Berkshire Healthcare NHS
NHS Foundation Trust

COUNCIL OF GOVERNORS

The next meeting will be held on Wednesday, 22 March 2017
starting at 10.15am
At Easthampstead Baptist Church, South Hill Road, Bracknell

AGENDA

ITEM	DESCRIPTION	PRESENTER	TIME
1.	**Welcome & introductions**	Chair	2
2.	**Apologies for Absence**	Company Secretary	1
3.	**Declarations of Interest** 1. Annual Declaration of Interests (*Enclosure*) 2. Agenda items	 All All	1
4.	**Minutes of Last Formal Meeting of the Council of Governors – 09 December 2016** (*Enclosure*)	Chair	2
5.	**Matters Arising**		5
6.	**Governor Elections Report**	Julie Hill, Company Secretary	2
7.	**Committee/Steering Groups** Reports: *a.* Living Life to the Full *(Enclosure)* b. Membership & Public Engagement *(Enclosure)* **c.** Quality Assurance meeting *(Enclosure)*	 Committee Group Chairs and Members	15
8.	Quality Account Report Quarter 3 *(Enclosure)*	Amanda Mollett, Head of Clinical Effectiveness and Audit	20
9.	**Executive Reports from the Trust** 1. Performance Report *(Enclosure)* 2. Patient Experience Quarter 3 Report *(Enclosure)* 3. Annual Plan Summary 2017-18	Alex Gild, Chief Financial Officer Jayne Reynolds, Deputy Director of Nursing Bev Searle, Director of Corporate Affairs	30
10.	**Governor Questions**	Chair	15
11.	**Trust's New Website - Demonstration**	Sabrina Meusel, Digital Marketing and Communications Officer	10

12.	**Dates of Next Meetings** 12th April 2017 – Council of Governors & Trust Board 14th June 2017 – Council of Governors 12 July 2017 – Council of Governors and Non-Executive Directors 13 September 2017 – Council of Governors and Annual Members' Meeting *(Meetings held at Easthampstead Baptist Church)*		

Berkshire Healthcare NHS
NHS Foundation Trust

COUNCIL OF GOVERNORS

22 March 2016

Governor Declarations of Interest

For Noting

Author: Julie Hill, Company Secretary

GOVERNOR DECLARATIONS as at March 2017

NAME	CONSTITUENCY	INTERESTS DECLARED
ALI-NOOR Ruffat	Public Slough	Independent legal advisor and advocate, High Court
ASSER Keith	Public Reading	Member of the Labour Party
BANSAL Mukesh	Public West Berkshire	None
BANSE Amrik	Public - Slough	None
BARRETT John	Public WAM	Chair, WAM Mental Health Service User and Carer Forum. WAM Mental Health Partnership Board – Core Member
BERRY Linda		None
BERTHOLLIER, Natasha	Staff Governor	None
CARMICHAEL June	Staff Governor	None
DOLINSKI Richard	LA Appointed - Wokingham	RBH Council of Governors; WBC Cllr; Woodley Town Cllr; volunteer, Sue Ryder, Duchess of Kent Hospice
EDWARDS Adrian	LA Appointed - West Berks	West Berkshire and Newbury Town Councillor; Member of the Royal Berkshire Fire Authority and Champion for Health and Wellbeing; Trustee for: Newbury Almshouse Trust; St Bartholomew School Foundation; and Patient Participation Group for Falkland Surgery, Newbury
HORNE Andrew	Public - Wokingham	Vice-Chair The Silver Workshop – Men's Sheds project, Reading. Member of the Labour Party.
LAKE Tom	Public – Reading	Director of inter-Glossa (non-NHS) software; Shares in GlaxoSmithKline, wife, Jill Lake Chair of Trustees of Reading HomeStart
LEEMING June	Public - WAM	None
LYNCH Robert	Public – Rest of England	None
MATTICK Isabel	LA Appointed – Bracknell	BFBC: Overview & Scrutiny; Health Overview & Scrutiny Care Portfolio. Personal: Chairman, patient group; patient assembly; Founder member Triple A; Frimley Park Dementia Group; President/Chairman Red Diamond Sports Club for disabled; Patient Rep GP Council; PLACE Inspector Frimley Park Hospital
MELABIE Alison	Appointed – Triple A	None

NAME	CONSTITUENCY	INTERESTS DECLARED
MOLLETT Amanda	Staff	None
MUNAWAR Sohail	Appointed – Slough Borough Council	
MURRICANE Verity	Public West Berks	Board member Sovereign Housing Association; Trustee Eight Bells mental health
MYERSCOUGH Paul	Public - Reading	None
O'KANE Tom	Public - WAM	Shares in GlaxosmithKline Member Berkshire NHS Research Ethics Committee
OLIVER Nigel	Public - Slough	None
PATEL Krupa	Public - Wokingham	None
PRINCE Julia	Staff Governor	Employee of BHFT
RODGERS Pat	Public - Bracknell	Secretary and volunteer, Ascot Area Alzheimer's (Triple A).
RONES Victor	Public - Bracknell	None
ROSE Suzanna	Berkshire Red Cross	President Berkshire Branch British Red Cross; Governor, Royal Star & Garter Homes
STEVENS Gary	Public – Wokingham	
STEEL Craig	Appointed – University of Reading	None
TICKNER Bet	LA Appointed - Reading	Partner Governor, Royal Berkshire Hospital Foundation Trust. Borough Councillor, Reading Borough Council

Updated as at March 2017

Berkshire Healthcare NHS
NHS Foundation Trust

Council of Governors

Friday 09th December 2016

Minutes

In attendance:	Martin Earwicker, Chair
Public Governors	Ruffat Ali-Noor
	Amrik Banse
	Linda Berry
	Andrew Horne
	Tom Lake
	June Leeming
	Robert Lynch
	Paul Myerscough
	Nigel Oliver
	Gary Stevens
Staff Governors	June Carmichael
	Jeremy Lade
	Julia Prince
Appointed Governors	Adrian Edwards
	Isabel Mattick
	Ali Melabie
	Richard Dolinski
	Bet Tickner
In attendance:	Minoo Irani, Medical Director
	Bev Searle, Director of Corporate Affairs
	Julie Hill, Company Secretary
	Louise Arnold, Office Manager and Assistant Company Secretary

Apologies:

Governors:	Mukesh Bansal
	Verity Murricane
	Krupa Patel
	Keith Asser
	Tom O'Kane
	Suzanna Rose
	Craig Steel
	John Barrett
	Victor Rones
	Amanda Mollett
	Pat Rodgers

1. Welcome & Introductions

Martin Earwicker welcomed the Governors to the meeting and introduced himself as the new Chair.

2. Apologies

Apologies for absence were received and noted above.

3. Declarations of Interest

3.1 Amendments to Register - there were none declared
3.2 Declarations of Interest - there were none declared

4. Minutes of the previous meeting – 20 July 2016

The Minutes of the previous meeting were taken as read and agreed as a correct record of discussions with one amendment:

- In the Living Life to the full section, it should read “Recovery Colleagues” rather than “Recovery Policies.”

5. Matters Arising

No comments.

6. Committee/Steering Group Reports –

6.1 Living Life to the Full

Tom Lake noted John Barrett’s absence and briefly explained the content of the last Living Life to the Full Committee meeting. The group worked together to agree the Terms of Reference for the Group, however there was not yet a draft version for the Council of Governors to approve formally.

The January meeting was going to focus on social prescribing and looking into the future. Tom further noted that work on continuing Mental Health support was being reviewed in terms of the recovery college structure.

All new Governors are welcome to join the January meeting.

6.2 Membership & Public Engagement

Tom Lake shared that the BHFT staff have excelled themselves this year with the help of Governors to recruit new members through public events. The Trust currently had a membership of over 12,000 which was more than other local Trusts.

It was hoped that with the new MES membership database system it would offer Governors more visibility of the Berkshire population and give the staff some different ways of working to attract and engage with members more effectively. Martin Earwicker noted the wide range of diversity in the Trust’s members.

Jill Barker had been invited to the next committee meeting and therefore Tom extended the invitation to all Governors to join the committee, specifically Governors based in the East as the discussions will be relevant to them.

The Terms of Reference were still being reviewed with Jenny Vaux and Bev Searle. The draft version was hoped to be taken to the next formal Council of Governors meeting.

6.3 **Quality Assurance Group**

June Leeming shared two experiences of Quality visits with the meeting. June specifically noted that the Campion unit staff were very pleasant and engaged when in the service, however the entrance to the ward did not reflect this initially. When the Governors revisited the service in July, there was a full staff team and the entrance area had been much improved.

June also noted the visit which had taken place to Berkshire Adolescent Unit (BAU) and commented that the various rooms and offices available were impressive. Previously young people would be allocated patient care outside of Berkshire; however BAU now provided opportunities for so many more patients within the borough.

The Terms of Reference had been agreed and June requested that the Council of Governors review and approve them. It was unanimously agreed that the Terms of Reference were confirmed with no amendments to be made.

Bet Tickner referred to the visit location list and asked whether you had to be part of the group to complete the visits as previously this had not been the case. It was agreed that if a Governor had a specific interest in a service then they were able to contact June Leeming or Paul Myerscough to arrange the visit with them in future.

Chris Fisher noted that quality visits, including 15 step visits were extremely helpful and agreed with the full report submitted by Paul and June. The quality of leadership had improved in the services and the quality of care will continue to progress.

7. Quality Account Indicators for External Audit Quarter 2

Jason Hibbitt was welcomed to the meeting to discuss the Quality Account. This report was an update which was also shared with the Board and sub committees.

The Quality Account was required to create a formal account on the quality of care across the Trust. It was noted that the majority of the report was mandated and therefore could not be changed in terms of format and information included. The account was created out of three main sections; Statement of Quality, how we achieved quality targets and health promotions. Each of these sections included the Trust's performance and how it was succeeding in all areas.

Paul Myerscough asked how many patients had not responded to the Friends and Family Test (FFT) and why they have not given an answer. Minoo Irani responded that the total number of patients will be reviewed by the FFT team and Julie is able to circulate the information to anyone who would like it by email. This will be separate to the Quality account. Minoo agreed that a sentence may be added to reflect the context of the FFT reporting results.

Tom Lake noted that this report was an improvement of last years. Tom gave a suggestion to give level indexes for an easier read and reference within the report. Jason Hibbitt highlighted that the report structure was mandated therefore the flow of the document could not be changed, however agreed that it took some getting used to. Minoo added that this report was only a snapshot of the Quality work which was occurring across the Trust and there was only a certain amount of information which was able to be included within one report. Andrew Horne suggested adding a page after the content to explain the structure of the report for an easier read.

Robert Lynch referred to the summary at the end of the report and asked whether there was an opportunity to showcase the plans to improve mortality reporting. Minoo responded that this would be included in Quarter 4 rather than in Quarter 2 and will show the outcomes rather than the plans.

Adrian Edwards asked whether the Trust vision related to outpatients as well. Minoo confirmed it did.

There were three indicators proposed; Delayed transfers of care, Complaints and Appraisals. It was requested that the Governor's choose one of these to focus on. The Governors formally agreed on option one "Delayed Transfers for Care".

8. Audit Matters: 2015/16

Chris Fisher (NED) and Satinder Jas, External Auditors (KPMG) were welcomed to the meeting. Chris Fisher is the Chair of the Audit Committee since August 2016. Chris Fisher gave some background information around the External Audit process and the work of the Audit Committee.

The risk ratings on page 94 were highlighted as those RAG rated in Amber and Red are areas of improvement for the Trust.

Once every three years there was a Tender process for the appointment of the Trust's external auditors. It was noted that the appointment of the External Auditors was a statutory function of the Council of Governors.

Paul Myerscough noted the vast improvement which had been seen over the past few years in terms of the audit work and highlighted that the report to the Governors was much more legible now.

Bet Tickner asked whether the Clinical team had been involved with the Audits. Chris Fisher confirmed they had been heavily involved and the transparency with the clinical teams was key.

Robert Lynch questioned what the link was between Quality Improvement and the internal auditors. Chris Fisher confirmed that the internal auditors reviewed what had happened within the Trust compared to the Quality Improvement programme which will review what the front line were currently doing and what changes could be made to improve patient care, experience and outcomes.

Tom Lake asked whether the £5k for auditoring the Trust's charitable funds was proportionate. Chris Fisher confirmed that the whole package was reviewed as a piece of work rather than separate reviews. More working days were spent on charitable funds for less spend because of the purpose of the budget.

Robert Lynch noted that Duty of Candour was an internal process which was a new requirement. Robert asked how much time was allocated specifically to this area. Chris and Satinder agreed to discuss this offline with Robert.

External Auditor – Satinder
Satinder Jas, Manager at KPMG is one of the external auditors which have been actively involved with the Audit of the Trust.

KPMG provide assurance on three key areas; the financial statements, an assessment about whether the Trust was achieving value for money and the quality assurances. The report stated on page 120 that there were no high recommendations for areas of improvement, but there was a medium priority recommendation; Quality Accounts to be reviewed. The Trust had accepted the proposed recommendation.

Adrian Edwards asked whether the projected favourable outturn position of £0.5million was surplus. Satinder confirmed that it was surplus and explained that within the process of budget setting there were some additional external funding received which moved the Trusts position from deficit position.

Martin Earwicker highlighted that the report was reassuring and despite the Trust's current financial pressures, there were improvements being made and targets were being achieved.

The Governors thanks to all those involved with this report were formally noted.

9. Appointment of External Auditors

The report was taken as read. Paul Myerscough led on this section and thanked for all governors involved in the tender process.

It was shared that the Deloittes met every area of requirement and the outcome for the Governors was to formally recommend the Deloittes to be used as the external auditors in future.

Adrian Edwards asked whether the Trust will be criticised for only reviewing one option during the process. Paul confirmed that others were considered however as there were only 4 main leading firms which can provide this service it reduced options. Isabel Mattick further noted that there was reassurance given to the governors involved that and shared that the process was thorough. KPMG had to step back on this occasion as they were also bidding for another Trust contract and if successful, they would have a conflict of interest.

The Governors formally approved and supported the recommendation to appoint Deloittes as the external auditors.

10. Executive Reports from the Trust

The report was taken as read. Bev Searle was welcomed to the meeting to discuss the Executive reports.

It was acknowledged that the information was well laid out and previous comments have been implemented.

Tom Lake shared his concern regarding the numbers received within Reading and the crisis resolution team during the last three quarters. Bev agreed to respond to Tom offline.

Andrew Horne noted that the size of the population will have an effect on the number of complaints received within localities.

Adrian Edwards noted that the agency costs were positive. Bev shared that there were plans in place to achieve significant savings in the coming years and it was important that the Trust's controls were in place. Bev noted that if zero was ever achieved then this would suggest the Trust is over-staffed.

11. Any Other Business

A question was asked to confirm whether expanding the staff bank had been successful. Bev confirmed that it had been and the agency programme had successfully converted some staff to the new bank way of working. The Board were working to employ more permanent staff and the next round of reductions should come from the removal of agency shifts into bank.

Paul Myerscough noted that the NHSP system was implemented as a tool for staff to use, however some staff have shared that it is difficult to use. Minoo stated that NHSP was used across the whole NHS and involved a variety of different roles to make it successful. Not all staff would be satisfied immediately, but as time goes on and changes are made to adapt the service to our Trust it will improve.

13. Dates of next Council meetings

15th February 2017 – Council of Governors and NEDs
22nd March 2017 – Formal Council of Governors
12th April 2017 – Joint Meeting of Council and Trust Board

I certify that this is a true, accurate and complete set of the Minutes of the business conducted at the meeting of the Council held on 09th December 2016

Signed:…….
(Martin Earwicker, Chair) Date: 22nd March 2017

Berkshire Healthcare NHS
NHS Foundation Trust

COUNCIL OF GOVERNORS

22 March 2016

Governor Election Report

For Noting

Author: Julie Hill, Company Secretary

ELECTORAL REFORM SERVICES
PART OF THE ERS GROUP

7th March 2017

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST
ELECTION TO THE COUNCIL OF GOVERNORS

My report of voting in the above election, which closed at 5pm on Monday 6th March 2017, is as follows.

Public: Reading

Number of eligible voters:		1,772
Votes cast by post: Votes cast online:	113 15	
Total number of votes cast:		128
Turnout:		7.2%
Number of votes found to be invalid:		5
Blank or Spoilt No declaration form received	5 0	
Total number of valid votes to be counted:		123

Result (1 to elect)

MYERSCOUGH, Paul.....63 **Elected**

SAMPSON, Margaret.....44
HILLIER, Eric John.....16

Public: Slough

Number of eligible voters:		729
Votes cast by post: Votes cast online:	43 4	
Total number of votes cast:		47
Turnout:		6.4%
Number of votes found to be invalid:		0
Blank or Spoilt No declaration form received	0 0	
Total number of valid votes to be counted:		47

Result (1 to elect)

BANSE, Amrik Singh.....32 **Elected**

GOPAL, Jagjiwan.....15

Staff: Clinical

Number of eligible voters:		3,118
Votes cast by post: Votes cast online:	334 71	
Total number of votes cast:		405
Turnout:		13%
Number of votes found to be invalid (blank or spoilt):		0
Total number of valid votes to be counted:		405

Result (1 to elect)

BERTHOLLIER, Natasha.....91 **Elected**

LADE, Jeremy Charles.....83
SUDDABY, Paul.....81
CUTTING, Christine.....62
RAHIMI, Yousuf Ali 59
SEEBURN, Jay 29

Electoral Reform Services can confirm that, as far as reasonably practicable, every person whose name appeared on the electoral roll supplied to us for the purpose of the ballot:-

a) was sent the details of the ballot and
b) if they chose to participate in the ballot, had their vote fairly and accurately recorded

The elections were conducted in accordance with the rules and constitutional arrangements as set out previously by the Trust, and ERS is satisfied that these were in accordance with accepted good electoral practice.

All voting materials will be stored for twelve months.

Yours sincerely

Ciara Norris

Ciara Norris
Returning Officer
On behalf of Berkshire Healthcare NHS Foundation Trust

Council of Governors

Report from Living Life to the Full Governors Group

22nd March 2017

The group met on 11th January 2017 for the first time without John Barrett who has been on extended sick leave, with former co-chair Verity Murricane in the chair.

In the circumstances the group agreed to recommend the re-adoption of the existing Terms of Reference unaltered.

Council is invited to re-adopt the existing Terms of Reference of the Group.

It may be worth recapping the purpose of the group - "To champion good practice, so enabling people to live their lives beyond diagnosis, by supporting autonomy, expertise and well-being. To help develop this philosophy both within the Trust and in its work with partner organisations by promoting training opportunities and supporting mechanisms to share information."

Community Marketplace at Prospect Park Hospital

Emma Davies – a senior occupational physiotherapist at Prospect Park Hospital spoke about the Community Marketplace held there on the last Wednesday of every month in the Art Therapy room. A good number of support organisations from across Berkshire attend and are available to make contact with inpatients andl support them prior to discharge. Emma is exploring whether this could also be made available to recently discharged patients.

Brighter Berkshire – Year of Mental Health 2017

Heidi Strickland-Clark spoke about this spontaneous initiative which has now gathered a good deal of support – not least since Richard Benyon MP spoke at the launch and then had a positive reply from the Prime Minister to a parliamentary question about the initiative.

The core team have liveed experience of mental health problems or of caring for those that do and are passionate about mental health and wellbeing.

The emphasis is on mobilising community resources to raise awareness, eliminate stigma and encourage employers educational establishments and local authorities to do more to help.

Initiatives so far include encouraging singing through choirs and a song competition, a trans-Berkshire bike ride, a logo designed by Reading college graphics students and a regular monthly 1-hour show on BBC Radio Berkshire during 2017.

The Brighter Berkshire website is at **brighterberkshire.com –** join in!

Next Meeting - 5th April

If you support the purpose of the group do come along. s

Report to Council from Governors Membership and Public Engagement Group
Tom Lake, Chair, Council of 22nd March 2017

1. The group met on 19th January. The new membership system is fully operational and the Trust had about 11,500 members, well above the regulatory target of 10,000. The public membership from East Berkshire and with Asian background is less than representative. The group discussed putting rebalancing the membership above increasing it for the next year in Marcomms membership recruitment activities.

2. The group is recommending a rewritten Terms of Reference to Council. This has arisen from much discussion, including with Trust management, about the Governors' relationship to the Trust's Public Engagement, and follows attempts to revise the current Terms of Reference, which referred to non-existent strategies. The new Terms of Reference recognises that strategy for Public Engagement is a matter primarily for Trust Management, but that Governors are entitled to consider Trust Public Engagement on behalf of the Trust members and public and that this group is the appropriate one to do so.

   Jenny Vaux, Director of Strategic Planning and Business Development, was present at the meeting and asked for her dissent from the recommendation of these Terms of Reference to be noted, arising from concern about the inclusion of the Trust's Public Engagement among the matters which the group might consider.

   We ask Council to approve these Terms of Reference.

3. The group has been working on a slide presentation for Governors to use when addressing general audiences. It is intended that Governors can select slides and add new ones as the occasion demands. The presentation has been distributed, with attendant notes.

4. The group welcomed Nigel Oliver and Ruffat Ali-Noor as members.

5. We hope to undertake further work in the following areas, which we request and recommend Council to refer to the group:.

   5.1. Explore useful organisations of civil society which Governors can engage with;
   5.2. Consider the revised Trust website as it appears (it is currently being worked on);
   5.3. Consider those aspects of volunteering for the Trust which are suitable for the general public, while leaving volunteering by former service users in the province of the Living Life to the Full group.
   5.4. The new membership system offers possibilities for engaging with members according to their interests. However, the Trust offers no means for members to change or enlarge their interests after first applying for membership, even though first recruitment may well be a hasty interaction at a public event. This should not hold up the current membership strategy but must be considered in the longer term.

6. The group has frequently noted the difficulty for Governors of knowing about Trust public engagement events (sometimes these are very local) in advance – Governors may want to use the opportunity to meet members of the public. We invited Jill Barker, Director East Berkshire, to discuss this, but our discussion was pre-empted by more pressing problems with setting up regular locality meetings for Governors. Since the re-organisation in East Berkshire locality meetings have not functioned properly. Jill Barker had a new proposal.

As this is more properly a matter for Council than for our group we recommend that it be discussed in Council.

7. We shall once again be inviting Governors to help with recruiting members at major public events. Those that have done this know that this can be quite entertaining. We have distributed a list of possible events – could you give an indication of whether you might be available for the event? Thank you.

D R A F T 10th Jan 2017

COUNCIL OF GOVERNORS

MEMBERSHIP AND PUBLIC ENGAGEMENT GROUP

TERMS OF REFERENCE

Authority

The group is established and authorised by the Council of Governors which is also responsible for approving these terms of reference and any amendments thereto.

Summary Purpose

The purpose of the group is to work with officers of the Trust and Governors to maintain and support Trust membership, to support Governor engagement with members and public and to offer support to the Trust in its public engagement. The group aims at the recruitment and maintenance of a representative Trust membership exceeding required numbers and the establishment of effective communication between the Council of Governors and the Trust membership, also between Governors and wider public where appropriate. The group will undertake specific scrutiny on relevant issues remitted to it by Council or by the Trust Board/Executtive.

Membership

Membership of the group is open to all Governors. The number of members is not specified but the group will seek to have a membership that ensures good representation of Trust membership constituencies without being too large to exercise its function. The quorum shall be 3 governors.

To enable the group to work effectively the Trust company secretary or their nominated representative should attend when matters related to Governors' engagement are tabled and the head of the Marketing and Communications group or their nominated representative should attend when matters related to membership recruitment or communication with members are tabled. Other officers of the Trust may be invited as appropriate.

Responsibilities

1. Working with officers of the Trust, to develop and evolve the Trust's membership strategy.

2. To offer support to officers of the Trust in developing and reviewing the Trust's communications and engagement strategies.

3. Working with officers of the Trust, to review the effectiveness of the Trust's membership strategy and to make recommendations as to the evolution of that strategy.

4. To support the recruitment of members according to the Trust's membership strategy.

5. To support Governors in communicating and engaging with Trust members and the public.

6. In these activities to target the reduction of discrimination and health inequalities and to

work towards parity of esteem for mental and physical health care.

7. To meet at least four times a year and to report on its work at every meeting of the Council of Governors.

8. To undertake specific scrutiny on relevant issues remitted to it by Council or by the Trust Board/Executive.

9. To review these terms of reference on a two-yearly basis.

QA Group Report to Council of Governors March 2017

Meetings

Since we last report there have been one meetings of the QA Group on 9 February 2017.

We welcome interest particularly from non-staff Governors as the service visits carried out by members of this group provide a real insight into the services of the Trust at a grass roots level.

The next meetings are:- Tues 2nd May, Thurs 7th Sep.

Special Reports

The team were keen to get an update about the Complex Needs service. This delivered psychological therapies to people through the Winterbourne House site in Reading. A cornerstone of the service was a Therapeutic Community which facilitated mutual and self help for participants.

Following a review in 2015 the TC was disbanded and the service reconfigured.

IMPACTT is the label given to the new service – Intensive Management of Personality Disorders and Clinical Therapies Team.

Although the manager dropped out at the last minute, we were fortunate to that Alex Tagg, a senior psychologist in the service could join us and answer questions.

Alex confirmed that the TC was stopped without causing any casualties amongst client members.

There are about 1300 referrals with complex needs.

The staff team of around 20 is now restructured with half becoming locality based adding on average 2 therapists to the local IPT teams, and the remainder constituting IMPACTT.

The IMPACTT service targets adults indentified as 'cluster 8s' – this implies complex personality disorders at the most severe level below that requiring hospital admission (non-psychotic).

The 12 staff are based in Early Road and provide two 'evidence based' therapies.

Dialectical Behaviour Therapy (DBT) aims to decrease emotional suffering and help build a life worth living. It involves teaching specific skills to help people manage their emotions and lives more effectively.

Mentalisation Based Treatment (MBT) focuses on developing a person's ability to make sense of their own mind in terms of thoughts, feelings, beliefs and actions and also what might be going on in other peoples' minds.

The team has a capacity to treat around 100 patients. Evident groupings are women who a big self-harmers, men who show anti-social traits, and mothers who damage their children.

Therapy is delivered in both group and individual sessions on a weekly basis over a period of one year to 18 months. Many patients have chaotic lives and strategies must be adopted to optimise the value of the groups so, for instance, in the men's group with a capacity of 8 members there are 16 patients registered.

Alex highlighted the fact that a lot of young people need the support of this service and the bridge with CAMHs service for under 18s is important area for attention.

As governors we would have liked to know how our capacity of 100 places matches the need in our area. Also of the original 1300 referrals per year, are their needs being better met under the new regime.

Complaints

Statistics show the level of complaints is extremely low, and that all are dealt with within the target time frame.

At each meeting we review the correspondence around a complaint chosen at random by the Director of Nursing. This not only reveals how the Trust responds to complaints but also areas around our services where there are common misunderstandings or difficulties. Generally the group feel those reviewed are handled satisfactorily. Sometimes we feel that additional information could be provided to the complainant – for example signposting to support groups.

Some governors were distressed to learn that one of the CAMHS services we deliver – ASD assessment, does not result in any therapy delivered by the Trust. This made the CAMHs complaint about delayed assessment that we discussed all the more poignant.

Service Visits

The team are gradually working their way down the list – see table below.

Location	Address	done
Snowdrop Ward	Prospect Park Hospital, Honey End Lane, Tilehurst, Reading, RG30 4EJ	y
CAMHS, wokingham	Wokingham Community Hospital, 41 Barkham Road, Clinic Building, Wokingham, Berkshire, RG41 2RE	
Intermediate Care, West Berks	WBCH, London Road , Benham Hill, Thatcham , Berkshire, RG18 3AS	
Sorrel and POS Wards	Prospect Park Hospital, Honey End Lane, Tilehurst, Reading, RG30 4EJ	y
Pharmacy Ward	Prospect Park Hospital, Honey End Lane, Tilehurst, Reading, RG30 4EJ	y
Rose Ward	Prospect Park Hospital, Honey End Lane, Tilehurst, Reading, RG30 4EJ	
Windsor and Ascot Wards	West Berkshire	y
CMHT, West Berkshire	Hillcroft House, Rookes Way, Thatcham, RG18 3HR	y
Campion Ward	Prospect Park Hospital, Honey End Lane, Tilehurst, Reading, RG30 4EJ	y
Talking therapies, Reading	TBC	y
CRHTT West	Prospect Park Hospital, Honey End Lane, Tilehurst, Reading, RG30 4EJ	
Daisy Ward	Prospect Park Hospital, Honey End Lane, Tilehurst, Reading, RG30 4EJ	y
Bluebell Ward	Prospect Park Hospital, Honey End Lane, Tilehurst, Reading, RG30 4EJ	
Henry Tudor Ward	St Marks Hospital, St Mark's Road, Maidenhead SL6 6DU	
BAU (Berkshire Adolescent Unit)	Wokingham Hospital, Barkham Road, Wokingham RG41 2RE	y
Dietetics	Skimped Hill Health Centre, Skimped Hill Lane, Bracknell, RG12 1LH	
ARC clinic	Upton Hospital, Albert Street, Slough , Berkshire, SL1 2BJ	
School Nursing Berkshire West	WBCH, London Road , Benham Hill, Thatcham , Berkshire, RG18 3AS	

Common Point of Entry (CPE)	The Old Forge, 45 – 47 Peach Street, Wokingham , Berkshire, RG40 1XJ	
OPMH, Slough	Upton Hospital, Albert Street, Slough , Berkshire, SL1 2BJ	
East Crisis Team	????	y
Podiatry	Podiatry headquarters at WBCH, London Road , Benham Hill, Thatcham , Berkshire, RG18 3AS	
Slough Walk in Centre	East Berkshire Health Authority, Upton Hospital, Albert St, Slough SL1 2BJ	y
Westcall OOH: preferably either a Sat or Sun	The Old Forge, 45 – 47 Peach Street, Wokingham , Berkshire, RG40 1XJ	y
Reading CMHT	Prospect Park House, Honey End Lane, Tilehurst, Reading, RG30 4EJ	
CAMHs, Newbury	Lower Henwick Farmhouse, Turnpike Road, Thatcham, Berkshire, RG18 3AP	
OPMH, West Berkshire	Beechcroft, London Road , Benham Hill, Thatcham , Berkshire, RG18 3HR	
District Nursing, Wokingham	Wokingham Hospital, Barkham Road, Wokingham, Berkshire, RG41 2RE	
Speech and Language Therapy	Southcote Clinic, Coronation Square, Reading , Berkshire, RG30 3QP	y
Little House Ward	Prospect Park Hospital, Honey End Lane, Tilehurst, Reading, RG30 4EJ	
Orchid Ward Ward	Prospect Park Hospital, Honey End Lane, Tilehurst, Reading, RG30 4EJ	
CMHT, Windsor and Maidenhead	Nicholson House, Nicholson Walk, Maidenhead , Berkshire, SL6 1LD	
District Nursing, Slough	Upton Hospital, Albert Street, Slough , Berkshire, SL1 2BJ	
Intermediate Care, Wokingham	2nd Floor, The Old Forge , 45-47 Peach Street, Wokingham , Berkshire, RG40 1XJ	
Occupational therapy, Slough	New Horizons, Pursers Court, Slough , Berkshire, SL2 5BX	
CRHTT East	West Berkshire	
Rowan Ward	Prospect Park Hospital, Honey End Lane, Tilehurst, Reading, RG30 4EJ	
CMHT, Bracknell	Church Hill House, 51-52 Turing Drive, Bracknell, RG12 7FR	
Health visiting, Reading	TBC	
Health visiting, Wokingham	TBC	

Each visit generates a report, which is available to Governors and Trust Management.

Visits discussed at our last meeting included West Call, Snowdrop Ward – this visit resulted in a follow-up visit to the East Crisis Team, and the Slough Walk-in Centre.

Council of Governors

Committee Meeting	Council of Governors Meeting- 22nd March 2017
Title	Quality Account 2016/17- Quarter 3 Report
Purpose	NHS foundation trusts must publish a quality account each year, as required by the NHS Act 2009, and in the terms set out in the *NHS (Quality Accounts) Regulations 2010* as amended by the *NHS (Quality Accounts) Amendments Regulations 2011* and the *NHS (Quality Accounts) Amendments Regulations 2012* (collectively "the Quality Accounts Regulations"). For the Trust this provides an opportunity to present a balanced account of its quality priorities and performance against these. The report includes some mandated content which can be complex, but should, in general, be accessible for members of the public.
Business Area	Trust Wide
Executive Director	Medical Director
Lead	Head of Clinical Effectiveness & Audit
Relevant Strategic Objectives	Strategic Goal 1- Improving Patient Experience: To provide accessible, safe and clinically effective services which improve patient experience and outcomes of care
CQC Registration/ Patient Care Impacts	N/A
Legal Implications	The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. NHS Improvement's annual reporting guidance for the quality report incorporates the requirements set out in the Department of Health's Quality Accounts Regulations and additional reporting requirements set by NHS Improvement.
SUMMARY	This is the Quarter 3 report of the Trust's Quality Account for 2016/17.The information included within the report is as of the end of Quarter 3. There are some sections of this report which will not contain any information until Quarter 4 due to external and national reporting time frames. In addition all completed sections will be updated in Quarter 4 with revised data. It will also be ensured that charts are consistent and clear before the final version is agreed in April and May 2017. Governors will note that changes have been made to the look of the quality account with the aim of making it more readable. In addition, blue coloured information notices have been added at appropriate points in the report to better explain and signpost its content to the reader. These changes have been undertaken with the input of Governor Tom Lake who has provided valuable insight into the readability of the document. The report shows that there has been progress to date with respect to all key quality priorities which were identified in the previous account. Services have been fully engaged and have sent significant contributions to be included within the service improvement section. The following substantive sections, not included in the Q2 report seen at the December Council of Governors Meeting, have been added to this Q3 report. 1. Quality Account Highlights 2016/17. Fully drafted, for update in Q4. 2. Section 1: Statement on Quality by CEO. Fully drafted. 3. Section 2.1.1: Patient Experience-National Community Mental Health Survey. This section has been included following publication of Trust results in in November 2016 4. Section 2.1.1: Patient Experience-National Staff Survey 2016. This section has been included following publication of Trust results in March 2017

	5. Section 2.1.5 to Section 2.1.12: Service Improvements. Fully drafted following external audit recommendations. Commentary also details areas for improvement where applicable. All input for this section has been drafted in collaboration with clinical directors, locality directors and service leads. 6. Section 2.2: Setting Priorities for Improvement for 2017/18. Drafted for update and alignment with trust priorities in Q4. 7. Section 2.3: Statements of assurance from the Board- Fully drafted with update on the number of services provided by Trust and proportion of income generated. Finally, the Council of Governors are asked to note the following: 1. NHS Improvement published its detailed guidance on production of Quality Reports in February 2017. Whilst this document does not mandate any substantial changes to the content of trusts' quality reports, the publication of the Single Oversight Framework in late 2016 has led to some changes to the core indicators that must be reported within Section 3 of the Quality Report. These changes have been incorporated into this report. 2. There is no formal requirement for trusts to report mortality data in their quality reports this year. However, the trust has been informed by NHS England that providers will be expected to report progress on their learning from deaths in their 2018 Quality Accounts. This will include how learning in this area is being used to inform quality improvement plans, and will include an annual summary of monthly/quarterly Trust Board reports on reviewing and learning from deaths.
ACTION REQUIRED	The Council of Governors is invited review the Quality Account, to seek any clarification required and to note progress with priorities at Q3. As in previous years the Lead Governor is invited to submit a response on behalf of the Council of Governors on their views of the quality account, this will then be included within the appendices of the final document alongside the Trust's reply. This will need to be received by 18th April 2017, and should be sent to: Jason Hibbitt- Clinical Effectiveness Facilitator Jason.hibbitt@berkshire.nhs.uk

Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

Berkshire Healthcare NHS Foundation Trust

Quality Account 2016/17

Quarter 3 Report

Our vision: To be recognised as the leading community and mental health service provider by our staff, patients and partners

Our Values:
Caring for and about **you** is our **top priority**
We are **committed** to providing **good quality, safe services**
and **working together** with **you** to develop **innovative solutions**

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 (BHFT) 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 216 mental health inpatient beds and 180 community hospital beds in five locations and we employ more than 4,000 staff.

Working in partnership with patients and their families is really important to us as this helps us to provide the best care in the right place. We support people with long-term health problems to manage their own lives as much as we can, so they can stay at home and do not need to be in hospital.

We organise our services around the six areas of Berkshire, to match the local authority boundaries. We call these Localities. Each Locality Director works together with a Clinical Director to make sure that our service management is informed by clinical knowledge and expertise.

We work closely with our commissioners to develop services that meet the needs of our diverse population – aiming to help people remain independent at home as far as possible. We provide many of our services in partnership with Local Authorities and also work closely with GPs, voluntary sector organisations and others.

We support the education of the future NHS workforce by working in partnership with Health Education Thames Valley and 10 universities, including the Universities of Reading, Oxford, Oxford Brookes, Southampton, Surrey and West London. We train a wide range of healthcare professionals including future doctors, nurses, psychologists, special care dentists, occupational therapists, health visitors, dieticians, audiologists and physiotherapists. These learners may be part of the care teams delivering our services and will work in a manner consistent with the NHS Constitution.

Table of Contents for Quality Account 2016/17

Quality Account Highlights 2016/17

Patient Experience

We ask patients and carers to tell us how they rate the care they received. There was an improvement across most areas of those who would rate us as good or very good, with a slight decrease in Mental Health Inpatients.
Community Hospitals- 96%
Community Physical Health- 94%
Community Mental Health- 86%
Mental Health Inpatients- 75%

Patient Safety

Priority targets have been met in relation to:

- the reduction of pressure ulcers that have developed due to a lapse in care by the trust
- the reduction of falls by patients in our hospitals

Clinical Effectiveness

The trust continues to demonstrate that relevant NICE Technology Appraisals are available and greater than 80% of all NICE guidance is being met.

Zero Suicide

The trust has launched its zero suicide initiative this year, with a focus on both challenging the culture relating to suicide and on giving people skills to address situations when people are at their most vulnerable

Care Quality Commission (CQC) Rating

The trust continues to be rated as 'Good' by the CQC and is committed to maintaining and improving on this rating

Service Improvements

Many successful improvements have been implemented across the trust, including:

- The Westcall Out of Hours GP Service have implemented a successful sepsis project
- The Children's Young People and Families Service continue to deliver a transformation programme
- The Adult Learning Disability Service have established a mortality Clinical Review Group
- All trust memory clinics are now accredited by the Memory Services National Accreditation Programme (MSNAP)
- A new Intensive Management of Personality Disorders and Clinical Therapies Team (IMPACTT) has been established
- Mental health inpatient services have run a successful "failure to return from leave" project
- Child and Adolescent Mental Health (CAMHS) have started a new Eating Disorders Service

The trust has set quality priorities for 2017/18 in the following areas:

Quality Improvement Priority

- To implement the trust Quality Improvement Initiative to link in with aspects of quality, safety, effectiveness and experience

Patient Safety Priorities

- Falls
- Pressure Ulcers
- Health promotion- To continue implementing the Zero Suicide initiative

Clinical Effectiveness Priorities

- To report on the implementation of NICE guidance identified as a Trust priority
- To review and report on mortality in line with new national guidance as it is published

Patient Experience Priorities

- To continue to prioritise and report on patient satisfaction and make improvements.
- To improve on national patient and staff survey results
- To continue to prioritise learning from complaints
- To continue to implement the Patient Leadership Programme.

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

Throughout the 2016/17 financial year, Berkshire Healthcare NHS Foundation Trust has continued to deliver effective, safe and efficient care for its patients. We have a trust-wide vision to be recognised as the leading community and mental health provider by our patients, staff and partners, and the results shown in this Quality Account help demonstrate our commitment to this aspiration.

We are committed to ensuring that patients have a positive experience of the care we provide, and evidence available from the Friends and Family Test results and our own patient satisfaction survey demonstrate that we continue to meet this commitment. A positive experience of our services by both patients and the people that care for them helps to support and enhance the high clinical quality of the care we provide. We aim to maintain and improve on these results and have set an ongoing priority in this area for 2017/18.

Patient safety remains of paramount importance to us. Our trust board monitors performance in this area through scrutiny of a variety of patient safety metrics, several of which are shared in this report. Our governance, patient safety, incident and mortality reporting systems are increasingly robust and are able to highlight areas for improvement in timely manner allowing for learning. In addition, results from our patient safety priority this year, detailed in part 2 of this report, highlight that we are meeting the targets set in relation to the reduction of patient pressure ulcers and falls. We will continue striving to deliver safe care and have set further patient safety priorities for the coming year.

Our clinical effectiveness agenda helps us to ensure that we are providing the right care to the right patient at the right time and in the right place. By performing clinical audit, we are able to measure our care against current best practice leading to improvement, and this report details some of the many audits that have been undertaken this year. In addition, our involvement in research has helped to inform future treatment and management of patients. We have also met our priority target of implementing 100% of relevant NICE Technology Appraisal Guidance and greater than 80% of all relevant NICE Guidance for the second year running.

The launch of our zero suicide initiative was a highlight this year as it focuses on both changing the culture in relation to suicide, as well as giving people the skills to address situations when people are at their most vulnerable. The first year of this initiative has seen the establishment of a steering group to oversee the project, with two leads in place to drive it forward. Additional crisis awareness and suicide prevention training has been delivered to relevant staff, and a new risk summary has been implemented across the trust to help clinicians better identify when patients are in need and to take timely actions as required. This project will continue to March 2018 and we will be reporting on further progress in next year's Quality Account.

Numerous other service improvement projects have been undertaken by trust services throughout the year. Many of these improvements are detailed within this report and they demonstrate the breadth of improvement work that is being undertaken, as well as the commitment of trust staff to improve services across the county.

The Trust continues to be rated as 'Good' by the CQC. We are proud of this rating and are determined to be recognised as the leading community and mental health provider by our patients, staff and partners.
In 2017/18 we will be embarking on a significant 18 month programme of Quality Improvement with the aim for our patients, carers, staff and the Care Quality Commission to view us as an 'outstanding' organisation.

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

Part 2. Priorities for Improvement and Statements of Assurance from the Board

2.1 Achievement of Priorities for Improvement for 2016/17

ⓘ This section details the trust's achievements against its quality account priorities for 2016/17. These priorities were initially identified, agreed and published as part of the 2015/16 quality account process. Specific priorities have been set in the areas of patient experience, patient safety, clinical effectiveness and health promotion.

These quality account priorities support the trust's quality strategy for 2016-20 (see 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:

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

Figure 1 below summarises the achievement of the Trust in 2016/17 against each of its quality account priorities. Each of these priorities is then discussed in more detail later in this section.

Figure 1- Summary of Trust achievement against 2016/17 Quality Account Priorities –

To be included in the Q4 Report (May 2017) with final results

2.1.1 Patient Experience

ⓘ One of the Trust's primary priorities is ensuring that patients have a positive experience of our services and receive respective, responsive personal care. This sub-section details our performance against our patient experience priorities for 2016/17.

Our 2016/17 Patient Experience Priorities:

- **To continue to prioritise and report on the Friends and Family Test (FFT) results for both patients and carers, and on the trust's own internal patient satisfaction survey throughout the year. By doing so, the trust aims to demonstrate continuing improvement.**
- **To improve on national patient and staff survey results**
- **To continue to prioritise learning from complaints**
- **To implement the Patient Leadership Programme.**

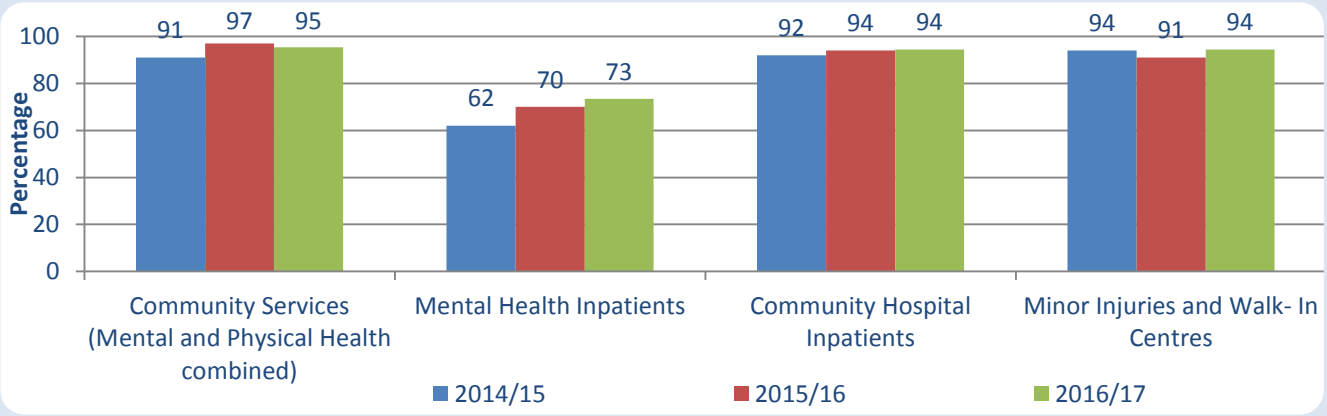
Patient Friends and Family Test (FFT)

ⓘ The Friends and Family Test (FFT) is used by most NHS funded services in England. It is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. The FFT asks people if they would recommend the services they have used, and can be completed by text messaging after discharge, card or on the internal trust patient survey.

Figures 2 and 3 below demonstrate the Trust's achievement in relation to the FFT. The figures show that recommendation rates for trust services are generally high. Responses up to the end of Quarter 3 2016/17 indicate that greater than 90% of respondents were very likely or likely to recommend Trust community services, community hospital inpatient services, minor injuries services and the walk in centre.

There is also an increased recommendation rate for mental health inpatient services up to the end of Quarter 3 2016/17 when compared with the 2015/16 full-year results. However, it should be noted that overall response rates are low and, as a result, the patient experience team are working with services to promote the FFT.

Figure 2- Patient Friends and Family Test (FFT): Percentage of patients extremely likely or likely to recommend the service to a friend or family member.



**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 3a- Patient Friends and Family Test- total number of responses

Survey and Service	2015/16			2016/17		
	Total no. of respondents	Respondents likely or extremely likely to recommend service		Total no. of respondents	Respondents likely or extremely likely to recommend service	
		No.	%		No.	%
Community Services- Mental Health & Physical Health Combined	11492	11193	97	8884	8471	95
Mental Health Inpatients	140	99	70	109	80	73
Community Hospital Inpatients	1128	1062	94	695	656	94
Minor Injuries Unit and Walk in Centre	8649	7871	91	4909	4636	94

Source: Trust Patient Experience Reports

Figure 3b: Response Rate for patient Friends and Family Test (latest available month)

For October 2016 (latest data available)	Total Responses	Total Eligible	Response Rate
Community Health services	1,224	23,654	5%
Mental Health Services	298	3,384	9%

Source: Trust Patient Experience Reports

Please note that response rates have been included above, but they only relate to the latest monthly data available. BHFT in line with national recommendations aim for a 15% response rate for the FFT across all services.

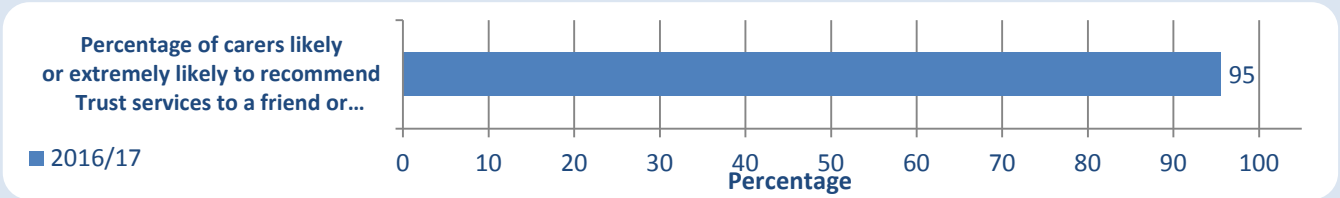
Carer Friends and Family Test (FFT)

ⓘ A Friends and Family Test for carers has also been created and distributed to trust services. This survey asks if carers would recommend trust services, thus allowing them the opportunity to share their experience with us in a dedicated way. Whilst this is not mandated nationally, the Trust recognises the crucial role that carers have and the value of their feedback.

Figures 4 and 5 below demonstrate the Trust's achievement in relation to the carer Friends and Family Test. The figure shows that, up to the end of Quarter 3 2016/17, 95% of respondent carers were extremely likely or likely to recommend the service to a friend.

The trust are working on increasing awareness of Carer FFT cards within the trust and the potential impact of the FFT on other carer feedback e.g. memory clinic accreditation.

Figure 4- Carer Friends and Family Test: Percentage of carers extremely likely or likely to recommend the service to a friend or family member



Source: Trust Patient Experience Reports

Figure 5- Carer Friends and Family Test- total number of responses

Survey and Service	2015/16			2016/17		
	Total no. of respondents	Respondents likely or extremely likely to recommend service		Total no. of respondents	Respondents likely or extremely likely to recommend service	
		No.	%		No.	%
All carers	N/A	N/A	N/A	133	127	95

Source: Trust Patient Experience Reports

Please note that the Trust does not have a response rate for this survey.

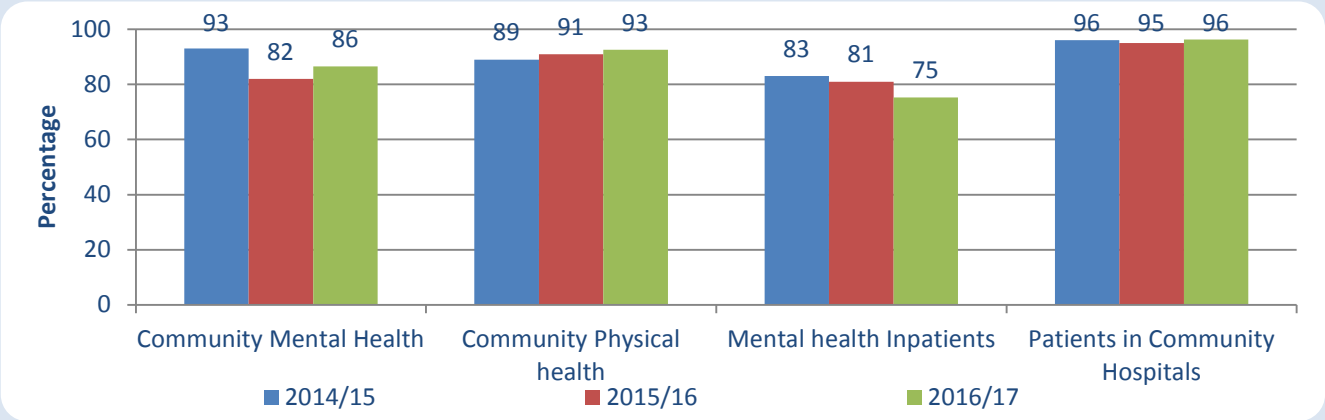
Trust Patient Satisfaction Survey

ⓘ The Trust also carries out its own patient satisfaction survey throughout the year to further ascertain and assure levels of patient satisfaction.

Figures 6 and 7 below demonstrate the Trust's performance in relation to its patient satisfaction survey.

The figures show that, up to the end of Q3 2016/17, over 85% of respondents rated the service they received from community health services (both physical and mental health) and community inpatient services as very good or good. The findings for mental health inpatients are below 80%, which is in line with the equivalent FFT findings.

Figure 6- Trust Patient Survey: Percentage of patients who rated the service they received as very good or good.



Source: Trust Patient Experience Report

Figure 7- Trust Patient Survey- total number of responses

Survey and Service	2015/16			2016/17		
	Total number of respondents	Total rating service as good or very good	% rating service as good or very good	Total number of respondents	Total rating service as good or very good	% rating service as good or very good
Community Mental Health	1308	1068	82	711	822	86
Community Physical Health	10947	10010	91	6602	7131	93
Mental Health Inpatients	703	567	81	183	243	75
Patients in Comm. Hospitals	1288	1229	95	409	425	96

Source: Trust Patient Experience Reports

Patient Leadership Programme

ⓘ The Patient Leadership Programme has been set up to improve involvement of patients and carers in the development of our services. The aim of the programme is to establish a group of people that have received training and support to work with us to design and change patient services for the better.

As at the end of Quarter 3 2016/17, two patient leaders have been appointed for the trust and have recently completed their patient leadership training. They are currently looking into projects to become involved in, with a particular interest being shown in involvement in in the Zero Suicide project.

A further update on this programme will be given at the end of Q4 2016/17.

Learning from Complaints and Compliments

The Trust has continued to respond to and learn from complaints and compliments during the year.

Figures 8 and 9 below show the number of complaints and compliments received by the Trust. From these charts, there appears to be a slight downward trend in the number of formal complaints received since April 2015 and an upward trend in compliments received over the same period.

The Trust received 36 formal complaints in Q3 2016/17. This is a reduction in comparison with the previous three quarters. The West Berkshire locality was the only locality to see an increase in the number of formal complaints received in comparison with the last quarter. Of the other localities, Slough received the same number and all of the other localities saw a reduction in complaints compared with the previous quarter.

The services with the greatest number of formal complaints during Q3 2016/17 were Community mental health (CMHT) and Care Pathways, Acute Adult Mental Health inpatients, Crisis Resolution/Home Treatment Team (CRHTT), Community Hospital inpatients and Community Nursing. However, CRHTT did see a continued reduction in complaints in comparison with quarters one and two. The Clinical Director for CRHTT continues to review all of the complaints received to ensure that themes or trends that require specific improvement are acted on.

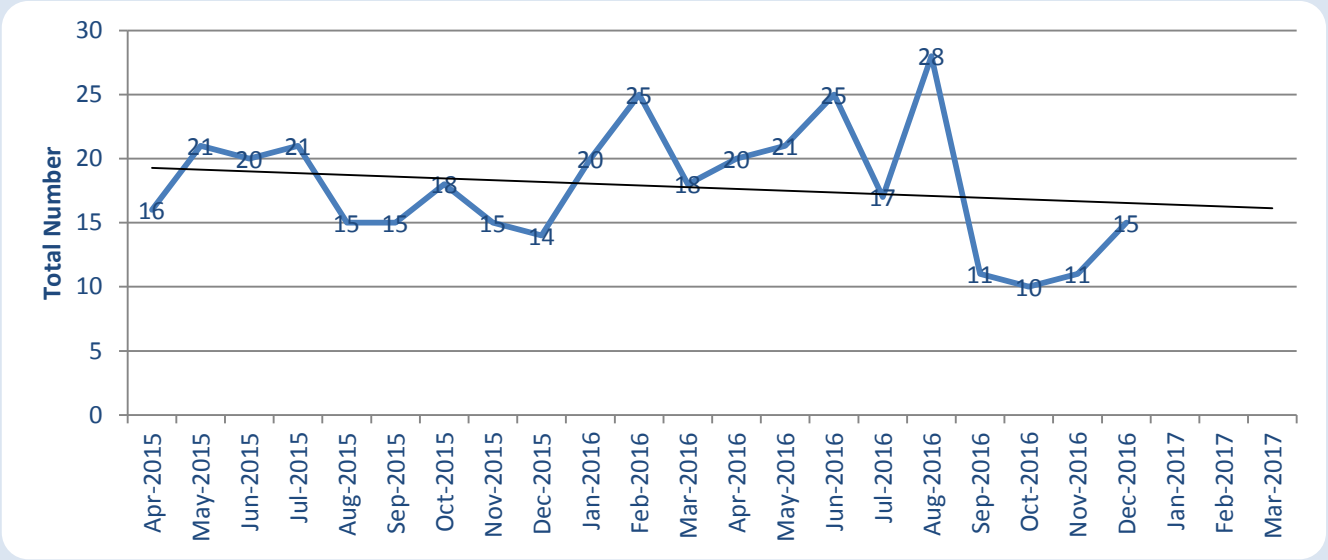
For Community Mental Health Teams and Community Hospital inpatients, the number of complaints was similar to the number received in quarter two, and Adult Acute Mental Health inpatients saw a significant reduction.

Child and Adolescent Mental Health Services (CAMHS) has seen a continued reduction in the number of formal complaints received, with 2 received during quarter three in comparison with 5 in quarter two and 6 in quarter one; the number of complaints received remains lower than those received during quarters one and two in 2015/16.

During quarter 3 of 2016/17 we achieved a complaints response rate of 100% within the timescale agreed with the complainant. This 100% result has been sustained from Q1 of 2016/17. Services on average took 33 days to investigate and respond to complaints in Q3 of 2016/17 (compared with 28 days in Q2 and 29 in Q1). Many complaints are responded to much quicker if they are less complex.

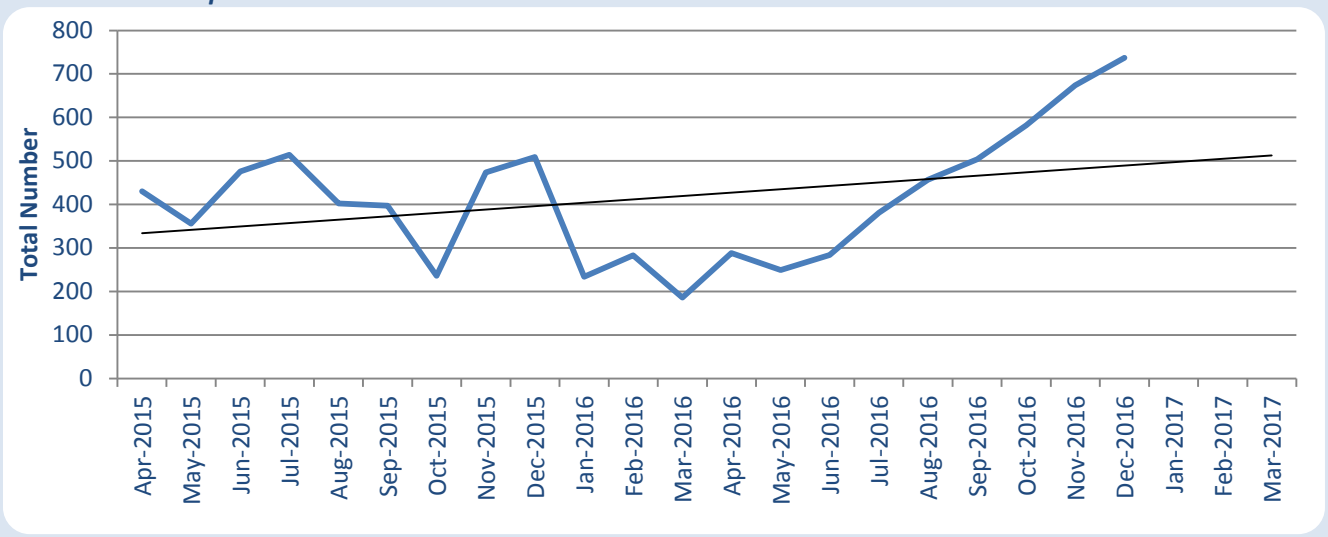
Please also note that the number of complaints, together with response and resolution times is included within section 3 of this report as they are core indicators.

Figure 8- Complaints received



Source: Trust Performance Assurance Framework

Figure 9- Compliments received



Source: Trust Compliments Reports

2016 National NHS Community Mental Health Survey

The National Community Mental Health Survey is an annual survey that aims to ascertain the experiences of people that receive specialist care or treatment for a mental health condition. Feedback from people about their experiences of our community mental health services is crucial in helping us highlight good care and to identify potential risks to the quality of services.

The results of the 2016 National Community Mental Health Survey were published in November 2016. Patients were eligible to receive and respond to this survey if they had been seen by community mental health services between 1 September 2015 and 30 November 2015. Surveys were sent to 850 people meeting this inclusion criteria, with responses received from 233 of them (27%). This is a decrease from 30% in 2015, but is in line with the national average (which has also seen a decrease).

The 2016 survey contained 36 questions across ten sections. Each question and section was scored out of a total mark of 10 and given a RAG rating (Red, Amber or Green) to indicate how the trust had scored in relation to an expected range of scores. For example, an amber score indicates that the trust is not significantly different than average for that question, with a green score indicating that the trust scored better and a red score worse.

The Trust scored amber (about the same as other Trusts) across all sections of the benchmarking report in the 2016 survey. The Trust also scored amber across all questions in this survey, with the exception of one question where the trust scored Red: When you tried to contact them (Crisis Care), did you get the help you needed? Improvement in scores was seen across all areas of the report that looked at support and wellbeing.

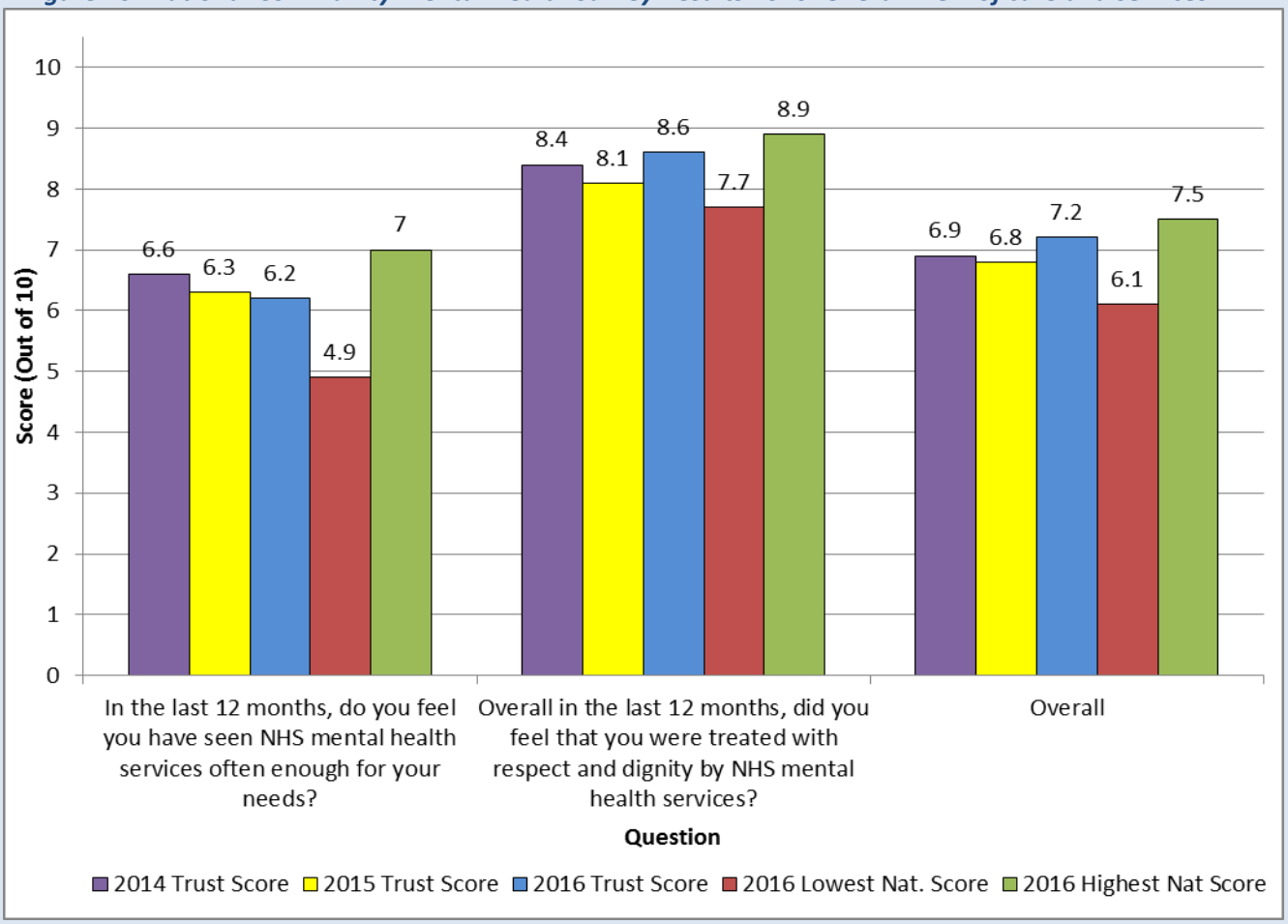
The Trust will shortly be carrying out a 'deep dive' into our crisis resolution/home treatment team, which had been scheduled prior to these results being published, as part of our ongoing patient experience programme. This is externally facilitated and will give us more in depth insight into the experience of people who use this service and those who care for them, as an addition to our local feedback methods.

There has been a significant increase in satisfaction about being supported to find work. Our Individual Placement and Support (IPS) employment service receive positive feedback through our internal patient survey and it is assuring to see that this is also reflected in this improvement.

These results are to be shared with the Community Mental Health Teams and the wider organisation.

Figure 10 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 2016 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 both 2014 and 2015. Please also note that the overall Community Mental health score for the Trust is also included within section 3 of this report as it is a core indicator.

Figure 10- National Community Mental Health Survey Results 2016- Overall view of care and services



Source: National Community Mental Health Survey

2016 National NHS Staff Survey

The results from the National NHS Staff Survey are used by the Trust to inform local improvements in staff experience and well-being. This is important as a positive staff experience plays an important part not only in staff welfare, but also in helping to maintain and improve on patient safety and experience. This section has been included here as staff satisfaction can have an impact on both patient experience and safety

Please note that this section currently contains an overview of findings, and will be updated for the Quarter 4 report.

Berkshire Healthcare NHS Foundation Trust took part in the 2016 NHS National Staff Survey between October and December 2016. The survey was conducted online, resulting in it being open to over 4000 of the Trust's employees, 1,911 (46%) of whom responded. This compares favourably with the 2015 response rate of 38%. Nationally the 2016 response rate was 38% for all 316 participating trusts and 44.2% for trusts similar to BHFT (29 combined mental health, learning disabilities and community health services trusts). The trust results were benchmarked against

these similar Trusts and showed that that for the 32 key findings, the trust had

- Better than average scores for 20, with 4 equalling the best score
- Average scores for 7
- Worse than average scores for 5

Of particular note, the 2016 staff engagement score was 3.91/5- the same as in 2015. This high score is important due to the link between staff engagement and the provision of good quality, safe services.

The trust scored well in 2016 in relation to a number of key findings, including the following:

- Staff motivation at work - 4.06/5 – the best score.
- Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months - 9%- a small increase on last year's score (7%) but the best score in our group
- Percentage of staff satisfied with the opportunities for flexible working patterns – 64% - the best score and an improvement on 2015 (61%)
- Percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month- 19% - the best score, although 1% higher than the trust score in 2015 (18%)

In addition, the trust experienced improved scores in 2016 compared with 2015 in the following areas:

- Percentage of staff working extra hours
  2015 Score- 79% 2016 Score- 75%.
- Percentage of staff feeling unwell due to work related stress in the last 12 months
  2015 score- 40% 2016 Score- 36%
- Percentage of staff reporting errors, near misses or incidents witnessed in the last month
  2015 Score 89% 2016 Score- 92%.

The trust experienced reduced scores in 2016 compared with the 2015 results in the following areas:

- Percentage of staff reporting most recent experience of violence.
  2015 score- 86% 2016 score- 80%.
  Please note that trust analysis of the data shows that BHFT have a very small number of staff experiencing violence and therefore this reduction represents a very small number of people. However, we are keen to encourage high rates of reporting and providing good support to staff.
- Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion
  2015 score 88% 2016 score 86%.
- Percentage of staff agreeing that their role makes a difference to patients / service users.
  2015 score- 93% 2016 score- 92%.
- Percentage of staff experiencing physical violence from staff in last 12 months
  2015 score- 1%. 2016 Score- 2%
- Effective team working –
  2015 Score 3.99 2016 Score- 3.93

Please also note that the overall National Staff Survey score for the Trust is also included within section 3 of this report as it is a core indicator.

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.

Figure 12a below details these findings for the Trust, separated into scores for white and black and minority ethnic (BME) staff.

As can be seen, trust scores for the four components of the workforce race equality standard (WRES), have either deteriorated or not improved enough. The trust will make a consistent and sustained commitment over time to achieve the required progress and have a programme of work in place to achieve this

Figure 12a- Staff survey results relating to the Workforce Race Equality Standard

Description	Race	Trust Score 2014 (%)	Trust Score 2015 (%)	Trust Score 2016 (%)	Average (median) for combined MH/LD and community trusts (29 Trusts)- 2016
KF25- Percentage of staff experiencing harassment or bullying from patients / public in the last 12 months	White	21	23	**22**	27
	BME	32	25	**27**	32
KF26- Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	White	19	19	**18**	20
	BME	23	27	**26**	24
KF21- Percentage of staff believing the Trust provides equal opportunities for career progression or promotion	White	88	91	**90**	89
	BME	76	74	**68**	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**	5
	BME	13	14	**17**	14

Figure 12b below details further results from the 2016 staff survey and compares them with previous Trust results, and the median score for similar Trusts in 2016.

Figure 12b- 2016 National Staff Survey

Question and reference (2016 Survey)		Trust Score 2014 (%)	Trust Score 2015 (%)	Trust Score 2016 (%)	Average (median) for combined MH/LD and community trusts (29 Trusts)- 2016
Q2a	*I look forward to going to work (often or always)*	59	67	**67**	59
Q2b	*I am enthusiastic about my job (often or always)*	74	79	**79**	74
Q5f	*How satisfied am I that the organisation values my work (Satisfied or very satisfied)*	47	48	**51**	45
Q8c	*Senior managers try to involve staff in important decisions (agree or strongly agree)*	41	43	**43**	35
Q8d	*Senior managers act on staff feedback (agree or strongly agree)*	41	43	**43**	32
Q12a	*My organisation treats staff who are involved in an error, near miss or incident fairly (agree or strongly agree)*	51	56	**60**	54
Q12b	*My organisation encourages us to report errors, near misses or incidents(agree or strongly agree)*	88	92	**91**	89
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	78	**78**	70
Q12d	*We are given feedback about changes made in response to reported errors, near misses and incidents (agree/ strongly agree)*	51	65	**67**	60
Q13b	*I would feel secure raising concerns about unsafe clinical practice (agree or strongly agree)*	78	73	**76**	72
Q13c	*I am confident that my organisation would address my concern (agree or strongly agree)*	65	66	67	60
Q21a	*Care of patients / service users is my organisations top priority (agree or strongly agree)*	73	80	**81**	73
Q21b	*My organisation acts on concerns raised by patients and service users (agree or strongly agree)*	78	82	**81**	75
Q21c	*I would recommend my organisation as a place to work (agree or strongly agree)*	62	65	**67**	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)*	71	74	**75**	66

Source: 2016 National Staff Survey

2.1.2 Patient Safety

ⓘ The Trust aims to prevent errors in healthcare that can cause harm to patients. The errors that occur in healthcare are rarely the fault of individuals, but are usually the result of problems with the systems they work in. Regardless, NHS patients should be treated in a safe environment and be protected from avoidable harm.

Our 2016/17 Patient Safety Priorities:

- **To continue to improve on the prevention and reduction of pressure ulcers during the year, maintaining the level of performance against current indicators on pressure ulcers that have developed due to a lapse in care by trust staff**
- **To reduce the number of falls experienced by trust inpatients**

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 2016/17. 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.

A list of trust quality concerns are also documented within this section, together with progress relating to the Trust Freedom to speak up (whistleblowing) process. Further information on Trust patient safety thermometer metrics, including those relating to various types of harm, are included in Appendix D.

Pressure Ulcer Prevention

ⓘ Pressure ulcers, sometimes known as 'bed sores' or 'pressure sores', are an injury that breaks down the skin and underlying tissue. They are caused when an area of skin is placed under pressure and can range in severity from patches of discoloured skin to open wounds. Pressure ulcers are graded from 1 (most superficial) to 4 (most severe)

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 target is to demonstrate continuing improvement during the year, maintaining the level of performance against current indicators on pressure ulcers that have developed due to a lapse in care by Trust staff.

Current interventions to ensure sustained best practice include completion of the Waterlow risk assessment and MUST scores on admission. Both of these identify someone's risk of developing a pressure sore and lead to implementation of an appropriate care plan to minimise the risk.

Further actions to be undertaken during 2016/17 to address this priority include:

- Continuing to support the Pressure Ulcer Prevention Champion Network (e.g. through education sessions)
- Learning summits for all developed category 3 and 4 pressure ulcers that are found to have had a Lapse in Care in the community.
- Involvement in improvement projects supported by the Oxford Academic Health Science Network looking at use of documentation at first assessment.

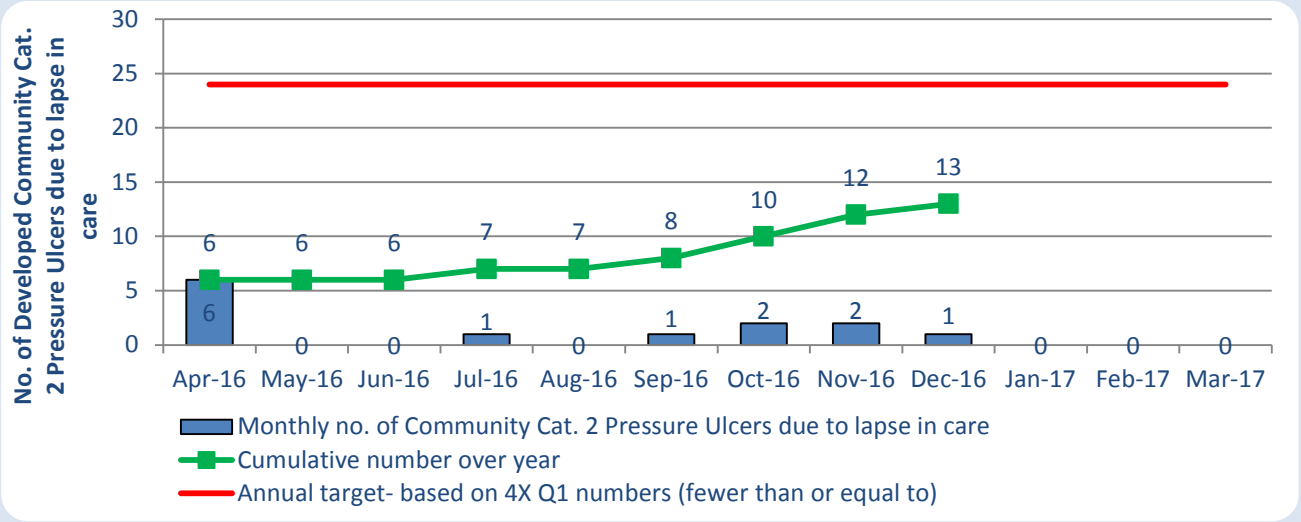
Progress against this priority has been monitored during 2016/17 using the following metrics, the results of which are detailed in figures 13 to 16 below:

1. To reduce or maintain the baseline from Q1 2016/17 of the number of developed community Category 2 pressure ulcers which occurred following a lapse of care from Trust staff. (Annual target has been set as less than or equal to 24 based on Q1 results)
2. To reduce or maintain the baseline from 2015/16 of the number of developed community Category 3 and 4 pressure ulcers which occurred following a lapse in care from BHFT staff. (Annual target set at less than or equal to 12)
3. To maintain or further reduce the number of inpatient acquired Category 2, 3 and 4 pressure ulcers which occurred following a lapse of care from BHFT staff. (Annual target has been set at less than or equal to 15)
4. Trust point prevalence of new pressure ulcers detailed in the Classic Safety Thermometer

It should be noted that from April 2016, 'avoidable' pressure ulcers are referred to as Lapse in Care (LIC) and 'unavoidable' as Appropriate Care Given (ACG)

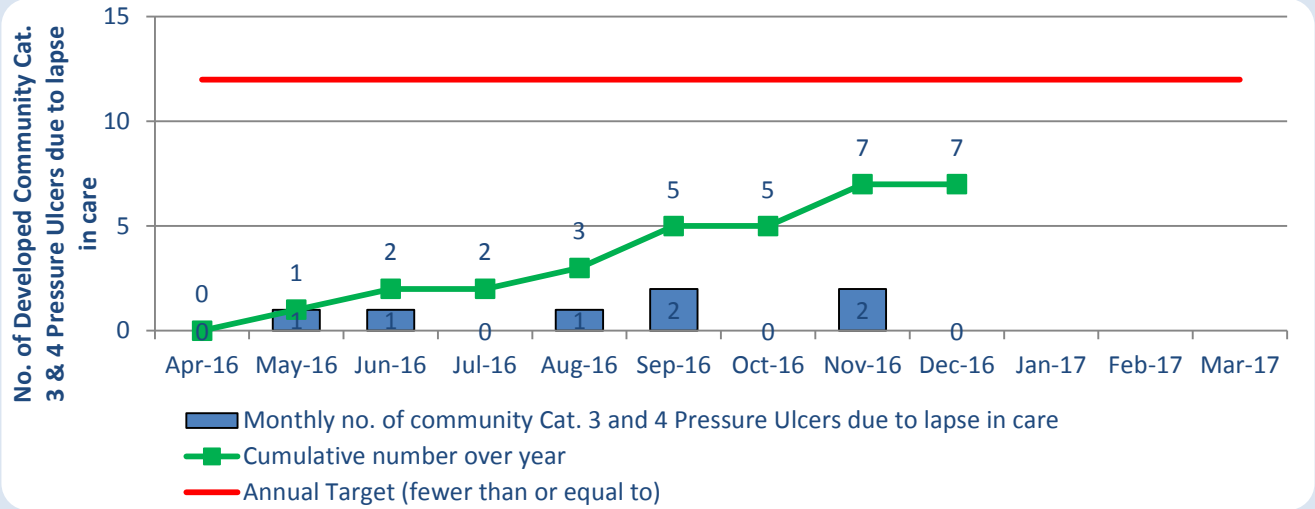
The charts below show that between Quarters 1 and 3 of 2016/17, the Trust is on track to meet the annual targets detailed above. Of particular note is the finding that there were no inpatient category 2, 3 or 4 pressure ulcers during these quarters that were due to a lapse in care by the Trust.

Figure 13- Number of developed community Cat. 2 pressure ulcers which occurred following a lapse of care from Trust staff. Target- To Reduce or maintain number from Quarter 1 2016/17 baseline



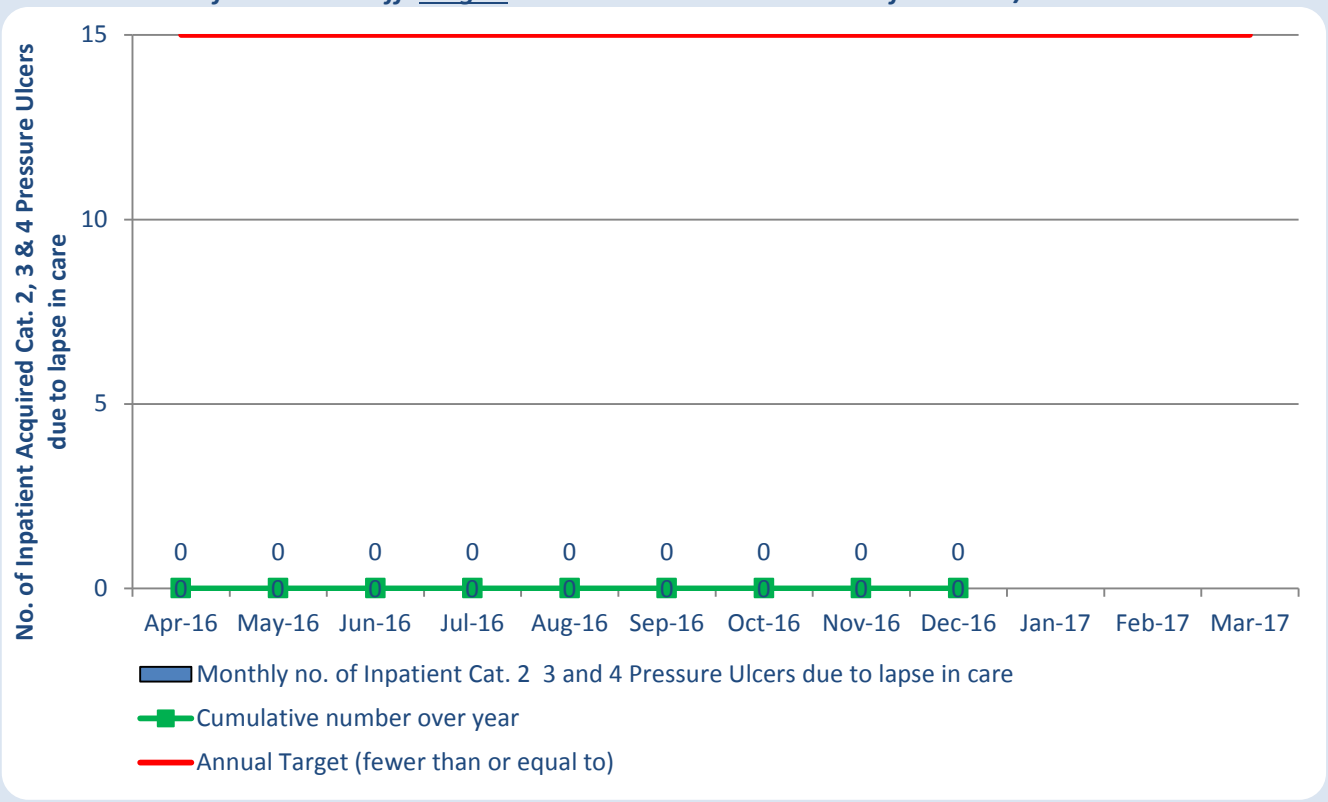
Source: Trust incident data (Datix) based on finally approved incidents

Figure 14- Number of developed community Cat. 3 and 4 pressure ulcers which occurred following a lapse of care from Trust staff. Target: To reduce or maintain number from 2015/16



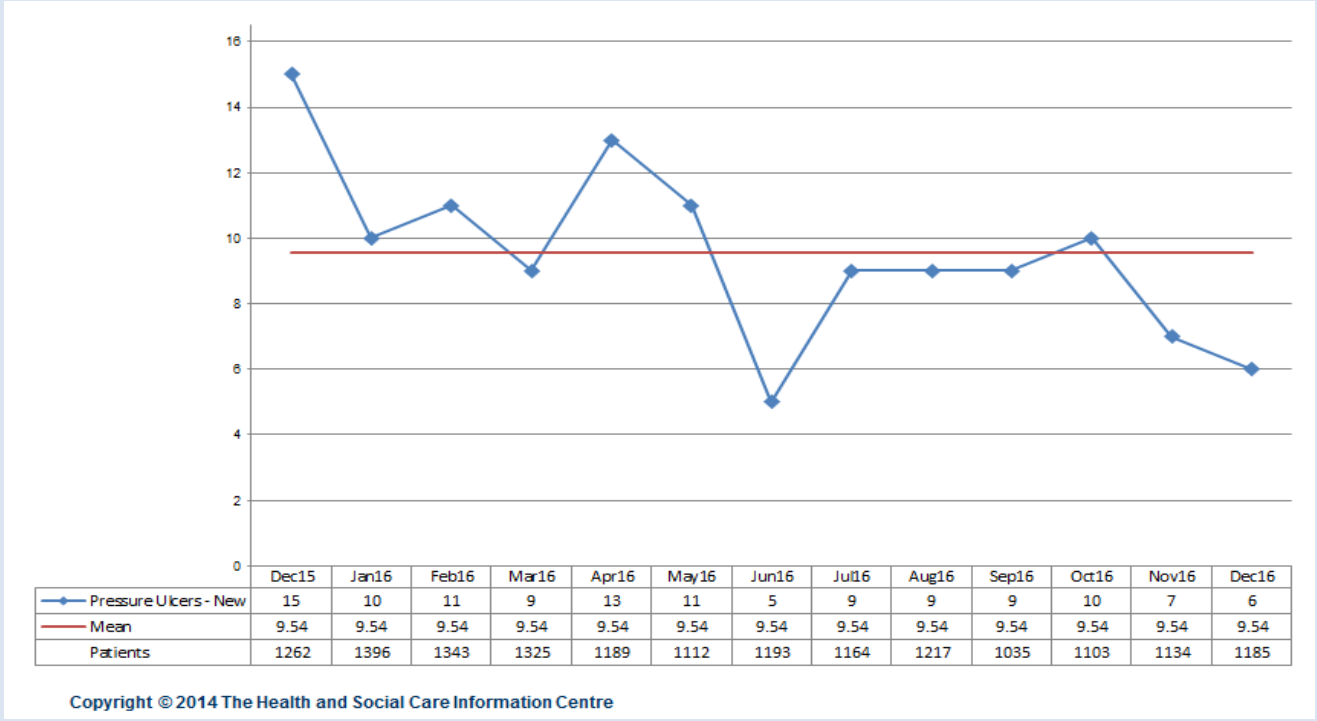
Source: Trust incident data (Datix) based on finally approved incidents

Figure 15- Number of inpatient acquired Cat. 2, 3 and 4 pressure ulcers which occurred following a lapse of care from BHFT staff. Target: To reduce or maintain number from 2015/16



Source: Trust incident data (Datix) based on finally approved incidents

Figure 16- Point prevalence of new pressure ulcers (all developed Pressure Ulcers for the Trust recorded at a specific point in time each month*)



	Dec15	Jan16	Feb16	Mar16	Apr16	May16	Jun16	Jul16	Aug16	Sep16	Oct16	Nov16	Dec16
Pressure Ulcers - New	15	10	11	9	13	11	5	9	9	9	10	7	6
Mean	9.54	9.54	9.54	9.54	9.54	9.54	9.54	9.54	9.54	9.54	9.54	9.54	9.54
Patients	1262	1396	1343	1325	1189	1112	1193	1164	1217	1035	1103	1134	1185

Source: Safety Thermometer

* **Please note** that the above Safety Thermometer chart does not show the total number of new pressure ulcers for the Trust, but only those that are recorded at a specific point in time each month.

Falls

ⓘ The Trust considers prevention of falls a high priority. The Royal College of Physicians report that falls are the most commonly reported type of patient safety incident in healthcare. Although most people falling 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). The personal consequences of a fall for the individual can be significant and even 'minor' falls can be very debilitating

During 2016/17, the aimed to reduce the number of falls experienced by inpatients. The Trust Falls Strategy was written and ratified in the autumn of 2015 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 on mental health and community wards, with no real understanding as to why that was. Many of the reasons people fall are out of our control (e.g. comorbidity) but equally many of the reasons people fall can be learnt about and practice changed.

During 2016/17, actions to address this priority included the following:

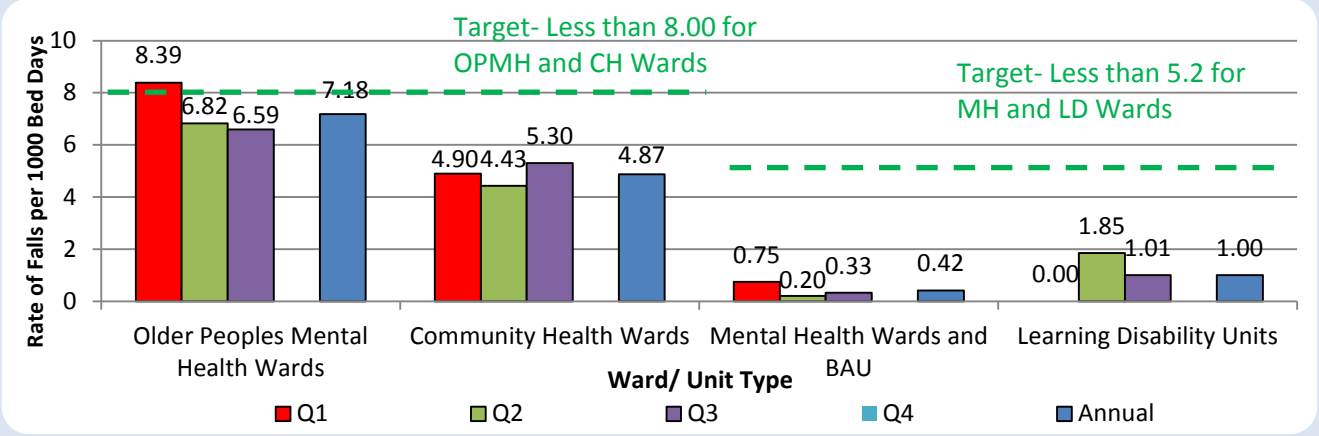
1. To introduce bespoke assistive technology equipment into all our inpatient wards that will alert nursing staff when at-risk patients are moving around so enabling staff to assist as required. This will be in the form of bed, chair and movement sensors as well as a new sensor for the WC (being developed for the Trust) maintaining patient dignity but alerting staff.
2. Closely working 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 include:
   - Replacing push-pedal bins 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.

Progress against this priority has been monitored using the following metrics the results of which are detailed in figure 17 below:

1. Monitoring of 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.
2. Evaluating the use of the assistive technology, adapting as required.

Figure 17 below shows the Trust's performance against its falls targets by ward type. The figure shows that at the end of Quarter 3 2016/17, the Trust had achieved its set targets for falls rate per 1000 bed days in Q3 and for the year overall.

Figure 17- Rate of falls per 1000 bed days- Split by Ward Type



Evaluation of the use of assistive technology To be included in Q4 report

Quality Concerns

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

The trust is currently rated as 'good' overall by the CQC.

Acute Adult Mental Health Inpatient Bed Occupancy
Bed occupancy continues to be consistently above 90%. Patients have high levels of need, 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). The Chief Operating Officer is leading a bed optimisation programme to try and alleviate this pressure. Delayed discharges are increasing and additional support has been brought in to support the team. A bed manager is to be appointed.

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. For Prospect Park Hospital a redesign of workforce has seen increased numbers of band 4 healthcare staff recruited. A similar programme is being explored for other services. The staff bank utilises framework agencies only and therefore processes are in place to assure quality of agency staff. A Head of Resources and Recruitment has 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. New leadership of CRHTT has been appointed which includes a nurse consultant. CPE has made significant changes to their service model which is demonstrating good improvements. CMHT's are currently reviewing caseload management.

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

The CQC undertook a focused inspection in December 2016. The trust is awaiting their report.

Freedom to Speak Up

ⓘ Following a review by Sir Robert Francis, a national 'Freedom to Speak up' policy was developed that contributes to the need to develop a more open and supportive culture that encourages staff to raise any issues of patient care quality or safety. It is expected that all NHS organisations in England adopt this policy as a minimum standard to help to normalise the raising of concerns

The Trust has recently reviewed its Whistleblowing policy which is now referred to as the policy on raising concerns/whistleblowing. This revised policy is largely based on the national template and is currently undergoing the final stages of the internal approval process. The policy is much simpler, clearer and staff-focused, and the intention is that staff should find it more accessible and easier to use The facility for staff to raise issues of concern via a third party (CiC) remains available. The policy makes it clear to staff that they are able to raise concerns anonymously if they wish, and this facility is used in the majority of cases. In the period from April to Sept 2016, the trust received six whistle blowing concerns raised by trust staff. All of these have been investigated and there are currently no live cases.

2.1.3 Clinical Effectiveness

ⓘ Clinical effectiveness aims to ensure that each patient receives the right treatment in the right place at the right time. Achieving this requires the application of the best knowledge (derived from research, clinical experience and patient preferences) to achieve optimum processes and outcomes of care for patients.

Our 2016/17 Clinical Effectiveness Priority:

- **To continue to implement National Institute for Health and Care Excellence (NICE) Guidance to ensure that the services that the trust provides are operating in line with best clinical practice. Achievement against this priority will be measured against the Trust targets**

Implementing National Institute for Health and Care Excellence (NICE) Guidance

ⓘ Since 1999, NICE have provided the NHS, and those who rely on it for their care, with an increasing range of advice on effective, good value healthcare. NICE guidelines, technology appraisals and quality standards provide valuable evidenced-based information on clinically effective and cost-effective services.

To ensure best clinical practice, 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 newly published NICE guidance are identified and assessed for their relevance to the Trust as soon as possible after their publication. The guidance is then sent to the clinical/ service leads in each area for which it is relevant. The relevance of the guidance and the proposed nominated lead is also reviewed and confirmed at the next available meeting of the Trust Clinical Effectiveness Group. Service Clinical Directors support this identification process.

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, each guideline is given either an 'adequate' or 'inadequate' rating. 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. Progress against these targets is as follows.

Trust Performance Target	Target (%)	Score (%)
1. Compliance with NICE Technology Appraisals	100	**100**
2. Compliance with all NICE Guidance	80	**85**

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.

2.1.4 Health Promotion

ⓘ Health promotion is the process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behaviour towards a wide range of social and environmental interventions.

Our 2016/17 Health Promotion Priority:

- **The Trust has selected the prevention of suicide and, in particular, the implementation of the Zero Suicide initiative as its health promotion priority.**

Suicide Prevention- Zero Suicide

ⓘ The Trust's vision is to develop a culture of zero suicide where patients, families and carers feel supported to manage illness when in crisis.

The focus of this initiative is on:

- Culture and changing attitudes and behaviours
- Training – giving people the skills to address situations when people are most vulnerable
- Monitoring and reporting processes

There is an established Steering Group to oversee this initiative.

The objective of the project is that, by March 2018:

- Our staff will have received suicide prevention training and feel confidence in their practice.
- We will have crisis plans that patients and carers recognise, understand and consider to be valid and useful.

In the first instance, the primary focus of this project is the Trust's mental health services, but there is an intention to raise awareness across all services.

In order to address this priority, the Trust will take the following actions during 2016/17:

1. A programme of training courses will be delivered through to March 2018.
2. Visits will be made to localities and teams to deliver short workshops
3. Launch event in autumn 2016.
4. Amendments will be made to RiO our electronic patient record to include a new Risk Assessment Tool and a new Crisis Plan
5. Monitoring arrangements will be put in place and overseen by the Suicide Steering Group
6. A lead for suicide prevention will be in place
7. Promotional material will be produced

Progress against this priority during 2016/17 will be monitored using the identified actions, the results of which are detailed below:

Please also note that monthly suicide numbers with associated rolling 12 month figures are included in Part 3 of this report.

a. Progress with implementation of Zero Suicide Project

Leads for suicide prevention are in place with regular meetings of the zero suicide steering group to monitor progress. The Zero Suicide Steering Group is chaired by the Director of Nursing and two leads have been appointed to the project. Workshops delivered to localities and teams with promotional material produced and circulated to staff and other relevant community facilities

As at the end of Q3 2016-17, the following has been achieved:

- Positive feedback has been received from training participants within all staff groups
- An additional component has been included in training about supporting families bereaved by suicide. A pilot intervention for supporting bereaved families is ongoing in Bracknell.
- Training has been updated to include staff support following suicide; guidance for staff on how, where and when to get support based on a psychological first aid model is being updated.
- Further analysis of suicide dashboard data has resulted in the development of a project to focus on the benefits of peer review; this will focus on

the decision making about risk and interventions implemented.

- Dashboard data has also highlighted the need to increase our focus on risk in the transition period, this is a high risk time and strategies for reducing the risk have been included in policy and training.
- Risk mandatory training materials have been finalised and are being tested throughout Q4.
- A range of guidance to assist staff with risk assessment and management is available on the zero suicide webpages.
- Two service user volunteers and a patient leader have been recruited to the zero suicide projects.

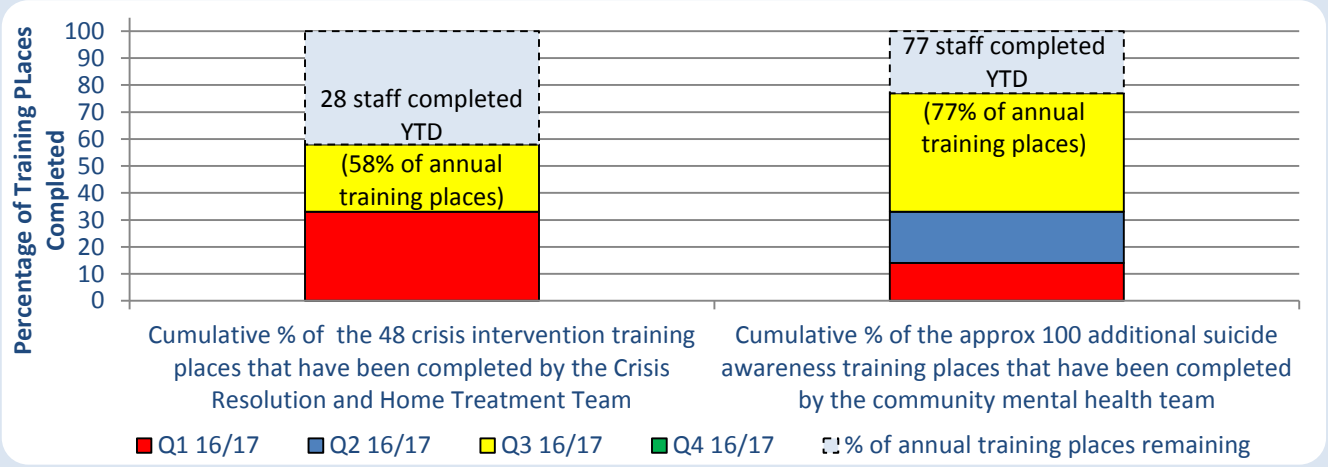
b. Progress with training

Figure 19 below details current progress against the training metrics for 2016/17.

Up to the end of quarter 3, 58% of the available annual training places for the crisis intervention training and 77% of the additional suicide awareness training places had been taken up by staff. More training sessions are planned for Q4

In addition, bespoke training relating to crisis telephone calls has also been undertaken by 22 Crisis Resolution and Home Treatment Team staff.

Figure 19- Trust performance against suicide prevention training metrics



Source: Trust Learning and Development Department

c. Results of Community Mental Health Team (CMHT) risk triangulation audit

Theh trust implemented a new risk summary at the beginning of January 2017 and, as a result, risk audits were suspended in December 2016 to enable staff to embed the new system. The new risk summary consists of a simplified format that allows the practitioner to complete one form to cover risk assessment, risk management and crisis contingency /service user focussed safety plan. The trust successfully launched the new form on 10th January 2017 along with a range of user guides and frequently asked questions. Champions in each area have helped staff to transfer information from the previous system into the new format. This work will continue during quarter 4 and a new qualitative audit system is being devised which will be tested in April 2017. Data is being collected from teams in relation to strengths and areas for improvements in the new system. This will be evaluated in April 2017.

2.1.5. Other Service Improvements achieved in 2016/17

ⓘ 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 in separate sections relating to the area of improvement

2.1.6. Improvements in Community Health Services for Adults

The Diabetes Centre

- From September 2016, the team have delivered structured education for people with Type 1 Diabetes in West Berkshire and this has resulted in very positive feedback. The team also deliver X-PERT structured education for people with Type 2 Diabetes in West Berkshire, winning four awards in the 2016 for this.
- The Diabetes Specialist Nurse Service (West) have been working alongside practice GPs and nurses to proactively identify and follow up patients with Type 2 Diabetes on insulin with sub optimal diabetes control, patients are seen in a group setting, resulting in their increased understanding of diabetes and insulin treatment as well as an average HbA1c reduction of 14.5 mmols.
- The Diabetes Patient's Focus Group in East Berkshire continues to meet quarterly to discuss, and feedback on the Diabetes Service
- Patient satisfaction survey results show 98% of service users rated the Diabetes Service as good or better

The Berkshire Community Dental Service continues to provide dental care for patients who are unable to be treated in a general dental practice, including those with learning and physical disabilities, complex medical problems, severe mental health problems and dementia. The service also provides care for children referred with a large number of cavities who are non-compliant with treatment.

The Hearing and Balance Service has maintained their UK Accreditation Service (UKAS) accreditation status for Improving Quality in Physiological Services (IQIPS). In addition, the team have collectively agreed the following three service improvement priorities:

- Maximising use of technology- By March 2017 to set up and offer service users video conferencing consultations for some aspects of Hearing and Balance Services. In the long term to scope opportunities with manufacturers to develop remote access functionalities through cloud based apps and on-line support for hearing aid users.
- Improving service user experience and engagement- To engage with service users to better understand what they value/want from future Hearing and Balance Services then to co-produce redesign of service provision. A service user forum has been set up to support and initiate further decisions.
- Integrating our services- To improve communication and working between services within and external to Berkshire Healthcare NHS Foundation Trust.

Adult Community Inpatients Wards Advanced Nurse Practitioners are supporting both the nursing and medical services to provide enhanced care to our patients. In addition, Oakwood Ward at Prospect Park Hospital in Reading has developed a patient expectation leaflet which will be sent to the Royal Berkshire Hospital to be given out to patients with the potential to be admitted to Oakwood Ward.

The Berkshire Health Hub is a single point of access for referrals for healthcare professionals and patients to scheduled and unscheduled community services and Wokingham Social Services. The Hub processes 145,000 referrals per year and receives 130,000 telephone calls. Future developments in the Hub include Enhanced Support for Care Homes via Skype to help avoid hospital admissions and the integration of Slough Social Services into the Hub.

The East Berkshire Palliative Care Team relocated to Thames Hospice in November 2016. This will enable closer integration with colleagues working in the hospice and will help ensure seamless, well-coordinated patient care. As cancer is now becoming a long term condition and with the majority of patients successfully treated for their cancer but often having to live with long term consequences, Macmillan funded a project to support such patients back into an active and fulfilling life. The team is a joint BHFT, Frimley Health and Royal Berkshire

Hospital team and, due to its success, has had its funding extended for another year.

Integrated Assessment and Rehabilitation Services for East Berkshire. Patients with frailty and long term conditions can now be referred to the Integrated Assessment and Rehabilitation Centre (ARC). The pathway includes urgent and routine appointments for Comprehensive Geriatric Assessments, ensuring patients can be assessed within 2 hours if necessary. The patient will receive treatments and input from the wider Multidisciplinary Team, including access to a range of specialist clinicians. Patients can also be admitted directly into our rehabilitation beds from the community if required, hence avoiding an unnecessary admission to an acute hospital bed.

East Berkshire Heart Failure Service has received additional funding to support an increase in nursing staff to manage increasing demand on the service.

Windsor and Maidenhead (WAM) Psychological care for patients with long term conditions pilot. This pilot initiative was implemented by WAM Community Nursing and WAM Older People's Mental Health team, specifically Psychology, supported by Improving Access to Psychological Therapies (IAPT), to work with patients with long term conditions. Patients experienced very positive outcomes with health interventions and dependency on health services significantly reduced for them. From January, IAPT investment is being used to fund continuation and development of this work on a greater scale across East Berkshire.

East Berkshire Community Nursing. Over the last few years East Berkshire Community Nursing Service has experienced an increased demand from a growing and ageing population, alongside a need to provide more complex care delivery to support and keep patients safely at home, without changes to resources. As is the national picture, this is resulting in significant and unsustainable pressure on District Nursing teams. In recognition of these issues the commissioners and Berkshire Healthcare Foundation Trust as the provider commenced a joint review of the current service. Early discussions have been commenced, with staff involvement in developing potential future models.

Wokingham Community Nursing has operated a community nursing triage system since September 2016 to streamline and efficiently manage all calls and referrals to the District Nursing (DN) service. The triage team review all calls and referrals to ensure that they were dealt with appropriately by allocating to the right DN teams, signposting and providing information. As at the end of December 2016, approximately 8000 calls and referrals have been processed by this team, with positive feedback from service users, nurses and administrators.

Reading Community Nursing have introduced a new approach called 'Home First' with the aim of integrating community services in Reading whilst keeping the patient at the centre and focusing services around the patient at home. The initiative brings together community nurses, Older People's Mental Health, Intermediate Care and Rapid Response and Treatment under one umbrella. The vision of this approach is to improve patient and carer experience whilst using resources effectively through a combined workforce, reducing the impact of unplanned work on community teams, working closely with multi-specialist teams and ensuring referrals are signposted to the correct services.

Reading Community Matrons and Care Coordinators have expanded the amalgamation of their services in 2016 to include all GP practices in their area. The data produced to date has demonstrated a reduction in the number of GP encounters, A&E attendances, unplanned hospital admissions and 111 contacts.

Reading Rapid Response and Treatment is a multidisciplinary service whose aim is to review residents/ patients who are entering a health crisis within the care home setting. Admissions to acute hospital have been avoided through the provision of advanced clinical nursing care, intravenous antibiotics and fluids and the ability to respond quickly and visit frequently. Feedback from carers, patients and families has been extremely positive and residents are grateful to receive acute care whilst remaining in their own care home.

Reading Community Cardiac service and Respiratory Specialist Service have been working hard to integrate their services. Joint clinics and rehabilitation sessions have been held, with the added effect of up-skilling staff. An integrated study day was also held for trust staff which resulted in very positive feedback.

Reading Adult Speech and Language Therapy (SALT) Staff have worked to make soaking solutions for patients on the community wards who have puree diet – this allows them to have snacks that look like a sandwich/biscuit but are actually puree. This improvement has meant some patients who were

refusing to eat the puree meals are now actively engaging in mealtimes. In addition, the team have put forward a change in the use of thickeners on the wards and in the community. SALT are running Lee Silverman Voice Treatment (LSVT) support/maintenance groups alongside and funded by Parkinsons UK. The team are also running transgender voice groups at West Berkshire Community Hospital and voice care groups together with therapy for transgender clients. They also deliver on-going training for nursing homes and Care homes on dysphagia and communication. Any service offered in the West or East of Berkshire will try to be matched so it runs across the service.

2.1.7. Improvements in Primary Care, Out-of-hours, Minor Injuries Unit and Walk-in Centre

The Slough Walk In Centre

This year the Slough Walk in Centre underwent a major refurbishment. All rooms were decorated and new flooring was laid in the clinical rooms and the waiting area. Following patient feedback, new magazine racks and magazines were also provided. The centre also purchased a Doppler machine to help manage diabetic foot care for patients. New sphygmomanometers have also been provided to assist patient triage and blood pressure management.

The centre have also streamlined their pharmacy as they had experienced issues with missing medication for the Walk in Service. A central pharmacy cupboard is now in place, together with a signing-out system in reception which is monitored by CCTV. This is now working well.

Staff have been working hard to improve access for their registered population and are working towards a new telephone system to further improve access to services.

The Walk in Centre is improving the care of patients with chronic diseases, especially diabetes and are looking at ways to encourage the hard to reach, vulnerable patients to ensure they get adequate access to healthcare.

WestCall Sepsis Project

In early 2015 the WestCall GP Out of Hours service planned a project to improve the management of patients with sepsis in the community, following the lead set by the UK Sepsis Trust. The priority stressed the importance of identifying patients with sepsis, assessing and treating them within a short time frame and then ensuring that their antimicrobial treatment was appropriate.

A new "Sepsis Kit" was designed that WestCall doctors should use to identify cases of sepsis more easily and where appropriate to commence treatment with the appropriate antibiotic immediately before admitting the patient to hospital.

Prior to this project the diagnosis of sepsis and septicaemia was not one that appeared and this was true of most Out Of Hours organisations in the country. Following the implementation of the project the diagnosis was recorded and hospital admissions for sepsis in Berkshire West began to rise quickly to what became often over twenty per month.

Sepsis is by no means an easy diagnosis to make so not all patients admitted were found to have sepsis but out of 175 admissions over the year to April 2016, 126 patients were confirmed as having sepsis and a further 20 probably had sepsis. Only 29 were found to have other disorders.

Where patients were previously admitted as being very unwell but with no clear diagnosis it is now possible to pre-alert the A&E departments to the arrival of septic patients so that they can open their specialised sepsis management procedures and commence antibiotics without delay.

For patients who are some distance from acute hospitals the WestCall doctors can start antibiotics using the Sepsis Kits. For every hour of delay in giving antibiotics the mortality rate for sepsis rises by 11% so speedy treatment is a priority. We are now well into the second year of the WestCall sepsis project and the rates of diagnosis are still rising.

.

2.1.8. Improvements in Community Health Services for Children, Young People and Families

Children, Young People's and Families (CYPF) Services Development.

During 2016/17, the CYPF service offer has continued to be developed, according to the 2015/16 Children's Services Strategy and Blueprint. Universal and specialist children's services have been restructured to align under one locality and, where it makes sense to do so, have begun to integrate both physical and mental health services for children. By integrating these services, the trust places itself in a better position to partner with both the Local Authorities and other system partners to deliver a Berkshire wide Children's agenda.

The transformation programme of work continues to include:-

1. Delivery of a CYPF Health Hub; including one integrated CYPF referral form
   Children's Services plan to launch the newly developed CYPF Health Hub On 3rd April 2017. All referrals to Children's Services (with the exception of Universal) will be triaged by a multi-professional clinical team within the hub and clinical decisions made on the appropriate support for the individual CYPF; including assessment and further intervention with integrated professional teams where appropriate.
2. Development of a comprehensive CYPF On-Line Resource.
   Advances in technology have enabled us to begin to develop a sophisticated and comprehensive on-line resource, which will be launched on 3rd April 2017 also, with the aim of supporting CYPF either to self-manage their needs prior to accessing our services as a preventative measure or as a tool to accompany intervention.
3. Growth of Young SHaRON, our on-line support network across CYPF services
4. Development of integrated assessment and care, where it makes sense for CYPF
5. A focus on effective transition to adult services
6. Development of our patient record system - Open RiO for CYPF.

Over the past year, Children's Services have worked hard to improve the engagement of service users. We continue to develop and grow our service user participation group and the current service development has been strengthened by co-design with our service users**.**

Health Visiting (HV) Bracknell service improvements include:

- A new streamlined service model focusing on delivery of the Healthy Child Programme and working with vulnerable families
- Joint Solihull approach parenting training with Children Centre staff
- A corporate approach to delivery of the service has ensured that all families are offered an equal service across Bracknell.
- Health Visitor in Multi Agency Safeguarding Hub (MASH), ensuring better contribution to decision making for social care
- Bespoke training for staff e.g. perinatal mental health, bloodspot screening for Community Nursery Nurses

Reading Health Visiting Central diary allocation has helped ensure that bank and agency capacity is well used

Health Visiting West Berkshire are offering antenatal groups to universal women who are pregnant in their third trimester. The groups are offered across different venues and at different times during the week. Information is shared in the antenatal group on the Solihull approach, breast feeding, immunisations, the healthy child programme and how to access the local health visiting teams.

Health Visiting Wokingham have held two listening into Action (LiA) events. The first looked at communicating with clients and, from this work, the service now has team generic email boxes set up so that parents are now able to email questions to the service. The staff have also been issued with smartphones to allow them to demonstrate apps to clients and have easy access to their email while mobile working. SMS text reminders have also been set up to automatically be sent 7 and 2 days prior to developmental review appointments.
The 2nd LiA event looked at increasing the quality and quantity of Antenatal contacts offered. Clients told the service what time of day and week they wanted to see a HV and what they wanted to discuss. The format has now changed and so has the contact letter after taking clients opinions into account. The number of

Antenatal contacts achieved in Wokingham almost doubled.
Due to the high volume of clients being referred from the HVs to the skill mix staff for baby massage it was decided to reintroduce the Talk and Touch Group. This group runs for 5 weeks and not only teaches massage, which in itself holds many positive benefits; it is also a safe environment for a few parents to meet and hold topical conversations facilitated by trained Nursery Nurse. This course has been extremely well evaluated and appreciated by staff and clients alike.

Health Visiting Slough improvements have included:

- Development of the Health Visiting Duty Telephone Line to include email messaging for service users.
- Incorporating the Family Health Needs Assessment within the RiO record system
- Implementing smartphones to help share resources with parents.
- Full time Health Visitor co-located in the Multi Agency Safeguarding Hub (MASH), ensuring secure research, analysis and assessment of risk relating to children safeguarding notifications to social services.

School Nursing improvements have included:

- Improved feedback from school age children receiving immunisations, using customer feedback user friendly machines and a simple feedback questionnaire.
- The use of the links on iPhones for nocturnal enuresis and general questionnaire giving a voice to the most vulnerable clients.
- Developing the use of email to send the web link to teaching / school staff for feedback post medical conditions training.
- Asthma bus to educate young people on their condition working with Frimley Health Trust.

2.1.9. Improvements in Services for People with Learning Disabilities

Our services for people with learning disabilities aims to ensure the best care is provided in the right place – which means working to enable people to remain living in their own homes and local communities, with our specialist inpatient services only being used when clinically necessary for people's safety and wellbeing.

During the past year our community services have been working on improving our record keeping and risk assessments – to ensure we can demonstrate how we work in collaboration with people and their families/carers in planning and providing care. We have been using our Learning Disability Outcome Measure as a tool to help us measure how effective people think our support of their care has been. In addition to working individually with people - there have also been a wide range of clinics, workshops and meetings across the county helping to improve the health and wellbeing of people with learning disabilities.

In our inpatient services there has been a focus on improving the environment – with new bedroom and communal furniture and an extension to the garden. We have also been increasing the range of activities available to people who are staying in hospital at the Campion Unit, Prospect Park Hospital, and ensuring there are activities for people to participate in every day. We have also been developing the skills of our staff to improve their ability to communicate more effectively with people who have limited or no verbal communication.

We also know that that people with learning disabilities are more at risk of dying prematurely, compared to the general population of people without a learning disability. We have established a Clinical Review Group to help us review the deaths of people with learning disabilities known to our services – to identify any immediate areas for improvement, good practice, but also areas where wider or longer term changes might be required to help improve the health and wellbeing of people with learning disabilities.

2.1.10. Improvements in Mental Health Services for Adults, Including Older Peoples Mental Health Teams

Memory Clinic Accreditation.

- All of the Trust's memory clinics are now accredited by the Memory Services National Accreditation Programme (MSNAP).
- Wokingham and Bracknell memory clinics have successfully completed their 2nd accreditation cycle and rank equal 1st and equal 8th respectively out of a total of 89 services.
- Reading memory clinic is also ranked equal 1st and is preparing for its second Peer Review at the end of February 2017.
- Slough memory clinic is accredited and is ranked equal 8th.
- WAM OPMH and Newbury Memory Clinic (rankings both tbc) achieved MSNAP accreditation this year.

Tier 1 Dementia Training has now been completed by almost 80% of the Trust workforce.

Younger People with Dementia (YPWD). Following the successful pilot of a YPWD model in East Berkshire last year, CCG's in the east of the county have commissioned a 3 day service provided by the YPWD Charity to deliver age-appropriate workshops for younger people with dementia and their carers in the east of the county. The Charity has secured a temporary grant funding for an Admiral Nurse to support carers of YPWD in Berkshire East and is hoping to demonstrate the need for a permanent Admiral Nurse position like the one already employed by BHFT funded by West Berkshire CCGs. (Berkshire now has the only 2 Admiral Nurses for YPWD in the UK). A Listening into Action (LiA) project is currently underway to develop a YPWD model and pathway for Berkshire East similar to that provided in Berkshire West. We are therefore nearing equity of provision for YPWD across Berkshire. The YPWD Charity & BHFT OPMH were shortlisted for the 2016 Royal College of Psychiatrist's Sustainability award.

Dementia Care Advisors. Thames Valley Clinical Support Network has funded an 8 month project led by BHFT comparing Dementia Care Advisor provision across Berkshire. The aim of this project is to produce a best practice Dementia Care Advisor pathway for localities to consider adopting.

Bracknell Older Peoples Mental Health team (OPMH) has held monthly case formulation sessions lead by a psychologist where complex cases are discussed and a deeper understanding is gained by sharing views and knowledge across all MDT staff. The session is open to all staff and it is protected time. This helps individual workers share complex cases, manage potential risk and deliver innovative solutions.
In addition, Bracknell OPMH has held Staff mindfulness sessions to help to support wellbeing. Mindfulness is paying attention to the present moment, non-judgementally and has been shown to have benefits for wellbeing. These sessions have been well received and attended and staff report that they find the sessions relaxing and grounding.

Reading OPMH Team have undertaken the 'Great Apples' pilot project in care homes focusing on reducing pressure ulcers and other common health issues. During the pilot at Walnut Close Care Home, no pressure ulcers were developed in 6 months. MUST, Weights and BMI were audited and measurements went from 50% and 65% to 100% compliance – helping to monitor risk more accurately.

Bracknell Community Mental Health Team for Older Adults (CMHTOA) and Home Treatment Team (HTT) integration. This integration is now embedded and the service will be evaluated in the coming year.

East Out of Area Placements (OAPs) Panel. There have been a number of changes to assessment, approval and monitoring for patients for whom a health- funded placement is recommended. The objective is for locality teams, who generally know the patient best, to be more closely engaged in overseeing and monitoring the quality of any placement, to ensure the patient's outcomes and need are being met, patient experience is improved, and resources are allocated most effectively. To this end, An OAPs panel has been established in East Berkshire along with a revised process for treatment placements to be considered and approved.

World Mental Health Day: SloughFest 10th October 2016. World Mental Health Day is celebrated each year on 10 October. This year in Slough, members of all sections of the local community came together for 'Slough Fest', a day of art, drama and music at the Singh Sabha Slough Sports Centre. The event was attended by more than 400 people, and provided an

opportunity to tackle stigma, raise awareness and celebrate of creativity and achievement by people who have mental health problems.

Perinatal Mental Health. Berkshire has received National Perinatal Development Funding for the next two years to help build on the service that is currently being provided. This funding has enabled the trust to recruit to a Perinatal Psychiatrist post and to increase Perinatal Cognitive Behavioural Therapy hours so that an improved service can be delivered to the women of Berkshire and their families. We have been seeing a year on year increase in referrals to the service and together with funding for other projects/pilots planned for the next two years we will be able to deliver training to a wider audience and trial perinatal clinics at our three most local maternity units.

Intensive Management of Personality Disorders and Clinical Therapies Team (IMPACTT). IMPACTT is a new specialist service which has been developed following the review and subsequent closure of the Complex Needs Service. IMPACTT provides comprehensive assessment and evidence-based treatments for individuals aged 18 and over as part of an updated care pathway for individuals with a diagnosed personality disorder, primarily Borderline Personality Disorder/Emotionally Unstable Personality Disorder (BPD/EUPD), but who may also have comorbid Antisocial Personality traits.
The team consists of highly skilled specialist staff who are experienced in working with people who have a diagnosis of Personality Disorder. They come from a variety of backgrounds and include Psychotherapists, Psychologists, Psychological Therapists and Assistant Psychologists. IMPACTT offers two evidence-based treatments: Dialectical Behavioural Therapy (DBT) and Mentalization-Based Treatment (MBT), as recommended by the NICE guidelines.

East Berkshire – ASSIST/Embrace- Assertive stabilisation for people with emotional intensity and instability. The Embrace group continues to engage with service users across East Berkshire, providing a supportive and enabling space for people who have engaged with ASSIST. There have been a number of positive developments this year, whereby Embrace and ASSIST group members have been active in representing the service, and offering Peer support. Two Embrace group members attend BHFT Patient Experience and Engagement meetings, and Embrace group members co-facilitate Carers and Family group, and group sessions on the ward of Prospect Park Hospital. From the group we have elected members who are now working as peer auditors for The Royal College of Psychiatry, on their Community of Communities projects.

Recovery Team: Hope College- Slough. Hope College has grown over the last year and now offers 22 different courses to students who are primarily people with mental health problems and their carers. 628 students have enrolled in the college since the launch in 2015. The peer mentor training course has trained 22 peer mentors who are engaged with many activities such as co-facilitation of Hope College courses and consultation activities within the service. The Hope College provides a positive link for service users in supported living facilities, with tailored courses to assist in developing independent living skills, self confidence and self-esteem.

Carers' activities for mental health carers. Carer Café for mental health carers is held once every 2 months , providing support from other carers and mental health professionals, opportunities for training, information, signposting, pampering, and time out from caring.

Reading CMHT successes include:
- Individual Placement and Support (IPS) employment service– 58 successful job outcomes.
- Service leaflets and carers leaflets being developed which gives an explanation of the CMHT and what service clients can expect from the CMHT.
- Ongoing review of out of area placement and, where appropriate, clients are accommodated in more cost effective placements.
- Safeguarding lead in place.
- Home treatment team piloted.
- Dual diagnosis lead.
- Improved performance
- Development of Recovery College.

The Psychological Medicine Service has carried out a number of service improvement projects in 2016.The three outstanding projects were namely:
- Frequent attenders project. This is an ongoing project which has had a positive impact on reducing the numbers of re-attendances to the emergency department.
- Follow up clinic for patients who frequently attend RBH emergency department. Patients reported that this experience was positive.

- Working with the RiO transformation team to establish referral pathways and to allow the service to capture activity.

The Liaison and Diversion Service improve access to healthcare and support services for vulnerable individuals through effective liaison with appropriate services. In addition, the service diverts individuals into health or other supportive services. Diversion can be out of the youth or criminal justice system (where appropriate) or within these systems. This results in the delivery of efficiencies within the youth and criminal justice systems as well as the reduction in re-offending, health inequalities and first-time entrants. There has also been an expansion of service provision available at Berkshire custody suites as well as the development of service information material.

The Health Outreach Liaison Team (HOLT) has provided multiple health drop-in clinics around Reading town centre and has implemented an Acute Hospital Discharge pathway for homeless clients. The team host the Reading Homeless Health Forum and have developed a Homeless Health Needs Audit.

Forensic Supervisors have developed regular Berkshire West Forensic MDT meetings and Local Forensic supervisors' meetings. There are also ongoing reviews of restricted patients and placements. In addition, links have been established between Reading CMHT management and Oxford Health NHS Foundation Trust forensic team.

The Attention Deficit/ Hyperactivity Disorder (ADHD) service is now offering joint assessment appointments so that clients have their complete assessment with both the psychologist and the psychiatrist on the same day. They are also submitting a book, "The Adult ADHD Treatment Handbook" regarding psychological treatments for ADHD, in March 2017.

The Autistic Spectrum Disorder (ASD) service offers a multidisciplinary assessment involving a speech therapist to many clients. They also ran a very successful training day in November 2016..

Clinical Health Psychology

- Dr Abigail Wroe, Clinical Health Psychologist, has joined the NICE Expert Review Group addressing guidelines for 'Integrated Mental and Physical Health'. She is a Clinical Health Psychologist working in a specialist Clinical Health Psychology Service, with knowledge of IAPT.

  Dr Sarah Scott works with the Melanoma education group in her Cancer Rehabilitation role and their poster came 2nd at the UK Oncology Nurses Conference.

  Claire Luthwood continues in her role as Visiting Tutor, Oxford Institute of Clinical Psychology Training, University of Oxford.
- Clinical Health Psychology Service improvements within the Royal Berkshire Hospital include:
  - Pain Unit- The pain psychologist and physiotherapist within the Royal Berkshire Pain Unit have reviewed and updated the Group Pain Management Programme to incorporate the latest and most reliable physiotherapy and psychological research for effective, non-medical management of persistent pain.
  - Bariatric Team- This service is now seeing an increased number of patients. This requires the team to work innovatively to make suitable adaptations to the multi-disciplinary assessments, pre-operative groups, post-operative groups and individual sessions for clients who require them. The service has increased its integrated working with secondary services such as adult mental health teams, and eating disorders team. In addition, the Bariatric team have made links with the Health Psychology team in University of Reading, and are looking into being part of a Randomised Control Trial to evaluate a post-op psychological intervention.
  - Haematology Service- This service has conducted a service improvement project at Royal Berkshire Hospital looking at patient experience of having a Stem Cell Transplant at the RBH. This has led to the development of a new information leaflet for patients to improve communication and ensure the right level of information was provided.
  - We provide Oncology Clinical Nurse Specialist (CNS) group supervision which is now provided for 24 specialist nurses, limited 1:1 supervision is provided if required.
  - Oncology consultant Supervision: One-to-one supervision is being offered to Consultant Oncologists at The Royal Berkshire Healthcare NHS Foundation Trust and there has been very good uptake since it was initiated in November 2016. 82% of the Consultants have attended at least one session and 73% have met three times and are being seen on a monthly basis.
- Other Services offered by the Clinical Health Psychology Team in BHFT include reaching out to Reading locality service leads, input into case

management of complex cases at the RBH, and limited psychological supervision for district nursing staff and community matrons.

Mental Health Inpatient services at Prospect Park Hospital (PPH)

The team are committed to improving patient care and safety through innovation. Some of the current projects that have been implemented across the wards at Prospect Park Hospital are outlined below.

- **Using Innovate Technology to Monitor Physical Observations Following Rapid Tranquilization (RT).** This project has shown an increase in RT monitoring, up to 100% in October 2016. We are still testing and in the future will spread the word to others as well as looking at other aspects of RT
- **A Unique Bespoke Preceptorship Programme Tailored To Inpatient Mental Health Nursing.** The aim of this project is to develop our newly qualified nurses with inpatient skill and expertise.
- **Safewards at PPH.** Research and recent policy initiatives support the promotion of ensuring proactive measures are in place to reduce conflict within inpatient settings The Safe Wards model, developed by Bowers et al (2013) introduces a dynamic model of what drives conflict and containment on acute mental health wards. There has been an extremely successful implementation of this on Rowan and Orchid wards which are the first older adult wards to successfully do this. The project has also been implemented on acute wards and has led to a 16% improvement in the number of days between conflict in 2016 compared to 2014/2015 on all in-patient wards.
- **Improving Failure to Return From Agreed Leave or Time Away From the Ward Using QI Methodology.** This project focused on patients failing to return from leave or time away from the ward. The risks involved in this area are high, whether a service user fails to return as an informal patient or under the mental health act. The aim of the project was to increase the proportion of patients returning on time from leave or time away from the ward by 50% on bluebell ward in 12 months. The project resulted in Bluebell (pilot ward) achieving a 90% improvement within 12 months. The team are currently looking to sustain this improvement and roll out the project to all wards.
- **Improving Access to Physical Activity with Sport In Mind and Sport England**. In 2015, through the Sport England 'Get Healthy Get Active' funding programme, we secured over £200,000 to enable a Berkshire wide physical activity programme to be rolled out, and to ensure the sport sessions for inpatients were sustainable in the long term. This project delivers a sustainable programme of 33 weekly supported sport and physical activity sessions across Berkshire. Wellbeing data will be analysed in August 2018 at end of project. Gym attendance has averaged 198 patients per month across 7 PPH wards since start of project.
- **Collaborative Working: Occupational Therapy and Reading Repertory Theatre** Reading Rep, Reading's regional producing theatre company has been working in partnership with Occupational Therapy at Prospect Park Hospital since January 2016. We have been delivering weekly sessions which last for around 1 hour. During these sessions we have looked at memories, films, sharing stories and creating frozen images and short scenes. Interest in and attendance to the group have surpassed our initial expectations and making this accessible to other patients is a priority. Reading Rep. has secured further funding to increase sessions at PPH.
- **Reducing Falls Through a Falls Prevention Programme for Inpatients.** We recognise that there have been a number falls during hospital admission at PPH, and for older people a fall can result in fatality. Therefore it is important for us to as proactive as possible in reducing and avoiding falls. As a result, an 8 week programme lead by an O.T. and Physiotherapist has been introduced with a balance between exercise and education. There is regular attendance from older adult and adult wards, with patients reporting feeling more confident walking outside. The project has resulted in a reduction in falls for Rowan Ward attendees
- **Aligning Psychological Interventions with NICE Guidelines.** Psychological therapy for patients at PPH is provided by clinical psychologists, assistant psychologists and trainee psychologists. Support is given in a variety of ways, including 1:1 sessions, family work and support groups, using evidence-based approaches such as cognitive behaviour therapy, interpersonal psychotherapy and systemic therapy. Interventions provided for inpatients have been aligned following NICE recommendations for a number of conditions.
- **Increasing the Opportunity for Patients to Access Shared Reading Groups.** Occupational Therapy staff have been delivering shared reading sessions called 'tea and tales' with The Reader Organisation for a number of years. Following ongoing positive feedback from our patients, in 2016 we have

enabled these sessions to now be delivered on all 7 wards. It was previously only available for 4 wards. In September 2016, a group of staff from PPH presented at the Thames Valley Suicide Prevention and Intervention Network (SPIN) conference, promoting the link between shared reading in tackling depression and preventing suicide.

- **Family Support in Psychosis Project (FSiPP)** Evidence suggests that family interventions are associated with positive outcomes for patients with psychosis, particularly in relation to service user relapse, hospitalisation rates and medication compliance. In addition, psychoeducation interventions have been found to improve the experience of caring, quality of life and to reduce psychological distress in family members of people diagnosed with a psychotic disorder. FSiPP is a safe, supportive and psycho-educational group for families or significant others whose relatives have been diagnosed with a psychotic disorder. It is an opportunity for family members to discuss, explore and develop ways of helping their relative with psychosis and themselves. Attendees felt they benefitted from having the opportunity to share experiences, feelings and concerns, be listened to and to receive support from both peers and professionals. It was helpful meeting others in a similar position and the group enabled attendees to gain a better understanding of psychosis and its treatment.
- **Introducing a 'Community Marketplace' - Increasing Referrals to Voluntary, Statutory and Non-Statutory Organisations before Discharge from Hospital.** This initiative was set up in September 2016 by a Senior O.T. for Daisy/Bluebell Ward. It is an open forum attended by a variety of third sector and voluntary agencies that can all provide support to patients when they leave hospital.

2.1.11. Improvements in Child and Adolescent Mental Health Services (CAMHS)

CAMHS has remained an area of national focus throughout 2016/17. Our service leads have been fully engaged with the multi-agency groups working to implement the Future in Mind recommendations to transform local services for children and young people's emotional wellbeing and mental health.
The recruitment undertaken following investment in 2015/16 has enabled CAMHS to make real progress this year with waiting times falling across all parts of the service.

Average waiting times for a first triage assessment in the CAMHS Common Point of Entry are now consistently below 6 weeks, which is less than the national average of 9 weeks. The introduction of an on-line support network for parents and carers of young people referred to this team is enabling us to provide both expert clinical and peer support to families prior to and following diagnostic assessment.

Improving information about the service has been a priority through 2016/17 in order to:

- improve knowledge and understanding of BHFT CAMHS referral criteria across all partner agencies
- reduce the number of referrals to CPE that should be managed through Tier 2/early intervention services
- improve system working to enable children and young people to access early intervention and targeted services where these are the right service to meet their needs
- improve partnership working with early intervention and targeted services to ensure children, young people and families are well supported

The Trust has dedicated communication resource to support this and a programme of CAMHS update newsletters has been produced to raise awareness of referral systems, provide information on the referral process and provide links to more detailed referral guidelines on the service website. These have been shared with key partners. Information to support improvements in referral quality is being provided via a dedicated programme of training to colleagues in primary care, education and other agencies. This will be progressed further through the development of the CYPF Health Hub and the Trust CPE education programme.

New investment in 2016/17 has enabled the development of pilot projects to enable a more rapid response to children and young people experiencing mental health crisis. These pilots were set up to offer enhanced care planning in conjunction with partner agencies to provide wrap-around care to keep young people safe. The teams are providing focussed, high level, crisis support to enable a more rapid response

to young people who present to emergency services at the point of crisis and to avoid escalation into crisis where possible; through intensive community support. The project in the West of the county has been running all year and has demonstrated significant benefits in terms of a more rapid response to young people presenting to emergency services in crisis, with reduced waiting times for assessment, reduced admissions and more rapid throughput resulting in fewer occupied bed days. The East project is smaller and has only been in place for a short period but is already showing similar positive outcomes. The trust is hopeful that these pilots will develop into a sustained new service in 2017/18, providing equity of care across the county.

CAMHs Eating Disorder Service

The new Community CAMHS Eating Disorders Service went live in October 2016. Recruitment, induction and training of staff are still ongoing, but the team is now offering a community based service to young people that is able to meet the national waiting time targets of 7 days for urgent referrals and 1 month for routine referrals.

The new service is providing high quality evidence-based interventions, including in-reach to the acute paediatric wards where required, for all new referrals and existing cases that have transitioned to the team where appropriate. The service is being managed alongside the adult eating disorder service to enable an all-age service with smooth transition when needed. The team have already delivered some training to key partners, including our acute paediatric colleagues and further training, including a launch conference are planned for 2017/18.

2.1.12. Improvements in Pharmacy

Pharmacy/Medicines Optimisation

Electronic Prescribing and Medicines Administration (EPMA): The Trust has committed to implementing EPMA. This will revolutionise current prescribing and administration processes across the Trust, enabling better monitoring and audit of medicines, thus contributing to improved patient safety. It will provide efficiency opportunities and will enable greater patient facing activity to be undertaken.

Joint Formulary

BHFT have strong relationships with Berkshire West CCGs and contribute to a Joint Formulary. We have recently met with Frimley Health Drugs and Therapeutic Committee and now have Trust representation across Berkshire East CCGs which is a significant improvement and will facilitate collaborate working which will ultimately improve patient care. There is also work within BHFT to harmonise our formulary with the CCGs and our acute trust partners.

The College of Mental Health Pharmacy (CMHP): The BHFT project student was awarded the CMHP Undergraduate Pharmacist Research Award for 2016 for 'An audit of Anticholinergic Cognitive Burden in elderly mental health and dementia patients'.

Safety Improvement

The Availability of Urgent Medicines Audit was awarded the runner-up prize at the CMHP conference and was also shortlisted for the Trust's Quality Improvement Awards. This audit resulted in the development and internal publishing of a standardised, detailed list of urgent medicines that wards/services should keep. It addressed many longstanding issues with a clear benefit to patient safety. The Research and Development Pharmacist was highly commended at the CMHP conference for their paliperidone service evaluation poster.

2.2. Setting Priorities for Improvement for 2017/18

ⓘ This section details Berkshire Healthcare NHS Foundation Trust's priorities for 2017/18. Specific priorities have been set in the areas of quality improvement patient experience, patient safety, clinical effectiveness and health promotion. They have been shared for comment with trust governors, local CCGs, Healthwatch Organisations and Health Overview and Scrutiny Committees. Responses to this consultation are included in Appendix G, together with the Trust response to each comment made by the stakeholders

2.2.1. Quality Improvement Priority

- To implement the trust quality improvement initiative. Metrics will be defined by the programme of work and will link with all three aspects of quality; safety, effectiveness and experience

2.2.2. Patient Safety Priorities

- Falls
- Pressure Ulcers
- Health promotion- To continue implementing the Zero Suicide initiative

2.2.3. Clinical Effectiveness Priorities

- To report on the implementation of NICE guidance identified as a Trust priority
- To review and report on mortality in line with new national guidance as it is published

2.2.4. Patient Experience Priorities

- To continue to prioritise and report on patient satisfaction and make improvements.
- To improve on national patient and staff survey results
- To continue to prioritise learning from complaints
- To continue implementing the Patient Leadership Programme

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 2018.

2.3. Statements of Assurance from the Board

During 2016/17 Berkshire Healthcare NHS Foundation Trust provided 63 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 63 of these NHS services.

The income generated by the NHS services reviewed in 2016/17 represents 100% of clinical services and 89% of the total income generated from the provision of NHS services by Berkshire Healthcare NHS Foundation Trust for 2016/17.

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

ⓘ Clinical audit is undertaken to systematically review the care that the Trust provides to patients against best practice standards. Based upon audit findings, the Trust makes improvements to practice to improve patient care. Such audits are undertaken at both national and local level.

National Clinical Audits and Confidential Enquiries

During Q1 to Q3 of 2016/17, 7 national clinical audits and 2 national confidential enquiries covered relevant healthcare services which Berkshire Healthcare NHS Foundation Trust provides.

During that period Berkshire Healthcare NHS Foundation Trust participated in 100% (n=7/7) 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.

The national clinical audits and national confidential enquiries that Berkshire Healthcare NHS Foundation Trust was eligible to participate in during Q1 to Q3 of 2016/17 are shown in the first column of Figure 22 below.

This column also details the national clinical audits and national confidential enquiries that Berkshire Healthcare NHS Foundation Trust participated in during Q1 to Q3 2016/17

The national clinical audits and national confidential enquiries that Berkshire Healthcare NHS Foundation Trust participated in and for which data collection was completed during Q1 to Q3 of 2016-17 are also listed below in Figure 22 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 that audit or enquiry (detailed in the second column of figure 22).

Figure 22- National Clinical Audits and Confidential Enquiries Undertaken by the Trust

National Clinical Audits and Confidential Enquiries that the Trust was eligible to participate in and did participate in during Q1 to Q3 of 2016/17	Data collection status and number of cases submitted	
1. National Clinical Audits (N=7)		
Falls and Fragility Fractures Audit programme (FFFAP) - Fracture Liaison Service Database	Data collection January and June 2016. 358 patients submitted, across 1 service. (Final figure not yet available). Report due 2017	
Learning Disability Mortality Review Programme (LeDeR)	Data collection delayed, due to extension in pilot.	
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme - Pulmonary rehabilitation	Data collection January to March 2017. 0 patients submitted, across 0 services. (final figure not yet available). Report due-date as yet unknown.	
National Diabetes Audit a) Adults - National Footcare Audit b) Adults- National Inpatient Audit c) Secondary care d) Primary Care – Slough Walk in Health Centre (SWiC)	a.	Data collection continuous. 45 patients submitted, across 1 MDFT team since 1st April 2016. 1st Report released 31st March 2016. NB: Report is registered and reported under Royal Berkshire Hospital NHS FT.
	b.	Not relevant to BHFT
	c.	Data collection 1st July 2016 to 18th Aug 2016. 1610 patients submitted, across 1 service. (final figure not yet available). Report due tbc 2017
	d.	Data collection July-August 2016. 250 patients submitted, across 1 service. (final figure not yet available). Report due tbc 2017
Sentinel Stroke National Audit programme (SSNAP) - SSNAP Clinical Audit (Post-Acute)	Data collection continuous. 410 Apr-Dec patients submitted, across 4 service elements. (final figure not yet available).	

National Clinical Audits and Confidential Enquiries that the Trust was eligible to participate in and did participate in during Q1 to Q3 of 2016/17	Data collection status and number of cases submitted	
	Report due: Apr-Jul Results – 19th Oct	
National audit of Early Intervention in Psychosis (EIP)	Data collected December 2015-January 2016. 19 patients currently submitted, across 1 service. Report received July 2016.	
Prescribing Observatory for Mental Health (POMH-UK) a) Prescribing antipsychotic medication for people with dementia b) Monitoring of patients prescribed lithium c) Rapid tranquilisation	a.	Data collection April 2016. 310 patients submitted, across 7 services. Report received November 16
	b.	Data collection June 2016 69 patients submitted, across 4 services. (final figure not yet available). Report due Dec 16/ January 2017.
	c.	Data collection September – November 2016. 29 patients submitted, across 1 service. (final figure not yet available). Report due June 2017
National Confidential Enquiries (N=2)		
Mental Health Clinical Outcome Review Programme a) Suicide in children & young people (CYP) b) Suicide, Homicide & Sudden Unexplained Death c) The management and risk of patients with personality disorder prior to suicide and homicide	a.	Data collection continuous. 2 patients submitted. (final figure not yet available). Report due 31st March 2017
	b.	Data collection continuous. 8 patients submitted. (final figure not yet available). Report due 6th October 2016
	c.	Data collection continuous. 0 patients submitted. (final figure not yet available). Report due 31st December 2016
Child Health Clinical Outcome Review Programme a) Chronic Neurodisability b) Young People's Mental Health	a.	Data collection Apr 2016 - March 2017. 0 patients submitted, across 1 service. (final figure not yet available). The Trust completed the organisational survey and were not required to collect data as we do not admit these patients. Report due November 2017
	b.	Data collection Apr 2016 to Mar 2017. 35 patients (inpatients) submitted, across 1 service in the prospective data collection and 9 patients (emergency attendances) for the retrospective data collection. (final figure not yet available). Report due November 2017

Source: Trust Clinical Audit Team

The reports of 11 (100%) national clinical audits were reviewed by the Trust in Q1 to Q3 of 2016-17. This included 10 national audits for which data was collected in earlier years with the resultant report being published in in 2016/17. Berkshire Healthcare NHS Foundation Trust intends to take actions to improve the quality of healthcare provided as detailed in Appendix B.

Local Clinical Audits

The reports of 36 local clinical audits were reviewed by the Trust in Q1 to Q3 of 2016/17 and Berkshire Healthcare NHS 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')

2.5 Research

ⓘ The Trust participates in research activity to help provide new knowledge that has the potential to be valuable in managing and treating patients. It is important that such research is open to critical examination and open to all that would benefit from it

The number of patients receiving NHS services provided or sub-contracted by Berkshire Healthcare NHS Foundation Trust in 2016/17 that were recruited during that period to participate in research approved by a research ethics committee was as follows:

981 patients were recruited from 65 active studies, of which 39 were recruited from studies included in the National Institute of Health Research (NIHR) Portfolio and 15 were from non-Portfolio studies.

Figure 23- R&D recruitment figures 2016/17

Type of Study	No of Participants Recruited	No of Studies
NIHR Portfolio	972	50 (11 of which are PICs)
Student	7	8
Other Funded (not eligible for NIHR Portfolio & Own Account (Unfunded)	2	7

Source: Trust R&D Department

2.6 CQUIN Framework

ⓘ The Commissioning for Quality and Innovation (CQUINs) payments framework was set up from 2009/2010 to encourage NHS providers to continually improve the quality of care provided to patients and to achieve transparency. CQUINs enable commissioners (such as the Clinical Commissioning Groups) to reward excellence, by linking a proportion of service providers' income to the achievement of national and local quality improvement goals.

To be updated in Q4

A proportion of Berkshire Healthcare NHS Foundation Trust's income in 2016/17 was conditional upon achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2016/17 and for the following 12 month period can be found in Appendix E & F.

The income in 2016/17 conditional upon achieving quality improvement and innovation goals is £X The associated payment received for 2015/16 was £X

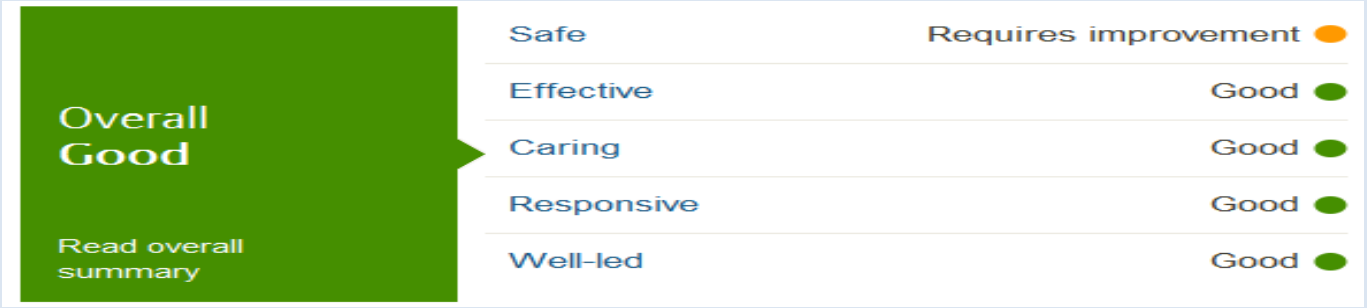
2.7 Care Quality Commission (CQC)

ⓘ The Care Quality Commission (CQC) is the independent regulator for health and social care in England. It ensures that services such as hospitals, care homes, dentists and GP surgeries provide people with safe, effective, compassionate and high-quality care, and encourages these services to improve. The CQC monitors and inspects these services, and then publishes its findings and ratings to help people make choices about their care.

Berkshire Healthcare NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is registered with no conditions attached to registration.
The Care Quality Commission has not taken enforcement action against Berkshire Healthcare NHS Foundation Trust during 2016/17.

Berkshire Healthcare NHS Foundation Trust is subject to periodic reviews by the Care Quality Commission and the last review was on 13th-16th December 2016.

The trust is awaiting the report from this latest review and the grid below shows the trust CQC ratings following its earlier CQC inspection in December 2015. This grid will be updated once the report from the December 2016 inspection is received by the trust.



Source: CQC Website

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

The CQC has carried out the following unannounced Mental Health Act (MHA) visits during the 2016/17 financial year. By law, the Care Quality Commission (CQC) is required to monitor the use of the Mental Health Act 1983 (MHA) to provide a safeguard for individual patients whose rights are restricted under the Act.

- 29th April 2016- Snowdrop Ward, Prospect Park Hospital.
- 28th September 2016- Orchid Ward, Prospect Park Hospital. The Trust is awaiting the report from this visit.
- 1st November 2016- Daisy Ward, Prospect Park Hospital
- 2nd November 2016 Little House (Learning Disability Unit), Bracknell
- 14th November 2016- Berkshire Adolescent Unit, Wokingham

All of these inspections highlighted a number of areas of good practice and also made some recommendations for improvement. Full action plans to implement these recommendations have been produced and are being implemented.

An MHA Monitoring visit was also undertaken by the CQC on Sorrell Ward in January 2017, and the Trust is awaiting receipt of the report following this visit.

Finally, the CQC carried out an unannounced inspection of the Slough Walk-in Centre on 9th August 2016. The resulting report, published in October 2016, gave the Slough Walk-in Centre an overall rating of 'Requires Improvement'. A rating of 'Good' was given in relation to the 'caring' and 'responsive' domains. A full action plan to address these findings has been developed and is being implemented, with many of the actions already completed.

2.8 Data Quality and Information Governance

It is important that data used by NHS services is of a high quality so that it can be best used to inform decisions on the management of patients. In addition, data must be of a high quality to help inform organisational decision-making and planning.

Berkshire Healthcare NHS Foundation Trust submitted records during 2016/17 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:
100% for admitted patient care
99.9% for outpatient care and
97.7% for accident and emergency care.

— which included the patient's valid General Medical Practice Code was:
100% for admitted patient care;
99.9% for outpatient care; and
99.9% for accident and emergency care.

Information Governance

Information Governance requires the trust to set a high standard for the handling of information. The aim is to demonstrate that it can be trusted to maintain the confidentiality and security of personal information, by helping individuals to practice good 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). (To be updated in Q4 2016/17)

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 2016/17 by the Audit Commission

Berkshire Healthcare NHS Foundation Trust will be taking the following actions to improve quality.
The Trust is using the latest Commissioning Data Set (CDS) version to send data. Data will continue to be monitored and improvements made where required.

The Trust continues to monitor the improvement of data quality. An overarching Information Assurance Framework (IAF) provides a consolidated summary of every performance information line and action plans.

Data Quality and Data Assurance audits are carried out throughout the year as part of the Information Assurance Framework (IAF) and where data issues are identified internal DQIPs are put in place. The data is monitored until assurance is gained that the Trust can have a high confidence level in the data being reported. The assurance reports are included in the monthly Finance, Performance and Risk Executive committee alongside the Performance Assessment Framework (PAF) and reviewed in monthly and quarterly Locality meetings. External Data Quality reports published on the Information Centre website are analysed to ensure consistency in reporting both internally and externally.

The clinical coding team continues to review and improve the Trust's diagnostic data. As part of our continuous improvement programme, a scheduled clinical coding audit took place in December 2016 and the primary diagnosis rate was 100%, and the secondary diagnosis rate was 95.1%. The coding team continues to work with consultants across the Trust to maintain accurate diagnosis data.

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

1. 100% enhanced Care Programme Approach (CPA) patients receiving follow-up contact within 7 days of discharge from hospital (Trust choice)
2. Admissions to inpatient services had access to crisis resolution home treatment teams- gatekeeping (Trust choice)
3. Minimising delayed transfers of care (Governors' choice)

2.9. Duty of Candour

ⓘ The Duty of Candour is a legal duty on hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. Duty of Candour aims to help patients receive accurate, truthful information from health providers.

Berkshire Healthcare NHS Foundation Trust have 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 and 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 2016/17

ⓘ In addition to the key priorities detailed in Part 2 of this report, the Trust Board receives monthly Performance Assurance Framework reports related to key areas of quality. The metrics in these reports 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. Information relating to specific areas of Trust quality and safety performance in 2016/17 is detailed below.

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 reported 0 never events in 2016/17.

Incidents and Serious incidents (SIs)

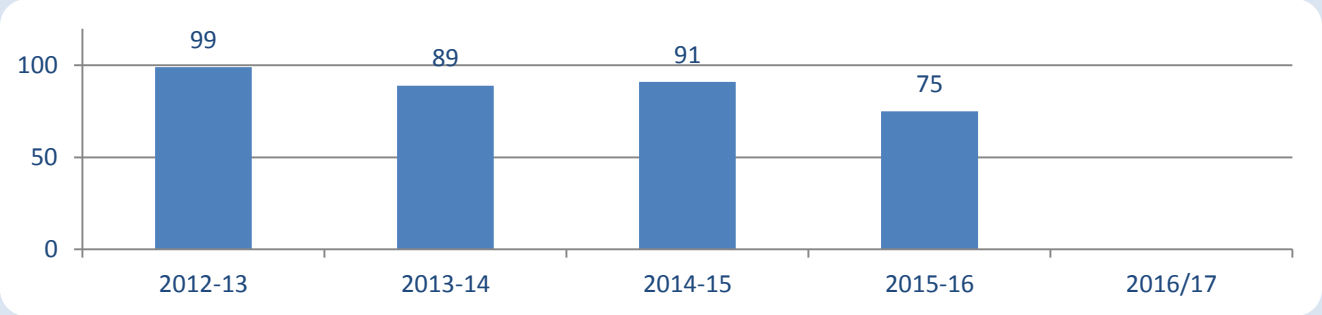
ⓘ An incident is any unintended or unexpected event which could have or did lead to harm for one or more people. Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response.

The Trust aims to maximise reporting of incidents whilst reducing their severity level through early intervention and organisational learning. Organisations that report more incidents usually have a better and more effective safety culture. The annual number of patient safety incidents reported by the Trust is detailed in part 3.2 below.

Figure 24 below shows the annual number of serious incidents reported by the trust in comparison with the previous financial years.

It should be noted that from 2015/16 Admission of Minors was no longer reported as an SI.

Figure 24- Number of SIs- Year on Year Comparison (excluding pressure ulcers) *(To be completed in Q4)*



Source: Trust Serious Incident Report

Summary of findings from Quarter 3 2016/17 Serious Incident (SI) reporting

Suicide cases: In Q3 there were 4 SIs reported as suicides/suspected suicides. This is 4 fewer than were reported in the previous quarter. There were no SIs reported as attempted suicides in Q3.

Unexpected Deaths: There were 5 unexpected deaths initially reported as SIs in Q3. Of these deaths, 4 were of patients known to Community Mental Health Services and 1 was a detained patient who was transferred to an acute hospital due to unexplained deterioration of his physical health. This death was reported to the CQC in line with their requirements; however it was downgraded from being reported as an SI following the cause of death being established. One of the unexpected deaths within the community was also downgraded once it was established by the Coroner that the cause of death was accidental. Therefore a total of 3 unexpected deaths have been captured.

Falls: In Q3, there was 1 SI reported for a patient fall on a trust ward. However, it was agreed with commissioners that this should be downgraded due to the patient's underlying medical condition.

Pressure Ulcers: Prior to April, 2016, category 3 and 4 pressure ulcers were reported as SI's if they developed when the patient was in our care and were assessed as being avoidable. However, in agreement with the Commissioners, since April 2016 there is no longer a need to report developed pressure ulcers as SIs unless it is deemed that there was a significant lapse in care. Instead, the Deputy Director of Nursing holds a Learning Summit with the ward/community team. The aim of this is to improve care by involving the teams in identifying learning and areas for improvement in care provision. The process also includes establishment of any themes that can be shared across the organisation. In Q3, 5 learning events were held for incidents of pressure damage where it was identified that there was a potential lapse in care that could have contributed to the development of the category 3 or 4 pressure ulcer. For 4 of these the learning summit agreed there to be a lapse in care. The remaining learning summit concluded that there had been no lapse in care by Berkshire Healthcare staff that would have contributed to the development to the pressure ulcer.

Downgrades: At the time of writing this report, 1 fall and 2 unexpected deaths that were initially reported as SIs in Q3 have been subsequently downgraded following further information from the Coroner and in agreement with the CCG.

Death of detained patients: There was 1 death of a detained patient in Q3. This was reported to the CQC and initially also reported as an SI. However, on confirmation of cause of death from the coroner and discussion with commissioners this was downgraded

Key themes identified in SI investigation reports approved in Quarter 3 2016/17, together with actions taken to improve services:

Carers and families: Already a theme from previous quarterly reports, the views of carers and families continues to be a focus in many of the recommendations made in recent investigations. The importance of seeking their view on the needs of the patient and how they view the level of risk and then how it is documented in RiO, features in a number of SIs closed this quarter. In addition, the need to offer carers assessments and structure assessments so that carers do not feel they are always being asked the same question has been raised.

Actions taken to address this are as follows:

- The recent Making Families Count Workshop provided for our staff was very well attended and gave an emotive and powerful insight into the importance of involving families both during care and treatment as well as after an SI.
- The CPA policy and document are being updated with a planned go live of 28th February 2017. The new CPA form captures Service User and carers views. A focus group with carers has informed the new CPA form and our approach to involving carers in CPA. We consulted a carer activist to advise us on this documentation and also our 2017 carer awareness training materials and this resulted in significant changes to the materials and language used based on carer feedback.
- The new risk documentation has a default section to prompt staff to record carer's views.
- A new element of our risk training focuses on involving carers, this includes:
    - a clip for helping staff to address information sharing and confidentiality when the service users does not wish for information to be shared,

- exploring the concept of carer involvement and strategies to enhance this using examples from practice,
- examination of family involvement with suicidal clients using participants own cases.

Overall quality of documentation of risk

This remains a theme and more than one investigation has highlighted that risk assessments are still not always being updated or being completed using all available information to ensure risk is appropriately assessed. Not updating nursing care plans and risk management plans has also featured. The lack of a clearly documented crisis contingency plan also needs to be addressed.

Actions taken to address this are as follows:

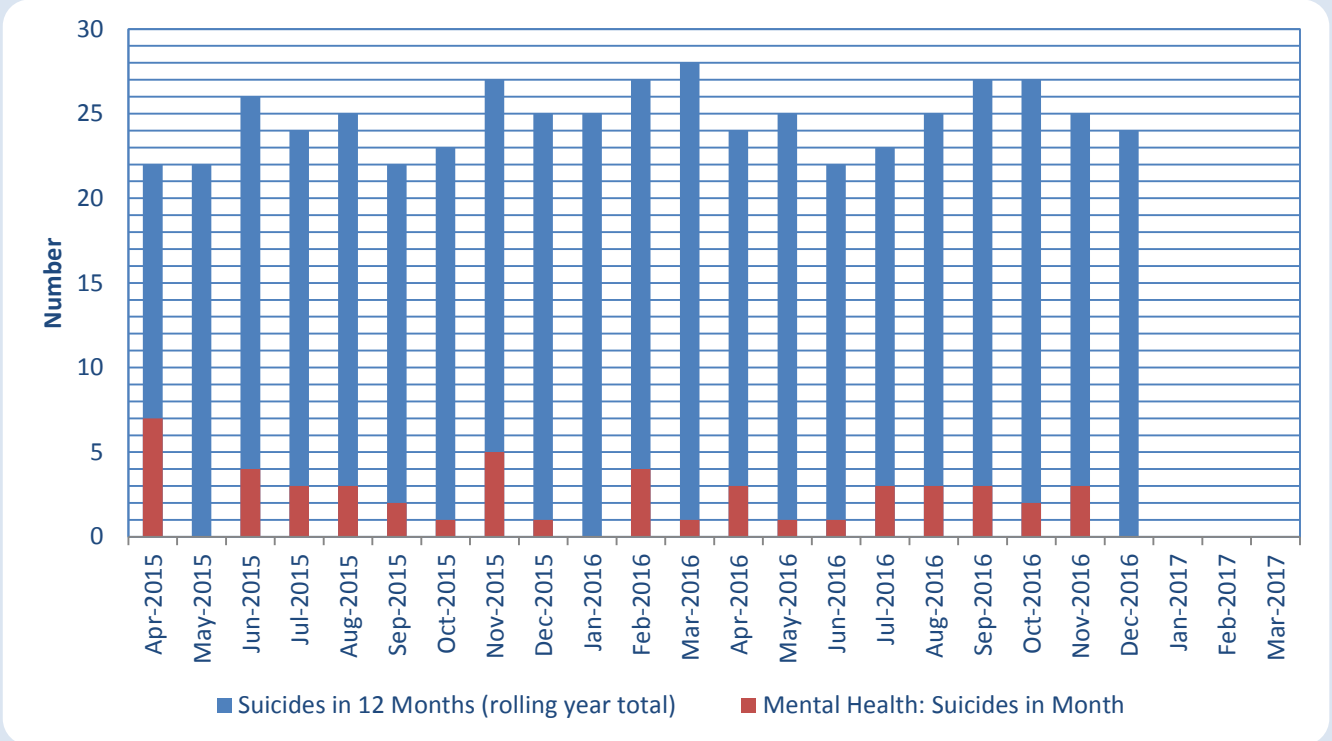
- In response to this on-going theme, the new risk tool in RiO went live on 10th January 2017. All mental health services have received several communications about this. The main change is that there will no longer be the tick boxes or the requirement to have a separate risk management care plan or crisis contingency plan as these are now embedded within the risk assessment in RiO. All information in the current risk document will pull through to the new version. Staff (with service users/carers) will now be completing risk management plans and safety/crisis contingency plans on the new format. Service users will also now be able to have a copy of their safety/crisis plan in a printable letter format.
- Clinical Directors will be attending team meetings to help staff with getting this embedded in practice throughout January and the risk trainers will also be helping staff.
- A RiO guide is being developed and there will be other resources available for staff to look at prior to the go live date. A new section will be available on the Trust intranet - this will contain resources and examples to help staff - hyperlinks on the RiO form will link to this.
- A new policy and SOP will also be circulated.

Suicides

Figure 25 below shows the number of suicides reported per month, together with the rolling 12 month figure.

The figure shows that there were 5 suicides reported during Q3 of 2016/17, compared with 9 suicides in Q2 and 5 suicides in Q1.

Figure 25- Suicides- Number per month and rolling year total per month



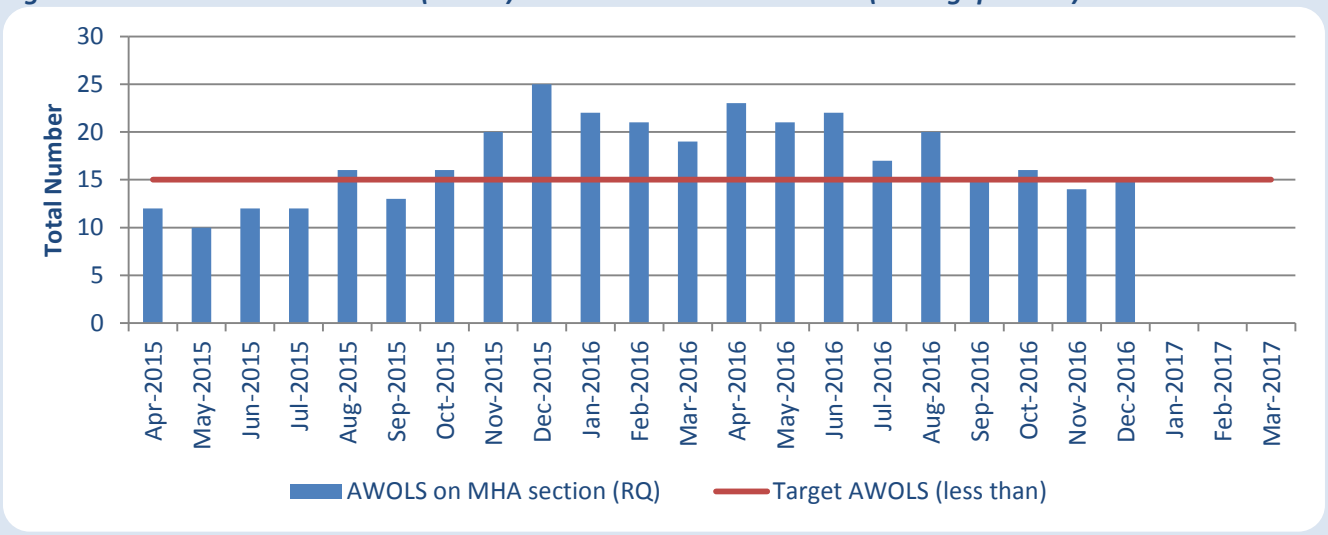
Source: Trust Performance Assurance Framework

Absent without leave (AWOL) and absconsions

ⓘ 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.

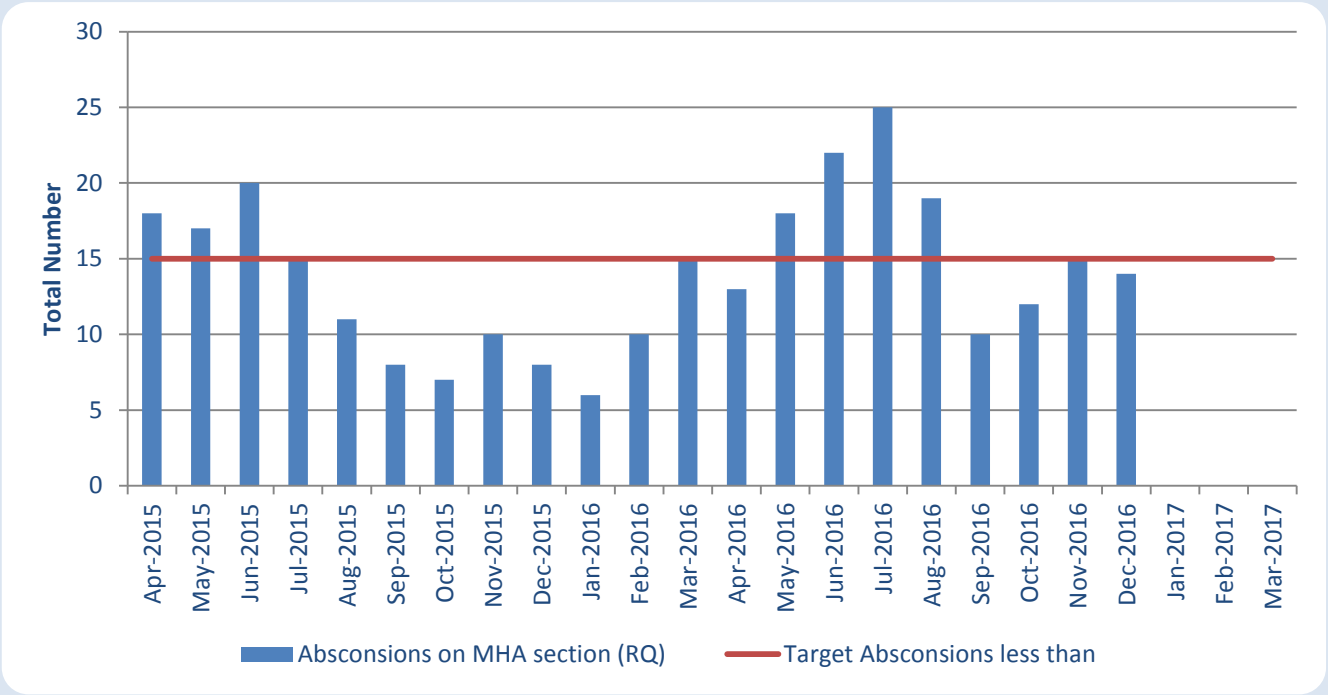
Figures 26 and 27 below detail the number of absconsions on a Mental Health Act Section and the number of patients absent without leave on a Mental Health section.

Figure 26- Absent without leave (AWOL) on a Mental Health Section- (Rolling quarters)



Source: Trust Performance Assurance Framework

Figure 27- Absconsions on a Mental Health Act (MHA) Section- (Rolling Quarters)



Source: Trust Performance Assurance Framework

Medication errors

ⓘ **A medication error is any patient safety incident where there has been an error in the process of prescribing, preparing, dispensing, administering, monitoring or providing advice on medicines. Such patient safety incidents can be divided into two categories; errors of commission (e.g. wrong medicine or wrong dose of medicine) or errors of omission (e.g. omitting a dose or failing to monitor).**

Moderate, major and severe medication errors attributable to the Trust

There were no moderate, major or severe incidents reported by Trust staff in this quarter.

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

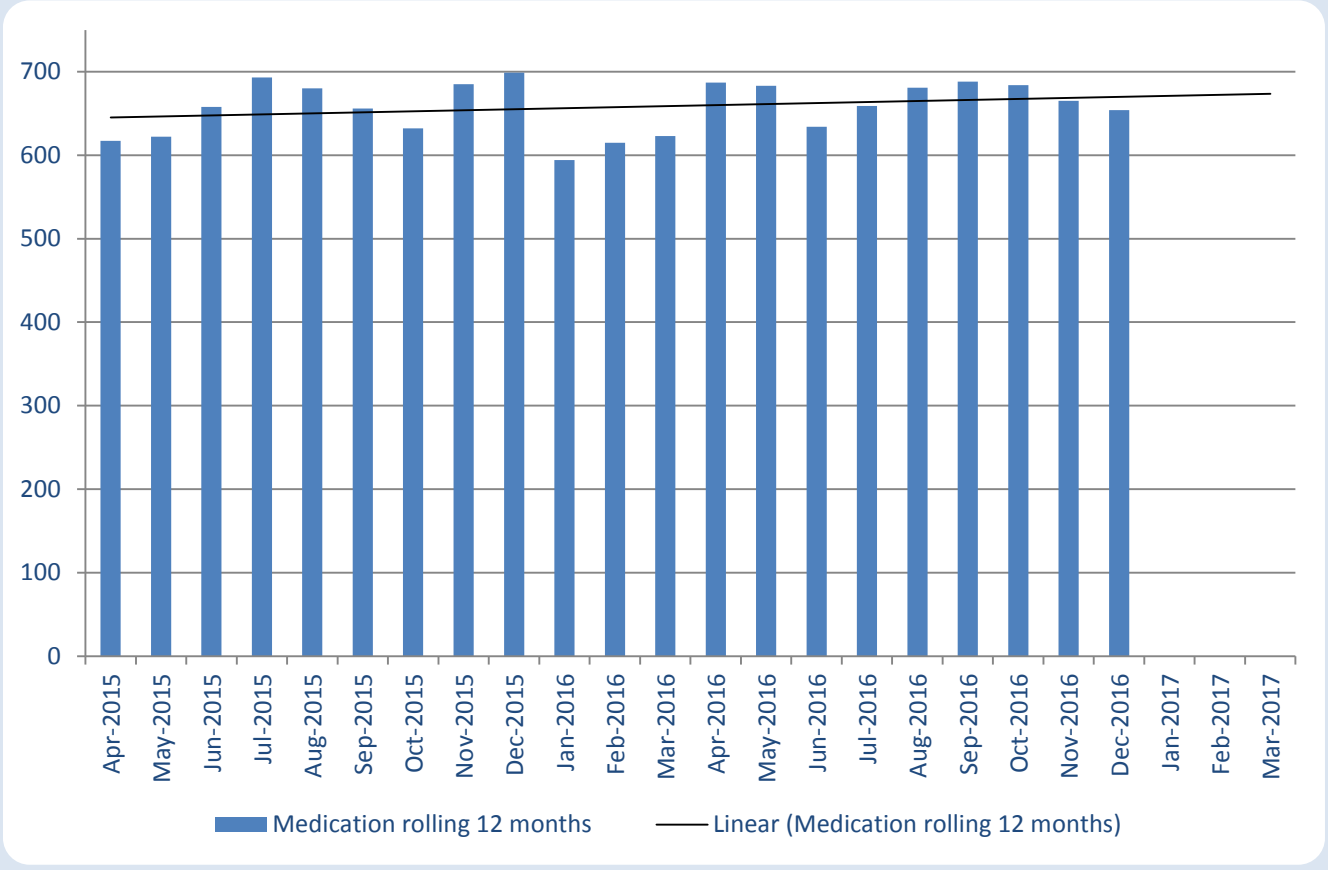
There were no moderate, major or severe incidents reported by Trust staff in this quarter.

Number of reported medication errors

Figure 29 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.

Figure 29: Medication Errors (Rolling 12 Months)



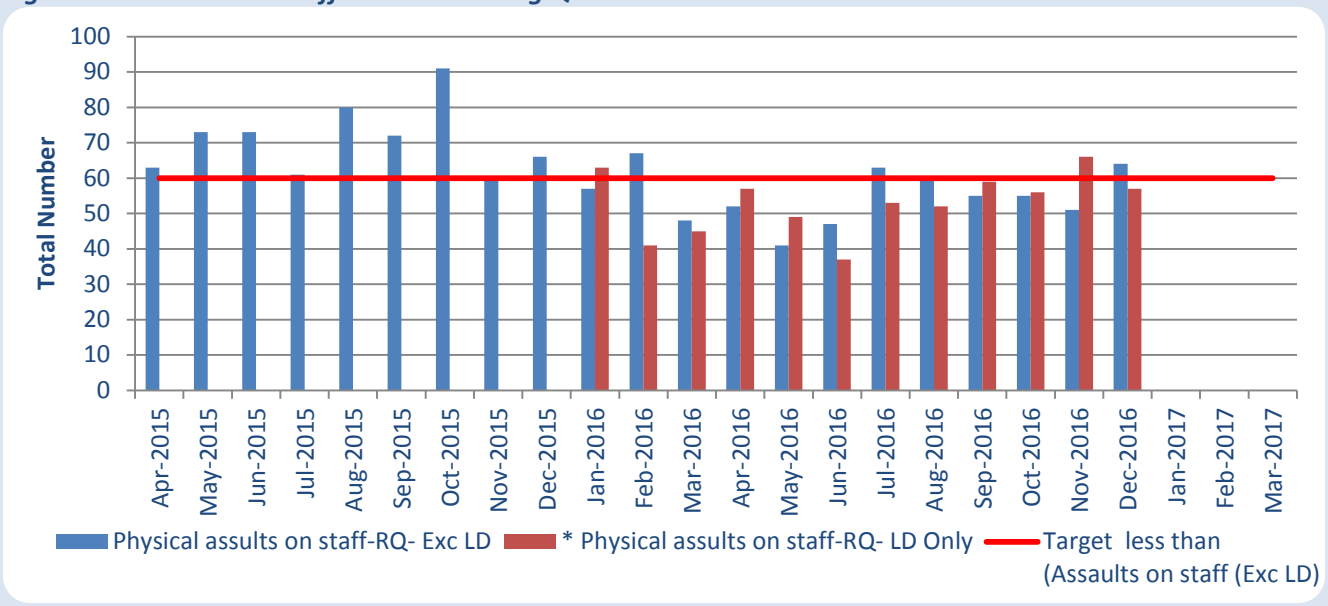
Source: Trust Incident Database (Datix)

Patient to staff physical assaults

Figure 30 below details the number of patient to staff assaults. This data has been separated to show assaults by patients with and without learning disabilities.

There have been fluctuations in the level of physical assaults on staff by patients. Often these changes reflect the presentation of a small number of individual inpatients.

Figure 30- Patient to staff assaults- Rolling Quarters



**LD data available from Jan 2016*

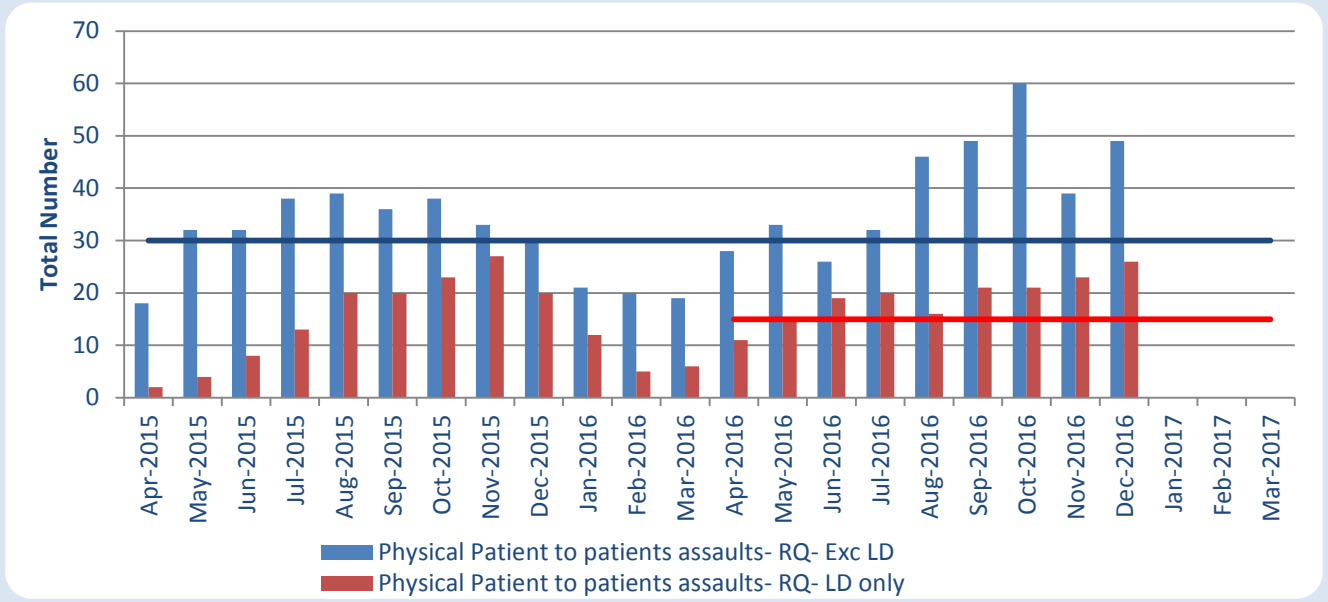
Source: Trust Performance Assurance Framework

Patient to patient physical assaults

Figure 31 below details the number of patient to patient physical assaults.

This data has been separated to show assaults by patients with and without learning disabilities. As can be seen, the level of patient on patient assaults appears to fluctuate.

Figure 31- Patient to Patient Physical Assaults- Rolling Quarters (RQ)



Source: Trust Performance Assurance Framework

3.2 Reporting against core indicators and performance thresholds

ⓘ **Since 2012/13, all NHS Foundation Trusts have been required to report performance against a core set of indicators. This section details the trust's performance against these core indicators.**

In addition, the section includes performance against specific indicators and thresholds that have been reported as part of the NHS Improvement's oversight frameworks during the whole year.

Where available, the national averages for each indicator, together with the highest and lowest scores nationally have also been included.

Figure 32	2014/15	2015/16	2016/17			National Average 2016/17	Highest and Lowest
			Q1	Q2	Q3		
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	98.20%	98.6% * 98.8% **	98%	97%	98%	TBC	TBC

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 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 we aim to ensure that all patients discharged from mental health inpatient care are followed up (either face to face or by telephone) within 7 days of discharge. This is agreed and arranged with patients before discharge and this facilitates our high compliance level

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 33	2014/15	2015/16	2016/17			National Average 2016/17	Highest and Lowest
			Q1	Q2	Q3		
The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period	97.7%	97.6%	99.5%	99.5%	99.0%	TBC	TBC

Berkshire Healthcare 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

Berkshire Healthcare 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

Source: Trust Performance Assurance Framework

Figure 34	2014/15	2015/16	2016/17			National Average 2016/17	Highest and Lowest
			Q1	Q2	Q3		
The percentage of MH patients aged— (i) 0 to 15; and (ii) 16 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	11.1%	7.7%	**7%**	**7%**	**6%**	**Not Available** (National Indicator last updated 2013)	**Not Available**
Berkshire Healthcare 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 trust has taken 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 35	2014/15	2015/16	2016/17	National Average 2016/17	Highest and Lowest
The indicator score of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends	3.77	3.83	**TBC** KF1. Staff recommendation of the organisation as a place to work or receive treatment- Score out of 5	**TBC**	**TBC**
	71%	74%	**TBC** Q21d."If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	**TBC**	**TBC**
Berkshire Healthcare trust considers that this percentage 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 trust has taken the following actions to improve this percentage, 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.					

Source- National Staff Survey

Figure 36	2014/15	2015/16	2016/17	How Trust compares nationally	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	6.9	6.8	**7.2** (Score out of 10)	**About the same as similar trusts**	**6.1-7.5**
Berkshire Healthcare trust considers that this percentage is as described for the following reasons: The Trusts score is in line with other similar Trusts					
Berkshire Healthcare trust has taken the following actions to improve this percentage, 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 37	2014/15	2015/16	2016/17			National Average 2016/17	Highest and Lowest
			Q1	Q2	Q3		
The number of patient safety incidents reported *	**3642** *	**3513** *	**950** *	**831** *	**785** *	**N/A**	**N/A**
Rate of patient safety incidents reported within the trust during the reporting period per 1000 bed days	**31.4** *	**31.3** *	**17.0** *	**29.2** *	**32.9** *	**TBC (Median)** **	**TBC** **
The number and percentage of such patient safety incidents that resulted in severe harm or death	**49 (1.3%)** *	**56 (1.6%)** *	**14 (1.5%)** *	**15 (1.8%)** *	**7 (0.9%)** *	**TBC (TBC%)** **	**TBC** **
Berkshire Healthcare trust considers that this percentage 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 MONTH 2017, the median reporting rate for the cluster nationally was X incidents per 1,000 bed days (but please note this covers the 6-month period XXXXX, for which period the NRLS gives the BHFT rate as X 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.							
Berkshire Healthcare trust has taken the following actions to improve this percentage, and so the quality of services, by: 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.							

Sources: * *Trust Figures*
** *NRLS report published in MONTH 2017 covering MONTH- MONTH relating to X Mental Health Organisations*

Figure 38 Annual Comparators	Target	2014/ 15	2015/ 16	2016/17			Commentary
				Q1	Q2	Q3	
Patient Safety							
CPA review within 12 months	95%	96.0%	96.1%	**96.3%**	**95.3%**	**95.3**	For patients discharged on CPA in year last 12 months. Fig shown is Monthly avg %
Never Events	0	0	0	0	0	0	Full year no. of never events. *Source Trust Patient Safety Report*
Infection Control- MRSA bacteraemia	0	0	0	**0**	**0**	**0**	Full year number MRSA
Infection Control- C. difficile due to lapses in care (Include Rate at Q4)	<6 p/a	0	1	**0**	**0**	**0**	Full Year number & rate per 1000 bed days of C. Diff due to lapses in care
Medication errors	Increased Report.	576	623	**634**	**688**	**654**	Cumulative rolling year no. of medication errors reported
Clinical Effectiveness							
Mental Health minimising delayed transfers of care (Relates to Mental Health delays only-Health & Social Care).	<7.5%	1.5%	1.7%	**8.15%**	**11.9%**	**10.3%**	Calculation = number of days delayed in month divided by OBDs (Inc. HL) in month. Fig. shown is Monthly avg %.
Meeting commitment to serve new psychosis cases by early intervention teams- New Early Intervention cases.	99	124	131	**51**	**80**	**108**	Cumulative total number in year
Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral	N/A	N/A	N/A	**91%**	**77%**	**90%**	Added from Q4 2015/16 Figure shown is average monthly %
Improving access to psychological therapies (IAPT): People with common mental health conditions referred to the IAPT programme will be treated within 6 weeks of referral	N/A	N/A	N/A	**98%**	**98.6%**	**98.6%**	Added from Q4 2015/16 Figure shown is average monthly %
Improving access to psychological therapies (IAPT): People with common mental health conditions referred to the IAPT programme will be treated within 18 weeks of referral	N/A	N/A	N/A	**99.7%**	**100%**	**100%**	Added from Q4 2015/16 Figure shown is average monthly %
A&E: maximum waiting time of four hours from arrival to admission/ transfer/ disch.	95%	99.5%	99.4%	**99.5%**	**99.3%**	**99.6%**	Fig shown is Monthly avg %
Completeness of Mental Health Minimum Data Set	99.6% 50%	99.6 99.2	99.8 99.2	**99.9** **98.9**	**99.9%** **98.6%**	**99.9%** **98.6%**	Fig shown is Monthly avg %

Figure 38 Annual Comparators	Target	2014/15	2015/16	2016/17			Commentary
				Q1	Q2	Q3	
Completeness of Community service data 1) Referral to treatment info. 2) Referral info. 3) Treatment activity info.	 50% 50% 50%	 72.3% 62.4% 98.0%	 72.1% 61.8% 96.9%	 **71.3%** **62.0%** **97.0%**	 **71.0%** **62.3%** **97.3%**	 **71.3%** **62.6%** **97%**	Fig shown is Monthly avg %
Patient Experience							
Referral to treatment (RTT) waiting times – non admitted –community.	95% <18 weeks	99.8%	99.5%	**99.3%**	**99.3%**	**98.3%**	Waits are for consultant led services in East CHS, Diabetes, and Paediatric services from referral to treatment (stop clock). Notification received from NHS England to exclude sexual health services. Figure shown is monthly avg. %
RTT waiting times Community: Incomplete pathways	92% <18 weeks	100%	99.7%	**99.3%**	**98.0%**	**99.9%**	Year-end average.
Access to healthcare for people with a learning disability		Green 21	Green 20	**Green 20**	**Green 20**	**Green 20**	Score out of 24
Complaints received		244	218	**66**	**56**	**36**	Total number in year or Qtr
1. Complaint acknowledged within 3 working days 2. Complaint resolved within timescale of complainant	100% 90%	100% 92%	96.3% 91.4%	**100%** **100%**	**100%** **100%**	**100%** **100%**	Full year % or Quarter %

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.
NHS Improvement 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 NHS 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 2016/17 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2016 to [the date of this statement]
  - papers relating to quality reported to the board over the period April 2016 to [the date of this statement]
  - feedback from commissioners dated XX/XX/20XX
  - feedback from governors dated XX/XX/20XX
  - feedback from local Healthwatch organisations dated XX/XX/20XX
  - feedback from Overview and Scrutiny Committee dated XX/XX/20XX
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated XX/XX/20XX
  - the latest national patient survey XX/XX/20XX
  - the latest national staff survey XX/XX/20XX
  - the Head of Internal Audit's annual opinion of the trust's control environment dated XX/XX/20XX
  - CQC inspection report dated XX/XX/20XX
- 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 NHS Improvement'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

DATE **Martin Earwicker Chairman**

DATE **Julian Emms Chief Executive**

Appendix A: Quality Strategy

Appendix B- National Clinical Audits- Actions to Improve Quality

National Clinical Audits Reported in 2016/17 and results received that were applicable to Berkshire Healthcare NHS Foundation Trust

National Audits Reported in 2016/17	Recommendation (taken from national report)	Actions to be Taken
NCAPOP Audits		
National Diabetes Audit SWIC (2819)	The National Diabetes Audit (NDA) is a major national clinical audit, which measures the effectiveness of diabetes healthcare against NICE Clinical Guidelines and NICE Quality Standards, in England and Wales. The NDA collects and analyses data for use by a range of stakeholders to drive changes and improvements in the quality of services and health outcomes for people with diabetes. The review recommended that the GP service should review local and national findings for any possible learning or improvements and identify any local issues and develop an action plan for improvement.	The following actions have been identified and are being implemented, including additional nurse training, locum medical support dedicated to diabetes screening and treatment, and amendments to the screening tools currently in place. Local audit is also taking place.
NCEPOD Sepsis Study (2042)	The national sepsis report was published in November 2015, with data collection taking place in August 2014 The report produced a number of recommendations; hospitals should have a formal protocol in place for the early identification and immediate management of patients with sepsis. NEWS should be used in both primary and secondary care for patients where sepsis is suspected. On arrival in the emergency department, a full set of vital signs, as stated in the Royal College of Emergency Medicine standards for sepsis and septic shock should be undertaken. In addition, hospitals should ensure that their staffing and resources are effective in recognising and caring for the acutely deteriorating patients. All patients diagnosed with sepsis should benefit from management on a care bundle as part of their care pathway. The report recommended that this bundle should be audited and reported on regularly.	The Trust has a Lead Clinician for sepsis and the Head of Infection Prevention and Control is coordinating the sepsis work stream in order to ensure compliance with national guidance and patient safety initiatives.
National Diabetes Audit – Secondary Care 2014/15 (2833) National Diabetes Audit - Secondary Care 2013/14 (2777)	The National Diabetes Audit (NDA) continues to provide a comprehensive view of Diabetes Care in England and Wales and measures the effectiveness of diabetes healthcare against NICE Clinical Guidelines and NICE Quality Standards in England and Wales. Nationally a number of recommendations were made for people with diabetes, care providers, on care processes and structured education and achieving treatment targets.	The results from the audit provide a picture of the overall care against NICE best practice for diabetic patients registered with Berkshire Healthcare Diabetic Centre. Overall, the service achieved a higher score than expected. Areas that require improvement are related to the recording foot care and smoking information. Actions relating to this audit will be in liaison with local secondary care colleagues.

National Audits Reported in 2016/17	Recommendation (taken from national report)	Actions to be Taken
National Diabetes Audit 2013-2014 (Commissioning West) (2039) National Diabetes Audit 2013-2014 (Commissioning East) (2603) National Diabetes Audit 2014-2015 (Commissioning East) (2821) National Diabetes Audit 2014-2015 (Commissioning West) (2852)	The National Diabetes Audit is a major national clinical audit, which measures the effectiveness of diabetes healthcare against NICE Clinical Guidelines and NICE Quality Standards, in England and Wales. Data was collected and submitted to national audit (on behalf of CCG).	Action: No action is required for BHFT.
National audit of Early Intervention in Psychosis (EIP) (2880)	The two main recommendations that resulted from the audit are as follows: (i) the Trust must ensure that treatment from these services should be accessed as soon as possible to reduce the duration of untreated psychosis and (ii) the results of the audit has showed that BHFT should ensure that by comprehensively assessing physical health they will enable health and social care practitioners to offer relevant physical health interventions if necessary. Since the time of the audit, BHFT has developed a single EiP service across the Trust. The service has team members based within each locality as well as people centrally based working either centrally (i.e. in CPE) or across localities (i.e. STR workers). The EiP service has a full multi-disciplinary team with dedicated psychological therapies. The team is currently working with people who are experiencing First onset Psychosis, those with suspected psychosis and at risk mental states. The current caseload is 220 people with the expectation that this will increased to around 300 in line with suspected prevalence rates.	The EIP service has significantly changed its structure since 2014 to provide EIP from a central team and improved both access and physical health care for patients. The Cardio metabolic CQUIN (Standard 6) for EIP in 2015/16 required the Trust to provide training to staff to ensure patients with Early onset Psychosis are having regular physical health assessment to reduce the health inequality and increase life expectancy. The service achieved 100% of its CQUIN in 2015/16 and has now added a Cardio Metabolic form on RIO which will allow the requirements of the 2016/17 CQUIN and National audits to be accessed and monitored easily. A digital dashboard has been created which links into the trust's electronic health record system showing daily updates of progress against the new access and waiting time standard for Early Interventional in Psychosis (EIP) which is helping improve outcomes in Berkshire. Work is in place to incorporate a new electronic template based on the Lester tool for physical health checks.

National Audits Reported in 2016/17	Recommendation (taken from national report)	Actions to be Taken
Non-NCAPOP audits		
POMH - Topic 15a - Prescribing valproate for bipolar disorder (September 2015) (2644)	The aim of the audit was to help mental health services improve prescribing practice. Valproate has some efficacy in the treatment of acute episodes of mania and is one of the treatment strategies recommend by NICE for the prevention of relapse in people with bipolar disorder. Like all medicines, valproate is associated with side effects and it is important that adequate attention is paid to reviewing both the benefits and harms associated with this treatment. BHFT provided data from 7 participating teams and 146 patient records were submitted (91% of which were from CMHT's). In comparing BHFT and national results, compliance varied. In some instances BHFT had better compliance than the national average with the exception of physical health checks. Whilst BHFT showed areas of good practice, there were many areas requiring improvement.	Physical health checks in inpatient mental health is an established CQUIN in the Trust and much work continues to be done to improve compliance. A similar CQUIN has begun for 2016/17 for CMHT's, so work will commence as to how to bring about improvements A diagnosis of bipolar disorder is a major driver for undertaking the NICE recommended physical health checks. The Trust will ensure that those patients prescribed valproate for more than 1 year have a clearly documented review of their treatment.
POMH - Topic 14b Prescribing for substance misuse; alcohol detoxification (January 2016) (2645)	This re-audit presents data on prescribing practice for alcohol detoxification conducted in acute psychiatric inpatient settings. BHFT was one of 43 Trusts who submitted data on any patients who underwent alcohol detoxification whilst an inpatient in the 12 months prior to January 2016. The report shows that BHFT performance varies through the audit criteria and compares only sometimes favourably against the national average.	Work is occurring, and being linked to a CQUIN. By linking, it is hoped that improvements will be streamlined. A tool to support assessment of the signs and symptoms of Wernicke's encephalopathy has been developed for use within the Trust.

Appendix C- Local Clinical Audits- Actions to Improve Quality

	Audit Title	Conclusion/Actions
1	Bed side blood transfusion practice (3081)	The audit was undertaken to comply with (BHFT's) blood transfusion policy requirement to undertake an annual audit of transfusion practice. The aim of the audit was to ensure that BHFT's blood transfusion practice is in line with the required National Standards. Action: A number of agreed actions have been implemented included recording the correct care pathway clinic documentation being updated, ensuring NEWS score is recorded at the beginning of the transfusion, and improving compliance to the NICE NG24 standard. There will also be an audit of transfusion practice on community hospital ward.
2	Personal Clinical Practice Audit Using NICE CG128 (2055)	Assessment and thereafter management of children for an autism spectrum disorder constitutes at least 50% of any clinical practice/caseload. NICE CG128 clearly defines criteria for the diagnosis, after diagnosis, medical investigations in children with autism. All patients on who received a confirmed diagnosis of Autism/ ASD between January and December 2014 were included in the audit. The audit findings were presented to community paediatricians at clinical governance meeting which confirmed that the Trust's clinical practice in concordance with the NICE guidelines. Action: No further actions required.
3	An audit of flumzenil use within the Berkshire Community Dental Service (2186)	Flumzenil is a drug used for reversing the actions of benzodiazepines. In the dental context, it may be used after outpatient intravenous sedation, to reverse the effects of midazolam. This may be to facilitate a safer return home where recovery is prolonged, or the patient has additional or special. Data collection was retrospective, covering a 29-month time period from 1st May 2013 to 30th September 2015. The audit found that the standard for the use of flumazenil within Berkshire CDS was met. Action: No further actions required.
4	Re-audit of the quality of the GP Referrals to the Slough Memory Clinic 2015 (2867)	The purpose of the re-audit was to re-assess the quality of the GP referrals sent to the memory services specifically the Slough memory clinic following the recommendations made in the initial audit (June 2014). The aim of the re-audit was to establish whether current referrals were in line with local guidelines and if any improvements were made following last year's recommendations. Overall compliance could be improved if GPs ensure that complete and good quality referrals (as per the requirements of the standards set) are sent to the Slough memory clinic. Action: The re-audit identified the need to educate GPs with regards to the importance of the referral standards and to emphasise the standards to ensure good quality referrals are sent.

	Audit Title	Conclusion/Actions
5	Mental Health CQUIN 2015/16 (Q1, Q3, Q4) (indicator 4a) (2782)	The Five Year Forward View (FYFV) has set out the vision for promoting well-being and preventing ill health. A key element of the Trust's work going forward will be to align incentives with the reform of payment approaches and contracts. The Trust will work with partners and the system to ensure that future incentive schemes are designed to help drive the changes required. The 2015/16 scheme is structured so that the national goals reward transformation across care pathways that cut across different providers. Mental Health: Improving Physical Healthcare for Patients with Severe Mental Illness (SMI) (Part 4) has a two part indicator: 4a: Cardio Metabolic Assessment and treatment for Patients with psychoses. 4b: Communication with General Practitioners. For indicator 4a, data on a total of 100 inpatients who fitted the eligibility criteria for this CQUIN was submitted. The Trust achieved 86% overall. Results of the CQUIN have been submitted to the CCG for consideration, and an outcome is awaited. Indicator 4b was audited without the involvement of the clinical audit department.
6	Audit of Child Protection Case Conference Reports & Documentation Following Case Conference (3296)	The aim of this audit was to establish if the actions relating to the previous audit in September 2010 were being adhered to in BHFT (School Nurses and Health Visitors) for children with a child protection plan. The audit assessed if all the required information was clearly documented in the records of a child with a child protection plan by Health Visitors and School Nurses, in the six localities. From the findings it can be concluded that of the 15 criteria included in the audit, none met the 100% compliance, 5% met compliance in 2010. 0% achieved compliance at 90% in 2015 compared to 40% in 2010. Although BHFT have failed to achieve compliance for any of the 15 criteria, West Berkshire achieved compliance in 10/15 criteria (67%). Action: Actions included introduction of safeguarding specific elements within RiO, and a programme of education to staff. All actions are complete and measures have been put in place to both improve record keeping and reduce risk.
7	Audit of NEWS Scores on Rowan and Orchid wards (3191)	The National Early Warning Score (NEWS) should be used for initial assessment of acute illness and for continuous monitoring of a patient's well-being throughout their stay in hospital. This re-audit aimed to establish areas of strength and weakness with a view to developing an action plan to fully embed NEWS in the clinical monitoring of unwell patients. It aimed to assess the compliance with BHFT NEWS policy (CCR116), the completeness and accuracy of the recording and appropriate action taken in response to the scores. Standards 6, 7 and 8 in terms of the timings of the next set of NEWS observations, contacting medical staff if score over 3 and documenting it, fall well below the compliance standards as well as from the results of the previous audit. Action: Rowan Ward to have supervised recording and outcome of NEWS of 3 and above. The Nurse in charge of the shift will supervise recording and outcome of NEWS of 3 and above.
8	JD/QIP - Falls risk assessment in new admissions of older adults (3107)	This audit aimed to review the patient population admitted to Orchid and Rowan wards with particular focus on their admission and ward clerking and whether a comprehensive falls assessment had been made. NICE Guideline CG161 which outlines examples of multifactorial assessment was referred to. The results of the audit identified areas for improvement in assessing falls risk Since the audit was undertaken, BHFT has begun work to ensure compliance with national guidelines. Action: Actions are to be integrated as part of the falls reduction work occurring in the Trust.

	Audit Title	Conclusion/Actions
9	Re-Audit of Health Visitors Risk Assessments at New Birth Contact (2665)	This audit had been undertaken as part of BHFT's - Health Visiting Sub Group work plan. The audit was performed to give quality assurance following the introduction of a revised electronic Word version of the Health Visitor New Birth assessment tool as recommended from the previous year's audit. The previous audit highlighted the need to improve completion of all sections of the assessment tool, to increase legibility and increase the uploading of all assessment documents into the client RiO record. The re-audit showed an improvement in compliance in recording information. However, a few recommendations were made relating to uploading documents, requirement to record the 'father's name, recording of action plans and to ensure training is provided for all staff on analysis of assessment information. Action: A number of agreed actions have been put into place, linked to supervision and peer review of assessments.
10	Is the local HIV service meeting national guidelines for care of older patients living with HIV (3085)	HIV patients are living longer and are at risk of developing co-morbidities at a younger age than the non-HIV population. There are preventable diseases of particular concern: cardio-vascular disease, osteoporosis and neurocognitive decline which can be assessed and detected early, if not prevented. National and European guidelines advise how clinicians should be performing risk assessments and how often these should be undertaken. Action: Agreed actions have been put into place to address; improve documentation in the pro-forma, have links to geriatricians with special interest and pathway referral to neurocognitive testing unit.
11	Re-audit of management of patients with genital Herpes infection (2765)	The initial audit done in 2011 looked at management of patients with first episode of genital herpes. The re-audit focused on BASHH's 2014 UK national guideline for the management of anogenital herpes to look if current practice fits best medical practice and if it has improved since the initial audit. The retrospective re-audit study predominantly showed an improvement in practise compared to the initial audit in 2011. Action: An action plan is in development.
12	JD/QIP – Audit looking at content of outpatient letters sent to GPs by Bracknell CMHT (3179)	The aim of the audit was to review the content and quality of outpatient letters for Bracknell CMHT. Using literature research and local guidance a list of standards were produced. A number of recommendations were made from recording the CPA status, recording the ICD10 codes to documenting the justification for medication changes. Action: A new template was trialled.
13	JD/QIP - Driving advice given to adults with first presentation of psychosis on discharge from in-patient units (3024)	The audit aimed to review whether on discharge staff were documenting for Cluster 10 patients if any driving advice was given to patients i.e. whether they could drive, should not drive for 3 months after discharge or should inform the DVLA of their diagnosis. The results showed poor compliance for documenting driving discussions and advice in preliminary discharge summary and notes. The audit recommended amending the discharge summary so staff could document these discussions. Action: An action plan is in development.
14	JD/QIP - Prolactin screening and monitoring on MH wards (3083)	This re-audit aimed to assess if there was an improvement since the original audit in 2014 for prolactin screening and monitoring. NICE guidelines state that symptoms of hyperprolactinemia should be monitored and an initial prolactin blood test should be taken prior to starting anti psychotics. The audit found a marked decline in compliance across all standards in comparison to the previous audit. One of the issues relating to this is that there is no clear guidance on monitoring and managing high levels of prolactin and no local and national agreed guidelines. Action: An action, in association with Dr Sodhi and Katie Sims, Pharmacy, for publication of revised Trust prolactin guidelines is in place.

	Audit Title	Conclusion/Actions
15	JD/QIP - Crisis team gate keeping service evaluation 2016 (3227)	This topic was chosen due to increasing admission rate in Prospect Park Hospital wards (PPH). This is the first audit in PPH which is based on key policies and standards. The audit was used to assess whether the crises team were meeting benchmarks as stated in the guidelines. This project aimed to review admissions during one month to evaluate the Crisis Team action as part of its role as gate keeper. This included monitoring of the activities of the crisis team, review of the management and support of acute patients in the community without hospital admittance, review of the maximum number of days in care or liaison with CRHTT, assessment of the effectiveness of the current system and ways to improve it, evaluation of communication between CRHTT and feedback to other relevant parties. The audit found that gatekeeping was not effective for acute cases where a high risk to self or others was identified and admission was imminent. Action: An action plan is in development.
16	Audit on the management of Molluscum Contaigiosum in the sexual Health service (2938)	This audit was initiated as a result of a patient complaint regarding skin complication (scarring) following treatment for molluscum with cryotherapy. Action: Action has been agreed to improve documentation in the notes and to produce an information leaflet for patients.
17	Re-Audit - People whose Behaviour Challenges -Care Pathway, BHFT Learning Disability Services, April 2016 (3194)	The re-audit measured against Good Practice Standards, set following the re-audit in 2015. The aim was to demonstrate that good practice recommendations were used with people whose behaviour challenges. The re-audit demonstrated positive findings, with many areas gaining 100%, however, monitoring and review results were slightly lower in comparison to the previous audit. Action: An action plan is being implemented and the process will be repeated in April 2017 in order to monitor progress and maintain good practice standards.
18	JD/QIP - Re-audit of quality and timeliness of full discharge summaries for patients discharged from adult wards (2952)	The aim of this re-audit was to evaluate the quality of discharge summaries, according to a set of criterion informed by published audits on similar topics, comparing against the initial audit, as well as research into GP preferences concerning discharge summary information content. The audit found that out of the total 55 patients, 20 patients did not have a full discharge summary on RiO relating to the admission, even after two weeks. Action: Recommendations including support templates and tools have been trialled.
19	Diagnostic formulation (3275)	This audit aimed to establish the quality of documentation and record keeping for diagnostic formulation by completing random spot checks of case notes. The audit aimed to establish documentation and record keeping for diagnostic formulation by completing spot checks of case notes. The purpose was to promote best practice in diagnostic formulation and for it to become a useful tool for all clinicians dealing with complex psychopathology. The audit showed that patient notes regarding diagnostic formulation are being kept in reasonably good order, with staff having a good understanding of its importance in determining the right course of patient care. Action: An action plan is in development.
20	JD/QIP - Improving vital signs monitoring in an acute adult inpatient ward (3129)	The audit aimed to implement changes in the way that doctors requested the vital signs from the nursing staff on Rose Ward, with a plan to improve the compliance. The audit found that vital signs monitoring does need improvement on the ward. However, the use of NEWS charts has a good impact in monitoring vital signs and is used as part of the management of patient care. Effective use of NEWS on wards is frequently audited throughout the Trust. Action: Action plan to be incorporated as part of deteriorating patient work stream.

	Audit Title	Conclusion/Actions
21	Audit of anti-infective prescribing on BHFT inpatient wards (Antibiotics) (2016) (3078)	This audit was a re-audit and part of the Quality Schedule for 2015/16 The last Trust wide antimicrobial audit was performed across all inpatient settings in February 2015 as part of the annual audit programme. The results demonstrated significant improvements in 3 of out of the 8 quality standards. These improvements were possible because of the opportunities that the successful bid made to the Patient Safety Federation enabled. 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. However, some improvements are still required. Action: An action plan specific to this audit is in development, but will be part of the overall Trust strategy in this area.
22	Infection Control - Sharps Management (2998)	The purpose of the audit was to identify whether sharps are handled safely to prevent the risk of needle stick injury; to assess practice and the correct use and management of sharps equipment; to assess staff knowledge relating to the management of an inoculation injury; to ascertain the current level of compliance with Health and Safety Legislation across the Trust. Overall compliance with safe handling and disposal of sharps showed improvements in compliance following the 2014-15 audit. Action: The audit report has been disseminated to all department and ward managers in accordance with the BHFT IPCT annual audit programme. The actions identified from the audit are to be addressed to resolve areas of non-compliance and that the service shows it is working towards completing the relevant requirements.
23	School Nursing RK Assessment Audit (3284)	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 re-audit was undertaken following the recommendation that the assessment form has been modified to ensure all data is captured. Overall the re-audit showed a high standard of record keeping for school nursing assessments, and showed a vast improvement in weak areas identified from the previous audit. The audit recommended that staff seek to improve the structure and flow of the assessments, to enable effective and timely completion; the building of the assessments into RiO is undertaken and training is provided on analysis of assessment information. Action: An agreed action plan has been put into place, incorporating feedback on structure of assessments, and use of RiO.
24	Consent to ECT Re-audit (3151)	The aim of the audit was to ensure that BHFT ECT Department complied with national guidelines for compliance to consent for ECT and to ensure all patients' had a robust capacity assessment with relevant documentation prior to ECT to ensure the consent was valid. The achievement of 100% in all but one of the entire audit criteria indicate that all staff involved in ECT are familiar with the consent to ECT procedure and complying with the policy. Action: No further action is required.
25	Infection Control: Enteral Feeding Community Patients (3276)	The aim of the audit was to assess the enteral feeding practices, of enterally fed adult patients, where this aspect of care was undertaken by either the patient or a carer, against pre-agreed standards. The audit was undertaken for patients who reside either in their own home or in a long term care facility. The total compliance for individual patient varied from 67% to 100%. Full compliance was achieved for 4 out of the total 16 standards that were measured. Other standards that did not fully achieve 100% compliance related to hand washing, maintenance of syringes, non-touch technique, training and provision of written information on care of the feed. Action: A number of agreed actions have been proposed for discussion within the Nutrition and Dietetics team. These include policy updates, training, and checklists for patients and carers.

	Audit Title	Conclusion/Actions
26	Preceptorship - good to outstanding (3321)	The Trust is fully committed to ensuring that every newly registered nurse, social worker or allied health professional commencing employment within the organisation has access to the comprehensive preceptorship programme. The aim of the audit was to formalise the existing preceptorship programme and to ensure the Trusts commitment to newly registered professionals is valued by achieving 100% take up across all disciplines. The key points recommended were to increase the number of preceptees following clinical practice educator involvement; develop a plan to improve capture of data for audit purposes and to ensure that the Trust preceptorship policy is being adhered to. Action: Changes have been implemented as part of the project to formalise the preceptorship programme.
27	Bed side blood transfusion practice (3356)	This re audit was undertaken during July 2016 as part of the 2016 bed side audit action plan in the infusion clinics which are held in Newbury, Wokingham and Maidenhead. The Trust achieved 100% compliance for the criterion of recording Temp/RR/P/BP pre transfusion, within 15 minutes and at the end of transfusion and 95% for recording NEWS score. Action: No further action required.
28	ECT clinical Global impression scale survey (3152)	The aim of the audit was to evaluate the ECT treatment using CGI (Clinical Global Impression), as the outcome measure in order to gather evidence to support continued use of the ECT service. This was the fifth year that the survey was repeated. The survey found that using the CGI- Efficacy Index as the post ECT CGI showed 96% of patients showed clinical improvement. Action: No further action is required as part of this evaluation.
29	Audit of Safeguarding response to alleged sexual assault/inappropriate behaviour on Mental Health Inpatient Wards (2957)	The purpose of the audit is to ascertain if appropriate risk triangulation between Care Plans/Risk Management Plans, Progress Notes and Risk Assessments in accordance with the Trusts' safeguarding policy has been made following increase of incidents of 'sexual behaviour.' The audit has enhanced the awareness by clinical and non-clinical staff of safeguarding incidents and associated risks and enabled actions to be implemented to ensure improvements. The audit has resulted in a standard operating procedure for staff being developed. Undertaking this audit has enhanced the awareness by clinical and non-clinical staff of safeguarding incidents and associated risks and enabled actions to be implemented to ensure improvements. Named professional working more closely with Prospect Park Hospital, spending a minimum of one day per week on site, assisting with Safeguarding and ensuring appropriate actions are being taken to safeguarding patients.
30	The quality of referrals to WAM memory clinic (3173)	The purpose of the audit was to assess the quality of the GP referrals sent to the memory services specifically the WAM memory clinic against the standards set by NICE guidelines. The aim of the audit was also to help to understand whether the current referrals are in line with the local guidelines. The audit included all GP referrals to the WAM memory clinic from October to December 2015. This clinical audit served to demonstrate that there are weaknesses in the quality of the GP referral letters sent to the WAM memory clinic. By improving the quality of the GP referrals, it will help the memory clinic to prioritize the patients and ultimately provide them with a good management plan in adequate time.

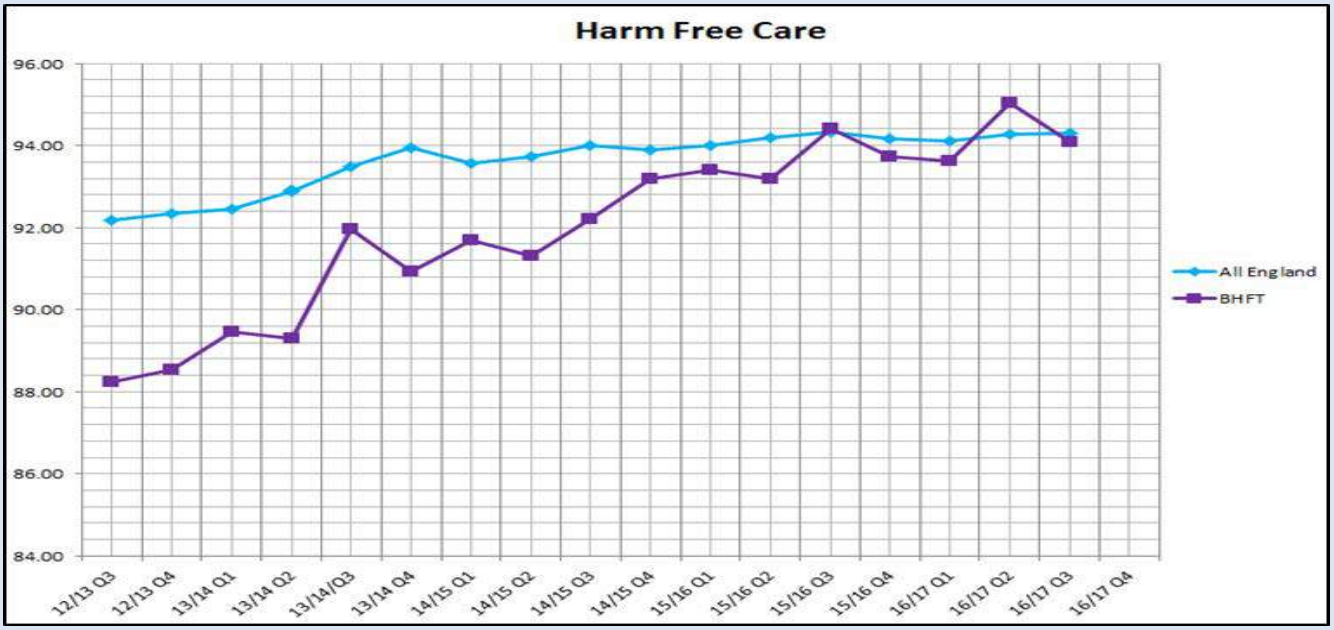
	Audit Title	Conclusion/Actions
31	Young people's transitions to adult services (BHFT CQUIN, 2016); re-audit of patient experiences. (3177)	This project was undertaken as part of the 2015/16 CQUIN Programme. The aim of the BHFT's CQUIN 2015/16 was to improve young people's transitions in care from BHFT-wide children's services (mental and physical health) to secondary care adult services. Services covered by the CQUIN include CAMHS Pathways and Specialist Community Teams, including the Berkshire Adolescent Service, in addition to Specialist Children's Services (SCS), which includes CYPIT, Specialist School's Nurses, Community Nurses and Community Paediatrics. The results exceed the 10% increase requirement set for overall satisfaction. There is a plan to communicate the outcome of the CQUIN across all BHFT children's services and encourage them to explore in-service initiatives to better the experiences of their service users during transition.
32	Audit of the usefulness and quality of brain scan reports in the Wokingham Memory Clinic (3175)	The aim of the audit was to measure the percentage of people with suspected dementia who have access to a scan and what type they receive, and to consider the added value that scans offer to diagnostic accuracy. The information from the audit will be used to inform a pilot with the AHSN to introduce a Neuroreader to enhance the accuracy and detail of scan reports.
33	Clinical Audit of the NICE and Triage Guidelines for the Eating Disorders Service at the Berkshire Adolescent Unit (2988)	The purpose of the audit was to evaluate the Berkshire Adolescent Unit's Eating Disorders' service adherence to NICE clinical guidelines for the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders. The information gained from the audit will be used to guide the development of a new eating disorder pathway within BHFT.
34	A study to evaluate the effectiveness and use of the Solihull Approach by Health Visiting teams (3082)	This audit was a University student project. The aim of this study was to investigate the impact for practice for Health Visiting staff using the 'Solihull Approach.' This was introduced as mandatory training for all Health visiting teams within BHFT. The project aimed to evaluate the perceived benefits and if there were any challenges of using this method. Additionally, the study aimed to find out what were the reasons if practice had not changed and how could the 'Solihull Approach' be better embedded into practice. Overall, staff found that using the 'Solihull Approach' positive as a new skill in helping to facilitate therapeutic relationships with patients.
35	National BHIVA audit 2015: Routine monitoring of adults with HIV infection (2886)	This audit is part of the British HIV Association (BHIVA) National audit programme. Although it is a national audit, it is not on an NCAPOP audit, nor is it on the national quality accounts list. The aim of the audit was to measure adherence to BHIVA guidelines for routine investigation and monitoring of adult HIV-1-infected individuals 2011 and where relevant, immunisation guidelines. The audit achieved good participation and highlighted good practice in some areas. It was noted some findings may reflect issues of recording and reporting especially in relation to care provided outside the HIV specialist service itself.
36	BASHH National Clinical Audit 2016: Sexual health screening and risk assessment (3280)	This audit was part of the British Association for Sexual Health & HIV (BASHH) National audit programme. Although it is a national audit, it is not on an NCAPOP audit, nor is it on the national quality accounts list. The aims of this audit were to enable quality improvement in relation to: Preventing late HIV diagnosis and achieving the STI Management Standards (STIMS) target of 97% offer and 80% uptake for HIV testing in GUM. Improving risk assessment and management, including alcohol/drug use. Clinical services are recommended to review and develop systems to prompt both performance and recording of recommended interventions. Thus the national findings will be incorporated into a local review of the clinical services.

Appendix D Safety Thermometer Charts

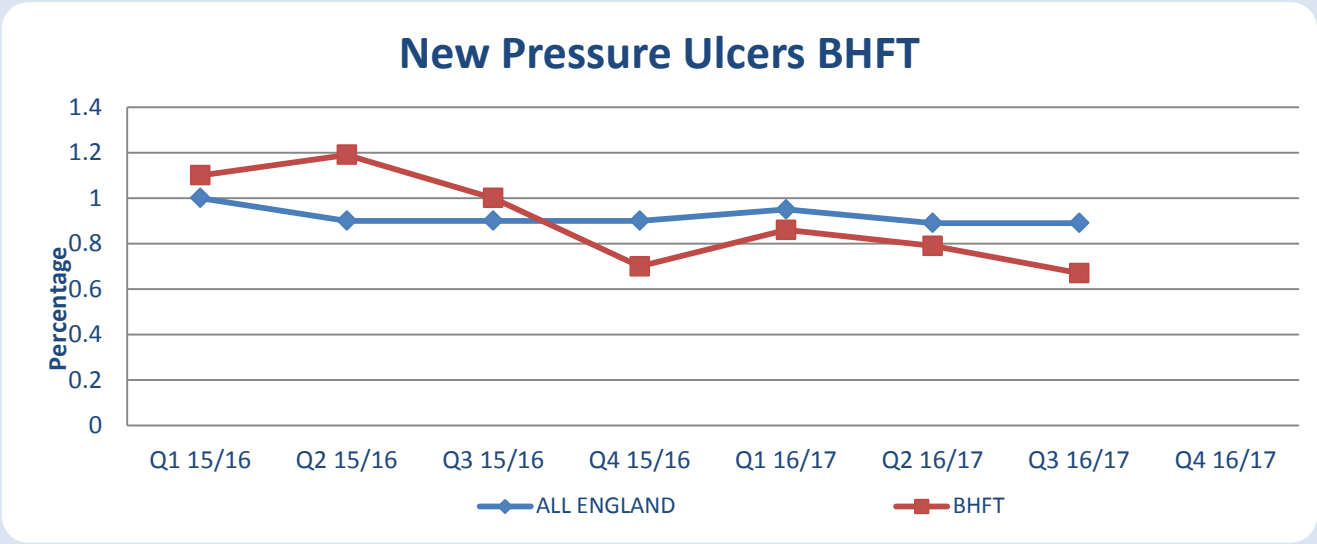
ⓘ Developed for the NHS by the NHS as a point of care survey instrument, the NHS Safety Thermometer provides a 'temperature check' on harm, that can be used alongside other measures of harm to measure local and system progress in providing a care environment free of harm for our patients. It allows teams to measure harm and the proportion of patients that are 'harm free'

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.

The figure below shows the percentage of harm-free care reported on the patient safety thermometer. Berkshire Healthcare have achieved 94% harm free care in Q3, 1% lower than last quarter. The all England Q3 percentage was 94.3. We expect to sit below the All England line as the harms include those inherited to the Trust which are largely beyond our influence.



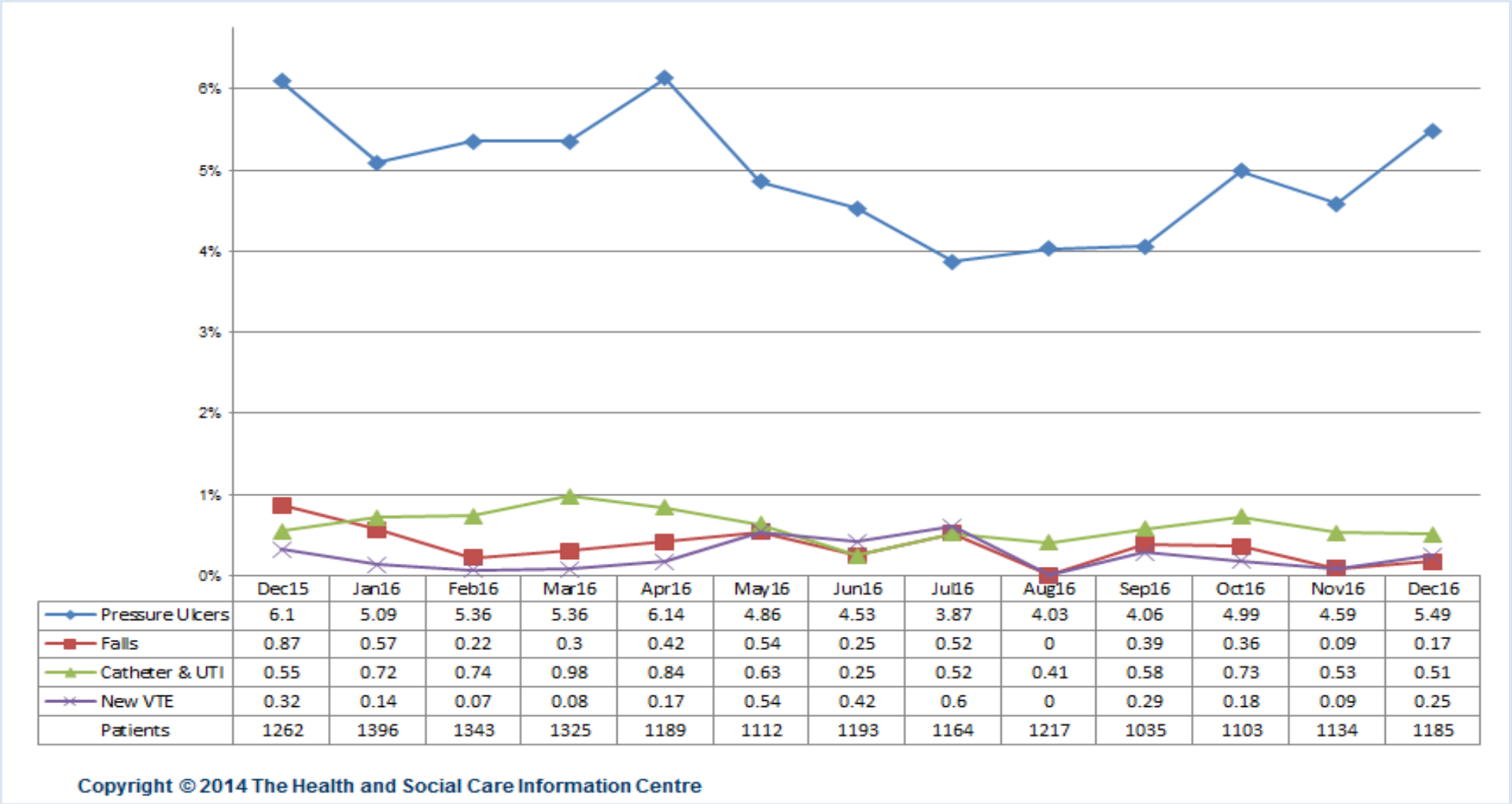
Source: Trust Safety Thermometer Reports



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.



	Dec15	Jan16	Feb16	Mar16	Apr16	May16	Jun16	Jul16	Aug16	Sep16	Oct16	Nov16	Dec16
Pressure Ulcers	6.1	5.09	5.36	5.36	6.14	4.86	4.53	3.87	4.03	4.06	4.99	4.59	5.49
Falls	0.87	0.57	0.22	0.3	0.42	0.54	0.25	0.52	0	0.39	0.36	0.09	0.17
Catheter & UTI	0.55	0.72	0.74	0.98	0.84	0.63	0.25	0.52	0.41	0.58	0.73	0.53	0.51
New VTE	0.32	0.14	0.07	0.08	0.17	0.54	0.42	0.6	0	0.29	0.18	0.09	0.25
Patients	1262	1396	1343	1325	1189	1112	1193	1164	1217	1035	1103	1134	1185

Source- Safety Thermometer

Appendix E CQUIN Achievement 2016/17 (anticipated)

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 continue 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 barrier to achieve positive outcomes with these patients. Feedback from CMHT clinicians has indicated the limitations of existing	559,764

		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 F CQUIN 2017/18

To be included in Q4 once agreed

Appendix G Statements from Stakeholders

To be included in Q4

Appendix H

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

To be included in Q4

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

Acronym	Full Name
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
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

Berkshire Healthcare NHS Foundation Trust

Berkshire Healthcare NHS Foundation Trust

Performance Report to Council

March 2017

Chief Executive Highlights Report

As part of the review of the quarterly performance report to Council, the Governor Reference Group asked that future reports include a highlights report from the CEO on key matters on interest/significance to supplement the performance data.

National context

- **NHS Improvement** NHS Improvement's Provider quarter three figures have been published and they showed that nationally the current provider deficit was at £886m.
- **Finance** The Trust is in a stable financial position and is on track to secure four quarters of NHS Improvement's sustainability and transformation funding. In addition, NHS Improvement has offered those Trusts which exceed their control total an additional incentive bonus of match funding every pound over and above the control total.
- **Sustainability and Transformation** NHS England has selected the Frimley Sustainability and Transformation Plan (STP) footprint for consideration as one of a small number of exemplars which it wishes to support for rapid transformation.

Local situation

- **Quality Improvement** The Trust has completed a procurement exercise to appoint an external partner to support the Quality Improvement programme. Four bidders were invited to present to around 100 staff from across the Trust in both clinical and non-clinical work areas. Martin Earwicker, Chair and Ruth Lysons, Non-Executive Director also took part. The successful bid was KPMG in partnership with Thedacare (a US based organisation) and Western Sussex NHS Foundation Trust.
- **Flu Vaccination Programme** 75.2% of Trust staff received the flu vaccination.
- **Agency Usage** The Trust is making good progress on reducing the cost of agency staff. Further savings will be made from April when the Trust stops using agency Health Care Assistants and will use the Staff Bank to cover shifts.

Performance Report to Council of Governors – Finance October to December 2016

Use of Resources Year to Date

Capital Service Cover	**2.3 Times**	2
Liquidity	**3.9 days**	1
I&E Margin	**0.6 %**	2
I&E Margin variance from plan	**0.0 %**	2
Overall Rating		2

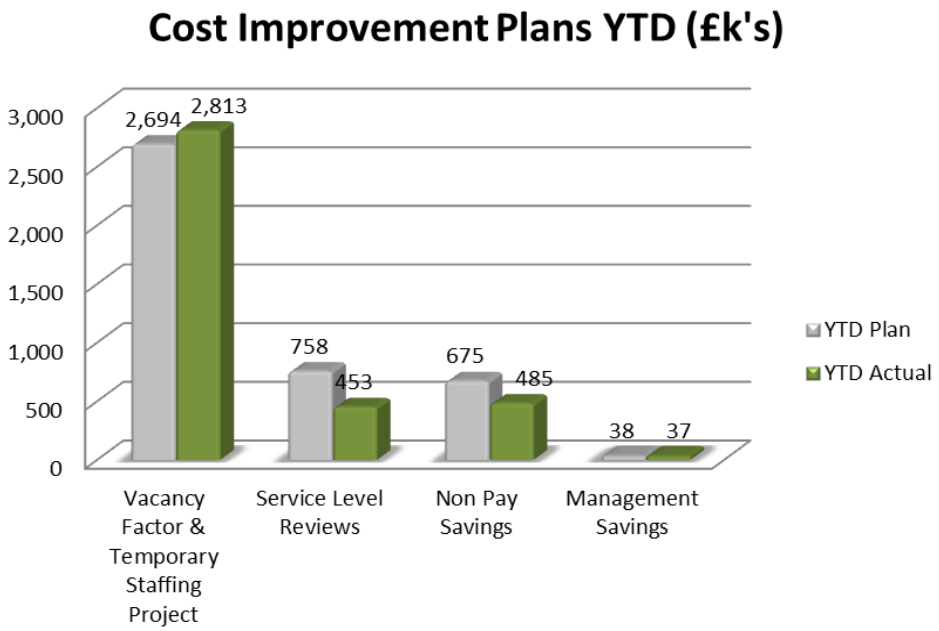
The thresholds (minimums) for each of the measures are as follows:-

Thresholds	*1*	*2*	*3*	*4*
Capital Service Cover	*2.5*	*1.75*	*1.25*	*<1.25*
Liquidity	*0*	*-7*	*-14*	*<-14*
I&E Margin	*1%*	*0%*	*-1%*	*<=-1%*
I&E Margin Variance	*0%*	*-1%*	*-2%*	*<=-2%*

Marked on a scale of 1 to 4 with 1 being the lowest financial risk and 4 being the highest financial risk. Monitor will require the trust to score a "3" or more as terms of the Trust's license.

To note the four metrics are equally weighted to give an overall score rounded to the nearest whole number. However, to note scoring a "1" in any metric would cap the overall score to a "2".

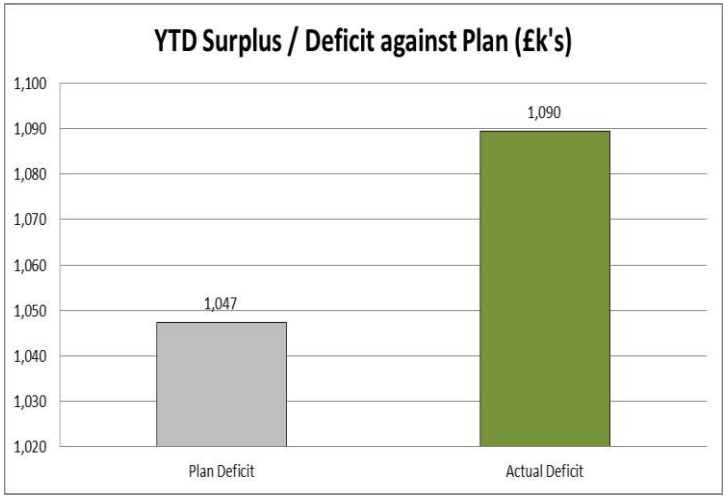
CIP Achievement YTD (£K's)



Overall CIP achievement is £3,787k against a plan of £4,164k. Service Level reviews are most behind plan Slough Walk In Centre and Diabetic Eye Screening yet to identify their plans to achieve CIP's.

As a public body, it is the trusts duty to look to be efficient in every £ that it spends. An efficiency factor is applied to the Trusts contract prices each year. In 2016/17 the efficiency requirement will be 2%. As part of this, ways of reducing costs are reviewed every year as part of Cost Improvement Plans.

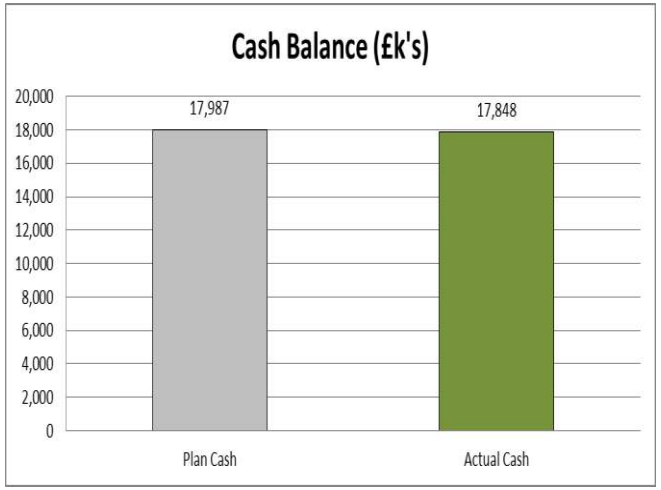
YTD Surplus/Deficit Against Plan (£k's)



The trust ends December 2016 with a surplus of £1,090k; in line with what was expected in the plan of £1,047k. The main cost pressure so far this year has been acute overspill beds (-£1,151k).
This has been partly offset by a national insurance rebate (+£316k) Other small favourable variances grouped together and a provision release account for the remaining offset

The Trust's surplus or deficit is how much it is under or over spending against the income it receives.

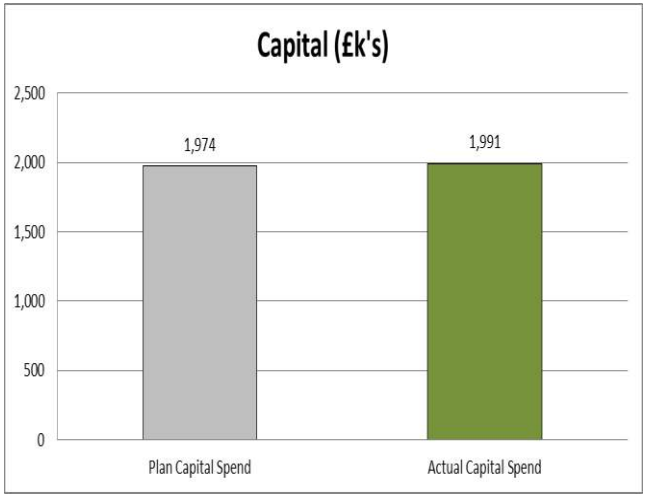
Latest Cash Position (£k's)



The trust is behind its cash forecast due to issues with some receipts of cash; the main ones being Royal Berkshire NHS FT and NHS England which are not anticipated to be a risk longer term.

The cash surplus shown in the graph supports liquidity and capital expenditure.

YTD Capex (£k's)



Capital spend is behind plan YTD by £141K. This is driven by an underspend against a number of projects in IM&T primarily driven by profiling of the plan rather than specific underspends on schemes that are forecast to complete in this financial year.

Capital Spend is cash spent on items that last longer than 1 year and have a value of over £5,000. Examples of this are buildings and networked IT. It is important that the trust re-invests in capital items to provide good facilities and equipment for patient care.

Friends and Family Test

Indicator	RAG Rating	Target
Recommendation Rate	92%	85%

The above number shows the number proportion of patients who when surveyed would recommend the Trusts services to friends and family. In Quarter 3 this was 92%

The response rate was 5% against a target of 15%

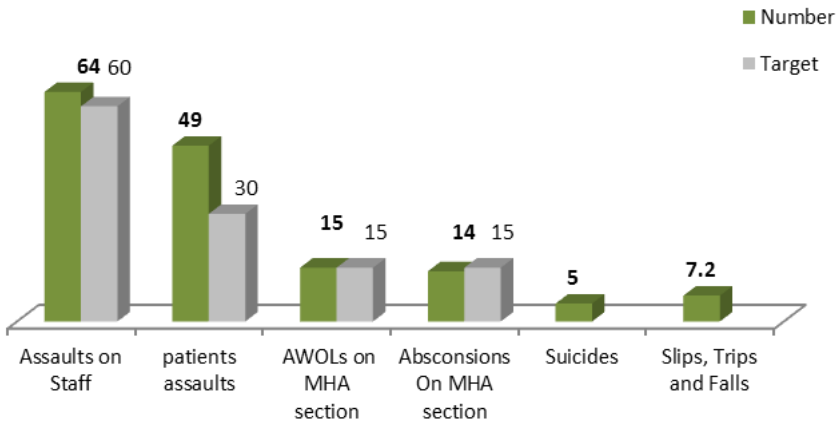
Safer Staffing

Indicator	RAG Rating
Safe Staffing	

The Trust is required to submit a return to the Department of Health which shows the staffing levels of all of our inpatient wards. For Quarter 3: the Trust rated itself as compliant based on achieving agreed staffing levels for each ward and the variance from that, this is reflected in the green rating.

There is a shortage of registered nursing staff available in the Thames Valley area and therefore registered nursing vacancies are hard to fill and good registered temporary nursing staff are equally hard to find. While we continue to actively advertise and take steps to recruit into the registered nursing vacancies on the wards we are using good temporary care staff who are available and know the wards to fill shift gaps because it is safer for patients. Whilst filling shifts with care staff maintains patient safety, having more registered nursing staff once recruited will improve staff morale as there will be greater peer support, more supervision of care staff and ultimately improved patient care.

Mental Health User Safety



The above chart is showing the rolling quarter Actual Vs local targets for incidents which largely take place in our Mental Health Inpatients area. Incidents have increased in Quarter 3. There has been an increase in staff assaults by patients, absconsions by patients detained under the mental health act and patient falls. The Trust has a rolled out a revised risk assessment tool as part of its Suicide Prevention Strategy.

Performance Report to Council of Governors - People October to December 2016

Annual Staff Turnover

Target	Actual
15.20%	18.10%

Agency Cost

Target	Actual
<10%	10.05%

Sickness

Target	Actual
<3%	4.17%

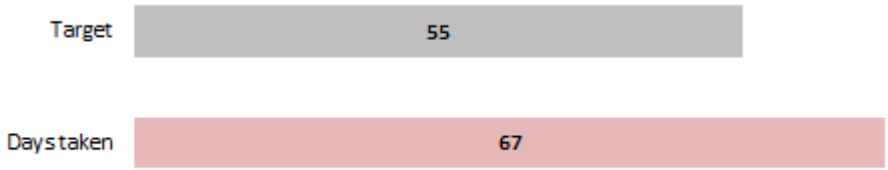
Note: Lower than the stated target means KPI has achieved its target. ***Turnover*** *is measured by the number of staff leaving the Trust divided by the number of staff in post.* ***Sickness*** *is measured by the number of days of staff sickness divided by the number of staff working days available.* ***Agency Cost*** *is shown here as a percentage of staff costs. All Trust services are included in each indicator*

Appraisals

Target	Completed %
>95%	91%

Note target was achieved in June 2016. These will increase as PDP take place in April to May 2017.

Days Taken for Recruitment



Note: ***Equal*** *or lower than the stated target means KPI has achieved its target of recruiting staff within 55 days. This is measured from the date that the vacancy is approved for recruitment to the date that the new staff member joins the Trust.*

The Board Assurance Framework sets out the key risks to the Trust achieving its strategy.

Each risk has an action plan, key control and sources of assurance.

The risk summary sets out the risk description and key mitigations.

Board Assurance Framework - Risk Descriptions	Summary of Key Mitigations
Risk 1 Failure to recruit, retain and develop the right people in the right roles at the right time and at the right cost could impact on our ability to meet our commitment to providing safe, compassionate, high quality care to our service users	Workforce Strategy (agreed by the Trust Board in December 2016). The Workforce Implementation Plan will be presented to the April 2017 Trust Board meeting.
Risk 2 Failure to involve clinicians and patients in the development of new pathways of care could result in less clinically effective services and poorer patient experience	Clinical involvement is a key component in the Quality Improvement methodology. Patients and carers are involved in any proposed service redesigns.
Risk 3 Failure to achieve national efficiency benchmarks could impact on the Trust's future sustainability and lead to increased regulatory scrutiny	Two-year Operational Plan agreed with Commissioners supported by two year contracts. The Trust is developing a financial improvement programme and Carter alignment cost improvement plan, for example, reviewing back office services.
Risk 4 Failure of the Sustainability and Transformation Plans to deliver transformational change and required investment in mandated national priorities, including in the mental health five year forward view, could result in the local health economy not being able to safely keep pace with the rising costs and demand for services.	The Trust is proactively working to influence and to maximise the opportunities presented by the Sustainability and Transformation Plans and Accountable Care System working.
Risk 5 Failure to maintain clinical standards could put patients at risk of poor quality care and could lead to reputational damage and a loss of commissioner and public confidence in the quality of the Trust's services.	The Trust has developed a new focussed internal CQC inspection process to ensure that clinical standards are met and maintained.
Risk 6 There is a risk that other providers may acquire the Trust's adult and children's community services which would impact organisational sustainability and reduce the Trust's scope to develop new models of out of hospital care	The Trust is continuing to develop and refine the Trust's Business Development Strategy.
Risk 7 Failure to develop collaborative working relationships with key strategic partners could result in the Trust losing influence in key decisions leading to less effective services for local people	The Trust has a stakeholder relationship management process in place and has developed positive working relationships with Commissioners and partner organisations
Risk 8 Failure of other Providers and Commissioners to deliver their services to the required standard due to financial constraints could impact on the Trust's ability to deliver high quality services	The Trust was fully involved in the development of the Sustainability and Transformation Plans and the Accountable Care System. The Trust is also represented at a number of system wide meetings, for example, the Emergency Care Board and the Learning Disability Transformation Steering Group.

Performance Report to Council of Governors - Monitor Requirements October to December 2016

KPI	Target	Actual
Mental Health 7 day follow up from hospital discharge	95%	97.7%
People with common mental health conditions referred to IAPT will be treated within 6 weeks from referral	>75%	99%
People with common mental health conditions referred to IAPT will be treated within 18 weeks	95.00%	100%
Early Intervention in Psychosis: People experiencing a first episode of psychosis treated with a NICE approved package of care within 2 weeks of referral	50%	91%
Crisis Resolution/Home Treatment Team Gate Keeping Of Mental Health Inpatient Admissions	95%	99.0%
A&E: maximum wait of four hours from arrival to admission/transfer /discharge : Percent	95.00%	99.5%
Referral to Treatment Community: incomplete	92.00%	99.6%

The regulator NHS Improvement has issued guidance for monitoring Performance from Quarter 3 2016/2017, the above indicators are included.

Berkshire Healthcare NHS
NHS Foundation Trust

Patient Experience

Quarter Three 2016/17

Presented by Jayne Reynolds, Deputy Director of Nursing

Overview

This overview report is written by the Director of Nursing and Governance so that Board Members are able to gain her view of services in light of the information contained in the quarter three patient experience report. In my overview I have considered elements of the feedback received by the organisation and drawn conclusions.

The Board is required to consider detailed patient feedback because it provides insight into how patients, families and carers experience our services.

During quarter three, the trust continued to achieve a complaint response rate of 100%.
The average number of days taken to resolve a complaint was 33 although a small number of complaints took longer than 40 days. Just over 65% of complaints were upheld or partially upheld which enables us to conclude that our complaint investigation is objective. It was useful to read that the process for identifying named members of staff is working and that assurance is being sought that behaviours have been addressed.

Overall the trust saw a decrease in the number of complaints received however two services received the highest number of complaints as in the previous quarter, the Community Mental Health Teams and Prospect Park Hospital acute mental health wards. The Crisis Resolution Home Treatment Team (CRHTT) featured again as a service that received a higher number of complaints.

It's important to note that Bracknell and West Berkshire Community Mental Health Teams received slightly more complaints than the other localities. Clinical care remained the common subject, with no specific themes identified. Both of these teams have experienced significant change over the last few months, Bracknell has had a number of staffing vacancies and West Berkshire has undergone a significant service change with local authority staff having been removed from the team leaving only health staff. It's interesting to see the Windsor, Ascot and Maidenhead (WAM) position with only one complaint received in each of the last two years. The Clinical Director for East Berkshire mental health is reviewing the position to ensure that patients know how to complain if they have a poor experience.

Prospect Park Hospital (PPH) acute ward's complaints has shown that a high number were categorised as 'alleged abuse, this would include allegations of bullying, physical, sexual and verbal'. This includes instances where patients have raised concerns about their experience of PMVA (prevention and management of violence and aggression) techniques and about the behaviour of staff and other patients during their stay on the ward. The trust is noted as an outlier in the use of prone restraint in the most recent national benchmarking so further work is required in this area even though only one complaint was partially upheld. Each restraint incident is reviewed by the lead nurse for personal safety. As the board is aware there are significant staff vacancies on the wards and therefore high agency and bank use which will affect patient experience.

The Clinical Director for CRHTT continues to review all of the complaints received to ensure that there are no particular themes or trends that require specific action.

This information is correlated with other quality information, particularly vacancy levels to inform our quality concerns and from this quarter it can be concluded that CRHTT and our acute mental health wards continue to cause some concern. Both services were rated 'good' by the CQC in the comprehensive inspection in December 2015.

I have asked the team to look at the following areas for trends in light of the number of complaints received:

- Henry Tudor, Oakwood and Ascot community health inpatient wards
- Reading, Wokingham and WAM Child and Adolescent Mental Health Services

As per previous quarters the top reasons for complaints being made during quarter two were care and treatment, attitude of staff and communication.

Each service takes complaints seriously and implements new ways of working if appropriate. 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 CQC published the annual Community Mental Health Survey in November 2016, later than usual. We were rated overall as performing the same as the majority of other trusts. The survey was conducted early in 2016. It was concerning to see that Crisis Care satisfaction has decreased and the patient satisfaction 'deep dive' commissioned will help understand the steps we need to take to improve. However it was heartening to see that there has been a significant increase in satisfaction with being supported to find work as a result of our employment service work. I find frustrating that commissioners are still unwilling to fund this service. The 2017 survey is due to commence shortly.

Our 15 steps programme continues to provide helpful, positive feedback however it was disappointing to read the observations by the team about Windsor Ward. The Wokingham wards do fluctuate in their performance and as a consequence this has been raised with the Locality and Clinical Directors. It was good to read that the experience of Sorrel and Campion was good which will hopefully be supported by the CQC when we receive their report from the most recent inspection.

The national benchmarking for the Friends and Family Test (FFT) with local similar trusts indicates a good performance however without a 15% response rate the results are not robust. The focus from the board on improving our response rate in key metrics will be helpful.

The patient and public involvement information collection is our long standing internal patient survey which asks patients how they rate their experience, 89.7% reported the service they received as good or better. This is a decrease in performance which is disappointing and I would hope to see an improvement in the next quarter. The patient experience team are going to review the use of the survey.

Conclusion

Patient experience is an important indicator of quality and this report provides good intelligence when considering quality concerns. In terms of volume, the level of positive feedback received by services far outweighs the negative feedback received. At this point of the year there are no new emerging trends with communication being an absolute and underlying issue in most complaints.

I believe that 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.

I do not take these lapses in care 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.

Helen Mackenzie, Director of Nursing and Governance

Introduction

Berkshire Healthcare Foundation Trust is committed to improving patient experience through the use of feedback to better understand the areas where we perform well and those areas where we need to do better.

This report details feedback from a number of sources including complaints, Patient Advice and Liaison Service (PALS), compliments, NHS choices and the Friends and Family Test data received during quarter three (October to December 2016), the report also compares this data with that of previous quarters so that trends and themes can be identified which help both the Trust and individual services to better understand the experience of patients and monitor the impact of changes made as a result of feedback received.

1. Formal Complaints

1.1 Formal complaints received

The Trust has received 36 formal complaints in quarter three; as detailed in table one, this is a decrease in comparison on the previous three quarters. The West Berkshire locality was the only locality to see an increase in the number of formal complaints received, in comparison with the last quarter, of the other localities: Slough received the same number and all of the other localities saw a decrease.

In addition to the complaints detailed in this section of the report, the following complaints have been received by other organisations (such as NHS England and Acute Trusts) with an element relating to the services we provide (compared with three in quarter two, two in quarter one) and relate to:-

- The advice and responsiveness from our Crisis Resolution/Home Treatment Team (CRHTT).

- The waiting time to see a psychiatrist and follow up support from the community mental health service.

- A complaint where a patient received a letter saying that they had not attended an appointment with the Diabetic Eye Screening Service when they had made contact with the service.

- A complaint about the care and record keeping provided by the community nursing service to a patient.

Table One: *Formal complaints received by Locality tables*

	2016/17			2015/16						
	Q3	Q2	Q1	Q4	Q3	Q2	Q1	2016/17 YTD	2015/16 Annual	2014/15 Annual
Mental Health Inpatients	5	11	10	8	15	3	10	26	36	47
Bracknell	6	7	4	10	4	6	8	17	28	37
West Berkshire	8	2	5	3	2	6	7	15	18	28
Reading	7	12	13	16	9	12	9	32	46	28
Slough	4	4	7	5	3	3	3	15	14	19
Windsor, Ascot and Maidenhead	2	10	9	8	3	13	11	21	35	36
Wokingham	4	10	17	13	10	8	9	31	40	41
Other inc Corporate	0	0	1	0	1	0	0	1	1	8
Total	36	56	66	63	47	51	57	158	218	244

during April the Crisis Resolution/Home Treatment Team was reported under Mental Health Inpatients and Urgent Care. This changed to Reading from May

For reporting purposes a complaint is logged under the Locality that the service receive their line management from, therefore services that operate trustwide for example Child and Adolescent Mental Health Services (CAMHS), although providing services in all localities will have any complaints about their services logged under one locality and not the locality where the services was received.

There has been a significant decrease in the number of formal complaints received during quarter three in comparison with both quarters one and two. The table below shows that half of these complaints were for the community nursing service and Community Mental Health Teams (CMHT). There was no commonality between the two CMHT complaints, however as the Community Nursing complaints raised concern about the clinical care provided by the same member of staff, specific competency monitoring and support practices have been put in place. The Chief Executive also asked for assurance that the concerns were being addressed.

Table Two: *Formal complaints received for the West Berkshire Locality by Service*

	2016/17		
West Berkshire Locality - Service	Q3	Q2	Q1
Community Nursing	2		1
CMHT/Care Pathways	2		2
Podiatry	1	1	
Integrated Pain and Spinal Service	1		
CMHTOA/COAMHS - Older Adults Community Mental Health Team	1		
Community Hospital Inpatient	1		1
Phlebotomy		1	1
Grand Total	8	2	4

Table Three shows formal complaints received grouped by service. By showing the information in this way, we are also able to draw comparisons across our inpatient and community health services.

Table Three: *Number of formal complaints received by individual services*

	2016/17				2015/16				
Service	Q3	Q2	Q1	% of total received	Q4	Q3	Q2	Q1	Total
CMHT/Care Pathways	7	8	9	15.19	11	6	6	7	30
Crisis Resolution & Home Treatment Team (CRHTT)	3	4	10	10.76	2	7	2	2	13
Adult Acute Mental Health Admissions	4	7	5	10.13	4	7	1	6	18
CAMHS - Child and Adolescent Mental Health Services	2	5	6	8.23	5	2	11	10	28
Community Hospital Inpatient	3	3	7	8.23	5	2	2	7	16
GP - General Practice	1	4	4	5.70	7	1	5	6	19
Out of Hours GP Services	1	3	4	5.06	5	1	5	3	14
Community Nursing	3	2	3	5.06	3	7	3		13
PICU - Psychiatric Intensive Care Unit	1	3	1	3.16	1			2	3
Minor Injuries Unit (MIU)	0	1	2	1.90	1	2		2	5
10 other services – no trends identified	11	16	15		19	12	16	12	59
Grand Total	36	56	66		63	47	51	57	218

The services with the highest number of formal complaints during quarter three were CMHT/Care Pathways, Acute Adult Mental Health inpatients, Crisis Resolution/Home Treatment Team (CRHTT), Community Hospital inpatients and Community Nursing.

However, CRHTT did see a continued decrease in comparison with quarters one and two, and the Clinical Director for CRHTT continues to review all of the complaints received to ensure that there are no particular themes or trends that require specific action.

For CMHT and Community Hospital inpatients the number of complaints was similar to the number received in quarter two, and Adult Acute Mental Health inpatients saw a significant decrease.

During 2016/17 a number of services are being specifically highlighted within this report because they received a higher number of complaints during 2015/16 and/or there have been quality concerns. The services identified are CMHT, Community Inpatient wards, CRHTT and CAMHS.

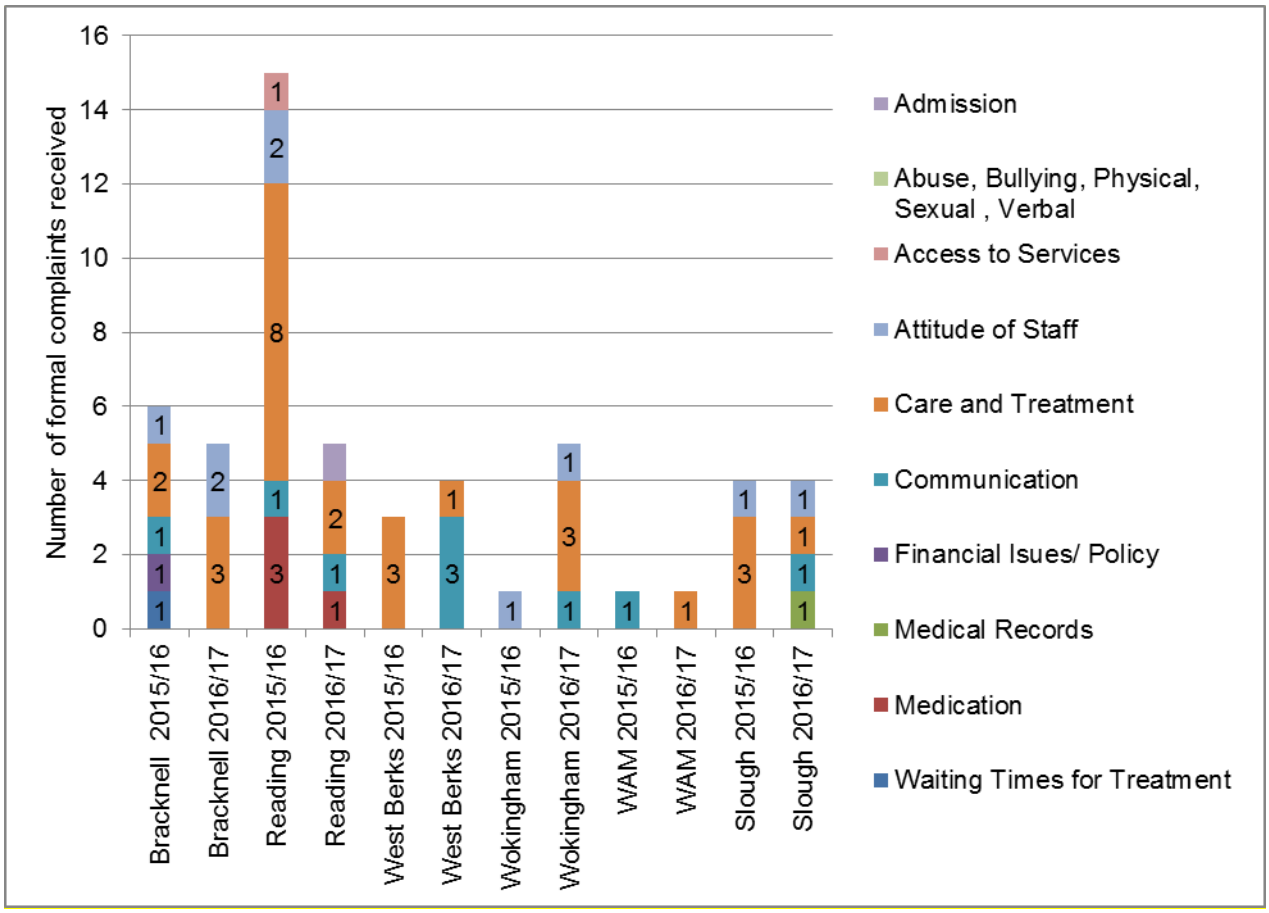
For these services the graphs below detail the total number of complaints by reason for 2015/16 and for complaints to date this year.

Following a review of the patient experience information received during quarters one and two 2016/17, the mental health inpatient wards at Prospect Park Hospital are also highlighted from quarter three.

CMHT/Care Pathways

During quarter three, CMHTs received 7 formal complaints a decrease from 8 in quarter two, 9 in quarter one and 11 in quarter four 2015/16. Bracknell and West Berkshire received the highest number of complaints (three and two respectively). Clinical care remained the common subject of complaints, with no specific themes identified.

Graph One: *Number of formal complaints received for CMHT/Care Pathways by location of the service comparing 2015/16 with 2016/17*

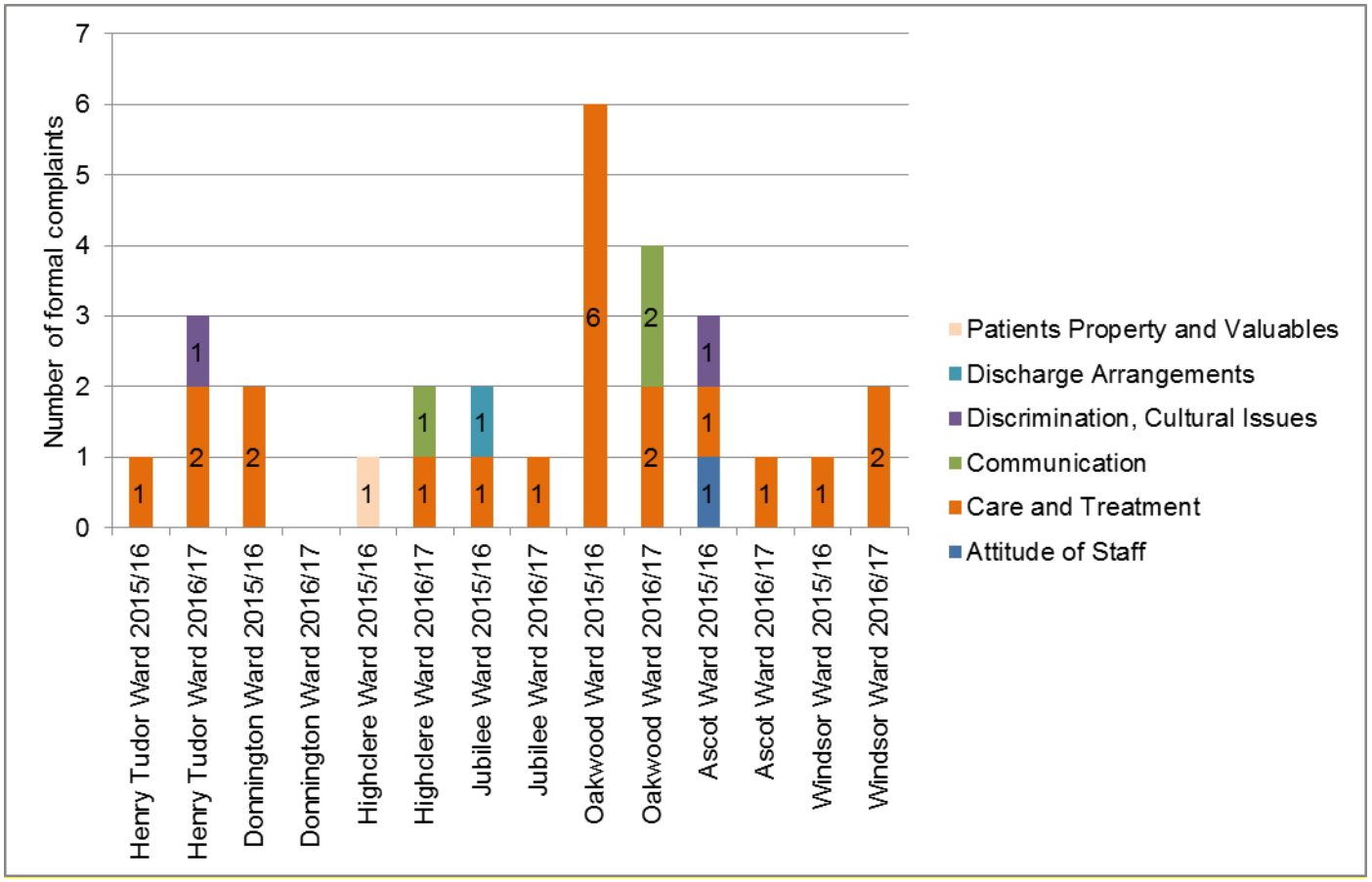


Community Hospital Inpatient Wards

During quarter three there were 3 formal complaints received about the community wards, this is the same as in quarter two and a sustained decrease compared with 7 in quarter one.

These were about the clinical care received on Henry Tudor Ward, Highclere Ward and the Oakwood Unit.

Graph Two: *Number of formal complaints received for Community Hospital Inpatient wards by location of the complaint and theme comparing 2015/16 with 2016/17*

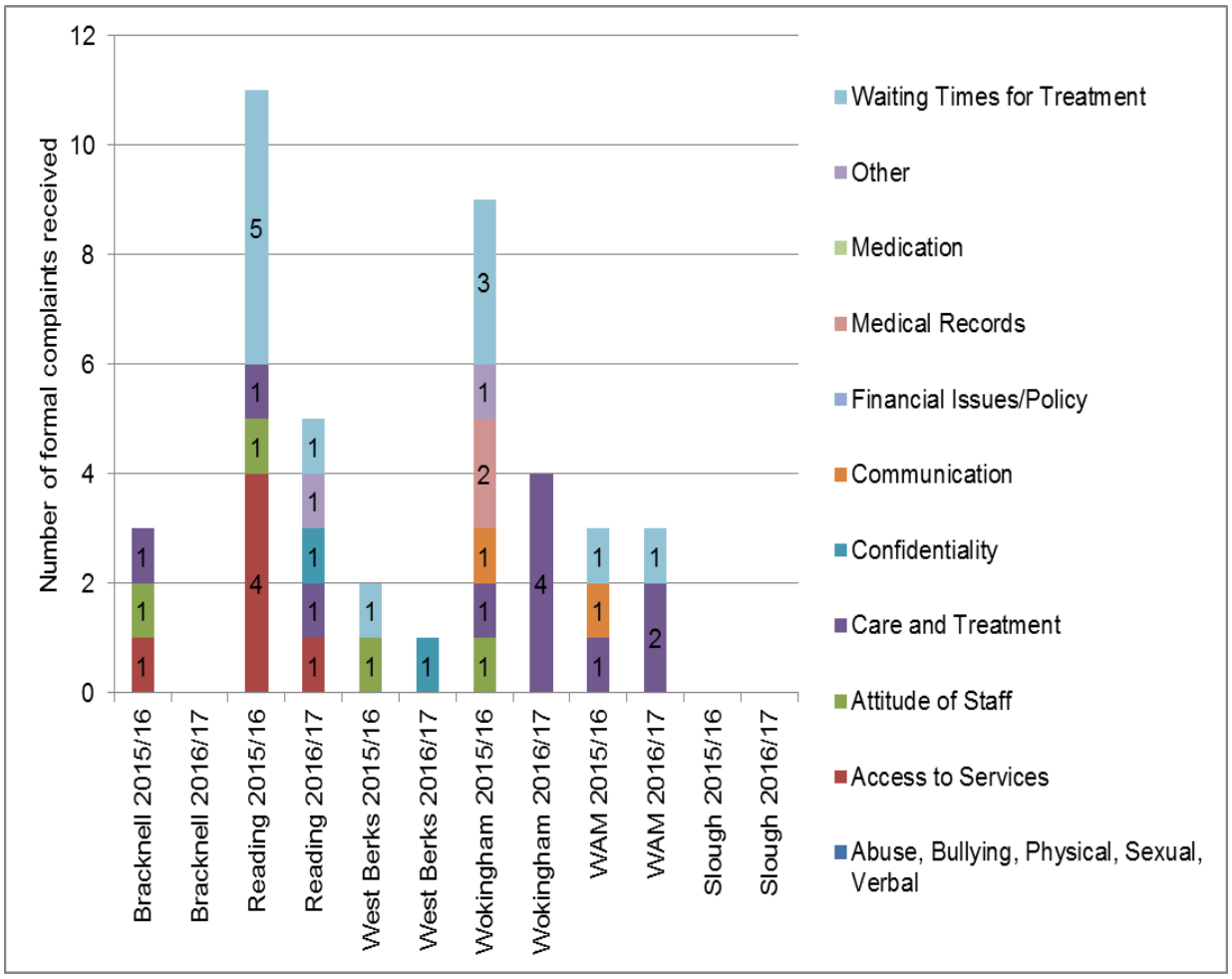


CAMHS - Child and Adolescent Mental Health Services

CAMHS has seen a continued decrease in the number of formal complaints with 2 received during quarter three in comparison with 5 in quarter two and 6 in quarter one; the number of complaints received remains lower than those received during quarters one and two in 2015/16.

Although for reporting purposes in table 1, CAMHS is reported under the Windsor, Ascot and Maidenhead Locality. Graph three shows the geographical locality where the service is based. Both of the complaints received were about care and treatment.

Graph Three: *Number of formal complaints received for CAMHS by location of the service comparing 2015/16 with 2016/17*



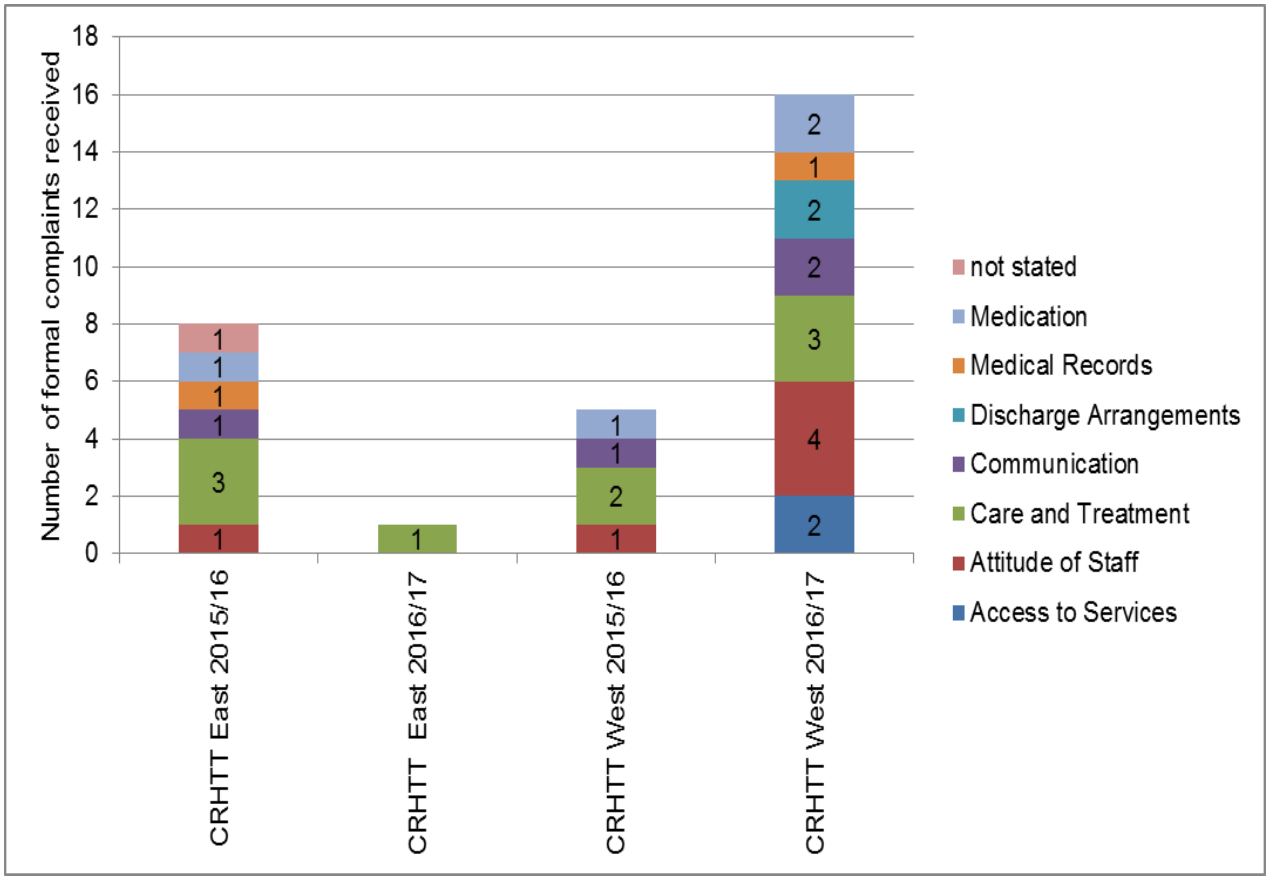
Themes within CAMHS continue to be monitored to ensure that this positive reduction in complaints around wait times and access, continues.

Crisis Resolution/Home Treatment Team (CRHTT)

CRHTT continued to see a decrease in formal complaints in quarter three, receiving three in comparison with 4 in quarter two and 10 in quarter one.

Reading continues to be the locality which has received the highest number of complaints with all 3 of the complaints for this quarter being in relation to services in the Reading area.

Graph Four: *Number of formal complaints received for CRHTT by location of the service (East and West) comparing 2015/16 with 2016/17*



Mental Health Inpatients

All of our mental health inpatient wards are based at Prospect Park Hospital in Reading.

The review of complaints received during 2016/17 shows that a high number were categorised as 'alleged abuse, this would include allegations of bullying, physical, sexual and verbal', by both staff and other patients. 3 of the 16 complaints raised in the 3 quarters were involving patients raising concerns about their experience of PMVA (prevention and management of violence and aggression) techniques. A further 4 complaints where about patients not feeling safe on the ward, in terms of their peers. This was on 4 different wards, but was confined to female complainants.

The Trust lead for PMVA is sent a copy of any complaints that are received about the use of physical restraint and containment, for their expert opinion and advice. Similarly, concerns relating to alleged assault involving staff or other patients are highlighted to our Safeguarding team. This brings a further level of objectivity to our complaint investigations.

To bring some context to the formal complaint activity for quarter three, there were 6 closed during the quarter and only one of these was found to be partially upheld. Further information on the outcome of complaints can be found in table seven.

Graph Five: *Number of formal complaints received for mental health inpatient wards*

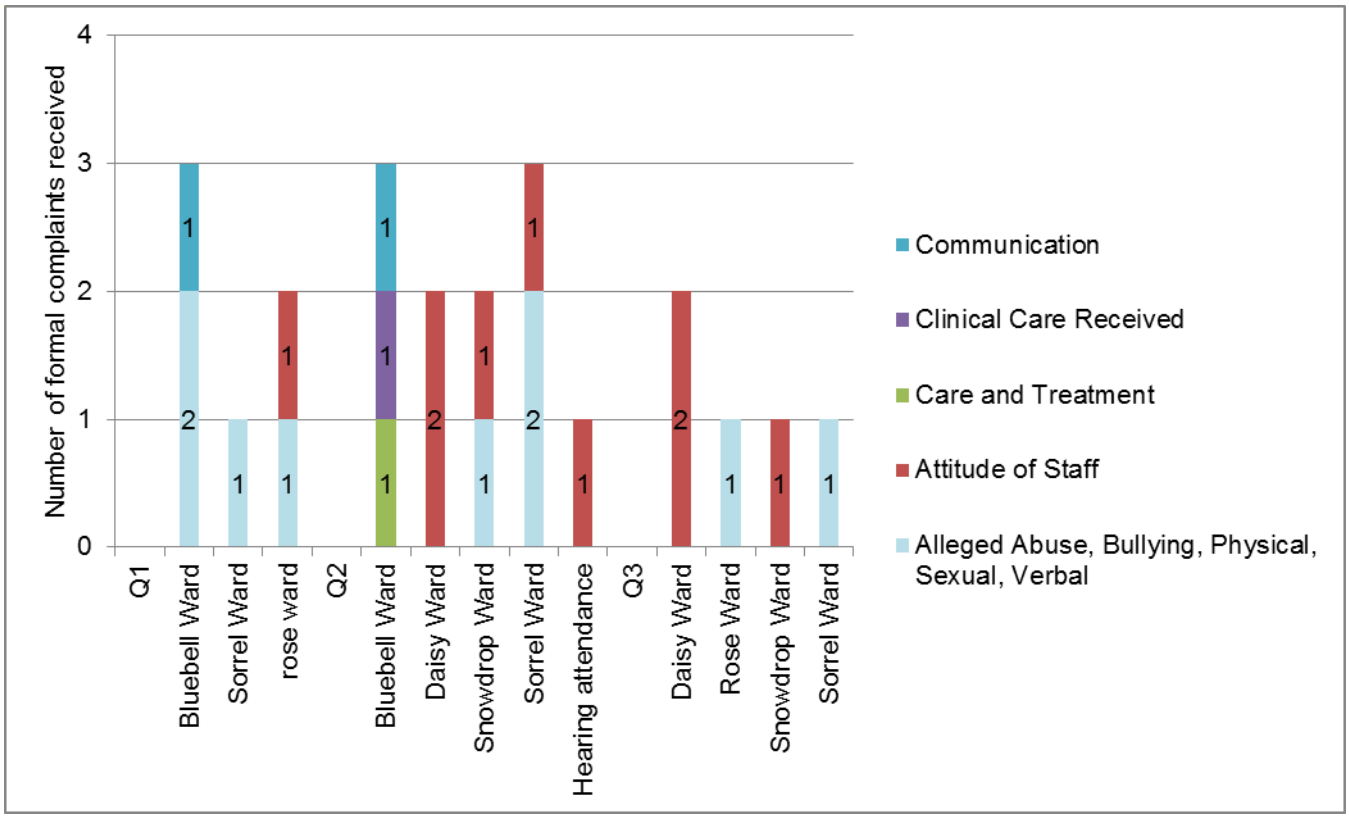


Table Four: *Themes of all formal complaints received*

	2016/17				2015/16			
Theme	Q3	Q2	Q1	% of 2016/17 received	Q4	Q3	Q2	Q1
Care and Treatment	**19**	**22**	**26**	**42.41**	27	17	15	19
Attitude of Staff	**7**	**12**	**14**	**20.89**	16	11	10	9
Communication	**7**	**4**	**8**	**12.03**	4	3	2	9
Alleged Abuse, Bullying, Physical, Sexual, Verbal	2	3	4	5.70		1	1	2
Access to Services			4	2.53	4	2	6	5
Medical Records			4	2.53		1	4	
Medication		2	2	2.53	4	3	1	1
Confidentiality		3	1	2.53	3		1	
Discharge Arrangements		3	1	2.53			2	
Waiting Times for Treatment		3	1	2.53	1		7	8
Support Needs (Including Equipment, Benefits, Social Care)	1			0.63				
Other/not stated		4	1		4	9	2	4

Grand Total	36	56	66		63	47	51	57

The top reasons for complaints being made during quarters one, two and three were:

- Care and treatment
- Attitude of staff
- Communication.

More detail about complaints received can be found in appendix one.

1.2 Formal complaints closed and action taken

As part of the process of closing a formal complaint, a decision is made around whether the complaint is found to have been upheld (referred to as an outcome). The table below shows the outcome of complaints over time.

Table Five: *Outcome of formal complaints closed*

	2016/17				2015/16				
Outcome	Q3	Q2	Q1	% of 2016/17 received	Q4	Q3	Q2	Q1	2015/16 Total
Case not pursued by complainant	5	1	4	5.99	4	1	1	6	12
Consent not granted	4	1	1	3.59	2		1	1	4
Local Resolution	0	1	4	2.99	3	3	3	5	14
Not Upheld	7	16	14	22.16	15	16	21	17	69
Partially Upheld	18	24	22	38.32	17	11	17	19	64
Referred to other organisation	0	0	0	0.00	1	0	0	2	3
Upheld	7	18	20	26.95	19	17	12	7	55
Grand Total	41	61	65		61	48	55	57	221

The percentage of complaints upheld has decreased in comparison with quarters one and two (31% and 30% respectively). Partially upheld complaints have continued to increase from 36.51% in quarter two, 33.85% in quarter one and 28% in quarter four.

The main themes of complaints found to be upheld or partially upheld are:

- Care and treatment (64%)
- Attitude of staff (12%)
- Communication (8%)
- Access to Services (8%)

Table Six below shows the services with upheld or partially upheld complaints during quarter three.

Table Six: *Upheld and Partially Upheld formal complaints*

	Outcome of complaint		
Service	Partially Upheld	Upheld	Grand Total
CMHT/Care Pathways	3	2	5
Crisis Resolution & Home Treatment Team (CRHTT)	1	2	3
Out of Hours GP Services	2		2
Psychological Medicine Service	1		1
Integrated Pain and Spinal Service	1		1
CAMHS - Child and Adolescent Mental Health Services	1		1
Talking Therapies	1		1
Community Hospital Inpatient	1		1
Learning Disability Service Inpatients		1	1
Palliative Care	1		1
Children's Occupational Therapy - CYPIT	1		1
Phlebotomy		1	1
PICU - Psychiatric Intensive Care	1		1
Community Nursing	1		1
Sexual Health	1		1
GP General Practice		1	1
Adult Acute Admissions	1		1
Hearing and Balance Services	1		1
Grand Total	18	7	25

Further information about the outcome of complaints about our mental health inpatient wards, community mental health teams and Crisis Resolution/Home Treatment service can be found below:

Table Seven: *Outcome of formal complaints by service*

	Outcome of complaint					
Service	Case not pursued by complainant	Consent Not Granted	Not Upheld	Partially Upheld	Upheld	Grand Total
Adult Acute Admissions	1	1	3	1		6
CMHT/Care Pathways	2	2	1	3	2	10
Crisis Resolution & Home Treatment Team (CRHTT)				1	2	3
PICU - Psychiatric Intensive Care	1			1		2
Grand Total	4	3	4	6	4	21

All services review the findings from complaint investigations and these are discussed in the locality patient safety and quality meetings with actions identified to affect positive change.

1.3 Response rate for formal complaints

Whilst the Complaint Regulations 2009 state that the timescales for complaint resolution are to be negotiated with the complainant, the Trust monitors performance internally against both a 25 working day timeframe and the negotiated timescale. The investigating managers continue to make contact with complainants directly to renegotiate timescales for complaints where there has been a delay and these are recorded on the online complaints monitoring system.

The table below shows the response within re-negotiated timescale as a percentage total, it demonstrates the commitment of both the complaints office and clinical staff to work alongside complainants. There are weekly open complaints reports sent to Clinical Directors and Service Managers, as well as ongoing communication with the complaints office throughout the span of open complaints to keep them on track as much as possible. This is reflected in the 100% cumulative percentage achieved for the quarter. This 100% within re-negotiated timescales has now been achieved for 10 consecutive months.

***Table Eight**: Response rate within timescale negotiated with complainant*

2016/17					2015/16			
Q3			Q2	Q1	Q4	Q3	Q2	Q1
October	November	December	Cumulative	Cumulative	Cumulative	Cumulative	Cumulative	Cumulative
100%	100%	100%	100%	100%	97%	85%	92%	95%

The average number of days taken to resolve formal complaints during quarter three was 33, an increase from 28 in quarter two, 29 in quarter one and the same as during quarter four 2015/16.

The number of formal complaints that took longer than 40 working days to resolve was nine in quarter three; a slight increase from the previous downward trend of 15 in quarter four 2015/16, ten in quarter one 2016/17 and eight in quarter two.

1.4 MP Enquiries

In addition to raising formal complaints on behalf of their constituents, Members of Parliament (MPs) can also raise service and case specific queries with the Trust. A review of the activity has been included in this report. During quarter three we received 13 enquiries from MPs: this was in comparison with 11 enquiries during quarters one and two combined. Ten of these were about mental health services, which is a continued trend as the majority of enquiries (8) were about mental health services in quarter two, whilst there were 2 enquires related to these services in quarter one.

2. Parliamentary and Health Service Ombudsman (PHSO)

The Trust continues to work with the PHSO as the second stage within the complaints process. The table below shows the Trust activity with the PHSO as at the end of quarter three 2016/17.

Table Nine: *PHSO Activity*

Month open	Service	Month closed	Current Stage
Dec-15	District Nursing	n/a	Not a BHFT complaint - community nursing records requested to inform investigation about a different Trust. Update requested.
Jan-16	Talking Therapies	n/a	Awaiting final report.
Jun-16	GP General Practice	Dec-16	Not upheld.
Sep-16	CAMHS	n/a	Following discussion with PHSO, complaint file will be sent once the scope of the investigation has been received.
Oct-16	District Nursing	n/a	Investigation underway.
Oct-16	Community Inpatient ward	n/a	Investigation underway.

The Patient Experience and Engagement Group monitor the action plans that arise from PHSO investigations on a quarterly basis, this provides a forum to share practice and learning across the different specialities and geographical localities.

3. Informal Complaints/Local Resolution

The complaints office will discuss the options for complaint management when people contact the service, to give them the opportunity to make an informed decision on if they are looking to make a formal complaint or would prefer to work with the service to resolve the complaint informally. Nine informal complaints were received during quarter three, an increase from three during quarter two.

The complaints office has been working with services to devise ways of resolving complaints that meet the expectation of patients and their families whilst capturing the information for staff to use in a friendly and manageable way. It is recognised that services are managing concerns effectively on a daily basis and an online form has been created as a mechanism for these concerns to be captured.

The number of local resolution complaints that the Patient Experience team have been notified about has increased during quarter three to 53, compared to 42 in quarter two, in comparison with 67 in quarter one and 52 in quarter four 2015/16. This does not necessarily mean that there have been more complaints locally resolved just that staff are continuing to improve the reporting of these.

4. NHS Choices

The internal monitoring of NHS Choices postings is an additional way of gathering feedback about our services. Similar to complaints, for an individual to take the time to post on a website their experience, means they feel very strongly about their position and therefore the Trust needs to take these comments seriously and respond appropriately.

15 negative comments were received in quarter three. Five of these were about the Slough Walk In Health Centre and the themes included waiting times for results, waiting time for an appointment, the attitude of staff and staffing levels.

There has been one positive post during quarter three: about Rowan Ward, an older persons mental health ward at Prospect Park Hospital. In this post, the husband of a patient said

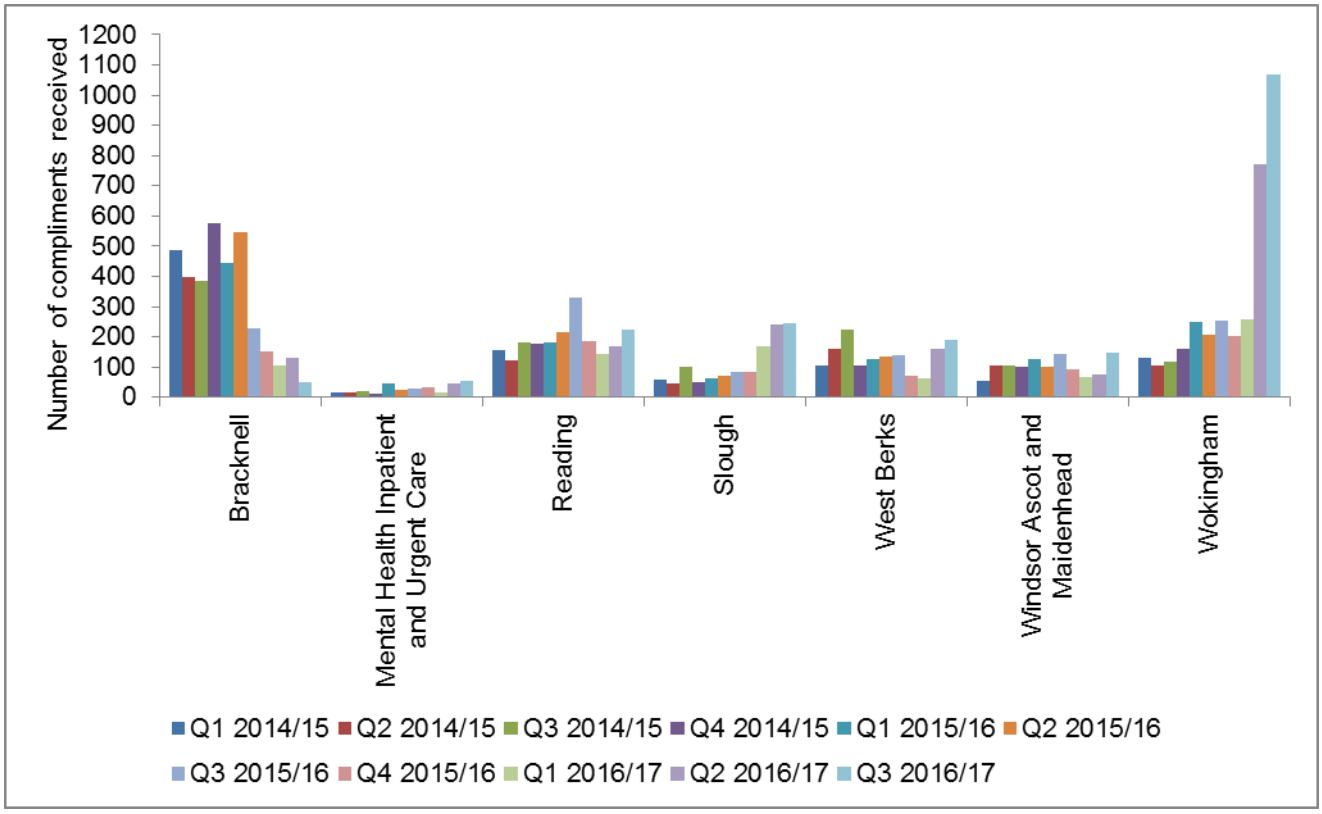
> *'the change in her has been amazing. The love, care and kindness she has received is a credit to all of the staff and without doubt the reason for her improvement. My family and I are so grateful to all concerned and will use Rowan as the bench mark for her future care when she moves to a care home.'*

5. Compliments

Graph six shows the number of compliments received since quarter one 2014/15 by Locality. Since quarter four 2012/13 compliments have been routinely reported directly by services through the web based Datix system. This method of collating feedback enables the Trust to capture compliments other than the traditional thank you card. We have listened to what staff have said about improving the way this system works and there is now a batch upload option for multiple compliments to be entered into the system.

The majority of the compliments that we receive are thanking staff for their time and care and are not specific about what made the difference.

Graph Six: *Number of compliments received since quarter one 2014/15*



There were 1993 compliments reported in quarter three of 2016/17, in comparison with 1602 in quarter two, 821 in quarter one, 826 in quarter four, 1219 in quarter three, 1313 in quarter two and 1262 in quarter one of 2015/16. Our IAPT (Talking Therapies Service) moved from the Bracknell reporting locality to the Wokingham locality which contributes to the change in activity.

The online compliment form enables people to add information such as staff group the compliment was received for and theme. As this is not a mandatory part of the form, and you can add more than one for each compliment it needs to be remembered that this will not make up 100% of the compliments reported.

Table Ten: *Top services to report compliments in quarter three*

Service	Number of compliments
Talking Therapies	903
ASSiST	165
District Nursing	123
Community Hospital Inpatient	109
CMHTOA/COAMHS - Older Adults Community Mental Health Team	90
Community Based Neuro Rehab	66
Older Peoples Mental Health (Ward Based)	43
Community Respiratory Service	41
Mobility Service	34

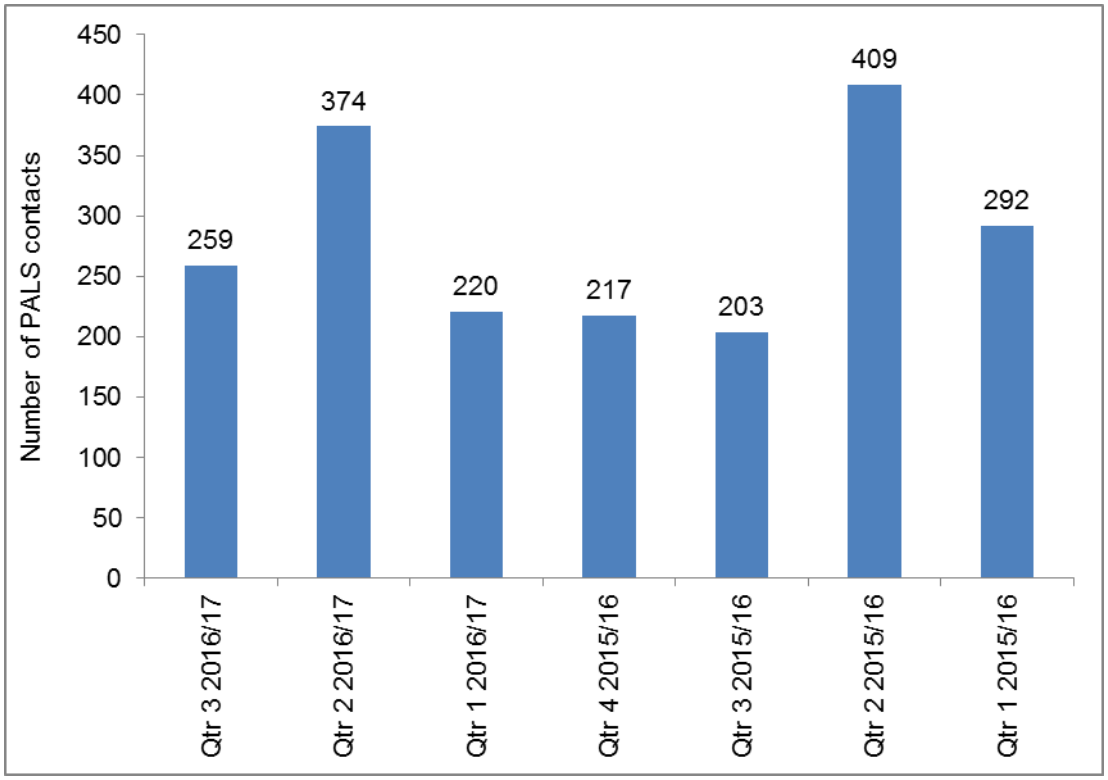
Cardiac Rehab	34

In addition, there were 198 compliments logged that were from sources other than patients, carers and the public. These include students on placements, other organisations and services.

6. Patient Advice and Liaison Service

The role of PALS is to offer a signposting service as well as to facilitate the resolution of concerns with services at the first stage of the complaints process. PALS have established drop in clinics in sites across the localities and continues to promote these to raise further awareness and increase accessibility.

Graph Seven: *PALS contacts*



There are still a large proportion of people contacting our PALS office about issues relating to their GPs, external groups and organisations and education. PALS are signposting these queries to the appropriate people.

Review of the data shows the themes which have attracted the highest number of queries / concerns to be:

- Communication
- Care and treatment
- Information requests

These have consistently remained the top reasons for contacting PALS over the last year. Many of the enquiries are, for example wanting a message to be passed to a service, advice and information on how to access services. There are no particular themes and the reason for calls into PALS is very variable

7. Patient and Public Involvement

Annual Community Mental Health Survey

The national CQC benchmarking report was published during quarter three. This showed that Berkshire Healthcare scored amber (about the same as other Trusts) across all sections and questions except one: When you tried to contact them (Crisis Care), did you get the help you needed?

We were in the lowest range for this question, rated as red. Crisis Care satisfaction has decreased in comparison with 2015.

We saw improvements across all areas of the report that looked at support and wellbeing.

In summary, the CQC benchmarking survey reported that satisfaction:

- Increased across 25 domains
- Decreased across 10 domains
- Stayed the same in 1 domain

In the previous survey, we scored the lowest national score for 'In the last 12 months, did NHS mental health services give you any help or advice with finding support for finding or keeping accommodation?' This question was not included in the 2016 survey.

There has been a significant increase in satisfaction with being supported to find work. Our Individual Placement and Support (IPS) employment service receive positive feedback through our internal patient survey and it is assuring to see that this is also reflected the annual survey.

Further analysis is attached as an appendix and the services are leading improvements based on this feedback.

Deep Dives

There are two 'Deep Dives' underway:

- to support the action plan from the National Audit of Schizophrenia
- the experience of patients and carers accessing the Crisis Resolution/Home Treatment Team

15 Steps

Ten visits have taken place during quarter three; five clinic visits and five inpatient visits.

Appendix Two contains the full quarterly report showing the feedback and themes from the 15 Steps visits which took place during quarter three.

8. The Friends and Family Test

The NHS Friends and Family Test (FFT) give an opportunity for patients and their carers to share their views in a consistent way across the Health Service. Berkshire Healthcare has set an aspiration of 15% response rate for the FFT in both physical and mental health service.

The monthly FFT results, for each service and reporting locality, are shared on our intranet to make them accessible to all staff. The comments are also available online and the patient experience team are currently exploring how to share these more visually, as 'wordles' or No Way Events (attitudes and actions that a patient should never experience) and Always Events (attitudes and actions that patients should always experience)

The tables below show the percentage of patients that would recommend the service they received to friends or family

Table Twelve: *FFT results for Inpatient Wards showing percentage that would recommend to Friends and Family*

		2016/17			2015/16			
Ward	Ward type	Q3 %	Q2 %	Q1 %	Q4 %	Q3%	Q2%	Q1 %
Oakwood Ward	Community Inpatient	-	85.71	89.47	95.16	94.55	88.71	91.94
Highclere Ward	Community Inpatient	90	100	96.3	96.88	81.48	85.19	90.32
Henry Tudor Ward	Community Inpatient	89.29	95.74	95.92	87.27	95.71	100	86.49
Donnington Ward	Community Inpatient	75.68	100	90.91	89.47	95.83	94.87	96.15
Windsor Ward	Community Inpatient	92	94.74	93.94	100	96.61	98.08	100
Ascot Ward	Community Inpatient	80	100	88.89	90	93.55	97.14	100
Jubilee Ward	Community Inpatient	90	100	97.78	97.44	95	97.22	92.73
Bluebell Ward	Mental Health	60	100	78.79	80	75	0	66.67
Daisy Ward	Mental Health	-	66.67	85.71	68.42	75	71.43	77.78
Snowdrop Ward	Mental Health	66.67	50	66.67	85.71	0	100	75
Orchid Ward	Mental Health	0	100	-	100	0	100	66.67
Rose Ward	Mental Health	0	80	33.33	54.55	58.82	100	75
Rowan Ward	Mental Health	0	-	72.73	100	-	-	-

Donnington ward saw a decrease in the percentage recommendation to a friend from consistently above 85% to 76% in quarter three. The data shows that out of the 37 completed friends and family test returns, 28 people would recommend to a friend. All of the remaining 9 people said that they would neither recommend or not. There were no responses that were unlikely or extremely unlikely to recommend.

Oakwood ward and Daisy ward had no friends and family test returns during quarter three. In comparison, Orchid ward, Rose ward and Rowan ward had responses but nobody stated that they would recommend to a friend.

There were 21 completed Friends and Family Test returns for our mental health inpatient wards during quarter three. This comprised of 11 people stating that they were either extremely likely or likely to recommend to a friend (52%) and 4 people saying that they were either unlikely or extremely unlikely to recommend (19%). The remaining 6 people said that they would neither recommend or not, which is classed as a neutral response.

The patient experience team have advertised for a volunteer to help with collecting feedback across Trust sites and have successfully appointed someone based in St Marks. However, the response rates for Prospect Park Hospital in particular are disappointing, especially as our Patient Advice and Liaison Service (PALS) manager started to support the collection of patient feedback during quarter three. This however is a new initiative and has not yet had the time to bed down or positively influence returns. Over Q4 we will review and look at how we can increase take up. Alongside this PALs plan to link in with the OTs and attend Ward Community meetings to increase the ability to gain patient feedback. Time will be spent on the wards by the Patient Experience Team to better understand the challenges with collecting feedback in this area during quarter four.

Table Thirteen: *FFT for Walk-in services showing percentage that would recommend to Friends and Family*

	2016/17			2015/16			
Walk-in Services	Q3%	Q2%	Q1 %	Q4 %	Q3%	Q2%	Q1 %
MIU - West Berks	91.03	96.92	97.37	96.54%	95.81	93.29	93.04
SWIHC – Walk-in	79.54	89.69	88.45	81.23%	77.69	84.94	93

Table Fourteen: *FFT for GPs showing percentage that would recommend to Friends and Family*

	2016/17			2015/16			
General Practice	Q3%	Q2%	Q1%	Q4 %	Q3%	Q2%	Q1 %
Circuit Lane Surgery	-	-	-	33.33%	-	66.67	60.78
Priory Avenue Surgery	-	81.34	73.87	73.42%	69.57	-	-
SWIHC - GP	70.09	74.75	41.67	58.04%	58.87	58.21	63.01

The combined community based physical health services recommendation rate for the services that have been reported on, and are not detailed above, was 90% for quarter three, 96% for quarter two, an increase from 90% in quarter one.

The results show there has been an increase in the percentage of people who gave a neutral or passive response to the FFT in quarter three (i.e. neither likely nor not likely) rather than being unlikely or extremely unlikely to recommend.

Table Fifteen: *Number of Carer Friends and Family Test responses*

	Number of responses
2016/17	
Q3	57
Q2	54
Q1	22
2015/16	
Q4	15
Q3	15
Q2	73
Q1	29

The responses received are generally positive; however response rates are low and we are aiming for 100 per locality per quarter. We are working on increasing awareness of Carer FFT cards within the trust and potential impact of the FFT on other carer feedback e.g. memory clinic accreditation.

8.1 FFT national benchmarking

Each month health services (both NHS and independent providing NHS services) submit a report to the Department of Health on their FFT results and activity. As each organisation differs in the services that they provide, and the guidance for calculating the response rate differs substantially.

Table Sixteen: *Number of Friends and Family Test responses*
Community health services FFT data for October 2016

Trust Name	Total Responses	Total Eligible	Response Rate	Percentage Recommended
BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST	1,224	23,654	5%	94%
SOLENT NHS TRUST	851	41,346	2%	96%
SOUTHERN HEALTH NHS FOUNDATION TRUST	3,031	40,915	7%	96%
OXFORD HEALTH NHS FOUNDATION TRUST	688	34,742	2%	94%

Table Seventeen: *Number of Friends and Family Test responses*
Mental health services FFT data for October 2016

Trust Name	Total Responses	Total Eligible	Response Rate	Percentage Recommended
BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST	298	3,384	9%	92%
SOLENT NHS TRUST	90	2,450	4%	89%
SOUTHERN HEALTH NHS FOUNDATION TRUST	388	11,941	3%	80%
OXFORD HEALTH NHS FOUNDATION TRUST	262	9,362	3%	90%

The available information demonstrates that the collection methodology with the highest response continues to be paper/postcard at point of discharge.

9. Other Patient Feedback

We continue to work closely with Healthwatch organisations to gather feedback on the services we provide and explore ways that we can improve this further. The Patient Engagement and Experience team hold a meeting every three months where we give an update on patient experience and incidents, and invite services that Healthwatch have asked for further information on. Localities also meet directly with their associated Healthwatch organisation.

Complaints review

During quarter three, Berkshire Healthcare has contributed towards a review of complaint handling and learning from complaints undertaken by Healthwatch Slough. One of the areas identified for further exploration is how organisations work together to facilitate multi-agency complaints. There were four other health and care organisations who took part in the review:

- Slough Borough Council
- Slough CCG
- Wexham Park Hospital
- Slough Children's Trust

The formal outcome of this review has not yet been received, however from initial discussions, multiagency complaint management has been highlighted as an area that could be improved.

Healthwatch report on the experience of mental health services

Healthwatch Windsor, Ascot and Maidenhead (WAM) published a report based on over one hundred and twenty comments received about concerns with local mental health services. The main themes of this report were:

- Getting through to the crisis team and crisis response time
- Feeling judged by professionals
- Communication between services regarding the needs of mental health patient
- Professional support and on-going services are in need of improvement
- Delay in seeing Child and Adolescent Mental Health Services (CAMHS)

Unfortunately we were not given the opportunity to respond to the concerns raised in this report before it was published and it did not contain a balance with positive experiences.

Complainant survey

We are currently reviewing the way we facilitate feedback on the complaints process. This has been carried out externally by NHS Benchmarking and the Patients Association; however the response rate has remained consistently low e.g. two per quarter.

Services are using a combination of devices and paper surveys as well as a mixture of surveying continually throughout the year, rotation of devices between localities and targeted times to survey. These are in addition to the FFT.

At the end of the quarter we have received feedback from **2,245** patients or carers, compared to 3,113 in the last quarter, 3,263 in quarter one and 4,016 in quarter four in 2015/16. This is a disappointing drop in the number of returns. The Patient Experience Team will be creating a targeted improvement plan to work with services.

Good or Better results

89.7% of people who responded in our internal patient survey reported the service they received care from as good or better. 8 of the services carrying out the internal patient survey were rated 100% for good and better with a further 1 service rating 85% or above.

This means there are many services noted as having below the desirable good or better rating during the third quarter, this will need to be looked into further.

17 services in all failed to log any responses for quarter three, this is disappointing. No mental health inpatient wards logged any responses for the quarter; this also needs to be discussed.

The Patient Experience Team continue to work with services to try to help wherever possible to increase response rates but it is clear that more work needs to be done to assist this as well as maybe reviewing target numbers.

Berkshire Healthcare NHS
NHS Foundation Trust

COUNCIL OF GOVERNORS

22 March 2016

Annual Plan Summary 2017-18

For Noting

Author: Bev Searle, Director of Corporate Affairs

Healthcare from the heart of your community

Annual Plan Summary 2017-2018

NHS Berkshire Healthcare NHS Foundation Trust

Goal 1: Improving patient safety and experience

To provide safe services, good outcomes and good experience of treatment and care

- All our services will contribute to an outstanding Care Quality Commission rating
- Every team will use peer review, accreditation or bench marking to guide improvement, so we can achieve consistently good performance across services and localities
- Our Friends and Family Test response rates will be at least 15% in each service
- We will introduce a consistent approach to quality improvement, building the foundation of a long term commitment to improving services, informed by staff, service users and carers
- As part of our Zero Suicide initiative, we will work to achieve a 10% reduction in numbers of people known to us, taking their own lives by 2021
- We will reduce our use of restraint so we are in the lowest 10% nationally
- We will continue to achieve low numbers of falls (less than eight per 1000 bed days) and no pressure ulcers as a result of a lapse in our care
- We will expand our on-line access to services to include three new service areas using Skype and our Support Hope and Recovery Online Network (SHaRON).

Goal 2: Supporting our staff

To strengthen our highly skilled and engaged workforce

- We will achieve at least 77% of staff saying they recommend our Trust as a place to receive treatment as reported in our staff survey
- Staff recruitment and retention plans will be completed and implemented in all services with high levels of vacancy
- Staff development opportunities will be provided in a fair and equal way, so that people are supported to develop their careers with us
- Managers will receive training in Compassionate Leadership, with an agreed charter in each service area
- We will develop a new intranet to support staff to make the best use of technology, and identify three services to develop technology solutions that can be applied across the organisation.

Goal 3: Money matters

To deliver services that are efficient and financially sustainable

- We will deliver our financial plan for the year
- Our internal savings programme will save £4.7m
- We will improve efficiency through procurement, completing e-rosters six weeks in advance and reducing agency staff to less than 8% of the total, and lower as agreed with services
- We will reduce our out of area placements to ensure that these are eliminated for people needing non-specialist acute mental health care by 2021
- We will use benchmarking information and peer review to make sure that corporate services are performing effectively across our organisation and in comparison with others.

Goal 4: Working together

Understanding and responding to local needs as part of an integrated system

- All our health and social care joint teams will have access to joined up patient records – we will use Connected Care to improve both patient experience and job satisfaction of staff
- We will achieve reductions in urgent admissions, delayed transfers of care and out of area placements across our inpatient services
- As a result of the outcomes we are achieving, we will maintain or improve levels of commissioner satisfaction and investment
- We will achieve the objectives set out in the Equality Plans for each locality
- Our targets for use of fuel and water and our green travel objectives will be met.

Our vision: To be recognised as the leading community and mental health service provider by our staff, patients and partners.

caring for and about you is our top priority

committed to providing good quality, safe services

working together with you to develop innovative solutions