Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

Berkshire Healthcare NHS Foundation Trust

Quality Account 2016

What is a Quality Account?

A Quality Account is an annual report about the quality of services provided by an NHS healthcare organisation. Quality Accounts aim to increase public accountability and drive quality improvements in the NHS. Our Quality Account looks back on how well we have done in the past year at achieving our goals. It also looks forward to the year ahead and defines what our priorities for quality improvements will be and how we expect to achieve and monitor them.

About the Trust

Berkshire Healthcare NHS Foundation Trust provides specialist mental health and community health services to a population of around 900,000 within Berkshire. We operate from more than 100 sites across the county including our community hospitals, Prospect Park Hospital, clinics and GP Practices. We also provide health care and therapy to people in their own homes.

The vast majority of the people we care for are supported in their own homes. We have 171 mental health inpatient beds and almost 200 community hospital beds in five locations and we employ more than 4,000 staff.

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Quality Account Highlights 2016

The Trust was awarded an overall rating of 'Good' following a comprehensive inspection undertaken by the Care Quality Commission (CQC) during the year.

Trust community Services (both physical and mental health) are highly valued by our patients. Results from the patient Friends and Family Test during the past year indicate that greater than 95% of respondents are either extremely likely or very likely to recommend these services to a friend or family member.
It is also evident that Trust community inpatient services, minor injury services and walk-in centres are highly valued with more than 90% of respondents stating they are likely to recommend these services during the year.

The overall Trust staff engagement score from the National Staff Survey in 2015 was 3.91 out of a possible 5 (compared with 3.85 in 2014). This gave the Trust a ranking of 5th out of 29 similar Trusts.

The Trust has delivered on its commitment to become smoke free across all of its sites.

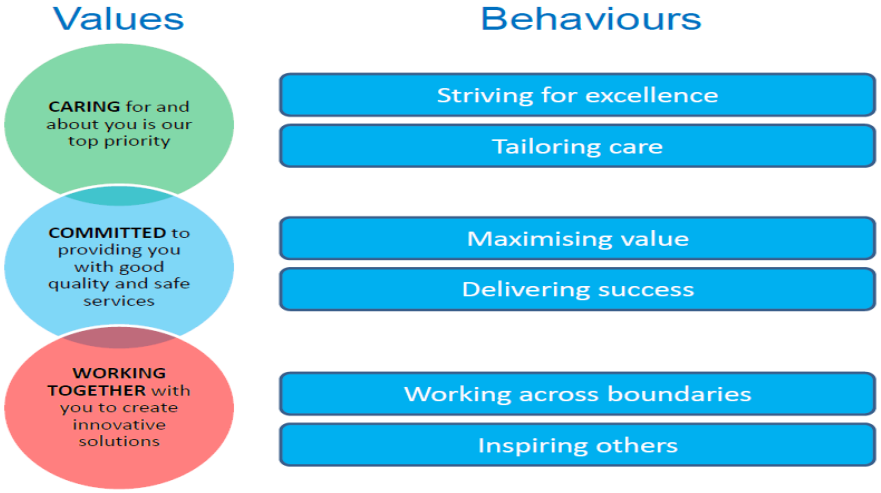
The Trust has demonstrated that 100% of NICE Technology Appraisals and greater than 80% of all NICE Guidance have been implemented across the Trust.

The Trust has introduced a more systematic and detailed method for logging information about and investigating whistleblowing concerns.

Many successful improvements have been implemented by services throughout the Trust, examples of which are included in this report.

The Trust has set quality priorities for 2016/17 relating to the following areas:

- Reducing patient falls
- Pressure ulcer prevention
- Implementation of NICE guidance and guidelines
- Patient experience priorities relating to the Friends and Family Test, learning from complaints and the Patient Leadership Programme
- Suicide prevention



1. Statement on Quality by the Chief Executive of Berkshire Healthcare NHS Foundation Trust

The Trust has continued to deliver effective, safe and efficient care for its patients throughout the year. Such care is reinforced by an organisational culture that embraces the Trust's values- *caring, committed and working together*- all of which are embedded within the Trust appraisal system for staff. Additionally, the principle of working together is extended through collaboration with external health, social care and third sector organisations to enable the delivery of practical solutions to complex health and social care challenges.

Evidence available from patient Friends and Family Test results and the Trust's own patient satisfaction survey demonstrate that the services we provide are highly valued by our patients. This enforces our commitment to ensure that the care we provide is not only of a high clinical quality, but also that patients have a positive experience of our services. We aim to maintain and improve on these results and have set an ongoing priority in this area for the 2016/17 year.

The national staff survey results for the Trust were also favourable for 2015. Our overall staff engagement score ranked us 5th out of 29 similar Trusts and this is a pleasing finding.

Patient safety remains of paramount importance to the Trust. Throughout the year, the Board has received reports on a variety of patient safety metrics, several of which are shared in this report. Trusts must also learn from experience when things go wrong and we now have increasingly robust governance, patient safety, incident reporting and patient experience systems that highlight areas for learning and improvement. In addition, the trust have implemented a policy encouraging a culture of openness when things go wrong (the Duty of Candour) as well as a more systematic and detailed method for logging information on and investigating whistleblowing concerns (Freedom to Speak Up). The Trust will continue striving to deliver safe care, with priorities relating to the reduction in falls and reduction of pressure ulcers set for the following year.

The clinical effectiveness agenda for the trust has increased during this year with progress being made in the areas of clinical audit and research. Clinical audit has allowed us to measure our care against current best practice leading to improvement, whilst our involvement in research has helped to inform future treatment and management of patients. In addition, the Trust has met its target of implementing 100% of relevant NICE Technology Appraisal Guidance and greater than 80% of all relevant NICE Guidance and Guidelines. We will aim to maintain this level of compliance and have set a further priority target for this.

In October 2015, the trust became smoke free across all of its sites. A staff smoke free policy has been implemented with many staff also taking the opportunity to reduce their tobacco intake or quit smoking altogether. Patients in the community are now asked to abstain from smoking whilst we provide their treatment, with staff helping to ensure that our grounds are smoke free. Our final milestone was realised when we became smoke free on our mental health wards at Prospect Park Hospital. Patients are being supported through this by being offered nicotine replacement therapy whilst on the wards and are given access to stop smoking services if they would like to be supported in making a serious quit attempt during their stay.

The year has also seen numerous other service improvement projects being initiated throughout the Trust. Improvements have been evident across the board, with cross-service and multi-agency improvement work also being undertaken. This report highlights some of the improvements that have been made and demonstrates our commitment to improve services across the whole of the Trust.

Our involvement in primary care management has proven successful during the year. Following our management intervention last year, the Priory Avenue GP Practice was taken out of special measures by the CQC. Resultant improvements to patient care and the processes adapted to enhance the delivery of primary care have been noticeable and highly commended by the Patient Participation Group.

Finally, in March 2016, the Trust was awarded an overall rating of 'Good' following a comprehensive inspection undertaken by the Care Quality Commission (CQC). This is a very pleasing result for the Trust, and we are committed to continue delivering services that are of a high standard in order to maintain and improve on this rating.

We are committed to continue ensuring that the people of Berkshire receive amongst the best care in the country for physical and mental health problems. At Berkshire Healthcare NHS Foundation Trust we are determined to play our part in making sure that this is the case.
This quality account is a vital tool in helping to support the delivery of high quality care.

The information provided in this report is, to the best of my knowledge, accurate and gives a fair representation of the current services provided

Julian Emms CEO

Feedback from a Service User

"A letter to my therapist

Though you were a stranger to me, you didn't judge me for my actions, no matter how crazy they were. You were kind, caring and very open minded. You took time to get to know the "real" me, you took time to listen to me. You saw past the facade that I masked so well to fool those close to me and saw a young person in desperate need of help, though you never made me feel like a patient, a statistic or a BMI number. You supported me, helped me understand the pain I was feeling and gave me the tools to deal with adversities without harming myself. You gave me the courage to put down the knife, flush away the pills, you gave me a second chance, a chance that I needed the most. You gave me the tools to break what seemed like a never-ending cycle. You believed in me when no one else would. You helped me make positive chapters in a once so gloomy book.

To my therapist, I wouldn't be here if it wasn't for you. You saved my life and I'm sure many others too. From feeling like I had no place in the world, no confidence with no acceptance of myself... I am now a confident, out-going person with a desire to help others like you helped me.

If I could I would give you a Dame, a title in which you so rightly deserve because you taught me to love myself, to be a strong individual who is capable of achieving anything! But for now I hope you take this letter as appreciation and recognition for helping me and many others too.

Yours sincerely

A forever grateful CAMHS service user"

2. Priorities for Improvement

2.1 Priorities for Improvement 2015/16

This section of the Quality Account details Trust achievements against the 2015/16 priorities and information on the quality of services provided during 2015/16. The priorities support the Trust's quality strategy (Appendix A) to provide accessible, safe, and clinically effective community and mental health services that improve patient experience and outcomes of care through the following six elements:

1. Clinical Effectiveness – Providing services based on best practice
2. Safety – To avoid harm from care that is intended to help
3. Efficient – To provide care at the right time, way and place
4. Organisation culture –Patients to be satisfied and staff to be motivated
5. Patient experience and involvement – For patients to have a positive experience of our service and receive respectful, responsive personal care
6. Equitable – To provide equal care regardless of personal characteristics, gender, ethnicity, location and socio-economic status.

The table below summarises the achievement of the Trust in 2015/16 against each of its priorities. Each of these priorities is then discussed further later in this section.

Summary of Trust achievement against 2015/16 Quality Account Priorities

Priority and Indicator		Results		
		2014/15	2015/16	Change
Patient Experience				
Friends and Family Test- % of patients likely or extremely likely to recommend the service to a friend or family member	Community Services (Mental health and physical health combined)	91%	**97%**	**+6%**
	Mental Health Inpatients	62%	**70%**	**+8%**
	Community Hospital Inpatients	92%	**94%**	**+2%**
	Minor Injury Units and Walk-in Centre	94%	**91%**	**-3%**
National Community Mental Health Survey- Overall result (score out of 10)		6.9	**6.8**	**-0.1**
Staff Experience				
National Staff Survey- Staff Engagement Score (Score out of 5)		3.85	**3.91**	**+0.06**
Patient Safety				
National Staff Survey- Indicators relating to errors and incidents	KF28. % witnessing potentially harmful errors, near misses or incidents in last month	23%	**18%**	**-5%**
	KF29. % reporting errors, near misses or incidents witnessed in the last month	90%	**88%**	**-2%**
	KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents (Score out of 5)	N/A	**3.85**	**N/A**
	KF31. Staff confidence and security in reporting unsafe clinical practice (Score out of 5)	3.81	**3.76**	**-0.05**
Number of Pressure Ulcers	Inpatient Wards- Developed Category 2 Pressure Ulcers (Number)	39	**14**	**-25**
	Inpatient Wards- Developed avoidable category 3 and 4 Pressure Ulcers on Inpatient Wards (Number)	5	**1**	**-4**
Medication errors- Total Number Reported (Increased reporting is encouraged)		576	**623**	**+47**
Cases of seclusion of patients (Number)		230	**170**	**-60**
Cases of prone restraint of patients (Number)		145	**206**	**+61**
Patient on patient physical assaults (Number)		348	**356**	**+8**

Priority and Indicator		Results 2014/15	2015/16	Change
Clinical Effectiveness				
Compliance with Trust NICE guidance implementation targets	Percentage of NICE Technology Appraisals implemented by the Trust (Target 100%)	100%	**100%**	**0%**
	Percentage of all NICE Guidance and Guidelines implemented (Target 80%)	73%	**84%**	**+11%**
Health Promotion				
Trust becomes Smoke Free on all sites		N/A	**Met**	**Met**
Delivery of Diabetes education sessions for staff and patients		N/A	**Met**	**Met**
Monitoring of Physical Health Risk Factors amongst patients with mental health problems	Result of 2015/16 CQUIN relating to physical health monitoring of mental health patients	N/A	**Met**	**Met**

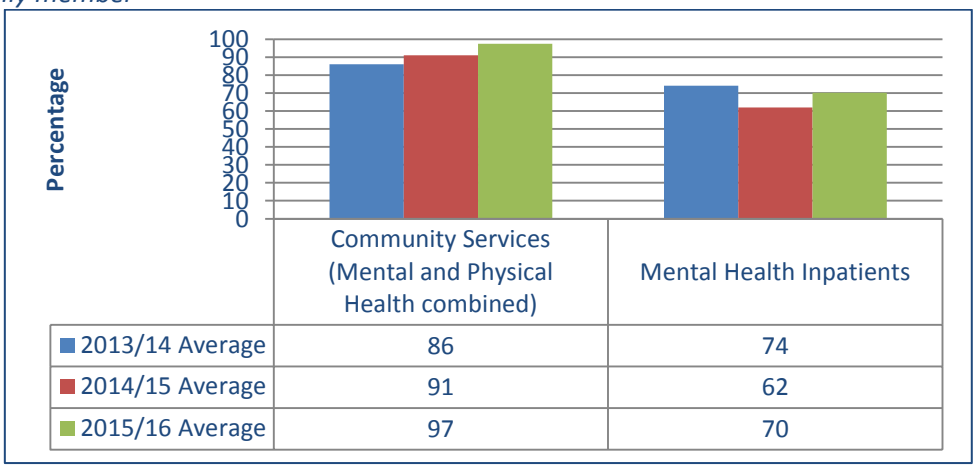
2.1.1 Patient Experience

The Trust has continued to report on the Friends and Family Test results and on the Trust's own internal patient satisfaction survey throughout the year. By doing so, the Trust aims to demonstrate continuing improvement. Learning from complaints and improving national survey results also remains a priority for the Trust. Achievement in relation to each of these areas is detailed further below.

Patient Friends and Family Test (FFT)

Figures 1 and 2 below demonstrate the Trust's achievement in relation to the patient Friends and Family Test. The figures demonstrate that Trust community services (both physical and mental health) are highly valued with 97% of people surveyed likely to recommend them. Additionally, Trust community inpatient services, minor injury services and walk-in centres are valued with over 90% of respondents recommending such services. For mental health inpatients, 70% of respondents in 2015/16 stated that they were either likely or very likely to recommend the service to a friend or family. This is an improvement from the 2014/15 score.

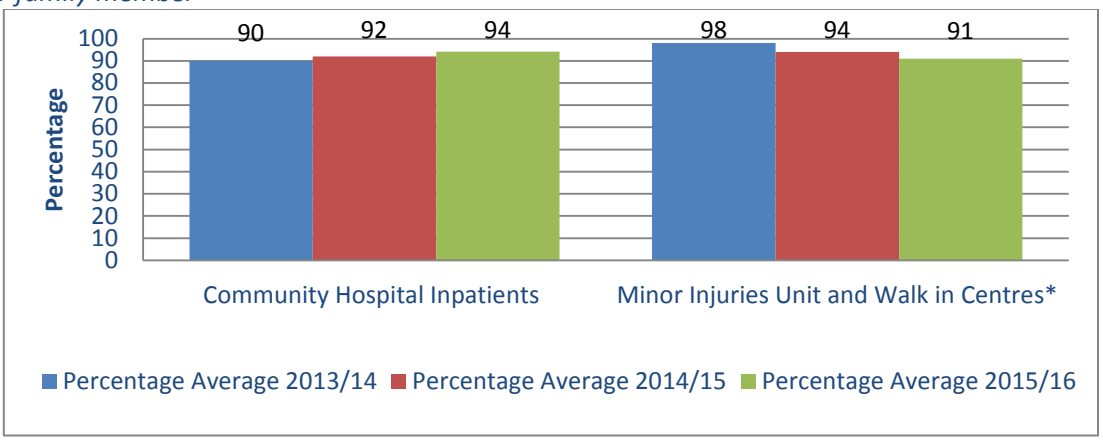
Figure 1- Patient Friends and Family Test: Percentage of Patients Extremely likely or likely to recommend the service to a friend or family member



	Community Services (Mental and Physical Health combined)	Mental Health Inpatients
2013/14 Average	86	74
2014/15 Average	91	62
2015/16 Average	97	70

**Mental Health figures for 2014/15 are for Nov 2014-March 2015 due to the change in national methodology.*
Source: Trust Patient Experience Reports

Figure 2- Patient Friends and Family Test: Percentage of Patients Extremely likely or likely to recommend the service to a friend or family member



** 2013/14 figures are for Minor Injuries Centre only. 2014/15 figures onward include Slough Walk in Health Clinic. There has also been some change in the methodology to ensure visitors report in higher numbers and anonymously.*
Source: Trust Patient Experience Reports

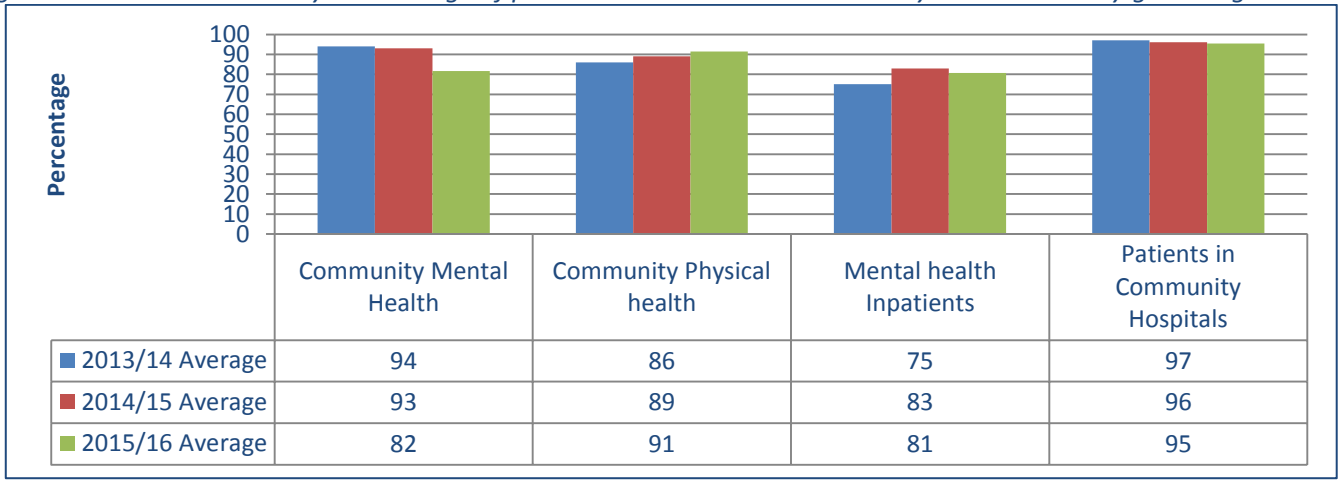
All services are now expected to gather Friends and Family Test (FFT) responses and in quarter four the trust has seen a significant reduction in its collection from 5844 in quarter three to 4793 in quarter four. For our community health wards the recommendation rate is above 85% but our mental health wards do not collect enough responses to give valid data. This has to improve and the patient experience team continue to work with the wards to improve their performance however it is challenging.

Circuit Lane GP surgery has a very low recommendation rate of 33%. We still have a low response rate from patients for other services and work is progressing to improve this. Where a response rate is less than 15% the recommendation rate validity can be questioned. The board will be monitoring FFT going forward.

Trust Patient Satisfaction Survey

In addition to the patient Friends and Family Test, the Trust has also carried out its own internal patient satisfaction survey throughout the year to further ascertain and assure levels of patient satisfaction. Figures 3 and 4 below demonstrate the Trust's performance in relation to this survey. It can be seen that during the 2015/16 financial year, a total of 14246 service users and carers have provided feedback through this survey programme, with 90% of people giving a good or very good rating of the care they received.

Figure 3- Trust Patient Survey: Percentage of patients who rated the service they received as very good or good.



	Community Mental Health	Community Physical health	Mental health Inpatients	Patients in Community Hospitals
2013/14 Average	94	86	75	97
2014/15 Average	93	89	83	96
2015/16 Average	82	91	81	95

Source: Trust Patient Experience Reports.

Figure 4- Trust Patient survey: Total number of responses to internal patient survey over the year. (2015/16)

	Total Number of Responses	Total Number of Good or Better Responses
Community Mental health	1308	1068
Community physical health	10947	10010
Mental Health Inpatients	703	567
Community Inpatients	1288	1229

Source: Trust Patient Experience Reports.

Carer Friends and Family Test (FFT)

A Friends and Family Test for carers has been created and has been distributed to services from February 2015. This allows carers the opportunity to share their experience with us in a dedicated way. Whilst this is not mandated within the Friends and Family national guidance, the Trust recognises the crucial role that carers have and the value of their feedback.

During 2015/16, the Trust received a total of 131 Carer FFT responses from all services. 122 (93%) respondents replied that they were either extremely likely or likely to recommend the Trust services

Learning from Complaints

The Trust has continued to respond to and learn from complaints during the year. Figures 23 and 24, shown in part 3 of this report, show the number of complaints and compliments received by the Trust.

During quarter four we achieved a response rate of 97% within the agreed timescale with the complainant, with January and March achieving 100%. When a patient or carer complains, getting a response within the timescale agreed is important and from a CQC perspective good response rates support a responsive culture within an organisation. This is excellent performance from both the complaints team and clinical directors. Services on average took 33 days to investigate and respond to complaints. Many complaints are responded to much quicker if they are less complex.

Of complaints closed during quarter four, just under 60% were upheld or partially upheld which demonstrates investigators are objective in their investigations.

Two services had the highest number of complaints in quarter four:

- Community Mental Health Teams – Clinical care was the most common subject of complaints, with specific concerns about delays to visit and referrals to specialist treatment. There were no common themes about the clinical care provided. Reading locality received the most complaints.
- GP surgeries in Reading – the majority relating to care and treatment provided by Circuit Lane surgery.

The highest numbers of complaints during this financial year have been received by mental health inpatients, child and adolescent mental health services (CAMHS) and community mental health teams and GP surgeries in Reading. In fact, as a consequence of the two surgeries in Reading, this locality had an increase in complaints from 28 in 14/15 to 46 in 15/16. Alongside of this one of the Reading MPs has raised concerns on behalf of 13 patients regarding Circuit Lane surgery. Our recent CQC comprehensive inspection rated Circuit Lane as 'requires improvement' in caring and responsive domains because access to appointments has continued to be challenging for patients. The locality team have undertaken considerable work with both surgeries to improve the patient experience.

At the beginning of 2015/16 the board agreed that the trust would focus on seeing a reduction in complaints received by Child and Adolescent Mental Health Services (CAMHS) and Crisis Response Home Treatment Team (CRHTT) as these services received investment from commissioners.

Compared to last year CRHTT have seen a reduction in complaints during this year from 19 to 13 whereas CAMHS have seen an increase from 21 complaints in

2014/15 to 28 in 2015/16 although most of the complaints for CAMHs were received in the first two quarters of the year. For CAMHs the complaints continue to focus on access to services and treatment, in particular the Autistic Spectrum Disorder pathway. Over 2016/17 the reducing trend seen in quarter 4 for CAMHS needs to continue.

The top reasons for complaints being made during quarter four were care and treatment, attitude of staff, access to services and medication. This is the first time that medication has been one of the top themes for complaints so this will need to be monitored as to whether a new trend is developing.

Each service takes complaints seriously and implements new ways of working if appropriate. If a staff member has been directly named, they are involved in the investigation and its findings and action taken if required. The service and staff directly involved in the complaint are asked to reflect on the issues raised and consider how they will change their practice.

The trust has received notification from the Parliamentary Health Ombudsman Service (PHSO) that they are intending to investigate one complaint associated with Talking Therapies and have requested information from the trust about another complaint so that they are able to decide whether to investigate. The trust tries to avoid referrals to the PHSO by giving patients the opportunity to come back to the trust if they are unhappy with the response they receive initially.

The number of posts on NHS Choices continue to increase with 41 negative posts predominantly about the two GP practices in Reading (21) and the phlebotomy service (11) provided from West Berkshire Community Hospital. The major trend for these posts involved access to services. There were 21 positive posts highlighting the positive environments our services operate from. The system the trust has in place means that we are able to respond quickly to each post. Our Patient Advice and Liaison Service (PALS) also saw GP services and phlebotomy providing the most contacts during quarter 4.

Our 15 steps programme continues to provide helpful, positive feedback. However, during the visit to Orchid Ward providing older people's mental health services, the team felt staff were not engaged with the patients on the ward. The trust's recent CQC inspection found that older people's mental health wards required improvement in the safe and effective domains. The 15 step findings would support this assessment. A focused action plan is in place to improve these domains.

Conclusion

In terms of volume the level of positive feedback received by services far outweighs the negative feedback found in complaints, surveys and on NHS Choices. At this point of the year there are no new emerging trends. The CQC comprehensive inspection identifies areas of concern in services which we were aware required improvement which demonstrates the value of analysing the patient experience of our services as an indicator of quality.

Services and individuals strive to provide the best possible care and generally patients have a good experience in our services but as a result of a number of variables, for some patients their experience is not good and care falls below the standard of care expected. These lapses in care are not taken lightly and it is important services recognise and take steps to prevent similar incidents and that this is shared across the organisation. This continues to be work in progress.

2015 National Community Mental Health Survey

The Trust uses national surveys to find out about the experiences of people who receive care and treatment. The results of the annual National Community Mental Health Survey were published in October 2015.

This year's survey allowed for comparisons to be made with the 2014 results as there were only minor amendments made. The survey contained 33 questions (the same number as in 2014) which were categorized within ten Sections. Each question was scored out of a total mark of 10.

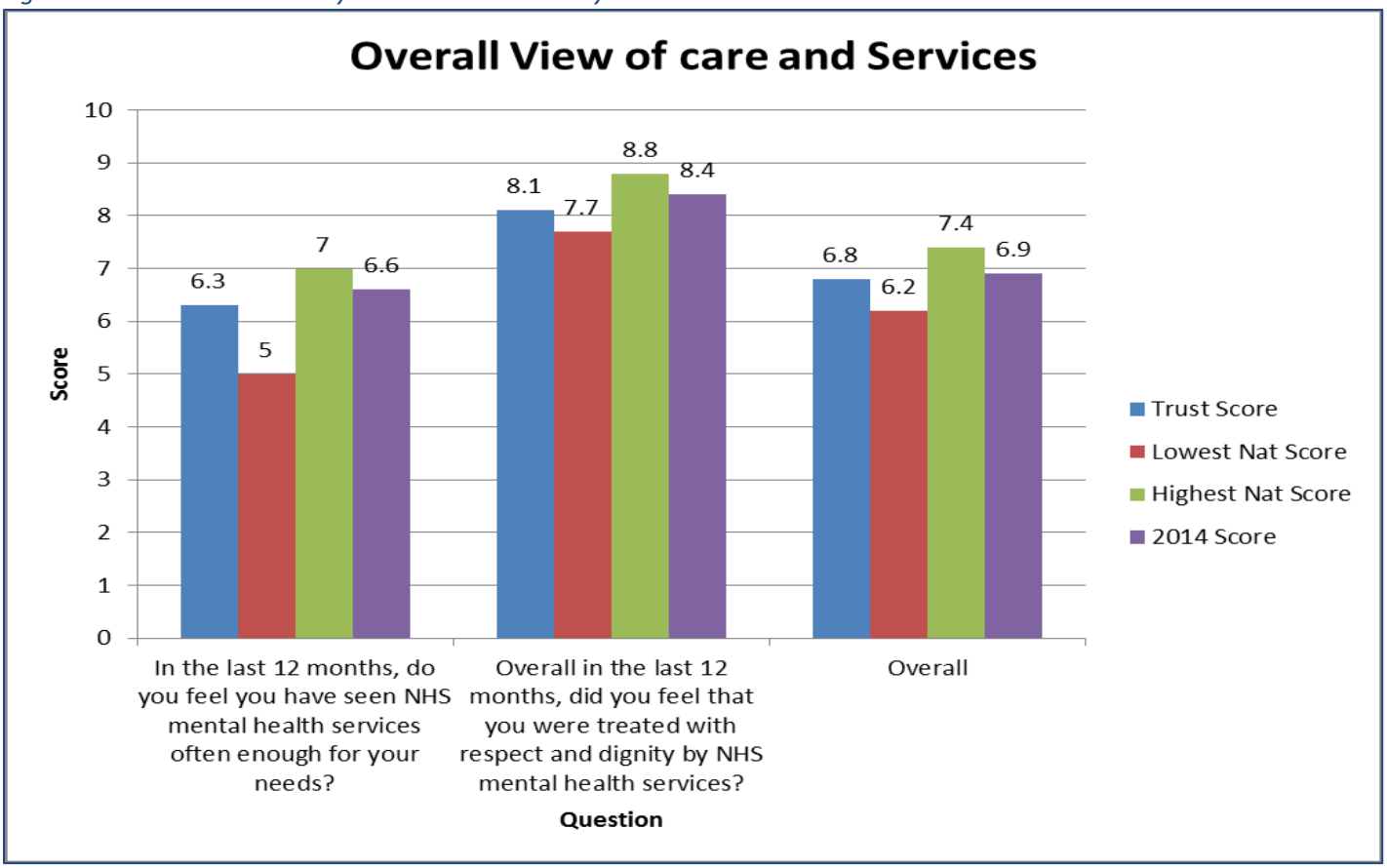
Patients were eligible to receive the 2015 survey if they had been seen by community mental health services between 1 September 2014 and 30 November 2014. Surveys were sent out to 850 patients meeting this requirement between February and July 2015, with responses received from 245 people (30%).

Out of the available 43 scores (including section scores), the Trust achieved 42 results that were ranked as about the same as the majority of other participating trusts.

For one question, the Trust received the lowest score: 'In the last 12 months, did NHS mental health services give you any help or advice with finding support for finding or keeping accommodation?'
These results are consistent with a deep-dive survey that was undertaken in the last financial year and an ongoing action plan is being implemented as a result.

Figure 5 below gives an overview of scores for the Trust in relation to respondents' overall views of the care and service they received and their overall experience. The 2015 Trust scores are compared with the highest and lowest scores achieved by other trusts this year, and with the comparable Trust score for the equivalent question in 2014

Figure -5 National Community Mental Health Survey 2015



Source: Trust Results from National Community Mental Health Survey 2015

2015 National Staff Survey

Berkshire Healthcare NHS Foundation Trust took part in the 2015 NHS National Staff Survey between October and December 2015. The survey was conducted on-line and, as a result, was open to over 4000 of the Trust's employees. 1,562 (38%) of staff responded to the survey compared with 1,816 (45%) in 2014. Nationally the 2015 response rate across all Trusts was 41%.

A total of 297 organisations in England participated in the 2015 survey. The results for each organisation were benchmarked against similar Trusts, resulting in the scores for the Trust being benchmarked against 28 other Combined Mental Health, Learning Disabilities and Community Health Services Trusts.

The overall staff engagement score for the Trust in 2015 was 3.91 out of 5 (compared with 3.85 in 2014). This gave us a ranking of 5th out of 29, maintaining our position in the Top 20% of similar Trusts.
An analysis against the other 28 similar trusts showed that out of the 32 Key findings, the Trust scored:

- 22- better than average scores;
- 7 - Average scores; and
- 3 - worse than average scores

Out of those 22 better than average scores, the Trust was ranked in the top three of similar trusts for eight key findings. Of the 32 key findings, the Trust was ranked in the top 20% for 14 and in the upper quartile for 19.

The Trust achieved lower scores in relation to staff working extra hours (79%), staff suffering work-related stress (40%), and staff reporting their most recent experiences of bullying and harassment (44%). The Trust is committed to improve upon these scores.

One of the Trust's patient safety priorities for 2015/16 was to achieve staff survey results that were amongst the best 20% of similar Trusts in relation to errors, near misses, incidents and concerns (Key Findings 28-31 of the survey). The table below demonstrates how the Trust performed in relation to this priority.
As can be seen, the trust has achieved a better score than the average (median) for other similar Trusts in 3 out of the four indicators. The Trust was also in the top 20% of similar trusts for these three indicators
Key Finding 29 suggests that staff witnessing potential harm are less likely than staff in other similar Trusts to report it. However, it should be noted that these results only relate to responses from 30 staff. In addition, the recently published NHS Improvement 'Learning from Mistakes League' has highlighted that the Trust has a good culture of openness and transparency, with a ranking of 28th out of 230 Trusts.

Errors and Incidents	Trust Score 2015	Average (median) for combined MH/LD & community trusts (29 Trusts)- 2015
KF28. % witnessing potentially harmful errors, near misses or incidents in last month	**18** **Top 20%**	23
KF29. % reporting errors, near misses or incidents witnessed in the last month	**88**	92
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	**3.85** **Top 20%**	3.72
KF31. Staff confidence and security in reporting unsafe clinical practice	**3.76** **Top 20%**	3.69

The Workforce Race Equality Standard (WRES) requires organisations to demonstrate progress against a number of indicators of workforce equality, with some of these indicators based on the Trust's National Staff Survey results. The Table below details these findings for the Trust, separated into scores for white and black and minority ethnic (BME) staff.

As can be seen, scores for BME staff in 2015 have improved for one Key Finding (KF25) and the gap between the experience of white and BME staff has reduced since 2014. Disappointingly the reverse is true for the other three findings.

The higher scores might be explained by the timing of the staff survey (October to December) following very shortly on the feedback in mid-October of findings from the BME focus groups held last summer. The recognition by the Executive of the problems faced by our BME staff may have encouraged more staff to complete the survey and / or disclose their experience of discrimination. The WRES results reinforce that the equality of opportunity initiatives, as well as having a strong staff BME network are the right things to prioritise. They will need dedicated HR / Equality management resources to support project work as well as locality action planning.

Description	Race	Trust Score 2014	Trust Score 2015	Average (median) for combined MH/LD and community trusts (29 Trusts)- 2015
KF25- Percentage of staff experiencing harassment or bullying from patients / public in the last 12 months	White	21%	**23%**	27%
	BME	32%	**25%**	30%
KF26- Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	White	19%	**19%**	20%
	BME	23%	**27%**	23%
KF21- Percentage of staff believing the Trust provides equal opportunities for career progression or promotion	White	88%	**91%**	91%
	BME	76%	**74%**	78%
Q17b- In the last 12 months have you personally experienced discrimination at work from manager/team leader or other colleagues	White	5%	**5%**	5%
	BME	13%	**14%**	13%

Figure 6 below details further results from the 2015 staff survey and compares them with previous Trust results, and the median score for similar Trusts in 2015

Figure 6- 2015 National Staff Survey

Question and reference (2015 Survey)		Trust 2013 (%)	Trust 2014 (%)	Trust 2015 (%)	Average (median) for combined MH/LD and community trusts (29 Trusts)- 2015
Q21a	*Care of patients / service users is my organisations top priority (agree or strongly agree)*	71	73	**80**	73
Q21b	*My organisation acts on concerns raised by patients and service users (agree or strongly agree)*	75	78	**82**	75
Q21c	*I would recommend my organisation as a place to work (agree or strongly agree)*	62	62	**65**	57
Q21d	*If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation (agree or strongly agree)*	69	71	**74**	67
Q2a	*I look forward to going to work (often or always)*	58	59	**67**	59
Q2b	*I am enthusiastic about my job (often or always)*	71	74	**79**	74
Q5f	*How satisfied am I that the organisation values my work (Satisfied or very satisfied)*	44	47	**48**	43
Q8c	*Senior managers try to involve staff in important decisions (agree or strongly agree)*	41	41	**43**	34
Q8d	*Senior managers act on staff feedback (agree or strongly agree)*	38	41	**43**	31
Q12a	*My organisation treats staff who are involved in an error, near miss or incident fairly (agree or strongly agree)*	54	51	**56**	53
Q12b	*My organisation encourages us to report errors, near misses or incidents(agree or strongly agree)*	90	88	**92**	88
Q12c	*When errors, near misses or incidents are reported my organisation takes action to ensure that they do not happen again (agree or strongly agree)*	67	67	**78**	69
Q12d	*We are given feedback about changes made in response to reported errors, near misses and incidents (agree/ strongly agree)*	48	51	**65**	57
Q13b	*I would feel secure raising concerns about unsafe clinical practice (agree or strongly agree)*	71	78	**73**	71
Q13c	*I am confident that my organisation would address my concern (agree or strongly agree)*	55	65	**66**	59

Source: 2015 National Staff Survey

2.1.2 Patient Safety

Throughout the year, the Trust's aim has been to foster an environment where staff are confident to raise concerns about patient safety. Learning occurs with respect to errors, incidents, near misses and complaints across the organisation. Initiatives to achieve this have been implemented during 2015/16. The Trust has continued to engage with and contribute to cross organisational initiatives such as the patient safety collaborative.

The Trust has also signed up to the 'Sign up to Safety' pledges and through this has committed to put safety first, continually learn, be honest and transparent, collaborate in learning and support staff to help them understand and improve on when things go wrong.

In order to assure patient safety, the Trust has continued to monitor a range of quality indicators on a monthly basis alongside the daily staffing levels. Progress is reported on the following indicators:

1. Community wards
   - Developed Pressure sores
   - Falls where the patient is found on the floor
   - Medication related incidents (Detailed in part 3 of this report)
2. Mental health wards
   -AWOL (Absent without leave) and absconsion (Detailed in Part 3 of this report)
   -Patient on patient physical assaults (Detailed in Part 3 of this report)
   -Seclusion of patients
   -Use of prone restraint on patients

Further information on Trust patient safety thermometer metrics, including the number of patients surveyed and the incidence of various types of harm are included in Appendix D.

Pressure Ulcers

The Trust collects data on pressure ulcers to measure its incidence and to make improvements in this area. Figure 7 below gives an overview of the number of developed pressure ulcers on inpatient wards during the last twelve months.

Figure 7 shows that, in the twelve months to the end of March 2016, there have been 14 category 2 and 1 avoidable category 3&4 pressure ulcers on Trust inpatient wards. This compares with 39 category 2 and 5 avoidable category 3&4 pressure ulcers during the whole of the 2014/15 financial year.

Figure 8 shows the number of community pressure ulcers as reported through the Trust Safety Thermometer. It should be noted that this Safety Thermometer data does not show the total number of community pressure ulcers for the Trust, but those that are recorded at a specific point in time each month.

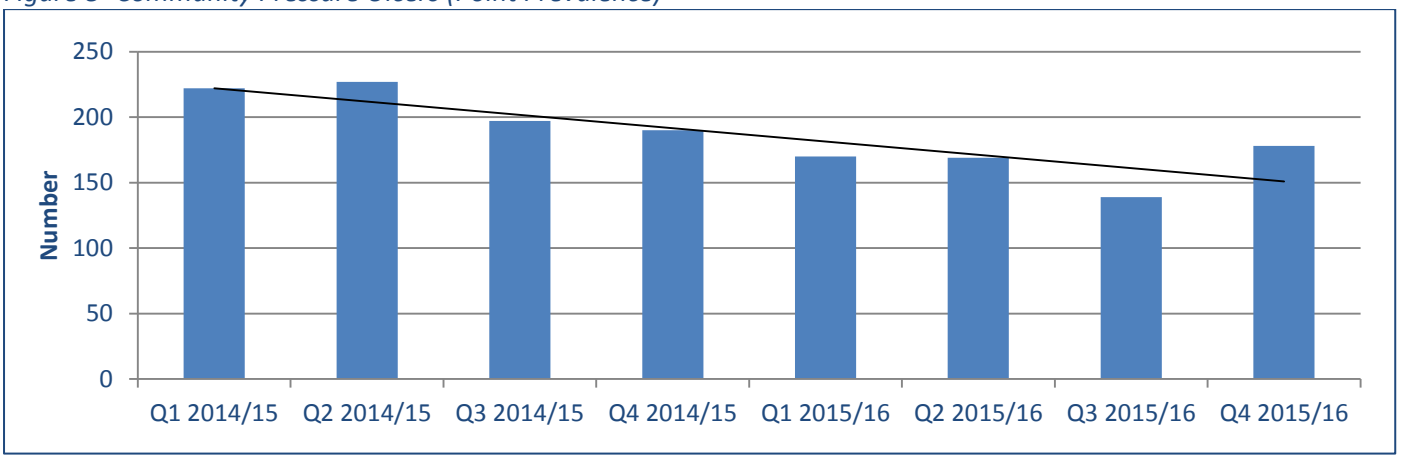
Figure 7- Overview of Developed Pressure Ulcers on inpatient wards during the last 12 months.

	Number of Developed Pressure Ulcers on Inpatient Wards													
	Q1			Q2			Q3			Q4			Year Total	
Type of Pressure Ulcer (PU)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	15/16	14/15
Category 2 PU	0	3	3	1	1	1	1	1	2	1	0	0	**14**	**39**
Cat 3 & 4 PU Avoidable	0	0	0	1	0	0	0	0	0	0	0	0	**1**	**5**
Cat 3 & 4 PU Unavoidable	0	0	1	1	1	1	1	0	0	1	1	0	**7**	**6**
Grand Total	**0**	**3**	**4**	**3**	**2**	**2**	**2**	**1**	**2**	**2**	**1**	**0**	**22**	**50**

**This is not all the PU events on the wards as we separate developed within our services and those inherited from other services. These are just the developed. We currently do not investigate developed category 2s so these cannot be identified as avoidable or unavoidable.*

Source: Trust Pressure Ulcer Reports.

Figure 8- Community Pressure Ulcers (Point Prevalence)



Source: Safety Thermometer

Falls

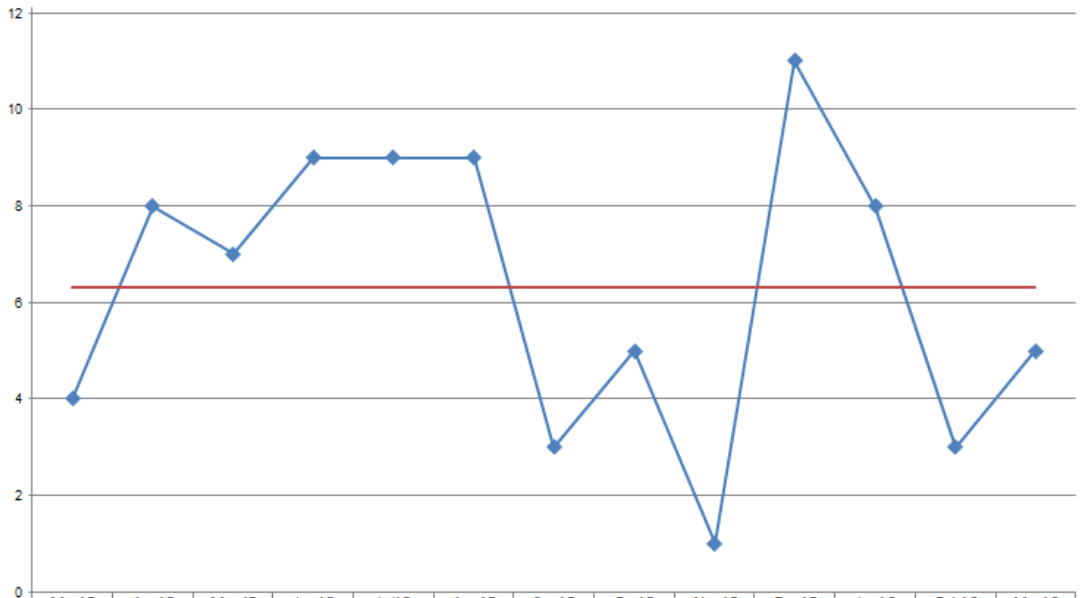
Figure 9 below details the number patients who have had a fall that has resulted in harm, taken from the Trust Safety Thermometer.

It should be noted that this Safety Thermometer data does not show the total number of falls resulting in harm for the trust, but those that have occurred in the last 72 hours of a specific point in time each month.

Also, the data is limited to those falls that have occurred on; Trust Community Health- inpatient wards and community; Older person's mental health- inpatients and community; Learning disability- inpatients and community.

The total number of falls calculated per 1000 bed days is contained within part 3 of this report.

Figure 9- Falls resulting in harm: All services, inpatients and community (point prevalence).



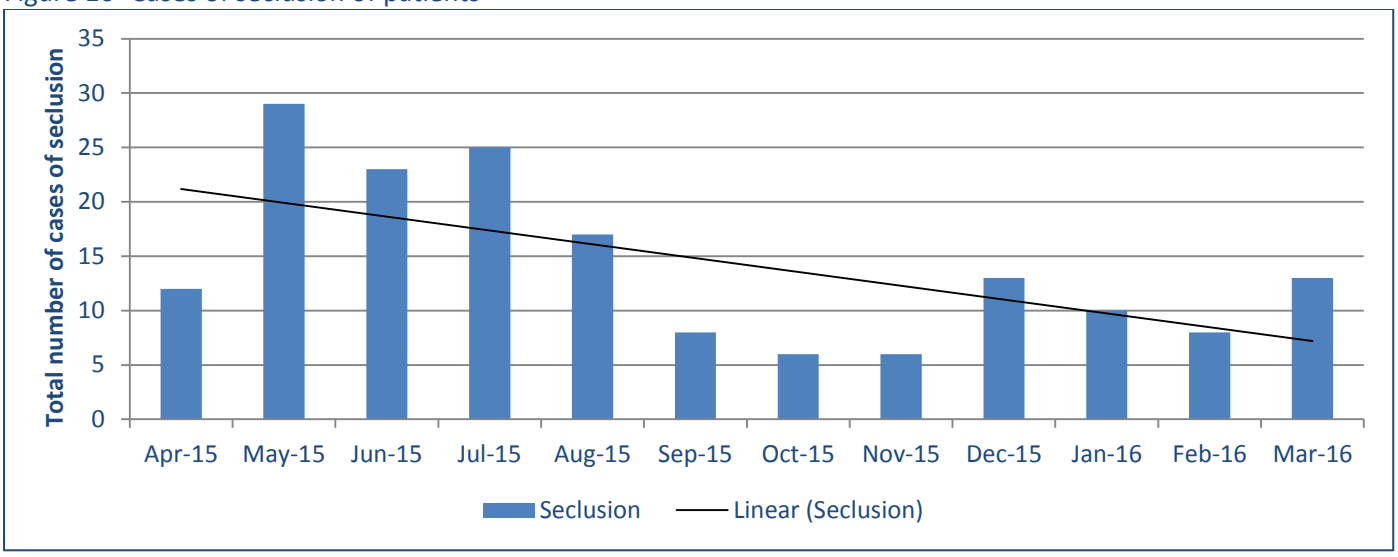
	Mar15	Apr15	May15	Jun15	Jul15	Aug15	Sep15	Oct15	Nov15	Dec15	Jan16	Feb16	Mar16
Falls with Harm	4	8	7	9	9	9	3	5	1	11	8	3	5
Mean	6.31	6.31	6.31	6.31	6.31	6.31	6.31	6.31	6.31	6.31	6.31	6.31	6.31
Patients	1327	1398	1363	1332	1346	1360	1254	1261	1296	1262	1396	1343	1325

Source: Safety Thermometer

Seclusion of patients

Figure 10 below shows the monthly number of cases of seclusion of patients during the year. As can be seen, there is a general downwards trend in the monthly number of secluded patients between April 2015 and March 2016. There were a total number of 170 cases of seclusion reported during the year.

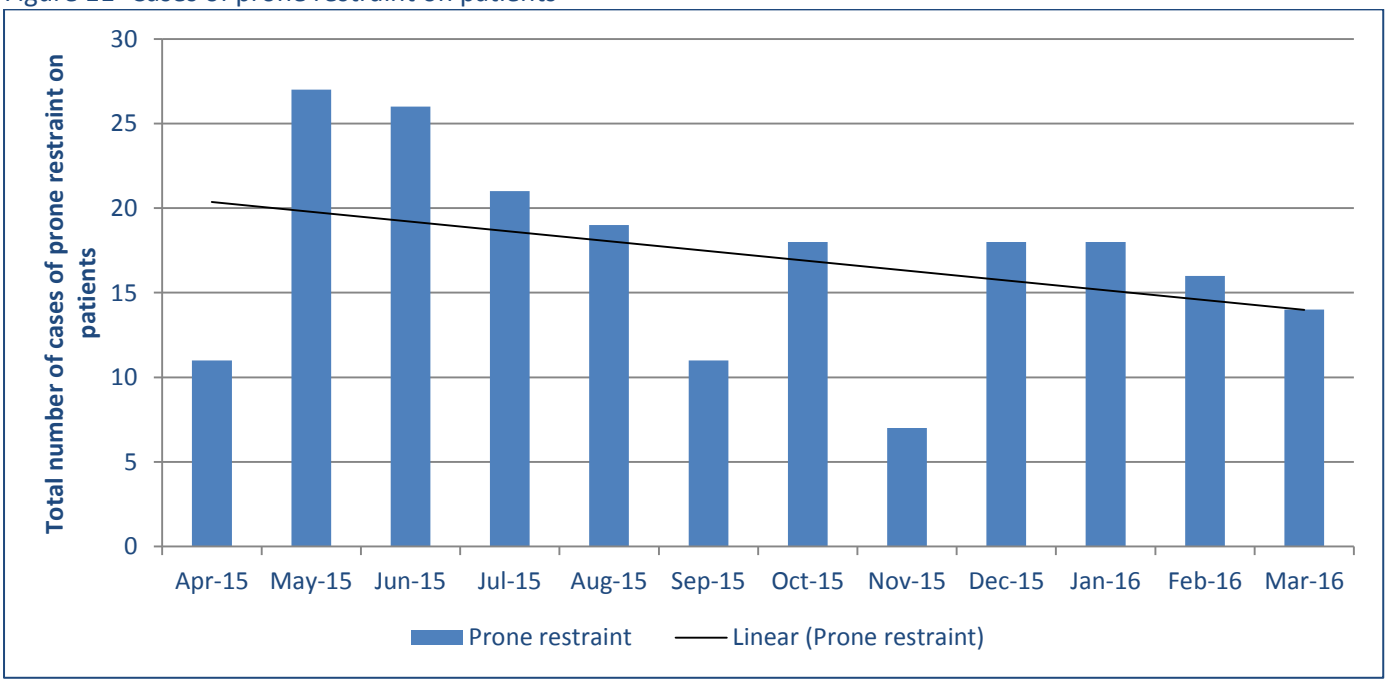
Figure 10- Cases of seclusion of patients



Use of prone restraint on patients

Figure 11 below shows the monthly number of cases of prone restraint on patients during the year. As can be seen, there is a general downwards trend in the monthly number of cases of prone restraint between April 2015 and March 2016. There were a total of 206 cases of prone restraint on patients reported during the year

Figure 11- Cases of prone restraint on patients



Quality Concerns

The Quality Committee of the Trust Board identify and review the top quality concerns of the organisation at each meeting to ensure that appropriate actions are in place to mitigate them. They are identified through some of the information sources provided within this account together with intelligence received from performance reports, our staff and stakeholders.

Our quality record is good and the trust has recently undergone a CQC comprehensive inspection and received a rating of 'good' overall.

Acute Adult Mental Health Inpatient Bed Occupancy

Bed occupancy has been consistently above 90% since August 2015. Patients have high acuity, there is disruption for patients who are on leave with concerns about where they will go on their return and patients are being placed out of area (this increases suicide risk on their discharge). There are clear weekly processes in place to mitigate risks.

Locked Wards

Our inpatient assessment and treatment unit for people with learning disabilities and psychiatric intensive care unit are both locked units managing very challenging and vulnerable patients, who frequently assault staff. Both of these units continue to experience high turnover of staff and agency use and therefore potentially provide a poor patient experience. Regular supervision is in place along with recruitment plans. Professional leads are working closely with staff to ensure standards of practice are maintained. Both wards are robustly monitored by Executive Directors.

Shortage of adult nursing and therapy staff

Mental and physical health inpatient and community services are now affected by shortages of nursing and therapy staff, which has resulted in increased agency staff use. This has a potential impact on the quality of patient care and experience, and increases our costs. A variety of mitigations are in place including 'over recruitment' and workforce redesign. Our plans to increase the use of framework agencies and develop an internal bank along with the embedding of e-rostering will also help us with effective distribution of resources.

Berkshire Adolescent Unit (BAU)

The BAU has provided tier 4 child and adolescent mental health services since July 2015. The unit has struggled to recruit permanent staff and has had a number of challenges implementing new ways of working and adapting the environment. A comprehensive action plan has been developed and implemented with the number of beds open reduced currently. New nursing and medical ward leadership has recently been appointed.

Interface between CRHTT, Common Point of Entry and Community Mental Health Teams.

Ensuring a smooth transition between components of our mental health services is a high priority, as we recognise the level of risk that this presents, particularly when services are busy. Short term initiatives to address this issue are being led by Executive Directors, alongside medium to longer term work to improve our understanding of and response to demand and capacity risks.

Mental Health Act (MHA) Code of Practice Compliance

The CQC comprehensive inspection and previous CQC MHA inspections has shown that our staff do not always adhere to the Code of Practice which may result in patients not knowing their rights and therefore potentially receive harm as a consequence. A training and audit programme is underway and plans for a MHA inspector role within the trust are in development.

CQC Regulatory Action

The CQC comprehensive inspection placed regulatory requirements on the following services:

- Berkshire Adolescent Unit
- Older People's Mental Health Inpatients
- Learning Disability Inpatient Units

Action plans are in place and in the process of implementation. These plans are being monitored by the Quality Executive Group.

Freedom to Speak Up

Whistleblowing cases are defined as cases where the member of staff has raised a concern under the Trust Whistleblowing policy or have referred to the complaint as 'blowing the whistle'.

In the period January 2015 to March 2016, the trust has received 12 whistleblowing concerns raised by staff of Berkshire Healthcare NHS Foundation Trust.

Since November 2015, the Trust has received one concern raised under the whistleblowing policy, and the investigation into this is nearing completion. This is the only live case currently; all other cases have been fully investigated and closed.

The Whistleblowing/Raising concerns policy has been updated in the light of a requirement to include regulatory information and the guidance also now includes a flowchart for easy reference and use.

The facility for staff to raise issues of concern via a third party and anonymously (CiC) remains available and which is used by some whistle-blowers.

2.1.3 Clinical Effectiveness

During 2015/16, the Trust prioritised the implementation of NICE Guidance to ensure that the services it provides were in line with best practice.

NICE Guidance

NICE guidelines, technology appraisals and quality standards provide valuable evidenced-based information on clinically effective and cost-effective services.

In order to ensure implementation of relevant guidance, the Trust has developed and implemented a policy and procedure for implementing NICE Guidance. In summary, the following steps are taken to fulfil the process of identification, implementation and monitoring of NICE Guidance across all Trust services.

1. Identification and Dissemination of Guidance.

All new pieces of NICE guidance are identified and assessed for their relevance to the Trust as soon as possible after their publication. Following this, the guidance is sent to the clinical/ service leads in each area for which the guidance is relevant. The relevance of the guidance, together with the nominated lead is also reviewed and confirmed at the next available meeting of the Trust Clinical Effectiveness Group. In addition, service Clinical Directors support the identification of services that guidelines would be relevant to.

2. Conducting an organisational gap analysis

Identified service leads undertake a gap analysis of their current compliance with all relevant recommendations in the guidance.

Based upon these analyses, the guideline is then given either an 'adequate' or 'inadequate' rating based upon whether the recommendations are deemed to be met. This rating is updated as and when new information emerges relating to the state of compliance with the guideline.

3. Implementing recommendations that are outstanding from the initial gap analysis

Following the initial gap analysis, the service lead, produces an action plan for implementing the recommendations that are not currently met. Where decisions are taken not to implement recommendations, these are referred to the Clinical Effectiveness Group for consideration.

4. Monitoring implementation of NICE Guidance

The Trust has set performance targets in relation to the implementation of NICE guidance. These are:

1. Compliance with NICE Technology Appraisals- 100%
2. Compliance with all NICE Guidance- 80%

These targets are monitored by the Trust Clinical Effectiveness Group, chaired by the Trust Medical Director. In addition, NICE Quality Standards are considered as part of the clinical audit core programme and services undertake a variety of audit activity relating to NICE guidance. At the end of 2015/16, progress against the Trust NICE performance targets was as follows:

Figure 12- NICE compliance March 2016

Trust Performance Target	Target (%)	Score (%)
1. Compliance with NICE Technology Appraisals	100	**100**
2. Compliance with all NICE Guidance	80	**84**

Source: Trust NICE Compliance Update Reports

Other clinical effectiveness activity, including that relating to service improvements, clinical audit and research, is reported later in this report

Feedback from Service User:

"Excellent team player, she is always willing to help and very passionate about her job. Grateful about her welcome and support. She is always smiling and goes out of her way to support others. Thank you"

2.1.4 Health Promotion

The Trust has committed to deliver on its priorities to become smoke free, to increase awareness of diabetes amongst patients and staff and to improve monitoring of physical health risk factors amongst patients with mental health problems. An update on each of these priority areas is detailed below.

Smoke Free

On 1st March 2015 our first major milestone was achieved and the staff smoke free policy came into effect. Many staff have used this as an opportunity to reduce their tobacco intake or quit smoking and we are hoping to publish some of their positive stories onto the smoke free teamnet intranet pages.

To support the staff smoke free policy we have updated the job description template, there is now reference to this in all adverts and the interview checklist now includes a reminder to advise applicants of the smoke free policy. A new paragraph will be included in terms and conditions.

Any staff with queries about going smoke free can contact a dedicated Trust e-mail address for advice. Business cards have been printed for staff and managers to give to colleagues as a reminder of the key elements of the policy and where to get support if required.

On 1st July 2015 we achieved our second milestone and all staff should now be asking our community patients to abstain from smoking whilst we provide their treatment/ care and will also be ensuring that our grounds are smoke free. To achieve smoke free in our grounds we are asking staff to advise their patients, and anyone that they see smoking that we do not allow this on our sites. We have leaflets / business cards to support any conversations that staff will have with patients, carers and visitors. To support the campaign new signage has been put up on the main Trust sites and posters designed. The policy is available on the intranet.

Smoke Free Life Berkshire have been working very hard to support our campaign and have ever increasing visibility with new clinics for staff, patients and the public being held at various Trust locations.

On 1st October 2015 we reached our final milestone and became smoke free on our mental health wards at Prospect Park Hospital.
All patients are being asked if they smoke on admission and where they are smokers are being offered nicotine replacement therapy. We are currently undertaking some further training with staff to help embed being smoke free particularly at Prospect Park Hospital and are also working proactively with smoke free life Berkshire to maximise the input and support that they can provide to our inpatients.

Diabetes Awareness

Several initiatives have been undertaken during the year to raise awareness of diabetes amongst patients and staff.

For patients, awareness Initiatives in East Berkshire includes:

- Diabetes Education & Awareness for Life (DEAL) structured group education for people newly diagnosed with Diabetes. These run regularly across East Berkshire and are facilitated by Diabetes Specialist Nurses and Dietitians.
- DEAL PLUS. These group sessions run once/twice a month and are for people who have had diabetes for greater than 1 year
- CHOICE. Group diabetes education for people with type 1 diabetes (run quarterly)
- Weekly Gestational Diabetes Education Group sessions

In West Berkshire Xpert Diabetes Group Education Sessions are run for type 2 diabetes.

The Diabetes Project Group has also been running initiatives for Trust staff during the year, including:

- Production of awareness posters
- Information on the Trust intranet and payslip leaflets helping staff to 'know your risk' of diabetes and signposting them to other resources.
- Diabetes education sessions for healthcare and social care professionals to help raise their awareness of diabetes.

Monitoring of physical Health Risk Factors amongst patients with mental health problems

There has been an increased focus on ensuring that patients with mental health problems also have their physical health risk factors monitored. This focus has been enhanced through delivery of a related CQUIN.

In Trust mental health inpatient settings, training has been disseminated on the importance of monitoring physical health symptoms. The CQUIN slide show has been circulated, with training also being delivered by request. This has been sent out for teams to utilise in their staff meetings.

Training focuses on where assessment and interventions should be recorded and for each of the following:

- Smoking status;
- Lifestyle (including exercise, diet alcohol and drugs);
- Body Mass Index;
- Blood pressure;
- Glucose regulation (HbA1c or fasting glucose or random glucose as appropriate);
- Blood lipids.

Importance has also been placed on recording where the assessment has been refused and that it is important to continue attempting to collect the information.

It is expected that this CQUIN was met in 2015/16

Service Improvements

In addition to improvements resulting from the priorities detailed above, services have undertaken additional initiatives to improve the quality, safety and experience of care provided to patients. Details of some of these improvements are detailed below.

1. Community Health Services for Adults

The End of Life Care Team have undertaken a full service review against the new recommendations relating to caring for dying adults detailed within 'One Chance to Get it Right'. As a result, the trust Individualised End of Life Care Plan was launched across community services, with monthly audit in place to review its usage and implementation. Policies related to this area have also been revised, and End of Life Awareness Training has been delivered.

The Diabetes Centre/ Teams have been involved in several initiatives to improve the quality of the service provided. Some of these are included within the Health Promotion section of this report above, with additional initiatives undertaken as follows:

- The West Berkshire Diabetes Team implemented the 'Optimisation of Insulin' programme. This is a bespoke package of education and one-to-one advice for patients with high HbA1c results putting them at further risk of complications
- Trust Inpatient Diabetes Specialist Nurses in East Berkshire have:
  - Introduced Hypoglycaemia boxes for use in the acute trust (Frimley Healthcare NHS Foundation Trust)
  - Supported the preceptorship programme for newly qualified staff nurses at Frimley Healthcare NHS Foundation Trust.
- The time and location of the Gestational Diabetes Mellitus (GDM) education sessions have been changed in line with patient and staff feedback.
- The development of the hypo-ambulance project will mean that patients will automatically be referred to Diabetes Specialist Nurses following paramedic callout/ A&E admission for hypoglycaemia.
- The Update on Glucometer Project has informed staff and patients of what glucometers to use based on patient and staff feedback, the clinical evidence base and cost.
- In addition, services continue to be updated in line with the latest NICE Guidance in this area.

The Podiatry Service has introduced wound care sandals to the community teams so that patients have quick access to them. These sandals aim to improve off-loading of forefoot wounds and reduce wound healing times. The team have also fully implemented a wound care template across the service to support clinicians with monitoring wounds, thus leading to better wound outcomes for patients. In addition, new guidance has been devised for clinicians regarding the admission process/ home visits for patients with acute foot conditions. This will support emergency admission and access to appropriate care for the condition.

The Berkshire Community Dental Service has held regular locality meetings throughout the year which include service improvement. One resulting improvement has been the introduction of designated members of staff with responsibility for specific areas such as cross-infection control, radiology, referral waiting lists and audits. The Service have also been able to reduce the costs of using agency dental staff at weekends by implementing a rota for permanent staff to work at Dental Access Centres on Sundays and bank holidays. Finally two articles have been published which have raised the profile of the team in a positive way.

The East Berkshire Mobility Service has been working hard throughout the year to maintain a successful service and have held group meetings addressing service improvements. The team also monitor the delivery of the wheelchair service by a provider organisation. This is achieved by receiving regular updates, monitoring delivery times and submitting incident reports if patients' appointments have to be cancelled due to non-delivery of wheelchairs.

The East Berkshire Musculoskeletal (MSK) Physio Service have launched an additional service offering appointment times on Saturday mornings and also extending clinic hours to 7pm at some sites. Patients are also now able to book their appointment online and chose the time and site of their appointment. Rehabilitation classes are now more varied and allow for better access to and types of rehabilitation. An antenatal class is also being planned to allow the service to respond more quickly to that patient group.

The West Berkshire Integrated Pain and Spinal Service was launched in September 2015 and consists of specialist physiotherapists and physiotherapists in the community receiving regular support from the Royal Berkshire Hospital pain and spinal consultants. Patients with acute spinal pain or long standing pain which has been fully investigated can be referred by their GP to the service. Following assessment, there are a range of options available for the patient including; MRI and direct listing for injections, psychology treatment, physiotherapy treatment, pain management classes and education sessions. Initial feedback from patients has been very positive with patients attending the pain programme showing an improvement in their outcome scores, and feeling more confident in dealing with their pain.
In addition, the service has recently been shortlisted by the British Society for Rheumatology for their Best Practice Awards.

The Bracknell Leg Ulcer Service was commissioned as a pilot in September 2014 as it was identified that there was a lack of equity in service provision across the CCG. The aim was that the district nursing service and primary care would work together to improve quality of life for people with or at risk of recurrence of venous leg ulcers through the delivery of clinically effective care and advice. The service worked with practices that chose to provide their own leg ulcer management within the service specification in order to secure the best possible outcomes for patients and their carers.
After a challenging start during which time many lessons were learned, the pilot became a commissioned service in April 2015. Four GP surgeries have opted to manage their own leg ulcer services and these are supported by the clinical lead who offers advice regarding assessments and treatment plans as well as ensuring that required competencies are assessed and met.
The remaining surgeries refer their patients with straightforward non-healing leg wounds to the tier 2 leg ulcer service.
The Trust runs five leg clinics per week in the CCG area across 2 sites (Great Hollands Health Centre and Skimped Hill Health Centre). A timely and individualised wound management and healing service is delivered with a maximum wait of 10 working days for initial assessment and commencement of treatment. The target of 50% of patients being seen within 5 working days is currently being met. All patients are contacted within 3 working days of receipt of referral; GPs are also sent acknowledgement of referrals within that time framework. Onward referrals are made if required to the specialist leg ulcer clinic or to secondary care. Since the start of the pilot only one patient has been admitted to hospital as a direct result of his leg ulcer.

Patients undergoing treatment for their leg ulcers report the improvement of symptoms such as pain, exudate and odour. This is achieved through the provision of best practice treatment in accordance with clinical evidence and guidance which is delivered by appropriately trained and experienced clinicians who are able to demonstrate high rates of wound healing through skilled care and advice. Care is always patient-centred from initial assessment through to discharge to promote long term care and reduce the risk of recurrence.
The service aim is that a minimum 70% of venous ulcers should be healed within a 12 week period across the service. In November 2015 the average healing time was 9 weeks across both local Trust and practice nurse led clinics.
To ensure requirements are met monthly reports also monitor the total number of referrals, patient satisfaction on discharge, the rates of recurrence, infection rates and PROMs (Quality of life).

Reading Community Health Services. A key feature of work for these services has been the development of integrated working across a range of services and organisations to improve the patient experience:

- Care Coordinators amalgamated with the Community Matron Service in June 2015 with the aim of combining their respective resources and experience to develop and deliver an improved MDT format to South Reading CCG surgeries. MDT meetings are held weekly, new assessments are presented and current patients reviewed. Core members of the group are Community Matrons, Case Co-ordinators, Social Workers and Age Concern (Wellbeing Project), representing the voluntary sector. The data produced from the first three months of MDT activity demonstrates the significant positive impact this type of intervention has generated. Next steps will be to develop the MDT group to include the patient, family, significant other and carers in the process and expand partnership working with a wider range of voluntary groups.
- The Care Homes Support Team has delivered a number of training sessions to care homes across

the West of Berkshire to improve the quality of life for people. The team was expanded to respond to needs identified with the care homes resulting in an Occupational Therapist, Physiotherapist and Speech and Language Therapist being recruited to the team in June 2015. The therapists have been addressing ways to enhance the current support provided by focussing on key areas to improve patient experience. These include; falls audit to reduce falls within care homes, seating and positioning for comfort, contracture prevention and promoting appropriate posture for eating drinking and swallowing and advising staff on correct diet and fluids to reduce the risk of aspiration.

The West Berkshire Locality Intermediate Care Team, together with the West Berkshire Local Authority Maximising Independence Team have embarked on a journey to help facilitate a simpler, more efficient and safer discharge process for patients requiring any type of personal care at home. The guiding principles of this pathway were that; there should be only one referral to a joint pathway with no need to decide between health and social care, the pathway should allow the team to work with patients at home to achieve their full potential, the team can accept care plans from the assessor in hospital, joint commissioning of care is in place and social workers in hospital can be used for fine-tuning if needed.
The team have now started using this new process and have a joint health and social care administration team to process all referrals from any hospital. The team continue to work in joining up other areas of staffing to enable joint working across organisations.

Highclere and Donnington Inpatient Units at West Berkshire Community Hospital have been working towards the development of a single inpatient unit. Historically, Donnington Ward provided care for patients requiring rehabilitation with Highclere ward providing sub-acute medical care and end of life care. This resulted in the skill sets of both sets of nursing teams being very different. Each ward housed a vast amount of experience and knowledge but this was not disseminated throughout the unit which in turn was not conducive to effective bed management when placing patients. In January 2015 all staff commenced a rotation programme giving them experience of working in areas of nursing that were new to them. This has resulted in a workforce with extended skills and has provided a more flexible option for patients being admitted to the unit. Feedback from staff has also been positive. In addition, following patient feedback indicating that patients did not always understand what different medications were specifically for, the wards have implemented the MAPPS system allowing them to share medication-related information with the patient. This has resulted in very positive feedback from patients.

2. Primary Care, Minor Injuries Unit and Walk-in Centre

The Slough Walk In Health Centre has consistently achieved over 85% in the Quality and Outcomes Framework (QOF). Action plans are also in place with Trust community services to support patients with mental health problems, those that misuse alcohol and drugs, those with long term conditions and also children.

Priory Avenue GP Surgery. The Trust entered into a contract with NHS England to manage this primary care service out of Special Measures. With the right leadership and support to showcase the skills within the practice, the journey has taken Priory Avenue out of Special Measures and from 'Requires Improvement' to a 'Good' CQC rating within 9 months of the Trust being awarded the interim contract. The improvements to patient care and the processes adapted to enhance the delivery of primary care have been noticeable and highly commended by the Patient Participation Group.

The Minor Injuries Unit (MIU) based at the West Berkshire Community Hospital has worked with the Royal Berkshire Hospital (RBH) to establish a Virtual Fracture Clinic to offer patients a safe and effective process in the assessment of fractures. Using secure technology, patient notes can be sent securely to the RBH trauma team. Every week day morning a consultant orthopaedic surgeon and two specialist orthopaedic nurses at the RBH review all the notes and X-rays received since the previous clinic and telephone the patient to give them advice on their injury, arrange follow-up with the most appropriate clinic or arrange admission for surgery. This stops the need for patients to travel to a clinic only to find they need to return to see a particular specialist or have surgery. It also reduces the number of missed appointments and provides a safety net for any patients who may, under the old system, have waited

several days to see a specialist only to find they needed urgent intervention or a change in treatment.
The MIU has also introduced a Telemedicine Referral Image Portal System (TRIPS), allowing for a secure way to make referrals with photographic evidence to the Burns Unit at Stoke Mandeville Hospital. Once the referrals and photographs are received and reviewed, the team at Stoke Mandeville will phone back the MIU practitioner with advice on whether the patient needs to be seen by them at once at Stoke Mandeville, in clinic, or to suggest a dressing that the patient can have that would prevent them needing to travel to Stoke Mandeville.

Feedback from a service user:

"We had cause to use WestCall over the Christmas weekend and we were dealt with quickly. The initial person triaging our call was thorough and helpful. We were called back by a doctor within 15 minutes and an appointment arranged at Royal Berkshire Hospital. The Doctor took a lot of care and there was no sense of being rushed, though I'm sure he was under pressure to see others. He treated us with respect and discussed treatment options with us as well as more generalised care for the problem. After we left he phoned through to the pharmacy and added two more items to the prescription he had given us.

He was excellent and we'd like to thank everyone involved for a professional and reassuring experience"

3. Community Health Services for Children, Young People and Families

The Children and Young People's Integrated Therapy Service (CYPIT) have continued to design, implement and evaluate the Speech and Language Therapy model of service throughout Berkshire.
Pre-school children and their families are now able to access drop in clinic sessions locally if they have concerns or queries regarding their child's speech and language development, without the need for a referral or pre-arranged appointment. These children and families no longer have to wait to access this service as they had to in the past.
The service also provide a school offer across mainstream schools in Berkshire, where the needs of the children in each school are jointly discussed with education staff and the therapist and a joint action plan is created to meet the ongoing needs of the school population as a whole.
In line with the success of these service developments, CYPIT are now focusing on aligning occupational therapy and physiotherapy services across Berkshire. The service has also created and implemented an integrated report and therapy plan template on RIO and is developing a clinical outcome measure to enable them to demonstrate the impact of CYPIT intervention moving forward.

The School Immunisation Team was established following the changes to and separation of commissioning of immunisations and school nursing. In addition, the Trust won the tender to deliver the seasonal childhood flu programme to children in years 1 and 2 in all primary schools across Berkshire. As a result, teams were established in East and West Berkshire, with both reporting into an Immunisation Service Lead
The team have recruited a number of new staff, and have given them the supervision and the mandated NHS England approved training to deliver immunisations. Alongside the pre-existing immunisation schedule, the team have delivered flu vaccinations across almost 300 schools in Berkshire over a period of 40 school days. This was a mammoth task undertaken by committed staff, resulting in the team surpassing the uptake target they were set.

Health Visiting and School Nursing Teams have continued to implement service improvements throughout the year.
In Slough, improved health assessments have been introduced for both Health Visiting and School Nursing

teams. Improvements have been made to include the voice of the child as well as strengthening the family and environmental factors, helping the practitioner work with the family. Preceptorship has also been implemented for newly qualified Health Visitors and School Nurses to help develop the knowledge and skills acquired during the formal training process.

Health visiting teams in Slough have also been trained to use the Solihull Approach in their work with children and families. This approach supports parents in understanding their child and promotes emotional health and wellbeing in children and families. In addition a new health visitor bloodspot screening service has been embedded for babies under the age of 1 year who have moved into the area and have no written record of screening for the nine conditions.

Reading Health Visiting service have developed an intranet message book that enables administrative staff to add messages which other staff can then access remotely. The method offers a clear audit trail and means that if staff are absent from work their messages can still be actioned by other members of the team. This has reduced the need for staff to return to base and has quickened the process for responding to messages. The message book has been adopted and rolled out across Berkshire in all children's services. In addition, the Reading Admin Support Team (RAST) has been developed. As a result, the clinic clerks working across Reading have been bought together on the Whitley site to enhance the reception and improve the basic admin support to the Health Visiting teams. This team required up- skilling to be able to offer the Health Visiting teams consistent practical support to ensure that the service was able to meet their needs. A training package consisting of basic IT and customer care skills was also developed, has been further enhanced in Wokingham and is now a Learning and Development package for admin staff. This service is fundamental to the smooth running of the Health Visiting service in Reading and gives the Health Visitors more clinical time.

Health Visiting teams in West Berkshire have changed the way that parents can book their infant/child into developmental clinics. This change was introduced due to the wide geographical area covered by West Berkshire and lower than expected uptake on developmental checks. The system for parents has now been centralised with one number to call. Depending on personal circumstances, parents and children now have a greater choice of when and where to attend appointments.

The Berkshire School Nursing Service have launched a Facebook page providing current health and wellbeing information for young people and sharing information on local services and public health events.

School nursing teams in Slough have implemented a School Nursing Service Manual that covers the Healthy Child Programme 5-19 years and locally commissioned services. It also includes up-to-date information on the management of medical conditions in schools

4. Services for People with Learning Disabilities

Services for people with learning disabilities continue to be focused on ensuring the best care is provided in the right place.
As a result, during this year we have been rolling out our easy read care plan and outcome measure to help ensure that we are focussing on the right things for people and that our service is making a difference. This has been particularly challenging in our inpatient services as we need to be able to support people with a wide range of needs and circumstances, but the team have been developing their skills and confidence in using the new documentation and this is helping us to improve how we involve people using our services and their families more in their care.
Meanwhile, our staff working in the community have broadened their opportunities to connect with people by working together with existing community groups and activities and providing specific training sessions and clinics to promote healthy choices. An example of this is the "Fit for Life" event in Wokingham where 61 people with learning disabilities attended a joint event hosted by Wokingham Partnership Board and supported by our Learning Disability Dieticians to learn about how small changes can make a positive difference.

Feedback from Service User:

'We appreciate magic wands don't exist! Appreciate the time and effort spent helping us all. Staff always very friendly, thank you.'

5. Mental Health Services for Adults

Slough Community Mental Health Team (CMHT) and Slough Borough Council have worked together to provide a new service called Hope College.

Hope College is a new way of delivering educational courses and activities to people with mental health difficulties, using the Recovery College model approach. The model is primarily a group of values which aims to move away from medicalising mental illness into symptoms and problems and helps the client focus on their strengths and goals. It is very much led by the client rather than traditionally a clinical team leading the care.

Hope is a very important element to embed within the recovery model which emphasises the importance of motivation and managing expectations of the client and their families. Self-management and personal discovery is encouraged and techniques to empower the client to learn how to manage their own wellbeing are very important (Shepherd et al, 2008). Students' friends and family are also welcome to participate in the courses and activities available through the college.

The purpose of the college is to provide hope, opportunity and control for every student as they embark on their recovery journey. We are now in the second term of the college and we ensured that we thoroughly evaluated the first term to continue to improve.

"I much prefer the College and the courses which are on offer. Before I would go to the drop in (day centre) once a week but wasn't really going anywhere. Now I feel that I am achieving and learning something which is great". (Service user feedback)

A volunteer peer support programme is also in place. This programme offers a unique service for past service users to use their own experiences of mental health problems to support others. If clients feel able to manage their mental health and feel ready for the challenge, they can apply to attend a ten-week volunteer induction course. Each week covers a topic to prepare for the role as a peer mentor. Topics include communication skills, boundaries and safeguarding. Once they have completed the course, they are invited to become a peer mentor. This role includes:

- Providing support and encouragement to others attending Hope College
- Helping to develop ideas for new services – co development
- Facilitating or co-facilitating groups and courses.

As a one-to-one volunteer peer mentor, clients will feel ready to use their experiences to support other service users, attend meetings once a week to offer emotional and practical support, share experiences, and support the clients to meet their objectives and personal goals.

A monthly 'open space' mental health forum is also offered. This forum is co-facilitated by peer mentors and the ethos of the forum is that everyone is equal and everyone is heard and listened to. The forum uses different ways to engage the client group which often includes breaking off into smaller groups to answer questions and generate ideas.

Hope College is being thoroughly evaluated and each and every course or workshop run is evaluated using several different methods including; Warwick Edinburgh Mental Wellbeing Scale (WEMWS), anonymous questionnaire style feedback forms and verbal feedback as a group using flipcharts. We feel that by having various mediums of feedback this caters to all the needs and level of functioning within the client group.

Reading Community Mental Health Team (CMHT) have reviewed their model of care during the past year to ensure timely allocation with a focus on early intervention and treatment for people newly referred into the service. A multidisciplinary focus on new referrals has enabled quicker access to the right type of treatment using most relevant interventions by the best placed practitioner to provide this treatment. The team have integrated their resettlement and reablement team with the main CMHT to support enhancing recovery focused work for people with longer term mental health problems and are working with the local authority and health colleagues across the whole of West Berkshire to develop a Recovery College. This exciting development is being led by IMROC (Implementing Recovery through Organisational Change), a nationally recognised group who have supported a number of organisations in the UK to co-produce more recovery focused services

with people who have experienced mental health difficulties. We are looking forward to developing this further in the coming year.

The team have been particularly successful in delivering a co-produced carer support programme. This has been designed and delivered by staff and carers who have experience of supporting people with mental health problems and has been of real benefit to the loved ones of people receiving mental health services within the CMHT. We intend to continue this programme in the coming year.

Another success has been the introduction of the Individual Employment and Support Employment Service (IPS). This national model aims to support people with a mental health diagnosis into paid work and already this dedicated service is proving to be successful in the Reading locality with 60 people being referred into the service in the first six months of it starting, way above target figures set at the start of the project.

Black African/ Caribbean Mental Health. On 16th March 2016 the Trust hosted a conference: "Black African / Caribbean Mental Health" at the Coppid Beach Hotel in Bracknell. This conference was opened by Julian Emms, CEO with David Townsend, COO, in attendance. Frank Bruno, Boxing Legend, was interviewed by Rajay Herkanaidu. The Conference was organised by the Head of Crisis Resolution & Home Treatment.

A presentation was made by Professor Sashidharan about ethnic disparities in mental health, focussing on the needs of Black African and Caribbean people. Other guest speakers included Dr Olajide and Dr Ayonrinde, Associate Medical Director and Consultant Psychiatrist respectively for South London and Maudsley Mental Health Trust. Service user and carer representatives as well as local African & Caribbean speakers spoke on the day. At lunch time guests were treated with African / Caribbean lunch as well as African live music.
Feedback from those who attended the conference has been excellent, with high demands for such events with a greater number of seats than the allocated 82. One participant said, 'this event has highly emphasised how we need to improve our practice to provide culturally sensitive care'.

This conference has been a great success. Last year the Trust organised a similar event about "South Asian Mental Health" which was a great success too. BHFT is committed to organising similar events to raise awareness and improve staff confidence.

Trust Older Peoples Mental Health Services.
The Trust was awarded a grant by Health Education Thames Valley and Health Education England to develop and deliver Tier 1 Dementia Awareness Training for all staff. From a starting point of 5%, greater than 50% of all staff have now completed one of the Tier 1 training options.
Health Education Thames Valley and Reading University are also developing an App of an abridged version of the Trust's Dementia Handbook for Carers suitable for use on mobile phones and tablets. The handbook is also available freely on the Trust website.
In addition, Dr Jacqui Hussey, Consultant- Old Age Psychiatry, has won the TVWLA Inspirational Leader of the Year award.

Memory Clinics in the trust have been working towards accreditation/ reaccreditation with the Memory Services National Accreditation Programme (MSNAP).

- Reading Memory Clinic was awarded an 'Excellent' accreditation rating by MSNAP this year and has also received an Outstanding Achievement Award.
- Wokingham Memory Clinic was accredited two years ago and retained its excellent rating for assessment and diagnosis and psychosocial interventions. They are preparing for their next peer review.
- Bracknell Memory Clinic was also accredited two years ago and retained its excellent rating for diagnosis and assessment. They are also preparing for their next peer review.
- Windsor and Maidenhead Memory Clinic and Newbury Memory Clinic are both due an accreditation visit in the next financial year, and preparations are well underway for this.
- Slough Memory Clinic will have their accreditation visit on 7th April 2016. In addition, following service user requests, a culturally adapted version of Cognitive Stimulation Therapy (CST) was delivered in Punjabi at Slough Memory Clinic between May and August 2014. To our knowledge, this was the first time CST had been delivered in a non-English language within a UK memory clinic. In a live, symbiotic manner, Punjabi group members led the adaptation process of the CST programme to suit

their cultural requirements. Following on from Punjabi CST, we have run a set of Dementia Information Groups, culturally and linguistically tailored to our Punjabi community, in order to raise awareness about the illness.

Windsor Ascot and Maidenhead Older Peoples Mental Health Team and Windsor and Maidenhead CCG (WAM CCG) have undertaken a highly successful improvement project with the aim of improving care for people living with dementia and their carers. The aim of this project was to:

- Re-design services for patients with dementia and their carers in line with NICE guidance and other best practice
- Develop a dementia strategy for agreement between the Trust, WAM CCG, The Royal Borough of Windsor and Maidenhead and all other stakeholders including patient consultation
- Improve recognition of dementia in all settings, and ensure appropriate services and support once dementia is recognised
- Improve dementia care in care homes, increasing knowledge by staff of psychological based approaches, reducing use of antipsychotics, decreasing hospital admissions and using NICE Quality Standards to guide the aims of care.

Windsor Ascot and Maidenhead did have traditional services of three day hospitals and little community development which resulted in little access to services for people with dementia and a disincentive for primary care services to identify dementia.

As a result of the project the following improvements have been achieved:

1. The new services have identified more people with dementia earlier. This has resulted in improved rates of diagnosis of dementia, going from third worst national rates to better than average rates in two years. The work led to the service becoming a finalist for a Health Service Journal award in 2014.
2. Services for people with dementia across all care sectors have been re-designed with the emphasis of care shifted to community settings.
3. More support has been offered to patients with dementia and their carers. An innovation grant was awarded by Windsor and Maidenhead CCG for the establishment of Cognitive Behavioural Therapy for carers groups. A further grant has been awarded to continue this work.
4. A fund was awarded to improve dementia services in 17 care homes. This has resulted in new state of art facilities and many homes have seen such positive results for residents, families and staff, that additional investments are now being made
5. A separate programme was initiated with the aim of reducing the use of anti-psychotics in care homes by reviewing all individuals on such medication. This was linked to a pilot in three care homes of staff training in the use of psychological based approaches. The pilot led to reductions in the use of anti-psychotics, increase in staff knowledge and reduced admissions to hospital. This was presented at the National Faculty for the Psychology of Older People and Royal College of General Practitioners conferences in 2014, and is being rolled out to all 48 care homes in the area this year as part of a “Harm Free” programme.

The success of the project has resulted in it being listed on the National Institute of Health and Care Excellence (NICE) website as an example of shared learning.
http://www.nice.org.uk/sharedlearning/living-with-dementia-%E2%80%93-improving-care-home-care
As a result, Dr Chris Allen, Joint WAM CCG Lead Dementia/Consultant Clinical Psychologist BHFT was asked to present the project to the NICE Conference and Patient Safety Conference in 2015. The work has also been shortlisted for a National Patient Safety Award in 2015.

The team is also implementing a project to help community nursing staff in Windsor and Maidenhead manage patients with physical and psychological problems. This will involve three elements:

- An Increasing Access to Psychological Therapies (IAPT) Older People Specialist and Assistant Psychologists working one day a week for three months with more complex clients, using a Cognitive Behavioural Therapy transdiagnostic manual developed by Professor Jan Mohlmann specifically for older people.
- A training workshop with community nurses about identifying psychological problems, assessment and approaches that can be used.
- A referral pathway to IAPT and Trust Psychology services for patients for whom our community nurses require input.

Bracknell Community Mental Health Team for Older Adults (CMHTOA) have reconfigured and integrated the CMHTOA and the Home Treatment Teams (HTT) following a formal consultation process. This integration has enabled the delivery of a model by

one team resulting in significant benefits in the patient experience and continuity of care, as their care and treatment is delivered by one team over a seven day period.
Following implementation in March 2015, monthly meetings were arranged to discuss any issues arising with most of the feedback being positive. This has included; more staff to share the weekends, dedicated Community Psychiatric Nurse (CPN)/ Duty/ HTT, increased use of diary, morning handover meetings, easier allocation to CPN from HTT caseload, team working/support, continuity of care and positive patient feedback. Overall, the team has done very well with adopting the new way of working and have been very supportive of each other.

West Berkshire Older Peoples Mental Health Team, based at Beechcroft have embedded pilot projects from 2014 into their best practice service model. These include the addition of a sixth session to their Understanding Dementia Course for Carers that concentrates on the wellbeing of the carer themselves, and four dates per year when carers can attend a discussion session on end of life care planning. In addition, the team's weekly memory clinic accreditation meetings throughout the year have generated multiple service improvements including aligning clinic schedules and admin team roles, sound proofing of consulting rooms and stream-lining the role of the memory clinic nurse to support timely reviews and more efficient recording of information. Current pilot programmes include offering the carer an opportunity to be heard prior to the client appointment and initiating a two-week post-diagnostic follow-up carer support phone call when required. Ideas from 2015 will be further developed in 2016.

Younger People with Dementia. In the west of the county, commissioners have approved a joint business case presented by the Trust and Younger People with Dementia Charity (YPWD) to fund a model of care for these patients and their carers. The funding has allowed for the Trust to recruit an Admiral Nurse for this group of patients. Admiral nurses are specialist dementia nurses who give expert practical, clinical and emotional support to families living with dementia to help them cope. Funding was also made available through this business case for the YPWD charity to deliver age-appropriate workshops for younger people with dementia and their carers in the west of the county.

A pilot rollout for this project in East Berkshire is also underway with the aim of demonstrating the need for such a service in this area of the county and funding has been approved by the East Berkshire CCGs to continue this beyond the pilot stage.
The project has achieved national recognition as a model of best practice and the Royal College of Psychiatrists have recently awarded the service the award for 'Team of the Year: Older Age adults'.

Older Adult Mental Health wards, following successful and internationally recognised implementation of the Safe wards programme, have commenced data collection in pursuance of accreditation from the Royal College of Psychiatrists.
In reducing falls, Assistive technology has been introduced into the older adult wards including alarms and high/low beds and looking to implement the Fall safe programme as part of the falls prevention best care group (Oxford Academic Health Science Network).

In-patient Mental health services have developed and are running a bespoke focused in-patient preceptorship programme for newly qualified nurses. The programme was developed and is facilitated by the Nurse Consultant. The programme runs over a period of a year and it helps to support nurses in their first year of qualifying as mental health nurses. The programme also tackles dilemmas and ethical issues for nurses whilst educating them about quality and wider trust strategies. It focuses on developing nurses' skills and focuses on building the resilience needed for in-patient wards. The programme also educates and develops important modern nursing skills such as service improvement skills and introduction to models of improvement (patient safety collaborative work). As part of the programme the preceptees are supported and encouraged to deliver a service improvement project which they present to senior leaders in May 2016. The programme also aims to retain staff on in-patient wards and mostly attracts newly qualified nurses to come and work in Prospect Park Hospital. It tackles the difficult aspects of in-patient nursing and the emotional impact and burn-out working on busy in-patient wards potentially can have on nurses. Reflective practice and the use of action learning sets are at the centre of the programme to develop skills, resilience and emotional intelligence. The programme also focuses on leadership and empowerment skills that each nurse needs in today's ever changing NHS.

Safe Wards is a project driven by 16 years of research creating a dynamic model of what drives conflict and containment on acute mental health wards. Researchers investigated the ways staff can act so as to produce an environment which will reduce the frequency of these events, and make wards safer place (Bowers et al 2013).
All in-patient wards in Prospect Park Hospital have successfully implemented the Safe Wards initiative. In addition to this, Prospect Park Hospital has been recognised for the progress they have made with Safe Wards by the Department of Health, and Safe Wards official website. Both older adults' wards, Rowan and Orchid, continue to excel with embedding interventions. They are both presenting their work to many conferences across the country and continue to have both national and International visitors. On the official Safe Wards website both older adult wards continue to be presented as excellent wards to visit for safe wards implementation. A lot of positive feedback is gathered by both service users and carers.

The Occupational Therapy Team, Mental Health Inpatients have expanded their service to span 7 days a week. One Occupational Therapist and an Occupational Therapy Assistant provide a variety of meaningful, therapeutic group activities across all 7 mental health wards at Prospect Park Hospital. Therapeutic activities are planned and facilitated following suggestion and feedback from patients in morning meetings and community meetings and individual therapy sessions. Activities that are provided for patients take place either in the ward environment, therapy centre or hospital gym. Group sessions have included; reminiscence therapy, cooking, creative activities, physical activities such as yoga and gym sessions.
This service improvement has received overwhelming positive feedback from patients and therefore has contributed to improving the overall patient experience during inpatient admissions at Prospect Park Hospital. It has also impacted out-of-hours safety as there has been a reduction in incidents occurring on weekends. Although there are many contributing factors to the occurrence of incidents, this data provides further evidence that engagement in meaningful activity, and routine and structure plays a positive role in preventing and reducing them.

Sport in Mind/Sport England- Get Healthy Get Active Project. The Trust is working collaboratively with local charity Sport in Mind who have received funding from Sport England for their 'Get Healthy Get Active' Project in 2015. The project, currently in its infancy, aims to set up and facilitate up to 33 weekly sporting sessions; 5 sessions per Berkshire locality, and 3 for mental health inpatient services. The project spans over 3 years and aims to improve the well-being of participants; psychologically, physically and socially. The programme will be delivered in a safe and supported environment where participants' mental health conditions will not pose a barrier to participation. Sporting sessions will include; yoga, badminton, football, walking and tai chi. The service evaluation aims to measure whether physical activity participation has a positive impact on participants' overall activity levels and mental wellbeing.

Drama Sessions Pilot on Orchid Ward at Prospect Park Hospital. In January 2016, Occupational Therapy staff at Prospect Park Hospital started a pilot of drama sessions with local theatre, Reading Repertory. Ten weeks of drama sessions are being delivered to the patients on Orchid Ward by Reading Repertory staff, collaboratively with the Occupational Therapist and Occupational Therapy Assistant on the ward. If successful, we are looking to increase the amount of drama sessions offered to inpatients at Prospect Park Hospital. There is increasing literature available which supports the positive role the arts, including music, dance, theatre, visual arts and writing plays, has in supporting health and wellbeing, and because of this the inpatient therapy team at Prospect Park Hospital are looking to maximise the opportunities to engage in activities such as these in the near future.

The Reader Organisation- Tea and Tales at Prospect Park Hospital. For the past three years we have been working with The Reader Organisation to deliver reading aloud sessions for patients at Prospect Park Hospital. The Reader Organisation's mission is to 'create environments where personal responses to books are freely shared in reading communities in every area of life'. Our patients commonly state that due to their mental health, they have been too unwell to be able to open a book, yet finish reading one, which is one of the reasons why these sessions are viewed as of high importance within the multidisciplinary interventions offered to patients during their treatment and recovery at Prospect Park.
Over the last year the 'Tea and Tales' reading sessions have been delivered for the patients on the four acute wards, and Rowan Ward at Prospect Park Hospital.

These shared aloud reading groups provide a place for participants to find their own thought as stories and poems are read aloud in a friendly, relaxed and informal environment. Participants can listen, or take turn to read and there is no pressure either way. Everybody is welcome, readers and non-readers alike, it certainly is not an English lesson! People are encouraged to come along and relax and enjoy the words. Excitingly, we have been able to train some staff at Prospect Park Hospital to 'read to lead' and deliver reading aloud sessions themselves, this means that all seven inpatient mental health wards at Prospect Park Hospital will now have the sessions delivered, including on the intensive care unit. We have received vast amounts of feedback from patients on how the sessions have positively impacted their lives and care they have received, including;

'I have not been able to read alone for several years. Since attending the group I am able to follow text now. Please continue – it is invaluable to our health and well-being as it offers friendship, which is missing in lives of some of the members'

Another patient stated that when they were in hospital it didn't feel right somehow, but here in the group with all of us she feels she can say anything and she won't be judged.

Reducing Failures to Return project on Bluebell Ward

This quality improvement work on Bluebell ward aims to decrease "failure to return" from agreed leave.

The project work sits within the patient safety collaborative work lead by the Director of Nursing and reduces risks associated with failing to return from agreed leave. As a result of this work, Bluebell Ward have now sustained 90% of patients returning back on time to the ward from a start of 20% before starting the work- an impressive improvement.

The Mental Health Crisis Resolution and Home Team (CRHTT) have been running weekly Carers Support groups in the evening both in the east and west of Berkshire. They run 4 sessions as follows:

Week 1: Mental Health – Services and sign-posting
Week 2: How you can help in a CRISIS?
Week 3: Promoting Recovery and Independence
Week 4: Promoting Recovery and Independence

The feedback from carers has been excellent. The service is currently running the 4th Cohort which is proving to be very popular with improved outcome for both Carers and Service Users.

Rowan Ward Staff Supervision Pilot Project.

The Ward Manager and Deputy Ward Managers on Rowan Ward are undertaking a pilot project to improve the quality and consistency of staff supervision, and to embed peer review of documentation within the supervision process. Work has been started to ensure that the ward supervision structures and key individual tasks are clearly identified within the Deputy Ward Managers' supervision sessions and to ensure that there is a consistent approach to what is required in terms of peer review of documentation, specifically with the registered nurses on Rowan Ward. This work is being supported through governance meetings which run every other week, alongside Orchid Ward senior nurses. The peer review process will focus on the quality of the risk summaries, care planning and progress notes for each registered nurse's key Patients.

This project is still in its infancy, however, the ground work has commenced and this will continue over the coming months.

Feedback from a Service User:

"One of the many things I have taken away with me from our sessions is that you taught me how to be kinder to myself and to believe in myself. More than ever now, I realise just how important that is…, I can't believe how far I've come since those troubling teenage years. …But it's the fact that I realised it wasn't ever as bad as I thought it would it be and it wasn't the end of the world. It made me realise that I am living a life without such excessive anxiety! I don't stop myself from enjoying life and achieving my goals. These few years have been so rewarding, thanks to you and the help you gave me."

6. Child and Adolescent Mental Health Services (CAMHS)

BHFT Community CAMH Service has focused on three key areas to improve quality of care and patient experience through 2015/16.

1. Improvement of risk management and support for young people to both prevent and respond more quickly to those in crisis. Activity undertaken included:
   - The continuation of the RAG rating scale and targeting of staff to provide timely support for young people presenting with high levels of clinical risk;
   - Extension of the Common Point of Entry opening hours to cover 8am -8pm Monday to Friday and closer working with the Psychological Medicine Service, the acute Hospital Trusts and Prospect Park Hospital to improve response times to young people presenting to those units in crisis. This focus had a significant impact on reducing deliberate self-harm/crisis presentations and demand on other parts of the system, with a notable reduction in presentations to the Place of Safety at Prospect Park Hospital and has been well received by stakeholders, young people and families, enabling quicker triage and an improved urgent care response.

2. Significant work has been undertaken across the service to improve the care and support provided to children, young people and families waiting for a CAMHS intervention, with improvements to the CAMHS website (http://www.berkshirehealthcare.nhs.uk/camhs/default.asp) and the implementation of regular communication with families who are waiting and the development of workshops to provide support. All CAMHS teams and pathways have customer care protocols in place to provide support for children, young people and families while waiting. Information on current waiting times is provided alongside contact details for the team, information about what to expect from the team, self-help information, signposting, details of the CAMHS website, referral to other sources of support and advice on when and how to escalate concerns. The service has dedicated customer care lines for young people/families that are waiting on all pathways, with access to clinical advice and support through the specialist community teams if needed.
   The service has developed a number of workshops for young people and families to provide support while waiting for individual treatment. I relation to the Autistic Spectrum Disorder (ASD) diagnostic pathway, which has the longest waiting times, the Trust has worked in partnership with Autism Berkshire (formerly the Berkshire Autistic Society) and Parenting Special Children to develop workshops for families waiting for an ASD assessment. These workshops were piloted early in 2015 and have been offered to all families waiting for an ASD assessment. These workshops have now been funded by the CCG's through the Future in Mind transformation funds.

3. Reduction in waiting times. The service attained investment in 2015/16 and has undertaken a recruitment, induction and training programme through the year. The additional capacity in the service has now started to enable a reduction in total numbers waiting for treatment and the length of waiting time for all teams and pathways. A particular focus has been on CPE, with waiting times now being less than 12 weeks and the majority of families being contacted within 6 weeks. This will remain a focus through 2016/17.

The Berkshire Adolescent Unit was officially opened as a Tier 4 CAMHS unit providing 24/7 in-patient and day care services for children and young people in Berkshire. The unit is now compliant with relevant NHS England standards, live on the national bed state and open to admissions following a substantial building project. A number of new staff have been recruited to the Unit, including a new Unit Manager and Consultant Psychiatrist, and work is on-going to embed the new staff and changes to process and practice related to the change.

Feedback from a Service User:

"Amazing support, time and effort put into helping my child get better/improve. Always happy to listen to parent concerns and help wherever possible."

7. Pharmacy

Medicines Optimisation.
NICE released its Guideline on Medicines Optimisation in March 2015. The main themes from the NICE guideline, together with Trust action to meet them are as follows:

- Improve awareness of how to report medicines related incidents and adverse effects both for staff and people using our services.
  With a recent review of the Trust's medicines management training e-learning package, staff will receive more comprehensive training around the importance of reporting both incidents and adverse effects of medicines. The updated package has been available since March 2016 and, with time, we would expect a continued increase in reporting.
- Introducing decision support aids/tools to the medicines prescribing, dispensing and administration process to improve safety and
- Giving consideration to electronic prescribing and medicines administration (EPMA), which will allow better monitoring and audit of medicines use as well as integration of decision support tools to improve safety for patients
  With the recent introduction of the new pharmacy computer system and robot, decision support has improved at the stage of dispensing. The Trust is currently considering the implementation of an electronic prescribing (EPMA) system, which would significantly improve access to decision support aids when prescribing and administering medication. Until then, paper based support aids are being evaluated for relevance and appropriateness for BHFT.

The Trust has a dedicated Medication Safety Officer Pharmacist dedicated to reviewing, monitoring and learning from all medicines related incidents across the Trust.

2.2 Priorities for Improvement 2016/17

The Trust has set the following priorities for 2016/17 in the areas of patient safety, clinical effectiveness, patient experience and health promotion.
These priorities have been shared with trust governors, local CCGs, Healthwatch Organisations and Health Overview and Scrutiny Committees for comment as part of the consultation process.
Responses to this consultation are included in Appendix G, together with the Trust response to each comment made by the stakeholders.

2.2.1 Patient Safety

Falls

During 2016/17, the trust will aim to reduce the number of falls experienced by patients. The Trust Falls Strategy was written and ratified in the autumn of 2015. This was in response to the recognition that our falls focus and assessments were not standardised across all our wards and that numbers were at times high both in the mental health and community wards with no real understanding as to why that was. Before the strategy there was no action plan to remedy this. As a result, quarterly meetings of a trust wide falls group are now held, keeping falls high on the agenda across mental health and community services as well as defined falls champions on each in -patient ward.

Patients admitted to Trust inpatient wards have complex needs, both physically and mentally, and it is well recognised that there is no one solution that will reduce the amount of falls. Many of the reasons people fall are out of our control (comorbidity) but equally many of the reasons people fall can be learnt about and practice changed. We know from data collected that the peak times that people fall are soon after breakfast, lunch and supper as well as in the middle of the night. Most falls occur in the toilet or bathroom. Fewer falls happen at the weekend (families are around to help).

In order address this priority, the Trust will take the following action:

1. In 2016 we plan to introduce bespoke assistive technology equipment into all our inpatient wards that will alert nursing staff when at risk patients are moving around so enabling staff to assist as required. This will be in the form of bed, chair and movement sensors as well as a new sensor for the WC (being developed for the Trust) maintaining patient dignity but alerting staff.

2. We are also working closely with the Oxford Academic Health Science Network (OAHSN) across the Thames Valley to implement evidenced-based ways of reducing falls in our services. This may be as simple as:
   - Replacing bins with push pedals with open topped bins, thus reducing the need for the patient to stand on one leg to dispose of paper towels
   - Leaving the light on/ putting a light sensor in the WC, so that the patient does not become confused with the pull cords or embarrassed they will pull the wrong cord and resulting in them using the WC in the dark.

   There is unfortunately not one easy answer to this challenge.

Progress against this priority will be monitored as follows:

1. We will evaluate the use of the assistive technology, adapting as required.
2. We will monitor and work to maintain the number of falls to under the set required per 1000 bed days metric and also be able to accurately understand why there are peaks in the numbers through close monitoring of patients who are at higher risk.
3. We will continue to link with the OAHSN and review what our neighbours are doing and implement changes as appropriate.

Pressure Ulcer Prevention

The aim of the Pressure Ulcer Prevention priority is to provide the best care to patients through prompt and thorough risk assessment, education of patients and carers, and early intervention to ensure prevention of pressure damage in the first instance.
In pursuance of this aim, the Trust will demonstrate continuing improvement during the year, maintaining the level of performance against current indicators on avoidable developed pressure ulcers and improving the quality of the reporting of tissue damage.

When people in our care develop pressure ulcers this is considered to be a harm. Pressure damage can have an enormous impact on the individual, causing discomfort or pain and delaying rehabilitation or discharge. In some cases this can be severe and have lasting effects. Since the launch of our 'Under Pressure' campaign and strategy in September 2013 there has been a sustained reduction in the development of unavoidable pressure ulcers across the trust and we aim to ensure continued provision of the best and safest care to patients. Current interventions to ensure sustained best practice include completion of the Waterlow risk assessment and MUST scores on admission and development of an appropriate action plan where a risk is identified.

The Trust currently monitors all developed pressure ulcer incidences of category 2 and above. Category 3s and 4s (and category 2s on inpatient wards) are investigated as serious incidents and deemed either avoidable or unavoidable, to ensure a root cause is identified and lessons are learnt. The Trust currently uses 90 days as a target for celebrating the achievement of being free from any developed pressure damage on the wards. This has proven very successful in embedding the Trust goal of embedding a change of attitude towards pressure ulcers. Nearly all community health service inpatient wards have achieved at least 90 days free from developed pressure ulcers.

Current quality schedule indicators with reductions of 15% and 20% have been challenging following on from the significant improvements already made and mostly these are on target for 2015/16 where they are achievable. However, as part of this priority, the Trust would like to see these targets maintained and this will require continued improvement work.

In order address this priority, the Trust will take the following further actions.

1. The Pressure Ulcer Prevention Champion network will continue to be supported by the tissue viability team with four educational days through the year providing an effective resource, continuing to undertake small improvement projects linking to the safety collaborative and the work of the Oxford Academic Health Science Network.
2. Improvement projects will be undertaken and include the piloting of a 'MOPS' tool to assist with distinguishing between moisture and pressure, and closer monitoring of Category 1 pressure ulcers, which is expected to impact on the development of category 2s.

Progress against this priority will be monitored as follows:

1. The number of pressure ulcers will be monitored against Quality Schedule targets
2. Pressure ulcers will also be monitored through the Classic Safety Thermometer with a focus on harm-free care. Work is almost complete with the rollout of the eHealth system which is an easier method for clinicians to collect data and the Trust expects that improved validation using this system will be demonstrated through an increase in Harm Free care.

2.2.2 Clinical Effectiveness

NICE Guidance

The aim of the NICE Guidance priority is to maintain the Trust achievement of 100% compliance with technology appraisals and greater than 80% compliance with all NICE Guidance during the year.
NICE guidelines, technology appraisals and quality standards provide valuable evidenced-based information on clinically effective and cost-effective services.

In order address this priority, the Trust will take the following actions.

1. The Trust will continue promoting the implementation of NICE Guidance by ensuring that it is identified, assessed and implemented in a timely manner. All guidance will be prioritised and assurance will be sought through expert opinion and clinical audit.

Progress against this priority will be monitored as follows:

1. The level of compliance with NICE guidance will be reported at the Trust Clinical Effectiveness Committee meetings. Targets will be 100% compliance with technology appraisals and greater than 80% compliance with all NICE Guidance during the year.

2.2.3 Patient Experience

The Trust patient experience priority will focus on the Friends and Family Test, learning from complaints and participation in the Patient Leadership Programme. Further information on each of these priorities is detailed below.

Friends and Family Tests

We will continue to promote and encourage the Friends and Family Test, integrating this wherever possible into our existing internal patient survey programme. We introduced the Friends and Family Test for Carers in 2015 and will continue to promote this throughout the year because we recognise the crucial role that carers have and value the feedback that they can provide.

Progress against this priority will be monitored as follows:

1. Monthly monitoring of patient Friends and Family Test results
2. Monthly monitoring of carer's Friends and Family Test results

Learning from Complaints

Sharing learning from complaints will remain a priority for the Trust. Progress against this priority will be monitored as follows:

1. Monthly monitoring of the number of complaints and compliments received
2. Monthly monitoring of the number of complaints that have been acknowledged within 3 days
3. Monthly monitoring of the number of complaints that have been resolved within an agreed timescale of the complainant
4. Quarterly patient experience reports to share learning from complaints

Patient Leadership Programme

The Trust will continue to improve on how we involve patients and carers in the development of our services. In pursuance of this, the Trust are going to take part in the Patient Leader Programme collaboratively with the Royal Berkshire Hospital NHS Foundation Trust with the aim of establishing a group of people that have received training and support to

work with us to design and change patient services for the better. Progress against this priority will be monitored as follows:

1. Recruit to the role and to engage patient leaders in developing services

2.2.4 Health Promotion

Suicide Prevention:

The aim of this priority will be to work with staff to prevent suicide through enhancing skills in assessment, interventions, and recording of risk for people who are managed within secondary mental health services.

In order address this priority, the Trust will take the following further actions.

1. All new staff starting employment in mental health services will receive clinical risk training as part of their induction as a minimum standard.
2. A bespoke training on crisis interventions, accredited through the University of West London, will be offered to all clinical staff working in Crisis Resolution and Home Treatment Team.
3. All BHFT clinical staff will be offered an additional 3 day suicide awareness and skills training package.
4. A robust audit process will be implemented to monitor risk record keeping

Progress against this priority will be monitored as follows:

1. Uptake of training detailed above by staff
2. Results of the audit of risk record keeping to be reported through the Trust Suicide Steering Group, chaired by the Director of Nursing, and Locality Patient Safety and Quality meetings which then feed into the Quality Executive Group.
3. Monthly suicide numbers with associated rolling 12month figures will be reported.

2.2.5. Monitoring of Priorities for Improvement

All priorities detailed above will be monitored on a quarterly basis by the Trust Quality Assurance Committee as part of the Quality Report and the Board of Directors will be informed of performance against agreed targets. We will report on our progress against these priorities in our Quality Account for 2017.

2.3 Statements of Assurance from the Board

During 2015/16 Berkshire Healthcare NHS Foundation Trust provided 61 NHS services.

The Trust Board of Berkshire Healthcare NHS Foundation Trust has reviewed all the data available to them on the quality of care in all 61 of these NHS services.

The income generated by the NHS services reviewed in 2015/16 represents 100% of clinical services and 92% of the total income generated from the provision of NHS services by Berkshire Healthcare NHS Foundation Trust for 2015/16.

The data reviewed aims to cover the three dimensions of quality – patient safety, clinical effectiveness and patient experience. Details of a selection of the measures monitored monthly by the Board which are considered to be most important for quality accounting purposes are included in Part 3. These incorporate more than three indicators in each to the key areas of quality.

2.4 Clinical Audit

The Trust uses clinical audit to systematically review the care that it is providing to patients against best practice standards. Based upon the findings of audits, the Trust makes improvements to practice where necessary, to improve patient care. Such audits are undertaken at both national and local level, and a summary of progress during this year is detailed below.

National Clinical Audits and Confidential Enquiries

During 2015/16, 11 national clinical audits and 2 national confidential enquiries covered relevant healthcare services which Berkshire Healthcare Trust provided.

During 2015/16 Berkshire Healthcare NHS Foundation Trust participated in 91% (n=10/11) national clinical audits and 100% (n=2) national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

Participated in:

1. National Clinical Audit and Patient Outcomes Programme (NCAPOP) – Long Term Conditions (LTC) 002 Diabetes (Adult)
   a. includes National Diabetes Primary Care (2013/14 & 2014/15),
   b. includes Diabetes in Secondary care (2013/14 & 2014/15),
   c. includes Diabetic foot care
2. NCAPOP – Older People (OLP) 008 Sentinel Stroke National Audit Programme (SSNAP)
3. NCAPOP - OLP009 Falls and Fragility Fractures Audit Programme (FFFAP)
   a. Includes Fracture Liaison Service Database
4. NCAPOP - National Audit - National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme.
   a. Includes COPD Rehab
5. Non- NCAPOP - National Audit - Prescribing Observatory for Mental Health (POMH) - Topic 13b: Prescribing for ADHD in children, adolescents and adults
6. Non- NCAPOP - National Audit - Prescribing Observatory for Mental Health (POMH) - Topic 14b: Prescribing for substance misuse: alcohol detoxification.
7. Non- NCAPOP - National Audit - Prescribing Observatory for Mental Health (POMH) - Topic 15a: Prescribing for bipolar disorder.
8. Non-NCAPOP - National Audit of Intermediate Care
9. Non-NCAPOP - National Memory Clinic Audit
10. Non-NCAPOP - National Early Intervention in Psychosis Audit

1. NCAPOP - MTH003 Mental health clinical outcome review programme: National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH)
2. NCAPOP - WCH005 Child health clinical outcome review programme:
   a. Includes Children with chronic neurodisability
   b. includes Mental Health Conditions in Young People

Did not participate in:

1. National Audit - UK Parkinson's Audit (previously known as National Parkinson's Audit)
   a. A decision was taken not to participate in this audit, due to the fact that previous audits had shown 100% compliance in all areas of relevance.

The reports of 7 (100%) national clinical audits were reviewed in 2015/16. This included 4 national audits that collected data in earlier years that the report was issued for in 2015/16.

- POMH – Topic 12: Prescribing for people with a personality disorder
- National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (In-Patient Suicide under observation) (2014)
- National Confidential Inquiry into Suicide and Homicide by people with Mental Illness (Annual Report) (2015)
- POMH - Topic 9c: Antipsychotic prescribing for people with a learning disability
- POMH13b - Prescribing for ADHD in children, adolescents and adults
- National audit of Intermediate Care (2015) Second English National Memory Clinic Audit

The national clinical audits and national confidential enquiries that Berkshire Healthcare Foundation Trust participated in, and for which data collection was completed during 2015/16, are listed in figure 13 alongside the number of cases submitted to each audit or enquiry as a percentage of the number of

registered cases required by the terms of the audit or enquiry.

The reports of all the national clinical audits were reviewed in 2015/16 and Berkshire Healthcare Foundation Trust intends to take actions to improve the quality of healthcare which are detailed in Appendix B.

Local Audits

The following gives a summary of the number of local clinical audits registered with the Trust and a comparison during this financial year, and compares this with the previous financial year.

- Registered – (106 last year) 144
- Completed- (87 last year) 135 (may have started in previous year, may include abandoned projects)
- Active – (170 last year) 135(may have started in previous year)
- Awaiting action plan – (21 last year) 9

The reports of 78 local clinical audits were reviewed by the Trust in 2015/16 and Berkshire Healthcare Foundation Trust intends to take actions to improve the quality of healthcare which are detailed in Appendix C. (NB: Projects are only noted as 'completed' after completion of the action plan implementation, which is why there is a difference in the number of local projects 'reviewed' than total 'completed').

Figure 13- National Clinical Audits and Confidential Enquiries Undertaken by the Trust

NCAPOP Audits		
Diabetes (Adult) ND(A), a. includes National Diabetes Primary Care, b. includes Diabetes in Secondary care, c. includes Diabetic foot care.	a.	2013/14 audit Data collected February – June 2015 186 patients reported upon, across 1 team. Report 1 – Care Processes and Treatment Targets released 28th Jan 2016 Insulin Audit Report released April 2016 Report 2: Complications of diabetes and mortality release later in 2016 (date tbc) 2014/15 audit Data collected July - September 2015 214 patients reported upon, across 1 team. Report 1 – Care Processes and Treatment Targets released 28th Jan 2016 Insulin Audit Report released April 2016 Report 2: Complications of diabetes and mortality release later in 2016 (date tbc)
	b.	2013/14 audit Data collected May – June 2015 1519 patients submitted, across 1 team. Report 1 – Care Processes and Treatment Targets released 28th Jan 2016 Insulin Audit Report released April 2016 2014/15 audit Data collected July - September 2015 1534 patients submitted, across 1 team. Report 1 – Care Processes and Treatment Targets released 28th Jan 2016 Insulin Audit Report released April 2016
	c.	Data collection continuous 40 patients submitted, across 1 MDFT teams for first report. 1st Report released 31st March 2016 NB: Report is registered and reported under Royal Berkshire Hospital NHS FT.

NCAPOP Audits		
Sentinel Stroke National Audit Programme (SSNAP)	Data collection continuous 339 patients submitted for January –December 2015, across 1 service. (Final figure not yet available). 1st Report due March 2016	
Falls and Fragility Fractures Audit Programme (FFFAP) a. Includes Fracture Liaison Service Database	a.	Facilities audit - Data collected September – October 2015 across 1 service Facilities Report due Spring 2016 (exact date tbc) Patient Audit due to collect January – September 2016 Clinical Audit report due early 2017 (date tbc)
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme a. Includes COPD Rehab	Data collected January – July 2015 77 patients submitted, across 2 services Organisational report released November 2015 Clinical Audit report released February 2016	
1. NCAPOP - MTH003 Mental health clinical outcome review programme: National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH)	Data collection continuous	
2. NCAPOP - WCH005 Child health clinical outcome review programme: a. Includes Children with chronic neurodisability b. includes Mental Health Conditions in Young People	a.	Data collection currently in progress. Due to be completed by 20th May 2016. Report due by November 2017
	b.	Data collected March 2016. 35 patients across Psychiatric Liaison Services. Report due by November 2017
Non-NCAPOP audits		
Prescribing Observatory for Mental Health (POMH) - Topic 13b: Prescribing for ADHD in children, adolescents and adults	Data collected May 2015 219 patients submitted, across 7 teams. Report due in November 2015	
Prescribing Observatory for Mental Health (POMH) - Topic 14b: Prescribing for substance misuse: alcohol detoxification.	Data collected January 2016 39 patients submitted, across 4 teams. Report due August 2016	
Prescribing Observatory for Mental Health (POMH) - Topic 15a: Prescribing for bipolar disorder.	Data collected October 2015 137 patients currently submitted, across 6 teams. Report due May 2016	
National Audit of Intermediate Care	Data collected June-July 2015 12 service elements included. Report received December 2015.	
National Memory Clinic Audit	Data collected September-October 2014. Looked at aspects of the service of all 6 teams. Report received January 2016	
National Early Intervention in Psychosis Audit	Data collected December 2015-January 2016 19 patients currently submitted, across 1 service. Report due End of April 2016	
Other audits reported on in-year (data collected in previous year(s)		
Prescribing Observatory for Mental Health (POMH): Topic 9: Antipsychotic Prescribing for people with Learning Disability	Data collected March 2015 Report received August 2015	

Non-NCAPOP audits	
Prescribing Observatory for Mental Health (POMH): Topic 12: Prescribing for people with personality disorder	Data collected June-July 2014 Report received January 2015
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (In-Patient Suicide under observation) (2014)	Data collected ongoing Report received July 2015
National Confidential Inquiry into Suicide and Homicide by people with Mental Illness (Annual Report) (2015)	Data collected ongoing Report received August 2015
Did not participate in.	
National Audit - UK Parkinson's Audit (previously known as National Parkinson's Audit)	Decision made January Clinical Effectiveness Group

Source: Trust Clinical Audit Team

2.5 Research

The number of patients receiving NHS services provided or sub-contracted by Berkshire Healthcare NHS Foundation Trust in 2015/16 that were recruited during that period to participate in research approved by a research ethics committee was as follows:

851 patients were recruited from 87 active studies, of which 653 were recruited from studies included in the National Institute of Health Research (NIHR) Portfolio and 198 were from non-Portfolio studies.

Figure 14- R&D recruitment figures 2015/16

Type of Study	No of Participants Recruited	No of Studies
NIHR Portfolio	653	55 (of which 12 are PICs)
Student	179	21
Other Funded (not eligible for NIHR Portfolio & Own Account (Unfunded)	19	11

Source: Trust R&D department

2.6 CQUIN Framework

A proportion of Berkshire Healthcare NHS Foundation Trust's income in 2015/16 was conditional upon achieving quality improvement and innovation goals agreed between the Trust and the Clinical Commissioning Groups (CCGs) through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2015/16 and for the following 12 month period can be found in Appendix E & F.

The income in 2015/16 conditional upon achieving quality improvement and innovation goals is £3,716,110. The associated payment received for 2014/15 was £3,549,929.

2.7 Care Quality Commission

Berkshire Healthcare NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is registered without conditions.

The Care Quality Commission has not taken enforcement action against Berkshire Healthcare NHS Foundation Trust during 2015/16.

The current quality intelligence draft report which has replaced the CQC Quality & Risk Profile can be found at: **http://www.cqc.org.uk/Provider/RWX.**

Berkshire Healthcare NHS Foundation Trust is subject to periodic reviews by the Care Quality Commission and the last review was in 7th-11th December 2015.
The report of this comprehensive review was published by the CQC in March 2016, and the Trust was awarded an overall rating of 'Good' as a result.
The CQC ratings grid from this inspection is shown below:

Of particular note, Trust community-based older peoples mental health services were given an overall rating of 'Outstanding.' In addition, Trust End-of Life Care Services received a rating of 'Outstanding' in the caring category.

The CQC comprehensive inspection also found that the following services required improvement:

- Berkshire Adolescent Unit
- Older People's Mental Health Inpatients
- Learning Disability Inpatient Units

Action plans are in place and in the process of implementation. These plans are being monitored by the Quality Executive Group

Berkshire Healthcare NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

In addition to the comprehensive inspection in December 2015, the CQC has carried out two unannounced Mental Health Act (MHA) monitoring visits on Trust wards during 2015/16. The CQC is required by law to make such visits to provide a safeguard for individual patients whose rights are restricted by law. These MHA monitoring visits were carried out on Sorell Unit (a psychiatric intensive care inpatient unit at Prospect Park Hospital) in August 2015 and on the Campion Unit (a learning disabilities inpatient unit at Prospect Park Hospital) in September 2015. There was no enforcement action taken against the Trust as a result of either of these visits.

The Care Quality Commission also visited the GP practice Priory Avenue on 29th July 2015 which was taken on by the Trust when in 'special measures'. The practice was taken out of 'special measures' following this inspection.

2.8 Data Quality and Information Governance

Berkshire Healthcare NHS Foundation Trust submitted records during 2015/16 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data which included the patient's valid NHS Number was as follows:
Records had 100% patient's valid NHS number Status Indictor:
1) out of which 99.8% had number present but not traced
2) and remaining had number not present and trace not required.

The percentage of records which included the patient's valid General Practitioner Registration Code was as follows:
Records had 100% patient's valid General Practitioner Registration Code
1) out of which 99.7% had the GP reg code
2) Remaining count had value set to default value.

Information Governance

Berkshire Healthcare NHS Foundation Trust's Information Governance Assessment Report overall score for 2015/16 was 68% and was graded as satisfactory (Green).

The Information Governance Group is responsible for maintaining and improving the information governance Toolkit scores, with the aim of being satisfactory across all aspects of the IG toolkit.

Data Quality

Berkshire Healthcare NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2015/16 by the Audit Commission

The Trust has taken the following actions to improve data quality.
The Trust has invested considerable effort in improving data quality. An overarching Information Assurance Framework (IAF) provides a consolidated summary of every performance information line and action plans.

Data quality audits were carried out on all lines that were rated as low ('red') quality in the IAF. The findings of these data quality audits were shared with the Data Quality Group and the Trust Senior Management Team

The key measures for data quality scrutiny mandated by the Foundation Trust regulator Monitor and agreed by the Trust Governors are:

- 100% enhanced Care Programme Approach (CPA) patients receiving follow-up contact within 7 days of discharge from hospital
- Admission to inpatients services having access to crisis resolution home treatment teams
- C Diff

2.9. Duty of Candour

Berkshire Healthcare NHS Foundation Trust has an 'Open Communication (Being Open) a Duty to be Candid' policy that supports our culture of openness when things go wrong.

To promote and help embed this policy face to face training has been provided, there is also a page on our intranet where staff can access information, flow charts and advice.

The patient Safety Team monitor incidents reported on our incident reporting system (Datix) to ensure that where incidents meet the requirement for formal Duty of Candour that this is undertaken.

Our process for formal Duty of Candour include meeting with patients and families, apologising for their experience, explaining the investigation process, inviting them to be involved in the investigation and then sharing the report and findings when the investigation is complete. We also ensure that support is offered to patients, family and carers as appropriate.

3. Review of Performance

3.1 Review of Quality Performance 2015/16

In addition to the key priorities detailed, the Trust Board receives monthly Performance Assurance Framework reports related to key areas of quality. These metrics are closely monitored through the Trust Quality Governance systems including the Quality Executive Group and the Board Audit Committee. They provide assurance against the key national priorities from the Department of Health's Operating Framework and include performance against relevant indicators and performance thresholds set out in the Compliance Framework. The data source for all information within this section is the Trust Performance Assurance Framework unless otherwise stated.

Patient Safety

The Trust aims to maximise reporting of incidents whilst reducing the severity levels of incidents through early intervention and organisational learning. Organisations that report more incidents usually have a better and more effective safety culture.

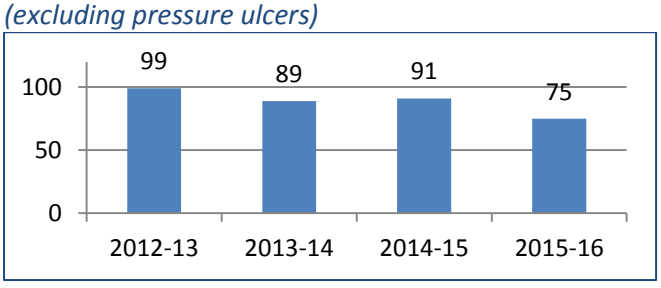
Never Events

Never events are a sub-set of Serious Incidents and are defined as 'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers'. The Trust has not reported any never events in 2015/16.

Incidents and Serious incidents (SIs)

Figure 15 below shows the number of serious incidents reported in comparison with the previous financial years.

Figure 15- Number of SIs- Year on Year Comparison (excluding pressure ulcers)



Source: Trust Serious Incident Report

It should be noted that whilst the total number of SIs is lower this year than in previous years this is because from 2015/16 admission of minors was no longer reported as an SI.

The significant features represented in Q4 SI reporting are:

- Suicide cases: 2015/16 has seen the highest number of suicides and suspected suicides in the past 5 years. This is comparable with national trends. There has been a 71% increase in reporting since 2014/15.

  Nearly 40% of all SIs reported in the year 2015/16 were suicides/suspected suicides.

  In Q4, there were a further 6 SIs reported as suicides/suspected suicides. This equates to 38% of all SIs reported in Q4 (excluding pressure ulcers). There have been no inpatient suicides in Q4. The suicides/suspected suicide cases have occurred across localities and services.

  In addition, there were 2 SIs reported as attempted suicides in Q4.

- Unexpected Deaths: There were 3 unexpected deaths reported in Q4; 2 were reported by CRHTT (west) and 1 by West Berkshire CMHT.

- Falls: There were 2 SIs relating to patient falls with harm in Q4, these occurred on Rowan and Windsor Wards.

  50% of the falls reported as SIs in 2015/16 occurred on Rowan Ward (total 4).

- Pressure Ulcers: Four pressure ulcer SIs were reported in Q4. 3 were category 4 and 1 was a category 3. Three of the SIs were reported by Community Nursing Services from Bracknell.

  Overall pressure ulcer reporting has shown a significant decrease to that reported in 2014/15.

- Inpatient Pressure Ulcers: There were no inpatient pressure ulcers meeting SI criteria in Q4.

Key themes identified in SI investigation reports approved in Q4

(Note: this is a discussion of learning from investigations completed and approved by commissioners in Q4)

The main themes that have been identified following completed and approved investigations in Q4 are:

- Communication between other BHFT Services and external agencies - lack of clear communication between both internal BHFT services and with services outside of BHFT to ensure timely, relevant care/ care planning and risk assessment has been identified. This includes the interface between BHFT services and the available substance Misuse Services.
- Poor Documentation in Rio - more than one investigation has highlighted that confusing and / or conflicting information on Rio has led to a lack of clarity regarding events that have happened.

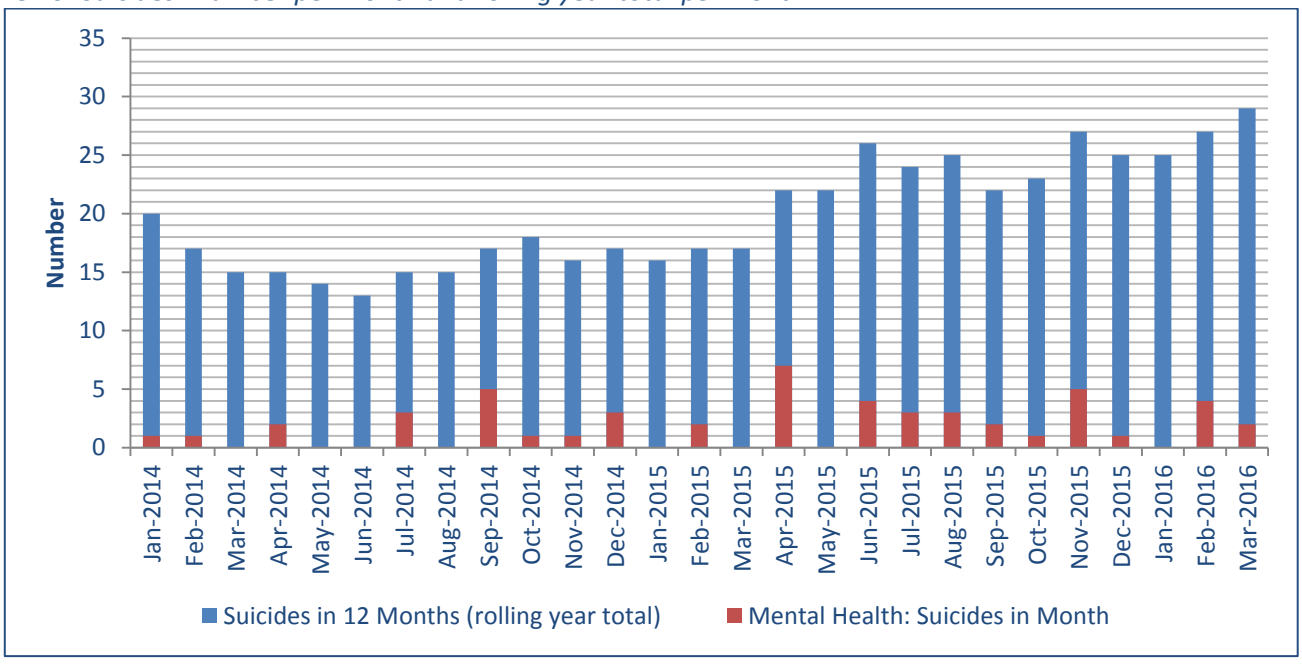
The following areas, some of which have been seen previously and discussed in earlier reports, continue to be highlighted in SI cases from Q4:

- Documenting complete risk assessments using the appropriate tool in Rio – this remains a concern and more than one investigation has highlighted that risk assessments are not always reflected in the Rio risk assessment tool; in many but not all cases, the risks are documented in the progress notes with the management plan but not using the appropriate tool.
- Patients who are Difficult to Engage – this continues to be a theme. There needs to be improved communication between GP, other health professionals, other services when a patient appears to be disengaging so that a greater understanding of their situation is obtained and appropriate risk mitigation / crisis contingency plans are agreed.
- Carer / Family Involvement – this continues to be a theme. Concerns by patients, staff and family were not actioned or followed up and information was not always gathered or passed on.

Suicides

Figure 16 below shows the number of suicides reported per month, together with the rolling 12 month figure. In 2014/15 there were 17 suicides during the year. During 2015/16 there have been 29 suicides. All recorded suicides have occurred in the community and there have been no suicides in any of our inpatient facilities.

Figure 16- Suicides- Number per month and rolling year total per month



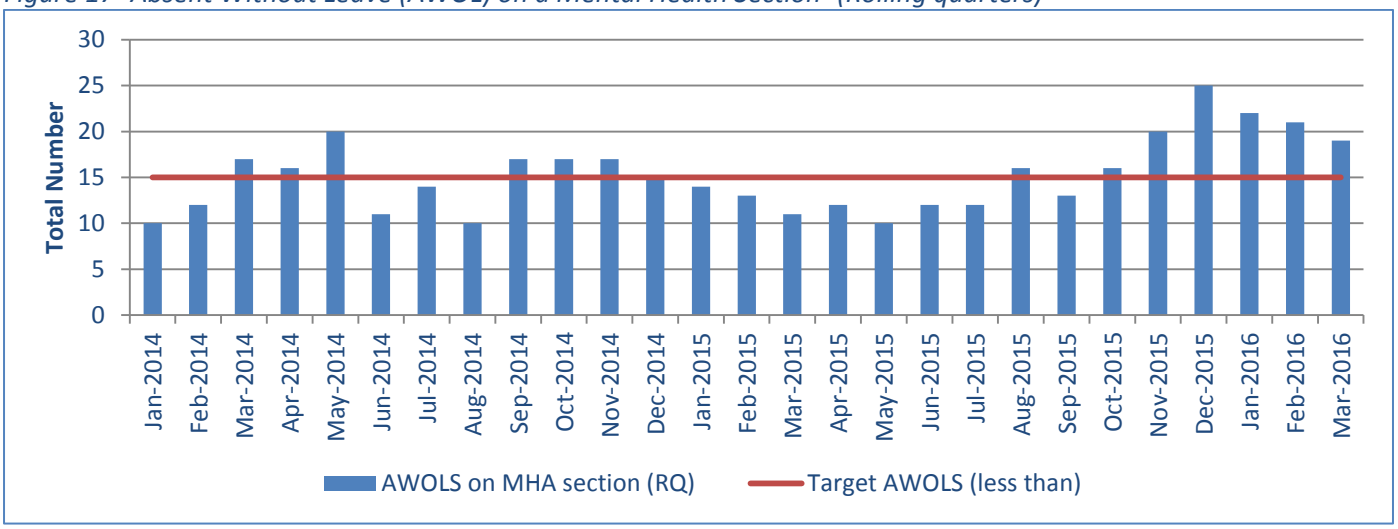
Source: Trust Performance Assurance Framework

Absent without Leave (AWOL) and Absconsions

Figures 17 and 18 below detail the number of absconsions on a Mental Health Act Section and the number of patients absent without leave on a Mental Health section. The definition of absconding used in the Trust is different than AWOL, in that this refers to the patients who are usually within a ward environment and are able to leave the ward without permission. There appears to be a correlation with the occupancy levels on the wards.

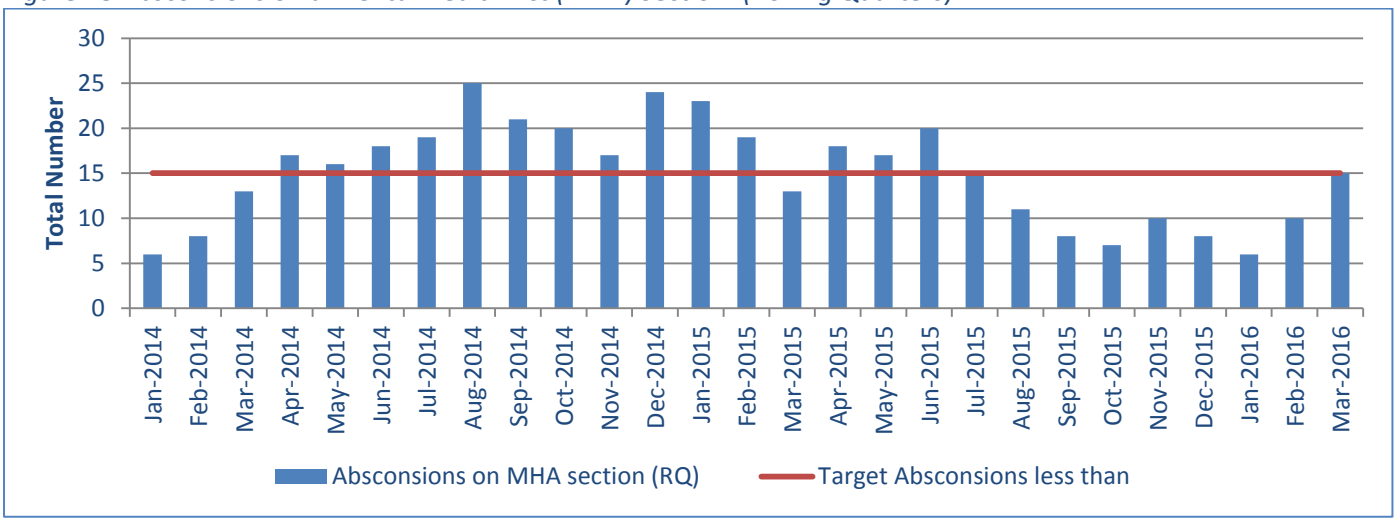
As can be seen there have been fluctuations in patients AWOL from the ward and in episodes of absconding. There has not been any clear trend in these areas. (The figures shown for each month are rolling quarters)

Figure 17- Absent Without Leave (AWOL) on a Mental Health Section- (Rolling quarters)



Source: Trust Performance Assurance Framework

Figure 18 Absconsions on a Mental Health Act (MHA) Section- (Rolling Quarters)



Source: Trust Performance Assurance Framework

A number of initiatives have been considered to help reduce the number of absconsions;

1. To make sure all the fences were in good repair, bolt down garden benches away from fences [so that they could not be moved to the fence to assist with absconding and instigate a regular checking programme of the fences / garden areas.
2. Tighten the function and process for having a dedicated member of staff out on the ward at all times. This person must be additional to the member of staff doing intermittent and general observations.

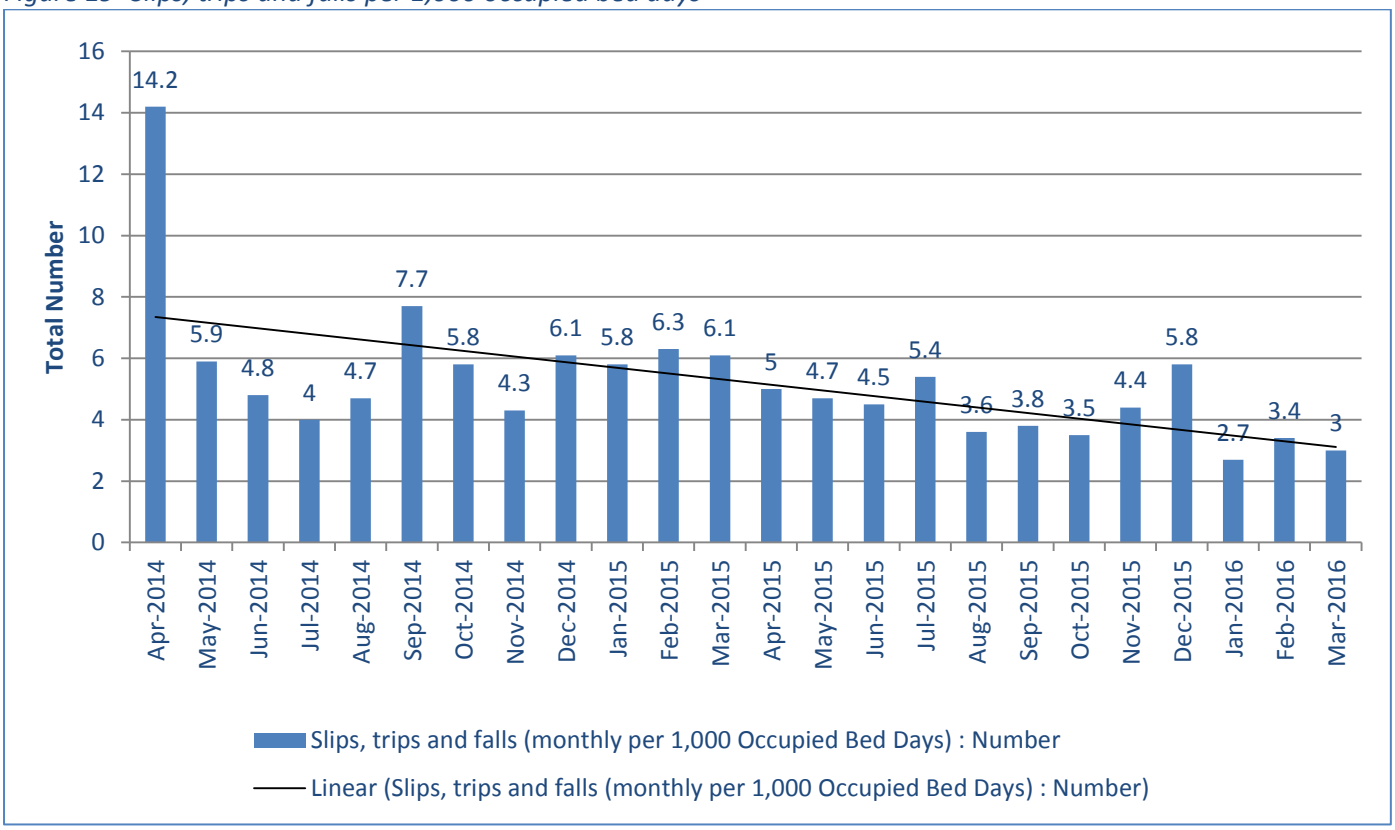
3. Extra vigilance within outside areas [garden/courtyard].
4. Implement regular slot in staff meetings where staff discuss and reflect on physical and relational security issues. This includes as a minimum: discussion of boundaries, therapy, patient mix, patient dynamic, patient's personal world, physical environment, visitors and other external communication and may be facilitated by the See, Think, Act Relational Security Explorer
5. Robust risk assessment and management plan on admission to focus on AWOL and Absconsions.

Implement anti-absconding interventions - all staff to complete the workbook training sessions on: rule clarity; signing in and out book; identification of those at high risk of absconding (targeted nursing time for those at high risk); promoting contact with family and friends; promotion of controlled access to home; careful breaking of bad news; contact cards; post incident debriefing; MDT review following two absconding episodes.

Slips, Trips and Falls

The number of slips, trips and falls per 1,000 occupied bed days is detailed in figure 19. As can be seen, the trend in falls is generally on the decline. However, falls continue to be above the target per 1,000 bed days on some of our wards. The 'Falls Safe Plan' is in place on all wards. Actions have included examining whether further assistive technologies may reduce the number of falls and changes to staff working hours as falls on the ward tend to occur between the hours of 6pm to 10pm. Since February 2015, the wards have been monitoring cognitive impairment of clients who have experienced a fall and whether the fall was witnessed. Future monitoring will include when the patient was last checked prior to the fall.

Figure 19- Slips, trips and falls per 1,000 occupied bed days



Source: Trust Performance Assurance Framework

Medication errors

This year there were just over six hundred medication incidents reported. This was a welcome increase of about 8% from the previous year and shows that the learning culture in the Trust continues to strengthen.

Moderate and severe errors attributable to the Trust

There have been no severe and one moderate medication error in this year that is attributable to the Trust.

The moderate error occurred when a patient with learning disabilities was discharged from inpatient services on 10mg olanzapine tablets labelled with a fourteen day supply of which she took one daily then obtained a further supply in the community. The supply was prescribed by the GP and dispensed by a community pharmacy and resulted in the patient having a supply of olanzapine 5mg tablets labelled "use every day as advised by specialist". As a result the patient took only 5mg daily and suffered a deterioration in her condition which led to her being readmitted under section. The professional who wrote the initial unclear discharge letter to the GP learnt personally from this incident and this patient now has their medication in blister packs to aid compliance. More broadly, twice weekly medication checks have been introduced for similar patients in the outpatient service so that should a similar incident occur again it can be rectified much more quickly.

Moderate and severe errors reported by, but not attributable to the Trust

During the year there has been one severe and two moderate medication errors which were not as a result of BFHT action or inaction but which our staff reported as they were involved in resolving the error.

The severe incident involved the sudden death of an elderly care home resident, who was being visited by a BHFT Community Psychiatric Nurse.
An initial investigation revealed some medication inconsistencies with regard to amisulpride and warfarin (although this was not a BHFT responsibility). The details of this case were investigated by the coroner and no shortcomings of medicines management by BFHT were fed back.

The first moderate incident was made by a community pharmacy but identified and reported by BHFT staff.

In this incident, the patient was supplied with the wrong patient's medications and then fell requiring an acute admission and period of inpatient physiotherapy. The incident was passed on to the community pharmacy and their head office to investigate, as well as to NHS England who have responsibility for monitoring the errors made by community pharmacies.

The second moderate incident involved a patient with depression who had been stable on buprenorphine 300mg daily for a number of years. When the patient changed GP practices the new GP would not prescribe this medication off license until they had seen the patient. This delay in supply led to a relapse in symptoms for the patient. The issue was resolved by:

- The Trust doctors urgently reviewing the patient and issuing a short term prescription
- The Trust doctors issued a new letter to the GP advising on the medication regime recommended
- The new GP has now agreed to prescribe the medication long term

To help engender the learning culture, feedback to the reporters of incidents has been increased by including examples of lessons learnt and changes in practice following incidents in each edition of the Trust Drugs and Therapeutics Committee Bulletin which is written and disseminated to all Trust staff six times a year.

Also, to ensure that a fair blame culture is embedded within the Trust, a 'Management of Medication Errors Procedure' has been written, approved and implemented in order to raise awareness of this. In addition, for a period this year, every time an incident was reported the investigator was emailed a hyperlink to this document.

Number of reported medication errors

Figure 20 below details the total number of medication errors reported, based upon a rolling 12-month figure.

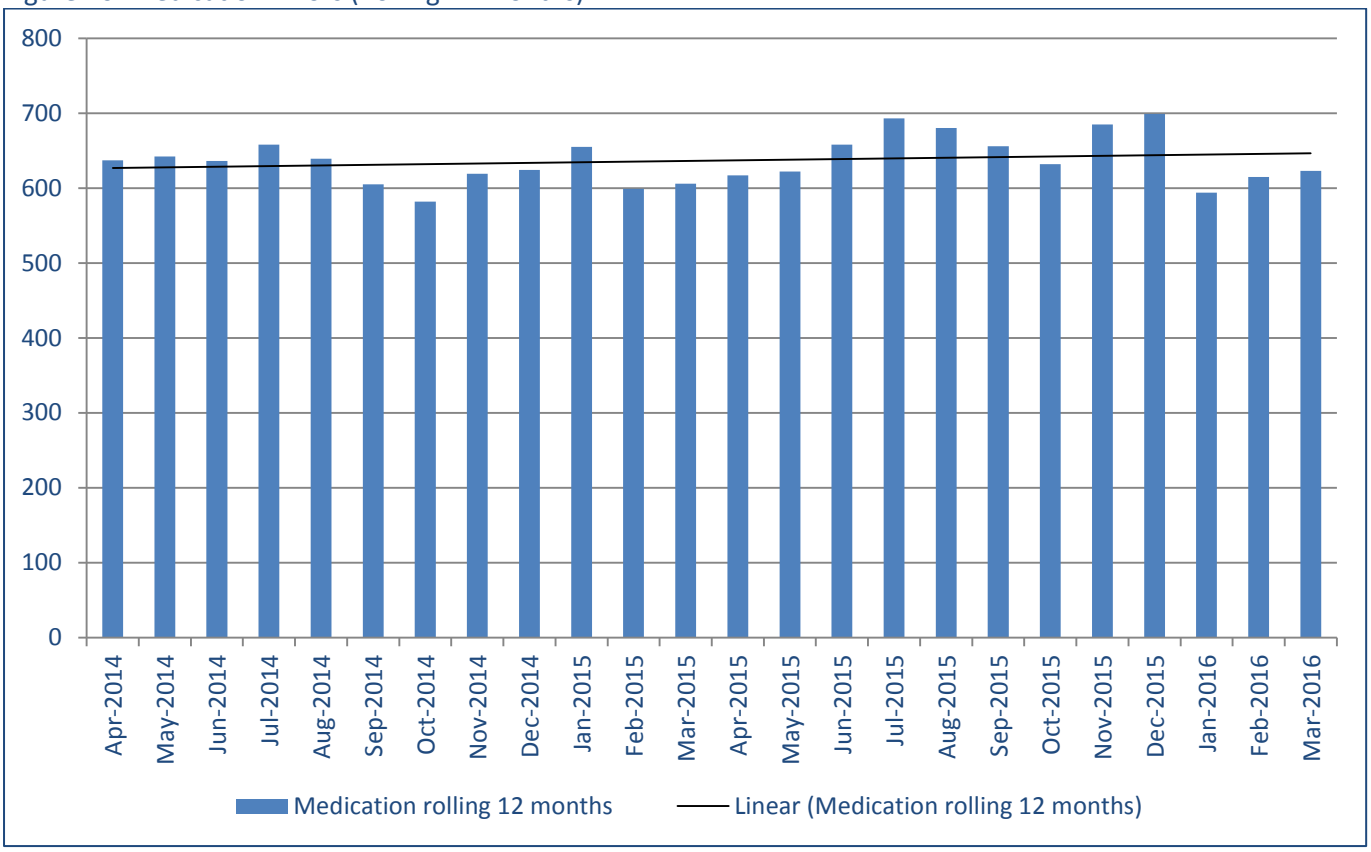
When interpreting this figure, it should be noted that a high and increasing rate of medication error reporting is a sign of a healthy learning culture in the organisation and that reporting of such errors is being encouraged as the first step in ensuring a robust safety culture exists.

In addition, it should be noted that the ratio of harm to non-harm errors in the Trust has been greater than 0.9 for a number of months (i.e. that patients experienced no harm as a result of the error in greater than 90 out of every 100 patients).

Therefore, the increased reporting of these errors, coupled with overwhelming proportion that have resulted in no harm, is the starting point for the learning which needs to take place to decrease the risk of harm to patients.

Finally, following the 2014 Patient Safety Alert on Improving medication error incident reporting and learning, the Trust has appointed a Medicines Safety Officer to drive forward this particular agenda.

Figure 20: Medication Errors (Rolling 12 Months)

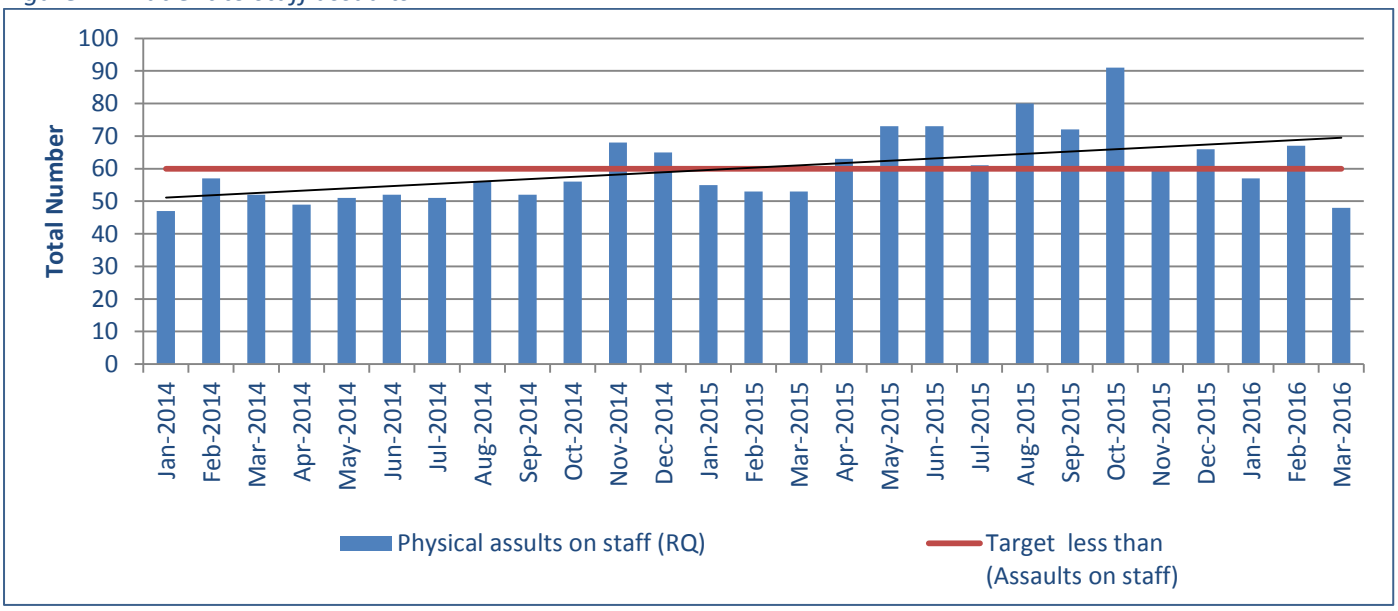


Source: Trust Performance Assurance Framework

Patient to staff physical assaults

Figure 21 below details the number of patient to staff assaults recorded in the Trust each month. There have been fluctuations in the level of physical assaults on staff by patients with an increase in trend over time. Often these changes reflect the presentation of a small number of individual inpatients.

Figure 21- Patient to staff assaults

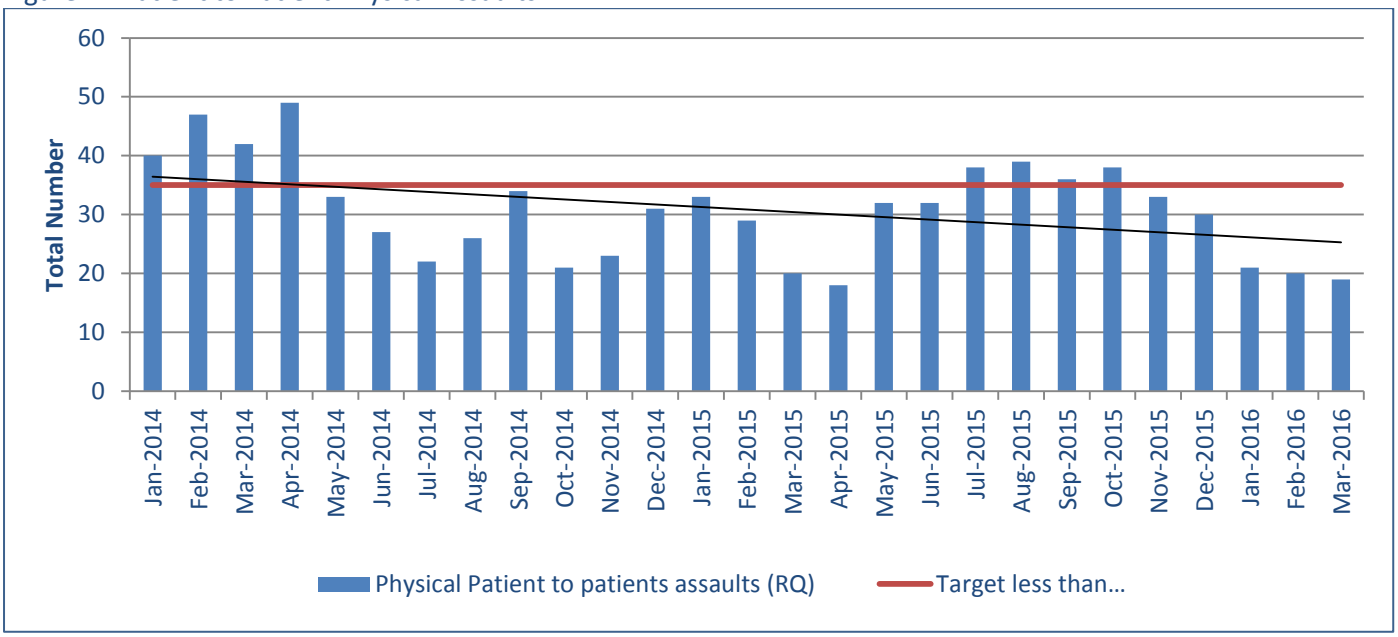


Source: Trust Performance Assurance Framework

Patient to patient physical assaults

Figure 22 below details the number of patient to patient physical assaults recorded in the trust each month. As can be seen, the level of patient on patient assaults appears to fluctuate with a slight downward trend in the past two years.

Figure 22 Patient to Patient Physical Assaults

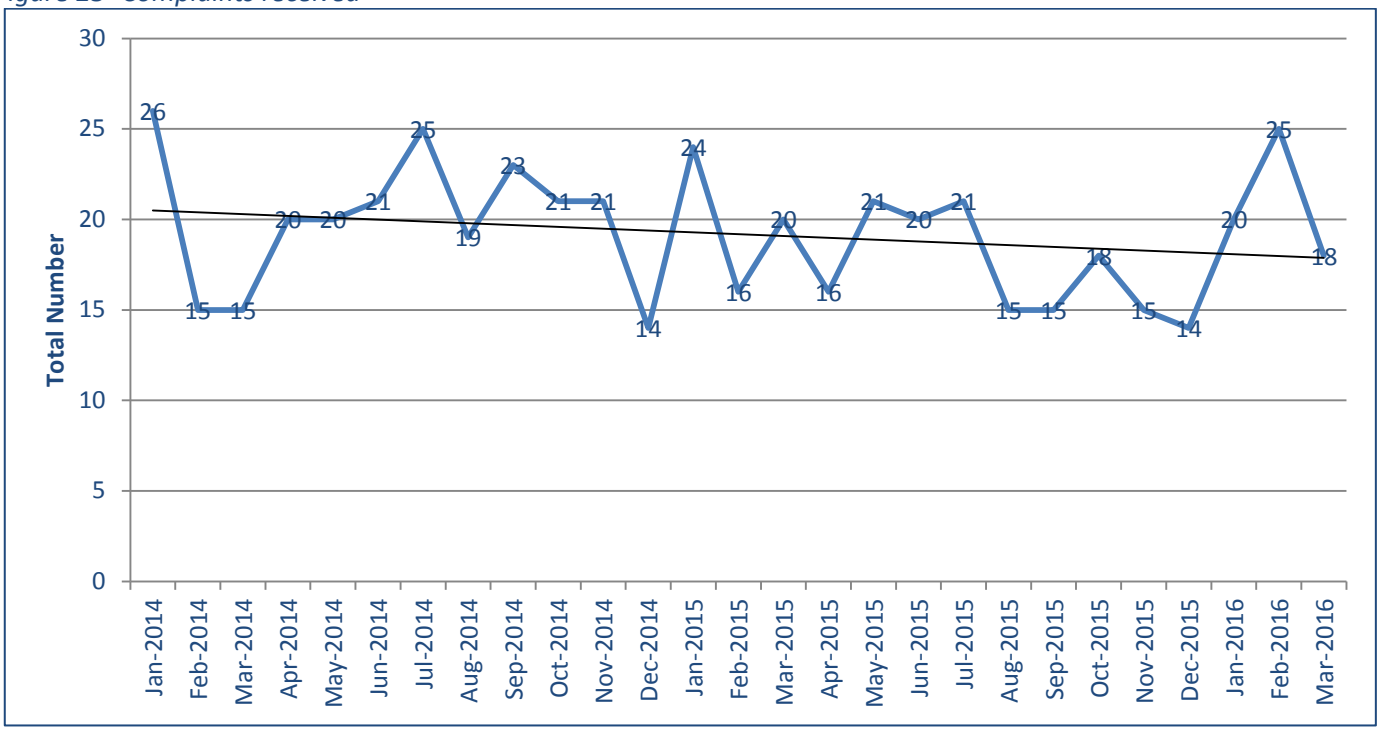


Source: Trust Performance Assurance Framework

Complaints and compliments

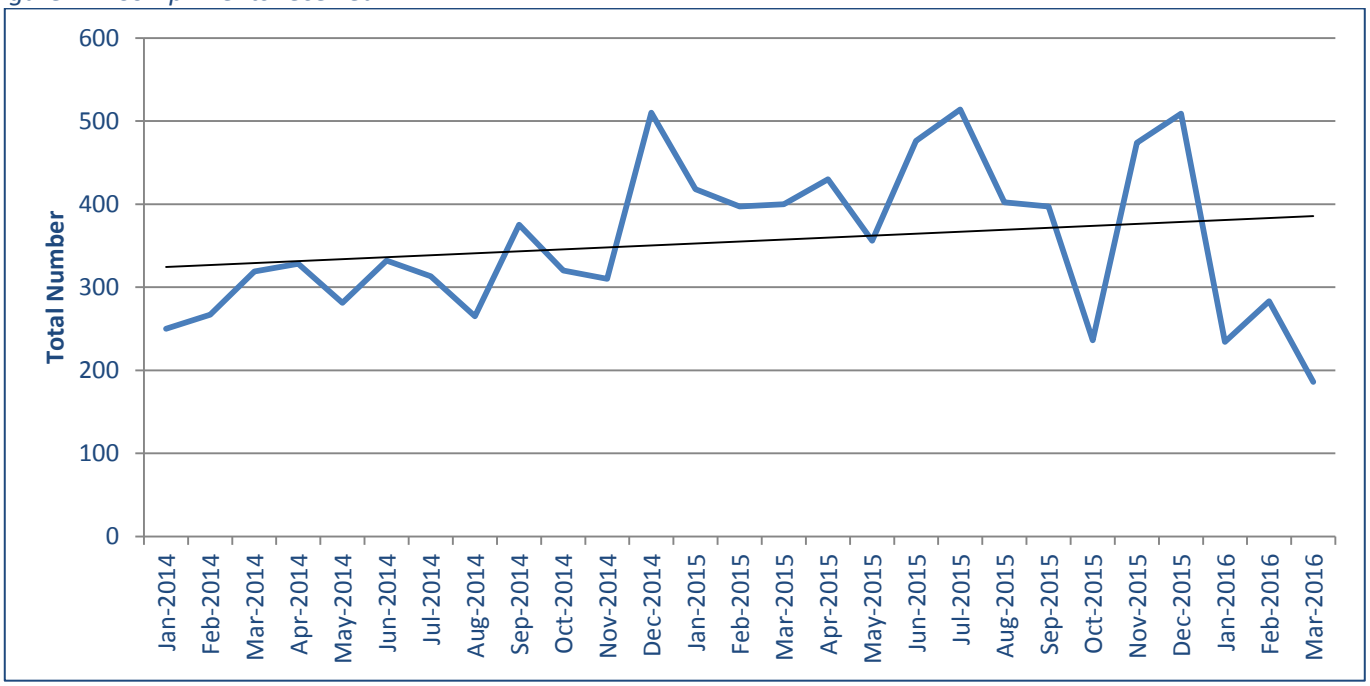
Figures 23 and 24 below detail the number of complaints and compliments received by the Trust throughout the year. As can be seen, there is a downward trend in the number of complaints received since January 2014, and an upwards trend in the number of compliments. Information on learning from complaints is recorded in Section 2 above.

Figure 23- Complaints received



Source: Trust Performance Assurance Framework

Figure 24- Compliments received



Source: Trust Compliments Reports

3.2 Monitor Authorisation

Performance in relation to metrics required by Monitor, the Foundation Trust regulator, has achieved the required targets for 2015/16. This relates to mental health 7 day follow up (98.6%), delayed transfer of care (1.7%), community referral to treatment compliance (99.5%), Care Programme Approach review within 12 months (96.1%) and new early intervention in psychosis cases (131 in 2015/16).

Figure 25	2011/12	2012/13	2013/14	2014/15	2015/16	National Average 2015/16	Highest and Lowest
The percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care during the reporting period	98%	96%	95.8%	98.2%	**98.6% *** **98.8% **** (Avg. Monthly %)	**96.9%** (Avg. Quarterly %)	**80%-100%** (For Q4 2015/16)
Key: * Data relates to all patients discharged from psychiatric inpatient care on CPA, ** Data relates to adult mental health patients only **Note:** The acceptable exclusions for these indicators are as follows: (i) patient dies within 7 days of discharge, (ii) where legal precedence has forced the removal of the patient from the country (iii) patients discharged to another inpatient psychiatric ward (iv) CAMHs patients are not included.							
Berkshire Healthcare NHS Foundation Trust considers that this percentage is as described for the following reasons: In line with national policy to reduce risk and social exclusion and improve care pathways (CQC 2008) we aim to ensure that all patients discharged from mental health in patient care are followed up (either face to face contact or by telephone) within 7 days of discharge, this is agreed and arranged with patients prior to discharge to facilitate our high level of compliance. **Berkshire Healthcare trust has taken the following actions to improve this percentage, and so the quality of services:** Berkshire Healthcare trust meets the minimum requirement set by Monitor of 95% follow up through the implementation of its Transfer and Discharge from Mental Health and learning Disability In-patient Care Policy. In addition the data is audited as part of the independent assurance process for the Quality Account and any actions identified through this are fully implemented to ensure that we maintain our percentage of compliance.							

Source: Trust Performance Assurance Framework

Figure 26	2011/12	2012/13	2013/14	2014/15	2015/16	National Average 2015/16	Highest and Lowest
The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period	100%	94%	97.6%	97.7%	**97.6%** (Avg. Monthly %)	**97.2** (Avg. Quarterly %)	**84%-100%** (For Q4 2015/16)
Berkshire Healthcare NHS Foundation Trust considers that this percentage is as described for the following reasons: Crisis resolution and home treatment (CRHT) teams were introduced in England from 2000/01 with a view to providing intensive home-based care for individuals in crisis as an alternative to hospital treatment, acting as gatekeepers within the mental healthcare pathway, and allowing for a reduction in bed use and inappropriate in-patient admissions. An admission has been gate kept by the crisis resolution team if they have assessed the patient before admission and if the crisis resolution team was involved in the decision making-process, which resulted in an admission. **Berkshire Healthcare NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of services, by**: The Trust Admissions policy and procedures provides a clear framework to ensure that no admissions are accepted unless via the urgent care service and has increased our percentage compliance							

Figure 27	2011/12	2012/13	2013/14	2014/15	2015/16	National Average 2015/16	Highest and Lowest
The percentage of MH patients aged— (i) 0 to 15; and (ii) 15 or over, readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period	9%	12%	13.3%	11.1%	**7.7%** (Average Monthly %)	**Not Available** (National Indicator was last updated in 2013)	**Not Available** (National Indicator was last updated in 2013)

Berkshire Healthcare NHS Foundation Trust considers that this percentage is as described for the following reasons:
The Trust focusses on managing patients at home wherever possible and has fewer mental health beds for the population than in most areas. Sometimes the judgement to send a patient home may be made prematurely or there may be deterioration in the patient's presentation at home due to unexpected events.
Berkshire Healthcare NHS Foundation Trust intends to take the following actions to improve this percentage, and so the quality of services, by:
Further work will be done by the relevant trust groups to work on the readmissions, to identify actions to reduce it.

Source: Trust Performance Assurance Framework

Figure 28	2011/12	2012/13	2013/14	2014/15	2015/16	National Score 2015/16 (For combined MH, LD and CH Trusts)	Highest and Lowest (For combined MH, LD and CH Trusts)
The indicator score of staff employed by, or under contract to, the trust during the reporting period	3.55	3.61	3.76	3.77	**3.83** KF1. Staff recommendation of the organisation as a place to work or receive treatment- Score out of 5)	**3.71**	**3.39-4.06**
who would recommend the trust as a provider of care to their family or friends *(Source- National Staff Survey)*	65%	64%	69%	71%	**74%** Q21d."If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	**67%**	**50%-75%**

Berkshire Healthcare NHS Foundation Trust considers that this data is as described for the following reasons:
The Trust's score is better than average and improving year on year. Possible scores range from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, their team and their trust) and 5 indicating that staff are highly engaged. Advocacy of recommendation along with staff involvement, and staff motivation are strong indicators of the level of staff engagement with in the trust.
Berkshire Healthcare NHS Foundation Trust has taken the following actions to improve this data, and so the quality of services, by:
Implementing a five year Organisational Development strategy which has at its heart the achievement of high levels of staff engagement and through that high quality care and service delivery. The specific objectives of the strategy, to be implemented in stages over five years are: To enable every member of staff to see how their job counts, to listen and involve staff in decisions that impact their areas of work, to provide support for their development, and to develop our clinical and managerial leaders. In this, Berkshire Healthcare Trust has signed up to the national Pioneer initiative – Listening into Action – aimed at engaging and empowering staff in achieving better outcomes for patient safety and care.

Figure 29	2011/12	2012/13	2013/14	2014/15	2015/16	National Average 2015/16	Highest and Lowest
Patient experience of community mental health services indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period	-	6.8	7.2	6.9	**6.8** (Score out of 10)	**About the same as similar Trusts**	**6.2-7.4**

Berkshire Healthcare NHS Foundation Trust considers that this data is as described for the following reasons: The Trusts score is in line with other similar Trusts
Berkshire Healthcare NHS Foundation Trust has taken the following actions to improve this data, and so the quality of services, by:
Being committed to improving the experience of all users of their services. Data is collected from a number of sources to show how our users feel about the service they have received. Actions are put in place through a number of initiatives to improve both an individual's experience and if required to change the service provision.

Source: National Community Mental Health Survey

Figure 30	2011/12	2012/13	2013/14	2014/ 15	2015/16 (Number)	National Average 2015/16	Highest and Lowest
The number of patient safety incidents reported *	**3995 ***	**3661 ***	**3754 ***	**3642 ***	**3513 ***	**N/A**	**N/A**
Rate of patient safety incidents reported within the trust during the reporting period per 1000 bed days *	**19.7 ***	**30.2 ***	**32.7 ***	**31.4 ***	**31.3 ***	**38.62 (Median) ****	**6.46- 83.72 (**)**
The number and percentage of such patient safety incidents that resulted in severe harm or death *	**29 (0.7%) ***	**42 (1%) ***	**33 (0.9%) ***	**49 (1.3%) ***	**56 (1.6%) ***	**1484 (number) (1.0%) ****	**0-95 ****

Sources: *= Trust Figures **= NRLS report published in April 2016 covering 1st April 2015- 30th September 2015 , relating to 56 Mental Health Organisations

Berkshire Healthcare NHS Foundation Trust considers that this data is as described for the following reasons:
The above data shows the reported incidents per 1,000 bed days with the targets set based on average reporting for the year. In the NRLS most recent report published in April 2016, the median reporting rate for the cluster nationally was 38.62 incidents per 1,000 bed days (but please note this covers the 6-month period April-September 2015, for which period the NRLS gives the BHFT rate as 52.78 incidents per 1,000 bed days). High levels of incident reporting are encouraged as learning from low level incidents is thought to reduce the likelihood of more serious incidents.
The percentage of such incidents resulting in severe harm or death is slightly higher than in previous years, but is proximal to the national rate for the cluster of 1.0% shown in the most recent NRLS report, published in April 2016.
Berkshire Healthcare NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of services, by the following:
Bolstering the internal governance and scrutiny of serious incident reports, their recommendations and action plans.
Implementation of strategies to address common findings in serious incident reports, including clinical record keeping and triangulation of patient risk information.

Figure 31 Annual Comparators	Target	2011/12	2012/13	2013/14	2014/15	2015/16	Commentary
Patient Safety							
CPA review within 12 months	95%	97.6%	97.9%	96.4%	96%	**96.1%**	For patients discharged on CPA in year last 12 months. Figure shown is Monthly average percentage
Never Events	0	1	0	0	0	**0**	Full year number of never events *Source: Trust Patient Safety Report*
Infection Control (MRSA bacteraemia)	0	1	0	0	0	**0**	Full year number MRSA
Infection Control (C.difficile due to lapses in care)	<6 per annum (reduced from <10)	15	5	5	0	**1 (0.009 per 1000 bed days)**	Full Year number & rate per 1000 bed days of C. Diff due to lapses in care
Medication errors	Increased reporting	574*	562	614	576	**623**	Cumulative total year end number of medication errors reported
Clinical Effectiveness							
Mental Health minimising delayed transfers of care	<7.5%**	3%	1.1%	2.6%	1.5%	**1.7%**	Figure shown is Monthly average percentage
Mental Health: New Early Intervention cases	99	155	154	136	124	**131**	Cumulative total number in year
A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge	95%	99.6%	99.9%	99.9%	99.5%	**99.4%**	Figure shown is Monthly average percentage
Completeness of Mental Health Minimum Data Set	1) 97% 2) 50%	1) 99.6 2) 97.9	1) 99.8 2) 98.6	1) 99.8 2) 97.8	1) 99.6 2) 99.2	**1) 99.8%** **2) 99.2%**	New Monitor target for Identifiers 97% for 2012/13, target for 2011/12 was 99%. Figure shown is Monthly average percentage
Completeness of Community service data Referral to treatment information Referral information Treatment activity information	 50% 50% 50%	-	-	 70% 67% 99%	 72.3% 62.4% 98.0%	 **72.1%** **61.8%** **96.9%**	Year-end average (new 2013/14) Figures shown are Monthly average percentages

**Delayed transfers of care (Monitor target) is Mental Health delays only (Health & Social Care), calculation = number of days delayed in month divided by OBDs (Inc. HL) in month. New calculation used from Apr-12

Source: Trust Performance Assurance Framework, except where indicated in commentary

Figure 31 Annual Comparators	Target	2011/12	2012/13	2013/14	2014/15	2015/16	Commentary
Patient Experience							
Referral to treatment waiting times – non admitted –community. (May 2013 - Updated figure to include Slough Walk in Health Centre)	95% <18 weeks	99.9%	99.9%	98.1%	99.8%	**99.5%**	Waits here are for consultant led services in East CHS, Diabetes, and Paediatric services from referral to treatment (stop clock). Notification has been received from NHS England to exclude Sexual Health services from RTT returns Figure shown is Monthly average percentage
RTT (Referral to treatment) waiting times - Community: Incomplete pathways	92% <18 weeks	-	-	99%	100%	**99.7%**	Year-end average (new 2013/14)
Access to healthcare for people with a learning disability	Score out of 24	22	22	Green 22	Green 21	**Green 20**	
Complaints received		232	250	193	244	**218**	Total number in year
Complaints	100% Acknowledged within 3 working days	100%	91.3%	93.3%	100%	**96.3%**	Full year %
	90% Complaints resolved within agreed timescale of complainant			64% (82%)	92 %	**91.4%**	2014/15 note change to indicator previously 80% Responded within 25 working days (% within an agreed time)

Source: Trust Performance Assurance Framework, except where indicated in commentary

3.3 Statement of directors' responsibilities in respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.
Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:
The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2015/16 and supporting guidance; The content of the Quality Report is not inconsistent with internal and external sources of information including:

1. Board minutes and papers for the period April 2015 to May 2016
2. Papers relating to Quality reported to the Board over the period April 2015 to May 2016
3. Feedback from the commissioners dated April 2016
4. Feedback from governors dated April 2016
5. Feedback from Local Health watch organisations dated April 2016
6. Feedback from Overview and Scrutiny Committees dated April 2016
7. The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2016
8. The national patient survey dated October 2015
9. The national staff survey dated February 2016
10. The Head of Internal Audit's annual opinion over the trust's control environment dated May 2016
11. CQC Intelligent Monitoring Report April 2016

The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered; the performance information reported in the Quality Report is reliable and accurate; there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice; the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

10th May 2016  **John Hedger Chairman**

10th May 2016  **Julian Emms Chief Executive**

Appendix A: Quality Strategy

Appendix B- National Clinical Audits- Actions to Improve Quality

National Clinical Audits Reported in 2015/16 and results received that were applicable to Berkshire Healthcare NHS Foundation Trust

National Audits Reported in 2015/16	Recommendation (taken from national report)	Actions to be Taken
NCAPOP Audits		
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2736)	Approximately 5,800 people die by suicide in the UK each year. Of these 1,638 (28%) are in contact with mental health services in the 12 months prior to death. 153 (9%) of the 1,638 mental health patients die by suicide on in-patient wards. There were on average 18 suicides by in-patients under observation per year in the UK over a 7 year study period. Ninety-one per cent of deaths under observation occurred under level 2 (intermittent) observation. Compared to in-patient suicides generally, patient suicides under observation were associated with personality disorder, alcohol and drug misuse, detention under mental health legislation and death in the first 7 days following admission. A third of suicides under observation occurred off the ward. The commonest location for a death by suicide on the ward was the patient's bedroom and the most frequently used method was hanging.	The report has been circulated for information to PSQ meetings. This work is also feeding into the Trust processes on safe staffing.
National Confidential Inquiry into Suicide & Homicide for people with Mental Illness (2780)	As part of its core work the Inquiry examines suicide, and homicide committed by people who had been in contact with secondary and specialist mental health services in the previous 12 months. It also examines the deaths of psychiatric inpatients which were sudden and unexplained. Previous findings of the Inquiry have informed national mental health strategies, and continue to provide definitive figures for suicide and homicide related to mental health services in the UK. The report sets out national information on suicide, and this summary is supported by local information. The current suicide rate (2011-13) in the UK is 10.1 per 100,000; for Thames Valley 9.0 and for Berkshire localities between 7.0 (WAM) and 9.0 (W Berks). Suicides in contact with mental health services have increased nationally, reaching a 10 year high, but even more so in Berkshire. Changing risk patterns across England for suicide, which are likely to be present in Berkshire also, particularly relate to middle aged males, CRHTT services, the importance of family involvement and attention to the physical health needs of mental health patients.	A full Summary Report was shared via QAC. This is in turn reported to the board where full discussions took place. Further work is being undertaken to raise the profile of this with community mental health teams and the crisis response and home treatment team.

National Audits Reported in 2015/16	Recommendation (taken from national report)	Actions to be Taken
Non-NCAPOP audits		
POMH13b - Prescribing for ADHD in children, adolescents and adults	The report focuses on the re-audit from QIP 13: Prescribing for ADHD in children, adolescents and adults. Practice standards are derived from NICE Clinical Guidance 72, updated March 2013. Although there have been marked improvements in the recording of heart rate, blood pressure, weight and height on centile and growth charts, this remains an area for improvement, particularly for longer-term monitoring. Classification of severity was not documented in over half of cases in all three clinical sub-samples. The prescribing of antipsychotics is relatively common in adults with ADHD, the majority of which is not for a co-morbid mental illness. Antidepressants were also relatively commonly prescribed for adults with ADHD but there is little difference in the prevalence of such prescribing in those who were prescribed ADHD medication and those who were not. ECGs were almost always conducted in the context of a broader cardiovascular risk assessment. However, in nearly a quarter of the total sample, neither a cardiovascular risk assessment nor an ECG was conducted before ADHD medication was initiated.	Results have been widely shared and discussed. Discussions over the most effective way to conduct health screening have occurred in CAMHS and adult services. Templates for ADHD assessment have been shared. RiO e-charts have also been shared with teams to facilitate improved recording.
National audit of Intermediate Care (2015)	The NAIC focuses on services which support, usually frail, elderly people, at times of transition when stepping down from hospital or preventing them being admitted to secondary or long term care. These services are a crucial part of the solution to managing increasing demand in the health and social care system. The outcome measure scores for NAIC 2015 show that the vast majority of service users had a positive functional outcome from their episode of intermediate care. There is no evidence in NAIC 2015 of a material increase in capacity nationally. The results suggest static capacity in health based intermediate care and reducing capacity in re-ablement. New questions on care planning suggest higher levels of compliance in bed based services with care plan documentation and review, than in home based and re-ablement services.	This report is being discussed at local ward and hospital development meetings as part of local planning. Locality based audit if required will be undertaken.
Second English National Memory Clinic Audit	Services National Accreditation Programme has been instrumental in raising standards across the country. There is variation across the country in service provision, in particular waiting times. This re-audit aimed to review waiting times, timely diagnosis, service provision, service user and carer involvement, and research. The national picture is as follows: - Capacity: no. of patients seen increased by 31% - Funding: 2/3 of clinics had same or increased budget. 1/3 had decrease. - Waiting times increased across all areas. - PSI: 2/3 clinics provided CST and life story work.	These were discussed at the Older Adult Clinical Effectiveness meeting in February, and follow up discussion regarding any need for action planning will be had in due course.

National Audits Reported in 2015/16	Recommendation (taken from national report)	Actions to be Taken
Other audits reported on in-year (data collected in previous year(s)		
POMH - Topic 12: Prescribing for people with personality disorder (June 2014) (1340)	This re-audit aimed to present data on prescribing practice for people with a personality disorder in acute psychiatric inpatient settings, and compare this with 2012 results. The Trust showed good practice for the prescribing of Z-Hypnotics with 0% cases of the medication being prescribed for more the 4 weeks. The Trust had a high compliance rate of 100% for evidence of documented medication review. Therapeutic response and a patient's view of treatment were considered at review more often than side effect and adherence to treatment. Areas for improvement centred upon documentation for reasons for prescribing the antipsychotic medicine, crisis plans, and patient's involvement in their crisis plan. NICE guidelines state all medication is to be documented and the reasons stated if medication is continued for more than 4 weeks, the Trust identified 22% cases where the duration had not been documented. This finding was also reflected in those patients who had been prescribed Benzodiazepines	For in-patients, WRAP will address the standard that there is a written crisis plan and there is evidence that the patient's views have been sought in its development. The prescribing of medication if longer than 4 weeks and how it is to be documented and recorded will be promoted via presentation at Academic Meetings and Medical Staffing Committee. Pharmacy is to monitor prescription of Z-Hypnotics and ensure stopped after 7 days on TTA.
POMH - Topic 9c: Antipsychotic prescribing for people with a learning disability (2629)	This audit was a supplementary audit for a quality improvement programme, addressing the use of antipsychotic medication in people with a learning disability. BHFT provided data from 4 participating teams, which involved reviewing 56 patient records. The audit was measured against 3 standards:- 1: The indication for antipsychotic medication should be documented in the clinical records. 2: The continuing need for antipsychotic medication should be reviewed at least once a year. 3: Side effects of antipsychotic medication should be reviewed at least once a year. BHFT was found to have excellent compliance, and in some cases the Trust was above the national average. However, Trust compliance has decreased from the previous audit in documenting evidence of assessment of EPS and blood pressure.	A lot of work is currently being done in the Trust to improve physical health monitoring and intervention, involving training of staff and purchasing equipment. There is a potential to that this could be rolled out to the LD service. The audit results have been presented to the LD governance group and a follow up meeting has been arranged with the relevant staff to formulate actions to increase compliance in monitoring EPS and blood pressure.

Appendix C- Local Clinical Audits- Actions to Improve Quality

	Audit Title	Conclusion/Actions
1	Audit on the completion of multi- disciplinary team meeting forms used in the Crisis Response and Home Treatment Team (1962)	The multidisciplinary team meetings are held weekly in the Crisis Team and Home Treatment Team. MDT meetings are a key part of care planning, if these do not happen effectively, then the patient may come to harm. This project was undertaken after a SIRI investigation following the death of a patient. As an outcome of this investigation it was found that that the MDT meetings were not recorded and hence, an audit was conducted across the six sectors (localities) of the Trust to identify the current practice of completing these forms. The audit identified that MDT forms were not completed in full and localities across BHFT were not following the same process in documenting the MDT meetings. It was further identified that medical records contained notes deemed as unnecessary and no benefit to patient care. A lack of accurate and timely clinical documentation for a patient under the care of a Crisis Resolution Home Treatment Team exposes both the patient and BHFT to unnecessary risk. Actions: The Trust's CHRTT MDT form is to be redesigned. Existing and new staff are to be updates on risks surrounding poor quality documentation. Progress is to be monitored with a re-audit to be undertaken in February 2015.
2	MH CQUIN(prt1) National Audit (2094)	The national CQUIN included a new national indicator on improving physical healthcare to reduce premature mortality in people with severe mental illness. Basic data analysis on the six screening measures and interventions shows a wide variability in which screening and intervention measures patients received. There was no consistency, and a low overall percentage score reflects this. For example all patients were screened for their smoking status but 14% did not have an intervention documented (for those recorded as smoking). Action: A significant action plan was implemented, which linked with many actions from the NAS audit, which will lead to significant improvements in this area.
3	Audit of anti-infective prescribing on BHFT inpatient wards (Antibiotics) (2015) (2648)	This audit was a re-audit and part of the Quality Schedule for 2014/15. The last Trust wide antimicrobial audit was performed across all inpatient settings in November 2013 as part of the annual audit programme. It highlighted which audit standards of good antimicrobial prescribing and stewardship required significant improvements. The re-audit looked at whether relevant cultures were being taken, if drug charts recorded drug allergies, the route of administration, the dose and frequency of the drug, the stated course length and the indication and if treatment prescribed was in line with Trust guidelines. The re-audit confirmed that some improvements had been made since the previous audit. Action: The report findings are to be disseminated to the next IPCSG and DTG, and an action plan is to be developed.
4	Audit of clinical practice standards in the Psychological Service for People with Learning Disabilities 2014. (2060)	This audit looked at the Psychology Service performance against its record keeping standards. Good record keeping and attainment with standards of clinical practice is important to maintain, to ensure safe and effective provision of services. The results were compared to the previous audit. The Trust failed to achieve 100% in 4/5 standards with a decrease in performance in the standard to maintain a continuous record of risk issues and actions in RiO progress notes. Action: Findings and recommendations were discussed by the by the team and an action plan has been put into place. Those areas deemed necessary to re-audit will be carried out in 2016.
5	JD/QIP Re-audit-bone density scans for female eating disorder patients referred to BAU Eating Disorder Service (2064)	Amenorrhea for over 6 months is correlated with an increased risk of osteopenia and osteoporosis which must be monitored and recorded, so appropriate treatment can be started. The objective of this re-audit was to reassess how closely the BAU eating disorder service was adhering to the NICE guidelines and whether there had been any improvement since the recommendations put forward in the last audit. For 4/7 standards the Trust achieved 100% compliance. Action: The Trust will continue to review compliance with standards via re-audit once measures have been implemented.

	Audit Title	Conclusion/Actions
6	Clinical characteristics of adolescents referred for anxiety (1630)	Adolescents with anxiety are under-researched and little is known about their clinical characteristics compared to children/adults. The finding that children and adolescents with anxiety disorders have distinct clinical characteristics has clear implications for treatment. The risk is that if best practice/latest evidence is not followed, we may persevere with treatment that is not as effective as it could be. The Trust has been carrying out diagnostic assessments since July 2012 on referred adolescents. The findings were published in a peer-reviewed journal. Action: The Report has been published in the Journal of Affective Disorders 167 (2014) 326-332.
7	JD/QIP - Audit of quality and timeliness of full discharge summaries for patients on adult wards (1924)	The objective of the audit was to evaluate the quality of discharge summaries according to a set of criteria informed by published audits on similar topics, as well as research into GP preferences concerning discharge summary information content. It was highlighted that different wards were using different templates for discharge summaries and discharge summaries were not being uploaded to RiO in a timely manner. There is potential risk as the period following discharge is a time of high risk for patients, with increased rates of suicide reported, with disruption of continuity of care associated with dramatically increased risk. Action: Audit results have been presented and will be circulated to medical staff and ward managers.
8	Audit of assessment letters sent to GP's by Clinical and Counselling Psychologists in Community OPMH Services (2724)	This audit supports other BHFT initiatives aimed at improving documentation as well as providing evidence to be shared with commissioning organisations who have previously wanted to ensure good communication between services and GPs. This audit addresses this through an audit of assessment letters to GPs written by clinical and counselling psychologists in BHFT Older Peoples Mental Health Services in each of the Trusts localities. The Trust was fully compliant across the four service standards. Action: No further action required.
9	Physical health monitoring post rapid tranquilisation (2244)	Rapid tranquillisation (RT) is when medicines are given to a person who is very agitated or displaying aggressive behaviour to help quickly calm them. The risk with RT is that it may cause loss of consciousness, loss of airway, respiratory and cardiovascular collapse. BHFT has a protocol in place which specifies the necessary physical health monitoring that should take place post RT. The aim of the audit was to document compliance to BHFT RT protocol. For each of the seven standards, the Trust was not 100% compliant. It was identified that there is a substantial shortfall between the standards set in the audit and the practice within the Trust. Action: To be raised in the DTC, to consider whether the physical health monitoring post RT needs to be added to the Trust "risk register." To raise awareness of the findings of this audit and to ensure guidance on RT is up to date and reflect practice as per the updated NICE guidelines.
10	Audit of Records on RiO for Patients Conditionally Discharged under S.37/41 of the MHA (2728)	Following an enquiry in 2014 by the Ministry of Justice to Berkshire Healthcare NHS Foundation Trust it became clear that, although Local Authorities are responsible for the provision of Social Supervision of patients conditionally discharged under Sections 37 and 41 of the Mental Health Act, BHFT is seen by the Ministry of Justice as the lead agency in Berkshire for such supervision. The audit was to ensure that effective governance arrangements for this group of patients are in place. If patient's records do not actively reflect the information around risk and other areas effectively, then patients may be at risk. The initial audit found evidence of good practice and high compliance rates in the management of conditionally discharge patients. However, the re-audit showed deterioration in the timeliness, completeness and quality of the clinical records. Action: An action plan has been agreed to improve case management processes, with a review to be undertaken six monthly.
11	Retrospective Audit on Neuro-imaging in Charles Ward inpatients (1576)	The audit aimed to measure the current practice of assessment and management of people with suspected dementia against the NICE Clinical Guidelines 42 in an Old Age Psychiatry inpatient setting. Guidelines advocate the use of radiology in combination with history to aid diagnosis and management of patients with dementia. The audit highlighted the fact that patients with possible dementia /cognitive impairment may remain undiagnosed or not accurately diagnosed if they do not have a full examination that includes a brain scan. Action: Relevant recommendations have been made and all actions completed.

	Audit Title	Conclusion/Actions
12	Audit of Urinary Catheter Care Bundle - Community Services (March 2015) (2842)	The aim of this clinical audit was to assess compliance of documentation with the standards set out in the Trust policy through review of documentation on the catheter care bundle. The audit included all patients with a catheter who received care from BHFT healthcare workers in the community setting. The audit found 5 criteria where 100% compliance was achieved; there were 6 areas where compliance had improved since the initial audit and 4 criteria where compliance was lower in comparison to the 2013/14 audit. Action: An agreed action plan to improve documentation and understanding of the care bundle.
13	School Nursing RK Assessment Audit (2588)	Good record keeping is an integral part of clinical practice and is essential to the provision of safe and effective care. This audit has been undertaken as part of BHFT School Nursing Sub Group following the implementation of new assessment templates across all six localities. The aim of the audit was to assist with the quality assurance and development of the School Nursing assessment process and recording. The audit identified training needs across staff with regards to fully completing assessments and updating all required fields on RiO and general record keeping training. Action: Staff training has been agreed in the relevant areas, the assessment form has been modified to ensure all data is captured. There is to be continuous evaluation of the School Nurse assessments.
14	An evaluation of psychiatric admissions from the RBH (2722)	The aim of the audit was to evaluate whether the increase in funding for Psychological Medicine could produce savings by decreasing the number of unhelpful admissions to Prospect Park Hospital. The audit confirmed that Psychological Medicine continues to be an important factor in decreasing unhelpful or damaging admissions from RBH to Prospect Park and thus ensuring appropriate care is given to 'high risk' patients only and potentially impacting on saving of costs.
15	JD-QIP - Psychiatric In-patient Patient Physical Health Assessment Audit (1791)	There is increased morbidity and mortality among patients suffering from mental illness. Physical healthcare is a key issue to be reviewed amongst this patient population. The Royal College of Psychiatrists recommends that all patients admitted to a psychiatric hospital should receive a full physical examination on admission, or within twenty-four hours of admission. A snapshot audit was carried out at Prospect Park Hospital in Reading, which highlighted that The Royal College of Psychiatrist's recommendation, along with Trust guidelines regarding physical examination were not being met, with only 78 out of 111 patients (70.3%) undergoing an examination during their admission. A psychiatric inpatient physical health assessment sheet (PIPHAS) was designed and introduced, providing a quick and standardised approach to the documentation of a physical examination. Following introduction of the PIPHAS form there was an increase in the number of patients undergoing physical examination on admission to hospital (75 out of 100 patients, 75% - an increase from 70%). Action: The project highlighted the requirement to implement the PIPHAS form, and its impact then evaluated.
16	JD/QIP Service evaluation of Memory clinic's telephone activities in WAM (2052)	The purpose of this service evaluation was to check if the memory clinic's service demand is beyond the memory service's remit. The main reasons for telephone contacts were clarified and action required following those calls was noted. This was to help identify the most common problems arising between appointments and the resources required. It was highlighted that follow up actions and the length of telephone calls place an impact on the work load of memory services which is likely to increase over time. Action: Action is to be agreed.

	Audit Title	Conclusion/Actions
17	JD/QIP Provision of information (written and verbal) to patients at PPH when commenced on drug treatment (2101)	The Royal College of Psychiatrists stipulates in their guidance that patients should be provided written and verbal information on the treatment they are receiving. The purpose of the audit was to explore medical records over a wider range of time to see if when changes to medication are being made that this is accompanied by provision of information both in verbal and written forms. The main finding was that when new psychotropic medication was prescribed it was not documented whether the patient had received any written information although in some cases verbal information was provided. Those patients that lacked capacity were not provided with any information about the drug. There is a risk to patients who are not provided with information, that they be less likely to be compliant with their medication. Action: Action is to be agreed.
18	Can known use of data logging increase hearing aid use (1833)	It is presented in literature that patient knowledge of data logging improves accuracy of self-reported Hearing Aid use. The aims of this study were to investigate whether patient knowledge of data logging increases daily amount of Hearing Aid use, and leads to more accurate estimates of self-reported Hearing Aid use. The study concluded that patient knowledge of data logging does not influence Hearing Aid use; and new Hearing Aid users are relatively accurate with their estimates of self-reported Hearing Aid use; irrespective of whether they are aware or unaware of data logging verification. Action: The audit report has been shared to CEG.
19	Annual Service Activity Report for The Psychological Service for People with Learning Disabilities (2013-2014) (2059)	The Psychological Service for People with Learning Disabilities in Berkshire completed a report of its activities annually since 2008. The aim of this report was to summarise the activities of the Service for People with Learning Disabilities (the Service) over the course of the period starting on 1 April 2013 and finishing on 31 March 2014. This identified projects undertaken, referral patterns and client related activities and Service evaluation (i.e. HoNOS-LD, PES). It is noted that no risks were identified to the Trust from this report, by the authors Action: A number of agreed recommendations to manage the referral process more effectively have been put in place.
20	LD Services; Re-Audit: People who Present Severe Challenging Behaviour: Positive Behaviour Support ICP -April 2015 (2188)	The aim of this re-audit was to demonstrate that good practice recommendations are used with people whose behaviour challenges. The audit included the process of assessment and intervention. Overall, the audit demonstrated areas of excellent practice with findings in the 90 - 100% compliance range. However, the audit highlighted that there are still areas where achieving consistent practice has proved difficult. Action: These areas will be followed up within the Clinical Audit Action Plan 2015/16.
21	MSNAP Audit of communication,& assessment of consent and capacity of patients attending Wokingham Memory Clinic (2696)	Wokingham Memory Clinic achieved an excellent rating by the Memory Services national accreditation Programme (MSNAP). This audit was to monitor that the service is maintaining excellent standards in terms of verbal and written communication and assessment of capacity and consent. Only new patients were assessed. 100% compliance in all of the standards was met. Action: No further action is required.
22	Quality schedule audit of referrals to Memory Clinic and compliance with NICE and MSNAP standards (2697)	The Prime Minister's Challenge on Dementia issued in 2012 set out an ambitious programme of improvements to be made to dementia care over a three-year period, including improved diagnosis rates. The aim of the audit was to look at the percentage referred with mild and moderate dementia and MCI as a reflection of timely diagnosis. All of the standards were met in the audit. Action: Findings of the audit report were to be disseminated to the OPMHS Clinical effectiveness Group.

	Audit Title	Conclusion/Actions
23	JD/QIP - Rapid Tranquilisation in older adults - re-audit (March 2015) (2691)	The use of rapid tranquilisation in older adults at Prospect Park was audited in 2013. Our compliance with the standards set out by the Trust were reviewed, and we only reached 100% compliance in 3 out of 11 of the standards. This is a re- audit, to identify whether there have been any changed to our practice since instating the following action plan one year later. The audit identified slight improvement in the results of the re-audit in comparison with the previous audit, despite an action plan having been implemented that involved numerous clinical staff. Action: An action plan has been put in place with the setting up of a steering group in order to develop actions to bring about improvements.
24	JD/QIP - Referrals and outcome audit (April 2013) (1438)	NHS England became responsible for commissioning CAMHS inpatient beds nationally from April 2013. Prior to April 2013 this was done on a population basis (Primary Care Trust/ Specialised Commissioning Group). The Berkshire Adolescent Unit was not included in the national bed stock. The audit sought to identify the number of patients referred to all services at BAU, what services were offered and to identify whether the implementation of the NHS England inpatient network would have any short term impact on the Trusts referral pattern. The audit found a percentage of missed appointments and unnecessary appointments being made. In addition, the need to educate staff about pathways was highlighted. It was suggested that pathways may need amending to ensure that non-applicable patients are prevented from continuing to receive appointment and that the existing pathway is appropriate. Action: An action plan has been agreed to improve appropriateness of referrals, and DNAs, and a re-audit is scheduled once all actions have been implemented.
25	An audit of model fidelity in Crisis Resolution Teams (1559)	This fidelity measure was developed from research evidence, government and expert guidelines, a survey of CRTs in England and interviews with all key CRT stakeholder groups. The risk of non-compliance may mean services are not cost effective. BHFT's overall score was 101, with the maximum score possible being 195. Actions: A number of agreed action plans –around staffing and assessment - for CRT have been developed.
26	Quality Schedule Audit into failed patient self-taken tests on the East Berkshire Chlamydia Screening programme (2227)	The CSP is responsible for developing effective self-taken test kits for Chlamydia & Gonorrhoea aimed at the under 25 population of East Berkshire. The audit identified that the instructions on the test kits need to be clearer, the need to review the method of testing requests via primary care and other clinical areas and to review clinical and non-clinical training standards to make sure IR is included. Action: The highlighted findings have resulted in a number of agreed actions. These include pictorial representation, and electronic ordering systems.
27	Evaluation of 'One chance to get it right' (scoping of end of life care). (2289)	The philosophy underlying "one chance to get it right" (OCTGIR) is that providing end of life care is everyone's business. Structured around 5 priorities all focussing on supporting the dying person and their families and carers, the five priorities of care are– dying recognised, excellent communication, with involvement and support of patients and families, and that patients have an individual and holistic plan of care. Following the audit of 34 Recommendations from One Chance To Get It Right (OCTGIR) an action plan was developed highlighting the main areas of development. The BHFT EOLC group will continue to develop a BHFT EOLC policy and BHFT Individualised EOLC plan. A review of training needs and EOLC training that is available needs to be undertaken. Action: Action is to be confirmed.

	Audit Title	Conclusion/Actions
28	JD/QIP - Audit of driving safety advice given to patients at Prospect Park Hospital (2450)	National Driver and Vehicle Licensing Agency (DVLA) guidelines recommend that patients fulfilling certain criteria are legally obligated to report themselves if they believe they are unfit to drive. Driving when medically unfit is against the law and continuing to drive may pose a significant risk of danger to self and to others. It is good practice that staff are meant to advise patients on their driving fitness, and are encouraged to report patients if they continue to drive when they should not be. This should then be documented in notes for accurate record keeping. The purpose of the audit was to assess staff awareness of DVLA guidelines and to review documentation for evidence of driving advice given to patients. The audit found that 100% of staff surveyed did not give advice to patients within the last six months. Action: An agreed action plan is to be confirmed.
29	Infection Control: Hand Hygiene Facilities (2784)	Following a gap analysis of NICE Quality Standard 61- Infection Prevention & Control the need for a review of hand hygiene facilities through an audit was identified. A total of 1841 hand wash bins were assessed and were fully complaint against the audit tool. The main area of non-compliance associated with cleanliness of the hand wash areas. Action: Agreed action is to be confirmed.
30	Monitoring allocation of complex & routine ADHD cases in ADHD pathway in CAMHS since NGC (Aug 2013) (1553)	The aim of the project was to study workload allocation on ADHD pathway and to establish if guidelines for ADHD pathway, NGC (next generation care) are followed. The project findings led to the below advisory recommendation. Action: Clinicians in ADHD pathway are to check their cases and allocate to appropriate clinicians in the ADHD pathway. If needed, they will discuss this with their supervisors.
31	Resident Experience Audit (Papist Way) (August 2013) (1556)	The decision has been made to close this project despite not receiving an update on whether actions were achieved due to this now being old data, the audit lead having left the Trust, and Papist Way since having been outsourced. (Old project following update)
32	Re-audit of compliance with Trust guidelines on monitoring patients receiving Antipsychotics (1573)	The was a re-audit and the aim was to optimise the physical health of inpatients prescribed on-going antipsychotics; and to ensure that relevant investigations are offered to inpatients receiving on-going treatment with antipsychotics. The Trust was fully compliant with all the audit standards.
33	Audit to Ensure the Quality of Preliminary Discharge Letters from MH Inpatients to GPs (1575)	This audit aimed to assess the effectiveness of the use of electronic preliminary discharge letter, to improve communication and reduce errors when discharging patients for psychiatric inpatient units to the community. The audit found that despite implementation of a new form to resolve issues of poor communication and errors, the form was not being fully completed, thereby continuing to lead to potential risks on discharge due to lack of information regarding safeguarding, named care coordinator and psychiatrist, and long term and depot medication details. Action: Action is to be agreed.
34	Re-Audit: People who Present Severe Challenging Behaviour. Formulation Planning Process (April 2014) (1715)	This is the fourth cycle of this audit and its aim was to demonstrate that good practice recommendations were used in the assessment and intervention for people who present challenges to services. The audit resulted in the Winterbourne Interim Report which advocates as best practice the use of Positive Behaviour Support. Recommendations from the report were presented to the Learning Disability governance meeting and a completion of an audit action plan. Action: The action plan included implementation of the outcome measures in the team, and improvement to DOLs processes. The audit was repeated in April 2015.

	Audit Title	Conclusion/Actions
35	JD/QIP - Audit of quality and timeliness of full discharge summaries for patients on adult wards (1924)	The objective of this audit was to evaluate the quality of discharge summaries according to a set of criteria informed by published audits on similar topics, as well as research into GP preferences concerning discharge summary information content. There were some areas of significant improvement compared with the previous audit. The audit found that different wards were using different templates for discharge summaries. Action: An action plan is in place, which includes sharing of findings, and work on the discharge summary template.
36	Blood transfusion bed side audit (2506)	The aim of the audit was to ensure that BHFT's blood transfusion practice is in line with the required National Standards. The initial audit was carried out in October 2012 and January 2013. Re-audits were undertaken during November and December 2013, January 2014 and March 2014. The 2014-15 audit was carried out in February and March 2015. The Trust was fully compliant with twenty-two of the twenty-eight standards the service was measured against. Action: A number of agreed actions have been discussed and implemented, around the transfusion care pathway.
37	JD/QIP - Audit of Clinic Letter to Patients/Relatives in the Slough Joint Memory Clinic (2685)	It is important for patients or their carers to be well aware of what has been discussed in clinics and what the plans are and has been a standard that all patients should have access to the letters sent to the GPs. The aim of this audit was to assess the current standard of writing clinical letters to patients or carers in the Slough Joint Memory Clinic and whether it met the local Berkshire Healthcare Trust Guidelines and national guidelines. The Trust was fully compliant. Action: No action is required.
38	Delirium NICE Quality Improvement Project (2726)	Delirium, also known as 'acute confusional state', is a common clinical syndrome characterised by disturbed consciousness, cognitive function or perception which has an acute onset and fluctuating course. Its prevalence tends to rise with increasing age. It is a serious condition that may be associated with poor outcomes if not effectively identified and managed. BHFT hosts a number of wards that manage patients that are at risk of or have been diagnosed with delirium. The aim of the project is to improve the outcome and experience of patients at risk of or diagnosed with delirium by ensuring that best practice is followed in line with NICE Quality Standard 63- Delirium (July 2014). 100% compliance was achieved for prescribing appropriate medication for patients with delirium and the diagnosis of delirium was communicated to their GP on discharge. Areas for improvement were based upon assessment of delirium on admission, assessment of all clinical factors within 24hs of admission and ensuring that tailored interventions were given to patients to prevent delirium. Recommendations to address the findings have been made and include the delivery of delirium awareness training for all relevant inpatient wards/ units and the development of a patient information leaflet that can be given to all patients diagnosed with delirium, as well as their family members. These recommendations have been written into an action plan attached to the main report.
39	Evaluation of Falls Risk Assessment Tool at Oakwood (2870)	Oakwood has a high instance of patient falls in comparison to other wards within BHFT. The ward has felt this links directly with the environment and there has been continual work on reviewing instances and evaluating what measures can be put in place to reduce falls. This is also now reflected trust wide on the quality schedule where there is an expected reduction required in number of falls across community hospitals as a whole. The consequences of falls are high for patients and staff and therefore it is a priority to continue to look at ways to reduce further instances. A wristband trial as a falls prevention tool was put forward as an opportunity to reduce incidence of falls on Oakwood inpatient ward. However, this did not provide any additional benefits for patient or staff – therefore this will not be continued. The review found that there was poor compliance with the falls prevention care plan. The main areas are lying/standing, blood pressure (BP) and urinalysis not being completed. Action: An agreed action plan has been put in place.

	Audit Title	Conclusion/Actions
40	High Dose Antipsychotic Audit 2015 (2661)	In 2010, Berkshire Healthcare NHS Foundation Trust (BHFT) introduced high dose antipsychotic guidelines and a monitoring form, following less favourable local results in a national POMH-UK re-audit on the prescribing of high dose antipsychotics. Soon after introducing the guidance, the Trust POMH-UK high dose antipsychotic audit results showed marked improvements and BHFT were considered a high performing organisation. This audit looked at the rate of compliance to the high dose antipsychotic monitoring guidelines in BHFT by reviewing all inpatients at Prospect Park Hospital. Data was collected in February 2015. The findings from the audit highlighted that there is significant room for improvement across all the set standards. Areas of concern included, poor documentation, lack of documentation surrounding the prescribing of high dose antipsychotics for a patient and what monitoring is required and lack of appropriate monitoring (and documentation of monitoring) i.e. whether the nurses are made aware of the patient being prescribed high dose antipsychotics and what monitoring they are required to undertake. Better communication (verbal and written) is needed to ensure that nursing staff are aware when increased monitoring is necessary for particular patients. Action: Non-compliance needs to be swiftly addressed as significant levels of risk exist for patients prescribed these medications if not properly monitored. As a result of the audit a number of agreed action plans have been put into place to increase compliance in this area.
41	Audit of Cardio-metabolic Risk Screening for Patients on Anti-psychotics in the Slough Pathways Outreach Team (2871)	The aim of the audit was to ensure cardio-metabolic risk parameters are being monitored at least annually and interventions provided if positive risks are identified for patients with psychosis on antipsychotic drugs in an assertive outreach team. The National audit of Schizophrenia 2014 (NAS2) was used as a comparison tool. The results show that apart from smoking and blood pressure, a higher percentage of patients in SPOT were screened for BMI (body mass index), glucose and lipids than the NAS2. Similarly, apart from BMI, interventions were offered to a higher percentage of SPOT patients compared to the NAS2 sample for smokers, abnormal glucose, lipids and blood pressure with a 100% standard being met for glucose and blood pressure. The audit found that barriers to screening and conducting the audit cantered upon problems accessing the data easily, lack of an integrated form in RiO to document information and problems accessing information via primary care. It was highlighted that in terms of training of staff it is ensured any change in guidance for diabetes, cardiovascular health and lipid modification is updated and communicated. It was found that it would be helpful if a systemised approach within the team to provide the necessary screening at the right time. Organisational change is essential to facilitate improvements in monitoring by reviewing RiO documents, training and working towards shared care protocols for physical health monitoring of patients with psychosis between primary and secondary care. Action: As a result a number of agreed action plans have been discussed implemented.
42	Audit of Crisis Resolution Home Treatment Team for Unlicensed Use of Antipsychotics (2144)	The Crisis Resolution and Home Treatment Teams (CRHTTs) often manage complex patients in the community who require intensive pharmacological treatment and often have changing and complex psychotropic medication needs. The audit followed the auditable process of ensuring that upon referral to the CRHTT, patients' GP Summaries or Summary of Care Records (SCRs) are obtained and uploaded to the patients notes in a timely manner to assist with the safe and effective treatment of the patient; medicines reconciliation on admission to mental health acute wards is a routine part of care co-ordination and admission to CRHTT and other mental healthcare teams; all prescribing should be recorded appropriately. The audit found some areas for improvement with regards to GP summaries or SCRs not being available, no documented evidence of health checks and monitoring requests and issues regarding patient safety and the extent of the patient notes for clarity and communication to other healthcare professionals. Action: An action plan is in the process of development.

	Audit Title	Conclusion/Actions
43	Audit of Intravenous therapy practice in community hospital wards with BHFT (2078)	This audit was carried out to look at clinical practice relating to IV therapy delivered within the community hospitals. As well as providing assurance of the compliance to external and internal standards of the IV therapy that is being delivered. The data collection was for 3 months beginning of November 2014 until the end of January 2015. The audit results showed that work is required in most areas to ensure 100% compliance with all standards is achieved. Areas identified were to establish why some wards were not giving IV therapy, to Improve prescribing of all aspects of the treatment plan and improve correct usage of VIP score. Action: A re-audit of the IV practice is to be arranged.
44	JD/QIP - Assessment and Management of Pain in patients with Dementia on a psychiatric inpatient ward at Prospect Park Hospital (2727)	The aim of the audit was to improve care that patients with dementia receive when they are admitted to a psychiatric ward, by ensuring their pain is effectively managed. The audit measured: 1. Percentage of patient days where there has been a documented pain assessment from patient's notes, drug cards and observation charts over a time course of the previous 2 weeks. 2. Percentage of drug charts that have appropriate step up analgesia prescribed for nurses to administer in case of moderate to severe pain. 3. In cases where moderate to severe pain documented, percentage that have follow up documentation to say pain has resolved or further investigation of cause is required. Key Findings from the Report were that pain is not assessed regularly as recommended by guidelines in the findings of this audit; if a pain assessment is documented, it is often only when the patient verbally volunteers the information; when patients do complain of pain, they are not routinely re-assessed and patients are not all prescribed appropriate step up analgesia. Action: An agreed action plan has been agreed and implemented for pain to be assessed via a pain assessment tool when observations are being recorded, intervention of analgesia if there is severe pain and doctors to prescribe PRN analgesia for all patients.
45	Re-audit of Records on RiO for Patients Conditionally Discharged under S.37/41 of the MHA Report Audit (February 2015) (2955)	This is a second re-audit looking at the progress made since the first re-audit which suggested deterioration in the timeliness, completeness, and quality of the clinical records. Recommendations and oversight of implementation of this was put in place at the time. 10 records per locality were audited. Overall, the findings were positive and a significant improvement on those of the previous audit. The overall findings were reported through Quality Executive Group, and were fed back to individual localities directly. The audit will be done on a yearly basis and provide a governance trail. Action: An action plan is in development.
46	UN Nations International Children's Emergency Fund (UNICEF) BFI Standards - Slough Locality (2837)	This audit has been undertaken as part of BHFT Health Visiting service, East localities working towards gaining full accreditation Baby Friendly Status. The audit aimed to give a baseline for all the health visiting areas that clients attend where they may receive breastfeeding assistance or have the need to breastfeed their baby within these areas as well as key areas that the service refers them to such as audiology. The baseline audit demonstrated excellent standards of practice across all BHFT sites and Children Centres with only minor additions needed to meet the full requirements for the environment. Action: An action plan is in development.
47	Annual Service Activity Report for the Psychology Service for People with Learning Disabilities 2014-2015 (2718)	The aim of this service evaluation was to review the activities of the Psychological Service for People with Learning Disabilities in Berkshire over the course of the period starting on 1 April 2014 and finishing on 31 March 2015. Following the previous Annual Service Activity Report, the Service actioned the recommendations agreed, the review established that the service has implemented these actions effectively. However, the completion of HoNOS to measure the outcome in all cases involving an intervention at assessment and closure is low at 39.3%. Action: The service will continue to update the referral spreadsheet, complete the HoNOS-LD measure and will continue to monitor and review referrals.

	Audit Title	Conclusion/Actions
48	Consent to ECT Re-audit (2290)	This was a re-audit to monitor the current standard of obtaining ECT, to ensure BHFT adheres to the national guidelines for compliance and to ensure all patients have a capacity assessment and relevant documentation prior to ECT to ensure consent is valid. The re-audit showed that the Trust has 100% compliance against all the standards. Action: No action required.
49	ECT clinical Global impression scale survey (2288)	ECT Department at Prospect Park Hospital is responsible for the provision of ECT treatment to all BHFT patients. This department has been assessed and awarded excellence status by RCP ECTAS (Royal College of Psychiatrist- ECT Accreditation Service) and has maintained this status for seven years, last awarded in March 2014. The review was to evaluate the ECT treatment response and efficacy of treatments in treatment studies of patients with mental disorders. The results showed that 95% of patients showed clinical improvement according to this survey. The Trust will continue to evaluate ECT treatment using CGI survey and will repeat the survey annually. Action: No action required
50	JD/QIP - Audit of driving safety advice given to patients at Prospect Park Hospital (2450)	This audit aimed to assess the level of information given to patients by staff at Prospect Park Hospital and to assess the level of staff awareness of DVLA guidelines. DVLA guidelines recommend that patients fulfilling certain criteria are legally obligated to report themselves if they believe they are unfit to drive. Driving when medically unfit is against the law and continuing to drive may pose a significant risk of danger to self and to others. The audit established that 73.3% of doctors and 36% of nurses were aware of DVLA guideline. 47.5% of the total 40 surveyed gave driving advice to patients at least once before discharge. No one had given advice to 100% of their patients within the last 6 months. As a result a teaching session for medical staff, nursing and support staff is to be implemented. Action: An agreed action plan has been put in place, via a teaching session, to place posters in clinical areas, distribute leaflets and re-analyse the data within 3 months after the changes have been implemented.
51	JD/QIP - Audit of recording of capacity and monitoring of time taken to complete clinic letters (2596)	This audit looked at clinic letters of patients seen by CMHT clinicians, assessing which patients attended the clinic and how quickly the letter was sent to their GP. When clients are seen at the CMHT by clinicians, the letter written to the GP details important information on their progress, mental state examination, risk assessment and future management plan, including any medication changes. The standard for all clinic letters to be communicated within 3 working days was set at 100%. The audit found that 68.3% of clinic letters were communicated to the GP with 3 days, 31.7% of clinic letters were sent later between 4 and 24 days. Action: An agreed action plan is in place, with the use of DOCMAN for those GP surgeries that have access to this, for all letters that contain medication changes or other changes in the client's risk or management plan are to be faxed to the GP. A re-audit is planned for the following year.
52	JD/QIP A clinical audit on Driving and Dementia (2080)	The aim of this project was to evaluate the documentation of the proportion of patients who are taking memory enhancing medication and documented as driving, who have not been advised to inform the DVLA when they should have been. The audit showed that 29% of patients were found to have no documented evidence of their driving status or any information on driving given. Action: The results of the audit have been presented and a re-audit was due in six months' time.
53	Management of Young People in the sexual health service (2694)	The audit aimed to review the management of those aged 18 and under within the sexual health service and to ensure that BHFT performance is within the recommended guidelines. Data was collected over a two month period July-August 2014. The review established that a larger proportion of young females attend the clinic than males, STI screening was completed for only 48% of people and a CSE risk assessment pro-forma was completed in only 35% of cases. In addition a fully electronic system needs to be implemented as the current system is outdated and is producing inaccurate data. Action: An agreed action plan has been put into place.

	Audit Title	Conclusion/Actions
54	Re - audit of use of Dementia Assessment Integrated Care Pathway in Learning Disability Services (2692)	This re audit was to look at the use of the Dementia Assessment Integrated Care Pathway on referrals received by the service in 2014. People with learning disabilities are at greater risk of developing dementia than the general population. The Trust did not meet 100% compliance for completion of the 12 areas included in the Dementia Assessment ICP. Action: An agreed action plan has been put in place covering feedback of the results to key clinicians, training for relevant teams on using the ICP, and uploading of the ICP paperwork onto RiO.
55	Compliance with faculty audit standards for emergency contraception provision (2104)	The aim of the audit was to assess if women are offered emergency contraception for the prevention of unplanned pregnancy. Clinically the FSRH guidelines should be followed and standards adhered to. Only 50% of women presenting for emergency contraception were offered an IUD. In addition, better use of the pro-forma is required to document cycle length. Action: An action plan is currently under review.
56	Management of Gonorrhoea in the sexual health service. (2625)	National service standards for sexual health services in UK have defined a set of quality outcome Indicators that have been adopted by Berkshire commissioners as benchmarks for East Berkshire Sexual Health Service. Standard 14 relates to Percentage of people who are NAAT (nucleic acid amplification test) positive for Neisseria gonorrhoea who have a culture performed. This audit is required on a quarterly basis. The compliance rate is 90%. The audit achieved a 93% compliance rate. Action: No further action is required.
57	The impact of the 2011 BASHH PEPSE guidelines - local re-audit (1881)	The re-audit aim was to review documentation of partners HIV treatment status following the institution of an updated PEPSE prescription proforma, and secondly, to compare PEPSE outcomes to BHIVA/BASHH auditable standards. The re-audit results showed an increase in compliance rates across the standards. Action: No further action is required.
58	Clinical Supervision (2791)	Clinical supervision is for all clinical staff. It is distinct from management supervision, which takes place for all staff with their line manager. Together, clinical supervision and management supervision complement and enhance other HR processes such as developmental review and appraisal, all of which aim to develop staff and improve standards of care. This report shows that from the previous audit in 2014, 3 criteria have shown an improvement, 3 criteria have remained the same. (2 criteria were not applicable). Action: Services which were not 100% compliant in the audit, to submit an action plan within 6 weeks of the report being cascaded.
59	Audit On The Use Of Cephalosporins At The Slough Walk In Centre - December 2014 to June 2015 (3046)	Cephalosporin are broad spectrum antibiotics which are used to a wide variety of infections (URTI, LRTI, UTI, Pelvic Infection, Skin Infections etc.). The common Cephalosporin used in Primary Care are Cefaclor, Cephalexin, Cefixime, Cefradine, Cefuroxime and Cefadroxil. Out of 34 patients, 9 of them were prescribed cephalexin as first line antibiotic. One of them was prescribed cephalexin as fist line antibiotic as the culture results indicated the necessity to do so. 8 Patients in total were prescribed Cephalexin as first line antibiotic when other antibiotics were available to be prescribed. The prescriptions were done by locum GPs at our practice. Action: re-audit in 1 year
60	Emergency Drugs Audit (1949)	There was previously no clear defined list of what each ward/service/ unit should keep and now there is a detailed list published in MRSOP 4008, Omitted, Refused or Wasted medicines. The baseline audit in May 2014 revealed an overall compliance rate of 62.27% The re-audit in June 2015 involved services being repeatedly followed up until full compliance was achieved. Full compliance of 100% was finally reached in November 2015 for all wards, community mental health services and West and East Berkshire Community Health Services. Action: Regular (annual or biannual) review of urgent medicines list for services alongside review of services administering medicines

	Audit Title	Conclusion/Actions
61	Priory Avenue - Antibiotic Audit (3007)	This was intended to get practitioners to look at their prescribing of Co-amoxyclav, Clindamycin, Ciprofloxacin & Cephalosporins that more commonly give side effects like clostridium difficile infection, or necrotising enterocolitis. Results of 1st cycle were discussed in clinical meeting of 11.3.15. 37.5% is not good and below acceptable target. Individual cases looked at where a different antibiotic could have been used. Practitioners were reminded of the local guidelines, and the avoidance of the 4C's policy. Results of the second cycle show improvement to 80%. This shows improvement, with a figure within the75% target. Results of audit were discussed in clinical meeting. Action: This is for the current clinicians to remain vigilant in the use of the "4C" antibiotics in clinical care.
62	Priory Avenue - End of Life (3006)	North West Reading CCG has been encouraging its practices to use advanced care planning for some years for patients expected to die within the next 12 months using an electronic notification system Adastra, hosted by the out of hours service serving West Berkshire, Westcall. The audit measured the number of care plans for end of life care expressed as a number per 1000 patients uploaded on to the Adastra system. The CCG as a whole exceeded the audit target of a 10% increase in electronically shared care plans, actually achieving a 50% increase, but Priory Avenue's increase was only 4.5% so failing to meet the agreed standard of a 10% increase. However this reflected the high starting position of this practice and so was probably an acceptable improvement. Action: A re- audit is planned the following year to ensure that the high level of shared electronic care plans is maintained.
63	Review of patients following prescription of Anti-dementia medication: An audit of current practice within the WAM OPMH network (2929)	Aim: To determine the level of compliance, as benchmarked against the relevant elements of the NICE dementia guidelines and the POMH-UK audit standards, on the review of patients following the initiation of Anti-dementia medication in the WAM OPMH Network. Overall compliance was acceptable. Action: Key recommendations made re: documentation, standardised assessment tools, and presentation of findings.
64	Audit of urinary catheter care bundle in inpatient services (March 2015) (2662)	Aims: The aim of this clinical audit is to assess the compliance of documentation of urinary catheter care bundle by healthcare professionals . This audit will assess compliance of documentation with the standards set out in the Epic 3 guidelines through review of documentation on the catheter care bundle. Actions: Department managers are responsible for ensuring deficiencies identified are addressed. An action plan should be devised for their area to address any on-going non-compliant criteria identified during the audit and compliance with this monitored and reviewed at locality Patient Safety and Quality meetings chaired by the Clinical Directors.
65	Infection Control: Enteral feeding (2876)	The aim of this audit is to assess compliance with policy and best practice in patients requiring enteral feeding in Berkshire Healthcare NHS Foundation Trust (BHFT) inpatients units. The objective is to ascertain current levels of practice relating to enteral feeding. The overall compliance with the enteral feeding audit was 97%. The main issues identified are discussed in the results section, Table 1 and Action plan for Non-compliant criteria of the full report. Action: specific actions relating to the control measure shave been identified.
66	Audit of Dental Service Compliance with HTM 01-05 (medical Devices) (2993)	The aim of the audit is to assess the salaried dental services' ability to comply with the essential quality requirements as set out in HTM 01-05 – Decontamination in Primary Dental Practices, in relation to the management of medical devices. Compliance with the standards outlined in the audit was reassuring with two clinics scoring full compliance and four further clinics scoring 91-95% (1 non-compliant standard). Action: to be agreed

	Audit Title	Conclusion/Actions
67	Circuit Lane - Amiodarone Audit (3004)	Patients on amiodarone can develop hypo or hyperthyroidism. These patients should therefore have TFT's measured on a regular basis: recommendation is before treatment and then every 6 months. T4,T3 and TSH should be measured. 5 patients identified on amiodarone. All 5 patients had had recent TFT's all within the last 6 months with the exception of one patient: achievement 80%. Action: All patients should have TFT's checked. To improve on this clinicians will be reminded by e mail and at regular audit meetings to check TFT's in patients on amiodarone.
68	Circuit Lane - Beta Blockers & Heart Failure (3005)	The aim of this audit is to ensure that as many appropriate patients as possible are treated with these drugs as possible. QOF sets the best standard as 60% of patients being treated with a beta blocker licensed in heart failure unless contraindicated or not indicated. EMIS population reporting shows for HF 4 Indicator in QOF that all our eligible patients are being treated: achievement 100% Action: none required.
69	Circuit Lane - Clopidogrel Audit (3002)	There is no evidence that branded clopidogrel (plavix) is more efficacious than generic clopidogrel. The latter is much cheaper and therefore it is recommended by the PCT that the generic form should be prescribed to save NHS costs. The CCG set a standard of 99% of clopidogrel to be prescribed as generic. CCG data showed Circuit Lane prescribe 98.6% as the generic form. Circuit Lane did not quite meet the target. A computer search was carried out on these patients and 1 patient was found to be on Plavix, this was changed to generic clopidogrel. Action: A repeat audit was carried out on 13/10/15 by searching the EMIS prescribing data which showed 68 patients on generic clopidogrel and no patients on branded clopidogrel. Thus the standard 0f 100% was met.
70	Circuit Lane - Increasing the uptake of Bowel Cancer screening (3003)	Regular bowel cancer screening reduces the risk of dying from bowel cancer by 16%. The national screening target is 60% and in April 2014 the charity Beating Bowel Cancer identified that the national uptake was 58% in April 2014. This had fallen to 56.05% by July 2015, referring to letters originally sent in January 2015 (personal communication NHS Bowel Cancer Screening Southern Program Hub). The figures at Circuit Lane had risen from 55.84% to 62.08% during the same period, suggesting that personalised letters from a GP known to the patient made a difference. It is suspected that once a patient has responded once to the rather uninviting screening test they will repeat the test every 2 years. The Surgery will continue to write to non-responders and hope to further increase uptake when we re-audit in July 2016. Action: continue practice.
71	Priory Avenue - Improving bowel cancer screening (3008)	Regular bowel cancer screening reduces the risk of dying from bowel cancer by 16%. The surgery was pleased to note a 6% increase in bowel cancer screening uptake, which exceeded the 3% target increase, following personalised letters from the practice. Anecdotally, the surgery believes that once a patient gets over doing this mildly unpleasant test once they will do it again at the 2 year follow up invitation, so the benefit of earlier cancer diagnosis will feed through in to future years of screening. Action: continue to monitor
72	JD/QIP - The quality of on call handover between doctors at PPH (2849)	The aim of this survey was to see if it would be possible to improve anything at changeover, which will be beneficial for all our doctors during their on call discussed. All doctors on call were happy with the current procedure of handover for the on call and did not have any suggestions for improvement. Action: none required.
73	Audit of Capacity to consent the treatment in a community setting (2931)	This audit aims to review documentation of the diagnosis and capacity to consent to medical treatment prescribed in the community. Compliance varied between very good and room for improvement. Action: Plan in development

	Audit Title	Conclusion/Actions
74	JD/QIP - Frequency of updating the risk assessment in Berkshire CAMHS ADHD specialist pathway 2015 (3079)	This audit aimed to see how frequently the risk assessment was updated in Berkshire CAMHS ADHD pathway. There is improvement required in clinicians updating the risk assessment in CAMHS ADHD pathway. If the risk assessments are not documented or updated regularly, significant information could be missed leading to very serious consequences for the patients and ultimately serious consequences for the Trust. Action: Risk assessment for CAMHS ADHD specialist pathway following presentation of audit findings, being developed.
75	JD/QIP - Re-audit of Clinical Risk at Assessment for Psychotherapy and Complex Needs (2932)	The overall objective of this re-audit was to ensure appropriate risk documentation for patients and to improve risk assessment practice. All patients who have a Level 2 assessment should have an assessment of risk within the Level 2 assessment report - 100% (37 patients) in 2016; 75% in 2009. All patients should have a reference to risk within the Level 2 psychotherapy assessment letter to the GP - 87% (40 patients) in 2016; 60% in 2009. All patients should have an assessment of risk of: a) suicide - 83.8% compliance, self-harm - 64.9% compliance, harm towards others - 45.9% compliance. Action: Plan in development
76	Did not attend mop up (3080)	The DNA mop up clinic means that each week two slots are made free on a Friday so if any patient from that week did miss a clinic appointment they can be booked in the same week and not have to wait another two months (or longer) to see a doctor. Evaluation showed this enabled five more patients to be seen in the week they were meant to be seen. Action: none required
77	Quality indicator audit of time for clinic letters to be sent to GP's (2945)	manner, considering that it involves information regarding their medication, management and risk. Clinical records should include relevant clinical findings, decisions made and an agreed action plan, medications and the information regarding when the patient was seen and the clinician who saw the patient. This is important in evaluating our current practice to see if letters are being sent to GP'S in a timely manner. Action: Plan in development
78	Emergency Drugs Audit (1949)	This audit aims to review the emergency drugs kept within all wards and teams in BHFT (both CHS and mental health). The baseline audit in May 2014 revealed an overall compliance rate of 62.27% (wards 63%, West CHS 75.4%, East CHS 58.47%). The re-audit in June 2015 involved services being repeatedly followed up until full compliance was achieved. Full compliance of 100% was finally reached in November 2015 for all wards, community mental health services and West and East Berkshire Community Health Services. Action: Recommendations from Drugs and Therapeutics Committee around urgent medicines provision to be cascaded down to staff to ensure compliance.

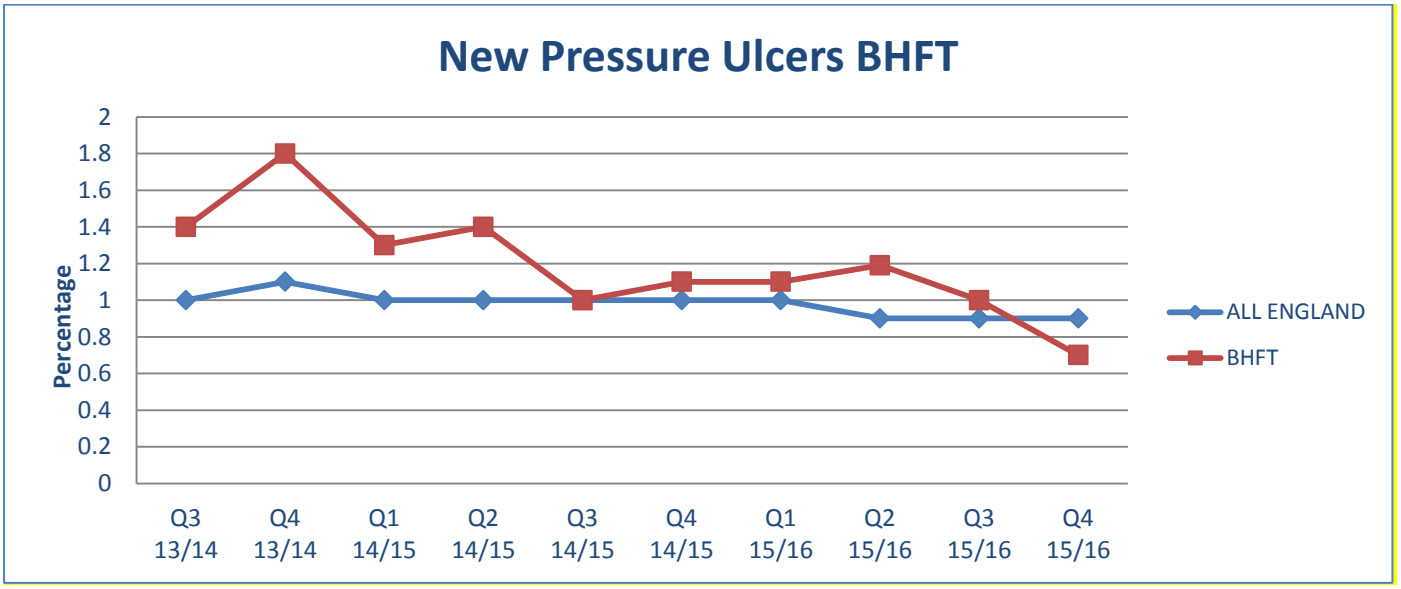
Appendix D Safety Thermometer Charts

When interpreting the charts below, it should be noted that this Safety Thermometer data does not show the total number of each type of harm for the Trust, but only those that are recorded at a specific point in time each month.

Below are the figures for the year on the number of patients surveyed

Data capture period	Number of patients surveyed	Harm free care in Berkshire Healthcare	Harm free care nationally
Q4 2015/16	4064	93.7%	94.2%
Q3 2015/16	3819	94.4%	94.2%
Q2 2015/16	3960	93.2%	94.2%
Q1 2015/16	4093	93.4%	94%

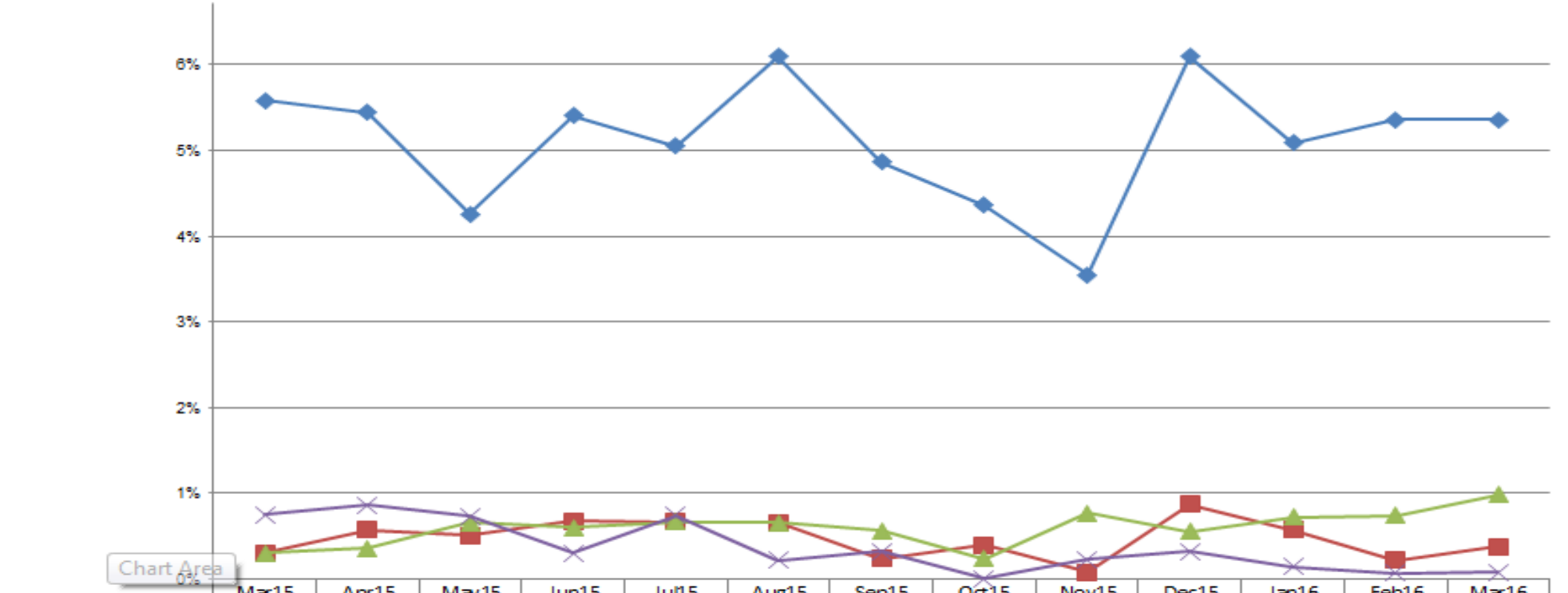
Source: Trust Safety Thermometer Reports



Source: Trust Figure- Safety thermometer, All England Figure- HSCIC Pressure Ulcer Reports

Types of harm

The chart below splits the types of harms across the whole organisation. Pressure ulcers remain the highest harm based on safety thermometer data.



	Mar15	Apr15	May15	Jun15	Jul15	Aug15	Sep15	Oct15	Nov15	Dec15	Jan16	Feb16	Mar16
Pressure Ulcers	5.58	5.44	4.26	5.41	5.05	6.1	4.86	4.36	3.55	6.1	5.09	5.36	5.36
Falls	0.3	0.57	0.51	0.68	0.67	0.66	0.24	0.4	0.08	0.87	0.57	0.22	0.38
Catheter & UTI	0.3	0.36	0.66	0.6	0.67	0.66	0.56	0.24	0.77	0.55	0.72	0.74	0.98
New VTE	0.75	0.86	0.73	0.3	0.74	0.22	0.32	0	0.23	0.32	0.14	0.07	0.08
Patients	1327	1398	1363	1332	1346	1360	1254	1261	1296	1262	1396	1343	1325

Source- Safety Thermometer

Appendix E CQUIN Achievement 2015/16

Goal Number	Goal Name	Description of Goal	Expected Financial Value of Goal
Local 1	Children's Transition	Increase in the percentage of young people who report the transition process as having been a positive experience.	£445.9K
Local 2	Hydrate	Education, risk assessment and care planning relating to oral hydration	£445.9K
Local 3	Engagement in activity	Increase number of secondary care patients under CMHT aged 18-65 years in education, training, employment or volunteering as at the last day of the quarter	£445.9K
Local 4	Smoking Cessation	Increase use of Nicotine replacement therapy	£445.9K
Local 5	7 Day Working	All new admissions under a section will be reviewed, on the phone, by the on-call Consultant between 5pm and 12 midnight, 7 days a week	£445.9K
3a	Dementia and Delirium	Find, Assess, Investigate, Refer and Inform (FAIRI)	£222.9K
3b	Dementia and Delirium	Staff Training	£37.1K
3c	Dementia and Delirium	Supporting Carers	£111.4K
4a	Cardio Metabolic	Cardio Metabolic Assessment and Treatment for Patients with Psychoses	£297.2 K
4b	Communication with General Practitioners	Communication with General Practitioners	£74.3K
7	Emergency Admissions	Reducing the proportion of avoidable emergency admissions to hospital.	CLOSED
Replaced 7	Suicide Preventions		£371.6K
8b	A&E MH re-attendances	Reduction in A&E MH re-attendances	£371.6K

Appendix F- BHFT CQUIN 2016/17

East Berkshire

Indicator Number	Indicator Name	Description of indicator	East Total Value (£)
National 1a	Introduction of Health and Wellbeing Initiatives	Introduction of health and wellbeing initiatives covering physical activity, mental health and improving access to physiotherapy for people with MSK issues. Providers should develop a plan and ensure the implementation against this plan. This plan will be subject to peer review. This should cover the following three areas; a) Introducing a range of physical activity schemes for staff. Providers would be expected to offer physical activity schemes with an emphasis on promoting active travel, building physical activity into working hours and reducing sedentary behaviour. They could also introduce physical activity sessions for staff which could include a range of physical activities such as; team sports, fitness classes, running clubs and team challenges. b) Improving access to physiotherapy services for staff. A fast track physiotherapy service for staff suffering from musculoskeletal (MSK) issues to ensure staff who are referred via GPs or Occupational Health can access it in a timely manner without delay; and c) Introducing a range of mental health initiatives for staff. Providers would be expected to offer support to staff such as, but not restricted to; stress management courses, line management training, mindfulness courses, counselling services including sleep counselling and mental health first aid training.	161,584
National 1b	Healthy Food for NHS Staff, Visitors and Patients	Part a Providers will be expected achieve a step-change in the health of the food offered on their premises in 2016/17, including: a. The banning of price promotions on sugary drinks and foods high in fat, sugar and salt (HFSS)1. The majority of HFSS fall within the five product categories: pre-sugared breakfast cereals, soft drinks, confectionery, savoury snacks and fast food outlets; b. The banning of advertisement on NHS premises of sugary drinks and foods high in fat, sugar and salt (HFSS); c. The banning of sugary drinks and foods high in fat, sugar and salt (HFSS) from checkouts; and d. Ensuring that healthy options are available at any point including for those staff working night shifts. Applies to BHFT sites where the Trust influence procurement – on other sites we will demonstrate engagement CQUIN funds will be paid on delivering the four outcomes above. In many cases providers will be able to achieve these objectives by renegotiating or adjusting existing contracts. Part b Providers will also be expected to submit national data collection returns by July based on existing contracts with food and drink suppliers. This will cover any contracts covering restaurants, cafés, shops, food trolleys and vending machines or any other outlet that serves food and drink. The data collected will include the following; the name of the franchise holder, food supplier, type of outlet, start and end dates of existing contracts, remaining length of time on existing contract, value of contract and any other relevant contract clauses. It should also include any available data on sales volumes of sugar sweetened beverages (SSBs)	161,584

Indicator Number	Indicator Name	Description of indicator	East Total Value (£)
National 1c	Improving the uptake of flu vaccinations for clinical staff	Achieving an uptake of flu vaccinations by frontline clinical staff of 65%	161,584
National 3a	Cardio Metabolic	To demonstrate Cardio metabolic Assessment and Treatment for Patients with Psychoses in the following areas: a) Inpatient Wards b) Early Intervention Psychosis Services c) Community Mental Health Services (Patients on CPA)	129,267
National 3b	Communication with GP (CPA)	90% of patients to have either an updated CPA i.e. a care programme approach care plan or a comprehensive discharge summary shared with the GP. A local audit of communications should be completed.	32,317
Local	End of Life	Identifying patients in the last year of life is clinically complex. It is recognised that approximately 1% of a GP practice lists are likely to be in the last year of life (ONS 2012). Recognising these patients supports advance care planning and meeting patients' wishes. Patients who are in their last year of life and on the GP End of Life Register can struggle to know what the appropriate service is when they enter a crisis. BHFT services (District Nurses, Specialist Nurses, Community Matrons, & Inpatients) are often in a position to raise with GPs the possibility that the patients on their caseloads may be entering the last year of life to support GP Practices maintaining an up to date End of Life register. When patients have been identified as potentially in the last year of life following a conversation between the GP and the patient and with the patients consent these patients will be flagged as EOL within BHFT RIO system, additionally in Berkshire West patients will be referred to the Palliative Care Hub (final name to be agreed.) These identified patients will be encouraged to contact the BHFT Health hub as a first point of contact 24 /7. The health Hub will undertake initial triage, identify the key issues and either liaise with the appropriate BHFT service or signpost to the most appropriate partner organisations.	415,486
Local	Dual Diagnosis	BHFT is seeing an increase in numbers and complexity of patients where substance and alcohol misuse is a significant part of the presentation. Substance misuse amongst individuals with mental illness has been associated with significantly poorer outcomes including: • Worsening mental health • Increased incidents of suicide • Increased rates of violence and homicide • Increased use of in-patient services • Poor medication adherence • Homelessness • Increased risk of HIV, Hepatitis infection • Poor social outcomes including impact on carers and family • Contact with the criminal justice system. In recent years, various agencies and interested parties have sought to improve treatment provision for this population at a local and National level and new guidance from NICE is expected in May 2016. CMHTs have made considerable efforts to improve partnership working with DAAT commissioned providers in localities, and continues to work on initiatives to promote joint working. CMHTs have taken steps to improve expertise and have developed the role of link workers and champions from within existing resources. Engagement in assessment and interventions has been identified as a significant barrier to achieve positive outcomes with these patients. Feedback from CMHT clinicians has indicated the limitations of existing assessments and profiling tools to support engagement and outcomes for this client group, and teams welcome the introduction of a tool to support practice, and training to enhance skills. It is	324,491

		proposed that systematic use of an evidence based tool will improve the proactive clinical management of CPA patients with dual diagnosis (cluster 16) under the care of CMHT, with the aim of enhancing assessment and care plan review, ensuring needs and risks are identified, and improving outcomes. Training for staff to improve dual diagnosis practice, and to provide skills in use of a profiling tool with this client group improve engagement and provide focus to the assessment and intervention. The CQUIN includes identification of an appropriate profile tool, development and delivery of training, application of the selected tool to identified patient cohort to improve engagement, monitoring of progress and outcomes. In order to enhance interface working with DAAT services, the completed tool will be shared wherever applicable with the local provider service, to further enhance joint working, improve engagement with provider services and improve outcomes. Training module will be worked up as part of the CQuIN and will cover relevant areas to equip staff with the skills, attitudes, and tools to manage and coordinate the care for this group of patients, as well as equipping them in use of outcome measure (e.g. Maudsley Addiction Profile / TOPS or other evidence based tool – this is to be confirmed as part of the CQUIN) Preparatory work in 15-16: Calculate baseline (numerator and denominator) (expected to be approx. 100 cluster 16 based on Q4 snapshot)	
Local	Failure to Return from Agreed Leave	At any time within the Inpatient Service, patients will leave the ward with permission for various activities to be undertaken off site. This may be escorted if clinical need dictates but more often unescorted following agreement by the MDT that a patient may utilise unescorted leave. Since the smoking ban came into force on 1st October 2015 the amount of unescorted leave being granted to patients will have increased as a large proportion of inpatients will be smokers. The Failure to Return from Agreed Leave indicator (FTR) is designed to improve patient safety by ensuring staff are aware of patients' movements and more importantly when they fail to return from an agreed leave period. For the purpose of the FTR indicator any inpatient, detained or informal, who fails to return later than 10 minutes over the leave period that was agreed and documented by ward staff, and who has not made contact with the ward to agree a later return time, will have a DATIX (incident) form raised to capture the breach. Weekly internally audit will analyse and process data of improvement and be reported on a quarterly basis. NOTE: By formulising the requirement for reporting all FTR on DATIX there is a risk that the number of incidents reported from Q2 will increase. However, this should still be seen as an indicator of improving patient safety secondary to the data collection and remedial clinical action that would be required thereafter.	229,526

West Berkshire

Indicator Number	Indicator Name	Description of indicator	West Total Value (£)
National 1a	Introduction of Health and Wellbeing Initiatives	Introduction of health and wellbeing initiatives covering physical activity, mental health and improving access to physiotherapy for people with MSK issues. Providers should develop a plan and ensure the implementation against this plan. This plan will be subject to peer review (further guidance will be issue on the peer review aspect in the next 4-6 weeks). This should cover the following three areas; a) Introducing a range of physical activity schemes for staff. Providers would be expected to offer physical activity schemes with an emphasis on promoting active travel, building physical activity into working hours and reducing sedentary behaviour. They could also introduce physical activity sessions for staff which could include a range of physical activities such as; team sports, fitness classes, running clubs and team challenges. b) Improving access to physiotherapy services for staff. A fast track physiotherapy service for staff suffering from musculoskeletal (MSK) issues to ensure staff who are referred via GPs or Occupational Health can access it in a timely manner without delay; and c) Introducing a range of mental health initiatives for staff. Providers would be expected to offer support to staff such as, but not restricted to; stress management courses, line management training, mindfulness courses, counselling services including sleep counselling and mental health first aid training.	233,235
National 1b	Healthy Food for NHS Staff, Visitors and Patients	Part a Providers will be expected achieve a step-change in the health of the food offered on their premises in 2016/17, including: a. The banning of price promotions on sugary drinks and foods high in fat, sugar and salt (HFSS)1. The majority of HFSS fall within the five product categories: pre-sugared breakfast cereals, soft drinks, confectionery, savoury snacks and fast food outlets; b. The banning of advertisement on NHS premises of sugary drinks and foods high in fat, sugar and salt (HFSS); c. The banning of sugary drinks and foods high in fat, sugar and salt (HFSS) from checkouts; and d. Ensuring that healthy options are available at any point including for those staff working night shifts. Applies to BHFT sites where the Trust influence procurement – on other sites we will demonstrate engagement CQUIN funds will be paid on delivering the four outcomes above. In many cases providers will be able to achieve these objectives by renegotiating or adjusting existing contracts. Part b Providers will also be expected to submit national data collection returns by July based on existing contracts with food and drink suppliers. This will cover any contracts covering restaurants, cafés, shops, food trolleys and vending machines or any other outlet that serves food and drink. The data collected will include the following; the name of the franchise holder, food supplier, type of outlet, start and end dates of existing contracts, remaining length of time on existing contract, value of contract and any other relevant contract clauses. It should also include any available data on sales volumes of sugar sweetened beverages (SSBs)	233,235

Indicator Number	Indicator Name	Description of indicator	West Total Value (£)
National 1c	Improving the uptake of flu vaccinations for clinical staff	Achieving an uptake of flu vaccinations by frontline clinical staff of 65%	233,235
National 3a	Cardio Metabolic	To demonstrate Cardio metabolic Assessment and Treatment for Patients with Psychoses in the following areas: a) Inpatient Wards b) Early Intervention Psychosis Services c) Community Mental Health Services (Patients on CPA)	186,588
National 3b	Communication with GP (CPA)	90% of patients to have either an updated CPA i.e. a care programme approach care plan or a comprehensive discharge summary shared with the GP. A local audit of communications should be completed.	46,647
Local	End of Life	Identifying patients in the last year of life is clinically complex. It is recognised that approximately 1% of a GP practice lists are likely to be in the last year of life (ONS 2012). Recognising these patients supports advance care planning and meeting patients' wishes. Patients who are in their last year of life and on the GP End of Life Register can struggle to know what the appropriate service is when they enter a crisis. BHFT services (District Nurses, Specialist Nurses, Community Matrons, & Inpatients) are often in a position to raise with GPs the possibility that the patients on their caseloads may be entering the last year of life to support GP Practices maintaining an up to date End of Life register. When patients have been identified as potentially in the last year of life following a conversation between the GP and the patient and with the patients consent these patients will be flagged as EOL within BHFT RIO system, additionally in Berkshire West patients will be referred to the Palliative Care Hub (final name to be agreed.) These identified patients will be encouraged to contact the BHFT Health hub as a first point of contact 24 /7. The health Hub will undertake initial triage, identify the key issues and either liaise with the appropriate BHFT service or signpost to the most appropriate partner organisations.	279,882
Local	Dual Diagnosis	BHFT is seeing an increase in numbers and complexity of patients where substance and alcohol misuse is a significant part of the presentation. Substance misuse amongst individuals with mental illness has been associated with significantly poorer outcomes including: • Worsening mental health • Increased incidents of suicide • Increased rates of violence and homicide • Increased use of in-patient services • Poor medication adherence • Homelessness • Increased risk of HIV, Hepatitis infection • Poor social outcomes including impact on carers and family • Contact with the criminal justice system. In recent years, various agencies and interested parties have sought to improve treatment provision for this population at a local and National level and new guidance from NICE is expected in May 2016. CMHTs have made considerable efforts to improve partnership working with DAAT commissioned providers in localities, and continues to work on initiatives to promote joint working. CMHTs have taken steps to improve expertise and have developed the role of link workers and champions from within existing resources. Engagement in assessment and interventions has been identified as a significant	559,764

		barrier to achieve positive outcomes with these patients. Feedback from CMHT clinicians has indicated the limitations of existing assessments and profiling tools to support engagement and outcomes for this client group, and teams welcome the introduction of a tool to support practice, and training to enhance skills. It is proposed that systematic use of an evidence based tool will improve the proactive clinical management of CPA patients with dual diagnosis (cluster 16) under the care of CMHT, with the aim of enhancing assessment and care plan review, ensuring needs and risks are identified, and improving outcomes. Training for staff to improve dual diagnosis practice, and to provide skills in use of a profiling tool with this client group improve engagement and provide focus to the assessment and intervention. The CQUIN includes identification of an appropriate profile tool, development and delivery of training, application of the selected tool to identified patient cohort to improve engagement, monitoring of progress and outcomes. In order to enhance interface working with DAAT services, the completed tool will be shared wherever applicable with the local provider service, to further enhance joint working, improve engagement with provider services and improve outcomes. Training module will be worked up as part of the CQuIN and will cover relevant areas to equip staff with the skills, attitudes, and tools to manage and coordinate the care for this group of patients, as well as equipping them in use of outcome measure (e.g. Maudsley Addiction Profile / TOPS or other evidence based tool – this is to be confirmed as part of the CQUIN) Preparatory work in 15-16: Calculate baseline (numerator and denominator) (expected to be approx. 100 cluster 16 based on Q4 snapshot)	
Local	Failure to Return from Agreed Leave	At any time within the Inpatient Service, patients will leave the ward with permission for various activities to be undertaken off site. This may be escorted if clinical need dictates but more often unescorted following agreement by the MDT that a patient may utilise unescorted leave. Since the smoking ban came into force on 1st October 2015 the amount of unescorted leave being granted to patients will have increased as a large proportion of inpatients will be smokers. The Failure to Return from Agreed Leave indicator (FTR) is designed to improve patient safety by ensuring staff are aware of patients' movements and more importantly when they fail to return from an agreed leave period. For the purpose of the FTR indicator any inpatient, detained or informal, who fails to return later than 10 minutes over the leave period that was agreed and documented by ward staff, and who has not made contact with the ward to agree a later return time, will have a DATIX (incident) form raised to capture the breach. Weekly internally audit will analyse and process data of improvement and be reported on a quarterly basis. NOTE: By formulising the requirement for reporting all FTR on DATIX there is a risk that the number of incidents reported from Q2 will increase. However, this should still be seen as an indicator of improving patient safety secondary to the data collection and remedial clinical action that would be required thereafter.	559,764

Appendix G Statements from Stakeholders

Response to Berkshire Healthcare NHS Foundation Trust Quality Account- 2016

From Berkshire Healthcare NHS Foundation Trust Council of Governors

At a meeting of their Strategy Group on the 13th April 2016, Governors' received the most recent version of the Quality Account including a detailed verbal update from Jason Hibbitt. It was acknowledged that there had been an overall drop in responses received from staff to the 2015 Staff survey this year and more work needs to be completed next year to ensure a better response rate to make the data even more meaningful.

One Governor highlighted that there could be more detail given on the negative points highlighted in the Trust findings for the 2015 Staff survey, such as working longer hours, increased stress and bullying within the workplace compared to the positive statistics. A suggestion was given to put similar amount of detail for each subject where possible to make it a more balanced report.

It was agreed by Governors that the new Service Improvement section of the document would read better if it was arranged in a more logical order, for instance by locality or even broken down by Service. This additional section otherwise was perceived as helpful and critical in understanding the BHFT staff.

It was also noted that there is no information included in the report about the diabetic eye screening clinic, which is a service which needs to be acknowledged in future.

Governors expressed their overall appreciation for the hard work put into the quality account and deemed it as generally extremely insightful and comprehensive.

Berkshire Healthcare NHS Foundation Trust Response:

Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

The Trust welcomes the feedback from Berkshire Healthcare NHS Foundation Council of Governors and for the suggestions to help improve the final report.

The Trust is grateful for the positive comments made in relation to the content of the Quality Account and work put into its production.

In relation to the comments made about 2015 staff survey content, the Trust agrees and has added a paragraph to the appropriate section, acknowledging awareness and commitment to improve upon some of the lower scores and making the section more balanced.

In relation to the 'Service Improvements' section of the Quality Account, this section is currently detailed by grouping of services thus allowing for an overall Trust-wide account of service improvements in each broad area (e.g. 'Adult Community Health Services', 'Adult mental Health Services', 'CAMHs' etc.).This allows for an overall account by service so that quality improvements are visible across the service rather than those limited to a locality level section of the service; however it has the disadvantage of spreading locality information throughout the section. The format for this section will be discussed for future reports to determine if indicating the locality hosting the particular service would give a more locality flavour to the section.

In relation to the Diabetic Eye Screening service, the Trust agrees with the comment made about the importance of this service and will look to gain input from them in future reports.

Response to Berkshire Healthcare NHS Foundation Trust Quality Account- 2016

From Healthwatch Slough

Healthwatch Slough commends the Trust for the information provided. The Quality Account appears to reflect people's real experiences as told to Healthwatch Slough by service users and their families and carers over the past year.

Healthwatch Slough commends the Trust for the transparent and learning approach taken to complaints. There does appear to be a genuine learning culture within the Trust that allows people's experiences to be captured and used to enable service improvement. Healthwatch Slough feels other organisations could learn from your positive approach to complaints handling.

Healthwatch Slough is disappointed not to see CAMHS waiting times on the priorities for improvement list as this is such a key area. Healthwatch Slough believes the Quality Account would benefit if it were clearer how the areas for improvement for the coming year were going to be measured and how improvement will be measured in the future

healthwatch Slough

Working to make sure the consumer's voice is always heard and helps shape the provision of health and social care services in Slough

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Berkshire Healthcare NHS Foundation Trust Response:

Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

The Trust welcomes the feedback from Healthwatch Slough and for the suggestions to help improve the final report.

The Trust is grateful for the positive comments made in relation to the information provided, the fact that the Quality Account reflects service users' real experiences and the approach taken by the Trust in managing complaints.

Although a CAMHS improvement goal has not been included for 2016/17, a section on service improvements made in the CAMHS service during the past year has been inserted into the Service Improvements section in the final Quality Account. This section details the steps that CAMHs have taken to improve services, and includes the work undertaken to improve waiting times.

The Trust agrees that the section on priorities for improvement for 2016/17 would benefit from being clearer. As a result, this section has been updated.

Response to Berkshire Healthcare NHS Foundation Trust Quality Account- 2016

From Healthwatch Wokingham

Healthwatch Wokingham Borough is happy to see that the care of patients/service user as an organisational top priority has increased in the staff survey
Healthwatch is pleased with its established relationship with the Trust and meet on a regular basis, giving us a chance to provide regular feedback

The Quality Account could do with some case studies and patient/service user quotes to bring it to life
It would be good if there was a summary of last year's priorities – which were achieved and which still have plans in progress to achieve.

Healthwatch Wokingham Borough were not aware of the Mental Health Crisis Resolution and home Team weekly carers support group. Lots of people have told us they feel unsupported and isolated when dealing with the Crisis team – Healthwatch are in an ideal place to promote these sorts of initiatives and signpost carers to it.
Not including an improvement goal around CAMHS is disappointing

In summary, we are pleased that BHFT is working towards consistent services and performance and continues to engage patients around how best to improve the current system. Although, Healthwatch would recommend a variety of methods to encourage patient engagement other than a reliance on surveys and the Family & Friends Test.

healthwatch Wokingham Borough

Working to make sure the consumer's voice is always heard and helps shape the provision of health and social care services in Wokingham

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Berkshire Healthcare NHS Foundation Trust Response:

Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

The Trust welcomes the feedback from Healthwatch Wokingham Borough and for the suggestions to help improve the final report.

The Trust is grateful for the positive comments made in relation to the care of patients as an organisational top priority, the relationship between Healthwatch and the Trust and our work towards consistent services and engaging patients.

The Trust agrees with comment regarding inclusion of case studies and service user quotes and, as a result, several service user quotes have been included within the final version of the Quality Account.

The Trust agrees with the Healthwatch Committee that a summary of last year's priorities would be a useful addition to the quality account. As a result, a summary table of priorities, together with Trust achievement against these priorities has been included in Part 2 of the final version of the Quality Account.

Although a CAMHS improvement goal has not been included for 2016/17, a section on service improvements made in the CAMHS service during the past year has been inserted into the Service Improvements section in the final

Quality Account. This section details the steps that CAMHs have taken to improve services, and includes the work undertaken to improve waiting times.

Patient surveys, the Friends and Family Test and 'Deep Dives' are some of the ways that we encourage engagement with people who use our services and those who care for them. We also enable, facilitate and link with forums and groups across Berkshire and the clinical specialties within our Trust e.g. Experteas carer group and a very active CAMHS service user group who have helped to design and shape how we communicate with young people and their parents. We also have an online system that our staff can fill in to let us know about activities in their local area – during 2016/17 our patient experience team will be looking at how we can adapt this to make it even easier for us to capture and share this across the Trust. We are also reinforcing the importance of co-production and our promoting our Patient Leader programme.

Response to Berkshire Healthcare NHS Foundation Trust Quality Account- 2016

Prepared on behalf of Bracknell and Ascot CCG; Newbury & District CCG; North and West Reading CCG; Slough CCG; South Reading CCG; Windsor, Ascot and Maidenhead CCG and Wokingham CCG.

Statement

The Clinical Commissioning Groups (CCGs) are providing a response to the Quality Account for 2015/16 submitted by Berkshire Healthcare Foundation Trust (BHFT).

The Quality Account provides information and a review of the performance of the Trust against quality improvement priorities set for the year 2015/16 and gives an overview of the quality of care provided by the Trust during this period. The priorities for quality improvement are also set out for the next 12 months.

The CCGs were very pleased to receive the news that the Trust achieved Good overall as a result of the CQC inspection in December 2015. It was positive to see that the community-based mental health services for older people received an outstanding rating, and that End of Life care received an outstanding rating for Caring. The CCGs will monitor the Trust following the development of an action plan to improve the areas where the Trust achieved Requires Improvement. The Trust has identified key areas for improvement in the Quality Accounts and what actions they have put in place to improve quality and patient safety.

The CCGs support the Trust's openness and transparency. They are committed to working with the Trust to achieve further improvements and successes in the areas identified within the Quality Account. This will be carried out through a number of both proactive and reactive mechanisms and collaborative and integral working.

Whistleblowing is very important in an organisation and the CCGs are pleased that the Trust has introduced a more systematic detailed method for logging information centrally about whistleblowing concerns.

The Trust's Quality Priorities highlighted in the 2015/16 Quality Account were Patient Safety, Clinical Effectiveness, Patient Experience and Health Promotion.

The CCGs welcomed the improved 2015 National Staff Survey, particularly around the significant improvement in the percentage of staff that feel that the Trust takes action to ensure that incidents do not happen again.

The Trust should be commended on the work already undertaken to reduce the number of developed pressure ulcers on the inpatient wards and in the community. The CCGs are pleased to support the Trust in 2016/17 to implement a process where category two pressure ulcers will be reviewed to identify if there was a lapse in care provided by the Trust.

It is positive to see that the Trust has achieved their targets for compliance with NICE Guidance, and have participated in all required National Clinical Audits and Confidential Enquiries.

Friends and Family Test results have improved from 2014/15 for Community Services (both physical and mental health), Mental Health Inpatients and Community Health Inpatients. It is disappointing to see that the results for Minor Injuries Unit and Walk in Centres have dropped from 2014/15, although the result remains above 90%.

The Trust has achieved its ambition of becoming a Smoke Free Organisation in 2015/16. The CCGs were very pleased to support the Trust as it achieved the final milestone of the Mental Health wards on Prospect Park Hospital becoming Smoke Free.

The CCGs are pleased to build on the Service Improvement work on Bluebell Ward in reducing Failure to Returns by agreeing a CQUIN for 2016/17 with the Trust to widen this work across all inpatient Mental Health wards.

Priorities for 2016/17

The priorities identified for 2016/17 are Patient Safety; Clinical Effectiveness; Patient Experience and Health Promotion. The CCGs are pleased to note the Trust has identified how these priorities will be delivered, and look forward to working with the Trust through the year to support implementation.

The Trust has placed falls as one of their priorities for 2016/17 in light of the number of falls in 2015/16. It is positive to see the support of the Oxford Academic Health Science Network being used to direct the falls prevention strategy.

The CCGs have noted an increased trend in the number of suicides of people who have had contact with Mental Health services in the previous 12 months. It is pleasing to note that the Trust are building on the work of using Joiner's Model, and have taken Suicide Prevention forward as one of their priorities for 2016/17.

The Commissioners would like to continue to be informed of any new Quality Concerns being identified during 2016/17 for the opportunity to support the Trust with these.

The CCGs acknowledge the Trust's achievement of the Monitor standards, and the CCGs note the reduction in the number of mental health readmissions within 28 days of discharge when compared to 2014/15.

Berkshire Healthcare NHS Foundation Trust Response:

Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

The Trust welcomes this response to its 2015/16 Quality Account, prepared on behalf of Bracknell and Ascot CCG; Newbury & District CCG; North and West Reading CCG; Slough CCG; South Reading CCG; Windsor, Ascot and Maidenhead CCG and Wokingham CCG.

The Trust is grateful for the positive comments made in relation to; the trust's 'Good' CQC rating, openness and transparency, whistleblowing, friends and family results, staff survey results, pressure ulcers, clinical effectiveness priorities and our achievement of 'smoke free' status.
The Trust also notes, and is grateful for, the support of the CCGs for the 2016/17 priorities set out in our Quality Account. We will report progress against these priorities in our 2016/17 Quality Account.

Finally, we look forward to working with the CCGs in the coming year to achieve further improvements and successes in the areas identified within the Quality Account.

Response to Berkshire Healthcare NHS Foundation Trust Quality Account- 2016

From Bracknell Forest Council Health Overview and Scrutiny Panel

1. We commend the Trust's achievement of a 'Good' inspection rating from the Care Quality Commission in April 2016. Notwithstanding that the CQC found the need for some improvements, this was a creditable outcome for the Trust.

2. There are no references in the Quality Account (QA) to a significant national initiative on Medicines Optimisation, other than a brief reference to insulin on page 17. It is important to educate patients to take all the medicines prescribed for them, and we consider there is a connection between this and – for example - the Trust's priority of falls prevention, also Crisis Resolution (page 26).

3. There are no references in the QA to a significant NHS initiative across East Berkshire: New Vision of Care.

4. It would be helpful if the QA could refer to what BHFT do to support Drug and Alcohol Action Teams (DAAT) clients who are at risk of Mental Ill-Health?

5. What is meant by 80% of NICE guidance having been implemented? How does the Trust measure that (page 3), and what systems are in place to ensure implementation of the guidance (page 28)?

6. The Panel is supportive of the Trust's quality priorities for 2016/17 (page 3), particularly the focus on suicide prevention given the increase in suicides (page 36). However, we do have some reservations:
   a) The priorities should include reference to the Child and Adolescent Mental Health service. There has been a long-running under-resourcing and under-performance in this area, which has been of constant concern to the Panel. This is reinforced by the high level of complaints about the service (see page 8).
   b) It is hard to see why falls prevention is a priority if there were very few falls resulting in harm - unless Figure 9 on page 12 is understating the prevalence of harmful falls?

7. The considerably lower patient feedback scores from mental health inpatients (page 6, Figure 1) are alarming. What are the reasons for that, and how is the Trust acting on this?

8. We commend the Trust's attention to patient satisfaction, and their performance on that (page 7)

9. What is the reason for the very small number of Friends and Family test responses from carers (page 8) and can this be improved upon?

10. (Page 10 and the recently released NHS staff survey results) We are very concerned about some features of the 2015 staff survey results, which together point to a common theme of a detached leadership, and a 'vicious cycle' of low staff morale, unacceptable behaviour between staff, and over-worked staff. Specifically, staff respondents say:
    a) There is only 41% satisfaction with senior management engagement;
    b) 88% reported errors/near-misses/incidents in the last month;
    c) 79% say they have worked extra hours;
    d) 40% say they have suffered work-related stress;
    e) 20% of staff have experienced harassment, bullying or abuse from other staff;
    f) Only 38% of staff responded to the survey.

    In our view, all this would have undermined staff retention and the Trust's ability to recruit new staff; which in turn would have worsened staff shortages (see page 14), and consequently the burden on the staff in post and the need to engage more costly agency/ bank staff. The Trust should set out how it intends improving the underlying organisational culture and these specific matters.

11. We commend the Trust's initiative on Diabetes awareness (page 16), and observe that this has a link to medicines optimisation.

12. We commend the Trust's initiative on care for dementia patients and their carers, and the sharing of learning in that regard (page 23).

13. Were patients aware that their records were being passed on to the Secondary Uses Service (page 34)?

14. We are concerned about the high and increasing level of medication errors (page 39). We have drawn attention to this in a previous Quality Account, and there is a connection to medicines optimisation. The Trust should describe the medical consequences of these errors and set out how it intends reducing the error rate.

Berkshire Healthcare NHS Foundation Trust Response:

Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

The Trust welcomes the feedback from Bracknell Forest Council Health Overview and Scrutiny Panel and for the suggestions to help improve the final report.

The Trust is grateful for the positive comments made in relation to our 'Good' CQC rating, the focus on suicide prevention as a priority for 2016/17, our attention to patient satisfaction and our initiative on diabetes awareness care for patients with dementia.

In relation to specific points made, the Trust responds as follows:

The Trust has considered the comment made in relation to medicines optimisation (point 2 in the submission). As a result, a section on medicines optimisation has been included in the 'Service Improvement' section of the quality account."

In relation to point 3 of the submission, Berkshire Healthcare is committed to the development of the New Vision of Care Programme across the East of Berkshire: this has been established with the twin aims of improving the experience and outcomes of people using health and social care services, alongside making effective use of our collective resources. We are represented on the programme Steering Group by an Executive Director, who is also responsible for the "workforce" work stream. A number of our clinical staff have made a significant contribution, via the Design Group, to the development of the model of care, and implementation planning is now in progress.

In relation to the comment made about supporting Drug and Alcohol Teams (DAAT) clients who are at risk of mental ill health (Point 4 of the submission), BHFT is not commissioned to provide Drug and Alcohol services. BHFT mental health services would work in collaboration with Drug and Alcohol teams to support patients who suffer from mental illness and also uses drugs and or alcohol.

In relation to the comment regarding implementation of NICE Guidance (point 5 of the submission), the relevant section in the final quality account has been updated to provide an overview of how the Trust measures compliance with this and the systems in place to achieve this

In relation to point 6a of the submission, although a CAMHS improvement goal has not been included for 2016/17, a section on service improvements made in the CAMHS service during the past year has been inserted into the Service

Improvements section in the final Quality Account. This section details the steps that CAMHs have taken to improve services, and includes the work undertaken to improve waiting times.

In relation to the comment regarding falls prevention (point 6b of the submission), the Trust considers prevention of falls a high priority for several reasons:
Firstly, The Royal College of Physicians report that falls are the most commonly reported type of patient safety incident in healthcare.
Secondly, although most people who fall in hospital experience no or low physical harm (such as minor cuts and bruises), others suffer severe consequences, such as hip fracture, head injury or, on rarer occasions, a fall will be fatal (falls are the commonest cause of death from injury in the over 65s).
Thirdly, the personal consequences of a fall for the individual can be significant and even 'minor' falls can be very debilitating: individuals can lose confidence and become nervous about falling again. This means they may become unwilling to move about, and as a result become more isolated and more dependent on others. This leads to greater concerns for carers, and an increased likelihood that an individual will need healthcare
In addition, Figure 9 on page 12 of the Quarter 3 Quality Account report that was shared with the Committee provided data from the patient safety thermometer. To give context, we would like to clarify that that the patient safety thermometer data relates to falls resulting in harm that occurred within a point in time, and not all falls. This has been clarified in the final Quality Account.

In relation to the Friends and Family Test (FFT) scores for mental health inpatients (point 7 of the submission), a significant proportion of patients admitted for inpatient care are detained under the Mental Health Act and the very nature of this process and their illness makes it less likely that patients will participate in service feedback or provide positive feedback. Equally, if patients are asked if they would recommended the service to a friend or family member they will often feedback 'no' as they would not like their friend or family member to require admission to hospital.
In addition, the wards can see an increase in positive scores from the responses collected from Patient Experience Test (PET) machines, especially around if patients feel safe on the ward. This has seen an improvement every quarter, and especially in relation to the question "do you feel safe on the ward" which is also part of the Safe Ward and In-patient Quality Standard.
The wards are also undertaking the following actions to improve upon patient experience:

- Hosting community meetings to give patients the opportunity to feedback about immediate gripes or concerns so that these can be actioned to improve their stay.
- Providing 'You said – we did' information demonstrating that we are listening and implementing change where possible.
- Increasing therapy provision to engage patients more frequently.
- Looking into utilising some volunteers we have working with us to encourage the use of Patient Experience Test (PET) machines as, whilst on the ward, patients are acutely unwell and have low concentration. However if someone sits with them for a while explaining and asking the questions they are more likely to agree to answer them.

In relation to the comment about the small number of carer Friends and Family Test (FFT) responses (point 9 of the submission) the introduction of the FFT to our carers is in addition to existing work that is carried out across our clinical teams. Over 2016/17 we are going to explore how we can link this into existing mechanisms such as the feedback collected as part of our memory clinic accreditation. We have built upon the NHS England guidance by using the FFT with our carers and are committed to continuing to recognise and support the vital role carers have, and we monitor the effectiveness of this through our Carer Strategic Development Group, chaired by our Chief Operating Officer

In relation to the comments made about our 2015 Staff Survey results, we would like to emphasise that the Trust was ranked 5th out 29 similar Trusts in the area of overall staff engagement. In addition, this year the Trust achieved more scores in the top 20% of similar Trusts than in any other year (14 out of 32 Key findings placed us in the top 20%). The Trust was ranked 1st for staff motivation when compared with the 28 other Trusts against which we were benchmarked.

Although the Trust has scored well in the majority of areas, we accept that there are some areas where we would like to improve our results. Some of these identified areas for improvement are detailed in your response and we would like to take the opportunity to respond to each of these separately:

a. The Trust score of 43% for Key Finding 6 (KF6)- % reporting good communication between senior management and staff- was better than the average for similar Trusts (33%), better than our 2014 result (39%) and 5% lower than the top scoring trust in our benchmark group of similar Trusts (48%).

b. The Trust score of 88% for KF29- Percentage of staff reporting errors, near misses or incidents witnessed in the last month- may suggest that staff witnessing potential harm are less likely than staff in other similar Trusts to report it. However, it should be noted that these results only relate to responses from 30 staff. In addition, the recently published NHS Improvement 'Learning from Mistakes League' has highlighted that the Trust has a good culture of openness and transparency, with a ranking of 28th out of 230 Trusts. Finally, the trust was ranked in the top 20% for the other three questions relating to errors and incidents in the 2015 Staff Survey (KF28, KF30 and KF31).

c. The Trust acknowledges the result showing that 79% of the staff responding to the 2015 survey worked extra hours (KF16). We acknowledge, and are grateful for the hard work of our staff and appreciate that it is undertaken to meet the demands placed on our services. However, we are not complacent about this finding. Although we continue to have high staff engagement scores, we have asked our localities to look into where low staff engagement is linked to long working hours and to identify appropriate actions following this. In addition, the Trust has a policy for time off in lieu which has been commended by the RCN in previous years.

d. In relation to the score of 40% of respondents stating that they have suffered work related stress in the last 12 months (KF17), our own monitoring of sickness absence has highlighted that this is an increasing problem. The survey results allow us to investigate by locality and this will add to our understanding of root causes and potential solutions. Whilst the nature of some roles brings a level of stress with it, it is recognised that not being able to fill vacancies and having to work with high levels of agency staff can create additional pressures. As part of developing our Health and Wellbeing Strategy, we will look at extending some of the good practice we already have for supporting staff (e.g. SPACE Groups) as well as identifying other support mechanisms. The work of the Agency Programme to set up a central bank will help reduce reliance on agency staff to meet temporary staffing needs. To reduce vacancies, we have a small team working on how we can make our website pages more persuasive in attracting great applicants to join us. Also, we will pilot financial incentives to help attract staff and will decide in which Recruitment Fairs and Open Days we should invest time and money.

e. In relation to the finding of 20% of respondents stating that they have experienced harassment, bullying or abuse from other staff (KF26), although this finding is in line with other organisations in our benchmark group, the Trust is clear that it will not tolerate bullying or harassment of any kind. We know there is under-reporting of bullying and harassment from staff against their colleagues. Finding an effective reporting mechanism that staff have confidence in and that works has been a challenge. We will ask the relevant Locality Directors and Professional Leads to look into the areas where the problems seem to be worst. This is a key area of focus for us and one we are determined to get right.

f. 38% of the Trust staff that were invited to participate in the 2015 staff survey responded to the survey. Although this is lower than the national response rate of 41%, we are grateful to all of our staff that did respond as the results provide us with useful insights and allow us to act upon findings. We think this response rate needs to be seen in context. Every Quarter, since it was introduced, we have invited all staff to respond to a Staff "Friends and Family" Test. We have had a consistently good response rate and constructive feedback from our staff. The results have shown a positive upward trend with the last two quarterly returns showing 81/82% of respondents were likely to recommend the Trust to a friend or family member if they needed care or treatment, and 71% of respondents recommending the Trust as a place to work to a friend or family member.

In relation to data being passed to the Secondary Users Service (SUS) (Point 13 of the submission), please note that sending such data is a national NHS Trust requirement, to submit data to commissioners. SUS is part of the NHS and abides by the strict confidentiality, security and governance of the NHS. Datasets are mandated and, wherever possible, patient identifiers are removed. The NHS number is the prime identifier.

In relation to the comment about the increased number of reported medication errors (point 14 of the submission), please note that a high and increasing rate of medication error reporting is a sign of a healthy learning culture in the organisation and that reporting of such errors is being encouraged as the first step in ensuring a robust safety culture exists. In addition, the ratio of harm to non-harm errors in the Trust has been greater than 0.9 for a number of months (i.e. that patients experienced no harm as a result of the error in greater than 90 out of every 100 patients). The medication errors section of the final quality account has been updated to take these factors into account.

Response to Berkshire Healthcare NHS Foundation Trust Quality Account- 2016

From Reading Borough Council Health overview and Scrutiny Committee

BHFT Quality Account Feedback from: Reading Borough Council
Jo Hawthorne Head of Wellbeing

Domain	Priority	Comments
Patient safety	Falls, pressure ulcer prevention.	All of the Patient Safety indicators suggested are important. Evidence based approaches and partnership working is key to reducing falls in services. Overall rates of falls in Reading remain below the England average but the trend is increasing. Focussing on falls prevention should help to keep rates below the England average and support a return to a downward trend. Education of patients and carers and early intervention to ensure prevention of pressure damage in the first place is also key. Reading Borough Council therefore feels that the above would be real priorities for the Trust to focus on including the development of pathways to refer patients at risk of frailty to exercise / support groups within council - link with RBRS work
Clinical effectiveness	NICE Guidance	Reading Borough Council fully supports the measures set out to maintain achievement of compliance with NICE guidance.
Patient experience	Friends and Family Tests, Learning from Complaints, Patient Leadership Programme	We believe that all the Patient experience priorities are important. We support the promotion and integration of the Friends and Family Test into existing systems a key mechanism for gathering information on patient experience. We would like to see how outcomes of the developing the Patient Leader Programme can be monitored to inform its priorities in relation to health.
Health Promotion	Suicide Prevention	We believe that the Suicide prevention priorities highlighted are important. We note that the Trust is an active part of the joint strategic partnership approach suicide prevention across Berkshire to help keep suicide rates which are below the England average. We would also like to see how the Trust is using information from the updated Joint Strategic Needs Assessment 2016 to inform its strategic priorities in relation to health promotion/public health and wellbeing. We would encourage the use of the national CQUIN with regards to improving health promotion/public health and wellbeing. The physical and cardiovascular health of patients with SEMI

Berkshire Healthcare NHS Foundation Trust Response:

Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

The Trust welcomes the feedback from Reading Borough Council Health Overview and Scrutiny Committee and for the suggestions to help improve the final report.

The Trust is grateful for the positive comments made in relation to our patient safety, clinical effectiveness, patient experience and health promotion priorities for 2016/17.

In relation to the comment made about patient falls, the falls team are integrated within the intermediate care service which is based at the Avenue school with Reading Borough Council reablement team. The team work alongside partners and, in particular, community and voluntary groups to deliver the Falls Prevention Classes. Patients are given information on falls classes that are provided in Reading.

In relation to the comment made about pressure tissue damage education, all of our community nursing staff are trained in pressure ulcer prevention. This focuses on prevention in the first instance, and is based on the SKIN mnemonic (Surface, Keep moving, Inspect & protect and Nutrition & hydration). Nursing staff also have cards that they give out and use to talk through with patients and carers about pressure tissue damage. Education and advice is provided by nurses on a 1 to 1 basis. Assessments are undertaken and, if appropriate, equipment is requested. Reassessments are also undertaken. On our inpatient units patients are assessed within 6 hours of admission and again all staff have training in pressure ulcer prevention.

In relation to the comment about the Patient Leadership Programme, updates on progress will be included in the Trust quality account report for 2016/17.

In relation to the comment about the use of the Joint Strategic Needs Assessment (JSNA), we understand that the JSNA informs commissioning priorities for our services, resulting in service specifications which we agree with our health commissioners. We also engage patients and the public through Trust patient engagement processes and use that to understand the public health needs for health and well- being for our patients and populations.
In addition, the Trust have used specific JSNA data for specialist services (e.g. heart failure, community neuro rehabilitation, respiratory, older persons mental health services etc.) to inform of prevalence.
JSNA data is also used within business cases for new services or service development.
Finally, the Trust CQUINS for 2016/17 include the national CQUINS relating to introduction of health and wellbeing initiatives and cardio-metabolic assessment and treatment for patients with psychoses. Information about these CQUINS have been added to the appendices of the final Quality Account report

Response to Berkshire Healthcare NHS Foundation Trust Quality Account- 2016

From Wokingham Health Overview and Scrutiny Committee

Members of the Wokingham Health Overview and Scrutiny Committee reviewed the draft Quality Account 2016 Q3 update report for Berkshire Healthcare NHS Foundation Trust and have made the following comments:

- Members questioned why for mental health inpatients, the percentage recommending services to family and friends has reduced in the third quarter following increases in the first and second quarters of the year.

- Members were pleased to note that with regards to Community Physical Health the percentage of patients who rated the service they received as very good or good, was increasing.

- Members felt that a glossary of acronyms would be helpful.

- Members were pleased to see that overall compliments were increasing and that the number of complaints was decreasing.

- Members were concerned that 2015/16 continues to have a high rate of suicide and suspected suicide cases, although it is appreciated that this is comparable with national trends.

Berkshire Healthcare NHS Foundation Trust Response:

Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

The Trust welcomes the feedback from Wokingham Health Overview and Scrutiny Committee and for the suggestions to help improve the final report.

The Trust is grateful for the positive comments made in relation to; community physical health friends and family test results, the increase in compliments and the reduction in complaints.

In relation to the Friends and Family Test (FFT) scores for mental health inpatients (point 7 of the submission), a significant proportion of patients admitted for inpatient care are detained under the Mental Health Act and the very nature of this process and their illness makes it less likely that patients will participate in service feedback or provide positive feedback. Equally, if patients are asked if they would recommended the service to a friend or family member they will often feedback 'no' as they would not like their friend or family member to require admission to hospital. In addition, the wards can see an increase in positive scores from the responses collected from Patient Experience Test (PET) machines, especially around if patients feel safe on the ward. This has seen an improvement every quarter, and especially in relation to the question "do you feel safe on the ward" which is also part of the Safe Ward and In-patient Quality Standard.
The wards are also undertaking the following actions to improve upon patient experience:

- Hosting community meetings to give patients the opportunity to feedback about immediate gripes or concerns so that these can be actioned to improve their stay.
- Providing 'You said – we did' information demonstrating that we are listening and implementing change where possible.
- Increasing therapy provision to engage patients more frequently.
- Looking into utilising some volunteers we have working with us to encourage the use of Patient Experience Test (PET) machines as, whilst on the ward, patients are acutely unwell and have low concentration.

However if someone sits with them for a while explaining and asking the questions they are more likely to agree to answer them.

In relation to the concern raised about the increasing number of suicides (although comparable with national trends), the Trust has selected prevention of suicide as one of its Quality Account priorities for improvement for 2016/17. Full details on this priority are included within the Priorities for Improvement 2016/17 Section of the final Quality Account.

Finally, in relation to the suggested inclusion of a glossary of acronyms, the Trust agrees with the suggestion and has inserted the glossary of acronyms into the final Quality Account.

Appendix H

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST ON THE QUALITY REPORT

We have been engaged by the Council of Governors of Berkshire Healthcare NHS Foundation Trust to perform an independent assurance engagement in respect of Berkshire Healthcare NHS Foundation Trust's Quality Report for the year ended 31 March 2016 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2016 subject to limited assurance consist of the following two national priority indicators (the indicators):

- 100% enhanced Care Programme Approach patients receiving follow-up contact within seven days of discharge from hospital; and
- Admissions to inpatient services had access to crisis resolution home treatment teams.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the sources specified in the Detailed Guidance for External Assurance on Quality Reports 2015/16 ('the Guidance'); and
- the indicator in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- board minutes and papers for the period April 2015 to May 2016;
- papers relating to quality reported to the board over the period April 2015 to May 2016;
- feedback from commissioners; dated April 2016
- feedback from governors; dated April 2016
- feedback from local Healthwatch organisations; dated April 2016
- the 2015 national patient survey;
- the 2015 national staff survey;
- the 2015/16 Head of Internal Audit's annual opinion over the trust's control environment; dated May 2016; and
- the February 2016 CQC Intelligent Monitoring Report.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Berkshire Healthcare NHS Foundation Trust as a body, to assist the Council of Governors in reporting the NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2016, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Berkshire Healthcare NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information', issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicator;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was determined locally by Berkshire Healthcare NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2016:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Report subject to limited assurance has not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

KPMG LLP

KPMG LLP
Chartered Accountants
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25 May 2016

Glossary of acronyms used in this report

Acronym	Full Name
ASD	Autistic Spectrum Disorder
AWOL	Absent Without Leave
BAU	Berkshire Adolescent Unit
BHFT	Berkshire Healthcare NHS Foundation Trust
BME	Black and Minority Ethnic
CAMHS	Child and Adolescent Mental Health Service
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
CDiff	Clostridium Difficile
CHS	Community Health Service
CMHT	Community Mental Health Team
CMHTOA	Community Mental Health Team for Older Adults
CPA	Care Programme Approach
CPN	Community Psychiatric Nurse
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CRHTT	Crisis Resolution and Home Treatment Team
CST	Cognitive Stimulation Therapy
CYPIT	Children and Young People's Integrated Therapy Service
DEAL	Diabetes Education and Awareness for Life
EPMA	Electronic Prescribing and Medicines Administration
FFT	Friends and Family Test
GDM	Gestational Diabetes Mellitus
HR	Human Resources
HTT	Home Treatment Teams
IAF	Information Assurance Framework
IAPT	Improving Access to Psychological Therapies
IG	Information Governance
IMROC	Implementing Recovery through Organisational Change
KF	Key Finding
LD	Learning Disability
MDT	Multi-Disciplinary Group
MHA	Mental Health Act
MHS	Mental Health Service
MIU	Minor Injuries Unit
MRSA	Methicillin-Resistant Staphylococcus Aureus
MSK	Musculoskeletal
MSNAP	Memory Services National Accreditation Programme
NCAPOP	National Clinical Audit and Patient Outcomes Programme
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NCISH	National Confidential Inquiry into Suicide and Homicide for people with Mental Illness
NICE	The National Institute of Health and Care Excellence
NIHR	National Institute of Health Research

Acronym	Full Name
OAHSN	Oxford Academic Health Science Network
PAF	Performance Assurance Framework
PHSO	Parliamentary Health Service Ombudsman
POMH	Prescribing Observatory for Mental Health
PROMs	Patient Reported Outcome Measures
PU	Pressure Ulcer
QOF	Quality and Outcomes Framework
RTT	Referral to Treatment Time
SI	Serious Incident
TRIPS	Telemedicine Referral Image Portal System
WIC	Walk-In Centre