Berkshire Healthcare NHS Foundation Trust

Quality Report

2nd & 3rd Floor
Fitzwilliam House
Skimped Hill Lane
Bracknell
Berkshire
RG12 1BQ
Tel:01344 415600
Website: http://www.berkshirehealthcare.nhs.uk

Date of inspection visit: 7 - 11 December 2015
Date of publication: 01/04/2016

Core services inspected	CQC registered location	CQC location ID
Acute Wards for adults of working age and psychiatric intensive care unitss	Prospect Park Hospital	RWX51
Crisis / health cased place of safety	Prospect Park Hospital	RWX51
Crisis / health cased place of safety	Prospect Park Hospital	RWX58
Community adult mental health service	Church Hill House	RWX58
Community child and adolescent mental health service	Trust HQ	RWXAT
Community child and adolescent mental health service	Wokingham Community Hospital	RWXX1
Inpatient child and adolescent mental health service	Berkshire Adolescent Unit	RWX70
Wards for older people with mental health problems	Prospect Park Hospital	RWX51
Community mental health services for older people	Wokingham Community Hospital	RWXX1
Community mental health services for older people	Prospect Park Hospital	RWX51

Summary of findings

Learning Disability Inpatient Wards	Prospect Park Hospital	RWX51
Learning Disability Inpatient Wards	The Little House	RWX54
Learning Disability Community	Church Hill House	RWX58
Community end of life care	St Marks Hospital	RWXX3
Community end of life care	Wokingham Community Hospital	RWXX1
Community end of life care	West Berkshire Community Hospital	RWX86
Community health inpatient services	West Berkshire Community Hospital	RWX86
Community health inpatient services	Upton Hospital	RWX85
Community health inpatient services	St Marks Hospital	RWXX3
Community health inpatient services	Wokingham Community Hospital	RWXX1
Community health inpatient services	Oakwood Unit	RWXW2
Community Health services for adults	St Marks Hospital	RWXX3
Community Health services for adults	Wokingham Community Hospital	RWXX1
Community Health services for adults	Upton Hospital	RWX85
Community Health services for adults	Church Hill House	RWX58
Community Health services for adults	West Berkshire Community Hospital	RWX86

This report describes our judgement of the quality of care at this provider. It 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

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 services at this Provider	Good
Are services safe?	Requires improvement
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 have given Berkshire Health Care NHS Foundation Trust a rating of good and this was because:

We rated all community and inpatient health services as good. Of the nine core services we inspected in mental health we rated seven as good, one as outstanding and one as requires improvement.

The trust has much to be proud of and also some areas that need to improve. The trust was well led with an experienced and proactive senior leadership team and board. There were also many committed and enthusiastic senior staff throughout the organisation working hard to manage and improve services. The trust responded in an open and honest way to the findings of the inspection team. They responded to put things right immediately where we had raised concerns. They were open, transparent and not defensive.

The main areas that were positive were as follows:

- The wards and clinical team bases were clean and well maintained.
- There was good evidence that medicines were well managed across the trust.
- Staff made good use of best practice guidelines and outcome measures.
- There was a strong culture of multi-disciplinary working. Professionals, teams and agencies worked well together.
- Staff recognised and understood their responsibilities in relation to safeguarding. Staff were aware of how to raise an incident and there was a good culture of learning post a serious untoward incident.
- Patients and their carers were positive about the care and treatment they received and felt they were treated with dignity and respect.
- Staff enjoyed working for Berkshire Health Care NHS Foundation Trust. They told us that the board were visible and approachable. They also spoke positively about the opportunities for professional development and told us that managers encouraged them to attend external training and conferences.
- The trust had taken on some challenging services, particularly in primary medical services, one of which had been placed in special measures. They had managed to turn this service around and it is now rated as good.
- Community health services were all rated as good across the board.

There were two core services that required improvement. These were the wards for people with a learning disability and the Circuit Lane medical centre. The main areas for improvement are as follows:

- There was poor management of ligature points on the learning disability inpatient wards and the child and adolescent inpatient ward. A ligature point can be used by people experiencing suicidal thoughts to harm themselves. On the learning disability inpatient wards the trust had identified numerous potential ligature points, and proposed an action plan to mitigate each. However, staff did not maintain the required level of patient observation; there were an insufficient number of ligature cutters given the physical layout of the ward; and, staff had not received training in the use of ligature cutters.
- Neither the child and adolescent inpatient ward or learning disability inpatient wards met the requirements set out by the Department of Health guidance 'Privacy and Dignity, the elimination of mixed sex accommodation'. This states that hospitals should provide accommodation which ensures that men and women are separated and have access to their own facilities, such as toilets and bathrooms. This was also a concern at the high dependency unit at Prospect Park hospital.
- Staff did not monitor people's physical health needs adequately for people with a learning disability.
- Some staff were not communicating well with people with a learning disability, as they lacked the necessary skills and training to do this.

Summary of findings

- The trust had not implemented or monitored changes needed in the appointment system in response to patients' at the Circuit lane surgery. This surgery also needed to ensure that they improved access by telephone to the GP practice.
- We were concerned about the quality and safety of care on the older people's mental health inpatient units. Not all staff were aware of the risks that individual patients faced, nor of the level of observation and support they needed to keep them safe. Not all staff knew how to prevent or care for pressure ulcers. Not all staff on these wards were receiving regular supervision.

We issued the trust with a warning notice in respect of the high dependency unit at Prospect Park Hospital. This was because the trust had failed to ensure that the rights of those people subject to long-term segregation were being met. This breached their policy and the Mental Health Act 1983 accompanying code of practice. We returned to the high dependency unit at Prospect Park on the 11th of February 2016 and were pleased to report that the trust had resolved the concerns raised in the warning notice and were fully compliant with the law.

Summary of findings

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

We always ask the following five questions of the services.

Are services safe?

Requires improvement

We rated safe as requires improvement for the following reasons:

- We were concerned that on the wards for people with a learning disability and the child and adolescent inpatient wards, that ligature points were not being well managed. A ligature point can be used by people experiencing suicidal thoughts to harm themselves.
- Some were not compliant with rules around gender segregation. This was in contravention of the Department of Health guidance 'Privacy and Dignity, the elimination of mixed sex accommodation' This sets out ensuring that men and women have separate facilities, ensuring their safety, dignity and privacy. This was on the inpatient ward for children and adolescents, the inpatient wards for people with a learning disability and on the high dependency unit at Prospect park hospital. We raised this at the time with the trust who responded to our concerns and rectified this at the Berkshire Adolescent Unit by the end of our visit. We returned to the high dependency unit at Prospect Park on the 11th of February 2016. The trust had addressed the concerns about the lack of appropriate gender segregation and had turned the unit into a single sex accommodation.
- On older people's inpatient wards and on the wards for people with a learning disability there were gaps in how risks to patients were monitored. We found that people, who were meant to be on continual observations, were sometimes left unobserved by staff for brief periods. This meant that people could be at risk of coming to harm. We were concerned that on the older people's inpatient wards, staff did not maintain food and fluid recording charts. Agency staff were not always made aware of these charts and the dietary needs of the patients.
- On acute inpatient wards the physical health of patients that were prescribed high dose anti psychotics was not monitored. On the wards for people with a learning disability, on-going monitoring of people with physical health needs was not consistent.

Summary of findings

- There were concerns about dignity and respect in some areas, for instance on Bluebell ward and Daisy ward the en-suite privacy curtains in the double bedroom areas did not provide adequate privacy or dignity when using the shower and toilet facilities
- On the wards for people with a learning disability not all staff were able to adequately communicate with people using appropriate means of communication, such as Makaton or signing. We observed some staff ignoring patients request for attention.
- On the high dependency unit at Prospect Park which is part of the acute inpatient wards for adults, we found that the unit did not afford those subject to long term segregation their rights, as defined by the Mental Health Act 1983, code of practice.
- There were blanket restrictions in place around the searching of patients on admission; this did not take into consideration individual risks and whether a search was necessary.
- Whilst we found that overall staffing levels were adequate, some wards were unable to increase their daytime establishments to staff the place of safety. This meant that staffing levels of the acute inpatient wards for adults could be affected if the place of safety was occupied.
- In the Westcall out of hour's service, printed prescription pads were securely stored, but there was no system in place to record the use of prescriptions to minimise misappropriation or misuse. Although risks to patients were assessed and well managed, some systems to address these risks were not implemented well enough to ensure patients were kept safe. For example, infection control risks and prescription security.

However:

- We found clean and well maintained environments, with good infection control policies and procedures.
- Clinic rooms were equipped with the necessary equipment to carry out physical examinations and equipment and appliances were regularly checked.
- Medicines were well managed across the trust.
- Staff understood safeguarding and when and how to raise an alert.
- The use of physical restraint was minimised by the proactive use of de-escalation techniques.
- There was a healthy culture in relation to reporting incidents and learning from these.

Summary of findings

- Written investigations into serious untoward incidents were carried out in a timely way and were of a high standard.
- There were safe staffing levels.
- There were good lone working policies in place.
- Staff had received mandatory training.

Are services effective?

Good

We rated effective as good for the following reasons:

- There was good use of outcome measures across services.
- Different professional groups such as occupational therapy, physiotherapy, social work, medical and nursing staff worked well together to plan and deliver multi-disciplinary patient care.
- Staff were supported to learn and had good access to continuous professional development.
- There was evidence of clinical audit happening across many services.
- Staff were regularly appraised; using a values based appraisal system.
- People were able to access psychological therapies that were evidence based and in line with the National Institute for Health and Care Excellence guidance.
- There were many examples of staff using best practice and innovative practice.
- For the most part staff received good access to supervision and this was documented.
- Care plans in most services were well written and involved people.

However:

- On the inpatient wards for children and adolescents, care plans we read were instructive rather than recovery oriented and were not written in the patients' voice. This meant that staff wrote what a patient needed to do and did not explain how this might improve their wellbeing. On inpatient wards for those with a learning disability, care plans were variable in their quality and there was a lack of evidence that staff had regularly reviewed and updated them, which could put patients at risk of inappropriate care and treatment.

- On older peoples mental health inpatient wards staff were not always supervised regularly. Staff supervision at band 6 and below was not formally completed, which could have implications for staff practice and patient care. However the trust have subsequently informed us that staff did have the opportunity to take part in a regular 'Space' reflective practice session facilitated by an independent professional.

Summary of findings

- On inpatient wards for people with a learning disability, supervision was not recorded for staff and we had concerns that staff did not have the necessary skills and training to communicate with patients'.
- On learning disability inpatient wards, there was some evidence to suggest that appropriate monitoring and reviewing of patient physical health was taking place. Regular medical checks did not always happen for patient's with long term conditions. The Trust told us that immediate action was taken and a GP is visiting Campion at least twice a month to assist the Multi-disciplinary Team.

Are services caring?

Good

We rated caring as good for the following reasons:

- Staff treated patients with kindness, dignity and respect.
- Most staff had a good understanding of the individual personality traits and emotional support needs of their patients.
- Staff supported individual patient dietary and feeding requirements in a respectful and discreet way.
- 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.
- Carers spoke positively about staff and said they were supportive and caring.
- There were opportunities for people to be involved in decision making and were able to be heard.
- In many services staff were collecting feedback from people and acting on this.
- There was outstanding practice in the caring domain in two of the core services we inspected. Staff demonstrated that they went above and beyond the call of duty and patients reflected this back to us.

However:

- We witnessed a couple of incidents where staff were brusque and did not interact in a way that would make the patient feel cared for.
- In one core service we have highlighted the need for that service to respond to national patient feedback survey, which showed that patients did not rate the practice as highly for several aspects of care as other practices in the area. A further local survey had seen an improvement.

Summary of findings

In mental health services people's involvement in their care planning was not consistent.

Are services responsive to people's needs?

Good

We rated responsive as good for the following reasons:

- Despite there being great pressures, the services were mostly managing to respond to the needs of patients' in a timely manner. The trust had clear timeframes in which to respond to those in the most need. Where there were waiting lists the trust managed these well to mitigate any risks to the patient.
- Teams were providing appointments where possible at times that were suitable for people using the service. If patients did not arrive for their appointment there were arrangements in place to check they were alright.
- The trust provided a good range of therapeutic activities for patients' using inpatient services.
- The trust provided people with spiritual support.
- The trust were responsive to the different needs of people and provided accessible environments and access to information in a range of languages.
- People knew how to complain and the trust responded well to complaints and shared learning from these.
- Beds were well managed and if someone needed a bed they got a bed. Readmission rates were going down.

However:

- In learning disability inpatient services, some staff were unable to communicate with patients using methods, such as Makaton and/or signing.
- In learning disability inpatient services, bedrooms were not personalised, even though three patients had periods of admission lasting longer than twelve months at the time of our inspection..
- There was a lack of written information on display around the wards, which was provided in an accessible form for the patient group on the learning disability inpatient wards.

In one of the GP practices, the trust had been slow to make necessary changes to the appointment system. This was needed to make sure that people could get through to a GP more easily by telephone.

Are services well-led?

Good

We rated well led as good for the following reasons:

- The trust had a strong executive and non-executive leadership team.

Summary of findings

- The trust vision was known by staff working across the trust and they understood how this informed their work.
- The board assurance framework, whilst continuously being refined, was providing the board with the information they needed to perform their role.
- The trust had the right meetings in place to ensure that relevant information on safety, performance, risk and finance was reviewed and monitored.
- The leadership team recognised the importance of strong engagement with patients, staff and external stakeholders. The staff survey put them in the top 20% of trusts for staff engagement.
- The trust was innovative and looked for ways to improve patient care.
- Key stakeholders were positive about their relationship with the trust, describing them as a strong partner in the local health care economy.
- The trust was meeting the fit and proper person test.
- The trust had the right policies and procedures in place to support staff to do their work.
- The trust had a values based appraisal system.

However:

- There were significant concerns about the management of the learning disability inpatient services. This received a rating of requires improvement for safe, caring and responsive and well led. It received a rating of inadequate for effective.

Summary of findings

Our inspection team

Our inspection team was led by:

Head of Inspection: Natasha Sloman, head of hospital inspection for the South East region at the Care Quality Commission.

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

Team Leaders: Louise Phillips and Lisa Cook, Inspection Managers for the South East region at the Care Quality Commission.

The team included CQC inspectors and a variety of specialists:

- Four inspection managers.
- 32 CQC inspectors.
- Three CQC assistant inspectors.
- Four medicine inspectors (pharmacists specialists)
- Two analysts.
- Five Mental Health Act reviewers.
- One inspection planner.
- Two CQC observers from the engagement team.
- One CQC observer from the Adult Social Care Directorate.
- Nine allied health professionals.
- Four experts by experience who have personal experience of using or caring for someone who uses the type of services we were inspecting.
- 21 nurses from a wide range of professional backgrounds.
- Four doctors.
- Two social workers.
- One mental health policy specialist.
- One practice manager.
- Three GPs.
- One person with governance experience.

Why we carried out this inspection

We inspected this core service as part of our on-going comprehensive mental health inspection programme.

How we carried out this inspection

To get to the heart of 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:

- Asked other organisations for information, including Monitor, NHS England, clinical commissioning groups, HealthWatch and other professional bodies and user and carer groups.
- Received information from patients, carers and other groups through our website.
- Requested information from the trust and reviewed the information we received.

During the inspection visit we:

- Visited 102 teams, wards and clinics.
- Spoke with at least 189 service users.
- Collected 412 comment cards from people using services.
- Spoke with at least 47 carers/relatives of service users.
- Went on at least 10 visits to patient's homes.
- Spoke to 94 ward/service managers.
- Spoke with at least 586 other staff members including, but not limited to, doctors, nurses, social workers, occupational therapists, psychologists, support workers and administration workers.
- Attended and observed 23 handover meetings and multi-disciplinary meetings.

Summary of findings

- Reviewed 235 treatment records of patients.
- Reviewed 81 prescription charts.
- Observed at least 10 duty handovers.
- Carried out specific checks of medicine management across the trust.

Reviewed many trust policy and procedure documentations.

Information about the provider

Berkshire Healthcare NHS Foundation Trust provides specialist mental health and community health services to a population of around 900,000 within Berkshire.

The Trust operates from more than 100 sites across the county, including community hospitals,Prospect Park Hospital, clinics and GP Practices. Staff from Berkshire Healthcare NHS Foundation Trust also provides health care and therapy to people in their own homes.

The trust, which was granted foundation status in May 2007, manages 369 inpatient beds across over 8 locations and employs 4,166 full time staff members. The total income for the trust for the 2014/15 financial year was £226.1 million. As a foundation trust, it is also regulated by Monitor.

Seven clinical commissioning groups commission services from the trust; Bracknell and Ascot CCG, NHS Newbury & District CCG, NHS North and West Reading CCG, NHS Slough CCG, NHS South Reading CCG, Windsor, Ascot and Maidenhead CCG and Wokingham CCG.

The Care Quality Commission has inspected services managed by Berkshire Healthcare NHS Foundation Trust on 17 previous occasions across six locations. It found two minor non-compliance issues with the Health and Social Care Act 2008 (2014). These have since been resolved.

CQC has also undertaken six 'Mental Health Act Reviews' since 1 August 2014. These found that Campion ward had the most 'issues' (six).

What people who use the provider's services say

During the inspection we spoke with at least 189 patients and over 46 carers/relatives of patients. We collected 412 comment cards in 43 boxes, none of which were returned empty. Of the comment cards we collected:

- 79% of cards were positive about the care and treatment people received,
- 4% were not positive about their care and treatment,
- 13% of the comments were mixed both negative and positive,
- 12% of the cards were blank,
- 4% unsure of sentiment.

Locations with a greater proportion of negative or mixed sentiments were Ascot and Rose ward, Nicholson's house child and adolescent service (CAMHS) and Bluebell ward. Some key issues that were flagged were:

- CAMHS waiting times.
- Behavioural issues on Rose ward.
- Some criticism of Crisis teams.

Feedback from the interviews carried out with patients and their carers was mostly positive across the majority of services we visited. People felt they were respected and treated with dignity. There were many examples where people told us of the compassion of staff and of the hard work to ensure that people had their needs met.

We received feedback from advocacy services and from the local authorities that there were concerns expressed from people about the long waiting times for child and adolescent community mental health services. The advocacy service also told us that they had received negative feedback in regards to mental health out of hour's services.

In relation to the patient led assessments of care and the environment the trust scored above the national average in all the domains. For the question of dignity, privacy and wellbeing they scored above the national average which stands at 90%.

Summary of findings

In relation to the Care Quality Commission community mental health patient experience survey, the trust generally performed at the same level as other trusts regarding the provision of help and advice to patients, although one area of concern was in support in other areas of life such as finding/keeping work and accommodation. These were the only two questions where the trust scored lower than the national average.

In relation to the 'friends and family test' 92% of users would recommend the trust as a place to receive care (Q1 2015/16). This is slightly below the national average of 96%.

Good practice

Community health inpatient services:

- There was excellent multi-disciplinary working and cooperation within the community hospitals that worked for the benefit of patients.
- There were rotational therapy assistant roles that were being developed to work across the occupational therapy and physiotherapy disciplines.
- There was a vision to integrate nursing and therapy into an overarching rehabilitation model that included all staff. One of the newly appointed ward leaders was a therapist by background and was part of this vision.

Community end of life care:

- The trust had developed an 'end of life care education' programme encompassing the five core competencies outlined in the 'national end of life care programme' along with other community providers such as hospice, GP surgeries and care homes. All eligible staff from community nursing teams, community hospital teams and palliative care nursing teams were able to attend the training programme.
- The East Berkshire palliative care team arranged a 'multi-agency family day' in conjunction with the local hospice three times a year to offer post bereavement support to children and their parents.

Community health services for children, young people and families

- The respite unit at Ryeish Green provided an outstanding service for children with complex needs. The service was child-centred, well organised and staff understood the needs of individual children. Staff maintained an excellent standard of records.
- The school nurses supporting young people in mainstream secondary and special schools demonstrated a high level of competency and compassion. We observed a drop-in session where the nurse showed an exceptional understanding of young people's emotional needs.
- The children and young people's integrated therapy team (CYPIT) had developed a useful, on-line tool-kit to help parents and carers take an active role in care and treatment programmes. People using the service said this had been helpful.

Acute wards for adults of working age and psychiatric intensive care units.

- The trust had access to two GP sessions. One clinic held was for monitoring existing chronic illnesses and treatment recommendations, such as respiratory and metabolic disorders. The focus of the second clinic was health promotion such as smoking cessation, weight management and diabetes.
- One ward had piloted digital dictation handovers to reduce the amount of time spent in protracted conversation during handovers; this time was released back to patient care.

Community mental health services for people with learning disabilities

- We saw good examples of innovative service being developed to address emerging needs in the local population. These included a wheelchair prescription service that served profoundly disabled people in their own homes rather than a clinic.
- Where staffing pressures were great, we saw excellent management of team resources to manage waiting lists.
- We saw an innovative project in development to socially engage people with profound and multiple disabilities.

Summary of findings

- We observed good practice across the service in promoting choice and seeking to enhance peoples' understanding and capacity to make decisions for themselves.

Child and adolescent mental health ward

- The joint work with the onsite education unit was good. Teachers in the unit passed school work to patients from their main schools to ensure the patients' learning was in line with other students in their classes. Ofsted assessed the school as 'Outstanding' in 2013. Education leads attended ward meetings to ensure that patients' health needs were taken into account when developing learning plans.

Wards for people with learning disabilities or autism

- The service had reduced the use of restraint through the use of proactive de-escalation techniques, within the PROACT-SCIPr-UK® system.
- The level of pre-discharge support given to patients was good; encompassing the use of the 'placement planning matrix' element of the 'planning live' system of person centred planning.
- There was good spiritual support available to patients, via a chaplaincy service and a multi faith support group. Patients at Campion Unit had access to the 'Sanctuary' multi faith room on the main Prospect Park Hospital site and spiritual care resources for prayer and meditation.

Wards for older people with mental health problems

- Both wards we visited had implemented the safe wards scheme, led by the occupational therapy team. These were the first wards for older people with mental health problems in the country to have done so. Safe wards are de-escalation and risk management approach that involves talking with patients using soft words and creating calming space on the wards. We saw evidence of visiting professors' commendations and national recognition for implementing the scheme. Mental health providers from America, Norway and within the UK have all visited the wards to see how safe wards are applied.

Specialist community mental health services for children and young people

- The trust had appointed a dedicated service user facilitator to support and develop an active user and carer participation group. The group had made improvements to service design such as, community buildings, so that they were more accessible and welcoming to young people. Young people were also involved in the development of a support, hope and recovery online network (SHaRON) specifically for young people. This was a younger person's version of the established web based forum providing additional online peer support between appointments through a secure and supported social networking site.

Community-based mental health services for older people.

- The Wokingham team had established the 'young people with dementia' (Berkshire West) charity. The charity was formed due to a shortage of local support and helped to meet the needs of people who develop dementia at an early age. The charity also supports relatives and carers of young people with dementia. The community-based older peoples mental health teams and the charity collaborate to provide seamless pathway for young people with dementia and their carers.
- Community based older people's mental health services in Berkshire have identified a higher number of young people with dementia than the national average. The charity has employed the country's first Admiral Nurse working with younger people with dementia. This specialist role is designed to help patients, carers and families learn about dementia and how to move forward with their lives. This is achieved by offering practical support and therapeutic intervention.
- The trust had developed a "dementia handbook for carers" which was widely available available in the 3 Berkshire West teams: Wokingham, Reading & Newbury teams and electronically on BHFT's intranet site 'teamnet'. The handbook contained detailed information for carers about the services available locally, day to day living, support, legal and money matters, an A-Z of symptoms and behaviours and a section on record keeping and updating relevant care documents. The handbook had been developed with the University of Reading and as part of its development a group of carers for people living with dementia were consulted for their input. The

handbook was given to those with a new diagnosis of dementia and their carers and was intended to offer useful support and information. GP practices had requested copies of the handbook and it was available in all local surgeries

- The trust offered an "Understanding Dementia" education course for relatives and carers of patients. The course is offered over six weeks and covered information about the illness and medicines, legal and financial aspects, long term planning, living well with dementia and managing new behaviours.

Westcall Out of Hours Service

- The service had introduced two near patient testing kits for diagnosing deep vein thrombosis (a blood clot in one of the deep veins of the body) and sepsis (where the body's immune system triggers a series of reactions including widespread inflammation, swelling and blood clotting). Both kits provided clinicians with the tools to make an early diagnosis and provide early intervention to prevent the worsening of the condition or even death. The use of these kits had prevented unnecessary hospital admissions and provided better outcomes for patients.
- 17,000 patients had advanced care plans, which contained care and treatment information about the individual patient. The development, usage and completion of these care plans were driven by Westcall leaders and clinicians. The initial care plans were entered by individual surgeries and hosted on the Adastra system. This included medicines, end of life care, palliative care needs, allergies etc. With the individuals consent these records could be accessed and updated by Westcall clinicians and staff, emergency department staff in Berkshire, district nurses, palliative care nurses and other health professionals, so up to date care and treatment could be provided 24 hours per day.

Community-based mental health services for adults of working age.

- An outstanding pharmacy led Clozapine service which uses the near-patient testing machine and blood results are received whilst the person is in the clinic. The medicines are pre-dispensed and supplied to the patient when the blood result is received. Service users told us how efficient and streamlined they found this service to be.
- 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 people who use services. Assist is a service commissioned to provide 12 weeks intensive work, which involves assertive engagement and psychological intervention to achieve stabilisation and reduce vulnerability to hospital admission.
- There was an 'individual placement and support' project at both Reading and Slough teams. The focus is on rapid access to open competitive employment, based on service user's willingness to work. We saw two case studies of service users in Slough and Reading teams assisted by this model. We saw literature that showed that 'individual placement and support' is a proven evidence based model and that the service had already exceeded its outcomes.
- There is excellent psychology input for both staff and service users in line with 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 are experiencing a crisis and need support. Where these teams are in place there is nobody on the waiting list for a care co-ordinator.

Mental health crisis services and health- based places of safety

- The crisis team had set up a carers' group in both east and west which was well attended and generated positive comments.
- The west crisis team had access to crisis beds at Yew Tree Lodge to prevent admission to a psychiatric ward.
- Street triage had been implemented in summer 2015 and had reduced the number of S136 detentions in custody.
- The health based place of safety had strong links with external agencies and good interagency policies and procedures.

Summary of findings

Areas for improvement

Action the provider MUST take to improve

Circuit Lane Surgery

• The trust must ensure they implement and monitor changes in the appointment system in response to patient feedback. For example, 86% said the last appointment they got was convenient compared to the CCG average of 91% and national average of 92%.

• The trust must ensure they improve access by telephone to the practice and monitoring the outcome of the installation of the proposed new telephone system. For example, 65% of patients said they could get through easily to the surgery by phone compared to the CCG average of 76% and national average of 73%.

Wards for people with learning disabilities or autism

• The trust must improve mitigation against identified ligature risks, to safeguard patients.

• The trust must improve assessment, monitoring, reviewing and recording of patients' physical health needs on Campion unit.

• The trust must take action to ensure patients' privacy, dignity and safety are not compromised as a result of a breach of same-sex accommodation guidelines.

• The trust must review the seclusion facilities on Campion unit, to ensure they are safe and meet current guidelines.

• The trust must ensure that where patients require constant observation this is provided.

The trust must ensure that staff receive the right support and training so that they can communicate with people with a learning disability.

Child and adolescent community mental health services

The trust, with commissioners must address the waiting times for those children and young people needing a service.

Child and adolescent mental health ward

• The trust must ensure that the ligature risk assessment is updated and includes details about how all risks are managed. All staff must know where the ligature risks are, understand how to manage those risks, and improve patient risk assessment when allocating bedrooms.

• The trust must ensure that all patient risks identified in risk assessments are included in care plans to improve risk management.

Wards for older people with mental health problems

• The trust must ensure that all staff working on the wards are aware of the requirements of individual patient needs and observations to ensure that these were being carried out appropriately and risks to patients were minimised. This includes physical and mental health issues.

• The trust must ensure all staff working on the wards are made aware of the risks of the patients in their care.

• The trust must ensure that individual care plans are developed for all risks identified in patients.

• The trust must ensure staff receive supervision to ensure they are provided with appropriate support to meet patient needs.

Westcall out of hours service

• The trust must ensure that there is a system in place to record the use of prescriptions to minimise misappropriation or misuse. The security of blank prescription forms required improvement as there was no system in place to monitor the use and movement of these.

Action the provider SHOULD take to improve

Circuit Lane Surgery

• The trust should ensure they are recording the checks of emergency medical equipment.

• The trust should ensure they are reviewing the controlled drugs held at the practice.

• The trust should ensure they promote the availability of the chaperone service.

Mental health crisis services and health based places of safety

• The trust should ensure that the improvement plan for the crisis services is implemented. The current policy needs updating to define clear referral criteria.

• The trust should ensure safeguarding referrals are recorded in patient notes.

Summary of findings

• The trust should ensure that the Mental Capacity Act 2005 is being used within the wider context, not just in relation to consent to treatment.

• The trust should ensure that the environmental review of the health based place of safety be completed and changes implemented.

• The trust should ensure that the bolt on the door separating the health based place of safety and crisis services is changed to a double key lock.

• The trust should ensure that environmental and ligature risk assessments are always available in the health based place of safety.

Specialist community mental health services for children and young people.

• The trust should ensure that there are consistent cleaning rotas.

• The trust should consider arrangements for personal alarms and alarms in treatment and interview rooms.

• The trust should ensure that all environmental risk assessments, including ligature risk assessments are routinely shared with staff teams.

• The trust should ensure the quality of risk assessment records.

• The trust should ensure that supervision records are accurately kept in line with policy.

• The trust should ensure access to independent advocacy.

• The trust should ensure clear signposting to carer's information and support.

• The trust should improve waiting times from referral to treatment for all pathway and specialist services.

Community mental health services for people with learning disabilities

• The trust should ensure all people using the service have accurate up to date risk assessments. These were not always in place and this could create a risk of harm to the person, staff working with the person or the wider public.

• The trust should ensure there is clear responsibility within teams for updating risk tools such as the risk register. These were mostly used very effectively across the services we inspected, apart from Slough, where the absence of a health team lead led to poor management of waiting lists.

Community-based mental health services for adults of working age.

• The trust should ensure a review of 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.

Community end of life care

• The trust should ensure that advance decisions and DNACPR decisions are discussed with patients and their families. These decisions are recorded in such a way as this information is accessible to all the services that the patient may use.

• The trust should ensure there is improvement in the collection of information about the dying persons' preferred place of care.

•The trust should ensure there is a consistent approach to advance care planning that occurs across the organisation for patients at end of life.

• The trust should ensure there is formal training for nurses to verify death and the competencies of the nurses who verify deaths are assessed regularly.

Community health inpatient services

• The trust should ensure that there is safe storage for spare oxygen cylinders on community hospital wards to reduce the risk of injury.

• The trust should consider implementation of an early warning system in the minor injuries unit, to help ensure the early detection of a deteriorating patient.

Wards for people with learning disabilities or autism

• The trust should ensure that all domestic cleaning materials are stored in a manner that complies with Control of Substances Hazardous to Health (COSHH) Regulations 2002.

Summary of findings

• The trust should review the consistency and quality of patients' care plans.

• The trust should ensure that, where possible, patients and/or their carers are involved in the planning and reviewing of their care. Patients should have access to and offered a copy of their care plan.

• The trust should ensure that all staff are trained in the use of the Mental Health Act (MHA) (including the 2015 Code of Practice), Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

• The trust should improve their provision of information in accessible forms for their patient group.

• The trust should ensure that evidence of explaining patient rights under the MHA (per s132) is uploaded to patient electronic systems and that they repeat an explanation of rights when patients fail to understand.

• The trust should increase weekend activity provision at Campion unit.

• The trust should review the quality and consistency of records, particularly in relation to the recording and retention of minutes of: supervision meetings, staff appraisals and staff meetings.

• The trust should improve staff involvement in strategic discussions affecting the service.

Community health services for adults

•The trust should ensure the service reviews the use of the pressure ulcer risk assessment tool to ensure staff use the tool consistently to monitor risks.

• The trust should ensure that services adhere to trust policies and procedures for the maintenance and fitness for purpose of equipment..

• The trust should ensure staff are aware of their responsibilities in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

• The trust should ensure staff are supported to attend clinical supervision and attendance is monitored.

Community health services for children, young people and families

• The trust should ensure assessment records for looked after children are completed by the staff who undertake the assessments, to minimise risk of misinterpreting assessment findings.

• The health team for looked after children should work with CCG and Local Authorities to ensure services for looked after child ` ren are planned effectively.

• The trust should ensure records for children with complex needs should include detailed instructions on how to prepare food of safe consistency, to minimise the risk of aspiration or choking.

• The trust should ensure guidance documents for people using the service are available in different languages and formats, appropriate to the local population.

• The trust should ensure sexual health services have electronic records system that links effectively with records created by other services.

• The trust should ensure staffing levels, for example of health visitors, occupational therapists, sexual health managers and looked after children staff, should be reviewed to ensure they meet the needs of the service.

Acute wards for adults of working age and psychiatric intensive care units.

• The trust should ensure that physical health monitoring for those patients' taking high dose antipsychotics is in place.

• The trust should consider how it would increase the access to psychological therapies on the adult acute wards and psychiatric intensive care units in line with NICE guidance.

• The trust should consider its strategy for managing those patients' with a diagnosis of a personality disorder whilst on the adult acute wards and PICU.

• The trust should review their policy for searching all patients within 30 minutes admission.

• The trust should review how they staff the place of safety as this depletes the ward and increases the amount of bank and agency staff on the adult acute wards and PICU.

• The trust should ensure that risk to patients' are identified and appropriate management plans are put in place to manage those risks.

Summary of findings

Child and adolescent mental health ward

• The trust should ensure that all staff understands Gillick competence. This is when a patient under the legal age of consent is considered to be competent enough to consent to their own treatment rather than have their parents' consent.

• The trust should ensure that patients have access to a mental health advocate to make sure they have a voice to ask for what they need.

• The trust should ensure that staff complete 'health of the nation scale for children and adolescents' and 'children's global assessment scale' outcome tools for all patients to monitor improvements in patients' wellbeing.

• The trust should ensure management develops and agrees a formal debriefing policy for staff following incidents on the ward.

• The trust should ensure that fire extinguishers around the ward are secured to stop patients using them to harm themselves or others.

• The trust should ensure that the unboxed fuse and other electrical point boxes on the corridor walls are secured to ensure they are tamper proof. They can be reached by patients to stop power supply to the ward.

• The trust should ensure that the unboxed metal pipe and tap on the ward is addressed so it is not a risk to patients.

Wards for older people with mental health problems

• The trust should ensure staff report all incidents that occur on the ward.

• The trust should ensure that patient confidentiality is maintained where patient names were displayed in the office on Orchid ward, which could also have been seen from the ward area.

• The trust should ensure the privacy and dignity of patients is promoted through the provision of curtains around the door of the bathrooms on both wards.

• The trust should ensure care plans reflect risks highlighted in the risk assessments.

• The trust should ensure patients are given more opportunity to be involved in their care plans, where able.

• The trust should ensure notices to inform patients not detained under the Mental Health Act 1983 are displayed inside the entrance to all wards.

• The trust should ensure a best interest discussion takes place for any informal patients attempting to leave the ward.

Priory avenue surgery

• The trust should provide practice information in a range of languages and formats.

Westcall out of hours service

• The trust should introduce a system of recording the cold chain for when medicines requiring refrigeration are transported between sites.

• The trust should ensure all nursing staff have received chaperone training and the chaperone service is clearly advertised to patients in both primary care centres.

• The trust should appoint a lead nurse to ensure appropriate support for nurses and, where appropriate, ensure appraisals are undertaken.

• The trust should review the provision and utilisation of nursing staff to allow greater responsibility and support for the care and treatment of patients, reducing the impact on GPs.

• The trust should review the infection control procedures to ensure a robust audit is undertaken, regular checks are in implemented and actions taken.

• The trust should ensure all staff received Mental Capacity Act training appropriate to their role.

• The trust should improve patient communications

Berkshire Healthcare NHS Foundation Trust

Detailed findings

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 head of Mental Helath Inpatients oversaw the operation of the Mental Health Act (MHA). The Mental Health Act group met every two months and reported MHA outcomes quarterly to the quality committee. The trust's MHA team which carried out the day to day work relating to the MHA 1983 compiled a monthly report on MHA activity and key information was circulated to the designated MHA lead on each ward. In addition, an audit on capacity to consent to treatment was completed quarterly and monitoring was taking place on reducing restrictive interventions.

There were robust systems in place to scrutinise documents. Overall, we saw good evidence that detention papers were properly filled in and correct. Working relationships with other staff groups such as police and ambulance services were good.

The MHA team told us that they had recently introduced a system of routinely offering advocacy to any patient that had experienced seclusion or restraint and that they offered drop-in sessions for patients on the wards.

The trust reported that all staff received MHA training as part of their mandatory annual training week. A number of actions had been taken to implement the new Code of Practice. These included producing a report highlighting the key differences which had been used in staff training, paper copies of the new Code on each ward, and updating relevant policies. On the majority of wards visited we found a copy of the new Code.

During the inspection we carried out a full Mental Health Act review on five wards in a range of core services and visited the section 136 suites. We also reviewed the documentation of 12 patients in two areas who were subject to a Community Treatment Orders (CTO). A community treatment order is a detention order for people who may be at risk of relapsing in relation to their mental health and subsequently be readmitted to hospital.

On three of the wards reviewed, we found that the involvement of patients in their care was well recorded and patients told us that they had copies of their care plans. Patients who had a CTO spoke highly of the service and felt fully involved in their care and treatment.

Staff on Rowan ward were good at recording the fact that they had informed patients of their rights under the MHA. Staff on some other wards were not so good at doing this. Some patients had received an explanation when first detained, but this was not repeated after critical events, nor if their ability to understand their rights changed. At the Berkshire adolescent unit there was no Independent Mental Health Advocacy (IMHA) as this had not been commissioned prior to the service opening.

Staff working on Sorrell ward appeared to not fully understand the definition of seclusion. Patients accommodated in seclusion and in the high dependency unit, were not afforded the safeguards as defined in the Code of Practice and the trust's own policy. This resulted in a warning notice being issued.

Requires improvement

Are services safe?

Staff authorised section 17 leave through a standardised system and generally did this well. They assessed risks before patients went on leave and gave patients a copy of the authorisation. On Rowan ward there were no photographs of patients, which is a requirement of the new Code of Practice.

Mental Capacity Act and Deprivation of Liberty Safeguards

Detention papers for those subject to a deprivation of liberty were available for review and were in good order.

Deprivation of Liberty Safeguards (DoLS) were being used appropriately on wards for older people. However in the Little House (acute admission ward for people with a learning disability), staff did not appear to understand that a patient who had been assessed as ineligible for DoLS, was in fact an informal patient.

Capacity to consent to treatment was fully documented on some wards, but on others was recorded only as a brief note, with no record of the assessment or reason for the decision. On the Berkshire adolescent unit (BAU) consent was being given by parents and staff were unaware of the criteria for 'Gillick competency' described in the Code of Practice.

Requires improvement

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

Summary of findings

We rated safe as requires improvement for the following reasons:

- We were concerned that on the wards for people with a learning disability and the child and adolescent inpatient wards, that ligature points were not being well managed. A ligature point can be used by people experiencing suicidal thoughts to harm themselves.
- Some were not compliant with rules around gender segregation. This was in contravention of the Department of Health guidance 'Privacy and Dignity, the elimination of mixed sex accommodation' This sets out ensuring that men and women have separate facilities, ensuring their safety, dignity and privacy. This was on the inpatient ward for children and adolescents, the inpatient wards for people with a learning disability and on the high dependency unit at Prospect park hospital. We raised this at the time with the trust who responded to our concerns and rectified this at the Berkshire Adolescent Unit by the end of our visit. We returned to the high dependency unit at Prospect Park on the 11th of February 2016. The trust had addressed the concerns about the lack of appropriate gender segregation and had turned the unit into a single sex accommodation.
- On older people's inpatient wards and on the wards for people with a learning disability there were gaps in how risks to patients were monitored. We found that people, who were meant to be on continual observations, were sometimes left unobserved by staff for brief periods. This meant that people could be at risk of coming to harm. We were concerned that

Requires improvement

Are services safe?

on the older people's inpatient wards, staff did not maintain food and fluid recording charts. Agency staff were not always made aware of these charts and the dietary needs of the patients.

- On acute inpatient wards the physical health of patients that were prescribed high dose anti psychotics was not monitored. On the wards for people with a learning disability, on-going monitoring of people with physical health needs was not consistent.
- There were concerns about dignity and respect in some areas, for instance on Bluebell ward and Daisy ward the en-suite privacy curtains in the double bedroom areas did not provide adequate privacy or dignity when using the shower and toilet facilities
- On the wards for people with a learning disability not all staff were able to adequately communicate with people using appropriate means of communication, such as Makaton or signing. We observed some staff ignoring patients request for attention.
- On the high dependency unit at Prospect Park which is part of the acute inpatient wards for adults, we found that the unit did not afford those subject to long term segregation their rights, as defined by the Mental Health Act 1983, code of practice.
- There were blanket restrictions in place around the searching of patients on admission; this did not take into consideration individual risks and whether a search was necessary.
- Whilst we found that overall staffing levels were adequate, some wards were unable to increase their daytime establishments to staff the place of safety. This meant that staffing levels of the acute inpatient wards for adults could be affected if the place of safety was occupied.
- In the Westcall out of hour's service, printed prescription pads were securely stored, but there was no system in place to record the use of prescriptions to minimise misappropriation or misuse. Although risks to patients were assessed and well managed, some systems to address these risks were not implemented well enough to ensure patients were kept safe. For example, infection control risks and prescription security.

However:

- We found clean and well maintained environments, with good infection control policies and procedures.
- Clinic rooms were equipped with the necessary equipment to carry out physical examinations and equipment and appliances were regularly checked.
- Medicines were well managed across the trust.
- Staff understood safeguarding and when and how to raise an alert.
- The use of physical restraint was minimised by the proactive use of de-escalation techniques.
- There was a healthy culture in relation to reporting incidents and learning from these.
- Written investigations into serious untoward incidents were carried out in a timely way and were of a high standard.
- There were safe staffing levels.
- There were good lone working policies in place.
- Staff had received mandatory training.

Our findings

Safe and clean care environments

Staff on some wards had not acted to reduce the risk posed to patients by potential ligature anchor points. A ligature anchor point is a fixture or fitting that a person who has suicidal urges could attempt to harm themselves. For example, in the child and adolescent inpatient ward, we observed ligature risk points on the ward which were not in the ward risk assessment. Five out of nine bedrooms had not been noted on the assessment had ligature risks and this meant that young people had unsupervised access to rooms with ligature points. However, following our visit, management immediately took steps to ensure all staff knew where the risks were and how to manage them. We evidenced this when we carried out an unannounced visit the following week.

The trust had identified numerous potential ligature points, and proposed an action plan to mitigate each. However,

staff did not maintain the required level of patient observation; there were an insufficient number of ligature cutters given the physical layout of the ward; and, staff had not received training in the use of ligature cutters.

Emergency resuscitation equipment was well maintained and procedures were followed across the trust.

There were concerns regarding gender segregation on both learning disability wards, where the trust was not meeting best practice. Toilet and bathroom facilities were shared at Little House and there were no day lounges for use by women only. Additionally, the location of female only facilities on Campion unit did not safeguard the dignity and privacy of females.

Environments were generally clean and well maintained across the trust. The trust as a whole scored better than the England average for both 'cleanliness' (97%) and 'condition, appearance and maintenance' (92%) on the latest 'patient led assessments of the care environment' (PLACE) scores, scoring 99% and 94% respectively. Only the West Berkshire community hospital and St Mark's hospital were sites which scored lower than the England average for the above categories. In primary medical services, infection control risks remained at the Westcall out of hour's service, as some systems to address these risks were not implemented well enough to ensure patient safety.

In children and young peoples' service staff explained they used a range of toys and equipment but ensured they were cleaned regularly. Respite centres for children had rotas for cleaning toys and staff gave examples of the advice they had received from the trust's infection, prevention and control team.

Safe staffing

The trust has experienced significant challenges in relation to the on-going recruitment and retention of staff. The trust told us that 'there is a shortage of registered nursing staff available in the Thames Valley area and therefore registered nursing vacancies were hard to fill and good registered temporary nursing staff are equally hard to find' The trust was working on this and a root cause analysis of the blockages to recruitment had been carried out. It identified key themes which needed addressing. These were:

- Too long a time to fill a job.
- Lack of early identification of vacancies that are hard to fill.
- Lack of presence, (website needed work, poor marketing, not being attractive enough)
- No analysis of turnover, so exit interviewing not happening consistently.

In order to address this the trust have:

- Brought in specialist help.
- Are improving the trust website.
- Have held recruitment fairs.
- Have had a series of open days.
- Are improving turn around, i.e. moving quickly to fill vacancies.
- Are improving how they receive feedback from staff leaving and joining the organisation.
- Making the first 100 days the best experience for staff, this was just being piloted from 1st December 2015.
- Targeting their recruitment campaigns.

As such, the places with the highest vacancy rates were:

- Royal Berkshire Hospital (older people's psychological service) reports 37% staff vacancies, with a total of 21 WTE staff.
- Bluebell ward at Prospect Park hospital on the intensive care unit for mental health has a 21% vacancy rate with 31 WTE staff.
- Milman road health centre (Community Nursing Service) has 5% vacancies, with 20 whole time equivalent (WTE) staff.

Currently, the highest sickness rates reported were by Whitley health & social services centre (children's community), Jubilee ward at Upton Hospital and Henry Tudor Ward on St Mark's hospital providing intensive community rehabilitation.

Between the period February-April 2015, three wards were reported as having fill rates of 80% or less (Bluebell ward, Donnington and Highclere)

At a service level it was noted that the trust is taking steps to manage the staffing issues.

In the children and adolescent mental health community services, staffing levels were improving to manage capacity and reduce the long waiting lists. Weekly allocation meetings included clear risk planning and risk mitigation. Additionally, in the health based places of safety and crisis services the trust had recognised problems within crisis

services and had implemented a thorough action plan. This included investing £1million and increasing staffing by 18 WTE over the last few months. Where there were high vacancies, the trust were managing this though the use of bank and agency staff. Where possible the trust attempted to use bank and agency staff on a regular basis, so that they were familiar with patients, systems and other staff.

Assessing and managing risk to patients and staff

There were two adult safeguarding professionals plus a team of named nurses for children and a 'Prevent' lead. The Prevent strategy is the government response to help counter the extreme ideologies that recruit vulnerable people and offers guidance and support to those who are drawn to them. Staff were provided with Prevent training and 60% of staff had received this at the time of the inspection.

There was a standardised process for safeguarding referrals, so that all referrals were reviewed by the safeguarding professionals. The safeguarding professionals then direct this to the appropriate safeguarding authority. All referrals made by trust staff are through the computerised incident reporting system. However, some safeguarding referrals involving children and young people were made directly to children's' social care unless they are part of an incident. The safeguarding professionals monitor the progress of safeguarding referrals and meet with local authorities monthly to follow up on any that were outstanding. Urgent referrals would involve more frequent contact. The safeguarding professionals had a presence at a number of partnership forums and boards across the local authorities and clinical commissioning groups that are involved with the trust.

The safeguarding professionals provide advice and safeguarding and Prevent training to all staff. All trust staff do a minimum of Level 1 safeguarding training, with 91% of staff having received this. Training was initially provided face-to-face, followed by e-learning refresher training every three years. Level 2 safeguarding training was provided to senior clinicians and staff who work with patients in their own home. The safeguarding training was in the process of being developed to include training on child exploitation and female genital mutilation. Some bespoke training was provided to wards/ teams where this has been requested, or where the safeguarding incident reports had indicated a trend. Examples of this included training around pressure ulcers and targeted work around Deprivation of Liberties Safeguards (DoLS).

Locally, safeguarding policies and procedures were good and adhered to, with staff able to recognise their responsibilities in relation to safeguarding across the trust. In community mental health services for adults, safeguarding information and contacts were visible on notice boards in the waiting areas. Each team had a safeguarding lead and staff across the teams were able to identify this lead and demonstrated good knowledge of how to identify and escalate any safeguarding concerns. In the primary medical services, there were clearly defined and embedded systems, processes and practices in place to keep people safe and safeguarded from abuse.

Individual risk assessments varied across the trust. In older people inpatient services, risk was not always appropriately planned for. We observed that staff did not always keep patients in line of sight as required. Temporary staff on Orchid ward were not made aware of individual patient needs and observations levels required to ensure that risks were minimised. However, patients did tell us that they felt safe on these wards. Additionally, in the child and adolescent inpatient services, staff did not include the risks they identified in two of the three inpatient care plans we read. In older people's community mental health services, however, risk assessments were undertaken and well recorded in all four teams. We saw examples of very thorough analysis of risk with crisis and contingency plans.

Services for children and families reflected the healthy child programme (HCP) and national child measurement programme. These programmes include assessment stages and tools to identify and respond to children and young people between 0 and 19 years of age who may be at risk of harm, disorder or ill health. The HCP meant that risks relating to parental or child welfare of child development could be identified at routine checks carried out by health visitors, nursery nurses, school nurses and medical staff. Staff used a colour coded flagging system on children's electronic records to describe their specific needs and risks. This helped advise all staff involved in the child's care of their individual risks quickly. For example, health visitors reviewed higher risk children and young people more frequently.

Requires improvement

Are services safe?

In community health inpatient units, the wards clearly displayed patient safety and quality information, such as numbers of pressure ulcers, falls and hospital acquired infections. There were low numbers of incidents that led to harm to patients. There were no acquired pressure ulcers that were reported to have developed in any inpatient unit since December 2014. At the Henry Tudor ward there had been no acquired pressure ulcers for two years.

Staff in these teams had volunteered to become ward champions for many aspects of clinical care such as tissue viability and falls. These staff received additional training and acted as a resource for other ward staff.

In community health services, risk assessments were undertaken as part of the initial assessment when a patient was referred to the service. For example, during a first home visit we observed full initial assessments were undertaken including an assessment of risk of pressure ulcers (Waterlow), malnutrition universal screening tool (MUST), moving and handling and falls. For specialist services, assessments including additional subjective and objective measures were undertaken.

Trust figures suggest that the trust is currently below its own target for mandatory training on completion for Mental Capacity Act 2005 and deprivation of liberty safeguards training. However in relation to mandatory training, such as infection control, this had a 95% completion rate and for safeguarding adults and children this stood at 95%. Overall the trust had good compliance with its mandatory training programs and overall the figure stood at 94%.

Use of control and restraint

Over the past six months, there were 312 reported uses of restraint, across the trust, with 107 (34%) of these in the prone position and 52 (48%) resulting in rapid tranquilisation. The highest use of seclusion and prone restraints was on the Sorrel ward, which is the psychiatric intensive care unit. Bluebell ward had the highest use of rapid tranquilisation with 17 incidents of its use (33%).

On the acute and psychiatric intensive care unit there were 80 episodes of seclusion in the six months up to August 2015; these episodes were all on Sorrell ward. Sorrell ward had the only seclusion room on the unit for the adult acute and psychiatric intensive care use.

The staff we spoke to regarding restraint and prone restraint in particular stated that the training that they received discussed the risks of prone restraint and alternatives to using prone restraint. Staff told us that the electronic incident recording system they used (DATIX) asked for each position that a patient was placed in during a restraint and the duration they were in that position. Staff told us if patients placed themselves into the prone position initially during a restraint that this would be recorded but patients would be turned as soon as it was safe to manoeuvre them.

Staff on Sorrel ward failed to follow the Mental Health Act 1983 Code of Practice (CoP). We observed a patient being nursed in the seclusion room, although staff reported the patient was not formally secluded. The patient was prevented from leaving the seclusion room. The Mental Health Act 1983: code of practice (CoP p26.103) states that "Seclusion refers to the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving." Therefore, the patient was secluded and had not been afforded the rights of clinical review and monitoring as prescribed in the CoP.

We spoke to and reviewed the records for both patients nursed in the high dependency unit (HDU), we found that one patient had been in the HDU for 6 days and the other had been there for 18 days. The trust had a policy on the management of long term segregation which was not being followed. As a result of this breach the trust were issued a warning notice.

The trust had a policy for the prevention and management of violence and aggression and offered staff comprehensive training programmes through a specialist training team.

There was good evidence of de-escalation procedures, which minimised the need for physical restraint in the learning disability services and older people's inpatient services. These techniques helped to calm distressed and anxious patients.

Medicines management

Two pharmacists and a pharmacist specialist advisor looked at medicines management within the Trust. Medicines were stored securely in locked rooms or locked cupboards and access to medicines was controlled appropriately. Temperatures for medicine refrigerators were recorded. Medicine stocks were managed by the

pharmacy department. We saw minimal and well organised stock. Medicines within the trust were safe for administration to patients. The ordering, storage and administration of controlled drugs was in accordance with the Misuse of Drugs Act 1971 and the associated regulations. In the services we visited there were suitable cupboards to store controlled drugs. Incidents involving controlled drugs were reported via the incident reporting system and the stock was checked at least every three months by the pharmacy department.

The Trust provided a clinical pharmacy service to all inpatient departments five days a week. Not all community services received pharmacist visits; in particular only two of the six community mental health teams received support from a pharmacist and the primary healthcare services did not have pharmacist input. However, medicine supply and advice was available 24 hours per day, seven days a week, which means that patients did not experience undue delays in receiving medicines. The pharmacy team completed the medicine reconciliation during the patient's hospital stay. Medicines reconciliation is a formal process of obtaining and verifying a complete and accurate list of each patient's current medicines. The medicines management team assessed the medicines that patients brought in to hospital to make sure that they were safe to use. These processes contributed to ensuring that patients received the right medicines in hospital.

Staff and patients told us that discharge from hospital was not delayed due to waiting for medicines to take home. There were processes in place to supply medicines directly from the wards which provided a responsive service to patients. The pharmacy department was proactive in supplying compliance aids and medicine information to help patients take their medicines safely at home.

The trust had an organisational structure to manage medicines safety. We saw that medicine incidents were reported by staff and investigated by the medicine safety officer. Medicine incidents were discussed at trust wide governance meetings and processes were changed as a result of incidents. We did not see evidence that the shared learning or changes to processes were effectively communicated to departments. It is therefore not possible to say that medicines governance was consistent throughout the Trust.

Track record on safety

A total of 3,601 incidents were reported to the 'national reporting and learning system' (NRLS) by the trust between 1st September 2014 – 31st August 2015, of which 1.5% of incidents accounted for were deaths (54). The majority of incidents resulted in 'no harm' (91%) or 'low harm' (32%) to the patient. Of these 7% resulted in moderate harm and 0.1% in severe harm.

There were 114 incidents that were reported to the serious incident reporting structure (STEIS) between 1st October 2014 and 30th September 2015. 29 (25%) of these pertained to deaths with 'apparent/actual/suspected self-inflicted harm' accounting for the majority of incidents (17%). There were no reported never events.

The health based place of safety service had their highest number of incidents recorded in August 2015. This 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 investigation and recommendations were made. Staffing was increased and activities were made available for patients to use while in the health based place of safety. New access card points had been fitted to ensure patients could not gain access to the staff office where the incident occurred. The CQC received a copy of the investigation following the above serious incident and this was found to be thorough and balanced.

On the acute and psychiatric intensive care units, there had been 26 serious incidents in the period August 2014 – July 2015. Nineteen incidents were classed as admission of a minor to an adult acute ward or psychiatric intensive care unit. There were four absent without leave over a period of 72 hours, two incidences involved allegations against staff (agency) and one incident involving a restraint of a patient.

The trust recognised that there was an issue relating to the admission of minors to the adult acute and psychiatric intensive care wards. The trust escalated this as a concern to NHS England, which agreed to fund nine tier four beds at the Berkshire adolescent unit as of October 2015. However, this ward at the time of inspection was only open to three patients, as the resources required to function at capacity was not in place.

In community health services, during September 2014 to September 2015, the number of new pressure ulcers per

month decreased from 21 in September 2014 to eight in June 2015. However, more recently the average was15 per month. The prevalence of new pressure ulcers was similar to the national average.

Also in community health services, between September 2014 and September 2015, the incidence of catheter related new urinary tract infections was lower than the national average in nine out of the last 13 months, with a monthly average of 0.27%, which is the same as the national average of 0.3%. The prevalence of falls with harm was 0.5% which is the same as the national average of 0.6%.

Across the directorate, the average percentage of patients receiving harm free care was above the national average of 91%.

The 'expected' suicide rate for Berkshire Health Care Trust of 22 for a 12 month period was exceeded for the first time in June 2015 (to 26). The trust has set about understanding this and has undertaken a review of local suicides and a thematic review of a cluster of deaths which happened in April 2015. These reports made a number of recommendations, which are being overseen by the suicide steering group. Additionally there was good collaboration in the Thames Valley, led by the strategic clinical network and the patient safety collaborative to reduce suicide rates across the region. Training is an important component of this and had been targeted at crisis staff. The training aimed to improve their knowledge, skills and experience with respect to interventions which reduce the likelihood of suicide, as well as robust risk assessment and documentation. The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, April 2015, highlights an increase in the numbers of suicide of people in contact with crisis services. The trust is also working more closely with families of individuals who are at risk of suicide.

Reporting incidents and learning from when things go wrong

The Trust had effective systems for reporting and learning from incidents. We found that staff knew how and when to report incidents and they were not afraid to raise concerns. There was a healthy safety culture within the trust.

There was a strong focus, following incidents, to learn and improve across all services of the trust. In community older people's mental health services, we saw evidence of incident logs in each of the teams that were also on serious incident reporting system (DATIX). When incidents were reported, each of the service managers investigated these and learning from the incidents was discussed and shared in team meetings.

For serious incidents, excluding pressure ulcers, the average investigation time was 51 days. If you include pressure ulcers, which can be less complex to investigate, the average investigation time was 46 days. Feedback from commissioners was that, investigating and learning from serious incidents meets with the South of England criteria. This was measured through the contract arrangements and no penalties had been imposed as a result of delayed reports. Commissioners also reported that the trust was respectful to patients and their families and worked hard to ensure that duty of candour is undertaken in a meaningful way. They said that reports were well written and provided a critical review of the incident. The action plans reflect the recommendations and monitored and completed in a timely way. We were also given examples of coroners giving the trust positive feedback on the quality of investigation reports.

We reviewed a number of reports and found them to be of good quality and completed in a timely way.

Staff said they received feedback from incidents they had reported, with emails providing them with an update and assurance that the incidents had been logged and carried forward. Incidents were also shared on the trust's intranet and via the 'team brief', which enabled staff to find out about incidents in areas outside their own teams.

Duty of Candour

'The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents' and 'provide reasonable support to that person.'

The trust was meeting their responsibilities under the duty of candour and was open and honest when things went wrong. We saw evidence that the trust had a duty of candour policy and saw examples of letters sent to patients and relatives following a serious incident. The trust kept a spread sheet so it could monitor that they were completing to timescale and had taken all necessary action. Staff across all services were aware of the duty of candour and were able to describe this.

Good

Are services effective?

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.

Summary of findings

We rated effective as good for the following reasons:

- There was good use of outcome measures across services.
- Different professional groups such as occupational therapy, physiotherapy, social work, medical and nursing staff worked well together to plan and deliver multi-disciplinary patient care.
- Staff were supported to learn and had good access to continuous professional development.
- There was evidence of clinical audit happening across many services.
- Staff were regularly appraised; using a values based appraisal system.
- People were able to access psychological therapies that were evidence based and in line with the National Institute for Health and Care Excellence guidance.
- There were many examples of staff using best practice and innovative practice.
- For the most part staff received good access to supervision and this was documented.
- Care plans in most services were well written and involved people.

However:

- On the inpatient wards for children and adolescents, care plans we read were instructive rather than recovery oriented and were not written in the patients' voice. This meant that staff wrote what a patient needed to do and did not explain how this might improve their wellbeing. On inpatient wards for those with a learning disability, care plans were variable in their quality and there was a lack of evidence that staff had regularly reviewed and updated them, which could put patients at risk of inappropriate care and treatment.
- On older peoples mental health inpatient wards staff were not always supervised regularly. Staff supervision at band 6 and below was not formally completed, which could have implications for staff practice and patient care. However the trust have subsequently informed us that staff did have the opportunity to take part in a regular 'Space' reflective practice session facilitated by an independent professional.
- On inpatient wards for people with a learning disability, supervision was not recorded for staff and we had concerns that staff did not have the necessary skills and training to communicate with patients'.
- On learning disability inpatient wards, there was some evidence to suggest that appropriate monitoring and reviewing of patient physical health was taking place. Regular medical checks did not always happen for patient's with long term conditions. The Trust told us that immediate action was taken and a GP is visiting Campion at least twice a month to assist the Multi-disciplinary Team.

Our findings

Assessment of needs and planning of care

For the most part, care planning and timely assessments were good across the trust however on inpatient wards for those with a learning disability, care plans were variable in their quality and there was a lack of evidence that staff had regularly reviewed and updated them, which could put patients at risk of inappropriate care and treatment.

However, in child and adolescent inpatient wards, we reviewed seven care plans and they demonstrated good evidence of including the patient's views and wishes.

In the health based place of safety, we observed two assessments of people detained under the Mental Health

Good

Are services effective?

Act 1983, which were completed in a timely way. In primary medical services we found evidence that staff were assessing patients' needs and delivering care that was in line with current evidence based guidance.

There were concerns across some services, regarding on-going monitoring of physical health needs and physical examinations. In the learning disability inpatient wards, we found little evidence demonstrating that appropriate monitoring and reviewing of patients' physical health were taking place. In particular, regular medical checks did not always happen for patients with long term conditions.

There was good practice in community mental health services for adults, where inspectors reviewed 23 care records. They found that all of them had comprehensive physical health assessments and that this was reviewed and monitored regularly. There was also good practice in acute and psychiatric services where all inpatients receive a physical examination on admission. We found that alongside the consultant and other medics on the wards the trust had access to two GP sessions. One session held was for monitoring existing chronic illnesses and treatment recommendations such as respiratory and metabolic disorders. The focus of the second session was health promotion such as smoking cessation, weight management and diabetes.

In children and young people's services staff had developed person-centred, detailed care plans for children and young people with long-term conditions or complex needs, who attended special services. The plans were up to date, clearly structured and included individual protocols, for example in relation to medicines. This was particularly evident in Ryeish Green respite service. Staff had implemented a readmission procedure, to check for any changes in people's health in advance of the admission date, to ensure they were suitably prepared.

It was noted in children and young people's services that staff collaborated well both within and across teams to provide joined-up services. Key challenges were working effectively with children and adolescent mental health services and social care services for looked after children. Staff escalated barriers to effective partnership working and managers and staff worked hard to find solutions. Service managers were fully involved in multi-agency partnerships, including those for child protection. Partners commented on their effective contribution.

Best practice in treatment and care

A range of treatments and therapies were utilised across the trust. For instance, in community mental health services for adults, we saw evidence of an excellent pharmacy led clozapine service. This ran six clinics per week and there was good practice of recording route of administration and dosage of medicines within British National Formulary (BNF) limit and in line with the National Institute for Health and Care Excellence guidance. All the primary medical services inspected were delivering care that was in line with current evidence based guidance

Many clinical audits were undertaken by the trust to guide best practice and care, with primary medical services demonstrating quality improvement through their audits. Additionally, in learning disability inpatient services, one of their therapy groups was clinically audited and was shown to have positive outcomes including reducing hospital admissions for the group.

In the minor injuries unit (MIU) staff used on-line guidance to ensure that care and treatment was delivered in line with best practice. The MIU had a list of exclusion criteria to ensure that sick patients were escalated to the A&E department.

Pain relief medicines were given to patients that required them. The effectiveness of pain relief was checked. In the MIU pain was assessed as part of the triage process. Patients with pain were immediately referred to a nurse by reception staff.

In end of life care, patient needs were assessed and care and treatment was delivered using evidence based guidance such as the 'five priorities for the care of the dying person' and the National Institute for Health and Care Excellence (NICE) guidance on 'end of life care' in adults. For example, clinical staff followed guidance on nutrition support, symptom control and psychological, social and spiritual support.

The trust's end of life care steering group had recently developed and implemented a new end of life care plan (September 2015) and 'care of the dying' policy (December 2015) along with other community partners. The new care plan supported implementation of the priority of Care (One Chance to Get It right 2013). This would replace the Liverpool Care Pathway (LCP), previously used for patients in the last days of their life, which ceased to be used in England in 2013.

Good

Are services effective?

In end of life care patient outcomes were monitored by individual services and information about these outcomes was included in the trust's clinical governance reports. Staff reports. Staff had access to specialist training courses and had appraisals.

The trust was contributing data about palliative and end of life care to the National Minimum Data Set (MDS).The community hospital teams and community nursing teams had participated in internal audits, such as falls prevention and management, National early warning score (NEWS), hand washing and care planning. Action plans were developed and implemented following the outcomes for these audits.

In community health services, tele-monitoring technology was used for remote monitoring of patients with long-term conditions such as chronic obstructive pulmonary disease (COPD) and heart failure. This was achieved through patient-recorded observations, such as pulse rate, blood pressure, coupled with electronic responses to key questions.

The dietetic service employed the use of tele-health to offer patients an alternative option for consultations.

In older peoples community mental health teams they ran a range of groups including cognitive stimulation therapy and memory clinics. Talking therapies were also available. The services followed a dementia pathway which was based on National Institute for Health and Care Excellence (NICE) guidance. The services used a range of outcome measures.

The trust has a rolling programme of clinical audit and was taking part in over 21 national audits in both physical and mental health care.

There were some gaps in the delivery of best practice. The child and adolescent mental health community service didn't strictly follow National Institute for Health and Care Excellence (NICE) guidelines. For instance, the availability of cognitive behaviour therapy for patients on the attention deficit and hyperactivity pathway.

Nutrition and hydration recording charts were not always completed by staff in the older people's mental health inpatient services and agency staff were not always made aware of these charts and the dietary needs of the patients. Additionally, staff did not take a preventative approach to managing the pressure care needs of patients.

The trust has carried out a programme of 'deep dives' into patient experience and had undertaken questionnaires, interviews and observations of patients experience. This includes, sitting and observing waiting rooms. Two services a year are visited to undertake this exercise. So far they have done this in community nursing services, community mental health teams, the walk in centre, health visiting services and community dental services. These 'deep dives' are commissioned externally.

The health based place of safety team had utilised the patient experience tracker tool to collect information from patients, with results from October 2015 looking encouraging. The acute mental health and psychiatric intensive care units operated a patient electronic feedback machine to collate patient experience.

Skilled staff to deliver care

There were enough skilled staff to deliver high quality and compassionate care and people had access to a range of disciplines with specialist expertise and knowledge. There were some concerns about the documenting of supervision for staff. In child and adolescent mental health community services, there were gaps in the records for staff supervision. This was mirrored in the learning disability inpatient services and acute mental health and psychiatric intensive care units, although staff there described that they received regular group/peer supervision. In older people's inpatient services, not all staff were receiving regular supervision.

Staff reported across the trust that there were good opportunities to take up training and that the trust offered a good range of continuous professional development opportunities. In specialist services, such as end of life care, there were numerous opportunities to develop staff and offer them education and learning to develop their skills. This ranged from degree courses to one day conferences and on line training.

In community health services, staff in the diabetic eye screening service, qualified as 'graders' and staff were assessed monthly to ensure they were performing in line with accepted standards.

New staff undertook a trust induction and a local induction. All new staff were allocated a mentor to help them orientate to the service. Unqualified staff were able to complete the care certificate.

Good

Are services effective?

Training pathways were good and opportunities were available. For instance many of the senior nurses have gone through the Bevin programme. The trust has nurse prescribers and posts in place for nurse educators and nurse consultants. The trust employed a head of clinical education.

Doctors had a good appraisal system in place that supported their revalidation with the General Medical Council. There was also the opportunity to undertake continuous professional development that is necessary for them to do their clinical work. We gathered that leadership development for doctors was an area of priority for which the trust had developed a clear plan.

Multi-disciplinary and inter-agency team work

A full range of staff and skill sets were utilised across the trust, with a wide range of professionals present at many meetings to plan and deliver good multidisciplinary patient care. This was particularly noteworthy in the learning disability community services, who had created and developed a range of initiatives such as 'switch Olympics' a proposal for a sport/social activity for people with profound and multiple disabilities. This aimed to promote social participation with reduced need for support.

The health based place of safety service demonstrated good inter agency working with the police, ambulance services and local authorities, with meetings scheduled between them every month. The objectives of the meeting were to share good practice, review the interagency joint protocol, review information and to look at the key role of the crisis care concordat.

Multidisciplinary team meetings occurred weekly in all community hospitals. These meetings included doctors, nurses, therapists, pharmacists and discharge co-ordinators. Therapy teams worked in conjunction with nursing staff to provide active rehabilitation for patients. Occupational therapists and physiotherapists, jointly assessed patients where possible to improve communication and goal setting for patients. The trust were piloting new therapy assistant roles to increase the impact of the service on the inpatient wards. The MIU communicated effectively with other services, such as the out of hour's service and other local hospitals.

In end of life care, staff worked in multidisciplinary teams to coordinate patient care. The local multidisciplinary team meetings were held at GP practices. Hospices were well attended by community nurses, specialist palliative care staff, hospice and hospital staff. Staff felt the multidisciplinary way of working was very strong and effective across this core service.

Community nursing staff attended gold standards framework meetings with GPs to ensure that they were aware of patients identified as being in their last year of life.

In older people's community mental health services, we observed four multi-disciplinary team meetings, one in each of the teams we inspected. They were all well attended and detailed and holistic discussions took place. We observed a patient-centred and respectful approach. Risk and safeguarding concerns were discussed. All team members present were given the opportunity to contribute to the meetings and their views were listen to and valued by all in attendance.

Adherence to the Mental Health Act 1983 and the Code of Practice

Overall we found good compliance in the application of the Mental Health Act 1983. We did have significant concerns about the management of long term segregation on the high dependency unit on Sorrell ward. We found that staff were not adhering to their own policy and were not complying with the Mental Health Act code of practice. As the trust has previously had this concern raised with them in a Mental Health Act monitoring visit, in September 2015, we issued them with a warning notice in this regard. A follow up visit on the 11th of February 2016 assured us that the trust had made the necessary changes and were compliant with the law.

Some staff within the learning disability inpatient service did not have sufficient knowledge or access to specialised areas of training for the Mental Health Act 1983 and Mental Capacity Act 2005.

There were further inconsistencies with the recording of patient rights on the adult acute mental health and psychiatric intensive care units. This made it difficult to ascertain when the patients' rights had been revisited.

Good practice in applying the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards

The Mental Capacity Act (MCA) does not apply to young people aged 16 or under. For children under the age of 16, the young person's decision making ability is governed by Gillick competence. The concept of Gillick competence

recognises that some children may have sufficient maturity to make some decisions for themselves. We had concerns that some staff we spoke to did not understand Gillick competence in the child and adolescent mental health inpatient service.

Training in Deprivation of Liberties Safeguards (DoLs) and the Mental Capacity Act 2005 (MCA) is provided face to face initially and then refreshed through e-learning. At the time of the inspection 74% of staff had been trained in MCA and 76% in DoLS.

The trust had a lead for the MCA, who staff were able to go to for advice and guidance when needed. The trust did not have a specific policy on the MCA but staff told us that they had links on the intranet to the Mental Capacity Act and other relevant legislation that they could access.

The staff we interviewed were aware of the basic MCA principles and that patients should be deemed to have capacity, unless proven otherwise. However, we reviewed one set of case notes, which said that a patient did not have capacity, but it did not demonstrate how this decision was made.

The monitoring of DoLS applications and the expiration of urgent referrals is carried out by locality managers. The clinical directors and safeguarding leads also have oversight of DoLS and prompt local authorities to carry these out where they are due to expire. However, this prompting was not recorded to demonstrate this had taken place. The safeguarding leads described that they had previously raised concerns with safeguarding adults board where DoLS assessments were not carried out which had resulted in some improvements to the timeliness of these.

The trust made 21 DoLS applications in the past year. Of these, 13 were granted and six (28%) were not granted. Rowan Ward (Older Adults) had the highest proportion of DoLS applications with seven, two applications had been declined.

In end of life care, staff were clear about their roles and responsibilities regarding the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Do not attempt cardio-pulmonary resuscitation (DNACPR) documents were correctly stored in the front of patient's hospital notes.

A handbook for carers had been developed in older persons community mental health services. This handbook contained information about lasting power of attorney (LPA) and advance statements. LPA is a way of giving a person you trust the legal authority to make decisions on your behalf if you lack mental capacity at some time in the future. An advance statement can be used to express wishes about future care options. We observed a memory clinic appointment and saw that LPA was discussed with the patient and their carer.

Good

Are services caring?

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

Summary of findings

We rated caring as good for the following reasons:

- Staff treated patients with kindness, dignity and respect.
- Most staff had a good understanding of the individual personality traits and emotional support needs of their patients.
- Staff supported individual patient dietary and feeding requirements in a respectful and discreet way.
- 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.
- Carers spoke positively about staff and said they were supportive and caring.
- There were opportunities for people to be involved in decision making and were able to be heard.
- In many services staff were collecting feedback from people and acting on this.
- There was outstanding practice in the caring domain in two of the core services we inspected. Staff demonstrated that they went above and beyond the call of duty and patients reflected this back to us.

However:

- We witnessed a couple of incidents where staff were brusque and did not interact in a way that would make the patient feel cared for.
- In one core service we have highlighted the need for that service to respond to national patient feedback survey, which showed that patients did not rate the practice as highly for several aspects of care as other practices in the area. A further local survey had seen an improvement.

In mental health services people's involvement in their care planning was not consistent.

Our findings

Kindness, dignity, respect and support

Across nearly all core services we rated the trust as good for caring and found that people were treated with dignity, respect and kindness. Feedback from service users, carers and family members were largely positive, noting the compassionate, kind, honest and respectful attitudes of all staff members. We observed many occasions whereby interactions between staff and patients was positive and supportive of patient needs.

In older people's community mental health services the trust was rated as outstanding. This was because staff demonstrated going above and beyond the call of duty and feedback from carers and patients was overwhelmingly positive.

The trust scored higher than the England average (90%) on the latest PLACE scores for 'privacy, dignity and wellbeing', scoring 94% with all sites across the trust scoring higher than the average too.

The Friends and Family Test (FFT) that was completed by service users and their carers, 92% of respondents recommended the whole trust as a place to receive services, which was slightly lower than the England average of 96%. This score was slightly better for community inpatient service users and carers, with 94%, but still scored lower than the England average. Adult community healthcare scored the lowest recommendation with 89%.

Of the staff members who completed the FFT survey, 81% of respondents said they would recommend the trust as a place to receive care, which scored slightly higher than the England average of 79%.

Most of the trust's services displayed acts of care that evidenced staff having a good understanding of individual patient's personality traits and emotional support needs. We witnessed a nurse from the older peoples community mental health service go out of their way to gain a history of a new patient recently discharged from the memory

Good

Are services caring?

service, in order to reduce levels of agitation and aggression of the patient. In the health based place of safety, we observed assessments where caring and respectful behaviour was noted throughout.

In the primary medical services whilst patients received compassionate and dignified care from Westcall out of hour's service and Priory Avenue surgery. Circuit Lane surgery fell slightly behind, with patients from the latest national patient survey not rating the practice as highly for several aspects of care. However, there had been a significant change in GP and nursing personnel since the survey was completed and patients we spoke with and comment cards did refer to improvement.

In West Berkshire Community Hospital we observed a registered nurse instructing other staff in the use of hand massage. The treatment was being promoted to staff so that they could give hand massages to patients, especially those who got few visitors.

Orientation support was offered by staff on the child and adolescent inpatient wards by way of welcome packs when they arrived at the ward. Additionally, new patients were invited to visit the ward for a day before being admitted. This was so staff could show them the environment and answer their questions before they were admitted.

In children and young people's service we visited a range of clinics, schools and children centres and also joined staff on home visits and telephoned people. We spoke with 28 patients or family members in receipt of young people's services. We observed that staff treated people with respect and that people's privacy and dignity was maintained at all times. Staff were observed to be professional; they listened actively and showed understanding.

Feedback from young mothers was consistently positive about the value of the family nurse partnership service, primarily because of the skills of the staff in providing support and care in a way that was patient and non-judgemental. They said they felt at ease with the staff and they valued their sensitive and professional approach.

In acute and psychiatric intensive care units, patients received orientation to the wards on admission and the wards had dedicated welcome packs. We saw information leaflets around the ward and in prominent positions in the communal areas of the ward. Notice boards contained various information, including the care programme approach (CPA) process, access to advocacy, Mental Health Act, Mental Capacity Act, key nurse, names and photos of staff and guidance about the philosophy of the ward as well as information about spiritual and pastoral care.

Whilst much of the observed levels of care were good and warm, it was noted at the learning disability inpatient service that some unqualified staff failed to interact with the patients, displaying a level of disinterest in them.

Involvement of people in the care they receive

The trust had a patient involvement strategy and its key strategic aims were:

- To have a body of people who will work with the trust to co-produce, review and monitor our services.
- To develop a culture of co-production.
- To encourage services to increase engagement with patients and carers and make it easier for services to tell us about their engagement.
- To introduce 'patient leaders' within the Trust through a programme.

There were quarterly patient experience and involvement groups across the trust. This included patient forums, which were patient led and had representation from the trust governors. It was expected that locality directors would regularly feedback to patient forums on actions taken to improve patient experience.

Inpatient wards had weekly community meetings, carers groups and patient councils. There was a rolling programme called the 15 step challenge. This always had a patient representative and board member involved in the programme. This was developed following feedback from a carer who had said she only had to take '15 steps onto a ward to see the quality of that ward'.

The health based place of safety team had a well-attended carers group which received good feedback and there was a carers group on the acute mental health and psychiatric intensive care units. There were weekly community meetings, where patients were able to feed back what was not working well on the ward. This meeting took place during 'protected time' and there was evidence of actions set from previous meeting in a 'you said, we did' format.

In the community services for child and adolescents, learning disability and mental health services for adults, patients told us they could get involved in their care and have their say in a variety of ways. This included active

participation groups and patient training. Patients co-facilitated group sessions with psychologists as 'experts by experience'. There were health promotion groups with learning disability liaison nurses and primary care liaison nurses.

The Berkshire mental health user group was well established and had been running for a long period of time. This was an active and well attended group.

The trust was involved in a 'patient leaders' programme and was doing this in collaboration with the Royal Berkshire hospital.

Good

Are services responsive to people's needs?

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

Summary of findings

We rated responsive as good for the following reasons:

- Despite there being great pressures, the services were mostly managing to respond to the needs of patients' in a timely manner. The trust had clear timeframes in which to respond to those in the most need. Where there were waiting lists the trust managed these well to mitigate any risks to the patient.
- Teams were providing appointments where possible at times that were suitable for people using the service. If patients did not arrive for their appointment there were arrangements in place to check they were alright.
- The trust provided a good range of therapeutic activities for patients' using inpatient services.
- The trust provided people with spiritual support.
- The trust were responsive to the different needs of people and provided accessible environments and access to information in a range of languages.
- People knew how to complain and the trust responded well to complaints and shared learning from these.
- Beds were well managed and if someone needed a bed they got a bed. Readmission rates were going down.

However:

- In learning disability inpatient services, some staff were unable to communicate with patients using methods, such as Makaton and/or signing.
- In learning disability inpatient services, bedrooms were not personalised, even though three patients had periods of admission lasting longer than twelve months at the time of our inspection..
- There was a lack of written information on display around the wards, which was provided in an accessible form for the patient group on the learning disability inpatient wards.

In one of the GP practices, the trust had been slow to make necessary changes to the appointment system. This was needed to make sure that people could get through to a GP more easily by telephone.

Our findings

Access and discharge

The trust was responsive to the needs of people who needed to access services or be discharged from services. Beds were well managed, as were waiting lists. The trust was proactive in planning for people's discharge and where there were delays, worked well with the local authorities to resolve this.

The trust's bed occupancy rates for mental health services was below the England average for 2014/2015, meaning there was capacity within the system to manage increases in demand for beds. However, since quarter four, this has risen sharply to now lie above the England average. Learning disability beds have been consistently below the England average for the past 12 months. Eight out of 15 wards are currently operating at just above the target of 85% for bed occupancy. CQC's intelligent monitoring flags the trust as a risk with regard to the number of detained patients allocated to a location, compared to the numbers of available beds. However, the level of pre-discharge support offered to these patients was found to be good and person centred. We found that the management of beds was robust, with daily bed monitoring meetings taking place to manage the demands being placed on the system.

The percentage of patients on the care programme approach (CPA) who were followed up within seven days after discharge from psychiatric inpatient care was above the England average, standing at 99% in quarter four of 2014/15.

The total number of patients who had delayed transfers of care peaked in June 2015, due to a spike in delays that were the responsibility of social care. The number of delayed patients that were the responsibility of the NHS fell to zero in August 2015.

50

Good

Are services responsive to people's needs?

There were long waiting times noted, from referral to treatment for the child and adolescent mental health service (CAMHS) for all pathways and specialist services. However, these were appropriately and safely managed with risks mitigated through regular monitoring. This included weekly multi-disciplinary discussion and face to face contact with young people on the lists. The CAMHS pathway was in the early stages of reducing waiting times, following an increase in staffing and capacity.

Innovative services were introduced by some teams in the trust to meet key performance indicators and improve services, such as a wheelchair prescription service, that served profoundly disabled people in their own homes, rather than a clinic. Street triage had recently been introduced in the west of Berkshire (Reading, West Berkshire and Wokingham) to reduce numbers of people detained in police custody and also the overall number of S136 applications made in the West of Berkshire . Additionally, the 'common point of entry' in child and adolescent mental health services had recently extended hours to provide a more responsive service.

The trust reported a total of 388 delayed transfers of care over the past six months. Donnington and Highclere wards at West Berkshire community hospital had the highest number of delayed discharges at 148. The Oakwood unit had 130 delayed discharges and 92 at the Windsor and Ascot Wards at Wokingham Hospital. The main reason cited for this was awaiting the availability of a nursing home placement.

Health visitors completed most new birth visits and developmental reviews in a timely way. Between July and September 2015, they completed between 85% and 93% of face-to face new birth visits within 14 days, across the six localities. Over the same time-period, they completed between 85% and 96% of the six to eight week developmental reviews (against a 95% target) and 71% - 91% of the 12- month and the 2-2.5-year reviews. Results were highest in the Bracknell locality and lowest in Reading. In 2015/16, data showed new birth visits were below target in quarters one and two.

Staff monitored the timeliness of assessments, referrals and interventions. Waiting times for most services had improved. Where children had to wait a long time for an Autistic Spectrum Disorder diagnosis, the children and young people integrated therapy service (CYPIT) intervened with interim treatment plans.

Feedback from Circuit Lane surgery reported that access to a named GP and continuity of care was not always available quickly, although urgent appointments with another GP were usually available the same day. The practice had responded to this feedback, but it was too early to assess whether the changes made were effective.

The facilities promote recovery, comfort, dignity and confidentiality

There was a good range of facilities and equipment across the trust for the benefit of patients. For example, there was good wheelchair access and disabled bathrooms across services.

There was good use of personalisation of bedrooms across services, with the exception of the learning disability inpatient service, where no personalisation of bedrooms was allowed. This was despite some patients having periods of admission lasting longer than 12 months.

There was a range of activities supplied to patients across the trust, with patients given real choice about their activities. However, there were concerns that there was a shortage of weekend activity provision on the learning disability inpatient and child and adolescent inpatient wards. Staff on the latter did tell us they were arranging more activities for the weekend as part of the transition from a five day service to a seven day service.

On acute and psychiatric intensive care units, each ward was similar in design. They had male and female corridors for patient bedrooms, with activity rooms and dining areas. There were designated male and female lounges on each of the wards where patients were able to go and spend quiet time away from others. All had access to outside space and kitchens where patients could carry out activities of daily living. The clinic areas also doubled as treatment rooms, with examination couches and examination equipment in each. The unit also had a therapy centre where off the ward activities took place and a gym. The wards appeared to be comfortable and clean, although in some areas of the wards, storage and clutter were an issue. There was access to a family visiting room so that patients' could have visits with their children and maintain contact with them whilst they were an inpatient.

Meeting the needs of all people who use the service

We found that there was good access to spiritual support and that patients' needs were catered for in relation to their

cultural and religious differences. There was a multi faith room at Prospect Park hospital known as the 'Sanctuary'. This facility was open 24 hours a day. It had resources to support worship of different faiths and there was a service held each Sunday that was suitable for all faiths.

In most services, there were access to advocacy services for patients, but there were concerns for both the inpatient and community child and adolescent mental health services (CAMHS) with regard to this. At the CAMHS inpatient ward, there was no independent mental health advocacy service available to the patients. In the community CAMHS services, there was no direct access to advocacy services for young people and they were directed towards the patients advice and liaison service (PALS).

Information was available in a range of languages and where interpreters were required these were available.

The trust scored particularly well for 'food overall' on the latest PLACE scores, scoring higher than the England average (89.8%) with 96% and the subcategory of 'ward food' scoring 100% across all sites, with the exception of Wokingham hospital. For those with dementia the trust scored over 94%, this is considerably above the England average of 75%.

In children and young people's services, staff supported the specific needs of children and young people in a range of ways. They facilitated meetings in locations suited to the family's needs, involved the right professional staff and prepared person centred care and treatment plans. There was evidence that staff took account of people's specific needs and ambitions when agreeing treatment goals. There were systems in place to identify and support vulnerable and hard to reach children and young people.

In the minor injuries unit, staff were aware of the particular needs of patients that were living with dementia or a learning disability and were given a priority in the minor injuries unit.

The musculoskeletal service offered a specific clinic session for patients with a learning disability to meet their needs in a more suitable environment.

The continence advisory service offered patients with learning disability individual appointments as opposed to group sessions to ensure they received the right level of support.

The trust had in place an equality strategy and it had four key principles:

:

- Everyone is treated with dignity and respect.
- Our practices are inclusive and fair.
- Our staff are proud of who they are, proud of their work and the difference we can make.
- We aspire to best practice against measurable national benchmarks.

Its strategic aims were to:

- Reduce inequalities in service usage by people with protected characteristics which correspond with inequity in life expectancy and health outcomes.
- Patients with protected characteristics have positive experiences of our health services.
- Strengthen equality and cultural competencies, in particular of middle managers, so that staff promote equality and work in an environment free from discrimination.
- Research and remove any potential barriers to diversity at senior leadership levels.

.

Listening to and learning from concerns and complaints

Overall, the number of complaints to the trust rose in 2014/15 to 251, although the percentage upheld remained broadly the same (44% in 2013/14 and 45% in 2014/15). Nursing, midwifery and health visiting received the highest proportion of complaints (100), followed by medical (57). The number of complaints received regarding all aspects of clinical care increased by 41% between 2013/14 and 2014/15, and the number of complaints regarding outpatient appointments increased by over 100% (from 15 to 40). Complaints regarding staff attitude fell by 17%, from 53 to 44. The trust provided data showing 43 complaints to them had been upheld in the last 12 months, with eight being referred to the Parliamentary and Health Ombudsman.

Patients were aware of how to submit an informal or formal complaint about the service across the trust. Staff were briefed on outcomes of complaints in fortnightly business meetings. There was evidence across all services that the trust responded quickly to concerns raised and learning from complaints was shared with staff and other stakeholders.

52

Good

Are services well-led?

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.

Summary of findings

We rated well led as good for the following reasons:

- The trust had a strong executive and non-executive leadership team.
- The trust vision was known by staff working across the trust and they understood how this informed their work.
- The board assurance framework, whilst continuously being refined, was providing the board with the information they needed to perform their role.
- The trust had the right meetings in place to ensure that relevant information on safety, performance, risk and finance was reviewed and monitored.
- The leadership team recognised the importance of strong engagement with patients, staff and external stakeholders. The staff survey put them in the top 20% of trusts for staff engagement.
- The trust was innovative and looked for ways to improve patient care.
- Key stakeholders were positive about their relationship with the trust, describing them as a strong partner in the local health care economy.
- The trust was meeting the fit and proper person test.
- The trust had the right policies and procedures in place to support staff to do their work.
- The trust had a values based appraisal system.

However:

- There were significant concerns about the management of the learning disability inpatient services. This received a rating of requires improvement for safe, caring and responsive and well led. It received a rating of inadequate for effective.

Our findings

Vision, values and strategy

The trust had a well-developed vision and set of values, with quality and safety as key priorities. Their core values were:

- Caring for you and about you is our top priority.
- Committed to providing good quality safe services.
- Working together with you to develop innovative solutions.

The quality strategy for 2014-2016 has six elements and aims to provide accessible, safe and clinically effective community and mental health services that improve patient experience and outcomes. The vision is providing 'the best care in the right place' the six elements of that vision are:

- Clinical effectiveness.
- Efficiency.
- Patient experience and involvement.
- Safety.
- Organisational culture.
- Equity.

Most staff understood and were committed to the trust's values and vision, commenting that they were easy to understand and were embedded in staff thinking from an early stage. Some services developed their own core values based upon the trust's vision and most staff were engaged in the direction the trust was heading. However, the exception to this was that staff on the learning disability inpatient service felt disconnected to the trust. They felt that there with a lack of involvement with them regarding the future of the service and safety of jobs.

The trust had published its workforce race equality standards. It also had an equality strategy and was working using the NHS equality delivery system.

Good governance

The trust has a robust governance structure, in which executives had clear roles and responsibilities. Non-executive directors were accountable for particular aspects of organisational governance, achieved through chairing

Good

Are services well-led?

executive meetings. The non-executive directors' chair various first tier board committees, including quality, audit, remuneration and finance, investment and performance committees.

The trust recently completed an independent review of its governance which was completed by Ernst & Young, using the Monitor well-led framework for governance. The draft report states that there "are no major omissions in respect of the arrangements we have assessed". The review made a number of recommendations for the trust board's consideration but these did not detract from Monitor's green governance rating in 2015/16.

During the inspection we drew attention of board members to their corporate risk register which, we believed needed firming up in terms of why risks were identified, what actions are in place to mitigate the risks or reduce them and when these are likely to yield results or be reviewed.

The trust submitted data that showed participation in a good range of national audits across a number of services: primary care, adult community (8), adult community mental health (4), children and adolescent mental health (1), adults with learning disability (1), early intervention in psychosis (1), and older people (1).

The audit manager demonstrated to us the trust's robust system of identifying and prioritising audits using Healthcare Quality Improvement Partnership guidance and how agreed action plans are tracked for completion using Datix. All NICE guidelines are also recorded on Datix and following review for relevance, clinical leads are asked to undertake a baseline assessment of implementation in relevant services. This helps the clinical effectiveness group discuss barriers to implementation and agree ways forward.

Prior to the inspection we carried out a series of focus groups with commissioners and the local authorities. These stakeholders were positive about their relationship with the trust. They all, without exception, referred to the trust as open and transparent. They described the trust as a strong and active partner in the wider health and social care system. They told us that the trust proactively addressed their quality concerns, for instance improving community child and adolescent mental health services waiting lists and developing the business case for adolescent inpatient beds and crisis services. This has led to significant additional funds for the trust. The provider has good working arrangements with commissioners, local authorities and other partners.

Fit and proper persons test

The trust met the fit and proper persons' requirement (FPPR) and was compliant with the law. This regulation of the Health and Social Care 2014 ensures that directors of health service bodies are fit and proper persons to carry out their roles.

The trust had developed a fit and proper persons policy and procedure had this had been implemented. The policy outlined the checks required to be in place for those identified as needing to meet the FPPR test, such as checks with the 'disclosure and barring service', proof of identity, evidence of capability to lead, references and checks against the insolvency and bankruptcy register.

We reviewed 10 personnel files of six directors and four of non-executive directors, seven of whom had been in post prior to the implementation of the FPPR in November 2014. The trust had ensured that all checks had been carried out for the existing directors and the requirements of the FPPR met for the all new directors.

Leadership and culture

There was a strong and experienced leadership at board level in the trust. They clearly aspire to be open and transparent and promote a culture of learning.

There are high levels of staff engagement and the staff survey shows they have been in the top 15% nationally for engagement for the past three years. This has been underpinned by a long term organisational development programme. This has 4 strands:

- Value based recruitment and appraisal.
- Excellent Manager Programme.
- Listening into Action (taking feedback and acting on this) (1st wave Trust in 2012)
- Talent management and succession planning.

Across services, staff were positive about management and felt that there was good leadership. There was a visible management presence on the wards and managers were supported with leadership training. Many staff felt listened to and supported by their management and were comfortable approaching them if they had a problem.

Good

Are services well-led?

One of the trust's top priorities was to foster an environment where staff felt confident to raise concerns about patient safety. In all wards patients, relatives and staff were encouraged to share concerns with ward leaders. In the community health inpatient units, staff told us that ward leaders were supportive of their safety and wellbeing and that they would be confident to approach them with safety concerns.

Staff had generally met the chief executive, for example at induction and said he was approachable. We were told of various examples of how he had helped resolve issues for staff.

In relation to the staff survey the trust performed better than the England average, scoring in the top 20% for:

- Staff receiving appraisals.
- Well-structured appraisals.
- % of staff witnessing potentially harmful errors, incidents or near misses.
- Fairness of incident reporting procedures.
- % of staff feeling secure about raising concerns about unsafe clinical practice.
- % of staff experiencing physical violence from patients, relatives or the public.
- % of staff experiencing harassment from patients, relatives or the public.
- % of staff reporting good communication between senior management and staff.
- Staff recommending trust as a place to work or receive treatment.
- Staff motivation at work.
- % of staff experiencing discrimination at work.

The trust recognises nine unions that include UNISON, the Royal College of Nursing, UNITE, the Chartered Society of Physiotherapists and the British Dietetic Association. We were informed that

meetings are held on alternate months for the joint consultative committee. The trust managers who attend this are the head of human resources, director of human resources and locality directors.

Union representatives said that they were consulted about issues that affect staff, with a recent consultations being around staff moving from one location to another and weekend working.

The union representatives said the equalities strategy was good and they were involved in the development of this. They also described a recent independent review into the workforce race equality data, which was in response to black and minority ethnic staff saying they were not being promoted/ given same opportunities as others.

They told us about the work the trust had done around lesbian, gay, bisexual and transgender issues, where they felt this had enabled staff to feel more confident to 'come out'.

There are support services available to staff, including stress resilience courses, muscular-skeletal assessments when needed and staff can access talking therapies.

We asked if they felt there was enough support around staff whistle-blowing. The feedback we received was that people feel nothing is done until this is formalised, which was difficult to do. However, they felt that at a senior level, whistleblowing was taken seriously and they felt confident that senior team looked deeply into these and carried out appropriate investigations.

Union representatives were provided with half a day union duties, which they feel is not sufficient to carry out the role effectively and can lead to delays in investigations and writing reports.

Engaging with the public and with people who use services

The trust engaged well with patients and people who use services and their carers. It had a patient participation strategy and a marketing and communications strategy. It engaged in a number of ways with the public and with people who use services. For instance:

- The use of Twitter, Facebook and other social media.
- Regular open days.
- Road shows.
- Patient involvement strategy and developing the use of co-production.
- Running campaigns, such as the 'smoke free' campaign.
- Supporting the 'time to change' initiative.
- Development of a mental health strategy with key partners.
- Working positively with the media.

We found many examples of patient involvement forums using the principles of co-production across many parts of the services, particularly in mental health. Minutes of the

patient participation forum detailed how this was evolving and growing. The trust had a recovery college, which is an adult education centre run using a co-production model. Staff and patients come together to design and deliver a range of courses which support people to better manage their mental health care.

Quality improvement, innovation and sustainability

The trust was committed to quality improvement and had many examples of using innovation to improve services. One it is particularly proud of and which they want to roll out to other parts of the trust is an on-line network called Sharon. Sharon uses technology to support people with eating disorders and promotes an ethos of hope and recovery. People can share experience and support each other and feedback from the project has been positive.

The older people's community services were rated as outstanding and this was because they:

- Established the Young People with Dementia (Berkshire West) charity. It had employed the country's first Admiral Nurse working with younger people with dementia.
- The trust had developed a "Dementia Handbook for Carers" which was widely available in Berkshire West teams and GP surgeries.
- The trust offered an "understanding dementia" education course for relatives and carers of patients. The course is offered over six weeks and covered information about the illness and medicines, legal and financial aspects, long term planning, living well with dementia and managing new behaviours
- The dementia services were going through accreditation with the Royal College of Psychiatrists and two services had been awarded excellent.

A number of services were accredited with national accreditation schemes. These were

- Acute mental health wards, Bluebell, Snowdrop, Daisy and Rose.
- The electroconvulsive therapy suite.
- Memory services.
- Royal Berkshire Hospital Liaison Team.
- Campion Ward and Little House.
- West Berkshire Stroke Services.

Monitor had rated the trust as green for financial sustainability. The trust has highlighted 'sustainability' as a risk on the corporate risk register. Both directors and non-executive directors expressed that long term sustainability sits as a major concern.

Some staff told us they attend the carer strategy group in the Trust and have worked on an action plan to improve carer services over the past year. This is linked to an accreditation for Triangle of Care. The Triangle of Care project is an initiative which brings 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. It runs carer training days, that have been co-designed and co-delivered with carers, based on psychological interventions/family work model. It is a ten day programme lasting over ten weeks and has received positive feedback.

The Trust gave us information on six National Institute of Health Research Studies (NIHR) portfolio studies being hosted in Berkshire Health Care Trust. The studies are taking place across the trust. An example of one of these studies is a piece of research which is looking into the genetics of bi-polar disorder and schizophrenia. The aim of the study is to pave the way for new treatments and preventative strategies. The full title of this study is 'Genetic Case Control and Brain Imaging Studies of Mental Illness and Dementia'.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Child and adolescent mental health ward** There were numerous ligature risks on the ward which had not been documented for mitigation in the ward risk assessment. This is a breach of regulation 17(b).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Child and adolescent mental health ward** Care plans did not describe how staff and patients would manage risks which were identified in patients' risk assessments. This is a breach of regulation 9 3(b).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Wards for people with learning disabilities or autism**

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Wards for people with learning disabilities or autism

The trust had not ensured that patients were protected against ligature risks. They had identified numerous potential ligature points, and proposed an action plan to mitigate each identified risk. However, staff did not maintain the required level of patient observation; there were an insufficient number of ligature cutters given the physical layout of the ward; and, staff had not received training in the use of ligature cutters

The physical health of patients on Campion Unit was not being adequately protected. Appropriate monitoring and reviewing of patient physical health was not taking place. Physical health care plans were inconsistent, with some blank sections and others containing vague or inaccurate information.

On Campion Unit we observed staff left patients who were designated constant one-to-one supervision for short periods of time. We were told by a carer that staff leave their relative unattended in the bathroom for long periods of time, even though they had been diagnosed as with a medical condition that could put them at risk. These practices could put patients at risk of harm.

This is a breach of Regulation 12(1) (2)(b)(d)

Female patients did not have their privacy and dignity adequately safeguarded due to a lack of appropriate gender segregation. There were no day lounges for use by women only. At Little House there was sharing of toilet and bathroom facilities for both sexes.

58

This section is primarily information for the provider

Requirement notices

On Campion unit the female bedroom was in a central location within the ward. There was a gap in the bathroom door, which meant that male patients would have the ability to look inside the bathroom when in use.

This is a breach of Regulation 10(1)(2)(a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Wards for older people with mental health problems Patients and others were not protected against the risks associated with unsafe care and treatment: Care plans were not always developed in response to risks identified. Observations of patients were not carried out consistently to ensure risks to patients and other were minimised. All staff working on the wards were not made aware of the risks of the patients in their care. This is a breach of Regulation 12(2)(a)(b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Wards for older people with mental health problems Staff did not receive appropriate supervision in their work.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Circuit lane surgery 17.—(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. (2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to— (a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); (e) Seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services. (f) evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e). Patient feedback relating to quality of care was below local and national averages. The provider had not evaluated the outcome of increasing clinical staff levels and changes in personnel on patient opinion. 60

Staff did not receive on-going supervision in their role to ensure that competence was maintained.

This is a breach of Regulation 18 (2) (a)

This section is primarily information for the provider

Requirement notices

Patient feedback on access to the service was below local and national average. Patients who contributed their views to the inspection also perceived difficulty in accessing GP appointments. The changes undertaken and planned to improve access had not been evaluated.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Westcall out of hours service** 1. Care and treatment must be provided in a safe way for service users. 2. Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— g. the proper and safe management of medicines; Specifically, the provider was not ensuring that blank prescription pads were securely stored and their movement monitored. There was no system in place to record the use of prescriptions to minimise misappropriation or misuse.

This page is intentionally left blank