HTAS
HOME TREATMENT
ACCREDITATION SCHEME

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

Home Treatment Accreditation Scheme (HTAS)

Pilot Report

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This document can be downloaded at our website:
www.rcpsych.ac.uk/HTAS

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Name	Trust / Organisation
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Hull Crisis Resolution & Home Treatment Team	Humber Foundation Trust
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Croydon Home Treatment Team	South London & Maudsley NHS Foundation Trust
Worcester, Malvern & Wychavon Home Treatment Team	Worcestershire Health & Care NHS Trust

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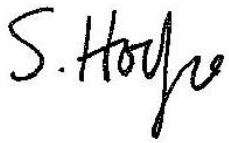
Foreword

In 2011 we compiled all the guidance and recommendations we could find on how Crisis Resolution/Home Treatment teams should operate, and presented this to a brand new group of experts in the field, including professionals, mental health service users, and carers. This vast document was whittled down to the key, measurable, points over the course of a year, and added to with further expert suggestions from the group.

Now in 2014, we are able to look back and see that as new accreditation programmes go, HTAS has been a success. We have seen the testing of the new standards in practice with a handful of pilot teams, the further development of the standards with feedback from those teams (with, I am pleased to say, relatively minor changes necessary) and the launch of the nationwide accreditation programme in 2013.

From 2011 to 2014 we can see the rise of a new accreditation programme which I am confident will go from strength to strength, and promises a good addition to the excellent range of mental health accreditation programmes offered by the Royal College of Psychiatrists' Centre for Quality Improvement (CCQI).



Sophie Hodge
HTAS Deputy Programme Manager

Section 1: Introduction to HTAS

The Home Treatment Accreditation Scheme (HTAS) is an accreditation programme for crisis resolution and home treatment (CRHT) teams in the UK and Ireland. It assesses teams through a process of self and peer-review, against a set of evidence-based standards. All necessary materials and guidance are supplied by HTAS. The process is a supportive one, designed to congratulate teams for aspects of their work which they do well, in addition to identifying areas for improvement and suggesting ways these could be improved. Teams that meet sufficient standards are awarded accreditation by the Royal College of Psychiatrists.

The Royal College of Psychiatrists' Centre for Quality Improvement (CCQI) manages a number of quality improvement and accreditation programmes, including Accreditation for Inpatient Mental Health Services (AIMS). Responding to requests to offer accreditation for other elements of the Acute Care Pathway, accreditation for CRHTs was decided upon as the initial focus for project development.

HTAS was developed between 2011-12; a team of experts from different professions involved in the work of CRHTs were brought together to help develop the programme and its standards, a process which was guided by staff from the CCQI. A list of contributors can be seen on page 3.

The structure of the programme is the same as other accreditation programmes such as AIMS. In addition, some core standards were drawn directly from AIMS and other accreditation programmes, although the vast majority were developed specifically for CRHTs. The standards were designed to be as inclusive as possible – it was agreed early on in the development process that HTAS did not want to promote a specific model of care. The aim was to accredit teams based on their functions and the standard of care delivered rather than the composition of the team or model of care, and the programme did not seek to penalise teams for acceptable variations in their ways of working.

A pilot phase of the programme was conducted in 2012, and following this the process and standards were further revised with the input of the standards development group and members who took part in the pilot. The nationwide programme launched in 2013.

Section 2: The Accreditation Process

Accreditation involves assessing services against a set of evidence-based standards through the processes of self review and peer review.

Standards

The relative importance of standards are rated using the following system:

Type 1 standards are essential to safety, rights, dignity and the law.

Type 2 standards are those that an accredited team would be expected to meet.

Type 3 standards are those that an excellent team would be expected to meet, or standards that are not the direct responsibility of the team.

Self review

Teams underwent a self review period of three months, which required the team to gather data using a range of audit tools which included:

- Service User Questionnaires

The teams were asked to distribute paper questionnaires to service users who received care from the team within the 3 month data collection period. Service users were asked about visits from the team, their contact with staff and discharge from the team. The teams also had the option of asking service users to complete the questionnaire online using login details provided by the HTAS project team.

- Carer Questionnaires

The teams were given carer questionnaires to hand out to carers of those who were treated by the team during the 3 month self review period. Carers were asked about visits from the team, support that was available for them, medication and discharge. The teams also had the option of asking carers to complete the questionnaire online using login details provided by the HTAS project team.

- Organisational Checklist

Each team was asked to complete an organisational checklist online which asked about the policies and procedures governing the team. It was recommended that this was completed at a team meeting with as many staff as possible present.

- Health Record Audits

The teams were each asked to audit a set of 20 health records against specific criteria.

- Staff Questionnaires

All staff from each team were asked to complete a staff questionnaire which asked questions about the induction they received when they joined the team, training, supervision, liaison with acute inpatient wards, the assessment process and contact with service users and carers.

- Team Manager Questionnaires

Each team manager was asked to complete a questionnaire which asked similar questions to the staff questionnaire as well as questions about service provision, service structure and psychosocial interventions.

- Inpatient Ward Questionnaires

Each ward for whom the home treatment team gatekeeps patients was asked to complete a questionnaire about their links with the team.

Peer review

Following self review, the teams received a peer review; a one-day visit delivered by a multidisciplinary team of reviewers, including peers who work in other member teams, a service user or carer and a member of the HTAS team or a representative from the Royal College of Psychiatrists' Centre for Quality Improvement (CCQI). The data collected from each team during the self review period was compiled into a

booklet which was sent to the members of the peer review team and the host team before the visit. The peer review team's role was to validate the self review findings, identify areas of achievement as well as areas for improvement, and suggest ideas for addressing the latter. All of the peer reviewers had attended a one day training course delivered by HTAS which allowed them to become familiar with the peer review process and peer review booklet.

The peer review day comprised several different meetings; some meetings were attended by all members of the peer review team, while during other sessions the peer review team were divided in order to attend concurrent meetings.

- Staff Meeting

The full review team met with as many members of the home treatment team as possible, without the team manager present. The responses from the staff questionnaires and checklist were discussed.

- Team Manager Meeting

Two professional members of the review team met with the team manager and a representative from the inpatient ward to discuss the responses from each of their questionnaires.

- Health Record Review

Two professional members of the review team met with a member of the host team to discuss health records, policies and procedures. The host team provided anonymised or training versions of their health records; no real service user records were seen.

- Service User Meeting

One professional member of the review team and the service user/carer representative on the team met with a group of service users who the host team had invited to discuss their experiences of being cared for by the team.

- Carer Meeting

One professional member of the review team and the service user/carer representative on the team met with a group of carers who the team had invited to discuss their experiences of caring for someone who was being treated by the team.

- Review Team Meeting

After these meetings the review team met in private to discuss the findings and consider whether the standards should be rated as Met or Not Met. Following this meeting, the review team then met with the host team to provide feedback.

Accreditation decision

On the basis of the self review and peer review data, the HTAS Accreditation Committee (AC), which meets quarterly, recommended an accreditation status for each team. These recommendations were then presented to the Royal College of Psychiatrists' Special Committee for Professional Practice and Ethics (SCPPE) for ratification. The SCPPE is the Royal College of Psychiatrists' awarding body.

There are four categories of accreditation status:

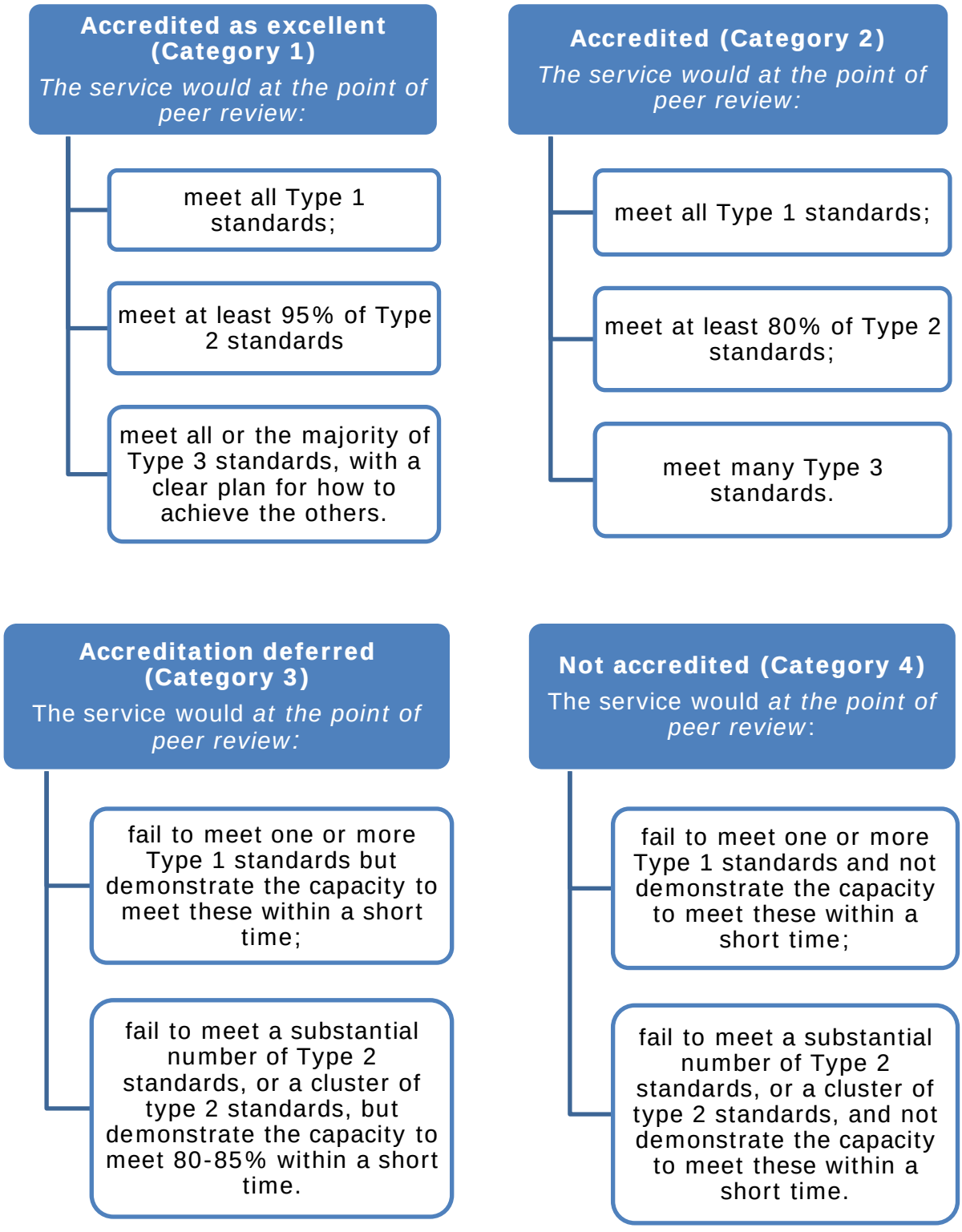


Figure 1. Categories of accreditation

Teams that did not achieve the required criteria for accreditation at the first AC were given a deferral period of 3 or 6 months, depending on the reason for deferral. At the end of the deferral period, teams were asked to submit further evidence for the AC to consider – at which point the AC would then award accreditation or request an additional deferral period.

Figure 2. HTAS Accreditation Cycle

Ongoing quality improvement

The HTAS process does not stop at the point of accreditation. Members are encouraged to continue thinking about how they can improve the quality of their service by submitting action plans shortly after being awarded accreditation. These action plans will incorporate the areas for improvement identified by the peer review team, and progress against the action plan will be taken into account as part of the brief interim review, which takes place 18 months after initial accreditation. HTAS Accreditation lasts for 3 years, after which time services undergo the full review cycle again. The areas for improvement from the last cycle are discussed at the team's next peer review visit.

Section 3: The Pilot Phase

Participating teams

17 CRHTs in England took part in the pilot. There were a wide range of different teams including urban and rural, large and small, integrated crisis resolution and home treatment teams and those with separate crisis assessment and home treatment teams.

Review process and accreditation

The self review period for all teams ran from April to July 2012, and the peer review visits took place in September and October 2012. An Accreditation Committee (AC) was formed from HTAS members who formally applied for positions, and included representatives from psychiatry, nursing, social work, occupational therapy, psychology, research, and service users and carers. The AC first met in November 2012 to recommend accreditation status for each member and the decisions were ratified by the SCPPE in January 2013. The AC met again in March, June and December 2013 and the decisions were ratified by the SCPPE a month later on each occasion. The results are shown in Table 1.

8 teams were deferred initially, and of those 7 were able to achieve accreditation within 12 months. For deferred teams, their accreditation was based on further evidence submitted to cover standards that were Not Met at the point of their peer review. Teams that had been previously deferred were able to achieve ‘Accredited’ status but they could not be awarded ‘Accredited as Excellent’. Teams could be deferred for up to 12 months; at this point one team was not able to provide sufficient evidence and they were Not Accredited. They were invited to address the standards they failed to meet and reapply when ready to start again from the beginning of the process.

The HTAS AC also set a precedent that teams which did not provide 24 hour, 7 day a week care, could be accredited but could not achieve ‘excellent’ accreditation.

Date of SCPPE meeting	Number of teams				
	Accredited as excellent	Accredited	Deferred for 3 months	Deferred for 6 months	**Total accredited**
17 Jan 13	2	7	4	4	**9**
24 Apr 13	-	4	-	-	**13**
10 Jul 13	-	1	-	3	**14**
15 Jan 14	-	2	-	-	**16**

Table 1 Accreditation Status of HTAS Pilot teams.

Reasons for deferral

The most common reason for deferral was failing to meet the Type 1 standard **22.6** *'Information is provided for service users and their families/carers about how to make a complaint or compliment about any aspect of the service'*. This was often rectified by editing the information leaflet given to all service users to include explicit information on how to make a complaint or compliment, and sending a copy for the AC to review.

The second most common unmet type 1 standard was **11.2** *'Staff receive regular formal clinical supervision, at least every 4 weeks'.* Following the pilot phase, this standard was revised to specify supervision every 8 weeks, as official guidance and Trust policies were taken into account. After the revision, the AC assessed teams against the new standard. Teams commonly provided copies of their supervision rota and log to the AC to demonstrate that staff members were now receiving regular, formal supervision.

Contextual Data

Each team which took part in the pilot was asked to complete a contextual data questionnaire to enable the HTAS project team and the peer reviewers visiting their team to gain some background information prior to the visit.

This information showed that all the teams assess service users within 24 hours of a referral being received, however the teams varied widely in terms of current

caseload and the number of patients they had seen within the last 2 weeks. This data is presented in table 2 below.

Table 2 – Aggregated data from contextual data questionnaire responses

Question (number of responses)	**Mean**	**Range**	**Median**
Current caseload (n=15)	27	6-66	22
Number of patients seen within the last 2 weeks (n=17)	35	10-82	28
Average time period between referral and first assessment (n=14)	13 hours	2-24 hours	4 hours

Key Themes in the Self Review data

The data collected from the 17 participating teams during their 3 month self review period showed some interesting themes. Some standards which were rated as 'not met' during the self review period had been improved upon by the time teams had their peer review visit. As this was a pilot study some of the standards were also misinterpreted during the self review and therefore standards which had been rated as met/not met during self review may have been discussed and amended at the peer review visit.

Staffing

Table 3 shows the different types of professions that the Home Treatment Teams received dedicated sessional time from, as judged at self review and peer review, as well as the average number of each type of staff the teams had.

As shown in Table 3, all teams had a team lead and at least one CPN, social worker, support worker and psychiatrist, however fewer than half the teams had dedicated sessional time from an occupational therapist and even fewer teams had sessional time from a pharmacist or a psychologist.

Table 3 – Different types of professions working within HTTs

Profession	Percentage of teams with dedicated sessional time **(indicated by self review data)**	Percentage of teams with dedicated sessional time **(indicated at peer review)**	**Average number in each team**
Team Lead	100%	100%	-
Community psychiatric nurse (s)	100%	100%	15
Social Worker (s)	88.2%	100%	2
Occupational Therapist (s)	52.9%	41.1%	1
Psychologist (s)	23.5%	17.6%	0
Support Worker (s)	100%	100%	5
Pharmacist (s)	29.4%	29.4%	0
Consultant Psychiatrist (s)	100%	100%	3

Induction, training and supervision

334 Staff Questionnaires were received; 146 were from community psychiatric nurses, 52 support workers, 22 social workers, 17 Approved Mental Health Professionals, 27 administrators, 2 psychologists, 1 pharmacist, 14 consultant psychiatrists, 8 Occupational Therapists and 44 “others”. 20 team managers also completed the Team Manager Questionnaire.

During their induction to the Home Treatment Team, 83% of those who responded to the staff questionnaires had received training in the principles of CRHT services; 82% received training in the CRHT model and its implementation in the local context, 85% had training about the roles and responsibilities of team members and staff in other services, and 87% had received training in promoting recovery, safety and positive risk management. At the peer review visits it was noted that staff

teams tended to be made up of more senior workers who frequently reported that they had lots of experience from working in other Home Treatment Teams or related posts, so it may not have been necessary for them to have this training as part of their induction. Table 4 shows the different types of training staff had completed.

Table 4 – The different types of training completed by HTT staff

Topic (number of respondents)	**% of staff who have had training**	**% of team managers who have had training**
Delivering crisis resolution/home treatment interventions (staff=267, team managers=20)	94%	90%
Carer awareness, family inclusive practice and social systems in the home treatment team (staff=267, team managers=20)	88%	90%
Basic counselling skills (n=267)	86%	95%
Medication including storage, administration, legal issues, concordance and side effects (staff=268, team managers=20)	91%	95%
Reflective practice and debriefing (n=267)	75%	90%
The relevant Mental Health Act and Mental Capacity Act (staff=267, team managers=20)	96%	100%
Personal safety issues including procedures for visits and assessments (staff=306, team managers=20)	95%	100%
Suicide prevention (staff=267, team managers=20)	64%	75%
Self harm (n staff=267, n team managers=20)	82%	95%
Alcohol and substance misuse (staff=267, team managers=20)	82%	90%
Diversity awareness (staff=334, team managers=20)	94%	80%

Training can be covered by a specific training course, as part of another course, internal knowledge sharing or 'on the job' learning. However many of the staff believed that the questions related to formal, specific courses only and so estimations of their training were artificially low. In addition to this, it may not be necessary for some of the staff who completed the questionnaires to have training on all of the topics mentioned, e.g. administrative staff. Following the peer review visits it was decided that 100% of the teams met all of the standards surrounding the training topics listed in Table 4.

Each of the 17 teams who were involved in the pilot was asked to complete an organisational checklist during their self review period. 100% of the teams confirmed that they had a strategy and policy for staff annual appraisal, personal development planning and supervision. Despite this, only 67% of the staff and 90% of the team managers reported receiving clinical supervision at least every 4 weeks. 71% of staff and 65% of team managers reported receiving professional supervision at least every 8 weeks.

Policies and Protocols

All the teams who participated in the pilot met all Type 1 standards surrounding policies and protocols. They each had a clear pathway for entry and exit to the service, a Lone Worker Policy, as well as policies and procedures for managing complaints. They were also compliant with statutory guidance on the safeguarding of vulnerable adults and children and reviewed their protocols every 3 years. However, only 15 teams undertake regular audit on their service provision and the same number have links with service user led organisations to provide input on practice and policy developments. 12 of the 17 teams involve service users and carers in service planning and development, which suggests that there is room for improvement.

Table 5 –Health Record Audit data

The routine assessment gathered from multiple sources includes:	% of audited cases where this was completed
A screening to establish if the service is appropriate for the service user	99%
Identification of the service user's primary carer(s), or lack thereof	98%
An investigation into the nature of the crisis, and the presented problems	100%
The identification of immediate social stressors and social networks	99%
Psychiatric history including past records and family history	96%
The identification of the presence of mental health problems and their severity	99%
The identification of the clinical signs and symptoms, if mental health problems are found	100%
An investigation of comorbid physical health problems	92%
An assessment of practical problems of daily living	97%
A risk screening and assessment	99%
The identification of the people affected by the crisis, and for whom it is a crisis	99%
Identification of dependants and their needs, including childcare issues	80%
A social assessment	91%
A physical health assessment	70%
A multidisciplinary assessment of the service user's needs	98%
A multidisciplinary assessment of the service user's level of risk	97%
Planning for supported transition to other services	98%

The Assessment

Each team was asked to complete 20 Health Record Audits during the self review period. In total, 376 Health Record Audits were submitted. The audit showed that in most cases a comprehensive assessment is completed, the details of which are presented in Table 5.

With the exception of the physical health assessment and the identification of dependants, all the assessment elements listed in table 5 were completed in over 90% of cases. When the assessments were not completed the teams were asked to provide details why this had not been done and there was often a good reason for this, for example a physical health assessment may not have been completed because the service user refused to have one.

Equality and Diversity

Whilst all the 17 pilot teams take into account the diversity of each service user and have 24 hour access to translation services, one of the teams was not using ethnicity monitoring forms and only 11 of the 17 teams monitor the quality of experience and service received by people from equality target groups.

Liaison with acute inpatient services

As well as asking teams to complete an organisational checklist, a team manager questionnaire and staff questionnaires, they were also asked to distribute questionnaires to the inpatient wards they gatekeep. One questionnaire per ward was completed and there were 47 responses in total. Table 6 compares the responses from the checklist questionnaire, staff questionnaire and inpatient ward questionnaire.

The figures in Table 6 demonstrate that the home treatment team felt they were meeting these standards more often than the inpatient wards did. This suggests that liaison with inpatient wards is another area for improvement. Good liaison between these services is vital as it ensures that service users experience a smooth transition from one service to the other at a difficult time of mental health crisis.

Table 6 – A comparison of responses from home treatment team staff and staff from inpatient wards

Standard	**Checklist** % 'yes' responses (n=17)	**Staff** % 'yes' responses (n=147)	**Inpatient ward** % 'yes' responses (n=47)
There are systems in place to ensure continuity of care between the home treatment team, acute inpatient care and other services	**100%**	-	**91%**
The team has a robust system of communication with acute inpatient services, including out of hours	**100%**	-	**71%**
There are specific link arrangements between acute inpatient wards and the home treatment team	**100%**	-	**87%**
Regular formal meetings take place between the team and the ward to ensure that service users are transferred out of the ward as soon as clinically possible	-	**93%**	**74%**
The team is involved in early discharge planning with the ward	-	**95%**	**81%**
Primary care and other services involved in service users' care are involved and kept informed of discharge plans from acute inpatient care	**100%**	-	**87%**
The team supports early discharge from acute inpatient services where appropriate, by offering intensive acute support in service users' home settings within 24 hours of discharge	**100%**	-	**89%**

Timely discharge from the Home Treatment Team

Only 62% of staff who responded to the questionnaire (n=147) and 85% of the team managers (n=20) reported that the involvement of the team is time-limited. 89% of staff and 95% of team managers reported that service users are discharged when acute care is no longer necessary. Feedback from the peer review visits was that staff may have answered 'no' to these questions as they sometimes have difficulty discharging service users to Community Mental Health Teams (CMHTs). There could be a number of reasons for these difficulties, including lack of capacity within the CMHT or concerns about high risk patients.

Service User and Carer Data

Teams were required to distribute questionnaires to service users and carers who had experienced care from the team within the self review period. There were 187 responses to the service user questionnaire and 113 responses to the carer questionnaire.

On the whole, feedback from service users and carers was positive and they were generally very grateful for the care they had been provided with:

"[The] team members kept me going. Without their help I don't think I would be here today".

Visits from the team

A greater percentage of service users reported that the Home Treatment Team had contacted them to arrange a time to meet (95%) than did carers (82%). Similarly, 84% of service users reported that the team had told them how often they would like to meet and how long the meetings would last, whereas only 77% of carers reported being made aware of this.

In most cases (87%) service users reported that staff had explained the reason for their assessment to them, however, only 68% had been made aware how long they could expect to be involved with the Home Treatment Team. 71% of service users had been given a choice about where they would like the assessment to take place, and just over half (56%) had been asked who they would like to be present at their assessment.

Contact with the team

72% of the service users who responded to the questionnaire said they knew the name of the person responsible for their care. This is consistent with the results from the team manager questionnaire which showed that 65% of teams designated named workers. This is not something that all teams offer. However, 97% of service users and 96% of carers reported that they had been given a telephone number which they could call to get help, 24 hours a day, so there would usually be

someone available to help at the end of a telephone even if it wasn't their specific named worker.

Support for carers

Support for carers was found to be an area requiring improvement (see figures shown in Table 7). However, post-pilot feedback showed that some of the standards relating to carers' needs were misunderstood and so they have now been re-worded. Nevertheless, this is clearly an area that requires some improvement and teams should do all they can to ensure that the person caring for the service user has access to the support and information they need to get them through a difficult time.

Table 7 – Provision of carer support

Question Asked	Percentage carers who replied 'yes'
Did the Home Treatment Team explain what was happening at each stage of the service user's care? (n=112)	87%
If this is your first contact with the Home Treatment Team, were you offered an appointment to discuss your family history and any worries you may have? (n=111)	64%
Were you offered an assessment of your own needs? (n=111)	50%
Were you offered a referral to the Carer Support Service? (n=110)	58%
Were you supported by the team to link with services who can help with the ongoing care of the person you care for? (n=110)	61%
Were you given information on mental health problems, what you can do to help, your rights as a carer and an up to date directory of local services you can access? (n=111)	44%

Recommendations

1. The health record audit data demonstrated that only 70% of service users had a physical health assessment documented. People with severe mental health problems die on average 20 years younger than the general population, and so there needs to be a concerted effort to address both the mental and physical health needs of service users.

2. Responses from carers indicated that many of them were not receiving relevant support and information from the home treatment team. Teams should ensure that the needs and voices of family and carers are fully taken into account when treating the person they care for, both to ensure the wellbeing of carers and a supportive social system for the service user.

3. All home treatment teams should have dedicated sessional time from a psychologist and occupational therapist.

4. Responses from the inpatient wards indicated that they were not as positive about their relationship with the home treatment teams as the teams themselves were. It is recommended that teams regularly ask their linked inpatient wards about their satisfaction with the amount and nature of contact, to ensure that patients are discharged from inpatient care as soon as is appropriate, and always receive a smooth transition between services.

Changes to the HTAS standards and process following the pilot phase

Post-pilot feedback

Following the peer review visits, staff members from each of the 17 participating teams were invited to a feedback event hosted by the HTAS project team which gave them the opportunity to discuss how the process might be improved. Suggestions were made regarding changes to the self review audit tools, changes to the peer review timetable as well as changes to the standards.

Standards development

Following the pilot phase, feedback was collated from HTAS members, the Standards Development Group who developed the Pilot Standards and CCQI staff, as well as the HTAS Team's observations of using the standards in practice. This input was used to revise the standards and the First Edition was published in 2013.

Standards revisions

Post-pilot feedback suggested that the standard regarding clinical supervision occurring at least every 4 weeks was unrealistic based on Trust and organisational policies, so the standard was changed to 8-weekly supervision. Some of the teams were also unclear about what "professional" supervision entailed so this standard has now been changed to "managerial" supervision.

A few new standards were added – '*The standard of care provided is consistent 24 hours a day, 7 days a week'*. This was to ensure that where teams do not operate a full service 24 hours a day, 7 days a week (e.g. out-of-hours service operates differently, or is provided by another team) that the team monitors the care provided out-of-hours to ensure that a similarly high standard of service is provided at all times of day.

The other standard revisions were largely clarifications of standards used in the pilot.

Process revisions

Some teams had difficulty getting their service users and carers along to the peer review day to talk to the team about their experiences, either because they did not agree to come, or because they were unable to make it on the day. The necessity of the service user and carer meetings being carried out face to face was questioned at the members' feedback event and the timetable now includes two meeting options with service users and carers – a face to face meeting and a telephone meeting which take place concurrently.

The review focussed a lot on the links and transitions with the inpatient wards and omitted the community mental health teams (CMHTs). Some teams reported problems in discharge to CMHTs owing to lack of capacity in the CMHT or reluctance to take on service users they perceive to be a risk. At the revision several new standards were introduced to cover the relationship between the CRHT and CMHT, and a CMHT Representative is now invited to the meeting with the CRHT Team Manager and Inpatient Ward Representative.

After the pilot phase, it was decided to remove the Inpatient Ward Questionnaire from the self review tools. The questionnaire had very few questions and the Ward Representative is invited to the peer review day so it appeared redundant; any questions could be answered in person instead.

Opportunities for HTAS members

Attending peer review visits

Staff from HTAS member teams have the opportunity to attend peer review visits to other services, which is an excellent learning opportunity. Peer reviewers are able to observe how other teams function, talk to staff, share knowledge and good practice, and create useful contacts. Staff that wish to become peer reviewers attend a one-day training event run by HTAS, which is free to attend for members. Trained peer reviewers are then asked to volunteer for visits, which happen around the UK throughout the year.

HTAS Forum

HTAS holds an annual members' conference; the first event took place on 11 November 2013 in London. This involves presentations and workshops delivered by the HTAS team and HTAS members, sharing and showcasing good practice and innovations, and updating members on the progress of the programme. Members were allocated free places at the conference, and future Forums will also welcome non-members for a small fee.

HTAS-Chat email discussion group

- HTAS members can join the email discussion group, which is a forum where home treatment staff can receive advice from their peers in other home treatment teams around the UK. Queries are sent to a central email address, and are then distributed to the group which currently has over 60 members. Members of the group can respond to these queries and replies are distributed to the group as a whole, so that others can benefit from the information.

Recent topics include: Occupational Therapists working in Home Treatment Teams, benchmarking admission thresholds, and alternatives to hospital admission provision.

To join HTAS-Chat, email 'JOIN' to HTASChat@rcpsych.ac.uk

Appendix 1

Benchmarking - teams listed in order of compliance with type 2 standards and overall compliance

Rank	Team Number	% Overall Standards Met
1	5	**97.7**
1	14	**97.7**
3	7	**96.6**
4	8	**96.1**
4	6	**96.1**
6	9	**95.4**
7	13	**93.6**
8	15	**93.1**
9	2	**92.7**
10	12	**92.2**
11	3	**92.0**
12	4	**91.6**
13	17	**89.9**
14	1	**89.7**
15	11	**89.1**
15	10	**89.1**
17	16	**87.7**

Rank	Team Number	% Type 2 Standards Met
1	5	**97.9**
1	14	**97.9**
3	8	**95.8**
4	7	**94.7**
5	9	**94.7**
5	6	**93.7**
7	15	**91.6**
8	13	**91.5**
8	3	**90.5**
8	12	**90.5**
11	2	**88.4**
12	4	**86.3**
12	17	**86.3**
14	11	**85.3**
14	1	**85.3**
14	10	**85.3**
17	16	**81.1**

NB: Home treatment teams that took part in the pilot phase of HTAS and were accredited by the time of publication of this report, were included in the above table and will be informed individually of their service number.

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