be introduced. However this could not be completed within the timeframe of the investigation and a date for the end of January 2016 was given for its completion. This was to ensure all relevant stakeholders were involved in the review including senior managers, place of safety staff and the police. This length of time was raised as a concern with the trust who responded that they were discussing a number of options, including about whether an emergency exit door could be fitted in the staff office.

Reporting incidents and learning from when things go wrong

- We were told that staff were debriefed and supported after serious incidents.
- We were told that staff were briefed on new protocols or procedures. HBPoS meetings were held regularly and the information was disseminated through team meetings and ward managers. Staff had access to serious incident information.
- We received a copy of the investigation following the above serious incident and this was thorough and balanced.
- Datix were filled in when needed.

Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

Assessment of needs and planning of care

- We reviewed ten care records over the east and west teams. All ten had up to date and thorough risk assessments. We found care plans present in all records. However, sometimes these were recorded in progress notes rather than on care plan templates. A new care plan template had been introduced in the last two weeks. Staff were getting used to this. Care plans were not particularly holistic. They tended to concentrate on the crisis element. Only one care record contained a note of a full physical assessment. All others relied on the GP or inpatient ward for the physical assessment.
- We reviewed 11 prescription charts and found these were all correct.
- Progress notes showed good assessment of needs and planning of care. All ten had evidence of giving information to enable informed decision making. Four records were found with formal capacity assessments. These were all around consent to treatment.
- We witnessed staff discussing deterioration in mental state, reasons for relapse and future care planning when out on visits.
- The trust used RIO for their electronic recording system. All records were secure and we found the system impressive with all information captured within the care records. Any paper documents would be uploaded on to RIO so all information was together. This meant that transfer between teams was straightforward as records could be easily accessed.

Best practice in treatment and care

- We were told by staff that NICE guidelines were used around prescribing practice and doctors took note of these. We found medication reconciliation to be variable across the teams. Only those patients who were prescribed from the CRHTT had drug charts and there was no dispensing service. We were told that GPs were routinely updated in a timely manner about medication changes and there was pharmacy input to the team. There was a lack of clear protocol around who had medical responsibility when a patient was on S17 leave from the ward.
- Physical health checks did not happen regularly. Although physical health was on the core assessment, recording was variable and physical health checks were not found in the notes. There was a reliance on GPs or the ward to carry out physical health checks. Trust data evidenced several clinical audits around physical health checks and these indicated less then optimal monitoring. We were told associated action plans would be implemented. However smoking cessation targets seemed to be frequently addressed.
- We observed clinical audits on risk assessment and multi disciplinary team meeting forms. Priority levels were given according to issues and action plans implemented.

Skilled staff to deliver care

- Staff in the CRHTTs were highly qualified. The service line lead was band 8c, the hub manager posts were 8b and the team leads were band 7. Consultant and doctor cover was sufficient for both teams and psychology input was provided and had recently been increased. Eighteen new members of staff had recently been recruited. However there was no occupational therapist in CRHTT east and only two social workers across both teams. The teams were medically strong but had limited social care expertise.
- We saw evidence of a robust induction programme. The corporate induction programme consisted of five full days and included all mandatory training. This was followed by a local induction programme at team level and we saw this was thorough and supportive. We spoke with several new starters who were positive about the recruitment and induction programme and felt welcomed and supported by the team. Long term agency and locum staff must ensure they were up to date with the trust requirements for mandatory training and short term temporary staff had to complete a shortened induction checklist.
- Staff reported feeling supported in applying for specialist training and felt encouraged to improve their skills. Staff talked about applying for nurse training, management training and other specialist skills.
- Although staff reported regular supervision, the formal supervision records did not confirm this. In the east CRHTT it was only 3% in April 2015. This started to improve and was 37% in October 2015 but had dipped again to 28% in November 2015. In the west CRHTT the best month was June 2015 at 80% but generally figures were below 50% and only 37% for November 2015. Staff informed us there was always someone to talk to for

Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

support and that much of the supervision was informal. A supervision plan we observed showed names of staff and dates for clinical and management supervision but in many cases no dates were booked. Managers told us that supervision was a priority and they were currently trialling a new system to provide both clinical and management supervision. All staff were being trained in supervision methods to enable staff to supervise lower grades. This training was to be completed by January 2016. Staff could also access SPACE groups which provided peer support and reflective practice.

- Appraisals were up to date and 96% of staff in the west and 98% of staff in the east had had an appraisal over the last 12 months.

Multi-disciplinary and inter-agency team work

- Regular handovers took place at 7.30am, 1.30pm and 9pm on a daily basis across both teams. Effective handovers were observed and handover logs were available trust wide. Excellent use of IT and electronic patient records were observed. Each patient was discussed and risk was reviewed. Handover guidelines were on the wall in the east hub. However it was noted that social issues were rarely discussed in handovers and there was a medical bias to the care provided.
- Communication with GPs was via electronic record and appeared effective. Any new referral before 3.30pm would have a letter sent over to the GP the same day via electronic record. Any referrals after this time would have a letter sent the following day. We were told by managers that CMHT workers regularly came to MDTs and MDTs took place weekly at each spoke. Liaison with the inpatient wards was also discussed.
- There was little social work input in to either team and social care issues were not always discussed.
- Links between external agencies appeared good. We were told of links with housing, with forensic services and in the west the local drug and alcohol team visited on a regular basis to discuss referrals.
- The west CRHTT had access to Yew Tree Lodge which provided three short stay crisis beds. This was run by Care UK but CRHTT supported the patients. We visited Yew Tree Lodge and were told by staff that if they were concerned about a patient they would contact the CRHTT who would respond. Clear plans were agreed on admission and regular monthly management/strategic meetings took place.
- However staff appeared unclear about the relationship between the common point of entry and the CRHTT. This was compounded by the fact that the common point of entry closed at 8pm and all calls were then taken by CRHTT.

Adherence to the MHA and the MHA Code of Practice

- Mental Health Act training was part of mandatory training and we were told that staff had had recent training on the new Code of Practice 2015.
- Of the care records reviewed there was only one detained patient on section 17 leave. There was no copy of the section papers in the file and no section 17 form in the notes.
- There were currently no patients under a community treatment order. One consultant told us that although patients may be on a CTO this was not always explicitly communicated. There were no approved mental health professionals (AMHPs) in the team but there was access to the locality AMHPs when needed.

Good practice in applying the MCA

- Mental Capacity Act (MCA) training was up to date and mandatory. One staff member had recently been on the training and was able to talk through the process of the decision making.
- Of the ten records we reviewed, four had formal capacity assessments but these were all related to consent to treatment. We saw no best interest decisions recorded.

Health-based places of safety

Assessment of needs and planning of care

- Policies were in place and up to date regarding the process for using the HBPoS.
- We observed timely assessments taking place. We witnessed one assessment that had been arranged in advance by the approved mental health professional in liaison with the police and HBPoS. Following arrival with the police the approved mental health professional and two S12 doctors arrived immediately afterwards. The arrival time was 11.45am. The patient was discharged home at 2pm.
- We witnessed a S136 and noted that the AMHP was contacted immediately on arrival. The staff had advance

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notice of the S136 from the police. A risk assessment was completed on arrival. Arrival time was 12.15pm and the Mental Health Act Assessment took place at 2.45pm. The patient was discharged home.

- However we were told that there were difficulties in getting S12 doctors for assessments and out of hours AMHPs may be on other calls. Although the policy stated that a preliminary assessment by the duty senior nurse happened prior to any Mental Health Act Assessment being called, in practice this did not appear to be happening. In most cases a full Mental Health Act Assessment was called which potentially meant longer periods of detention than necessary. The patient may be able to be discharged sooner if a preliminary assessment was undertaken as this may indicate there was no need for a full Mental Health Act Assessment.
- All records were stored securely on RIO. All paper records were uploaded on to RIO and paper documents were stored securely in line with trust policy.

Best practice in treatment and care

- The trust had regular audits on the number of times HBPoS was used and the outcomes of the assessments. Data was routinely collected on length of waiting time for assessment, how many times people were turned away from the HBPoS, incidents and data around gender, ethnicity and age.
- There was an increase in the use of HBPoS between April and August 2015 which coincides with the introduction of the street triage service and a reduction in the number of times patients were taken to custody.

Skilled staff to deliver care

- We saw good interagency working between the HBPoS and external agencies – AMHPs, police and ambulance. Contact numbers for locality AMHPs were visible on the staff office wall.
- All staff had block mandatory training when appointed although specialist S136 training was provided on the job.
- All staff had yearly appraisals and we were told they received clinical supervision from the ward managers. There was a SPACE group for peer support and reflective groups looking at issues and practice.

Multi-disciplinary and inter-agency team work

- We observed good interactions between police, ambulance and nursing staff in the HBPoS. Good working relationships had been established with the local authorities and AMHP contact numbers were available on the staff office wall.
- There appeared to be very good interagency working. We viewed minutes of the Berkshire protocols in practice meetings which took place monthly and were well attended by all stakeholders. CRHTT leads, CMHT leads, inpatient senior nurses, trust security management, AMHPs, Thames valley police, transport police, ambulance, A&E were all involved. The meetings were scheduled every month for 2.5 hours. Objectives were to share good practice, review the interagency joint protocol, review information and to look at the key role of the crisis care concordat. Quarterly director meetings were also held.
- We viewed the management of the mental health crisis interagency partnership agreement between thames valley police and health and social care agencies. We found robust procedures about how partners worked together in the face of a mental health crisis situation that needed the intervention of a S135 or a S136.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

- Responsibilities under the Mental Health Act 1983 were covered in the interagency policy agreement and this had been updated following the new Code of Practice 2015.
- Ten records were reviewed and nine out of ten had evidence of rights being read. S136 rights were also displayed in HBPoS rooms. Risk assessments were recorded on eight forms but were found to be variable in quality and detail.
- We observed rights being given and paperwork completed for the assessments that we witnessed.
- The start time of the S136 was recorded on nine records but the end time was only recorded on two. The S136 forms were not designed to easily record the time of discharge of the S136 and this was reported to the manager.
- Monitoring forms did not include information on AMHP delays or mode of transport and were not always fully completed.

Good practice in applying the Mental Capacity Act

Are services effective?

Good

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- The principles of the Mental Capacity Act were outlined in interagency partnership agreement and the crisis care concordat reviewed policies on the MCA.
- We were told by the manager that capacity would be assumed in line with the law but consent to treatment and admission would always be considered. There were separate forms available to record these decisions. Access to a best interest assessor was through the MHA office. Two recent DoLS applications were reported.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Our findings

Kindness, dignity, respect and support

- All interactions we observed with patients were caring and respectful. All four shadowed visits were reported to be thorough, supportive and patient centred.
- We viewed compliment boards in both teams where patients reported being grateful, satisfied and that it was a fantastic service.
- All people who used the service who we spoke to apart from one gave positive feedback.
- We observed a carers group run by CRHTT which was well attended and we heard positive comments from the participants. Staff available at this meeting included nursing staff, consultant psychiatrist, psychologist and a drug and alcohol worker. All carers were treated with respect, given time to talk and were supported.
- However feedback received prior to the inspection and comments from other service users in other core services were not as positive. Staff had been accused of being rude and there had been complaints about continuity of care and cancelled visits. CRHTT had been placed on the trust risk register as a result and this all seemed to be improving. Staff also reported that things were much improved.

The involvement of people in the care they receive

- We noted hand written care plans written in the patient's own words and signed and scanned onto RIO. Care plans were reviewed with patients on the home visits we shadowed. Service users told us that they felt listened to and respected and were given flexibility when possible with appointment times.
- Both teams had begun to collect patient and carer feedback through the patient experience tracker. Results from October 2015 were overall positive and encouraging. Negatives were around manner of staff both in person and on the phone.

Health-based places of safety

Kindness, dignity, respect and support

- We observed two admissions to the HBPoS. We observed caring and respectful behaviour from staff to patients at all times. Staff were calm and supportive.
- Water and food was offered to both patients.
- The policy advised that where possible an ambulance should be used as the preferred mode of transport rather than police transport.
- Patients were meant to access HBPoS via the private side entrance however with both the above admissions the main entrance of the hospital was used. This compromised dignity and privacy and was against trust policy.
- Staff were advised not to use HBPoS as a through route to Sorrel ward when it was in use. However at the time of the above assessments staff were attempting to walk through the suite regardless of signs on the door and again not in line with trust policy. After our visit we received an updated policy document that attempted to strengthen these procedures.

The involvement of people in the care they receive

- Rights were routinely given and recorded in the HBPoS. Advocacy was not offered as a matter of course unless the patient was admitted to the ward. IMHA service was available if needed. Again access to this was limited, the reason given that in order to limit the time spent in the HBPoS the assessments were arranged as quickly as possible.
- Feedback was not actively chased up for HBPoS but feedback forms were available if the patient was admitted.
- Interpreters were accessed if needed.

Good

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Our findings

Access and discharge

- The CRHTT operational policy dated September 2013 outlined objectives, access to services, response times and other targets. There was a clear referral check list on the wall in the east hub outlining risk assessment, clustering and management plan. However the trust had placed CRHTT on the risk register as a result of huge increases in demand, low morale, leadership issues and poor patient experience. In practice it did not appear that a clear referral criterion was followed. There appeared to be an open policy for referrals and staff reported this made it difficult to reject potentially inappropriate referrals.
- The team was managing an increased referral rate which had increased year on year for the last four years. Episodes of care were over target for 2013 – 2014 by 11,106. Nevertheless the team managed to maintain a low admission rate.
- Referrals were seen promptly and urgent referrals were seen face to face within 4 hours. All new referrals would receive an initial phone call to ascertain risk and plan the assessment. Routine referrals were seen within 24 – 48 hours. All staff we spoke with thought that the teams would work better if they were split into home treatment and crisis teams. One consultant confirmed there were many inappropriate referrals and staff were stretched by dealing with calls that were inappropriate for the service. All staff felt that the team needed to define itself and take ownership of the referral process.
- The service manager confirmed that the targeted action plan addressed these issues and that he was piloting the splitting of the team into crisis and home treatment early next year. He had been in discussion with charities about taking over the role of the crisis line. The operational policy was to be updated once all actions had been agreed.
- All referrals not known to services or closed longer than six months were triaged by the common point of entry. However the process was not clear and when the common point of entry closed at 8pm all referrals came over to the CRHTT, creating more confusion for staff and people using the service as conflicting messages were given as to where and who to refer to.
- In CRHTT west there was a duty worker at all times receiving calls. This was a band 6 post but it was observed that many of the calls were administrative in nature and could have been taken by less qualified staff. There were ten calls received in one hour. In the east all staff shared the calls, however this meant that at times people would call in and get an answer phone which they found frustrating.
- Trust data showed that they had performed below the England average for proportions of acute admissions gate kept by CRHTT for three of the four most recent quarters surveyed. However the trust performed better than the England average in quarter one 2015 – 2016. The gatekeeping protocol was seen and figures for the last 12 months show above 95% were gate kept each month.
- CRHTT achieved a 100% target in days from referral to treatment January 2015 to April 2015.
- The percentage of patients under the care programme approach who were followed up within seven days of discharge from psychiatric hospital was above the national average for the entire period 2014 – 2015. We saw the protocol for the seven day discharge. An internal audit in May 2015 looked at 19 records (50%) of discharges and all 19 were contacted within seven days of discharge. However staff recording of this was variable and in the majority of cases they were not recorded as a seven day follow up. New guidance had been produced in August 2015 to address this.
- Funding for the out of hours service had been increased and there were three staff on at night in the west CRHTT. This area had a stand alone psychiatric liaison service that could be accessed. In the east the CRHTT was responsible for A&E liaison and staffing levels were increased to deal with this.
- Patients informed us that where possible they were given flexibility in appointment times, examples included working around school hours or church services.

The facilities promote recovery, comfort, dignity and confidentiality

- The interview room at CRHTT west was unable to be used if a young person was brought in under S136 as this was also the HBPoS for young people.
- Where possible visits were arranged to see people in their own homes.

Meeting the needs of all people who use the service

Good

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

- CRHTT west was based at Prospect Park Hospital on the ground floor and hence had disabled access.
- Interpreters were available if needed.

Listening to and learning from concerns and complaints

- Datix reports recorded 14 formal complaints from November 2014 to November 2015. Of these, one was not pursued by the complainant, one did not give consent, four were not upheld, six were partially upheld and one was upheld. One had no outcome recorded.
- Many negative comments had been received about the CRHTT and the targeted action plan had clear strategies to deal with this. The patient experience tracker was used at the point of discharge from the team and the responses were becoming more positive. Central reports were on the trust intranet and local results were disseminated to all staff.
- All patients we spoke to knew how to complain.
- Team leaders informed us that in the first instance the complaint would be dealt with at local level. It would be escalated to a formal complaint if not resolved.

Health-based places of safety

Access and discharge

- We had a copy of the operational policy which was up to date and thorough. There was a clear protocol for referrals and clear guidelines about staffing and interagency working.

  We witnessed a S135 (1) and a section 136. On both occasions the duty senior nurse had been contacted in advance and was aware of the referrals. Both these admissions received a timely assessment.

- Length of waiting time for assessment in the HBPoS was regularly recorded. In the year 2014-15, 21% of the patients admitted to HBPoS under section 136 MHA waited more than 5 hours to have an assessment. Some patients had waited up to 24 hours if the detention happened at the weekend, either due to the AMHP being busy or difficulties in finding section 12 doctors. In order to improve monitoring, waiting times had been expanded to include 5 -6 hours, 6-7 hours, over eight hours and over 24 hours.

- The trust reported they routinely collected data around gender, ethnicity and age but not disability or protected characteristics. Data was also collected on the outcome of the assessment, delays in initiating a MHA assessment, how many times people were turned away from HBPoS and clinical decisions taken. We saw evidence of these figures.

- The number of times that the HBPoS was used increased between April and August 2015, from 32 assessments to 58 assessments. This coincided with the introduction of street triage which helped identify potential mental illness and therefore a decrease in the number of S136 in police custody.

- We were told that in the majority of cases the detained patient did not see a doctor until the Mental Health Act Assessment. Good practice (Mental Health Act Code of Practice 2015, paragraph 16.50) would include a preliminary assessment to ascertain whether the patient had a mental disorder and whether a full mental health act assessment was warranted. This was not happening.

The facilities promote recovery, comfort, dignity and confidentiality

- In HBPoS one and two there was a secure place in the staff office for patients' belongings. During the day valuables would be sent to the hospital cashier and put in the safe. At night they were placed in the night safe. The book was signed by both staff and patient.

- The protocol stated that patients brought to the HBPoS should be brought in via the private side entrance. This was not happening in practice and both the S135 (1) and S136 that we witnessed were brought in via the main hospital entrance, thereby compromising privacy and dignity.

- New furniture was on order for the HBPoS and activities were provided in the staff office to help occupy patients.

- Rights were routinely explained to patients and were visible on the walls in the HBPoS.

Meeting the needs of all people who use the service

- The HBPoS had no exclusion criteria and was available for use 24 hours a day, seven days a week. People were only not accepted in exceptional circumstances and after a discussion with all the partners as to whether the HBPoS was a suitable place to assess.

Good

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

- Street triage had been introduced in summer 2015 in the west of Berkshire. This had helped to reduce the number of S136 admissions detained in custody and reduced the overall number of S136 applications made in west Berkshire.
- Young people under the age of 18 were taken to HBPoS three based next to the CRHTT offices. Access to toilet and kitchen facilities were available but there were no bathing/shower facilities. The young person may be able to access the showers in HBPoS one and two if these rooms were not in use. If occupied they would use the showers in the ECT suite. Children aged 15 or under were never to be admitted to an adult ward. In such a scenario children may be kept in the HBPoS for a few days and the suite then classed as a ward for this purpose until a suitable CAMHS bed could be found.

Listening to and learning from concerns and complaints

- Trust data recorded that from August 2014 to July 2015 there were 13 complaints none of which were upheld or referred to the ombudsman.

Are services well-led?

Good

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

Vision and values

- Staff told us that the trust values were simple and easy to understand. They permeated through the work of the trust. We were told that vision and values was part of the recruitment process and this was embedded in staff thinking from an early stage.
- The CRHTT had a clear improvement plan in place with set objectives. Staff felt listened to and had attended listening events regarding this. However some staff felt it was taking too long for the changes to happen.
- Some staff said that senior managers were visible within the organisation.

Good governance

- The trust recognised that CRHTT was struggling in relation to increased service demand, increased complaints from service users and increased whistleblowing concerns from staff. It was placed on the risk register, extra funding was secured to increase staffing and a clear improvement plan was established. The project team met every week. The project plan addressed the role and function of the service and recognised the impact of inappropriate referrals and lack of clear referral protocol.
- The service line lead had taken the opportunity to visit other CRHTT models in other areas of the country to learn from best practice.
- Other posts were being considered, such as band 8b nurse consultant post to establish links with the universities and embed NICE guidelines. The trust had invested in a clinical governance lead for the teams. This post supported the service improvement plan and key responsibilities included audits, risk register, incident reviews on datix, attending serious incident reviews, looking at themes from incidents and sharing these with team leads. A local risk register had been developed for the CRHTT and included the phone system, office space, capacity and demand. The care plan audit was the main audit seen with plans to review 15 care records from each team per month and the findings reported to the managers and disseminated down to staff.
- We witnessed several other audits around discharge plans, safeguarding, standard and style of risk assessments.
- There was adequate administrative support across the teams. Administrators told us that they were responsible for supervision and mandatory training spreadsheets, monitoring and recording of training and supervision, and reminding staff when this was due. We also spoke with the KPI lead for the team.
- We saw evidence of seven supervision records which were complete and signed by supervisor and supervisee. All had actions agreed. Supervision training was being provided for all staff to improve access to supervision. Higher bands were to supervise lower bands and this would increase supervision opportunities for all staff. This was due for completion January 2016.

Leadership, morale and staff engagement

- A robust recruitment plan was in place. Eighteen new members of staff had been recruited, and substantive manager posts in both hubs had been filled, although these were not due to start until February 2016. Band 7 team leaders were in post and feedback from staff was positive about their leadership.
- The trust had recruited more staff on higher bands to help with leadership and team morale. Staff were positive about the band 7 leadership and the service line lead. Most staff told us that staffing was improving and that the teams were very supportive of each other. Most staff said that morale had been low but over the last six months was improving.
- All staff we spoke with felt supported by management although were frustrated that changes were taking a long time to happen.
- Staff told us they had opportunities for further training and development.
- Staff knew how to use whistleblowing processes and this was evidenced by the number of whistleblowings prior to the service improvement plan.
- Staff had attended listening in action events and were able to air their views. Results from the trust staff survey friends and family test reported 68% of staff would recommend the trust as a place to work. This is above the England average.

Commitment to quality improvement and innovation

- Staff informed us that the teams were in the process of gaining accreditation for the Home Treatment Accreditation Scheme. They were currently completing a self assessment. They were part of the Crisis Care

Are services well-led?

Good

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Concordat. This is a national agreement between services and agencies involved with people in mental health crisis. It sets out how organisations will work together to ensure the best care and support for people experiencing crisis. We met with the service lead who was passionate and entrepreneurial about the service. He had looked at other models and spoken to charities about staffing the crisis line.

- The CRHTT had won three trust awards in team working, partnership working and leadership.
- We saw evidence of two research studies. One study aimed to establish the prevalence of pathogenic antibodies in patients with first episode psychosis. Circle was looking at efficacy and cost effectiveness of contingency management for reducing cannabis use in patients with early psychosis.
- Funding had been secured through the Health Foundation by the CRHTT principal psychologist to trial eye movement desensitisation and reprocessing within a mental health crisis team and on an acute mental health ward. This was based on using timely interventions for individuals experiencing a mental health crisis to help prevent death by suicide and facilitate positive mental health. This was an innovative project as it used well researched therapy in a new setting.

Health-based places of safety

Vision and values

- The staff member we spoke with had regular contact with senior managers and attended regular meetings to discuss objectives.

Good governance

- We saw good policies and procedures and interagency policy agreements. However on the day of inspection we were not able to access the environmental risk assessment and ligature risk assessment. These were sent within a few days.
- We saw evidence of robust interagency partnership agreements and evidence of regular Partnership in Practice meetings and quarterly and annual reports.
- Staff were provided from the wards on a rotational basis. They received their mandatory training and supervision as part of their substantive posts on these wards.
- The senior nurse on duty had authority to ask for more staff members from the wards if needed.
- Safeguarding procedures were followed in line with trust policy.

Leadership, morale and staff engagement

- Following the serious incident in August this year, staff in focus groups told us they felt unsafe and apprehensive about staffing the HBPoS. Staffing had been increased, policies updated and a full environmental review was underway.

Commitment to quality improvement and innovation

- Street triage had been introduced in the west of Berkshire. This had helped to reduce the number of S136 admissions detained in custody and reduced the overall number of S136 applications made in west Berkshire.