Good

Berkshire Healthcare NHS Foundation Trust

Community-based mental health services for adults of working age

Quality Report

2nd and 3rd Floors, Fitzwilliam House, Skimped Hill Lane, Bracknell, Berkshire
RG12 1BQ
Tel:01344415600
Website: www.berkshirehealthcare.nhs.uk

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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)
RWX58	Church Hill House	Reading Community Mental Health Team	RG30 4EJ
RWX58	Church Hill House	Windsor, Ascot and Maidenhead Community Mental Health Team	SL6 1LD
RWX58	Church Hill House	Slough Community Mental Health Team	SL2 5BX
RWX58	Church Hill House	Wokingham Community Mental Health Team Common Point of Entry	RG40 1JX
RWX58	Church Hill House	West Berkshire Community Mental Health Team	RG18 3AS

Summary of findings

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.

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

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Overall summary

We rated community based mental health services for adults as good because:

- All of the teams we visited were situated in buildings that were clean and in a good state of repair.
- All of the interview rooms and areas that patients had access to were comfortable and equipped with a wall alarm. Each staff member was issued with a lone working device that was GPS enabled and connected to the device's management incident centre when activated.
- Arrangements were made to cover for sickness, leave and vacant posts. There was a duty rota in place in each team to cover this work.
- Some of the teams we visited had short term teams who saw people in a crisis for a short period of time. Where these teams were present, the number of people on the waiting list for a care co-ordinator was reduced. In the teams that had a waiting list we saw that measures had been put in place to monitor and act on any risks to people waiting to use the service. This included regular contact by the duty team.
- All the teams had a duty system in place to support people who did not have or were waiting to be allocated a care co-ordinator. Staff were able to respond promptly to a sudden deterioration in people's health using a red, amber and green rating system to identify any changing risks to people in the care of the service.
- In the 23 electronic care records we looked at we saw evidence of thorough and clear risk recording across all of the teams and risks were updated regularly with robust crisis relapse and contingency planning was in place.
- The Trust held a monthly 'positive risk panel' with senior management where clinicians can bring cases that are causing concern to discuss the way forward. Staff found this to be very supportive.
- Each team had a safeguarding lead and staff across the community mental health teams was able to identify this lead and demonstrated good knowledge of how to identify and escalate any safeguarding concerns.
- We observed an excellent pharmacy led clozapine service in place across the community mental health teams with six clinics per week. The nurse or pharmacy technician was always available to give the patients information about their treatment. Patients were very happy with the service.
- We observed good practice of recording route of administration and dosage within British National Formulary (BNF) limit and in line with National Institute for Health and Care Excellence (NICE) guidance.
- There was good evidence that patients' ongoing physical care needs were being monitored and this was reviewed at least six monthly at out-patient appointments or care programme approach meetings.
- The psychology department in the community mental health teams offered many of the therapies recommended by National Institute for Health and Care Excellence (NICE) including cognitive behavioural therapy.
- Staff were extremely positive about the opportunities for professional development in particular the trust's commitment to non-psychology staff training in cognitive behavioural therapy techniques, such as graded exposure, behavioural activation and problem solving.
- Staff spoke and behaved in a way that was respectful, kind and considerate. Patients we spoke to told us that they were treated with dignity and respect by staff.
- Patients told us that they felt able to make choices about their treatment and felt very involved in their care. They felt they had a say in all aspects of their care and their opinions on medicines and other treatments were sought and respected.

Summary of findings

- There was good feedback from carers. Many told us they had had a carer's assessment, felt supported and had access to carers groups.
- Staff told us that they reviewed their waiting lists daily by using the (red, green and amber) RAG rating system and risks were re-evaluated and acted upon as necessary. People on the waiting list were contacted regularly to gauge any changes to their risk and need.
- There were multi-language leaflets available on the Trust's intranet which had a link to google translator so that translation could be accessed as and when needed.
- There were two telephone interpreting services available to Trust staff (Mother Tongue and Pearl Linguistics) which offered telephone and face to face interpretation.
- Staff were aware of the Trust's complaints procedure and they told us that they reminded patients and carers how to complain and tried to view it in a positive way.
- Morale was very good across the teams and the staff across all of the teams said that their team was good to work in and very supportive of each other.
- Staff told us that the trust management visit the unit and there were regular 'listening into action' sessions held by the chief executive which they felt had led to positive change.
- Staff benefitted from support offered by psychology and the trust's trauma service after incidents and immediate debriefs in supervision and in their teams.
- There were opportunities for patients to become peer mentors with a focus on access to groups that were patient led and focussed. We also observed a group for people with emotional instability at Upton hospital, Slough run by (ASSIST) assertive stabilisation service. Patients and carers we spoke to told us how much they valued this service.
- Based on feedback from staff and patients, the services were very recovery focussed with an emphasis on individualised and personalised care that was not risk averse.

Summary of findings

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

Are services safe?

Good

We rated safe as good because:

- All of the teams we visited were situated in buildings that were clean and in a state of good repair. We saw that cleaning records were in place and were signed and dated. Clinic rooms were clean and tidy and fridge temperatures were checked daily and were within the correct range of between 2°C and 8°C. All of the interview rooms and patient accessible areas were equipped with a wall alarm. Each staff member was issued with a lone working device that was GPS enabled and connected to the device's management incident centre when activated.
- Some of the teams we visited had short term teams who saw people in a crisis for a short period of time. Where these teams were present the number of people on the waiting list for a care co-ordinator was reduced. In the teams that had a waiting list we saw that good measures had been put in place to monitor and act on any risks to people waiting to use the service like regular contact by the duty teams and discussion in weekly meetings.
- All the teams had a duty system in place to support people under the care of the team who had not been allocated a care co-ordinator, were waiting for a care co-ordinator or when the care co-ordinator was on leave or absent. Staff covering duty were able to respond promptly to a sudden deterioration in people's health using a rating system to identify any changing risks to people in the care of the service. The duty rota covered sickness, leave and vacant posts. We looked at duty policies and procedures that demonstrated how duty staff should escalate concerns based on risk but these policies were not in place in all of the teams we visited.
- All the teams had regular allocation and referral meetings and multi-disciplinary team meetings where the waiting list was discussed and strategies put in place for risk escalation.
- The 23 care records we looked at showed evidence of thorough and clear risk recording across all of the teams and risks were updated at least six monthly but more frequently if necessary. As well as initial risk assessments and reviews, the records showed that robust crisis relapse and contingency planning was in place.
- The trust held a monthly 'positive risk panel' with senior management where clinicians could bring cases that were

Summary of findings

causing concern to discuss the way forward. The focus was on working in a way that allowed for positive risk taking and the panel allowed for the sharing of this responsibility. Staff we spoke to found this to be very supportive.

- Staff demonstrated that they knew how to report incidents using the trust's incident reporting system DATIX which in turn sends an alert regarding severity and what should be done next. Staff in all the teams we visited told us that there were various forums in which learning from any incident was fed through to the team and also outside of the team. We saw examples of change to team processes as a result from learning identified from serious incidents.
- Safeguarding information and contacts were visible on notice boards in the waiting areas. Each team had a safeguarding lead and staff across the community mental health teams were able to identify this lead and demonstrated good knowledge of how to identify and escalate any safeguarding concerns.

However:

- Some teams had high rates of sickness that exceeded their trust's sickness target of 3% but where this was the case the risk was recognised and measures had been put in place to reduce the impact on patients. Staff in each team we spoke to confirmed that if a care co-ordinator was absent plans were made to cover their work during this time, particularly around the administration of medicines.

Are services effective?

Good

We rated effective as Good because:

- There was an excellent pharmacy led clozapine service in place across the community mental health teams with six clinics per week. The clinic used the near-patient testing machine and the patient received their blood results while they were still in the clinic. The medicines were pre-dispensed and supplied to the patient when the blood result was received. The nurse or pharmacy technician was always available to give the patients information about their treatment. Patients were very happy with the service.
- We observed good practice of recording route of administration and dosage within British National Formulary limit and in line with National Institute for Health and Care Excellence (NICE) guidance.

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- The patients care records demonstrated good evidence that patients' ongoing physical care needs were being monitored and reviewed at least six monthly at out-patient appointments or care programme approach meetings.
- Nineteen of the 23 patient care records we looked at showed that a diverse range of needs were considered and where appropriate least restrictive discussions about the treatment and patient involvement were evidenced. The majority of these were holistic, personalised and recovery focussed. However, two of the 23 records did not have a care plan in place at all. One of these related to a patient who had been under the care of the early intervention team for two months and we were told that the care plan was not completed due to difficulties engaging the patient. The care plans for two patients were held in a separate place by the psychology department and were not on the RIO system. Staff across the teams we spoke to told us that three different systems of RIO had been merged into one and this had caused difficulties in finding risk information right away. Staff also voiced some frustration at being required to access and record documentation on two different electronic systems; both the Trust RIO system and the local authority system.
- The psychology department in the community mental health teams offered many of the therapies recommended by National Institute for Health and Care Excellence (NICE), including cognitive behavioural therapy, family therapy and cognitive analytical therapy. Also in line with NICE guidelines, psychologists also offered a good range of recommended therapies for people with personality disorder.
- Staff were extremely positive about the opportunities for professional development and were encouraged to attend external training and conferences so they could bring this knowledge to the team. Examples of this included training on personality disorder, substance misuse, dual diagnosis, family work for psychosis, psychopharmacology training, and suicide risks. The trust had encouraged psychology training to be made available to all staff and many staff we spoke to had received this and were able to offer basic Cognitive Behavioural Therapy techniques, such as graded exposure, behavioural activation and problem solving.

However:

- Shared protocol and joint working between community mental health teams and GPs was not consistent across the teams as

not all GPs were signed up to this. Staff were required to deliver both physical and mental health medicines to patients. It also wasn't clear who had an ultimate overview of patients receiving both physical and mental health medicines.

- Staff employed as approved mental health professionals told us that there were sometimes difficulties in accessing a Section 12 approved doctor when needed. Although we were not aware of any incidents where this has happened, this could potentially result in delays when needing to assess someone under the Mental Health Act 1983 (MHA 1983).

Are services caring?

Good

We rated caring as Good because:

- Staff in all the teams spoke and behaved in a way that was respectful, kind and considerate. Staff were knowledgeable and helpful, and took time with patients. The patients we spoke to and those who completed comment cards told us that they were treated with dignity and respect by staff. They told us that the service was flexible to meet their needs and that when their nurse or care co-ordinator was away they were contacted by the team to say who would be visiting instead.
- Almost all of the patients told us that they felt able to make choices about their treatment and felt very involved in their care. They felt they had a say in all aspects of their care and their opinions on medicines and other treatments was sought for and respected.
- Patients we spoke to told us that they were aware of, had a leaflet about or had already used the advocacy services like SEAP or POHWER, we saw in patient records that referrals were being made.
- There was generally good feedback from carers. Many told us they had had a carer's assessment by a carers support worker which they found helpful and has resulted in their engagement in outdoor activities. Overall, they told us that staff kept them updated regularly and felt more confident about being a carer. They told us they receive copies of their relative's care plan as well as updates.

However

- Ten of the 19 care plans we looked at did not evidence that a copy had been given to the patient. However the majority of patients we spoke to across the teams told us they had received a copy of their care plan and also subsequent updates.

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Are services responsive to people's needs?

Good

We rated responsive as Good because:

- We saw information on notice board in waiting areas in all the teams around Safeguarding, Advocacy services such as POWHER and SEAP, information on the Mental Capacity Act and Deprivation of Liberty and how to complain.
- Patients were seen in comfortable and clean interview rooms as well as larger rooms for groups and meetings.
- Waiting times from referral to assessment was dependent on whether the referral requested care coordination and was dependent on risk factors, but ranged from 7-10 working days. The waiting times from referral to treatment ranged from 7 working days to a maximum of eleven weeks.
- Staff told us that they reviewed their waiting lists daily by using the (Red, Amber and Green) RAG rating system and risks were re-evaluated and acted upon as necessary. People on the waiting list were contacted regularly to gauge any changes to their risk and need.
- Staff told us about the multi-language leaflets available on the intranet which had a link to google translator so that translation could be accessed as and when needed. There were two telephone interpreting services available to Trust staff (Mother Tongue and Pearl Linguistics) which offered telephone and face to face with no reported delays in accessing interpreters. Information CDs were also available in different languages.
- Staff told us about the complaints procedure on the intranet and was aware of the procedure themselves. They told us that they reminded patients and carers how to complain and tried to view it in a positive way.

However:

- Patients told us that they saw their psychiatrist regularly and there was flexibility around appointment times. However two patients told us that they had had difficulties in getting to see a psychiatrist and when they did see one they felt the meeting was too short.

Are services well-led?

Good

We rated well-led as Good because:

- Morale was very good across the teams and the majority of staff across all of the teams said that their team was good to work in and very supportive of each other.

Summary of findings

- Staff we spoke to told us that the trust management visit the unit and there were regular 'listening into action' sessions held by the chief executive which they felt had led to positive change. The vast majority of staff spoke highly of their immediate managers and also felt supported by senior managers, feeling able to voice their opinions and effect change. Staff seemed motivated to work in the Trust, they told us they felt able to influence change and could submit new procedural ideas.
- Staff overwhelmingly told us that there were excellent opportunities for them to progress in their career with access to internal and external training, with particular mention for the access to cognitive behavioural therapy techniques training and workshops.
- Staff told us about the benefits of having support from psychology and the trust's trauma service after incidents and immediate debriefs in supervision and in their teams.

Summary of findings

Information about the service

Berkshire Healthcare NHS Foundation Trust is contracted to provide mental health and learning disabilities services to all registered NHS patients of one of the seven clinical commissioning groups (CCGs) in Berkshire.

The community mental health service is for adults of working age and is provided for people who experience severe and complex mental health difficulties. The teams also work with people who have a personality disorder and people who misuse drugs and alcohol who also have a serious mental illness (dual diagnosis).The teams offer support to carers and family members through education therapy.

The teams use a multi-disciplinary approach to support patients in their own homes to reduce inpatient admissions and work with people to develop a plan to meet their health and social care needs. Each community mental health team is made up of psychiatrists, community mental health nurses, clinical psychologists, medical staff, social care practitioners, therapists and support workers.

Referrals for community mental health services go to one place; this is known as the common point of entry and is a nurse-led service. After an initial screening assessment the common point of entry will direct the person referred to the most appropriate service to meet their needs.

The teams we visited during the inspection were:

- Common point of entry, which was based at Wokingham
- Windsor Ascot and Maidenhead community mental health service which was based in Maidenhead
- Reading community mental health service which was based in Reading
- Slough community mental health service which was based in Slough
- Wokingham community mental health service which was based at Wokingham
- West Berkshire (Newbury) community mental service which was based at Thatcham

Community mental health services for adults of working age had not been inspected previously.

Our inspection team

Chair: Dr 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 inspection team that inspected this core service comprised: three CQC inspectors, a clinical psychologist, a specialist advisor pharmacist, a social worker and two Mental Health Act reviewers.

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?

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- 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 people who use services at focus groups.

During the inspection visit, the inspection team:

- visited five community mental health teams for adults of working age
- spoke with 27 patients and viewed 46 comment cards
- spoke with seven carers
- observed a food and mood group and a support group for people with emotional instability, where we spoke with 13 patients
- observed four home visits
- observed five outpatient clinic appointments
- spoke with the team managers for each team and head of service for three teams
- spoke with 37 other staff members; including doctors, nurses, social workers, occupational therapists, psychologists, support workers and admin workers
- attended and observed three multi-disciplinary meetings
- looked at 23 electronic care records and 46 medicine charts
- carried out a check of the equipment in clinic rooms
- 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 told us that they were treated with respect and kindness and that they felt very involved and active in their care. The majority received care plans and updates and were able to involve their carers as appropriate. They felt able to disagree about medicine changes and told us that this was respected where possible.

Some told us that without the support they received they did not know how they would have coped and others told us that they no longer felt the need to seek help from the crisis team as they once had.

The majority of carers we spoke to felt involved in the care of their relative and had been offered carers assessments and had access to carers groups.

There were 46 comment cards completed by patients and these were overwhelmingly positive about the service they receive from the Community Mental Health Teams.

Good practice

- There was an excellent pharmacy led Clozapine service which used the near-patient testing machine (POCHI), the blood result is provided immediately and medicines are pre-dispensed and supplied to the patient while they are in the clinic. Patients told us they found this service to be efficient and streamlined.
- We observed and had excellent feedback about an 'embrace' group offered by Assist and the Hope Recovery College which have opportunities for training and peer mentoring for patients. ASSIST is a service commissioned to provide 12 weeks intensive work which involved assertive engagement and psychological intervention to achieve stabilisation and reduce vulnerability to hospital admission.
- There was Individual Placement and Support (IPS) project at both Reading and Slough teams. The focus was on rapid access to open competitive employment based on patients' willingness to work. We saw two case studies of patients in Slough and Reading teams assisted by Individual Placement and Support. We saw literature that showed Individual Placement and Support was a proven evidence based model and that the service had already exceeded its outcomes.
- There was excellent psychology input for both staff and patients in line with the National Institute for Health and Care Excellence (NICE) guidelines.
- Three community mental health teams incorporated a smaller short term team that offered 12 week input for

people not suitable for secondary mental health services but who were experiencing a crisis and needed support. Where these teams were in place there was nobody on the waiting list for a care co-ordinator.

Areas for improvement

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

- The provider should review the shared protocol between community mental health teams and GPs to ensure consistency of approach so that there is an overview of patients who receive both physical and mental health medicines to ensure that the combined effects are being monitored.

Berkshire Healthcare NHS Foundation Trust

Community-based mental health services for adults of working age

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
COMMUNITY MENTAL HEALTH TEAM for Adults of Working Age, Reading,	Churchill House
COMMUNITY MENTAL HEALTH TEAM for Adults of Working Age, Slough	Churchill House
COMMUNITY MENTAL HEALTH TEAM for Adults of Working Age, Wokingham and the Common Point of Entry	Churchill House
COMMUNITY MENTAL HEALTH TEAM for Adults of Working Age, Maidenhead	Churchill House
COMMUNITY MENTAL HEALTH TEAM for Adults of Working Age, Thatcham	Churchill House

Mental Health Act responsibilities

- The majority of records we looked at showed that correct documentation under the Mental Health Act 1983 was maintained. For people on community treatment orders (CTOs), there were good documentation and capacity to consent to treatment was captured and recorded accurately.

Detailed findings

- Most of the staff were trained and up to date in Mental Health Act training and knew how to access further specialist advice if needed.
- Staff told us that care co-ordinators inform patients of their rights every three months where applicable and patients told us that they were aware of their rights and had access to Independent Mental Health Advocates (IMHAs).
- However we found little evidence across the teams of advance decisions or wishes expressed in advance to meet the Mental Health Act Code of Practice under Chapter 9.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Overall, we saw evidence of good practice in the application of the Mental Capacity Act (MCA); the majority of care records we looked at showed evidence of informed consent and assessment of mental capacity where appropriate.
- Most of the care records were in date for capacity and consent to treatment although we saw two where consent to treatment documents were more than a year old.
- We saw Mental Capacity Act and Deprivation of Liberty information and contact details on notice boards in waiting areas.
- Staff received Mental Capacity Act training and demonstrated that they felt confident about the key principles of the Act.

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

- All of the interview rooms and patient accessible areas were equipped with a wall alarm.
- There was limited equipment for undertaking physical health monitoring as most physical healthcare checks were carried out by patients' GPs. However there were blood pressure monitoring equipment and weighing scales with stickers on them showing they had been checked and the date that they were next due for checking. The teams that had patient accessible areas had defibrillator equipment and we saw evidence that these were being checked regularly.
- Reading community mental health team risk register recorded that an internal audit showed a red rating for monitoring of medical devices which was addressed with new medical equipment recorded on the audit and calibrated. Training was planned for staff to use the new equipment and the risk register showed that the team became compliant with the storage of medical equipment.
- All of the community mental health teams we visited were housed in buildings that were in a good state of repair and cleanliness. We saw that cleaning records were in place and were signed and dated. Clinic rooms were clean and tidy and fridge temperatures were checked regularly and within the correct range of between 2°C and 8°C.

Safe staffing

- Slough community mental health team had the highest vacancy rate for qualified nurses at 5.7 wte (Whole Time Equivalent). The vacancy rates for the other teams were low overall with Wokingham at 0.3 wte. Slough community mental health team's risk register identified the number of vacancies and mentions unsuccessful recruitment as a risk with higher agency use as a result. An update to the risk assessment in September 2015 showed that two key posts had been filled.
- Staffing establishment for qualified nurses was: Slough 18.5, Windsor, Ascot and Maidenhead, 6.7, West Berkshire 12.8, Reading 16, Wokingham 9. Vacancy rates for qualified nurses in each team were: Slough 5.7, Windsor, Ascot and Maidenhead 1, West Berkshire 0.7, Reading 2.6, Wokingham 0.3.
- The manager of Windsor, Ascot and Maidenhead Community Mental Health Team had recruited nine new staff over the past year and this was reflected in the low number of vacancies for qualified nurses shown for that service and was also evident in the high staff turnover rate for this team at 27%.The percentage of staff turnover (the proportion of employees who leave an organisation over a set period of time) in the past six months for each Community Mental Health Team we visited was: Slough 3.1%, Windsor, Ascot and Maidenhead 27%, West Berkshire 15%, Reading 9.8%, Wokingham 0%.
- Slough and West Berkshire Community Mental Health Teams did not have an establishment for healthcare assistants. Staffing establishment for healthcare assistants in other teams was: Windsor, Ascot and Maidenhead 1 wte, Wokingham 1 wte, Reading 2.7 wte. Vacancy rates for healthcare assistants were: Windsor, Ascot and Maidenhead 1 wte, Reading 0.7 wte.
- Staff told us that agency staff were usually well established as part of the team and well known to staff and patients. Windsor, Ascot and Maidenhead team had the highest use of agency staff. The percentage of agency cover used for each team over the past six months was: Slough 12%, Windsor, Ascot and Maidenhead 14%, West Berkshire 7%, Reading 6%, Wokingham 0%.
- The percentage of staff sickness rates for each Community Mental Health Team over the past six months was: Slough 4.4%, Windsor, Ascot and Maidenhead 6.3%, West Berkshire 12.4%, Reading 4%, Wokingham 0.1%. We looked at the Trust board minutes dated December 2015 and note the Trust wide sickness target rate as at October 2015 was 3% which meant that all of the teams we visited with the exception of Wokingham exceeded the trust sickness target.

West Berkshire risk register highlighted high levels of sickness as a risk. To address this they had allocated

Good

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patients to different care co-ordinators while the person's care co-ordinator was off sick and used additional staffing as partial backfill. Staff in each team we spoke to confirmed that if a care co-ordinator was absent plans were made to cover their work during this time, particularly around the administration of medicines. Other teams had weekly reviews of sickness levels and used their duty system as a contact point for people whose named worker was off sick.

- The common point of entry had five to six clinical staff during an a.m. shift and four to five clinical staff on an evening shift. Senior staff we spoke to told us that historically retention of staff had been poor and sickness rates were high however we do not have any figures for this. This was addressed by increasing the number of Band 7 nurses responding to referrals. The number of Band 7 nurses has increased to 12 to also improve the assurance of the common point of entry assessment to community mental health teams.
- Arrangements were made to cover for sickness, leave and vacant posts. There was a duty rota in place in each team to cover this work although each team's duty system was set up differently with different protocols and policies in place. Staff in each team we spoke to confirmed that if a care co-ordinator was absent plans were made to cover their work during this time, particularly around the administration of medicines.
- There was a variation in medical cover across the teams with the following medical establishment cover in each team: Slough 4.8, Windsor, Ascot and Maidenhead 2.8, West Berkshire 4, Reading 4.8, Wokingham 2.8. Windsor, Ascot and Maidenhead management and staff told us that they felt that the team functioned well despite the relatively low number of psychiatrists available in the team compared to other teams. Staff across the teams told us they had no problems getting input from a psychiatrist when needed.
- However staff employed as approved mental health professionals told us that there were sometimes difficulties in accessing a Section 12 approved doctor when needed. Although we were not aware of any examples of this having happened, this could potentially result in delays when needing to assess someone under the Mental Health Act 1983 (MHA 1983).
- Care co-ordinator caseload numbers varied across the teams but ranged from 15-36. Staff told us that they discussed their caseload and any relative concerns in supervision.
- Senior staff at Windsor, Ascot and Maidenhead showed us guidance on a new system they were piloting to address caseload management. The 'Workload Weighting Tool' was a caseload management system already used in a London Trust to establish staffing capacity at supervision. It was used to indicate the levels of demand on team members based on four key indicators; level of risk/vulnerability, care co-ordinating, time commitment, indirect professional demand/ additional responsibilities.
- Staff told us that they were up to date with their mandatory training. We did not receive mandatory training figures from all of the teams so we cannot report on this overall. The trust was meetings its own overall target of 91%.

Assessing and managing risk to patients and staff

- We looked at 23 electronic patient care records across the Community Mental Health Teams on their dedicated electronic notes system 'RIO'. There was thorough and clear risk recording across all of the teams and risks were updated at least six monthly but more frequently if necessary. As well as initial risk assessments and reviews, the records we looked at showed that robust crisis relapse and contingency planning was in place.
- Many staff members told us that the recent merging of three different RIO systems had made it difficult to find certain key pieces of information relating to risk assessments and care plans which sometimes caused delays and confusion. Despite this the level and quality of risk recording was very good across the teams we visited. There was good evidence of triangulation of risk across risk assessments, care plans and progress notes which meant that risks were recorded across different parts of a person's care record so they were less likely to be missed. We also saw that the latest recorded risk of a patient was flagged on the front page of the electronic patient notes system (RIO) so it was quickly identifiable.
- The teams carried out risk audits to monitor how well risks were being recorded. The Reading community mental health team care records we checked for August to December showed that 63% linked to audit. This

Good

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

indicated an improvement since October 2015 when compliancy was then 53%, according to minutes from Reading's October patient safety and quality meeting. Wokingham multi-disciplinary team meeting minutes showed that they were undertaking 15 risk audits a month.

- All the teams had a duty system in place to support people under the care of the team who had not been allocated a care co-ordinator, were waiting for a care co-ordinator or when the care co-ordinator was on leave or absent. Staff covering duty was able to respond promptly to a sudden deterioration in people's health using a RAG (red, amber and green) rating system to identify changing risks to people in the care of the service as well as those on the waiting list. Duty workers made 'check in' calls to patients and visits could be prioritised. We looked at duty policies and procedures that demonstrated how duty staff should escalate concerns based on risk but these policies were not in place in all of the teams we visited. There was no policy for duty in Reading community mental health team but staff told us that there was guidance provided to give pointers about what to do with duty calls.
- In West Berkshire, Reading and Wokingham community mental health teams there were 'short term teams' which were very well received by staff and people we spoke to who used the service. The short term team provided short term support for up to 12 weeks for people experiencing a crisis but not suitable for secondary mental health services from the community mental health team. The presence of these smaller teams in West Berkshire, Reading and Wokingham coincided with there being nobody on their waiting lists for allocation of a care co-ordinator.

Some staff who worked in teams without a short term team told us that feel this would be beneficial addition for their own team as there was a pressure on duty workers to manage people on the waiting list or patients whose only contact is with a psychiatrist in the team.

- Common point of entry staff told us that they were able to direct urgent referrals to the community mental health teams that have short term teams in place. In the teams that did not have this service there was felt to be some disconnect and a way of managing this was to target the time of the new Band 7 nurses at these teams so they could work closely with them. All the nurses in the common point of entry had links with the community mental health teams and worked towards developing and maintaining good relations.
- All the teams had regular allocation and referral meetings and multi-disciplinary team meetings where the waiting list was discussed and strategies put in place for risk escalation. We saw team meeting minutes that showed discussion about the needs of patients using the service or waiting to, with staff members named and action to be taken.
- The Trust held a monthly 'positive risk panel' with senior management where clinicians can bring cases that are causing concern to discuss the way forward. The focus was on working in a way that allowed for positive risk taking and the panel allowed for the sharing of this responsibility. A formal letter of recommendation to support positive risk management was then produced by the panel. Staff we spoke to told us they found this extremely supportive.
- Each staff member was issued with a lone working device that was GPS enabled and connected to the device's management incident centre when activated. If the device was not in use when the staff member was out visiting the administration team sent an email to that staff member. However it was noted in some team minutes that clinicians were to be reminded to use these.
- New intramuscular prescription charts were being rolled out across the teams to allow for recording of allergies, physical health alerts and a space for regular review and signature of doctors.
- Safeguarding information and contacts were visible on notice boards in the waiting areas. Each team had a safeguarding lead and staff across the community mental health teams was able to identify this lead and demonstrated good knowledge of how to identify and escalate any safeguarding concerns.
- The Trust provided data to show that there were a total of 148 referrals made to the safeguarding team in the last 12 months period. We saw minutes of different multi-disciplinary meetings which showed there was a section in the meeting to review and discuss safeguarding alerts.

Good

Are services safe?

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

Track record on safety

- Information provided by the Trust showed that from September 2014 to July 2015 the total number of serious incidents requiring investigation for the teams we visited was 13. All except one of these incidents involved the unexpected or avoidable death or severe harm of one or more patients, staff or members of the public. Each team had the following number of serious incidents requiring investigation:
- Windsor, Ascot and Maidenhead 3
- West Berkshire 4
- Slough 2
- Reading 4
- Wokingham 0

Reporting incidents and learning from when things go wrong

- Staff demonstrated that they know how to report incidents using the Trust's incident reporting system DATIX which in turn sends an alert regarding severity and what should be done next.
- Staff in all the teams we visited told us that there were various forums in which learning from any incident was fed through to the team and also outside of the team. We saw team meeting minutes that discussed learning and action plans from serious incidents and the need to share this with other community mental health teams.
- An example of change as a result of learning from a serious incident requiring investigation was the new way the admin staff passed on risk information from a phone call to named workers in the team. Before they would speak to the named worker on the telephone, now they would be required to email them instead. We saw this development minuted in a multi-disciplinary team meeting and then rolled out across the rest of the community mental health teams. However some administration staff voiced discontent over the new system as they felt it would increase their workload and possibly increase risk.
- Staff in one team told us that following the death of a patient in relation to medicines a pharmacist held a seminar to indicate side effect factors in detail.
- Staff at Windsor, Ascot and Maidenhead team told us that learning from a serious incident had led to the development of a more formal process to cover staff leave so that when a care co-ordinator was on leave another nurse would be designated to give medicines in their absence.
- Reading team staff told us they have a buddy system where two members of staff look through RIO together and check how the notes around the incidents were documented.
- The performance lead for Slough team regularly sent out a 'monthly hot topics' briefing to staff with information on and learning around serious incidents and complaints. Staff told us that they also received copies of serious incident reports.
- All staff we spoke to told us that if they have been involved in an incident they have received debriefing immediately and felt supported. Serious incident reports are sent to psychologists in the team who provide support to staff after an incident and there is also a Trauma service that supports staff after an incident.
- The psychologists we spoke to told us that learning from incidents is well managed in the trust, with discussion with clinicians, a monthly team business meetings where serious incidents requiring investigation are discussed in detail with a follow up email summary. Any changes to policy or procedure were clearly identified with learning from incidents incorporated into training packages, such as risk management. Learning was cascaded well and we saw that policy and procedures were changed as a result.
- Common point of entry staff told us that they were planning to start communicating back to GPs outcome of serious incidents, which demonstrates an aspiration to achieve good communication between these services.

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

- Information was stored securely electronically on the RIO electronic system and was available to staff when they needed it.
- Staff across the teams told us that three different systems of RIO had been merged into one and this had made it difficult to find certain key pieces of information relating to risk assessments and care plans right away. Minutes from an operational meeting for Reading team show that there was an issue with RIO duplicating clients on the system.
- Staff we spoke to voiced their frustration at being required to access and record documentation on two different electronic systems; both the trust RIO system and the local borough system. This means that there was duplication of some documentation and some confusion of staff we spoke to about which system to use for what purpose. This had been highlighted as a risk on the risk register for Windsor, Ascot and Maidenhead team with staff advised to use RIO for primary inputting but still with the need to duplicate on the local authority system.
- We looked at 23 electronic patient notes during our inspection. Two of these did not have a care plan in place at all and two were held separately by the psychology department and were not accessible on the RIO system. The 19 care plans we looked at all showed that a diverse range of needs were considered and where appropriate least restrictive discussions about the treatment and patient involvement were evidenced. The majority of these were holistic, personalised and recovery focussed. However ten of the 19 care plans we looked at showed that a copy had not been given to the patient.

Best practice in treatment and care

- There was an excellent pharmacy led clozapine service in place across the community mental health teams with six clinics per week. The clinic uses the near-patient testing machine (POCHI) and blood results were received whilst the person was in the clinic. The medicines were pre-dispensed and supplied to the patient when the blood result was received. It was noted that there were processes in place to ensure patient safety if amber or red results received; i.e. limited supply of tablets, recall for re-test.

The nurse or pharmacy technician was always available to give the patients information about their treatment. Patients were very happy with the service and one commented that it was 'very stream-lined'.

- We observed good practice of recording the route of administration and dosage within British National Formulary (BNF) limit and in line with National Institute for Health and Care Excellence (NICE) guidance. We also found good evidence of medicine changes being recorded on the RIO and in Care Programme Approach (CPA) meetings. The medicine policies we saw were robust and included numerous references to NICE guidelines.
- Early intervention for psychosis teams were in place across the community mental health teams and we heard compliments about the service they provided from both staff and patients.
- In line with the NICE quality statement that adults with psychosis or schizophrenia should have specific comprehensive physical health assessments, we found good evidence of this being put into practice across the teams. Over the 23 care records we looked at we found good evidence that patients' ongoing physical care needs were being monitored and that this was reviewed at least six monthly at out-patient appointments or Care Programme Approach meetings.
- Staff told us that patients' physical needs were addressed, either by the community mental health team or by the GP. We observed a Care Programme Approach meeting during which time the doctor discussed lifestyle and physical health in a personalised way in line with NICE guidance. We saw team minutes (Slough) where the physical needs of patients were discussed in detail with subsequent actions allocated to named individuals. Reading team staff showed us an example letter that was sent to GP if the yearly physical health assessment offered is refused by the person who uses the service.

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- Patients told us that they had their blood pressure taken at the community mental health team and they were asked by the team about their physical health, they were encouraged to take exercise, eat healthily and any tests that were needed were arranged at the hospital.
- Psychiatrists from Reading team told us that there was good liaison in place between themselves and the GP and they have electronic access to blood test results carried out in primary care to enable monitoring that appropriate physical healthcare checks are being conducted. In this team there was also a good GP liaison programme with regular meetings between all surgeries and community mental health team link workers. Staff told us this has led to positive outcomes of improved physical healthcare and good feedback from GPs to community mental health teams regarding this with GPs reporting that they feel supported to manage people better without the need to refer to community mental health teams.
- Performance leads were in place in each team and were improving performance recording and addressing previous variations in standards of record keeping. They gave support to staff around how to record risks correctly. Some performance leads had set up a Red, Amber and Green rating to alert staff about Commissioning for Quality and Innovation (CQUINs) targets. This framework encourages care providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare. Windsor, Ascot and Maidenhead team has a monthly performance day which looks at risk assessments, clustering, CPA meetings and crisis contingency plans.
- The teams used a number of outcome measures to rate severity and outcome, including HoNOS (Health of the Nation Outcome Scales) to measure the health and social functioning of people with severe mental illness. We saw the Berkshire Healthcare NHS Foundation Trust (BHFT) locality performance quality framework that showed clustering at 92% overall, although there are some variations between teams.
- Some staff told us they also used outcome measures for their own work such as CORE - This is a client self-report questionnaire designed to be administered before and after therapy. Hospital anxiety and depression scale, Beck's Depression Inventory.
- Many of the therapies recommended by NICE were offered by the psychology department in the community mental health teams, including Cognitive Behavioural Therapy, Family Therapy and Cognitive Analytical Therapy. These were offered either in one to one sessions or in a group format. Groups offered by psychologists include a hearing voices group, a relapse prevention group for people with bi-polar disorder and a mindfulness based cognitive therapy group.
- In line with NICE guidelines, psychologists also offer a good range of recommended therapies for people with personality disorder. Dialectical behaviour therapy is a comprehensive, evidence-based treatment for borderline personality disorder used by psychologists in Trust. Stepps is a 20 week group treatment programme offered by psychologists designed to help people with emotionally unstable personality disorder manage emotional regulation. It was skills based and psychoeducational in approach drawing on cognitive behavioural therapy and schema therapy. A range of skills were taught over the 20 weeks including both emotion management skills and behavioural management skills.
- Psychologists told us that that the effectiveness of groups like the hearing voices group and emotional regulation groups were being audited and that clinical psychology trainees audit outcomes periodically.
- We heard about the work of a clinical nurse specialist and their own innovative service to facilitate discharge to primary care. Their post was established to enable patients visiting outpatient clinics to move on to primary care and offered individually tailored interventions including stabilisation.
- ASSIST was a service commissioned to provide 12 weeks intensive work which involved assertive engagement and psychological intervention to achieve stabilisation and reduce vulnerability to hospital admission. Psychological therapies were also provided over the longer term. The service also provided the Embrace group which is run along therapeutic community lines and is chaired by a patient. Patients could attend the Embrace group for as long as they wanted and were supported to move on to a range of projects and activities, including the opportunity to train as a peer mentor.

Are services effective?

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- We observed an 'embrace' group in progress and saw the compassionate attitude of staff while patients themselves highlighted to us the level of empathy and commitment they felt from staff. We saw that staff provided an individually tailored response to patients and were flexible in their approach. People spoke about the skills they had acquired and the value of peer support. Patients described having their lives transformed and consistently described that the group had engendered hope, helped them overcome suicidal urges and helped keep them out of hospital. All of the patients we spoke to echoed their own belief that this has been of vital importance for them. One patient told us they had the opportunity to chair the Embrace group and take minutes. A carer also present said they had opportunity to come into sessions and told us that they believed it to be essential.
- We were also able to observe a 'food and mood group' run by Recovery Hope College. This seemed inclusive and well run and the patient as peer mentor. The aims of the group were set at the start followed by a positive discussion around food links to mood and mental health, recipes and food plans discussed and food samples provided. The courses provided by the Recovery College are facilitated by peer mentors or people with lived experiences as well as staff members. The Recovery College had created a peer mentor programme which trained patients to become ASSIST and EMBRACE peer mentors. One patient told us that the peer mentor course "turned hope into belief".
- Difficulties in finding appropriate housing for patients were often cited across the teams as a problem. Senior staff in Windsor, Ascot and Maidenhead team told us about a local housing panel they set up that included local providers and together they prioritise and look at how they can work more effectively together. Reading team incorporates two housing support workers from Ability Housing Association who support patients to complete the application forms for housing. Slough team work closely with housing liaison office employed by Slough Borough council.
- We spoke with staff and patients about the Individual Placement and Support project at both Slough and Reading teams. This project is part funded by the government's Innovation, Excellence and Strategic Development Fund through the Department of Health. The focus is on rapid access to open competitive employment based on the patient's willingness to work. We saw two case studies of patients in Slough and Reading teams assisted by Individual Placement and Support.
- Individual placement and support is a proven evidence based model already tested in two earlier projects involving the Centre for Mental Health. These projects improved practice and achieved greater numbers of paid work outcomes for people with mental health needs into paid employment. Since February 2015 there have been 79 referrals and the project had already exceeded its service outcomes with 36 job outcomes exceeding the 31 target.
- We heard about staff involvement in different types of audit across the teams. Psychiatrists in Reading team gave us examples of their participation in the national schizophrenia audit and told us about local audits undertaken by junior doctors regarding driving advice/ DVLA notification. We were told about an external Care Programme Approach (CPA) audit around the entering of details onto CPA information such as diagnosis and physical health information.

Skilled staff to deliver care

- Windsor, Ascot and Maidenhead, Wokingham and Reading showed that every member of staff were up to date with their appraisals. Staff we spoke to told us they had monthly supervision and yearly appraisals.
- There was full access to a range of experienced and qualified multi-disciplinary team members working as care co-ordinators in each team with a variety of backgrounds including nursing, occupational therapy and social work. All of the team meetings we attended had representation from all members of the multi-disciplinary team working there and minutes from other meetings reflected this diverse attendance.
- All of the staff we spoke to across the teams told us that they had been fully inducted which included training on RIO and had received an induction pack. Slough team members told us that new agency staff receives a week's medicines induction alone.
- All teams receive the same level of pharmacy input and are able to get advice from a pharmacist over the telephone as and when needed.

Are services effective?

Good

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- Staff were extremely positive about the opportunities for professional development and told us they are encouraged to attend external training and conferences so they can bring this knowledge to the team. Examples of this were training on personality disorder, substance misuse, dual diagnosis, family work for psychosis, psychopharmacology training and suicide risks. Some staff we spoke to had completed post graduate course in mental health and substance misuse but told us that there was no internal dual diagnosis training in the Trust.
- The trust encouraged psychology training to be made available to all staff and many staff we spoke to had received this training and were able to offer basic Cognitive Behavioural Therapy techniques, such as graded exposure, behavioural activation and problem solving. The Charlie Waller Institute is a collaborative initiative between the Charlie Waller Memorial Trust, Reading University and Berkshire Healthcare NHS Foundation Trust. Staffs have opportunities to attend four one day workshops and achieve a Cognitive Behavioural Therapy certificate. All staff reported excellent opportunities for non-psychology staff to achieve skill development in psychology.
- Psychologists told us that they felt that it was a very 'psychologically minded Trust'. They told us that 'Eye Movement Desensitisation and Reprocessing' training for psychologists at levels two and three was funded by the Trust.
- We viewed the team supervision structure for Windsor, Ascot and Maidenhead team and it appeared comprehensive with good supervision arrangements for psychologists.

Multi-disciplinary and inter-agency team work

- All of the teams had regular multi-disciplinary team meetings, business meetings and referral and allocation meetings. Reading team has two multi-disciplinary team allocation and referral meetings a week to allocate referrals. Windsor, Ascot and Maidenhead team had a weekly allocation meeting and two team meetings a week which also looked at the waiting list. We observed one of these meetings and saw that there was a good representation from different disciplines, it was efficiently chaired and had clear agenda. There was a good range of expertise displayed by team members and respectful challenges were made.
- We observed the short term team meeting at Reading community mental health team. Caseloads and referrals were discussed in detail and RIO was used during the meeting which meant that changes could be made there and then to patient records. Risks were outlined and we saw good examples of joint multi-disciplinary team work. The aspirations and expectations of patients were included in discussion and team approach was observed to be caring and respectful.
- Community mental health team staff attended ward rounds and joint meetings with crisis resolution and home treatment teams providing a link between inpatient services and the community.
- Senior management in Windsor, Ascot and Maidenhead team told us about an initiative they were involved in setting up called the 'chaotic lifestyle group'. This was a monthly group with a focus on managing risk in a multi-agency way, including housing, mental health and substance misuse services, the police, GPs. Each service brought a case for discussion and shared knowledge. We were told that there have been good outcomes from this initiative, with an improved lifestyle and stable mental health for people very difficult to engage with due to complex or chaotic lifestyles.
- Approved mental health professionals told us that they have good links with the police and attend multi-agency public protection arrangements meetings and some are engaged in multi-agency work with abuse team. Other teams told us they work closely with a named police officer for mental health in their area. Staff also told us that there has been very good feedback from police regarding the street triage initiative in the West of Berkshire. They said that there have been fewer incidents of people being sectioned under Section 136 in place stations already since starting in the summer of 2015.
- Wokingham team staff members who were also perinatal leads told us that they trained midwives and health visitors which had resulted in direct referrals from midwives alongside those from other sources.

Are services effective?

Good

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- However, shared protocol and joint working between community mental health teams and GPs was not consistent across the teams as not all GPs were signed up to this. Where appropriate staff were required to deliver both physical and mental health medicines to patients. It also wasn't clear who had an ultimate overview of patients receiving both physical and mental health medicines. Although we saw no evidence of associated incidents the Trust should consider reviewing this protocol to ensure consistency and reduce the possibility of medicine errors in the future. It was already noted in a Slough operational and clinical meeting that GP prescribing remained an issue to be resolved and that key pharmacy contacts were to be invited to future consultants meeting.

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

- The patient care records we checked showed correct documentation under the Mental Health Act 1983 (MHA 1983) with good community treatment order (CTO) documentation and capacity to consent to treatment and CTO 11 and 12 treatment certificates were in place. However we saw that some treatment certificates CTO12 were not attached to prescription charts. We saw little evidence across the teams of advance decisions or wishes expressed in advance to meet the MHA Code of Practice 2015 under Chapter 9.
- There were two yearly classroom based MHA training with an MHA Administrator and a yearly e-learning refresher. The Mental Health Act Code of Practice 2015 (COP) training was ongoing and a rolling programme. Staff told us that they were trained and up to date in MHA training and if they needed further advice they would ask the legal team at the borough council or the MHA office within the Trust.
- Staff told us that care co-ordinators inform patients of their rights every three months where applicable.
- Staff told us that medicine leaflets are given to patients along with explanations about rights, how to appeal, legal advice and leaflets, mandatory conditions and recall details.
- Patients told us they were aware of their rights and some had requested a tribunal hearing via their solicitor and many also had access to an Independent Mental Health Advocate (IMHA).

Good practice in applying the Mental Capacity Act

- Overall we saw evidence of good practice in the application of the Mental Capacity Act 2005 (MCA).
- Notice boards in waiting areas contained information about Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act; with relevant contact details.
- Where this was applicable, the majority of care records we looked at showed evidence of informed consent and assessment of mental capacity. The majority of care records we looked at were in date for capacity and consent to treatment. However we noted on RIO the capacity and consent for treatment for one patient was last reviewed 2013/2014. Consent to treatment documentation for another patient on a CTO was dated back to 2012.
- There is yearly DoLS in house teaching and MCA training yearly (in house). Staff told us they had received MCA training and felt confident about the key principles. One staff member told us they would like more input on autism/Asperger's issues in relation to the MCA.
- In a Reading team meeting we observed that the capacity of patients was discussed.

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

- Staff in all the teams we visited spoke and behaved in a way that was respectful, kind and considerate. Staff were knowledgeable and helpful, and took time with patients.
- The patients we spoke to and those who completed comment cards told us that they were treated with dignity and respect by staff. Many commented that if it were not for the support they currently get, they would need to contact the crisis team or would be in hospital.

The involvement of people in the care that they receive

- The 19 care plans we looked at all showed that a diverse range of needs were considered and where appropriate least restrictive discussions about the treatment and patient involvement were evidenced. The majority of these were holistic, personalised and recovery focussed. Ten of the 19 care plans we looked at showed that a copy had not been given to the patient. However, patients told us that they did receive copies and updates of their care plan.
- Patients told us that they felt able to make choices about their treatment and felt very involved in their care. They felt they had a say in all aspects of their care and their opinions on medicines and other treatments was sought and respected.
- We spoke to carers who had received assessments of their own needs as carers and who had been referred to carers support groups. In team meeting minutes for Wokingham we saw feedback from staff that carers and patients the carers assessments they had received.
- The majority of patients we spoke to told us that they were aware of, had a leaflet about or had already used the advocacy services like SEAP or POHWER, we saw in patient records that referrals were made and it was noted that the advocates sit in on tribunals and team meetings.
- In one team staff told us that they had changed the name of a large room from 'tribunal room' to 'large meeting room' directly because of a request by patients due to the negative associations they had with the word 'tribunal'.
- At Windsor, Ascot and Maidenhead team we observed an outpatient appointment during which we saw that the psychiatrist was respectful in their approach and took the time to discuss a variety of subjects with the patient, including activities and work options. The psychiatrist gave a rationale for the suggestion that the patient continue on medicines and listened to their opinion. A carer was also present.
- Patients were encouraged to co-facilitate groups as experts by experience along with team psychologists. Some patients told us that the Trust had funded them to attend training specific for this role.
- Patients told us they knew how to complain but would first speak to their care co-ordinator and that any complaints they have had have been resolved. They felt the service was flexible to meet their needs and that when their community psychiatric nurse or care co-ordinator was away they were contacted by the team to say who would be visiting them instead.
- We observed four home visits and on each occasion staff members were respectful, positive and supportive, there was an holistic focus with a range of issues discussed.
- We observed five outpatient appointments and we saw that staff were highly respectful with a caring and collaborative approach that was recovery focussed and holistic. We saw that the psychiatrists gave full information about proposed interventions and rationales behind their suggestions. We saw that the patients' views were encouraged and respected. We saw that a consistent attention was paid to a range of needs as well as mental health, including discussions around the patient's physical, occupational and social aspects. We saw creative ways were used to address patients concerns around medicines, such as the suggestion of a pharmacist home visit and joint research on the internet with the person's community psychiatric nurse.
- We observed a Care Programme Approach meeting between a psychiatrist, a patient and a care co-ordinator. A wide range of issues was discussed with a good deal of attention paid to the patient's physical health. Discussed new job opportunities, physical health (lifestyle, diet, blood sugar). The patient was given the time to voice their own areas of concern and these were addressed appropriately.

Good

Are services caring?

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

- There was good feedback from carers. Many told us they had had a carer's assessment by a carers support worker which they found helpful and has resulted in their engagement in outdoor activities. One carer told us that it was six months before their relative saw a psychiatrist and felt unhappy with the lack of support during this waiting period, but didn't feel there was an immediate risk. They didn't feel very involved with their relative's care or care plan. However they attend a carers group which they find very helpful. Others we spoke to also attend groups as well as receiving 1:1 sessions with a carers support worker.
- Another carer in the same team said all staff kept them updated regularly. They had been given a carers book about what to do as a carer and felt that their questions were always answered. They told us they received copies of their relatives care plan as well as updates. It was described as a 'Brilliant service' especially the input received from carer/family support workers. The support and interventions by family liaison and carer leads and support workers across the teams was praised by carers we spoke to.
- One carer highlighted problems they had experienced around staff having the wrong phone number, a general lack of communication and feeling they had to fight to get information about their relatives care. Since then the team has a specific person established in the team to act as a link between supported accommodation and the community mental health team to improve communication. Another carer said that they had not received a carer's assessment or any leaflets and sometimes felt that if they didn't advocate for the patients' needs they would be missed. We checked RIO and it stated that the carer had been given carers information and was offered a carer's assessment.

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

- There was a variation across the community mental health teams for waiting times for a care co-ordinator and those teams that incorporated a short term team had a waiting list of zero. Waiting times from referral to assessment was dependent on whether the referral requested care coordination and was dependent on risk factors, but ranged from 7-10 working days. The waiting times from referral to treatment ranged from 7 working days to a maximum of eleven weeks.
- Both Reading and West Berkshire Community Mental Health Team had nobody on the waiting list for a care co-ordinator, Slough Community Mental Health Team had 11 people on the waiting list. Windsor, Ascot and Maidenhead Community Mental Health Team had 20 new referrals waiting for allocation of a care co-ordinator, some considered low risk had been waiting for nine months.
- The community mental health teams told us that they reviewed their waiting lists daily by using the red, green and amber (RAG) rating system and risks were re-evaluated and acted upon as necessary. People on the waiting list were contacted regularly to gauge any changes to their risk and need. If someone was on the waiting list for psychology or a care co-ordinator they could access duty service 9-5 and crisis team out of hours. They would then be discussed at the next team meeting and allocated to a staff member.
- The common point of entry as a single point of access the service seemed to focus well on risk but due to the 'open door' policy staff reported it was difficult to cope with the increased number of referrals. They told us that referrals were increasing by 150 a month and stood at 900 referrals a month when we visited. Staff used a RAG rating system to determine the urgency of each referral. They then decide which were considered urgent and these people would then be assessed by the common point of entry, while those considered an emergency would be referred to the crisis and home treatment teams. The common point of entry then pass on approximately 30-35 referrals a month to each community mental health team, while a large volume would be signposted to improving access to psychological therapies (IAPT) and some would be directed to substance misuse or bereavement services.
- The recent disbanding of the complex needs service for people with personality disorder and emotional instability has meant that the community mental health teams have had to incorporate this work and staff told us there is some confusion and uncertainty about how this will look in practice. This was highlighted as a risk on Slough team's risk register, actions include support from complex needs link workers to community mental health teams. The register states that the complex needs service will continue to manage the existing waiting list and there will be engagement in working group to implement new proposed model.
- Staff told us that in the event of the service cancelling an appointment a letter was sent to the patient.
- The majority of patients we spoke to told us that they saw their psychiatrist regularly and there was flexibility around appointment times, however some patients told us it could be difficult to get hold of a psychiatrist and when they did see one they felt the meeting was short.

The facilities promote recovery, comfort, dignity and confidentiality

- We saw lots of information on notice board in waiting areas in all teams around Safeguarding, How to Complain, Advocacy services, The Mental Capacity Act and Deprivation of Liberty.
- In the community mental health teams that had patient access the interview and group rooms were comfortable and clean. People talking in the rooms that we passed were not audible from the outside. We saw no evidence of a breach of confidentiality at any team we visited.

Meeting the needs of all people who use the service

- For community mental health teams we visited where parking was available we saw that there were disabled parking spaces available. We did not observe or hear about any problems with regard to access to the buildings for people with a disability.

Good

Are services responsive to people's needs?

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

- Staff we spoke to across the teams was aware of the multi-language leaflets available on the intranet with a link to a google translator, so translation could be accessed as and when needed.
- There were two telephone interpreting services available to trust staff (Mother Tongue and Pearl Linguistics) which offered telephone and face to face with no reported delays in accessing interpreters. Information CDs were available in different languages also.
- Both Windsor Ascot and Maidenhead and Slough community mental health teams had in place a community development lead in each team who work with minority communities (both geographic areas have a diverse ethnic population). The community development lead's role was to look at equality in healthcare and service improvement, while making links with faith leads in the area and other interested organisations. The community development lead for Windsor, Ascot and Maidenhead team was also the training instructor for the trust and offered training for staff on cultural competency.

Listening to and learning from concerns and complaints

- The total number of complaints received between August 2014 and July 2015 across the community mental health teams for adults of working age were 55, five of which were upheld and four were referred to the Ombudsman. The common point of entry received five complaints, one was upheld and two were referred to the Ombudsman. There seemed to be an even mixture of themes behind the complaints, including attitudes of staff, medicines, communication and care and treatment.
- An example of where patient feedback had impacted on the service was seen in a patient experience overview of 'You said, we did' where the Trust responds to suggestions by patients. A patient commented that they had had a 09.00hrs appointment at Wokingham team but the building was not accessible until 09.05 which had increased their anxiety levels. The Trust responded with reassurance that the Manager has ensured the building would open at 09.00hrs.
- The monthly 'hot topics briefing' sent to some community mental health team staff had information on complaints and subsequent learning. Complaints, compliments and feedback were visible on noticeboards in most of the waiting areas we saw.
- Staff told us about the complaints procedure on the intranet and was aware of the procedure themselves. They told us that they reminded patients and carers how to complain and tried to view it in a positive way. However some staff told us that they themselves don't always get to hear outcomes of complaints.

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 we spoke to told us that the trust management visit the teams and there are regular 'Listening into Action' Sessions held by the chief executive which they felt has led to positive change. The vast majority of staff spoke highly of their immediate managers and also felt supported by senior managers, feeling able to voice their opinions and effect change. In particular they had very good things to say about their chief executive.
- Staff told us that the clinical directors in the trust reflect the multi-disciplinary team as they come from a variety of disciplines and backgrounds.
- None of the staff we spoke to were able to correctly identify all of the trust's values but they were able to name one or if not, able to talk about the core values that they believe align with the trust's values and their own.

Good governance

- There appeared to be very good governance overall. Staff had regular supervision and annual appraisals and the trust was meeting its own target for staff mandatory training with the exception of infection control. There were excellent opportunities for professional development with staff having access to both internal and external courses. Incidents were reported and openness seemed to be encouraged.
- There was evidence of a variety of clinical audits taking place as well as audits around risk, carer engagement and psychological therapies. There were several ways in which learning from incidents was disseminated and one such example was implemented across the teams (how calls are communicated to the named worker). We saw examples where patient feedback was acted upon, such as the name of a room being changed. Overall Safeguarding, MCA and MHA procedures are followed. Key performance indicators were used to gauge the performance of the team.
- Managers at one of the community mental health teams raised concerns about a member of staff who had not been referred to the professional regulator regarding falsification of records. In the subsequent disciplinary hearing the staff member's manager informed the disciplinary panel that they had not had any concerns regarding the trust and integrity of the member of staff previously. The director of nursing would be reviewing the case in December 2015 and would discuss the situation with the staff member's professional regulator.

Leadership, morale and staff engagement

- All of the staff we spoke to told us that they were aware of how to access the Whistleblowing policy. Some told us that they would flag anything they saw that was inappropriate and would get advice from management about escalation. They felt that it was important to encourage patients to explore dissatisfaction by making a complaint if necessary, and that their crisis contingency plan informed patients how to complain.
- One staff member told us that there had been some evidence of harassment and bullying among staff members in the past but this had been addressed effectively by Managers. The majority of staff across the teams told us that they were not aware of any bullying or harassment cases in the team and that they were aware of whistleblowing procedure.
- Morale was very good across the teams and the majority of staff across all of the teams said that their team was good to work in and very supportive of each other. Staff in some teams felt that since the restructuring and new team management over past year has led to it becoming more effective and more supportive. Three changes of management within one year has left some staff feeling unsettled in one team. Some staff expressed difficulty with the number of people on waiting lists and felt an added pressure because of this.
- Administrative staff told us they felt that their views were not listened to regarding implementation of the new system of communicating calls from patients to relevant staff.
- One team had a fortnightly informal meeting called 'space' which is a relaxing time for staff to get together, talk about stresses and how to manage them. Another team held a weekly Mindfulness session where staff sit away from their desks and take time out with each other which was well attended and well received by the staff we spoke to.

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.

- Staff we spoke to felt that restructuring and new management in their team over the past year has made it more effective and more supportive.
- Staff told us that there were excellent opportunities for them in leadership skills and these were encouraged as was their professional development both internally and externally, with the opportunities of secondments and funding in certain subjects. They were highly complementary of their opportunities for future development and training, citing the Cognitive Behavioural Therapy workshops as an example.
- Staff told us that it was rewarding to work in their teams and they seemed motivated to work for the trust; they told us they felt able to influence change and can submit new procedural ideas.
- Many staff mentioned that the Trust's 'Listening into Action' project had made a positive difference and that they would have no worries of victimisation within the organisation. They said that they felt as though management were listening to the 'shop floor' and acting on what they heard.
- Some staff expressed concern about staffing levels adding to stress of an increased waiting list for allocation but that overall staffing levels were good with lots of recruitment over the past year. In the meantime there was the use of well-known agency and bank staff.
- Staff told us about the benefits of having the Trust Trauma Service for support after incidents and immediate debriefs in supervision and in their teams.

Commitment to quality improvement and innovation

- Some staff told us they attended the carer strategy group in the Trust and have worked on an action plan to improve carer services over the past year. This was linked to an accreditation for Triangle of Care. The Triangle of Care project is an initiative running the Carers' Trust (formerly known as the Princes Royal Trust for Carers); to bring together carers, carers' centres, third sector organisations and mental health service providers. Staff told us that it aims to achieve the standardisation of carer experience with carer training days that have been co-designed and co-delivered with carers, based on psychological interventions/family work model.
- The Trust gave us information on six National Institute for Health Research Studies (NIHR) Portfolio studies hosted in BHFT recruiting in community mental health teams, one is summarised here:

Full Title: Genetic Case Control and Brain Imaging Studies of Mental Illness and Dementia. This is shortened to DNA Polymorphisms in Mental Illness (DPIM is the short study title. Study Design: The study is using genetically matched case and normal control samples Aim of the Study: Research is looking into the genetics of Bipolar Disorder, Schizophrenia and Alcoholism. The aim of the study is pave the way for new treatments and preventative strategies.

- The National Audit of Schizophrenia was carried out in 2011 – 2012 NAS1 and NAS2 carried out in 2013 – 2014. All Trusts/Health Boards were asked to return 100 returns for the audit of practice. Trusts were also asked to send out 200 patient surveys to get 50 returns. Notable findings for the trust were: The availability and uptake of Psychological Therapies was average for the trust but was below what should ideally be provided. Performance in monitoring of Physical Health risk factors was average, but was below the ideal target and was poor for provision of intervention for service users with elevated blood pressure. Many aspects of Prescribing Practice were about average for the trust, however, a higher than average proportion of service users whose illness was not in remission did not appear to have an acceptable reason for not having had a trial of clozapine.
- The Trust provided information about clinical audits they took part in in 2014/2015 and these included:
- Effectively embedding psychosocial interventions into Slough Community Mental Health Team.
- POMH - Topic 12: Prescribing for people with personality disorder (June 2014)
- The Trust also told us what National Audits/National Confidential Enquiries that will take part in in 2015/2016 and those relevant to Community Mental Health services for adults of working age include:
- POMH Mental health prescribing - Topic 15a: Prescribing for bipolar disorder. (2644)
- National audit of Early Intervention in Psychosis (EIP) (2880)