Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

Berkshire Healthcare NHS Foundation Trust

Quality Account 2017/18

caring for and about you is our top priority

committed to providing good quality, safe services

working together with you to develop innovative solutions

"Our vision is to be recognised as the leading community and mental health service provider by our staff, patients and partners"

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

We are a community and mental health Trust, providing a wide range of services to people of all ages living in Berkshire. To do this, we employ over 4,500 staff who operate from our many sites as well as out in people's homes and in various community settings.

Having been rated as 'Good' by the Care Quality Commission– our ambition is to now reach 'Outstanding'.

We are also a digital pioneer, having been named by NHS England as a 'Global Digital Exemplar'– one of only seven mental health Trusts in the country to gain this status. This will allow us to transform patient care through new technologies.

We deliver joined up physical and mental health services, helping people to remain independent at home for as long as possible and providing the care and support that best meets the needs of our patients, in the most suitable location. From early years to end of life, we offer a wide range of services to keep you and your family well. We run a number of specialist clinics and services aimed at young people, adults and older people to support and treat mental health, physical health and sexual health conditions.

We work in partnership with Berkshire's two acute hospital Trusts, Royal Berkshire Hospital NHS Foundation Trust and Frimley Health NHS Foundation Trust. We also work closely with Berkshire's six local authorities and a diverse range of community and charitable organisations.

As a foundation Trust we are accountable to the community we support. NHS Improvement regulate our financial stability, and have given us a financial sustainability risk rating of 4, which is the best rating we could have (they rate from 1 to 4, with 1 being at most risk and 4 being the least risk). The Care Quality Commission oversee patient quality and safety – and they rate us as 'Good'

Table of Contents for Quality Account 2017/18

Quality Account Positive Highlights and Overall Summary 2017/18

Patient Experience

- The Trust is implementing a project to improve transition to adult mental health services for young people in our Child and Adolescent Mental Health Services (CAMHS)
- The Trust continues to prioritise and report on patient satisfaction to inform improvement and to involve people who use our services in the development and implementation of our plans and strategies

Patient Safety

- The Trust has launched a Quality Improvement (QI) programme and this has continued throughout the year
- The Trust has continued implementing its zero suicide programme
- Targets have been met relating to the development of cat. 2 pressure ulcers following a lapse in care by Trust staff. Community health wards continue to meet falls targets
- An IAPT (Talking Therapies)- long term conditions pilot has been implemented

Clinical Effectiveness

- Trust services have been assessed against NICE Guidelines relating to falls, pressure ulcers and patient experience of adult mental health services
- An internal audit of the Trust's adherence to National Guidance on Learning from Deaths resulted in substantial assurance being awarded to the Trust

Organisational Culture

- The Trust achieved positive results in the 2017 national staff survey
- The Trust continues delivering the Excellent Manager programme as well as values based recruitment and appraisal
- The Trust continues delivering its 'freedom to speak up programme', ensuring that staff are able to raise concerns in a variety of ways

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

The Trust has set quality priorities for 2018/19 in the following areas:

Patient Safety Priorities

- To drive improvement through the Trust Quality Improvement (QI) Programme
- To deliver 'Harm Free' objectives relating to falls, self-harm and suicide
- To achieve reductions in urgent admissions, and delayed transfers of care for inpatients

Clinical Effectiveness Priorities

- To demonstrate evidence-based services by reviewing them against NICE guidance
- To continue reviewing, reporting and learning from patient deaths

Patient Experience Priorities

- To achieve a 95% satisfaction rate in our Friends and Family Test, and 60% of staff reporting use of service user feedback to inform decisions in their department
- To reduce our use of prone restraint by 90% by the end of 2018/19
- To focus on understanding and supporting outcomes of care that are important to patients
- To contribute to Integrated Care System work streams to improve outcomes

Organisational Culture Priorities

- To achieve improvements in staff feeling empowered to make improvements at work, staff recommending the Trust as a place to receive treatment and a reduction in assaults on staff
- To reduce vacancies by 10%
- To train an additional 24 services in our Quality Management Improvement System
- To achieve the objectives set out in the Equality Plans for each area

Figure 1- Summary of Trust achievement against 2017/18 Quality Account Priorities

Priority and Indicator		Results 2016/17	Results 2017/18	Comment & Change from 16/17- 17/18
Patient Experience				
Initiate project to improve transition from Child and Adolescent Mental Health Services (CAMHS) to Adult Mental Health services		N/A	**Met**	**Target Met**
Friends and Family Test- Achieve a response rate of at least 15%		N/A	**11.25% (Q4)**	**Target Not Met**
Friends and Family Test- % of patients likely or extremely likely to recommend the service to a friend or family member	Community Services (Mental health and physical health combined)*	95%	**96%**	**Change: +1%**
	Mental Health Inpatients*	74%	**67%**	**Change: -7%**
	Community Hospital Inpatients*	95%	**97%**	**Change: +2%**
	Minor Injury Units and Walk-in Centre*	95%	**98%**	**Change: +3%**
Trust Patient Satisfaction Survey- % of Patients rating the service they received as good or very good	Community Mental Health	85%	**82%**	**Change: -3%**
	Community Physical Health	93%	**95%**	**Change: +2%**
	Mental Health Inpatients	72%	**67%**	**Change: -5%**
	Patients in Community Hospitals	97%	**99%**	**Change: +2%**
Carer Friends and Family Test- % of carers likely or extremely likely to recommend the service to a friend or family member		96%	**97%**	**Change: +2%**
Continue Patient Leadership Programme		Met	**Met**	**Target Met**
National Community Mental Health Survey- Overall result (score out of 10)		7.2	**7.3**	**Change +0.1**
Patient Safety				
Initiate Trust Quality Improvement Programme		N/A	**Met**	**Target Met**
Continue Zero Suicide Programme		Met	**Met**	**Target Met**
Number of Pressure Ulcers developed following a lapse in care by Trust staff	Community Patient or Inpatient Category 2 pressure ulcers (Target- Less than or equal to 19)	N/A	**14**	**Target Met**
	Community or Inpatient Category 3 and 4 pressure ulcers (Target- Less than or equal to 9)	N/A	**18**	**Target Not Met**
Rate of inpatient falls per 1000 bed days on wards for older people	Older Peoples Mental Health Wards (Target- less than or equal to 8 per 1000 bed days)	6.62	**9.66**	**Target Not Met**
	Community Health Wards (Target- less than or equal to 8 per 1000 bed days)	4.95	**4.65**	**Target Met**
Smoking cessation for mental health inpatients- Meet CQUIN and Quality Schedule targets		N/A	**Met**	**CQUIN Target Met**
Initiate an Improving Access to Psychological Therapies (IAPT)- Long Term Conditions (LTC) expansion across Berkshire		N/A	**Met**	**Target Met**
Clinical Effectiveness				
Compliance with Trust NICE guidance implementation targets	Compliance with NICE Guideline on Pressure Ulcers	N/A	**94%**	**Target Met**
	Compliance with NICE Guideline on Falls	N/A	**95%**	**Target Met**
	Compliance with NICE Guideline on Patient Experience in Adult Mental Health	N/A	**91%**	**Target Met**
Gain internal audit assurance on the Trust's adherence to the National Guidance on Learning from Deaths (March 2017)		N/A	**Substantial Assurance from internal audit**	
Organisational Culture				
National NHS staff survey results- Percentage of staff agree or strongly agree they would recommend our Trust as a place to receive treatment (target 77%)		75%	**75%**	**Target not met**
Continue delivering the Excellent Manager Programme, Values Based Appraisal and Values Based Recruitment to ensure that we promote a culture of shared values and related behaviours across the entire organisation.		N/A	**Met**	**Target Met**
Continue the Trust 'freedom to speak up programme', ensuring that staff are able to raise concerns in a variety of ways.		N/A	**Met**	**Target Met**

***Specific Friends and Family Test targets have been set for 2018/19.**

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

Berkshire Healthcare NHS Foundation Trust has continued to deliver effective, safe and efficient care for its patients through 2017/18. We have a Trust-wide vision to be recognised as the leading community and mental health provider by our patients, staff and partners.

The Trust continues to be rated as 'Good' by the Care Quality Commission (CQC) and we are committed to achieving an 'Outstanding' rating in 2018.

We have successfully introduced an organisational Quality Improvement (QI) programme which will enable us to apply a consistent approach to continuous improvement by developing the ability of each and every staff member to make improvements to the way we deliver care for our patients. This programme has supported the development of our priorities for 2018/19 detailed within this account.

We are committed to ensuring that patients have a positive experience of the care we provide and we continue to prioritise learning from patient experience surveys, complaints and compliments. Overall, feedback from these results is positive, and we aim to maintain and improve on this during 2018/19.

Patient safety remains of paramount importance to us, and 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. We maintain robust governance, patient safety, incident and mortality reporting systems which are able to highlight areas for improvement in a timely manner allowing for learning.

Our clinical effectiveness agenda helps to ensure that we are providing the right care to the right patient at the right time and in the right place. Our clinical audit and NICE programme allows us to measure our care against current best practice leading to improvement. This report details the work undertaken in this area.
The National Quality Board launched its Learning from Deaths policy in March 2017 in response to the CQC's report 'Learning, Candour and Accountability'. It has become increasingly important for Trusts to evidence that they are systematically and continuously reviewing patient outcomes including mortality (patients who have died). It is acknowledged that most deaths do not occur as a result of a direct patient safety incident. None the less, it is important that opportunities for learning from deaths and learning from the review of the care provided and the experience in the period prior to the person's death are not missed, and this is scrutinised by our Board and reported publicly.

Berkshire Healthcare is committed to the principles of system working and is actively involved with the Berkshire West and Frimley Integrated Care Systems in finding sustainable population based solutions for meeting the physical and mental health needs of our patients and service users.

This report demonstrates the breadth of improvement work that is being undertaken, as well as the commitment of Trust staff to improve services for patients across the county.

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

"I would rate them positively in every way, both in their care towards my mother & their interaction and involvement with me in her care program… CMHT work with my mum has been invaluable. If I was allowed to give specific praise & name individuals in this review I would! All I can say is the nursing staff in the elderly mental health team have been excellent. Personally I have attended the 6 week course they run on understanding Alzheimer's; whilst much of the content I already knew I would still strongly suggest this course to others, as the 1 or 2 'nuggets' of information each week were invaluable. Keep up the good work!"

From a relative of a patient- Community Older Adult Mental Health Service- Maidenhead

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

2.1. Achievement of Priorities for Improvement for 2017/18

ⓘ This section details the Trust's achievements against its quality account priorities for 2017/18. These priorities were initially identified, agreed and published as part of the Trust's 2016/17 quality account. Specific priorities have been set in the areas of patient experience, patient safety, clinical effectiveness and organisational culture

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 services 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.

2.1.1 Patient Experience and Involvement

ⓘ One of the Trust's 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 2017/18.

Our 2017/18 Patient Experience Priorities:

1. To improve transition to adult mental health services for young people in our Child and Adolescent Mental Health Services (CAMHS)

2. To increase response rates for the Friends and Family Test (FFT) to at least 15% in each service and to continue to prioritise and report on patient satisfaction leading to improvements.

3. To involve people who use our services in the development and implementation of our plans and strategies

Transition from Child and Adolescent Mental Health Services (CAMHS) to Adult Mental Health Services

ⓘ The Trust has established strong arrangements for service user and family engagement in our CAMHS and this has helped to inform actions required to improve transition into adult services. We recognise how important this is; given that 50% of young people receiving CAMHS transfer into adult services.

Transition from CAMHS to Adult Mental Health Services has been addressed as part of a Commissioning for Quality and Innovation (CQUIN) project in 2017/18. This CQUIN aims to incentivise improvements to the experience and outcomes for young people as they transition out of CAMHS into Adult Mental Health Services.

Actions taken to meet the aim included the following:

- A transition policy was been agreed and distributed across the organisation
- Tools were developed to aid the process, including a transition care plan
- Joint agency planning for transition was rolled out across the localities
- Training and presentations took place across children's services to increase understanding of transition requirements and to embed the processes outlined in the transition policy and Standard Operating Procedure
- Engagement with clinical directors was undertaken to ensure that the transition process was embedded across services
- Engagement with Community Mental Health Team (CMHT) leads was undertaken to outline requirements, in accordance with the plan
- Ownership and expectations of the project were embedded in the CAHMS leadership team

In order to demonstrate that the requirements of the CQUIN were met, the following was undertaken:

1. A case note audit in order to assess the extent of Joint-Agency Transition Planning; and
2. A survey of young people's transition experience ahead of point of transition (Pre-transition / Discharge readiness); and
3. A survey of young people's transition experience after the point of transition (Post- Transition Experience)

The results from these three exercises demonstrated the consistent effort within the Trust over the last three years to set up a transition process in order to improve the experience of young people and their families and prevent vulnerable young people from falling between gaps in the service. In particular, the study found that:

- 88.9% of young people audited had evidence of joint agency transition planning and 11.1% had the requirements partially met.
- 88.6% of the young people audited had evidence of discharge planning completed.

- 80% of young people responding to the survey who had completed a transition into Adult Mental Health Services were satisfied with their pre-transition experience and 60% agreed that their plan had helped achieve their transition goals.

However, there was a gap identified in services for young people with neurodevelopmental disorders, particularly Attention Deficit Hyperactivity Disorder (ADHD) and Autistic Spectrum Disorder (ASD), and the varying prescribing practices between health providers appear to contribute to concerns around this. Families did not feel supported when discharged from CAMHS to their GP for medical monitoring while awaiting an appointment within the Adult ADHD service. The young people also indicated their preference for more frequent contact from the Adult Mental Health Services. In addition, some families believed that the transition process had been rushed and should have been discussed earlier on in treatment. It would have also been beneficial to meet a clinician from the adult service more than once to feel more at ease about transferring into to the care of another clinician, as some young people found the change difficult to adjust too.

The transition report will be disseminated and shared with the CAMHS and Adult Mental Health Services to inform further planning and development of our transition process.

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, by card or on the internal Trust patient survey.

The Trust aim for 2017/18 was to achieve a response rate of at least 15% in each service for the Friends and Family Test. Figure 2 details achievement against this target and shows that the response rate stayed below the target during the year, but was at its highest in Quarter 4. It is believed that the low response rate during the year has been impacted on by staff capacity to support the FFT programme and resource has been identified to address this.

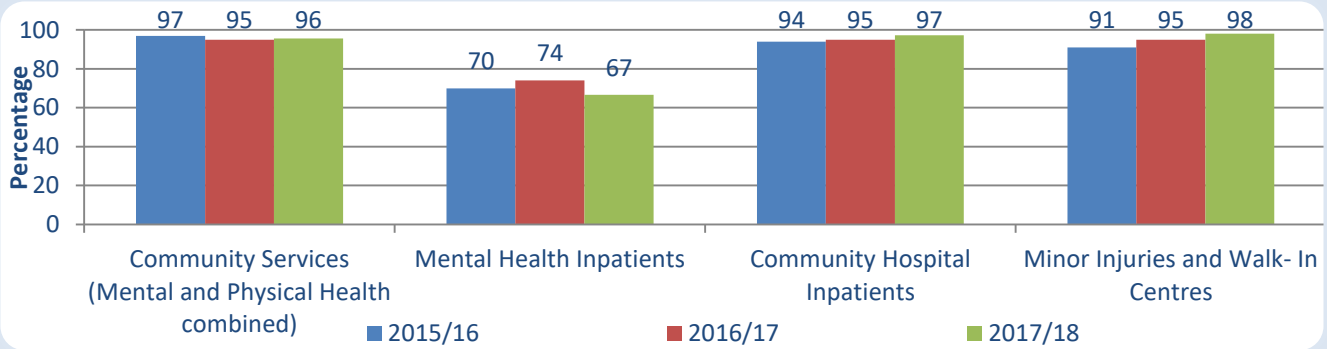
Figure 2: Response Rate for Patient FFT

Timeframe	Q1	Q2	Q3	Q4
% Response Rate	7.04	9.6	6.8	11.25

Source: Trust Patient Experience Reports

Figures 3 and 4 below demonstrate the Trust's achievement in relation to recommendation rate in the patient FFT. The figures demonstrate an increase in the percentage of patients that were either likely or very likely to recommend community services, community hospital inpatient and minor injuries and walk-in centres in 2017-18 compared with 2016-17. The figures also show that 67% of mental health inpatients would recommend the service in 2017/18, compared with 74% in 2016-17. However, these figures should be interpreted with caution due to the low number of responses by mental health inpatients.

Figure 3- Patient Friends and Family Test (FFT): Percentage of patients very likely or likely to recommend the service to a friend or family member.



Source: Trust Patient Experience Reports. Please note that the management of the Slough Walk-In Centre transferred to another organisation on 1st September 2017.

Figure 4- Patient Friends and Family Test- total number of responses

Survey and Service	2016/17			2017/18		
	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	11339	10815	95	15399	14718	96
Mental Health Inpatients	141	104	74	87	58	67
Community Hospital Inpatients	887	845	95	1057	1028	97
Minor Injuries Unit and Walk in Centre	5869	5577	95	3094	3035	98

Source: Trust Patient Experience Reports. Please note that the management of the Slough Walk-In Centre transferred to another organisation on 1st September 2017.

Carer Friends and Family Test (FFT)

ⓘ A Friends and Family Test for carers has also been created which asks if carers would recommend Trust services. Whilst this is not mandated nationally, the Trust recognises the crucial role that carers have and the value of their feedback.

Figures 5 and 6 below demonstrate the Trust's achievement in relation to the Carer Friends and Family Test. The figure shows that 97% of respondent carers in 2017/18 were likely or very likely to recommend Trust services to a friend or family member. This is 1% above the 2016/17 figure.

Figure 5- Carer Friends and Family Test: Percentage of carers extremely likely or likely to recommend the service to a friend or family member

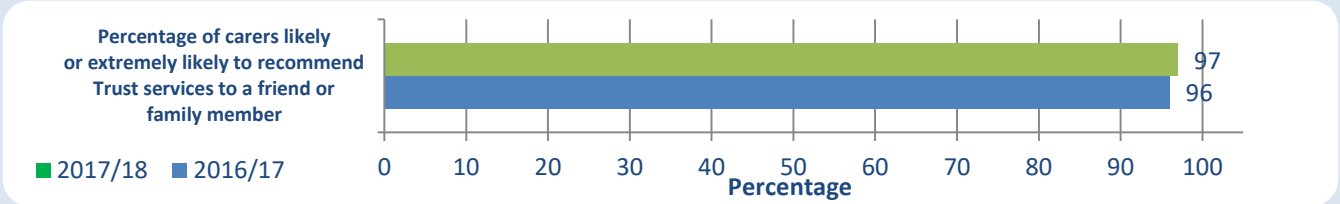


Figure 6- Carer Friends and Family Test- total number of responses

Survey and Service	2016/17			2017/18		
	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	207	198	96	269	261	97

Source: Trust Patient Experience Reports Please note that the Trust does not have a response rate for this survey.

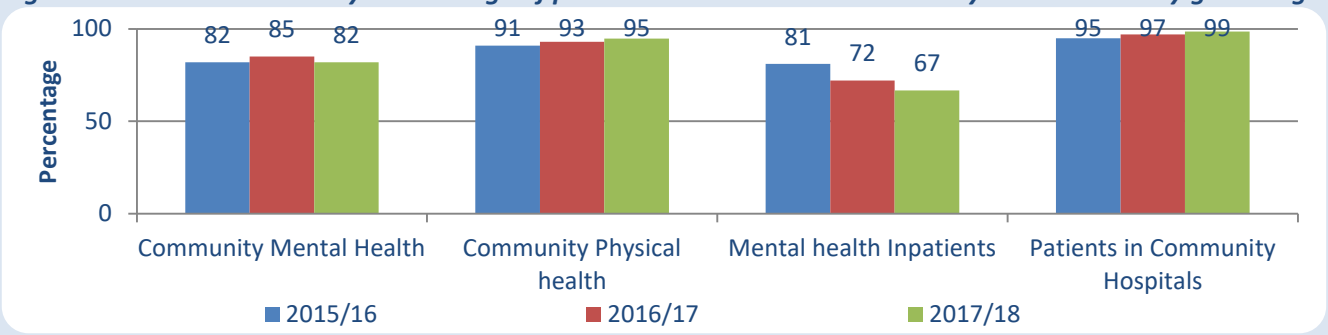
Trust Patient Satisfaction Survey

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

Figures 7 and 8 below demonstrate the Trust's performance in relation to this survey.

The figures show that in 2017/18, 82% or more respondents rated the service they received from Trust community mental health services, community physical health services and community hospitals as good or very good. 67% of mental health inpatients responding gave a rating of good or very good, but this figure is based on a small numbers of respondents (6).

Figure 7- Trust Patient Survey: Percentage of patients who rated the service they received as very good or good.



Source: Trust Patient Experience Report

Figure 8- Trust Patient Survey- total number of responses

Survey and Service	2016/17			2017/18		
	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	1254	1067	85	1203	985	82
Community Physical Health	9228	8544	93	12193	11559	95
Mental Health Inpatients	271	196	72	6	4	67
Patients in Comm. Hospitals	622	601	97	341	336	99

Source: Trust Patient Experience Reports

The Patient Leadership Programme

The Patient Leadership Programme aims to establish a group of people that have received training and support to work with us to design and improve patient services.

Patient Leaders are engaging with the Quality Improvement team and work around improving access to activities in the community for carers in Bracknell.

The Trust are proactively co-facilitating the Patient Leadership Programme with the Royal Berkshire Hospital who have led the training and are looking at opportunities for patient leaders to be involved in projects across both Trusts.

Learning from Complaints and Compliments

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

Figures 9 and 10 below show the number of complaints and compliments received by the Trust.

There were a total number of 209 formal complaints received in 2017/18 and this is the same as the number of complaints received in 2016/17.

Community Mental Health Teams (CMHTs)/Care Pathways received the highest number of formal complaints during 2017/18 (44 complaints in total) and these accounted for 22 % of the total complaints received by the Trust. In comparison CMHTs received 32 total complaints in 2016/17 and 30 in 2015/16. Care and treatment remains the main theme of complaints across the CMHTs, accounting for half the complaints received.

The community inpatient wards have seen a reduction in formal complaints from 17 in 2016/2017 to 11 in 2017/2018.

Child and Adolescent Mental Health Services (CAMHS) have seen an increase in formal complaints from 18 in 2016/2017 to 26 in 2017/2018. The majority of the complaints received relate to care and treatment. Three of the twenty six complaints received in 2017/2018 involved waiting times. There has been work undertaken in the system to address this issue and maintain a better position going forward, with more effective communication with young people and families about the wait times.

Crisis Resolution and Home Treatment Teams (CRHTT) received 20 complaints in 2017/2018, one fewer than the previous year. Care and treatment, communication and attitude of staff are the main themes of complaints received, and this aligns with the main themes for all complaints received.

All of our mental health inpatient wards are based at Prospect Park Hospital in Reading. During 2017/18, the mental health inpatient wards received 25 complaints. Care and treatment was the main theme of the complaints received, making up 68% of these complaints. There are no other emerging themes. There were fewer complaints about our older person's inpatient wards (Orchid Ward and Rowan Ward).

There were no formal complaints received about community or inpatient Learning Disability Services in quarters three and four of 2017/18.

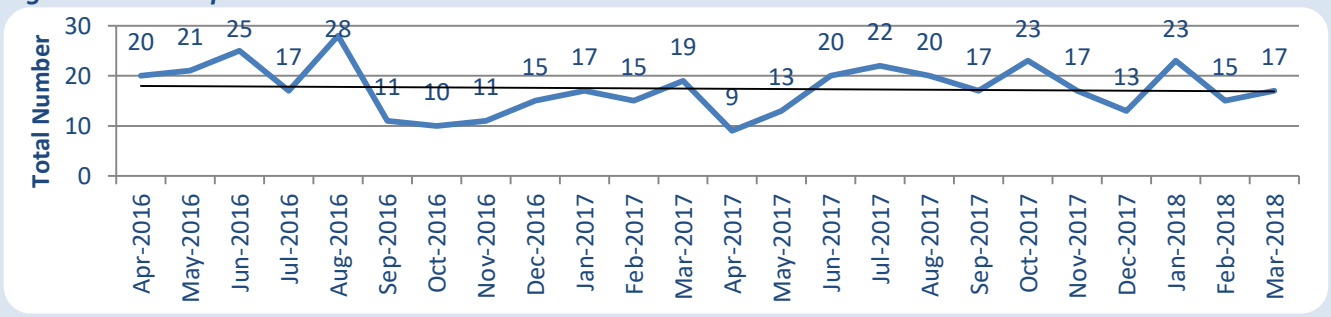
All services review the findings from complaint investigations and these are discussed in the locality patient safety and quality meetings with actions identified and monitored to affect positive change. This information is also available via real time dashboards accessible to both the Locality and Clinical Directors.

During 2017/18 the Trust achieved a complaints response rate of 100% within the timescale agreed with the complainant. In addition, 100% of new complaints were acknowledged within three working days.

The average number of days taken to resolve formal complaints during quarter four for 2017/18 was 24. This represents an increase from 18 in quarter three, and a decrease from 25 in quarter two and 27 in quarter one of 2017/18. This remains a significant decrease in comparison with 33 days in quarter three of 2016/17.

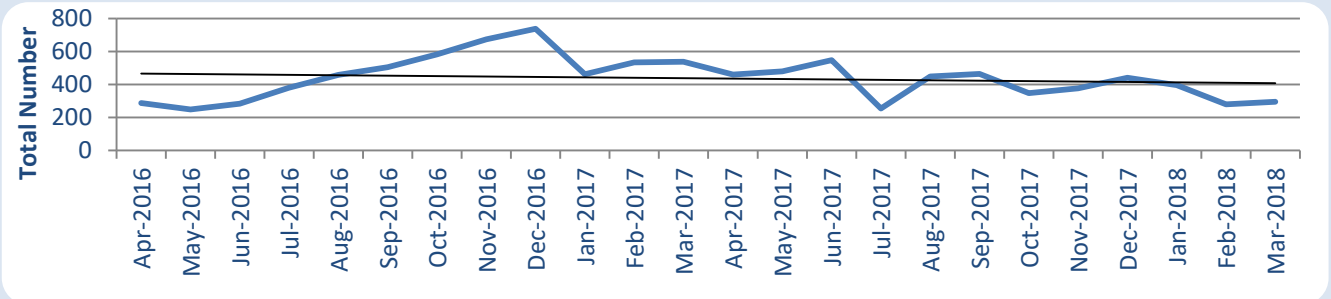
The Trust uses complaints to help inform service improvements, some of which are detailed later in this report. Please also note that the number of complaints, together with response and resolution times is included within section 3 of this report as they are indicators of quality.

Figure 9- Complaints received



Source: Trust Complaints Report

Figure 10- Compliments received



Source: Trust Compliments Report- this is based on compliments being submitted voluntarily by services

National NHS Community Mental Health Survey 2017

ⓘ The National Community Mental Health Survey is an annual exercise 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 2017 National Community Mental Health Survey were published in November 2017.

The Survey Sample. Patients were eligible to receive and respond to this survey if they had been seen by Community Mental Health Services between 1st September 2016 and 30th November 2016. Surveys were sent to 850 people meeting this inclusion criteria, with responses received from 241 of them (29%). This is an increase in the Trust response rate from 27% in the 2016 survey, and above the 2017 survey national rate of 26%.

About the Survey and how it is scored. The 2017 survey contained 36 questions organised 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 indicated that the Trust score was not significantly different than average for that question, with a green score indicating that the Trust scored better and a red score worse.

Summary of Trust results. The Trust scored amber (about the same as other Trusts) across all sections of the 2017 survey- the same as in the 2016 survey. The Trust also scored amber across all questions in the 2017 survey, with the exception of two questions:

- Organising your care: Do you know how to contact this person (the person who is in charge of organising your care and services) if you have a concern about your care? Trust Score- Amber/ Green.
- Changes in who people see: What impact has this had on the care you receive?
  Trust Score- Green, the highest score of all Trusts for this question.

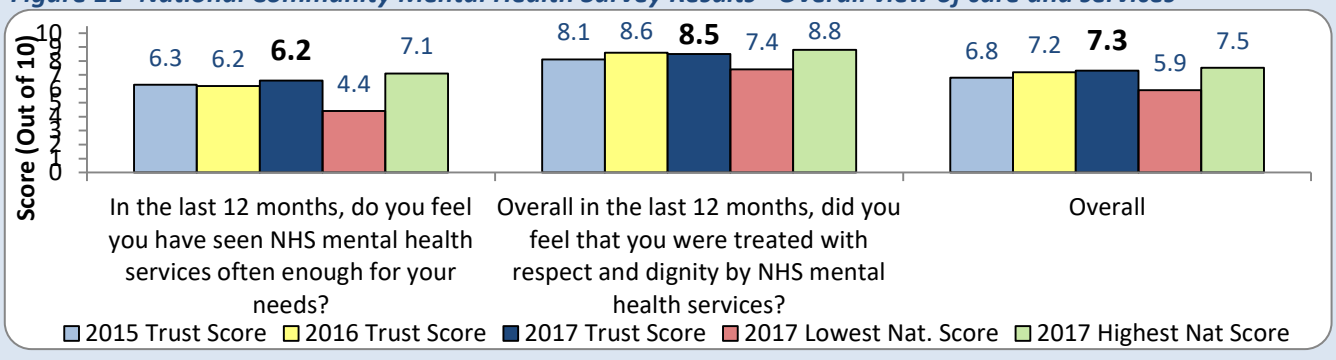
In addition, there has been an improvement in Trust scores relating to contacting the crisis team, where the Trust scored in the red range in the 2016 survey, but improved to the amber range in the 2017 survey.

Respondents' overall view of care and experience. Figure 11 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 2017 Trust scores (shown by the dark blue bar in the middle of the chart) are compared with the highest and lowest scores achieved by other Trusts in 2017 (the red and green bars), and with the comparable Trust score in both 2015 and 2016 (the light blue and yellow bars).

These results are to be shared with the Community Mental Health Teams and the wider organisation. An analysis of the Trust reports and an associated action plan has been produced to be made available to our commissioners as part of our Quality Schedule.

The overall Community Mental health score for the Trust is also included within section 2.4 of this report as it is a core indicator.

Figure 11- National Community Mental Health Survey Results - Overall view of care and services



Source: National Community Mental Health 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 staff work in. Regardless, NHS patients should be treated in a safe environment and be protected from avoidable harm.

Our 2017/18 Patient Safety Priorities:

1. To drive quality improvement through the use of improvement methodology and supporting innovation
2. To continue implementing the Zero Suicide initiative, working to achieve a 10% reduction in numbers of people known to us taking their own lives by 2021
3. To provide 'Harm Free Care' in relation to two specific aspects of our community health services:
   - To continue to improve on the prevention and reduction of pressure ulcers developed due to a lapse in our care during the year, maintaining the level of performance against current indicators
   - To continue to achieve low numbers of falls on our older people's inpatient wards (less than eight per 1000 bed days)
4. Responding to people's needs for both physical and mental health care through prioritising support to stop people smoking in our inpatient mental health services and developing psychological support for people with long term physical health problems through our talking therapies service (IAPT)

Throughout the year, the Trust's aim has been to foster an environment where staff members can be 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 2017/18. 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 and information relating to the Duty of Candour are also documented within this section. Further information on Trust patient safety thermometer metrics, including those relating to various types of harm, are included in Appendix D.

"I took my mother to the 'Falls Clinic' where the staff were not only efficient and diligent but kind and humorous. Her wonderful doctor and nursing team and physiotherapist did a complete range of tests on her and took their time to listen. We both felt she couldn't be in better hands and are very grateful. Thank you St Mark's.

From a relative of a patient- Mobility and Falls Service - St Marks Hospital, Maidenhead

The Trust Quality Improvement Programme

ⓘ The Trust introduced an organisational Quality Improvement (QI) Programme in 2017/18 as part of its commitment to achieve an 'Outstanding' rating by the CQC. This programme will enable a consistent approach to continuous improvement across the whole Trust and will be achieved by introducing new techniques, education, tools and training that focus on what patients value most.

The Trust Quality Improvement Programme was launched by the Chief Executive in April 2017 and has continued throughout the year.

As part of the programme, the Trust commissioned a partnership of KPMG, Thedacare (a world leader in healthcare improvement) and Western Sussex Hospitals to help develop new ways of working. This has been achieved in a variety of ways, including introducing new techniques, education, coaching tools and training. Staff have been trained in new Quality Improvement techniques, with many invited to take part in improvement events and workshops.

A Head of Quality Improvement, together with five Quality Improvement Practitioners have been appointed from inside the Trust to help drive and sustain the programme in the long term, and to build capacity and capability.

Ultimately, the Trust wants to provide all staff with the right support, knowledge and skills to give them the confidence to make changes and take away the frustrations that stop them focusing on the important parts of their job which really make a difference to patient care and experience. The Trust also wants to empower staff to solve problems rather than wait for the managers to do so.

Workstream Updates.

The work required to set in motion and sustain Quality Improvement throughout the Trust is set out in four workstreams. These are currently being progressed by the Quality Improvement Team, and a summary of progress against each of these at the end of 2017/18 is given below.

1. **Strategy Deployment**
   Identifying a small number of strategic priorities and cascading these through the organisation

The development of a mechanism for prioritising Trust projects continues. The aim of this is to ensure that all Trust projects are aligned to where the Trust wants to be (the "True North" direction of the Trust) and that they do not overburden the workforce

2. **Quality Management and Improvement System (QMIS)**
   A management system that aligns performance and daily improvement to the Trust's strategic goals.

QMIS training has been introduced to two cohorts of staff with a third cohort starting the training in Quarter 4 of 2017/18. Training for senior leaders also started from Quarter 4 of 2017/18.

3. **Improvement projects**
   Making improvements in areas that are too complex to be resolved through daily continuous improvement techniques

A project has been initiated to develop an end-to-end pathway for some of our most challenging mental health patients, including those with non-psychotic personality disorder. Detailed process maps for each part of the pathway have been produced that outline clinical detail and the process to follow. The design of the new clinical pathway has been co-produced with service users. Work has also been undertaken with the finance team looking at the resource required for the implementation of the future pathway.

4. **Quality Improvement office**
   Ensuring structured accountability, support and dedicated resources are in place for improvement activity. Developing capabilities for improvement across the Organisation

The QI Team have developed the training material provided by KPMG to make it more interactive and engaging, and are developing a Trust-wide training strategy. In addition, the QI team are working on the roll-out of QI over the next 2 years. The Head of Quality Improvement is also working closely with the Global Digital Exemplar programme team.

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 Trust Zero Suicide programme was initiated in 2016. Four areas were prioritised to achieve the Trust vision, and these are based on the best available evidence, Trust values, data from Serious Incidents (SIs), staff feedback and resources:

- Leadership
- Optimising systems (RiO patient management system, use of data and audit)
- Training
- Support for service users, staff and families

The initial action plan focussed on the development of risk documentation that incorporated a risk summary, risk management plan and safety plan. The aim was to provide staff with the tools to assist them with their engagement and assessment. A programme of work and development of resources to assist with implementation was successful and this system is now fully operational. Monitoring was improved through the production of a suicide surveillance dashboard which also helped to inform learning and training.

Building upon the progress made in 2016/17, the Trust then focused on the following goals during 2017/18:

1. To achieve a 10% reduction from the 2015/16 baseline rate of suicides of people under Berkshire Healthcare NHS Foundation Trust mental healthcare by 2020/21.
2. To demonstrate an increase in positive staff attitude and a proactive approach to suicide prevention.
3. To develop an optimised RiO clinical record system for recording risk
4. To ensure families, carers and staff feel supported and know where they can get specific support after a suicide.

Progress made against each of these goals during the 2017/18 year is detailed below.

Goal 1: A 10% reduction from the 2015/16 baseline in suicides of people under Berkshire Healthcare NHS Foundation Trust mental healthcare by 2020/21.

Figure 12 below shows the yearly rate of suicides per 10,000 people under Trust mental healthcare. The 2015/16 rate was 9.2 per 10,000 people under Berkshire Healthcare NHS Foundation Trust mental healthcare, and whilst the Trust have met the 10% target reduction it is important to view this over a sustained period given the very small numbers and recognising the natural peaks and troughs in suicide rates.

Figure 12- Number of suicides per 10,000 people under Berkshire Healthcare NHS Foundation Trust Mental Healthcare

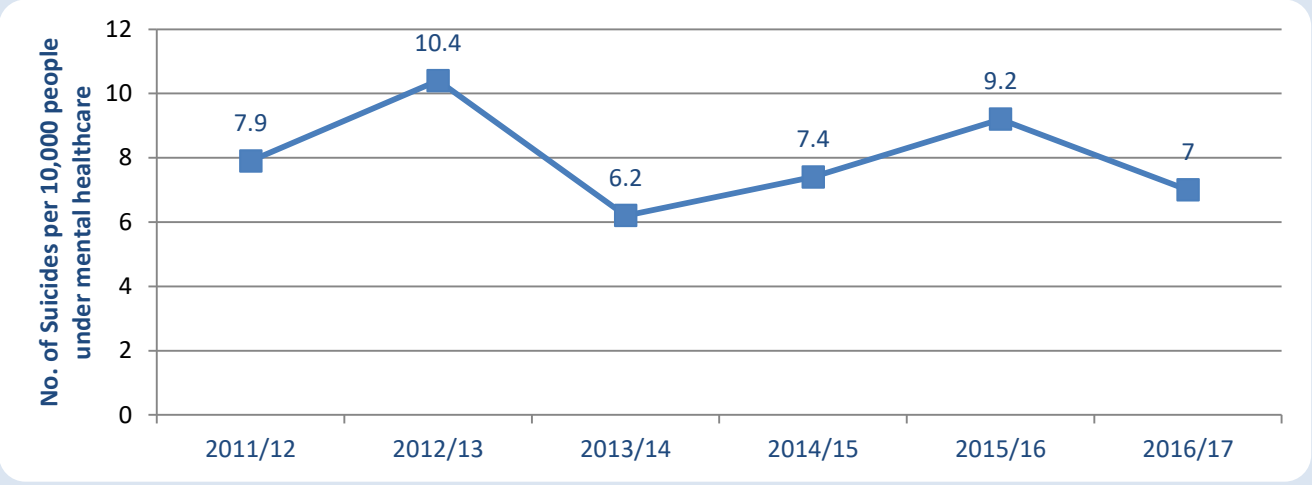
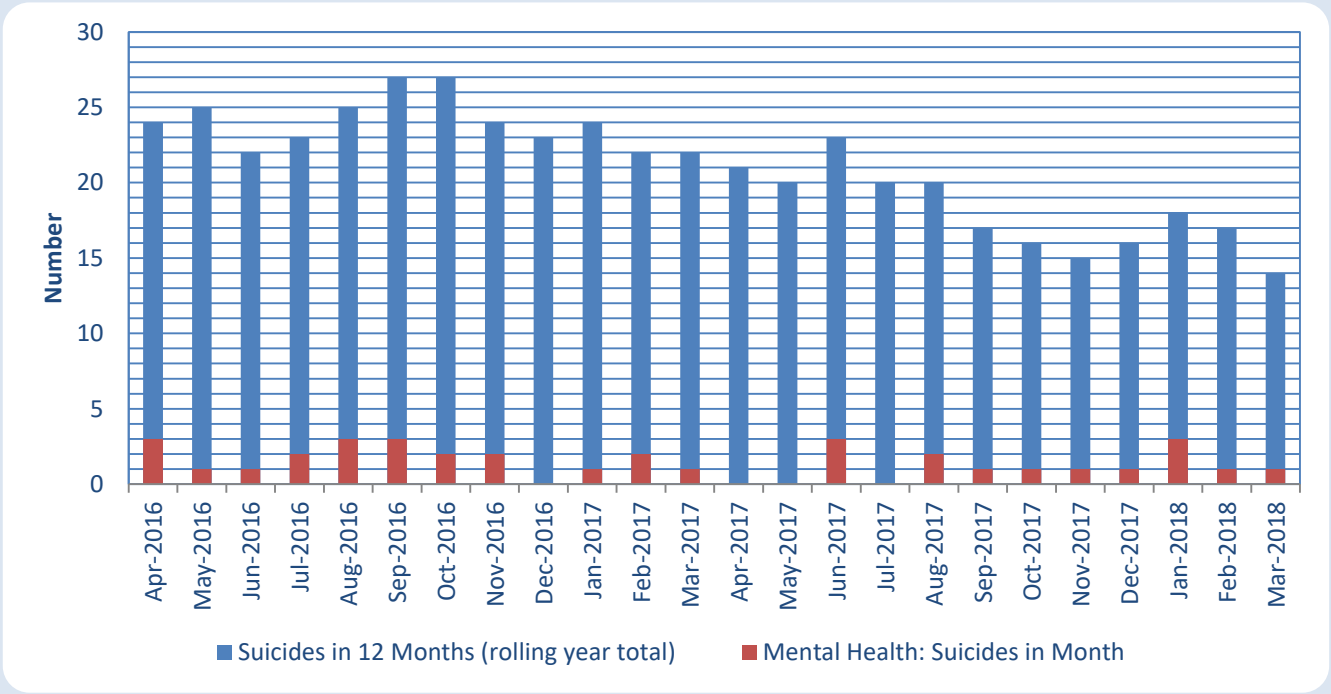


Figure 13 below shows the number of suicides of patients under Trust mental healthcare reported per month since April 2016. The rolling year total is also shown.

Figure 13- Suicides of patients under Berkshire Healthcare NHS Foundation Trust mental healthcare Number per month and rolling year total per month



Source: Trust Performance Assurance Framework

Goal 2: To demonstrate an increase in positive staff attitude and a proactive approach to suicide prevention

It is the aim of the Trust that staff will report an increase in confidence and competence in suicide prevention. This will be achieved through delivery of updated and improved suicide prevention and awareness training. Current training includes:

- Mandatory clinical risk one day induction training and mandatory monthly smart risk training. All materials for these courses have been updated based on evaluations, feedback and dashboard data
- A 3-day suicide awareness course
- Bespoke team training delivered in 1-2 hour workshops using incident data and near miss information from across the Trust and wider
- Specialist training modules
- Safety plan training sessions

The 3-day suicide awareness course continues to be well attended and evaluated. It has also been possible to see that those completing the training are more likely to achieve compliance with risk audit standards (detailed in Goal 3). New materials have been devised to focus on safety planning and learning from Serious Incidents, and the safety planning aspect will be the focus for improvement going forward

Figure 14 below shows the number of participants undertaking suicide prevention related training courses during 2017/18.

Figure 14- Suicide prevention training undertaken during 2017/18

Training description	Number of staff undertaking training during 2017/18
3-day suicide awareness training	139
Crisis intervention training	21
Bespoke crisis telephone training	17

The extent of the change in confidence and competence of staff in suicide prevention will be measured with reference to the results of the Trust Zero Suicide Workforce Survey, the first of which was undertaken in April 2017. Figure 15 below details some of the results of this survey. The Trust will not be undertaking this survey again until May 2018 due to the demand on the Zero Suicide Workforce Survey, which is an international database. Improvement will be measured once this survey has been undertaken again.

Figure 15- Trust Zero Suicide Workforce survey results relating to confidence of workforce- 2017

Respondent Group	Question	Total number responding to this question	Respondents that agreed or strongly agreed with statement	
			Number	%
All Respondents (Includes those working in clinical, managerial, support and admin roles, in both an inpatient and/or outpatient setting)	I have the knowledge and training needed to recognise when a patient may be at elevated risk for suicide	593	407	69%
	I am confident in my ability to respond when I suspect a patient may be at elevated risk of suicide	592	437	74%
Respondents that stated they are responsible for conducting screenings of suicide risk	I have the knowledge and skills needed to screen patients for suicide risk	263	246	94%
	I am confident in my ability to respond when I suspect a patient may be at elevated risk of suicide	263	234	89%
Respondents that stated that they are responsible for conducting suicide risk assessments for patients who screen positive for suicide risk	I have the knowledge and skills needed to conduct a suicide risk assessment.	246	221	90%
	I am confident in my ability to conduct a suicide risk assessment.	246	213	87%

Goal 3: To develop an optimised RiO clinical record system for recording risk

The Trust implemented a new risk summary at the beginning of January 2017. This 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 summary was launched alongside a range of user guides, frequently asked questions and a new policy and standard operating procedures.

The implementation of this risk summary has been measured using a new qualitative audit system that looks for evidence that the risks and needs of the individual have been accurately captured through genuine engagement and that a collaborative plan is in place to manage any modifiable risks.

The risk audits continue to show a steady improvement and the focus will now be to ensure that that safety plans are in place and on the quality of the safety planning. The audit has been revised to capture this work.

Goal 4: Families, carers and staff will feel supported and know where they can get specific support after a suicide.

A support leaflet has been developed for families and carers, and 'Help is at Hand' material is provided to all families as part of the Trust's Duty of Candour. In addition, face-to face support is also provided and a support after suicide psycho-educational intervention has been developed and is being tested.

Carer training on suicide awareness, mental health first aid and also Zero Suicide has been made available, with six carers have undertaken Mental Health First Aid training. Zero Suicide online training has also been well received. The Trust has no way of knowing the exact number of Trust participants undertaking this online training, but as of April 2018 6453 people have completed the course overall. Each person completing the training will be provided with the skills they need to approach situations where they may encounter someone with suicidal thoughts. They will also be supported to better understand and be able to help anyone expressing suicidal thoughts or behaviours.

The Trust have secured the screening of the film 'Suicide- the ripple effect' in Camberley on 25th April 2018. In this film Kevin Hines shares his journey in relation to his suicide attempt. He is also filmed meeting with families and survivors all over the world.

As summarised under Goal 2 above, a range of support is available for staff, and a leaflet summarising this has been devised. This information is also included in the induction guide for staff. In addition, permission has been given to the Trust to utilise the resources of PAPYRUS, a national charity for the prevention of young suicide.

The extent to which staff feel that they are supported is being measured with reference to the results of the Trust Zero Suicide Workforce Survey, the first of which was undertaken in April 2017. Figure 17 below details some of the results of this survey. The Trust will be undertaking this survey again in May 2018, at which point improvement will be measured.

Figure 17- Trust Zero Suicide Workforce survey results relating to support to workforce- 2017

Respondent Group	Question	Total number responding to this question	Respondents that agreed or strongly agreed with statement	
			Number	%
All Respondents (Includes those working in clinical, managerial, support and admin roles, in both an inpatient and/or outpatient setting)	This organisation provides me access to ongoing support and resources to further my understanding of suicide prevention.	602	356	59%
Respondents Who Reported that they interacted with a patient who ended his/her life by suicide.	I felt supported by this organisation when a suicide occurred.	256	128	50%

In 2018/19, the programme of work will focus on the following:

- To continue supporting those in a leadership role in promoting the message that suicide is preventable, supporting their staff and teams to develop suicide awareness and ensuring we have a "no blame" culture that focuses on learning from incidents.

- To continue working on ensuring those who are under the care of secondary mental health services are offered a robust safety plan and that this is collaborative and shared with other stakeholders as appropriate. The Trust have recruited two peer volunteers to work on our inpatient wards to assist with this work.

- As well as providing support for service users and our staff, the Trust will keep a focus on involving and supporting carers.

Pressure Ulcer Prevention

ⓘ Pressure ulcers, sometimes known as 'bed sores' or 'pressure sores', are damage to the skin and underlying tissues caused by pressure or pressure and friction. They can range in severity from a red patch or blister to a complex open wound. Pressure ulcers are graded from 1 (superficial) to 4 (most severe).

The aim of the pressure ulcer prevention priority during 2017/18 was 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 was to demonstrate continuing improvement during the year, maintaining the level of performance against current indicators on pressure ulcers that have developed following a lapse in care by Trust staff.

Current interventions to ensure sustained best practice include completion of a pressure ulcer risk assessment. Waterlow and Malnutrition Universal Screening Tool (MUST) scores are completed on admission and, together with the patient's clinical condition, inform the development and implementation of an appropriate care plan, advice and education to minimise the risk. From April 2016, 'avoidable' pressure ulcers are referred to as Lapse in Care (LiC) and 'unavoidable' as Appropriate Care Given (ACG)

Progress against this priority has been monitored throughout 2017/18 using the following metrics, the results of which are detailed in the figures below:

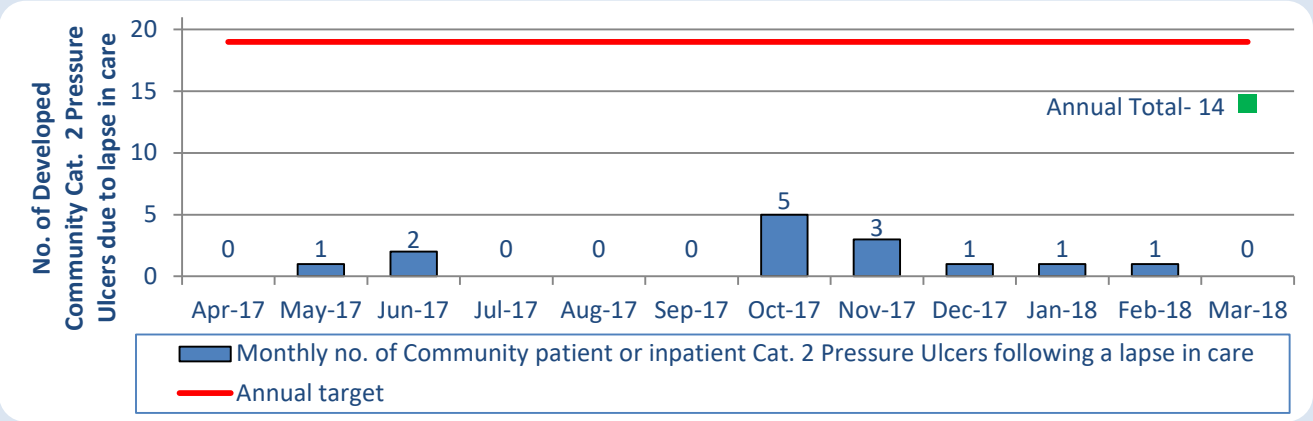
1. To achieve fewer than or equal to 19 community patients or inpatients annually developing Category 2 pressure ulcers which occurred following a lapse in care from Trust staff.
2. To achieve fewer than or equal to 9 community patients or inpatients annually developing Category 3 and 4 pressure ulcers which occurred following a lapse in care from Trust staff.
3. To monitor Trust point prevalence of new pressure ulcers as reported in the Classic Safety Thermometer

The charts below show that, during 2017/18, the Trust has kept below the target of 19 community patient or inpatient category 2 pressure ulcers following a lapse in care (LiC) by Trust staff. However, the Trust has exceeded the target of 9 category 3 and 4 pressure ulcers following a lapse in care by Trust staff (this does not necessarily mean that the pressure ulcer would have been prevented).

Focussed work as part of the Trust's wider quality improvement programme is being undertaken and learning events are continuing for every developed Category 3 and 4 pressure ulcer in the community with a potential lapse in care, and all pressure ulcers category 2 and above that have developed on our inpatient wards. These are positive events that are well attended by clinicians and supported by a senior manager and specialist Tissue Viability Nurse who are all engaged in looking for opportunities for improvement. There are processes in place to ensure local actions are undertaken and any learning is shared with wider teams. All teams have identified pressure ulcer champions who attend a quarterly forum. This provides support to their wider teams, however the workforce pressures on teams is considered to be attributing to the increase in developed pressure ulcers where there is an identified lapse in care.

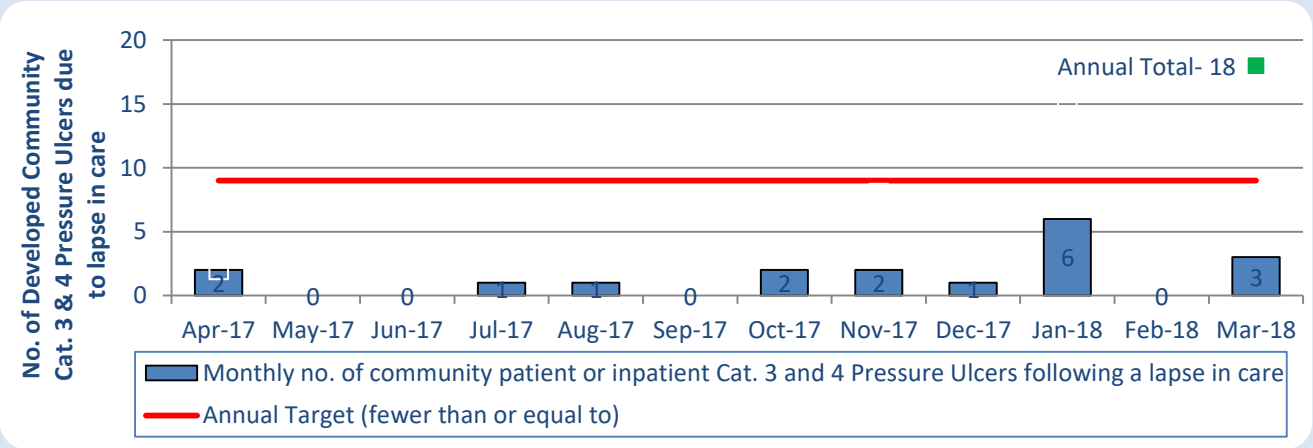
The numbers shown are subject to change as the investigation of some incidents is in progress and are subject to confirmation following the learning event.

Figure 18- Number of developed community patient or inpatient Cat. 2 pressure ulcers which occurred following a lapse of care from Trust staff. Target- Less than or equal to 19



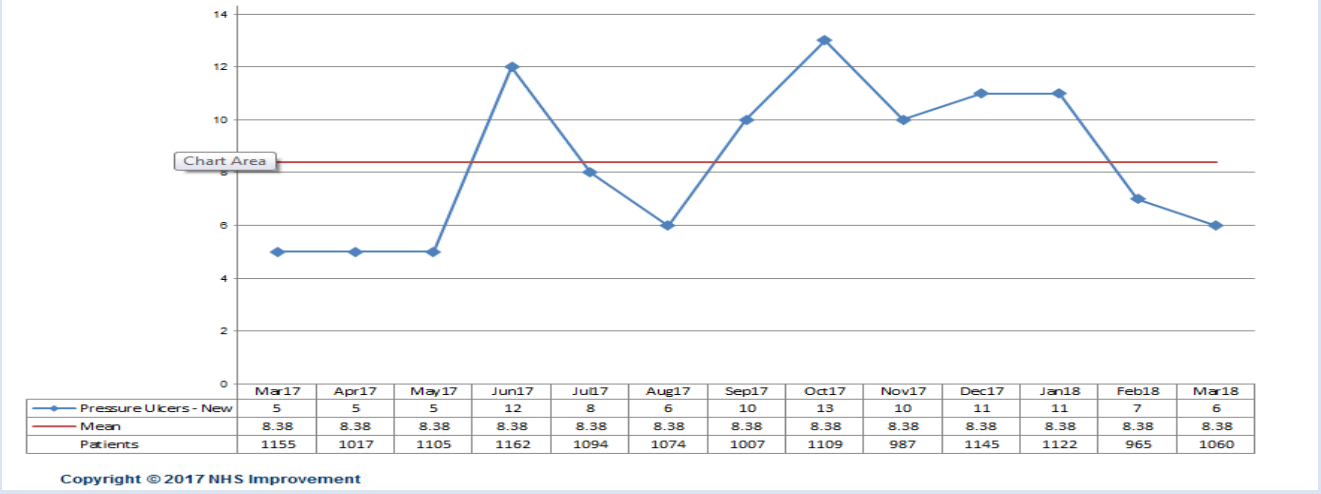
Source: Trust incident data (Datix) based on finally approved incident

Figure 19- Number of developed community patient or inpatient Cat. 3 and 4 pressure ulcers which occurred following a lapse of care from Trust staff. Target: Less than or equal to 9



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

Figure 20- Point prevalence of new pressure ulcers (all developed Pressure Ulcers for the Trust recorded at a specific point in time each month*)



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 on older peoples inpatient wards

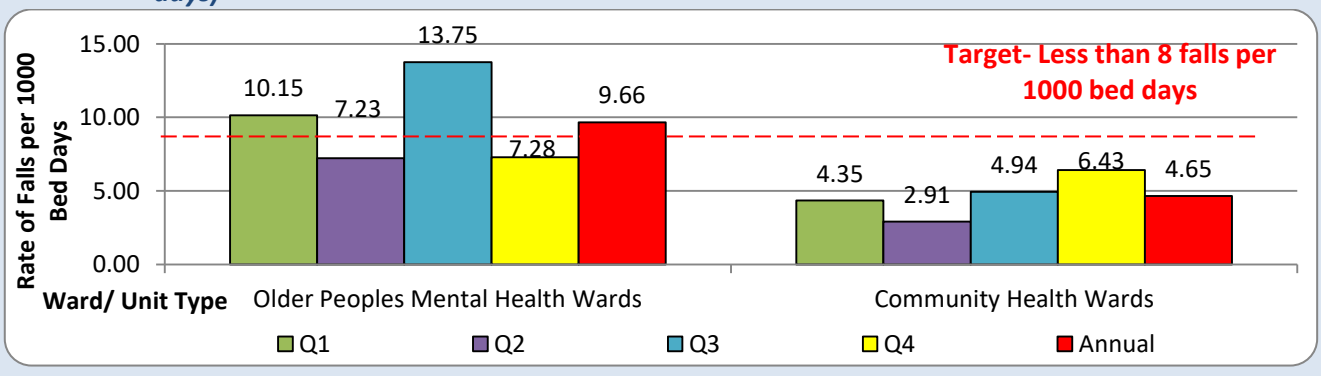
ⓘ The Trust considers prevention of falls a high priority. The Royal College of Physicians report that falls are the most commonly reported type of patient safety incident in healthcare. Although most people falling in hospital experience no or low physical harm (such as minor cuts and bruises), others 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 2017/18, the Trust aimed to continue to achieve low numbers of falls experienced by inpatients on older people's inpatient wards (less than 8 per 1000 bed days). The Trust Falls Strategy was written and ratified in the autumn of 2015 in response to the recognition that its falls focus and assessments were not standardised across all its 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 the control of the Trust (e.g. co-morbidity) but equally the Trust can learn from many of the reasons people fall, and change practice.

During this year the Trust has worked closely with the Oxford Academic Health Science Network (OAHSN) across the Thames Valley to implement evidence-based ways of reducing falls in its services. This includes implementing the Royal College of Physicians FallSafe care bundles, which involves the analysis of falls data on each ward, completing a gap analysis and then identifying suitable care bundles to implement on each ward to reduce falls. Work is in progress to add the falls paperwork to the RiO risk summary on the patient record used on the Older People's Mental Health (OPMH) wards, and once that is done the Trust will resume the FallSafe work on Rowan and Orchid Wards (older people's mental health wards at Prospect Park Hospital) with the Oxford AHSN.

Progress against this priority was monitored by analysing the number of inpatient falls against a target of no more than 8 per 1000 bed days. Figure 21 below shows the Trust's performance against this target, together with the total number of falls. The figure shows that the target rate has been met for Community Health Wards but not for Older Peoples Mental Health (OPMH) Wards. Both of the Trust's OPMH Wards are undertaking Quality Improvement Training (QMIS) and have selected falls as their driver metric. They will be using and analysing their falls data to understand the root cause of falls on the wards and will introduce a number of countermeasures over the coming months using Plan Do Study Act (PDSA) methodology. In addition to this Rowan Ward (an Older People's Mental Health Ward at Prospect Park Hospital) are trialling 2 different assistive technologies to help staff monitor patients at risk of falls.

Figure 21- Rate of falls per 1000 bed days- Split by Ward Type (Target- less than or equal to 8 per 1000 bed days)



Number of Falls in 2017/18	Q1	Q2	Q3	Q4	Total
Older Peoples Mental Health Wards	26	18	37	19	100
Community Health Wards	57	39	63	86	245

Please note- patients may fall more than once, and this table represents the total number of falls, not the total number of individual patients that have fallen

Responding to people's needs for both physical and mental health care

ⓘ As a provider of both community and mental health services, the Trust is in an ideal position to deliver holistic services to individuals which assess and respond to their physical and mental health needs. As a result of this, the Trust prioritised support to help people stop smoking in our mental health inpatient services, as well as developing our psychological support for people with long term physical health problems through Talking Therapies.

Targeted smoking cessation for mental health inpatients

The Trust is committed to enhancing the quality of life of its patients. To this end, targets were set as part of the Commissioning for Quality and Innovation (CQUIN) programme and Quality Schedule relating to targeted smoking cessation for mental health inpatients. 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.

For the CQUIN target, the sample included all unique adult mental health inpatients admitted during 2017/18 (i.e. if a patient was admitted in both Quarter 1 and Quarter 2 of 2017/18, then they were excluded from the Quarter 2 analysis).

For the quality schedule the sample included 25 patients, from which patients who smoke were identified and assessed against the audit criteria.

The table below details the Trust's performance against these targets. Actions have been put in place to address where criteria are not being met and include reminding ward staff to complete RiO documentation correctly and to follow and complete the admission protocol accurately. This will be supported by the ward managers. In addition, the Drug and Alcohol Lead will continue to support, educate and mentor staff to ensure patients are being asked throughout their admission whether they would like Nicotine Replacement Therapy (NRT) and/or referral to smoking cessation groups.

Figure 22- Trust performance in relation to targeted smoking cessation for mental health inpatient metrics

Quality Reference and Requirement	Target	Quarter	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4
		Patients Audited	223	204	142	134
CQUIN 9a- Percentage of unique adult patients who are screened for smoking status AND whose results are recorded.	90%	% of patients meeting requirement	**100%**	**96%**	**94%**	**94%**
CQUIN 9B- Percentage of unique patients who smoke AND are given very brief advice	90%	% of patients meeting requirement	**92%**	**96%**	**93%**	**83%**
CQUIN 9C- Percentage of unique patients who are smokers AND are offered referral to stop smoking services AND offered stop smoking medication.	30%	% of patients meeting requirement	**92%**	**76%**	**73%**	**61%**
Quality Reference and Requirement	**Target**	**Patients Audited**	**25**	**25**	**25**	**25**
		Pts identified as smokers	**12**	**12**	**10**	**7**
Quality Schedule- Percentage of eligible patients who are identified smokers and are offered Nicotine Replacement Therapy (NRT) within 2 hours of admission	95%	Number and % of patients meeting requirement	**11/12 (92%)**	**7/12 (58%)**	**8/10 (80%)**	**7/8 (88%)**
Quality Schedule- Percentage of those patients who have consented to Nicotine Replacement Therapy (NRT), and where this therapy is commenced within 2 hours of admission	95%	Number and % of patients meeting requirement (of those consenting to NRT)	**6/7 (86%)**	**0/4 (0%)**	**2/5 (40%)**	**½ (50%)**

Source: Trust CQUIN and Quality Schedule Reports relating to Smoking Cessation for Mental Health Inpatients

Improving Access to Psychological Therapies (IAPT) - Long Term Conditions (LTC) expansion across Berkshire 2017/18

The Improving Access to Psychological Therapies (IAPT) service in Berkshire, known as 'Talking Therapies', is a nationally recognised highly performing service. This service was awarded an NHS England/Clinical Commissioning Group (CCG) grant to become an Early Implementer Integrated IAPT-LTC pilot site: two (one in East Berkshire and one in West Berkshire) of 22 nationally.

The initial tranche of funding has secured the staff resources to build up the new integrated service from the pre-existing IAPT service. The new service has focussed on chronic obstructive pulmonary disease (COPD), asthma, diabetes, cardiac conditions, and Medically Unexplained Symptoms (MUS). Ongoing funding is required from the CCG's in 2018/19 to secure staff resources to meet the Five Year Forward view to increase access to IAPT treatments for people with an anxiety and depression diagnosis alongside a physical health condition.

Initial service user satisfaction scores have been above 94% and treatments have yielded a 55% recovery rate (against a target of 50%). Reduced A&E attendance by IAPT-LTC service users has also been demonstrated.

In Berkshire, the new staff have completed specialist training and have started integrating within practice surgeries and running drop-in sessions for surgery patients. The focus is on treatment for patients with co-morbid presentations and those who are frequent attenders and high users of surgery resources. The limited results available to date are encouraging from both a patient quality and cost reduction perspective.

Work continues with specialist nurses to integrate the service into rehabilitation clinics and education sessions for patients with diabetes, Chronic Obstructive Pulmonary Disease (COPD) and heart failure. Members of the psychological therapies team are attached to more than 10 surgeries to date and are also integrated with specialist nurses.

Psychological training, known as PiPP care and 10 minute Cognitive Behavioural Therapy, has been delivered to over 100 health professionals to date and a mental resilience module has been developed and offered to practice staff at all levels.

The new IAPT-LTC service is collecting routine activity and outcome data and is also taking part in a national and Thames Valley wide health utilisation evaluation study due to report in September 2018 in conjunction with the Academic Health Science Network and Oxford University.

New and innovative service developments resulting from this funding have also included the Psychological Interventions in Nursing and Community services (PINC) project, developed out of a Royal Borough of Windsor and Maidenhead pilot, which offers a psychological programme to community nurses and patients to help improve management of selected patients' physical and mental health needs. This service has supported treatment of painful on-going conditions and patients with agoraphobia, for whom the treatment resulted in successful re-integration into healthy, independent life in the community.

Another initiative has seen the extension of HealthMakers from Bracknell into Slough and Windsor, Ascot and Maidenhead under the management of Talking Therapies within Berkshire Healthcare. HealthMakers are a group of volunteers with long term health conditions that provide peer support to others managing their long term health conditions. So far, HealthMakers have made a difference to the lives of people in Bracknell by acting as patient peers and facilitators who work closely with local health services to improve patient care and quality of life. The service also delivers structured, evidence-based training to help others become HealthMakers and has now established a programme of self-management courses to complement Talking Health.

These initiatives are not only having an impact at a healthcare level but are also enabling the residents of Berkshire to play a more active, safe and supported role in managing their own health conditions with confidence.

Overall the IAPT-LTC team are extending and continuing the work of the established Talking Health team and have demonstrated cost reductions, improvements in physical health markers (e.g. HbA1c) and benefits to the wider health system.

Quality Concerns

ⓘ The Quality Assurance 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 information sources provided in this account, together with intelligence received from performance reports, our staff and stakeholders.

The Trust is currently rated as 'good' overall by the Care Quality Commission (CQC).

Acute Adult Mental Health Inpatient Bed Occupancy
Bed occupancy continues to be consistently above 90%. Patients have high acuity, there is disruption for patients who are on leave with concerns about where they will go on their return and patients are being placed out of area (this increases suicide risk on their discharge). The Chief Operating Officer continues to lead a bed optimisation programme to try and alleviate this pressure. Delayed discharges have stabilised although Sorrel Ward at Prospect Park Hospital has its female beds closed as the ward is being refurbished. The new bed management system is working well and the number of out of area placements is reducing but the pressure remains on local beds.

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 leadership challenges, 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 monitored robustly by Executive Directors.

Shortage of permanent nursing and therapy staff
Mental and physical health inpatient and community services are now affected by shortages of permanent nursing and therapy staff. This has a potential impact on the quality of patient care and experience, and increases our costs. Community nursing services are experiencing significant staff shortages alongside increased demand for care. There are 10 inpatient beds closed in the West of Berkshire due to lack of staff. Prospect Park Hospital has recruited 60 staff since January 2017 which is alleviating the pressure there. A recruitment and retention programme is being developed for community nursing services.

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 has an 'Open Communication (Being Open) a Duty to be Candid' policy that supports our culture of openness when things go wrong. To promote and help embed this policy, face to face training has been provided and there is also a page on our intranet where staff can access information, flow charts and advice.

The Trust 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.

The Trust 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. The Duty of Candour supports the Trust learning from deaths programme detailed in Section 2.3.6. The table below details the total number of incidents requiring formal duty of candour during the year. The trust considers that the Duty of Candour was met in all cases.

Month	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
Incidents with formal DOC	8	8	15	4	6	10	8	14	7	22*	23*	30*

*Q4 increase relates to pressure ulcers detected at time of initiating duty of candour. However, at the time of writing, we do not know if these will be due to lapse in care as this is being investigated. However, most of them will not be due a lapse in care

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 2017/18 Clinical Effectiveness Priorities are as follows:

1. To demonstrate our delivery of evidence-based services by reporting on the implementation of NICE guidance related to Trust priorities identified in this Quality Account
2. To review, report and learn from deaths in line with new national guidance as it is published. Information on learning from deaths is included is included within the 'Statements of assurance from the board' in Section 2.3.6 of this report

Implementing National Institute for Health and Care Excellence (NICE) Guidance related to Trust priorities identified in this Quality Account

ⓘ 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.

Falls in Older people: Assessing Risk and Prevention

To support the falls priority in the patient safety section of this Quality Account, a re-assessment of compliance against NICE Clinical Guideline 161- Falls in Older People- has been undertaken.

This assessment was completed with input from the Trust lead for falls and included a review of 31 NICE recommendations that were deemed to be applicable to the Trust. These recommendations covered the areas of; risk identification and assessment, strength training and exercise, home hazard and safety intervention, psychotropic medications, falls prevention programmes and preventing falls during hospital stays.

The assessment found that the Trust was meeting 29 (94%) of the 31 recommendations.

Areas identified as not meeting recommendations included; the Trust not having a formal strength and balance training programme. However, a strength and balance programme was being piloted in one of the localities, and Trust physios are also available in the community and on wards to give advice.
In addition, NICE does not recommend using a falls prediction tool as a method of assessing patients' risk. However, Trust wards do use a traffic-light assessment tool, but only as the first stage of a more in depth assessment and care planning approach.

Pressure ulcers: Prevention and Management

To support the prevention of pressure ulcers priority in the patient safety section of this Quality Account a reassessment of compliance against NICE Clinical Guideline 179 on Pressure Ulcer Prevention and Management has been undertaken.

This assessment was completed with input from the Trust Tissue Viability Nurses (representing adult community services, adult community inpatient services and Older Peoples Mental Health Services), Children's Services (including Community Children's Nurses, Willow House Adolescent Unit, and Children's Respite Units), and Learning Disability Services.

The assessment included a review of 93 NICE recommendations that were deemed to be applicable to the Trust. These recommendations covered the areas of risk assessment, skin assessment, repositioning, nutritional supplements and hydration,

pressure redistribution devices, care planning, information and training

The assessment found that the Trust was meeting 88 (95%) of the 93 recommendations.

Areas identified as not meeting recommendations included; ensuring that screening and assessment of risk is undertaken on adult mental health inpatient wards. These wards are working with the Tissue Viability Nurses to implement a suitable system to ensure this. In addition, pressure ulcer training and information is being reviewed to ensure that recommendations are being met in these areas.

Service User Experience in Adult mental Health.
To support the patient experience priority in this Quality Account, an assessment of compliance against NICE Clinical Guideline 136 on Service User Experience in Adult Mental Health has been undertaken.

This assessment was completed with input from the Clinical Director and Clinical Lead for Zero Suicide, Inpatient Mental Health Services, Community Mental Health Services, the Common Point of Entry Team and the Crisis Resolution and Home Treatment Team.
The assessment included a review of 89 NICE recommendations that were deemed to be applicable to the Trust. These recommendations covered the areas of access to care, assessment, community care, crisis care, hospital care, discharge and transfer of care and treatment under the Mental Health Act.

The assessment found that the Trust was meeting 81 (91%) of the 89 recommendations.
Areas identified as not meeting recommendations included; waiting times for patients to see a mental health professional once referred (due to demand on services), content of appointment letters and the length of one-to-one time spent with inpatients. These have been highlighted to service leads with action being undertaken to address these findings

Other clinical effectiveness activity, including that relating to service improvements, clinical audit research and learning from deaths, are reported later in this report in Section 2.3- 'Statements of Assurance from the Board'.

2.1.4. Organisational Culture

ⓘ The Trust is committed to acting in line with our values, with a strong focus on delivering services which provide good outcomes for patients and their families. We will listen and respond to our staff and provide opportunities for training and development

Our 2017/18 Organisational Culture Priorities are as follows:

1. To improve on our National NHS staff survey results, with at least 77% of our staff saying they would recommend our Trust as a place to receive treatment
2. To continue delivering our Excellent Manager Programme, providing a strong foundation for all managers in our Trust
3. To continue Values Based Appraisal and Recruitment to ensure that we promote a culture of shared values and related behaviours across the entire organisation
4. To continue the Trust Intelligence Monitoring Group, thus enabling the review of a range of relevant indicators, including incidents, complaints and workforce data. Please see the 'Quality Concerns' paragraph in the patient safety section of this report for further information on this
5. To continue the Trust Freedom To Speak Up programme, ensuring that staff are able to raise concerns in a variety of ways

2017 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 wellbeing. 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.

The Trust took part in the 2017 NHS National Staff Survey between September and November 2017.

The Survey Sample.

The survey was conducted online, resulting in it being open to over 4000 of the Trust's employees, 1,796 (44%) of whom responded. This is slightly lower than the Trust's 2016 response rate of 46% and the 2017 national response rate of 45% for similar Trusts (29 combined mental health, learning disability and community health services Trusts).

Summary of Trust Results.

The survey contained 32 Key Findings. The Trust results were benchmarked against the other 28 similar Trusts and showed:

- Better than average scores for 22 key findings (compared with 20 in 2016), with 6 equalling the best score
- Average scores for 6 key findings (compared with 7 in 2016)
- Worse than average scores for 4 key findings (compared with 5 in 2016)

The Key Findings (KF) where the Trust score equalled the best amongst similar trusts in 2017 were:

- KF4: Staff motivation at work: 4.04 out of 5
- KF7: Percentage of staff able to contribute to improvements at work: 76%
- KF8: Staff satisfaction with level of responsibility & involvement: 3.98 out of 5
- KF6: Percentage of staff reporting good communication between senior management and staff: 47%
- KF3: Percentage of staff agreeing that their role makes a difference to patients: 92%
- KF23: Percentage experiencing physical violence from other staff in the last 12 months: 1%

In addition, the Trust achieved a top 3 score amongst its peers in the following areas:

- Percentage of staff satisfied with the opportunities for flexible working patterns: 63%
- Staff recommendation of the organisation as a place to work or receive treatment: 3.88 out of 5
- Effective team working: 3.93 out of 5
- Recognition and value of staff by managers & the organisation: 3.65 out of 5

The Trust achieved a worse than average score amongst similar trust in 2017 in the following areas:

- Percentage of staff experiencing discrimination at work in last 12 months: 13%– peer avg. 11%
- Percentage of staff working extra hours: 77%- peer avg. 71%
- Percentage of staff/colleagues reporting most recent experience of violence: 83%– peer avg. 88%
- Percentage of staff reporting most recent experience of harassment, bullying or abuse: 53%– peer avg. 57%

The staff engagement score for the Trust in the 2017 survey was 3.93 out of 5, which was an improvement on the 2016 score of 3.91, and is important due to the link between staff engagement and the provision of good quality, safe services. In addition, one of the Trust targets for 2017/18 was for at least 77% of our staff saying they would recommend our Trust as a place to receive treatment. This target was just missed as the 2017 survey results show that 75% of respondents agreed or strongly agreed that they would be happy with the standard of care provided by the organisation if a friend or relative needed treatment. This is the same result as in 2016.

Please note that the overall National Staff Survey score for the Trust is also included within section 2.4 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 23 below details these findings for the Trust, separated into scores for white and black and minority ethnic (BME) staff. The Trust has made positive progress in relation to three of the four survey results during 2017, whilst the score for KF25 (staff experiencing harassment or bullying from patients/ public) is the same as in the 2016 survey. The Trust continues making a consistent and sustained commitment over time to make progress in this area, and have in place a programme of work to achieve this.

Figure 23- Staff survey results relating to the Workforce Race Equality Standard

Description	Race	Trust Scores (%) 2014 (%)	2015 (%)	2016 (%)	2017 (%)	2017 Average (median) for combined MH/LD and community Trusts (29 Trusts)
KF25- Percentage of staff experiencing harassment or bullying from patients / public in the last 12 months	White	21	23	22	22	25
	BME	32	25	27	27	28
KF26- Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	White	19	19	18	18	20
	BME	23	27	26	21	23
KF21- Percentage of staff believing the Trust provides equal opportunities for career progression or promotion	White	88	91	90	89	88
	BME	76	74	68	74	76
Q17b- In the last 12 months have you personally experienced discrimination at work from manager/team leader or other colleagues	White	5	5	5	7	6
	BME	13	14	17	11	11

Source- 2017 National Staff Survey

Figure 24 below details further results from the 2017 staff survey and compares them with the Trust's results in prior years, and the median score for similar Trusts in 2017.

Figure 24- Annual comparison of Trust scores

Question and reference		Trust Score 2015 (%)	Trust Score 2016 (%)	Trust Score 2017 (%)	2017 Average (median) for combined MH/LD and community Trusts (29 Trusts)
Q2a	*I look forward to going to work (often or always)*	67	67	**65**	59
Q2b	*I am enthusiastic about my job (often or always)*	79	79	**78**	73
Q5f	*How satisfied am I that the organisation values my work (Satisfied or very satisfied)*	48	51	**55**	44
Q8c	*Senior managers try to involve staff in important decisions (agree or strongly agree)*	43	43	**47**	34
Q8d	*Senior managers act on staff feedback (agree or strongly agree)*	43	43	**46**	32
Q12a	*My organisation treats staff who are involved in an error, near miss or incident fairly (agree or strongly agree)*	56	60	**61**	53
Q12b	*My organisation encourages us to report errors, near misses or incidents(agree or strongly agree)*	92	91	**92**	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)*	78	78	**78**	68
Q12d	*We are given feedback about changes made in response to reported errors, near misses and incidents (agree/ strongly agree)*	65	67	**68**	60
Q13b	*I would feel secure raising concerns about unsafe clinical practice (agree or strongly agree)*	73	76	**77**	73
Q13c	*I am confident that my organisation would address my concern (agree or strongly agree)*	66	67	**67**	60
Q21a	*Care of patients / service users is my organisations top priority (agree or strongly agree)*	80	81	**82**	72
Q21b	*My organisation acts on concerns raised by patients and service users (agree or strongly agree)*	82	81	**81**	75
Q21c	*I would recommend my organisation as a place to work (agree or strongly agree)*	65	67	**66**	58
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)*	74	75	**75**	67

Source: 2017 National Staff Survey

Excellent Manager Programme

ⓘ The Excellent Manager Programme was launched in 2013 and has proven successful in shifting culture, and engaging and motivating staff. The programme covers a range of managerial capabilities including vital conversations, maximising individual and team performance and leading service development and change.

All existing mangers have been trained and the programme will continue to be delivered to newly recruited or promoted managers and those seeking to progress within the Trust.

One measure of success has been seen in the annual staff survey which has demonstrated year-on-year increases in managers seeking views, manager support, staff feeling valued and engaged and improvement in general communication.

Values Based Recruitment

ⓘ Values based recruitment is a way of assessing candidates' strengths and development needs in relation to the values we are looking for to be successful in a role at Berkshire Healthcare NHS Foundation Trust. A number of assessment methods can be used to assess the candidates' performance against a pre-determined set of behavioural indicators.

Values-based recruitment went live in the Trust in early 2016 and was another important milestone in making real our commitment to our values and behaviours. Because of the involvement of colleagues, the Trust is confident that it has a first class approach that both recruiting managers and candidates will value.

Values Based Appraisal

ⓘ It is the policy of Berkshire Healthcare NHS Foundation Trust that every member of staff has an annual review, incorporating a review of performance against objectives, a review of behaviours against Trust values, setting of new objectives for the coming year and a personal development review and plan

The Trust values based appraisal process matches the values based recruitment process and ensures that Trust values run throughout the organisation and are reinforced. As such, the Trust values are embedded within the appraisal documentation.

In 2017, 96.5% of staff had a values-based appraisal conducted. This exceeded the Trust target of 94%. As a result, the target for 2018 will be increased to 97%.

Freedom to Speak Up

Following a review by Sir Robert Francis, a national 'Freedom to Speak up' policy was developed that contributes to 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's Freedom to Speak Up Guardian role is now fully embedded and staff are aware of this additional resource or avenue to raise concerns.

In the period April 2017 to March 2018 there have been six concerns raised and investigated using the Trust's policy on raising concerns and whistleblowing. All of these cases are now closed, with an average completion time of 51 days against the target of an average 53 days.

The Trust will remind staff of the avenues open to them to raise any concerns they have. If preferred, concerns can be raised anonymously via a dedicated whistleblowing helpline telephone number which is managed by an external Employee Assistance Programme provider.

Compassionate Leadership Programme

The Compassionate Leadership Programme has been developed to support the Trust in becoming a consistently compassionate organisation by 2020. Its aims are to develop motivation to care for ourselves, to inspire and motivate managers and teams to lead with compassion, to develop compassionate charters within teams to enhance team resilience and wellbeing and to enhance compassionate resilience within the workforce

The Compassionate Leadership Programme includes a two-day course on Compassionate Leadership and a one-day Introduction to Compassionate Resilience.

As at the end of 2017/18, 404 staff have attended the two day programme, with 483 staff attending the one-day course or a team event. Anecdotal feedback from individuals and teams has been extremely positive so far, and the programme is being evaluated for its impact.

Making it Right (MiR).

The Making it Right programme has been introduced in response to Trust Workforce Race Equality Standard (WRES) data. The programme has the overall aim of seeking to close the gap between the work experience of our white staff and our Black, Asian and Minority Ethnic (BAME) staff. It is part of the Trust's ongoing commitment to develop a high performing, diverse and inclusive workforce.

The Making it Right Programme pilot draws on best practice evidence aiming for; fair recruitment for all, career progression for all, zero tolerance of bullying and harassment, prioritising staff health and wellbeing and ensuring all individuals are valued and feel included. There has been wide consultation and input into the design and development of the programme.

The Programme is made up of three one day workshops which aim to develop participants' attitude, knowledge and skills. This in turn will enable them to communicate in a range of professional settings, compete effectively for jobs and feel

empowered to conduct themselves constructively when faced with discrimination or conflict at work. Participants are also assigned a mentor and paired together for the duration of the pilot.

The pilot was evaluated in February 2018 and showed encouraging signs that the training modules and mentoring programmes have been well constructed and have a good fit with the needs of BAME staff. The programme benefited by having been trialled before the roll-out of the formal pilot. It was also clear from participants' responses that the resulting training course was well designed, stimulating, content-rich and professionally delivered.

Nursing Associates

ⓘ In 2017 a number of new initiatives were being introduced to broaden opportunities for people to enter the nursing profession. There were no changes to the requirement that anyone joining the nursing profession must complete a degree in nursing. However, going forward, there are now opportunities in the Trust to combine working whilst studying to gain a nursing degree. As part of career development and progression the first major step on the work-based learning journey is the new profession of the Nursing Associate.

Trainees are recruited to the Band 3 role and will be appointed to a Band 4 Nursing Associate role once qualified. The qualified Nursing Associate supports the registered nurse. This highly trained support role helps the Registered Nurses deliver effective, safe and responsive care. Nursing Associates work independently, within defined parameters of practice, under the direction of registered nurses, to deliver care in line with an agreed plan of care.

The Trust is a lead employer in the Thames Valley pilot. Eight Trust employees started on this two-year programme in April 2017, attending university one day a week. For the remainder of the time they are working in the clinical settings with nine weeks a year in other placements. The Nursing and Midwifery Council (NMC) has agreed to register the new Nursing Associate workforce.

Some of the Nursing Associates are expected to move on to complete the degree programme and register as fully qualified nurses but most are likely to stay in their new role for a few years to consolidate the learning and to fill the skills gap. Nurse leaders in England have been clear that the intention is for nursing associates to support and not substitute nurses. Having a more highly educated and skilled support staff should enable better use of our graduate nurse resources.

There has been a great deal of interest and support for this role in the Trust. A new cohort of trainees is due to start in the spring of 2018 with the cohort size to double to at least 16.

"I have read a lot of generally negative comments on the internet about CAHMS in general but I would like to say the reception staff at Wokingham CAHMS are exceptional. I went there to complain however I was dealt with so professionally that I left there with a smile on face and the feeling that they were trying to do the best for us. Well done and Thanks."

Child and Adolescent Mental Health Services (CAMHS), Wokingham

2.1.5. Other Service Improvement Highlights in 2017/18

ⓘ 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

The Trust also participates in quality improvement programmes and accreditation schemes that are facilitated by the Royal College of Psychiatrists. These are a key part of the Trust annual plan. A table detailing the projects that the Trust is participating in, including the accreditation status of Trust services, is included in Appendix G

2.1.6. Improvements in Community Health Services for Adults

The New Vision of Care programme in East Berkshire enabled local stakeholders to deliver an ambitious new model of care that integrates care around each individual and supports them to maximise their independence. This is being taken forward by the Frimley Health and Care Integrated Care System (ICS) work streams.

The Frail Elderly Programme in Berkshire West has developed integrated ways of working in West Berkshire, Reading and Wokingham to develop joined up community services in partnership with GPs and Local Authorities as well as community and voluntary sector organisations.

Some of our Community Inpatient Wards have started implementing the Digital Inpatient Community Project, resulting in patients being admitted/discharged/transferred within an hour on the Trust electronic patient record system (RiO). Six Step Up beds were introduced in December 2017, receiving admissions directly from the patient's home serving as an alternative to an acute hospital admission.

Reading Community Matrons. Associate community matrons have been introduced into the service. Data shows that MDT meetings are continuing to reduce hospital admissions as well as GP/ out- of-hours contacts for patients that have been assessed by community matrons.

The Integrated Pain and Spinal Service (IPASS) moved into its 3rd year in operation and has continued to demonstrate a significant reduction in appointment wait times The integrated nature of the service has also led to a 1/3rd reduction in repeat secondary care attendances and has empowered patients to self-manage. The service has been commended by commissioners, who have put IPASS forward for a Health Service Journal award for which they were subsequently chosen as a finalist for the category Acute, Community and/or Primary Care Services Redesign.

The Musculoskeletal (MSK) Physiotherapy Service has demonstrated that 80% of service patients completing treatment experience statistically significant improvement following their physiotherapy intervention.

Reading Adult Acute Speech and Language Therapy team (SLT) work in the Royal Berkshire Hospital providing assessment, therapy, advice and support, as part of various medical MDTs, for all adults with swallowing (dysphagia) and communication difficulties. The team secured funding and have recruited into the Intensive Care Unit, thus improving safe tracheostomy weaning. The team also won a grant from UK Parkinson's Disease Excellence Network and were awarded funds to employ a highly specialist SLT to audit and improve SLT services. The specialist stroke team won the Royal Berkshire Hospital NHS Foundation Trust CEO's Transforming Services fund to provide endoscopic swallowing assessment for stroke patients. Alongside the catering team, the SLT team also reviewed the ward menus to ensure safe food texture options were available and provided training for the catering team in this. Through collaborative working, the team helped influence Royal Berkshire Hospital to change the kosher and Afro-Caribbean meals provider to comply with safe feeding recommendations.

The Nutrition & Dietetics Service. In order to reduce waiting times, the service are piloting monthly groups for parents with an infant with cow's milk allergy, enabling them to provide timely milk-free weaning

advice and reduce the number of appointments offered. As part of the Making Mealtimes Matter initiative, service staff assist ward-based staff at the Royal Berkshire Hospital at mealtimes, on a monthly basis, helping to increase their presence on the wards and building a good rapport with patients and nursing staff.

The Hearing and Balance Service continue to maintain their United Kingdom Accreditation Service (UKAS) accreditation status for Improving Quality in Physiological Services (IQIPS). Public awareness about hearing aids and hearing loss was also highlighted by the service at a combined charities fair attended by the Prime Minister at Maidenhead Town Hall.

The Sexual Health Service is participating in the National HIV pre-exposure prophylaxis clinical trial, a four and a half year clinical trial that will shape the future of the national HIV prevention strategy.

The Tissue Viability Team introduced a live line service In September 2017, offering advice and support to Trust clinicians in managing hard to heal and complex wounds.

The Diabetes Service Education for patients continues to be delivered through the Diabetes Education Through Adult Learning (DEAL), Carbohydrate and Insulin Calculation Education (CHOICE) and Xpert education programmes, and the service have received Quality Institute for Self-Management Education and Training (QISMET) accreditation.

2.1.7. Improvements in GP Out-of-hours Services and Urgent Care Services

WestCall is the out of hours (OOH), GP-led primary care service in West Berkshire. Following a comprehensive review of the position and challenges facing the WestCall service, new 'non-medical' practitioner posts were introduced into the service. This allows multidisciplinary working within the service to provide greater capacity to meet demand and allow the service to be more robust and will allow the team to spend more time focussing on the quality impact of our care delivery. Westcall has also been fully involved in the delivery of the TVIII Clinical Advisory Hub, and Emergency Department Streaming detailed further below.

The Thames Valley 111 (TV111) Clinical Advisory Hub. The TV111 Clinical Advisory Service hub, based at The Old Forge in Wokingham, provides an enhanced clinical assessment service and provides a GP to review calls through clinical streaming for particular patient groups; those over 85 years, under 5 years, complex frail elderly and Ambulance Green calls. Calls can be transferred directly from 111 to the GP or receive a call back within 10 minutes.

Emergency Department Streaming. Toward the end of 2017, the Trust was asked to provide primary care services at the front door of the Royal Berkshire Hospital (RBH) Emergency Department. This has a positive impact on the flow of patients through the Emergency Department. Whilst the service has only been operational for 4 months, it continues to grow steadily and now provides care to approximately 250 patients each week.

The Minor Injuries Unit (MIU) at West Berkshire Community Hospital, in liaison with the Royal Berkshire Hospital (RBH) have introduced a pathway to refer patients with acute soft tissue knee injuries into clinic at the RBH. This has reduced delay in assessment for patients who previously would have gone to their GP if their knee injury wasn't healing or would have taken up an appointment in fracture clinic before being referred on. Furthermore, the team have developed a new pathway with the physiotherapy team at West Berkshire Community Hospital that allows MIU to make direct referrals, thereby reducing the need for patient to see their own GP for a referral.

"The Audiology department bent over backwards to replace my mother's hearing aids after they were lost following a stroke. THANK YOU!"

From a relative of a patient- Hearing and Balance Service– King Edward VII Hospital Windsor

2.1.8. Improvements in Services for Children, Young People and Families (CYPF), including Child and Adolescent Mental Health Services (CAMHS)

Over the past year the Trust has undertaken a major project to continue transforming our Children, Young People and Families (CYPF) Services. Physical and mental health services have been brought together under one directorate. Initial Changes to our new, integrated CYPF Services went live on 2nd May 2017. A new CYPF online resource was launched for Children, Young People and Families, which has been designed and created alongside our service users, parents, carers and fellow professionals in education and healthcare. They have aimed to address the key questions that are asked by service users, providing them with the tools and information they require to self-manage in the community, alongside clear advice on when to seek further help and signposting to the best place to find it. You can access the online resource at: https://cypf.berkshirehealthcare.nhs.uk/.

The Health Visiting Service was re-accredited at level 3 of the UNICEF Baby Friendly Initiative (BFI) Accreditation. This high level of BFI accreditation allows the Trust to be nationally recognised.

The Community Child and Adolescent Mental Health Service (CAMHS). The new Community CAMHS Eating Disorders team is now well-established and meeting access and waiting time standards. A CAMHS Rapid Response service has now been funded following a successful pilot in East and West Berkshire in 2016/17. Service user engagement remains a core principle of the service with models of engagement and participation developed in CAMHS now informing the development of a strategy that has been rolled out more widely across CYPF services.

Work has been undertaken to improve prevention and early intervention services across the county. However, referrals to CAMHS have continued to increase in line with the national picture and this is starting to have an effect on waiting times, particularly in the Autism Assessment, ADHD and CAMHS Eating Disorder teams. These issues have been raised with our commissioners and we are engaged in work with our partners to review care pathways and improve joint working across the different providers involved in caring for these patients.

2.1.9. Improvements in Services for Adults with Learning Disabilities

During the past year, a new Intensive Support Team for people with learning disabilities has been established as part of the local response to "Transforming Care" for people with learning disabilities. This team has been developed to provide a specialist service to those adults with learning disabilities who are at risk of admission to inpatient services as a result of a significant change in their behaviour.

The specialist inpatient service (Campion Unit at Prospect Park Hospital) has been working towards achieving accreditation by the Royal College of Psychiatry through the Quality Network for Inpatient Learning Disability Services (QNLD). In December 2017, the service hosted an external peer review, when a team of reviewers visited the ward and spent the day with patients and staff. The service was accredited by the Royal College of psychiatrists in January 2018.

The service has also continued developing how they review and learn from the deaths of people with learning disabilities. The national Learning Disabilities Mortality Review (LeDeR) Programme has also been implemented locally during this year with service staff being trained to undertake these reviews.

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

Adult Mental Health Services

The 7 day working Quality Standard was introduced in 2016 as part of the Trust's commitment towards ensuring that there is senior medical input into care of inpatients at Prospect Park Hospital. Admission to hospital is a critical point in patient care. The 7 day Working Quality Standard requires the admitting junior doctors to discuss all out of hours admissions until 12 midnight with the consultant psychiatrist on call. This helps avoid unnecessary delays in commencement of treatment for patients admitted out of hours. Unless immediately necessary, admissions after 12 midnight are discussed with the teams the following morning.

Talking Therapies (IAPT). Talking Therapies were accredited by the Accreditation Programme for Psychological Therapies Services (APPTS) in October 2017. A key development in the service has seen the setting up of 'Our space' cafes in three localities to support service users after discharge from the service, to help prevent relapse following therapy and to sustain health benefits. The core Talking Therapies service has been developed to increase access to evidence based Psychological therapies across all CCG's. In addition, 39 therapists have received high intensity and psychological wellbeing practitioner training to support service growth. Working with the Common Point of Entry team (CPE) has been enhanced by a daily presence of an IAPT clinician or supervisor within the CPE hub to share decision making and support risk assessment across primary and secondary care service entry.

Community Mental Health Team (CMHT) accreditation. The Trust CMHTs are working towards the Royal College of Psychiatrists' Accreditation for Community Mental Health Services (ACOMHS). Bracknell CMHT has been the first to register. The process has required self-assessment against a rigorous set of standards, and has already driven up quality through initiatives such as standardising staff induction programs and providing reflective practice sessions facilitated by psychologists. This process has also encouraged the service to develop more standardised transfer pathways from Child and Adolescent Mental Health Services.

Windsor Ascot and Maidenhead (WAM) CMHT-Sectorisation. WAM CMHT identified the potential for improvement in multi-disciplinary and partnership working with primary care, and devised a process of 'sectorisation', whereby the team was sub-divided and aligned more closely with GP practices. This has resulted in shorter, more clinically relevant meetings. As the sectors are aligned to primary care surgeries, relationships with GPs have improved, and there has been excellent feedback from MDT staff.

West Berkshire CMHT has introduced a complex case forum which focuses on a single service user leading to the development of a plan for moving forward with the individual. This forum helps staff remain open to their patients, as well as sharing the problems with the team which increases the available information and team understanding.

The Circle of Friends (Mother and Baby Group) aims to provide a care pathway for mothers accessing mental health services, promoting a smooth transition to community based groups and the provision of ongoing support for mothers with severe and enduring and perinatal mental health conditions.

The Perinatal Mental Health service offers care to women and their families across Berkshire requiring intervention during pregnancy or in the first year post-partum. The provision of a perinatal Cognitive Behavioural Therapy (CBT) intervention, which is delivered in the woman's home, has been supplemented and complemented by perinatal nursery nurses delivering perinatal frame of mind support. The access that referrers and the team have to our perinatal psychiatrists and perinatal pharmacy has enhanced the advice that the women receive in respect of prescribing at this critical time.

The Lived Experience Group has grown in number and six of the members have talked about their experience to enhance the training we deliver. Alongside the ladies with lived experience, the perinatal team has contributed to regional awareness training delivered to nearly 200 individuals working with women during the perinatal period. The team have also delivered local training during the year to midwives and Health Visitors and have also supported

the training of nursery nurses to deliver the maternal well-being interventions at the post-natal check.

The Perinatal Trauma Pilot Project is now delivering specialist intervention to this cohort of women as part of national funding and. In addition to service development, the national funding is enabling an enhanced range of services and interventions for women who require them across Berkshire.

MOON is the name for the maternal wellbeing aspect of the Trust online support network, SHaRON. MOON has continued to grow during the past year and the numbers activating to use the resource is steady. The clinical moderating team is now supported by six women who have used MOON and who have completed recruitment to hold voluntary contracts with the Trust as peer moderators for MOON.

Assertive Intervention Stabilisation Team (ASSiST) is the service in east Berkshire which supports people with emotional instability, through psychological, social and practical interventions. The service aims to reduce the amount of time people spend as inpatients with mental health services, as hospital stay can be unhelpful for this patient group. This year, the ASSiST team have developed an inpatient group at Prospect Park Hospital (PPH) to help give confidence to the inpatients about community services waiting to support them upon discharge. The ASSiST team have also co-produced an innovative structure for Friends and Family sessions. ASSiST patients identified and scripted difficult social interactions, which were acted by ASSiST staff and filmed Lastly, ASSiST has worked with patients to co-produce a smoother discharge pathway to primary care. This includes using Safety plans and instructions on how their particular mental health difficulties can be best managed in the future, all co-developed with patients.

Hope House is a new recovery-focused supported living project, developed as a joint initiative between the Trust, Slough Borough Council and Lookahead Housing Association. Hope House is a 10 bedded unit with self-contained accommodation where residents stay for up to two years, with tailored support according to their needs. Several services are involved in providing flexible support to patients, including Slough CMHT, HOPE Recovery College, and ASSiST Team. Residents can then graduate to an independent block of six flats close by to Hope House, where they can stay for a further period to build confidence and progress their recovery.

Recovery colleges in East Berkshire. The Trust is commissioned to provide Recovery Colleges in two localities in East Berkshire. Hope College has now been running in Slough for 3 years, and Opportunity Recovery College has been running in Windsor Ascot and Maidenhead since October 2017. Key to the recovery college principles are adoption of education and training opportunities to promote mental health and recovery. The feedback from the clients has been positive.

Volunteer Peer Mentors. In November 2017**,** seven service users graduated from a ten-week volunteer ready induction programme run by Hope College, to become fully fledged volunteer peer mentors. Slough has now trained over 40 peer mentors who are actively supporting others with mental health problems in social and therapeutic activities and recovery college courses. Volunteers also assist on the CMHT reception, meeting and greeting clients and helping the reception team with anything they need.

Volunteers at Compass Recovery College have lived experience of their own Mental Health problems and feel they would like to give something back to the community. Their activities include running a games group, serve beverages and delicious cake at Caversham Court Kiosk, helping out with mother and baby groups and providing a social group. Some of the groups have been running for over 10 years and we are extremely lucky to have such dedicated volunteers.

Early Intervention in Psychosis Services (EIP). The Royal College of Psychiatrists EIP Network carried out a Developmental Review of the service during the year. The team are awaiting the full report, but verbal feedback from the visit has been very positive. In addition, a review was undertaken by the South West Early Intervention in Psychosis Peer Review pilot, with positive feedback.

The Oxford Academic Health Science Network awarded £5000 to the EIP service to implement a Personal Training Pilot during the year. The project involved a 12 week Personal Trainer pilot in Reading and Slough for 8 participants with a BMI of between 25 and 35 who were at the 'contemplation/ determination/ action' stages of change. In conclusion, the results indicated suitability of the intervention and the service are looking to expand in a more sustainable and inclusive way, targeting those whose physical health is deemed high-risk, as well as

clients new to the service to preserve their physical health.

Volunteers are also being recruited into the EIP service to support service users with improving their physical health and reducing social isolation. Art Therapy is also now provided within the EIP service. Finally, An EIP Young Person's group has been established in Slough for patients aged 25 and below.

The Crisis Resolution and Home Treatment Team (CRHTT). The last year has seen a substantial increase in the provision of psychology in CRHTT, with Assistant Psychologists (AP's) now playing an important role in each Home Treatment Team. Psychologists within CRHTT continue to support staff across the service offering regular clinical case reflection groups. Training in Solution Focused Therapy is being rolled out to all staff across CRHTT and to date has been well received.

Eye Movement Desensitization and Reprocessing Therapy (EMDR) continues to be delivered where possible within CRHTT and have demonstrated a clinically significant improvement, most notably a reduction in the desire for suicide post treatment. A recent audit of selected cases showed a 70% reduction in contacts with CRHTT and 79% reduction in admissions for those treated on the project.

The Intensive Management of Personality-disorders and Clinical Therapy Team (IMPACTT) has been rolling out evidence based therapy programmes across Berkshire for service users with Emotionally Unstable Personality disorder (EUPD) who present with current self-harm and chronic suicidal thinking and behaviours. All therapy programmes are being evaluated using valid outcome measures. In addition to the therapy work, the IMPACTT team have been rolling out a teaching programme for colleagues from other services within the organisation (such as inpatient wards, CRHTT and CMHT) to help them build confidence and skill with service users who present with self-harming/ chronic suicidal thinking and may meet criteria for an emotionally unstable personality disorder.

The Psychological Medicine Services (PMS) - Frequent attenders Pathway (FAP) has been looking at patients frequently attending the Emergency Department since January 2016. Multi-agency professional meetings are scheduled quarterly to discuss these clients and formulate individualised management care plans.

The Liaison and Diversion Service identify people who have mental health, learning disability, substance misuse or other vulnerabilities when they first come into contact with the criminal justice system as suspects, defendants or offenders, to help improve health and criminal justice outcomes. A single model of service has been established across Thames Valley. Services have been established within Reading Crown Court and there is an all age and all vulnerability service in Milton Keynes.

The Community Health Psychology Service (CHPS) have delivered training sessions with GPs around working with a psychological approach for patients with fibromyalgia, which received very positive feedback. Excellent feedback was also received for a training course delivered as part of the Oxford Clinical Psychology Doctorate on Working at the End of Life.

The Neuropsychology Service offers a service for adults in three main clinical areas: Acquired Brain Injury, adult diagnostic assessment for Autism/Asperger's Syndrome and adult diagnostic and medical treatment service for adults with ADHD. The team have recently set up long term support or self-help groups in all three clinical areas for those who have been through the system of initial diagnosis and pyscho-educational groups, and still have needs for continuing support.

Family Safeguarding Service. The Trust is part of the new Family Safeguarding Model being developed in Bracknell Forest Borough Council and West Berkshire District Council that builds upon new approaches in Children's Social care. The approach is described as a whole system change to child protection services, focusing on the children and families at the highest level of risk due to domestic abuse, mental health and substance misuse (known as the 'Toxic Trio'). Under the new service, the Trust has been commissioned to employ adult mental health workers and clinical psychologists, who are co-located with child protection social workers, domestic abuse and substance misuse workers, and work closely with police and probation services. The project is in its early stages of implementation with the expectation that the service will evolve over time. It is anticipated that addressing the mental health of parents will have a positive impact on outcomes for vulnerable children.

Older People's Mental Health Services (OPMH)

Memory Clinic Accreditation (ongoing cycle of quality improvement). All Trust Memory Clinics are accredited under the Royal College of Psychiatrists Memory Services National Accreditation Programme (MSNAP) and are preparing for their next MSNAP Peer Review.

Parity of provision for Younger People with Dementia (YPWD). Berkshire East Clinical Commissioning Groups (CCGs) approved funding to extend the YPWD Charity provision of workshops and weekday respite for YPWD and their carers to 5 days a week. This is equivalent to that provided in Berkshire West.

A Listening into Action (LiA) project has achieved its objective of defining a YPWD pathway which has been adopted across Berkshire. Teams are currently embedding the pathway in practice and monitoring the process for referrals to the YPWD charity and an Admiral Nurse to ensure it is robust. Each OPMH Service now has at least one YPWD Champion and have formed a network with members of the YPWD Charity.

The model of care for Young People with Dementia used in the Wokingham Memory Service is to be published as an example of positive practice by the Royal College of Psychiatrists.

The Dementia Care Advisor Pathway was funded by Thames Valley Strategic Clinical Network (TVSCN), with the aim of comparing Dementia Care Advisor provision across Berkshire. The resulting report proposed a best practice pathway that has been presented to Commissioners and various stakeholders. The Trust has been invited to present the paper at a TVSCN workshop in May 2018. Reading CCG have incorporated most of the report recommendations into a revised Dementia Care Advisor Service Specification.

Patient and Carer engagement. OPMH services hold forums and feedback sessions to seek feedback from patients and carers about their experience of pathways and processes and how they can be improved.

Dementia Pathway Reviews An Integrated Care System (ICS) outpatient workstream has been established in Berkshire West to review existing Memory Clinic pathways and identify opportunities to improve effectiveness and efficiency and maximise our ability to manage future demand and referral to diagnosis targets.

Training for Primary Care Practitioners. At the request of Berkshire West Clinical Commissioning Group, Wokingham OPMH is developing a training session to improve the skills and confidence of Practice Nurses and Healthcare Assistants in exploring patients/carers concerns about memory problems and obtaining the information required to request a Memory Clinic Assessment rather than asking the GP to make the referral.

Long term Conditions- Psychological Interventions in Nursing and Community (PINC) Services. Following a successful pilot in 2016 in WAM, PINC Services have been extended to the whole of East Berkshire in 2017 alongside IAPT and HealthMakers to provide therapy for people with long term conditions. PINC sees people who require a home visit and is an integrated service based with the community/district nurses. PINC was awarded innovative project of the year by the Trust in 2017, and a paper concerning PINC was presented at the national IAPT Connect 2017 conference at the British Library. A consultant has been shortlisted for a Winston Churchill Fellowship Award to visit similar services in the USA in 2018 and has had a paper "Integrating care in the UK" accepted by the American Psychological Association for their 2018 annual conference. In a further development, Health Education England (HEE) have awarded a grant for a pilot of a PINC type service with the Heart Failure and COPD services in East Berkshire in 2018.

2.1.11. Improvements in Pharmacy

The Trust is a Mental Health Global Digital Exemplar site. All mental health wards in PPH have now implemented Electronic Prescribing and Medicines Administration (ePMA). The system enables seamless linking between ePMA and the Trust patient record. EPMA is currently being rolled-out in the trust and benefits realisation evaluations are expected in the future. Standard benefits noted in other NHS trusts where the system has been implemented include legible prescriptions, no missing drug charts, improved audit trail and surveillance and ability to prescribe remotely. Dispensing processes have also been noted to be safer and timelier.

2.2. Setting Priorities for Improvement for 2018/19

ⓘ This section details Berkshire Healthcare NHS Foundation Trust's priorities for 2018/19. Specific priorities have been set in the areas of patient experience, patient safety, clinical effectiveness and organisational culture. They have been shared for comment with Trust governors, local Clinical Commissioning Groups (CCGs), Healthwatch Organisations and Health Overview and Scrutiny Committees. Responses to this consultation are included in Appendix H, together with the Trust response to each comment made by the stakeholders

2.2.1. Patient Safety Priorities

1. To drive quality improvement through the continued delivery of the Trust Quality Improvement Programme

2. To align our efforts and work to deliver the following harm-free objectives:
   - Reducing patient falls incidents by 50%
   - Reducing patient self-harm incidents by 30%
   - Reducing rates of suicide of people under our care by 10% by 2021

3. All our services will contribute to an Outstanding overall Care Quality Commission rating

4. At a system level, to achieve reductions in urgent admissions and delayed transfers of care across our inpatient services, working in collaboration with provider partners and commissioners.

2.2.2. Clinical Effectiveness Priorities

1. To demonstrate our delivery of evidence-based services by reporting on the implementation of NICE guidance related to Trust priorities identified in this Quality Account, specifically:
   - Depression in Adults (to support Zero Suicide)
   - Self Harm (to support Harm Free Care)
   - Psychosis and Schizophrenia in adults
   - Bipolar Disorder

2. To continue to review, report and learn from deaths in line with new national guidance as it is published

2.2.3. Patient Experience Priorities

1. To achieve a 95% satisfaction rate in our Friends and Family Test and 60% of staff reporting use of service user feedback to make informed decisions in their department

2. To reduce our use of prone restraint by 90% by the end of 2018/19

3. All our services will focus on understanding and supporting outcomes of care that are important to patients

4. At a system level, to contribute to Integrated Care System work streams to improve patient experience and outcomes.

2.2.4. Organisational Culture Priorities

1. To achieve improvements in the following key areas:
   - 66% of our staff feeling they can make improvements at work
   - 75% of our staff recommending our Trust as a place to receive treatment
   - A 20% reduction in assaults on staff

2. Our recruitment and retention plans will reduce vacancies by 10%

3. An additional 24 services will be trained in our Quality Improvement System

4. To achieve the objectives set out in the Equality Plans for each area

5. At a system level, to participate in Integrated Care System work streams, enhancing job satisfaction and career development opportunities.

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. The Trust will report on our progress against these priorities in our Quality Account for 2019.

2.3. Statements of Assurance from the Board

During 2017/18 Berkshire Healthcare NHS Foundation Trust provided and/or sub-contracted 52 relevant health services.

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

The income generated by the relevant health services reviewed in 2017/18 represents 100% of the total income generated from the provision of relevant health services by Berkshire Healthcare NHS Foundation Trust for 2017/18.

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.

2.3.1. 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 2017/18, 15 national clinical audits and 6 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=15/15) national clinical audits and 100% (n=6/6) 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 2017/18 are shown in the first column of Figure 25 below.
This column also details the national clinical audits and national confidential enquiries that Berkshire Healthcare NHS Foundation Trust participated in during 2017/18.

The national clinical audits and national confidential enquiries that Berkshire Healthcare NHS Foundation Trust participated in and for which data collection was completed during 2017-18 are also listed below in Figure 25 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 fig 25).

Figure 25- 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 2017/18	Data collection status and number of cases submitted as a percentage of the number of registered cases required by the terms of the audit (where applicable)
1. National Clinical Audits (N=15)	
National Clinical Audit and Patient Outcomes Programme (NCAPOP)	
Falls and Fragility Fractures Audit programme (FFFAP) - Fracture Liaison Service Database	Data Collection: April 2017 to March 2018. 612 patients submitted, across 1 service (final figure not yet available). Report due: TBC. Please note that this service was taken over by the Royal Berkshire Hospital on 1/10/17.
Learning Disability Mortality Review Programme (LeDeR)	Data Collection: April 2017 to March 2018 26 (100%) patients submitted, across 1 service. Report due: TBC
National Audit of Anxiety and Depression	Registration: January 18 – March 18 Data Collection: June 18 – Sept 18. Report due: TBC 2019
National Audit of Psychosis	Data Collection: October 2017 to November 2017. 100 (100%) patients submitted, across 3 services. Report due: June 2018

National Clinical Audits and Confidential Enquiries that the Trust was eligible to participate in and did participate in during 2017/18	Data collection status and number of cases submitted as a percentage of the number of registered cases required by the terms of the audit (where applicable)
National COPD Audit - Pulmonary Rehabilitation (2017)	Data Collection: January 2017 to July 2017. 49 (100%) (West) plus 38 (97%) (East) patients submitted, across 2 services. Service level reports published: 25th January 2018. National report published: 12th April 2018
National Diabetes Audit - National Diabetes Foot Care Audit	Data Collection: Continuous. 76 (100%) patients submitted, across 1 service. Reported published: March 2018
National Diabetes Audit - National Diabetes Audit (Secondary Care)	Data Collection: April 2017 to March 2018. 1844 (100%) patients submitted, across 1 service. Report Published: 14th March 2018 Insulin Pump report due: April 2018
National End of Life Care Audit	Registration February 2018 – March 2018. Data Collection: June 2018 – October 18. Report due: May 2019
National Sentinel Stroke Audit	Data Collection: Continuous. 703 (97%) patients submitted for 2017/18, across 4 services (final figure not yet available). Annual report for 16/17 published: Dec 17
National Audit of Intermediate Care (NAIC)	Data Collection: May 2017 to August 2018. Data submitted across 11 services. Benchmarking Project. Reports published: December 2017
Non- NCAPOP Audits	
Prescribing Observatory for Mental Health (POMH-UK) - Prescribing high dose & combination antipsychotics on adult & PICU wards	Data Collection: February 2017. 75 (100%) patients submitted, across 5 services. Reported: October 2017
Prescribing Observatory for Mental Health (POMH-UK) - Use of depot/Long Acting antipsychotic injections for relapse prevention	Data Collection: May to June 2017. 139 (100%) patients submitted, across 5 services. Report published: January 2018
Prescribing Observatory for Mental Health (POMH-UK) - Prescribing for bipolar disorder (use of sodium valproate)	Data Collection: September to October 2017 181 (100%) patients submitted, across 7 services (final figure not yet available). Report due: May 2018
Prescribing Observatory for Mental Health (POMH-UK) – Rapid Tranquilisation re-audit	Data Collection: March 2018 – May 2018. TBC patients submitted, across TBC service (final figure not yet available). Report due: Sept 2018
UK Parkinson's Audit: (Elderly care)	Data Collection: May 2017 to October 2017. 20 (100%) patients submitted, across 1 service. Service level report published: March 2018. National report due: May 2018
National Confidential Enquiries (N=6)	
Child Health Clinical Outcome Review Programme - Young People's Mental Health	Data Collection: April 2017 to March 2018. TBC patients submitted, across TBC service (final figure not yet available). Report due: TBC
Mental Health Clinical Outcome Review Programme - a. Suicide by children and young people in England(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: April 2017 to March 2018. 1 Questionnaire sent out to the Trust, 1 submitted. Report due: May 2018 b. Data Collection: April 2017 to March 2018 31 Questionnaires sent out to the Trust, 24 submitted (final figure not yet available, to be confirmed at end of Q4). Report due: Oct 2018 c. Data Collection: April 2017 to March 2018. 0 Questionnaires sent out to the Trust, 0 submitted. Report due: June 2018
NCEPOD - a. Chronic Neurodisability study	a. Data Collection: April 2016 to March 2017 (extended). 0 patients submitted, across 1 service. The Trust completed the organisational survey and were not required to collect data as we do not admit this patients.1 patient was identified for the case note review for paediatric community care and the questionnaire was submitted. Report published: March 2018

National Clinical Audits and Confidential Enquiries that the Trust was eligible to participate in and did participate in during 2017/18	Data collection status and number of cases submitted as a percentage of the number of registered cases required by the terms of the audit (where applicable)
b. Mental Health Conditions in Young People	b. Data Collection: April 2016 to March 2017 (extended) 35 patients submitted, across 1 service and 9 patients (emergency attendances) for the retrospective data collection. The Trust submitted 8 questionnaires for 3 patients only. All service users were included in the data collection. (aged 11 – 25 years who present to hospital with anxiety, depression, an eating disorder or an episode of self-harm, during the study period).Report due: April 2018

Source: Trust Clinical Audit Team

The reports of 7 (100%) national clinical audits were reviewed by the Trust in 2017-18. This included 4 national audits for which data was collected in earlier years with the resultant report being published in 2017/18. 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 63 local clinical audits were reviewed by the Trust in 2017/18 and Berkshire Healthcare NHS Foundation Trust intends to take actions to improve the quality of healthcare which are detailed in Appendix C.').

2.3.2. 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 relevant health services provided or sub-contracted by Berkshire Healthcare NHS Foundation Trust in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee was 1113 from 51 active studies.

2.3.3. 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.

A proportion of Berkshire Healthcare NHS Foundation Trust's income in 2017/18 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 2017/18 and for the following 12 month period can be found in Appendix E & F.

The income in 2017/18 conditional upon achieving quality improvement and innovation goals is £2,135,032 against named CQUINs (anticipated- with results due in June 2018), with a further £1,708.000 against STP conditions (anticipated- with results due in June 2018).

The associated payment received for 2016/17 was £3,949,099.

2.3.4. 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 2017/18.

Berkshire Healthcare NHS Foundation Trust is subject to periodic reviews by the Care Quality Commission.

The CQC visited the following wards during May 2017:

- Willow House, child and adolescent mental health ward, and found that there were some elements of safeguarding that needed improvement and therefore rated the unit as requires improvement for safety
- Bluebell Ward, Prospect Park Hospital finding that improvements were required in record keeping, ward environment and the process of governance involving audits.

The Trust remains overall rated as good across all five domains. The Trust expect a focused CQC inspection, including a well led assessment, to be undertaken by the CQC during 2018/19.

Berkshire Healthcare NHS Foundation Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2017/18:

- CQC Review of the Bracknell Forest Health and Social Care System.

Berkshire Healthcare NHS Foundation Trust intends to take the following action to address the conclusions or requirements reported by the CQC:

- The Trust have been working with Bracknell Local Authority to agree a new integrated service model. This will be a joint team, working 7 days a week, comprising health and social care staff to actively support and keep people at home and/or in a community setting, thereby preventing hospital admission. The team will also In-reach to Frimley Park to support timely and safe discharge back to a community setting.

Berkshire Healthcare NHS Foundation Trust has made the following progress by 31 March 2018 in taking such action:

- The resource required to support the new model has been approved and we are now awaiting final contractual sign off, to allow the recruitment process to begin.
- Further discussions are also on going in local workshops with Bracknell Local Authority and Primary Care to further develop the ICS Integrated Decision Making Hub model (IDMH)

By law, the Care Quality Commission (CQC) is also 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.

The CQC has carried out the following unannounced Mental Health Act (MHA) visits during the 2017/18 financial year.

- 22nd and 23rd May- Bluebell Ward, Prospect Park Hospital
- 23rd June 2017- Rose Ward, Prospect Park Hospital
- 17th October 2017- Bluebell Ward, Prospect Park Hospital
- 19th January 2018, Orchid Ward, Sorrell Ward, Snowdrop Ward and Daisy Ward, Prospect Park Hospital
- 21st February 2018- use of seclusion visit, Campion Ward, Bluebell Ward, Sorrel Ward, Daisy Ward, Snowdrop Ward and Rose Ward, Prospect Park Hospital

2.3.5. 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.

The Secondary Uses Service (SUS)

Berkshire Healthcare NHS Foundation Trust submitted records during 2017/18 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
100% for accident and emergency care.

— Which included the patient's valid General Medical Practice Code was:
100% for admitted patient care;
100% for outpatient care; and
100% 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 2017/18 was 82% and was graded Green.

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

Data Quality

Berkshire Healthcare NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2017/18 by the Audit Commission.

Berkshire Healthcare NHS Foundation Trust will be taking the following actions to improve data 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 action plans 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 NHS Digital website are analysed to ensure consistency in reporting both internally and externally.

The clinical coding team continue to review and improve the Trust's diagnostic data. As part of our continuous improvement programme, a scheduled clinical coding audit took place in February 2018 and the primary diagnosis rate was 98%, and the secondary diagnosis rate was 91.3%. The coding team continues to work with consultants across the Trust to maintain accurate diagnosis data. Further audits are scheduled for August and December 2018.

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

1. Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral (Mandated)
2. Inappropriate out-of-area placements for adult mental health services (Mandated)
3. Improving access to psychological therapies (IAPT): waiting time to begin treatment (from IAPT minimum dataset): within 6 weeks of referral (Governors' Choice).

2.3.6. Learning from Deaths

ⓘ For many people death under the care of the NHS is an inevitable outcome and they experience excellent care from the NHS in the months or years leading up to their death. However, some patients experience poor quality care resulting from multiple contributory factors. The purpose of mortality review is to identify whether problems in care might have contributed to the death and to learn in order to prevent recurrence.

In March 2017, the National Quality Board published Guidance on Learning from Deaths for all NHS Trusts to implement. The Trust has fully implemented this guidance, and a new Trust policy and procedures for learning from deaths was approved in August 2017.

An audit of this was undertaken by internal auditors as part of the approved internal audit plan for 2017/18. The audit reviewed the Trust's adherence to the National Guidance on Learning from Deaths and found that the Trust is effectively identifying, reporting, investigating, monitoring and learning from deaths of patients in their care. Substantial assurance was given that the controls upon which the organisation relies to manage the identified risk are suitably designed, consistently applied and operating effectively.

The Trust learning from deaths process includes all patients identified on our electronic patient records who have accessed one of our services in the year before death.

In most cases these are expected deaths but where a specific trigger is noted (as identified in our policy) we then review these deaths further.

The level of review required will depend on whether certain criteria are met, and we review the care provided for all patients who had a learning disability and died.

During 2017/18 4381 of Berkshire Healthcare NHS Foundation Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 1194 in the first quarter;
- 1111 in the second quarter;
- 1112 in the third quarter;
- 964 in the fourth quarter.

By 31st March 2018, 307 case record reviews and 153 investigations have been carried out in relation to 4381 of the deaths included above.
In 153 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 38 in the first quarter;
- 39 in the second quarter;
- 35 in the third quarter;
- 41 in the fourth quarter.

In September 2017 in line with our policy we implemented the national quality board recommendations, as of quarter 3 we were required to make judgement on whether problems in care were associated with a death.

1 representing 0.02% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.
In relation to each quarter, this consisted of:

- N/A for the first quarter;
- N/A for the second quarter;
- 1 representing 3% for the third quarter;
- 0 representing 0% for the fourth quarter

These numbers have been estimated using either Initial Findings Report or Root Cause Analysis methodology.

In Quarter 3 of 2017/18, a lapse in care was identified relating to a patient with sepsis seen by the Westcall out of Hours GP service. It is not possible to conclude if the death could have been prevented had the patient been immediately transferred to the acute hospital. This death was investigated as a serious incident. Learning was identified by the service and an action plan is in place.

The learning from this case will be reviewed by all services involved in the care of the patient and this will include South Central Ambulance Service, NHS 111 and Westcall out of Hours GP service. Immediate actions taken included supervision discussions with the clinicians involved and training for GPs working within the Westcall Service to ensure they are aware of the sepsis pathway and immediate red flags and clinical signs which need to be considered and escalated appropriately.

The following paragraphs are mandated by NHS Improvement. However, they are N/A for this year as this is the first year of reporting.

[Number] case record reviews and [number] investigations completed after [date] which related to deaths which took place before the start of the reporting period.

[Number] representing [number as percentage of number in item 27.1 of the relevant document for the previous reporting period]% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the [name, and brief explanation of the methods used in the case record review or investigation]

[Number] representing [number as percentage of number in item 27.1 of the relevant document for the previous reporting period]% of the patient deaths during [the previous reporting period] are judged to be more likely than not to have been due to problems in the care provided to the patient.

"This is my second batch of treatment for PTSD (Brought on by recent active service in the Army) at this NHS run facility. The counter staff are welcoming, professional, attentive and a smiling face when you attend for your appointments which puts you at ease straight away, they should be commended for the work they do and the keen and courteous way they do it. The consulting staff are the most professional, knowledgeable and understanding people I have ever met, I have had other treatments for my condition but these people get to the heart of the matter and help you deal with it, the reason I am back for a second time is that the team gave me the tools to recognise when things were starting to go bad again and to seek help before it all got out of hand, this tool alone was worth the counselling sessions I attended, my appointments were arranged within weeks and a treatment plan discussed and implemented, so off I go again!! When it seems nobody has a good thing to say about the NHS look no further than the amazing team at Erleigh Road, thank you all so much for helping me and other veterans like me.

From a patient- Traumatic Stress service

2.4 Reporting against core indicators

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.

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

Figure 27	2015/16	2016/17	2017/18	National Average 2017/18	Highest and Lowest
The percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care during the reporting period	98.6%	97.8%	**97.7% (12M Average Percentage)**	**96.1% (12M)**	**68.8%-100% (For Q4)**
Data relates to all patients discharged from psychiatric inpatient care on CPA					
Note: The acceptable exclusions for these indicators are as follows: (i) patient dies within 7 days of discharge, (ii) where legal precedence has forced the removal of the patient from the country (iii) patients discharged to another inpatient psychiatric ward (iv) CAMHs patients are not included.					
Berkshire Healthcare NHS Foundation Trust considers that this percentage is as described for the following reasons: In line with national policy to reduce risk and social exclusion and improve care pathways 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 NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of services: The Trust meets the minimum requirement set by NHS Improvement of 95% follow up through the implementation of its Transfer and Discharge from Mental Health and Learning Disability Inpatient Care Policy.					

Source: Trust Performance Assurance Framework

Figure 28	2015/16	2016/17	2017/18	National Average 2017/18	Highest and Lowest
The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period	97.6%	99.1%	**99.2% (12M Average Percentage)**	**98.6% (12M)**	**88.7%-100% (For Q4)**
Berkshire Healthcare NHS Foundation Trust considers that this percentage is as described for the following reasons: Crisis resolution and home treatment (CRHT) teams were introduced in England from 2000/01 with a view to providing intensive home-based care for individuals in crisis as an alternative to hospital treatment, acting as gatekeepers within the mental healthcare pathway, and allowing for a reduction in bed use and inappropriate in-patient admissions. An admission has been gate kept by the crisis resolution team if they have assessed the patient before admission and if the crisis resolution team was involved in the decision- making process					
Berkshire Healthcare NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of services, by: The Trust Admissions policy and procedures provides a clear framework to ensure that no admissions are accepted unless via the urgent care service					

Source: Trust Performance Assurance Framework

Figure 29	2015/16	2016/17	2017/18	National Average 2017/18	Highest and Lowest
The percentage of Mental Health 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	7.7%	6.2%	**7.9%** **(12M Average Percentage)**	**Not Available** (National Indicator last updated 2013)	**Not Available** (National Indicator last updated 2013)
Berkshire Healthcare NHS Foundation Trust considers that this percentage is as described for the following reasons: The Trust focusses on managing patients at home wherever possible and has fewer mental health beds for the population than in most areas. Sometimes the judgement to send a patient home may be made prematurely or there may be deterioration in the patient's presentation at home due to unexpected events					
Berkshire Healthcare NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of services, by: Work being undertaken around gatekeeping for admission to the hospital should start to ensure all admissions are appropriate and/or have greater consideration of their benefits and risks. The Trust are introducing to all wards a 72 hour review for all patients following admission that will start to give greater clarity on what the purpose of the admission is, including what the presentation on discharge should look like. This is then more likely to be planned and coordinated in a shorter time with the appropriate community services.					

Source: Trust Performance Assurance Framework

Figure 30	2015/16	2016/17	2017/18	National Average 2017/18	Highest and Lowest
				For combined MH/LD and community Trusts	
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	3.84	3.88	**3.88** KF1. Staff recommendation of the organisation as a place to work or receive treatment- Score out of 5	**3.68**	**3.40-3.90.**
	74%	75%	**75%** Q21d."If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	**67%**	**55%-76%.**
Berkshire Healthcare NHS Foundation Trust considers that this percentage is as described for the following reasons: The Trust's score is better than average and this is maintained. The Possible scores for KF1 above range from 1 to 5, with 1 indicating poor engagement of staff (with their work, their team and their Trust) and 5 indicating high engagement. The strength of recommendation as a place to work alongside staff involvement and staff motivation are strong indicators of the level of staff engagement with in the Trust.					
Berkshire Healthcare NHS Foundation Trust has taken the following actions to improve this 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 31	2015/16	2016/17	2017/18	National Figures 2017/18	Highest and Lowest
Patient experience of community mental health services indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period	6.8	7.2	**7.3**	**7.1 (Median Trust Result)**	**5.8-7.5**
Berkshire Healthcare NHS Foundation Trust considers that this percentage is as described for the following reasons: The Trusts score is in line with other similar Trusts					
Berkshire Healthcare NHS Foundation Trust has taken the following actions to improve this 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 32	2015/16	2016/17	2017/18	National Figures 2017/18	Highest and Lowest
The number of patient safety incidents reported	**3513 ***	**3195 ***	**4824 ***	**167,477 ****	**N/A**
Rate of patient safety incidents reported within the Trust during the reporting period per 1000 bed days	**31.3 ***	**29.1 ***	**45.9 ***	**44.2 ** (Median)**	**16.00-126.47**
The number and percentage of such patient safety incidents that resulted in severe harm or death	**56 (1.6%) ***	**35 (1.1%) ***	**44 (0.9%) ***	**1744 (1%) ****	**1-172 ****
Berkshire Healthcare NHS Foundation Trust considers that this percentage is as described for the following reasons: The above data shows the reported incidents per 1,000 bed days based on Trust data. In the NRLS/ NHSI most recent organisational report published in March 2018, the median reporting rate for the Trust is given as 71.46 incidents per 1000 bed days (but please note this covers the 6-month period April 2017- September 2017. 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 NHS Foundation 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/ NHSI Organisation Patient Safety Incident Report covering 6 months between April 2017- September 2017 relating to 55 Mental Health Organisations Only*

Part 3. Review of Quality Performance in 2017/18

ⓘ 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, the Quality Assurance Committee 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 2017/18 is detailed below.

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 Figure 29 above.

Never Events

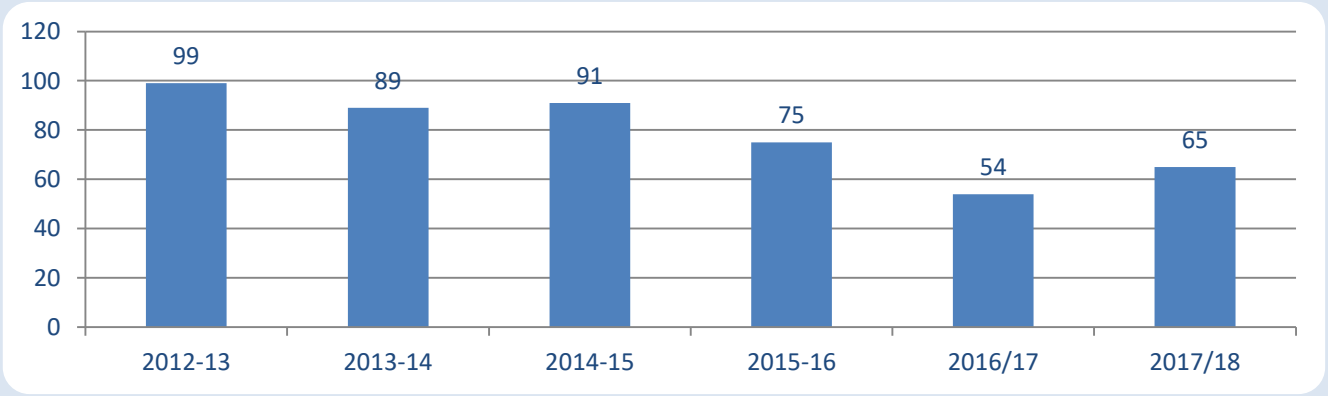
ⓘ Never events are a sub-set of Serious Incidents and are defined as 'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.

The Trust has reported 0 never events in 2017/18.

Figure 33 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 33- Number of SIs- Year on Year Comparison (excluding pressure ulcers)



Source: Trust Serious Incident Report

Summary of findings from Quarter 4 2017/18 Serious Incident (SI) reporting

Suicide cases: In Q4 of 2017/18 there were 5 SI's reported as suicides/suspected suicides. This is an increase on all other quarters in 2017/18 where 3 were reported each quarter. The 5 incidents reported as a suicide/ suspected suicide during Q4 are from different localities.

Unexpected Deaths: There were 3 unexpected deaths reported as SI's in Q4 of 2017/18. Of these deaths, 1 was a person found dead in their house with cause of death unascertainable, 1 was a person whose cause of death has been confirmed by the coroner as alcohol toxicity and 1 was a patient found unresponsive during the night at Prospect Park Hospital, and at the time of writing this report the cause of this death has not been confirmed by the coroner.

Falls: In Q4, there was 1 SI reported for a patient fall resulting in serious harm. This incident occurred on Henry Tudor Ward at St Marks Hospital**,** Maidenhead.

Information Governance Breaches: There were 3 SI's reported as information governance breaches in Q4. 1 was related to the Diabetes Service, 1 related to Westcall and 1 related to Diabetic Eye Screening.

Alleged Assaults: There was 1 SI reported for alleged patient-on-patient sexual assault at Prospect Park Hospital**.**

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. However a learning event is undertaken for any incident where there was a potential lapse in care to explore learning with the teams involved. In Q4 there were no pressure ulcer incidents that were reported as an SI. In Q4 there were 11 learning events held for incidents of category 3 and 4 pressure damage where there was a potential lapse in care. Of these, 5 were agreed to be as a result of a lapse in care (these were in Wokingham intermediate care, 2 in Reading Community Nursing, and 1 each in Ascot and Oakwood wards). For 1 incident in each of WAM, Wokingham and Bracknell Community Nursing, although learning events revealed that the skin damage was not as a result of pressure there was learning for the teams.

AWOL/ Abscond: During Q4 there was 1 serious incident reported of a detained patient who failed to return from planned leave; whilst absent took an overdose and as a consequence was delayed in being able to return to Prospect Park Hospital.

Other SIs reported in Quarter 4: 1 incident of misdiagnosis in the Minor Injury Unit (MIU), this has subsequently been downgraded as detailed below, following investigation. 1 Road traffic accident of a patient who was on planned leave.

Downgrades: At the time of writing this report the incident of the misdiagnosis in Minor Injuries Unit (MIU), detailed above, has been downgraded following completion of the investigation and review by CCG.

Death of detained patients: There have been no deaths of a detained patient during this quarter.

Comparison to 2016/17: There has been 65 SIs reported this year compared to 54 reported in 2016/17 (excluding downgrades).This increase is in the main due to an increase in information Governance breaches with 18 reported during this year and 4 during 2016/17. Falls with harm has increased from 4 in 2016/17 to 7 in 2017/18, whilst SI for suspected suicides has decreased from 22 to 14.

Preventing Future Death reports (Reg. 28): During 2017/18 Berkshire Healthcare has provided information and/ or attended 37 inquests, with 23 of these relating to incidents occurring in 2017/18. There have been no Regulation 28 reports issued to Berkshire Healthcare NHS Foundation Trust.

Key themes identified in SI investigation reports approved in Quarter 4 2017/18, together with actions taken to improve services:

The main themes identified from investigations completed and approved by commissioners in Q4 are:

Safety planning: A number of investigations have highlighted the importance of robust safety planning that is updated for the person's current circumstances, involves family and friends and is shared with the patient's family and friends.

Working with and involving carers and families: The importance of involving families and carers during the

care and treatment of mental health patients has been highlighted as a theme. This theme continues with the importance around hearing concerns and gaining information from family and friends to help inform risk assessments; treatment and safety plans.

Understanding choking risk in patients with swallowing problems: The importance of understanding and following specialist dietary advice provided

Record Keeping: A number of SIs closed in Q4 highlight the need for good record keeping including recording of all interventions, rationale and decision making around care and treatment

Developed Pressure Ulcers: During 2017/18 there have been 22 learning events held for developed pressure ulcers with a potential lapse in care. Both Wokingham Community Hospital and WAM Community Nursing Team have now identified pressure ulcers for their current quality improvement driver metric and will undertaking quality improvement work to reduce developed pressure ulcers within their care

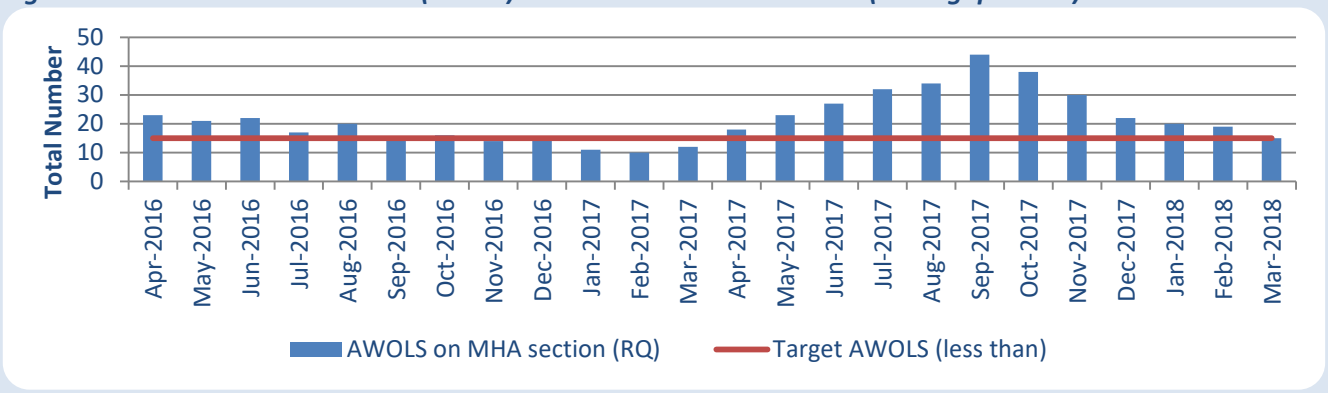
Actions are being undertaken to address these main themes.

Absent without leave (AWOL) and absconsions

ⓘ The definition of absconding used in the Trust is different than AWOL. Absconsion refers to patients who are usually within a ward environment and are able to leave the ward without permission.

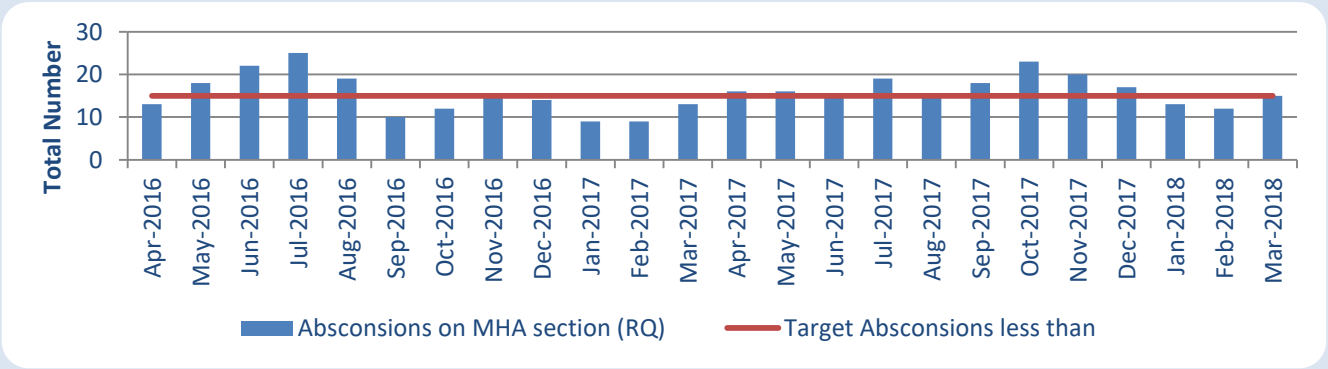
Figures 34 and 35 below detail the number of absconsions on a Mental Health Act Section and the number of patients absent without leave on a Mental Health section.

Figure 34- Absent without leave (AWOL) on a Mental Health Section- (Rolling quarters)



Source: Trust Performance Assurance Framework

Figure 35- 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).

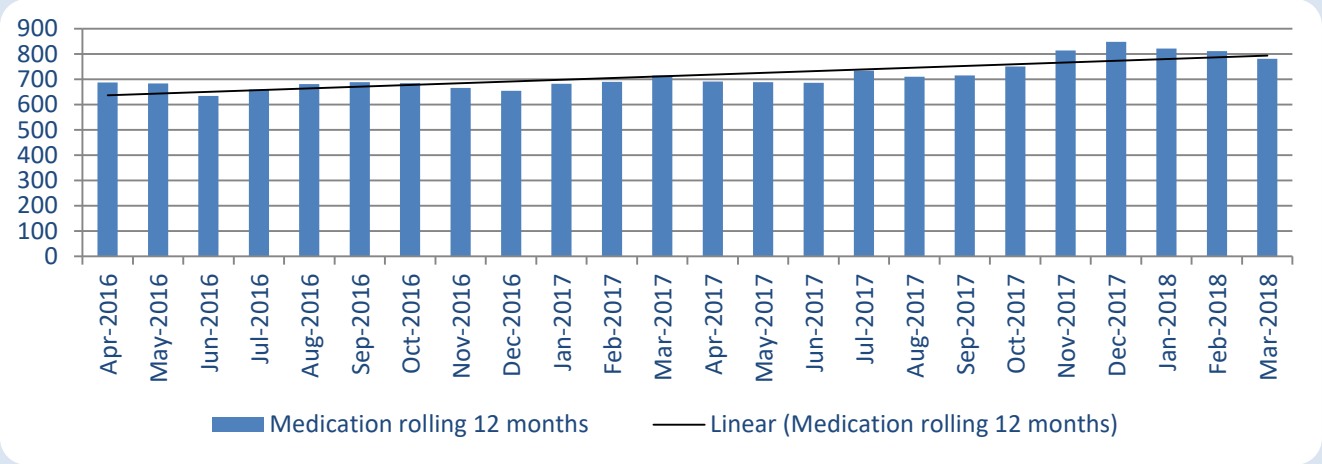
Figure 36 below details the total number of medication errors reported, based upon a rolling 12-month figure.

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.

All medication errors are considered by the Trust's Medication Safety Officer(s) and the Medication Safety Group (MSG) who consider trends and educational interventions appropriate to the errors. This group is a formal sub-group of the Trust Drug and Therapeutics Committee (DTC)

During quarter 4 of 2017/18 there were no moderate, major or severe medication errors.

Figure 36: Medication Errors (Rolling 12 Months)



Source: Trust Incident Database (Datix)

"I attend the centre for weekly therapy and DBT group therapy. I find the environment and atmosphere restful yet full of positive energy. It is clean and inviting. I am treated with respect, dignity and concern. I am lucky to have a place on this well planned course".

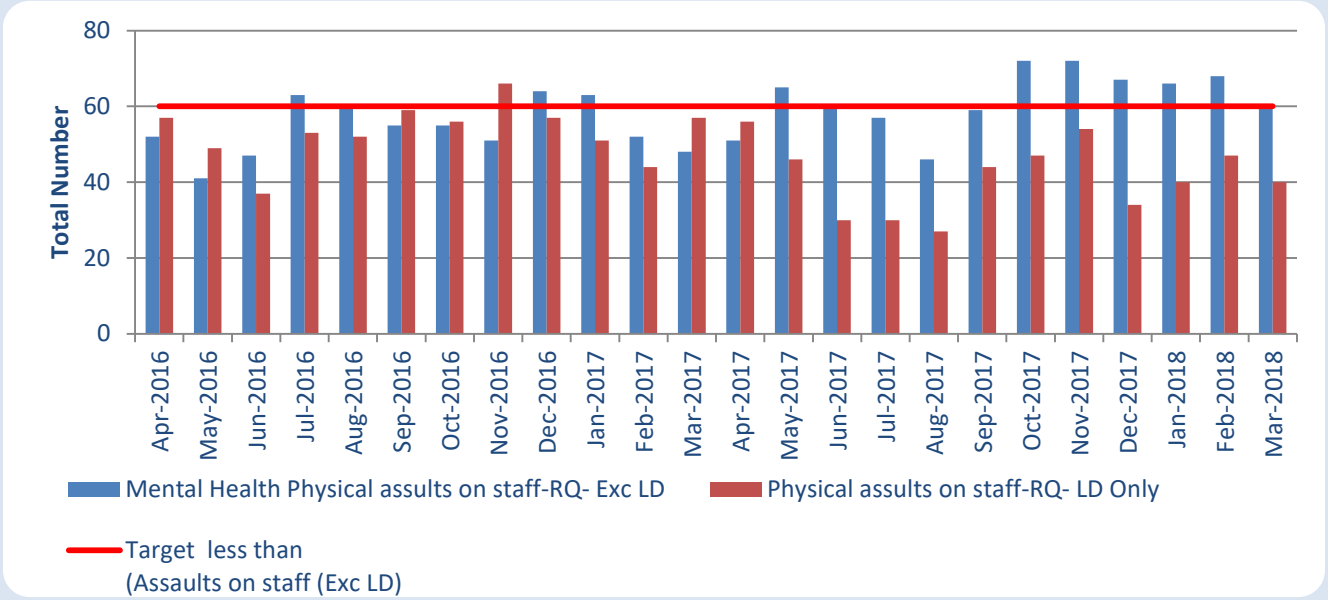
From a patient- Assertive Intervention Stabilisation Team (ASSIST) - Upton Hospital, Slough

Mental Health and Learning Disability Patient to Staff Physical Assaults

Figure 37 below details the number of patient to staff assaults. This data has been separated to show assaults by patients with and without learning disabilities (LD).

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 37- Patient to staff assaults- Rolling Quarters (RQ)

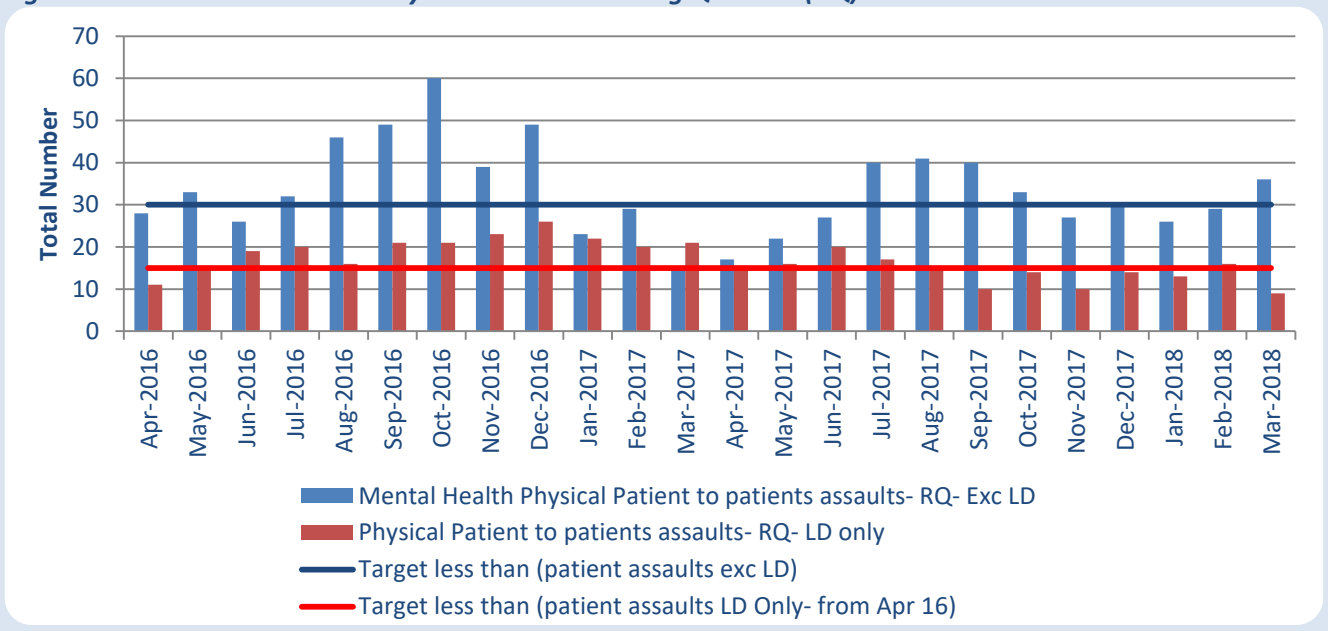


Source: Trust Performance Assurance Framework

Mental Health and Learning Disability Patient to Patient Physical Assaults

Figure 38 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 (LD). As can be seen, the level of patient on patient assaults appears to fluctuate.

Figure 38- Patient to Patient Physical Assaults- Rolling Quarters (RQ)



Source: Trust Performance Assurance Framework

Other Quality Indicators

Figure 39	Target	2015/16	2016/17	2017/18	Commentary
Patient Safety					
CPA review within 12 months	95%	96.1%	95.3%	**94.2%**	12 month average %. For patients discharged on CPA in year last 12 months.
Never Events	0	0	0	**0**	Full year number of never events. *Source- Trust SI Report*
Infection Control- MRSA bacteraemia	0	0	0	**0**	Full year number of MRSA. *Source- Trust Infection Control Reports*
Infection Control- C. difficile due to lapses in care	<6 p/a	1	2	**3 (0.029 per 1000 bed days)**	Full year total number & rate per 1000 occupied bed days of C. Diff due to lapse in care by Trust. *Source- Trust Infection Control Reports*
Medication errors	Increased Report.	623	715	**781**	Full year total number of medication errors reported. *Source- Trust Datix incident management system*
Ensuring that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas: a) inpatient wards b) early intervention in psychosis services c) community mental health services (people on care programme approach)	a. 90% b. 90% c. 65%	N/A	N/A	**a. 87.5%** **b. 88.5%** **c. 100%**	Percentage meeting requirement *Source- Trust CQUIN report*
Admissions to adult facilities of patients under 16 yrs. old	0	N/A	N/A	**0**	Full year total number of <16yr old admissions *Source- Service Generated Data*
Inappropriate out-of-area placements for adult mental health services (Bed days)	Reduce	N/A	N/A	**247**	Average monthly total bed days for Q4 17/18 *Source- Service Generated Data*
Clinical Effectiveness					
Mental Health minimising delayed transfers of care (Relates to Mental Health delays only-Health & Social Care).	<7.5%	1.7%	12.38%	**11.3%**	12 month average %. Calculation = number of days delayed in month divided by Occupied Bed Days in month.
Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral	50%	N/A	85.8%	**84.5%**	Total year %. Added from Q4 2015/16
Improving access to psychological therapies (IAPT): proportion of people completing treatment who move to recovery	50%	N/A	N/A	**58.8%**	Total year % *Source- Service Generated Data*

Figure 39	Target	2015/16	2016/17	2017/18	Commentary
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	75%	N/A	98.4%	**98.9%**	12 month average %. Added from Q4 2015/16
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	95%	N/A	99.9%	**100%**	12 month average %. Added from Q4 2015/16
A&E: maximum waiting time of four hours from arrival to admission/ transfer/ disch.	95%	99.4%	99.5%	**99.3%**	12 month average %.
Completeness of Mental Health Minimum Data Set	99.6% 50%	99.8% 99.2%	99.9% 98.7%	**99.9%** **99.1%**	12 month average %.
Completeness of Community service data 1) Referral to treatment info. 2) Referral info. 3) Treatment activity info.	 50% 50% 50%	 72.1% 61.8% 96.9%	 71.3% 62.5% 97.2%	 **72.9%** **62.6%** **97.9%**	12 month average %.
Patient Experience					
Referral to treatment (RTT) waiting times – non admitted –community.	95% <18 weeks	99.5%	99.3%	**100%**	12 month average %. 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.
RTT waiting times Community: Incomplete pathways	92% <18 weeks	99.7%	99.9%	**99.8%**	12 month average %.
Access to healthcare for people with a learning disability		Green	Green	**Green**	Score out of 24
Complaints received		218	209	**209**	Total number of complaints in year
1. Complaint acknowledged within 3 working days 2. Complaint resolved within timescale of complainant	100% 90%	96.3% 91.4%	100% 100%	**100%** **100%**	Total year %
Please note- there is no longer a requirement to report the number of new early Intervention in psychosis cases to NHS Improvement as part of their Single Oversight Framework. This indicator has therefore been removed.					

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

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 2017/18 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 2017 to May 2018
  - papers relating to quality reported to the board over the period April 2017 to March 2018
  - feedback from commissioners dated April 2018
  - feedback from governors dated April 2018
  - feedback from local Healthwatch organisations dated April 2018
  - feedback from Overview and Scrutiny Committee dated April 2018
  - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated April 2018
  - the 2017 national patient survey November 2017
  - the 2017 national staff survey March 2018
  - the Head of Internal Audit's annual opinion of the Trust's control environment dated May 2018
  - CQC inspection report dated May 2017
- 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

8th May 2018  **Martin Earwicker** **Chairman**

8th May 2018  **Julian Emms** **Chief Executive**

Appendix A: Quality Strategy

Appendix B- National Clinical Audits- Actions to Improve Quality

National Clinical Audits Reported in 2017/18 and results received that were applicable to Berkshire Healthcare NHS Foundation Trust

	National Audits Reported in 2017/18	Recommendation (taken from national report)	Actions to be Taken
	NCAPOP Audits		
1	National Diabetes Audit - Foot care Audit 2016/17 (2779)	The National Diabetes Foot Care Audit (NDFA) is a measurement system of care structures, patient management and outcomes of care for people with active diabetic foot disease.	The Head of the Foot care Service is leading on an action plan to improve outcomes with regards to time from referral by any healthcare professional to assessment by the Multi-Disciplinary Foot-care Team (MDfT). Actions include employing a part time Foot Protection Lead role, this will support community podiatry wound care clinics along with increasing capacity in the weekly MDfT. Work on referral pathways is also underway and is being supported by the RBH Diabetes Clinical Governance meeting.
2	National Diabetes Audit 2015/16 – SWIC (3363)	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.	Since the data collection for this audit, the service has undertaken an internal audit against the standards in the National Diabetes Audit, therefore the results and action plan for the local audit has superseded the results within this report. (due to the time lag in publication of national findings)
3	Falls and Fragility Fractures Audit Programme (FFFAP) - Fracture Liaison Service Database 2016/17 (3366)	The audit aimed to measure primarily against NICE technology assessments and guidance on osteoporosis and the National Osteoporosis Society (NOS) clinical standards for Fracture Liaison Services (FLS). This was the first national patient level audit of quality of FLS's.	An EPR nurse clinic now exists, meaning the Virtual Fracture Clinic (VFC) and specialist clinics can place an order for the service. Vertebral fractures identified incidentally by radiology can be booked into the Fracture Liaison Services (FLS) Virtual Clinic. The FLS has recently obtained software which provides staff access to patients via additional clinics, for example those being treated for hand injury. The contract for this FLS is being reviewed, which will transfer its provision to the local acute Trust.
4	National COPD Audit Programme. Pulmonary Rehabilitation Re-audit 2017. – 3373	The National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme comprises a number of ambitious programmes of work that aims to drive improvements in the quality of care and services provided for COPD patients in England and Wales. This programme looks at Quality Statements derived from the British Thoracic Society: Quality standards for Pulmonary Rehabilitation in Adults	Create protocol for completing outcome measure to ensure standardisation. Update Rio patient Assessment form to include new outcome measure to record data To begin to include 5 x sit to stand assessment test in Berkshire West Pulmonary initial and final assessments. Add outcome to patient's discharge letter and feedback to GP. Update Standard Operating Procedure. Berkshire east to add BMI pre & post to assessment paperwork

	National Audits Reported in 2017/18	Recommendation (taken from national report)	Actions to be Taken
	Non-NCAPOP audits		
5	POMH - Topic 16a - Rapid Tranquilisation (Sept 2016) (2885) – Part of the POMH National Audit programme	This is a national audit coordinated by the Prescribing Observatory for Mental Health (POMH) as part of their on-going programme of clinical audits. Acutely-disturbed behaviour is common in inpatient psychiatric settings, placing both the patient and others at risk. The importance of preventing and appropriately managing such behaviour is addressed by NICE in CG10: violence and aggression: short-term management in mental health, health and community settings (NICE, 2015).	Work on improvement in documenting by staff by on-going work to improve risk management plans, new emphasis within Trust on involving patients in their risk assessment, Pharmacy providing training to RT clinical staff, and on-going work in Trust to improve adherence to National Early Warning Score (NEWS) standards. Actions to improve Datix reporting. To consider if more frequent RT training would be possible.
6	POMH - Topic 17a - Use of depot/LA antipsychotic injections for relapse prevention (May 2017) – 3475	This is a new topic within the POMH programme of national audits. The standards are derived from NICE Guideline CG178 'Psychosis and Schizophrenia in adults: prevention and management'. The audit aims to review practice against standards for use of depot/LA antipsychotic injections for relapse prevention.	Work being done around care/safety plans for patients without care co-ordinators as the patient is outpatient only or depot clinic. Also work on template/standard wording to be agreed around recording the patients relapse signatures and for clinicians to discuss and document these at patient's appointment.
7	Summary POMH Topic 1g & 3d: Prescribing high dose and combined antipsychotics on adult psychiatric wards (3474)	This was a re-audit of prescribing of high-dose and combination antipsychotics. . Though this is the 7th time that POMH has run this audit, and the 6th occasion that Berkshire Healthcare NHS Foundation Trust has taken part (2008 was missed), the last time this was audited as part of the POMH programme was back in 2012.	1. Trust high dose antipsychotic guidelines have been revised for review by the Trust Drugs and Therapeutics Committee. These guidelines will have more focus and clarity around roles of different staff groups. Revised concise guidelines to be circulated to inpatient medical, pharmacy and nursing staff through consultants meeting, Patient Safety and Quality meetings, pharmacy meetings, and nursing development programmes. 2. The high dose monitoring has been revised as part of the revision of the guidelines to improve layout and ease of use- this includes the physical health monitoring required when a patient is prescribed high dose antipsychotics. 3. To develop an e-form for monitoring on RiO with the RiO transformation team. The RiO transformation team has started building this e-form.

Appendix C- Local Clinical Audits- Actions to Improve Quality

	Audit Title	Conclusion/Actions
1	JD/QIP - Audit of VTE assessment and prophylaxis on Orchid and Rowan Wards (Prospect Park Hospital) (3519)	The purpose of this re-audit is to establish if all patients admitted to old age psychiatry wards had Venous Thromboembolism (VTE) risk assessment on admission in accordance with NICE venous thromboembolism quality standard and Berkshire Healthcare NHS Foundation Trust guidelines. Following review of this audit at a clinical effectiveness meeting, immediate measures were put in place to mitigate the risk associated with current practice and policy. The Trust policy has been changed to reflect current NICE recommendations and will be reviewed by the Drugs and Therapeutic group before final approval. Senior medical staff working on the wards have been made aware of the up-to-date good practice which is being followed.
2	Evaluation of the Behavioural Activation intervention work in CAMHS A&D pathway (2623)	The aim of this project is to conduct an audit on consecutive cases receiving Brief Behavioural Activation (BA) in the Trust CAMHS Anxiety & Depression Pathway, to assess feasibility and acceptability of this specific approach. If the findings from this audit are replicated in such studies as are recommended, brief BA should become a standard standalone treatment option offered to depressed adolescents within Trust CAMHS. This however is a long-term goal.
3	Treating comorbid anxiety and depression: A comparison of one vs. multiple interventions. (2717)	The main objective is to compare the impact of one vs. multiple simultaneous Cognitive Behavioural Therapy (CBT) interventions for patients with comorbid anxiety and depression. In patients with clinical levels of depression and anxiety of equal severity, there is no advantage of a broader treatment addressing both anxiety and depression compared to a treatment focused on depression
4	JD/QIP - Audit on implementation of Positive Cardiometabolic Health Resource in Prospect Park Hospital Acute Adult Inpatients (2924)	The overall aim of the audit is to assess compliance with the Lester Tool and associated Commissioning for Quality and Innovation (CQUIN) targets. Greater awareness of the Lester tool amongst staff, should lead to improved monitoring.
5	Delirium NICE Quality Improvement Re-audit (3246)	The aim of the delirium project is to improve the outcome and experience of patients at risk of or diagnosed with delirium by ensuring that best practice is followed in line with NICE Quality Standard 63- Delirium. The re-audit has shown that risk has reduced compared with the initial audit; however there is still scope to improve. Failure to identify and manage patients with delirium is associated with significant increased risks for the patient. People with delirium are likely to have longer and more complicated hospital stays (pressure sores, increased risk of falls etc.). They are also more likely to be admitted to long-term care when they leave hospital. There are also cost implications from failures to recognise delirium.
6	Audit of confidence in continuing use of techniques and managing relapse after Cognitive Behavioural Therapy (3252)	The aim of this is to improve client confidence in maintaining and continuing with progress after therapy. Therapy summaries have been recognised as helpful to both staff and clients.
7	JD/QIP – Multi- Disciplinary Team (MDT) documentation in Prospect Park Hospital acute wards (3290)	The objective of this audit is to assess the current practice of Multi-Disciplinary Team (MDT) documentation in order to analyse what improvements can be made. This audit has been useful in highlighting practice regarding use of MDT templates. Whilst a form is now available on RiO (the electronic patient record), staff will still need to be made aware of the importance of completing MDT forms with as many disciplines as possible attending and contributing to make the MDT meeting meaningful. A potential risk exists of poor patient management or significant events if the MDT meetings are not utilised effectively or documented accurately. Ward managers or consultants in charge need to take a lead in implementing a standardised MDT template as well as ensuring complete documentation

	Audit Title	Conclusion/Actions
8	JD/QIP - Establishing and monitoring the physical health needs of patients in Reading Short Term Team (3408)	This project aims to establish the physical health needs and prior diagnoses of patients referred to the Short Term Team at the time of referral and whether these have been identified or addressed appropriately by community mental health services during contact. As a result of this audit a prototype proforma for easily and intuitively requesting specific physical health monitoring tests from the GP has been designed.in addition, since this audit an electronic shared summary care record has been implemented within outpatient and inpatient psychiatric services at Prospect Park Hospital for easy access of historic and up to date patient information from GP to psychiatric services
9	Safe Handling and Disposal of Sharps Audit 2017 (3424)	The aim of the project is 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, and to ascertain the current level of compliance with Health and Safety Legislation across the Trust. A clear and well understood process for management of sharps will mean that any risk to staff and patients is minimised.
10	An audit on the management of nongonoccocal urethritis. (3444)	Nonspecific urethritis (NSU) is often a preliminary diagnosis in men who have lower urinary tract symptoms. Recently there has been a rise in treatment resistant NSU predominantly due to Mycoplasma genitalium and in the UK most centres do not test for this. A programme of education about the most up to date guidance is shared with staff to ensure best practice recognition and management.
11	Blood transfusion bed side audit (3460)	The aim of the audit is to ensure that the Trust's blood transfusion practice is in line with the required National Standards. A plan is being implemented to ensure all prescribers of transfusions are made aware of the criteria for NICE Clinical Guideline 24 and Quality Standard 138 when a referral is made for transfusion.
12	Audit of Routine Assessment for Home Treatment Team (3496)	The Royal College of Psychiatrists have set a series of standards for the Home Treatment Accreditation Scheme (HTAS) which have been accepted nationally. As part of this scheme there are recommendations for routine assessments when patients are referred to the team. The Royal College of Psychiatrists have developed standards for Home Treatment Teams and after thorough assessment if a service meets these standards provides accreditation. The Trust achieved accreditation from the Home Treatment Team Accreditation Scheme (HTAS) in September 2016.
13	Fluenz PGD Audit (3531)	This audit has been undertaken to review the consent forms of children who were administered the Fluenz Tetra nasal spray. Immunisation policy updated to add in additional measures around consenting very young children for nasal flu.
14	Management of anogenital warts in the sexual health service (3565)	The audit was undertaken to look at Garden Clinic standards of adherence to treatment algorithms, clearance rates and internal standards associated with diagnosis and management of anogenital warts. Obsolete clinic guidelines are being replaced with current national guidelines. Improvements to documentation and dynamic forms will support accurate recording.
15	Audit of compliance with sepsis early recognition tool community health inpatient units (3563)	This audit was undertaken to ascertain baseline compliance following the implementation of the sepsis early recognition tool. Within Berkshire Healthcare timely recognition and diagnosis of sepsis via identification and management of the deteriorating patient, including escalation, are key interventions in reducing mortality rates due to sepsis.
16	Re-audit of Antimicrobial Prescribing on all Trust Inpatient Wards 2016-17 (3494)	This audit monitors compliance with local standards for safe antimicrobial prescribing and practice, and national (Health and Social Care Act) requirements. This project supported the role-out of improving Antimicrobial Stewardship (AMS) awareness and face to face training sessions across all inpatient sites and sharing and spreading the Trust improvements across the other Trusts within the Thames Valley and Wessex region.

	Audit Title	Conclusion/Actions
17	An Audit on the Anticholinergic Cognitive Burden (ACB) in the Elderly population within Prospect park Older Peoples Mental Health (OPMH) wards (3045)	Anticholinergic cognitive burden (ACB) is the cumulative toxicity of anticholinergic medications leading to reversible mild cognitive impairment (MCI). The study successfully highlighted areas of patient care in need of improvement and recommended ways in which to reduce risk levels. High ACB was a prevalent problem across both groups. Poor compliance with the standards suggested limited awareness of ACB in practice, although there was some evidence of risk-mediation in the dementia population.
18	JD/QIP - Testing for blood borne virus infection in mental health inpatients (3479)	The aim of the project is to determine whether patients on the inpatient psychiatric ward are being offered testing for blood borne virus (BBV) infections. The project will raise awareness amongst psychiatry trainees and nurses about the prevalence of undiagnosed HIV in mental health inpatients, the risk factors for infection, the protocols/procedures involved in testing and what to do with a positive/negative result (information about local HIV services).
19	JD/QIP - Re-audit of assessment and management of pain in patients with dementia in a psychiatric inpatient ward (3561)	Pain is commonly experienced by older people and it is known that in patients with dementia it is under-recognised. Two recommendations by the Royal College of Anaesthetists suggest effective management of pain by regular assessment in all older patients. In comparison to the previous audit, this re-audit found similar results in terms of under recognition of pain management. There is still much potential for improvement as previous recommendations appear not to have been met in ensuring that pain assessments were included in routine observations.
20	Audit of arrangements for clear and accurate information exchange based on NICE Quality Standard 15, Statement 12 (3430)	The aim of the project is to ensure that there are local arrangements in place to support coordinated care through clear and accurate information exchange between relevant health and social care professionals. There are local arrangements in place to support coordinated care through clear and accurate information exchange between relevant health and social care professionals.
21	Cardio Metabolic CQUIN for Mental Health – Inpatients (IP), Community Mental Health Teams (CMHT) & Early Intervention in Psychosis (EIP) (2016/17) (3346)	This audit was as a National Commissioning for Quality and Innovation (CQUIN) project for 2016/17 and therefore a contractual requirement with an associated payment based on outcomes. The audit was conducted by the Royal College of Psychiatrists (RCP). It requires all patients to have a number of physical health screenings and interventions or referral for interventions when the screening meets a threshold (Identified by the national Lester Tool). More patients have received the full complement of recommended healthcare screening checks, across a range of EIP, IP and Community mental health services.
22	An evaluation of Paliperidone Palmitate within the Trust (1508)	An evaluation of the cost effectiveness using Health of the Nation Outcome Scales (HoNOS) and clustering and also a measure of whether patients are satisfied with the new treatment. Patients with schizophrenia prescribed Paliperidone Palmitate Long Acting Injectables (PPLAI) showed a significant improvement in mean Care Cluster scores when these are linked to payment (indicating lower costs of mental healthcare), a reduction in the Severe Disturbance factor, and a faster discharge from hospital at the point of initiation, as well as an increase in medication satisfaction.
23	Care Contact Time (2829)	As part of the national safer staffing expectations all Trusts are required to ensure that their wards undertake care contact time analysis on a regular basis. Wards have their data and are able to review how their time is spent with the initial aim of focusing on % of time was spent on non-patient facing non- patient related activity to ascertain if this could be converted into patient facing time.

	Audit Title	Conclusion/Actions
24	JD/QIP - Establishing and monitoring the physical health needs of patients in Reading Short Term Team (3408)	This project aims to establish the physical health needs and prior diagnoses of patients referred to the Short Term Team from Spring - Summer 2016 at the time of referral and whether these have been identified or addressed appropriately by community mental health services during contact. As a result of this audit a prototype proforma for easily and intuitively requesting specific physical health monitoring tests from the GP has been designed.in addition, since this audit an electronic shared summary care record has been implemented within outpatient and inpatient psychiatric services at Prospect Park Hospital for easy access of historic and up to date patient information from GP to psychiatric services, which should improve compliance to improving shared care via the GP summary on re-audit and ensure that important physical health problems are not missed.
25	Re- Audit of Patient Consent to Sharing Information based on NICE Quality Standard 15, Statement 13. (3428)	The aim of this re-audit project is to ensure that patients' preferences for sharing information with their partner, family members and/or carers are established, respected and reviewed throughout their care. Patients' preferences for sharing information with their partner, family members and/or carers are established, respected and reviewed throughout their care.
26	Assessment of compliance of healthcare workers practice with policy & best practice in patients requiring intravascular devices (3476)	The aim of this audit is to assess compliance of healthcare workers practice with policy and best practice when providing care for patients. This audit is part of the Berkshire Healthcare annual infection prevention and control audit programme 2016-17. The audit of the vascular access devices demonstrated excellent results achieving 100% compliance with all criteria of safe insertion, maintenance and removal of devices as per the Berkshire Healthcare policy and NICE guidance.
27	ASD/Anxiety Evaluation - Factor Structure and Measurement Invariance of the SCAS-P (1925)	The SCAS-P is used to assess anxiety in children with Autism Spectrum disorders (ASD) but its validity has not been established. The team compared the psychometric properties of the measure between young people with anxiety who were assessed at the Berkshire Child Anxiety Clinic and other young people with anxiety / ASD (recruited from outside the Trust) and to disseminate this further by publishing the findings in a peer-reviewed journal. Cross-group comparisons between ASD and anxious samples based on the SCAS-P scores may not always be appropriate.
28	Service evaluation of frequency pain flashbacks in patients at the Berkshire Traumatic Stress Service (2738)	The objective of this service evaluation is to analyse routinely collected data from patients assessed at the Berkshire Traumatic Stress Service to identify the prevalence of this experience in this population. The present study served two purposes: to determine the prevalence of pain flashbacks, and to begin the development of a measure. Clinicians could be encouraged to ask about pain and other somatosensory experiences, and to target these in therapy.
29	Promoting Dysphagia Awareness of Safety and Quality of Care in Patients with Swallowing Disorders (3295)	The aim of this project is to reduce numbers of incidences by 80% of non-compliance with dysphagia best practice recommendations by imparting dysphagia awareness training to housekeeping staff on the Acute Stroke Unit. The project highlighted areas of patient care requiring improvement and implemented actions to increase compliance and staff confidence. The project led to a significant increase in patients on modified dysphagia diets being offered drinks compliant with Speech and Language Therapist recommendations, thereby improving patient care.
30	Audit of Sharps use in Berkshire Eating Disorders Service (3425)	This audit is to review the safe handling and disposal of sharps within the Eating Disorders Service based at St Marks Hospital Ongoing audit is an important tool in the Quality Improvement process for managing sharps.
31	Compliance with HTM01-05 in the Dental Environment (Dental decontamination) - 2016/17 (3450)	The aim of the audit is to assess the salaried dental services' ability to comply with the essential quality requirements as set out in HTM 01-05 - Decontamination in Primary Dental Practices, in relation to the environment and their use of personal protective equipment. Good infection control and decontamination practices are essential in dental services in order to minimise the risk of infection to both patients and staff.

	Audit Title	Conclusion/Actions
32	EIPN Self-Assessment Tool (3452)	Monitoring of Early Intervention in Psychosis (EIP) services following the 2016 National audit (ID:2880) will be through participation in a quality assessment and improvement programme, organised and administered by the College Centre for Quality Improvement (CCQI). The EIP service monitors it's compliance levels closely, to ensure best practice is delivered, via a range of means.
33	JD/QIP Capacity and consent relating to Medication decision in the memory clinic (3533)	Documentation of the diagnosis and capacity to consent to medication prescribed in memory clinics is necessary in order to demonstrate that memory clinics are acting ethically and that they meet standards set by the Department of Health and Care Quality Commission (CQC) amongst others. The findings of this audit are being shared, and will feed into the accreditation process.
34	Do Not Resuscitate Forms (3638)	The aim of the audit is to review the "completeness" of the Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) paperwork used across the Trust, evidence discussion with patients re DNACPR , where possible, review involvement of "relevant other" e.g. Next of kin, family member in discussion re DNACPR, and address CQC findings as part of Good to Outstanding process. Although the audit has had its limitations it has been able to demonstrate improvements and clear areas that need further work which will assist in focusing action plans for both Community Nursing Teams and inpatient wards.
35	Evaluating HIV positive patients adherence to anti retro viral therapy (Slough 2016) (3371)	The topic is important to explore reasons and barriers for adherence/non adherence of anti-retro viral therapy. The aim is to explore what can/does help patients to be adherent. To project helped the service to gain up to date and local information from patients in the Slough area as there was no recent and local research available at present.
36	JD/QIP - Quality Improvement Project on Handover using Situation, Background, Assessment, and Recommendation (SBAR) between Nursing staff and Out of Hours (OOH) doctors (3394)	The aim of this project is to establish whether clinical staff (doctors and nurses) working out of hours (anything outside normal working hours of Monday to Friday 09:00-17:00 excluding bank-holidays) are aware of the SBAR handover system and, if so, whether they use it and are confident in doing so. This project highlighted that further work needs to be undertaken into improving current handover systems and practice.
37	JD/QIP - Radiology referrals (2015-2016) from Prospect Park Hospital to Royal Berkshire Hospital: audit of the referral process (3395)	This project aimed to review the Radiology referral process from inpatient wards at Prospect Park Hospital to the Royal Berkshire Hospital Radiology Department to improve the process of direct Radiology referrals, improve the quality of these referrals and to increase junior doctor awareness and improve completeness of referral forms, thereby improving quality of Radiology reports. Awareness of this audit and its dissemination to doctors provides potential for higher quality and more comprehensive referrals to Radiology, and in turn, higher quality reports received back from Radiology.
38	MPharm Student Project: Investigating shared care arrangements in mental health prescribing (3419)	The purpose of this study is to investigate issues around shared care arrangements in mental health prescribing. Stereotypes of mental illness allude to the ideologies reinforced by society. The study allowed for a range of media to be examined to understand the representation of drugs, mental health and pregnancy and the predominant themes relating to these concepts. Greater understanding of preconceptions can support adherence conversations.
39	An evaluation of multidisciplinary team meetings in a community mental health team (3446)	The aim of this project is to gather data to determine whether staff in the Community Mental Health Team feel that their Multi-disciplinary Team (MDT) meetings are effective, following structure change. Effective use of staff time in meetings allows patient face-to-face care to be increased.
40	JD/QIP - Psychotropic drug prescribing for people with intellectual disability (3501)	The aim of this audit is to determine the level of compliance with the current practice standards for psychotropic medication prescribing in intellectual disabilities as highlighted by the report of the Faculty of Psychiatry of Intellectual Disability, Royal College of Psychiatrists. The results from this audit demonstrated that overall, regular reviews of patients on psychotropic medication in the Reading and Newbury Community Teams for People with Learning Disabilities (CTPLD) are taking place.

	Audit Title	Conclusion/Actions
41	JD/QIP Evaluation of Use of Interpreters for Reading Common Point of Entry (CPE) Assessments (3560)	This audit evaluated Reading secondary service Community Mental Health Team's use of interpreters in accordance with principles set out by NHS England for high quality interpreting and translation services for primary care services. All patients included in the audit had documentation indicating that an interpreter had been booked for the CPE appointment.
42	Trust re-audit of POMH Prescribing for substance misuse: alcohol detoxification (3405) – Local re-audit of POMH topic	In August 2016 we reported on the POMH-UK alcohol and substance misuse audit to the Trust Quality Assurance Committee. There were certain areas where the Trust performed poorly, in comparison to other Trusts. As a result, the Quality Assurance Committee requested a local re-audit in 12 months' time to give assurance that improvement had been made. The 6 standards that were re-audited from the original POMH audit had all increased in compliance bar one ('documented assessments of the signs and symptoms of Wernicke's encephalopathy'). The lead Consultant raised this at the junior doctors' induction in Aug 17 and followed it up by emails to all trainees. Clinical Governance Nurse and psychiatric trainee will undertake monthly audits of 5 patients per ward on the use of the alcohol screening questionnaire and will attend the MDT on each ward to discuss expected compliance with Alcohol Detox
43	To Improve Compliance with Physical Health Monitoring for Service Users on Antipsychotic Medication in Slough Community Mental Health Team (CMHT) (3624)	The aim of the project is to improve compliance with regards to physical health monitoring for patients on antipsychotic medications. Attention to the physical health of patients is part of a holistic approach, and has been recognised as an increasingly important part of the work within mental health services (Rowlands, 2013). Work is on-going through CQUINS on Physical Health monitoring Trust wide
44	Evaluation of a treatment for childhood anxiety (the 'overcoming' programme).(3041)	This is an evaluation of treatment for childhood anxiety in which parents are taught the principles of cognitive behavioural therapy either in groups or individually (the 'overcoming' programme). Promising Results regarding children's outcomes following Group GPD-CBT. Group GPD-CBT was viewed by clinicians as acceptable and helpful. There is a need to develop and evaluate low-intensity treatments for childhood anxiety disorders in order to improve accessibility to psychological treatments.
45	Re-Audit- People whose Behaviour Challenges - Care Pathway (April 2017) (3535) – Local Audit	The publication of national guidance on working with people whose behaviour challenges the service prompted our service to agree a number of tasks designed to address the issues raised. The guidance stressed the importance of multidisciplinary and consistent approaches to the assessment and intervention of behaviour plans. The audit demonstrated areas of excellent practice with the vast majority of findings meeting standards 100% of the time a part from one 98%. The audit also demonstrated that our original Good Practice Standards and the more recent NICE Quality Statements are both being met to a very high degree.
46	JD/QIP Re-audit: Provision of Verbal and Written Drug Information on Adult Inpatient Psychiatric Wards (3659	The aim of this re-audit is to examine the provision of verbal and written information to adult inpatients prior to introducing a new psychotropic agent. This audit was undertaken as a part of audit cycle to assess whether recommendations from previous audits were followed and whether it has yielded any improvement in our practice. Encourage team to use the new template whenever changing/introducing new medication to avoid any possibility of under-recording of information. Create a separate form to fill in if it is felt that the capacity is not likely to change and repeated MCA forms are not required. This may be accessible in patient's care plan and improve record keeping practice. Make staff aware of existence of any leaflets available on the ward. This could be included in induction package. It has been shown that amount of information retained following verbal information alone is very limited. Therefore providing written information for patients to confer to and supplement their understanding is important.

	Audit Title	Conclusion/Actions
47	Berkshire Eating Disorder Unit Risk Assessment and Record Keeping Audit (3418)	This audit aims to investigate the service's compliance with standards relating to risk assessments and record keeping. Clinicians within Berkshire Eating Disorder Service (BEDS) should conduct their own risk assessment during assessment, reviews and discharge communicated with relevant other professionals. All staff made aware of policies and allocated dedicated admin time at the end of the day. Appropriate management support provided to improve confidence. Audit report and the action plan to be put on service shared drive and monitored. Findings and main actions to be presented at October 2017 Business meeting. Clinicians to identify sufficient administrative time in consultation with their clinical supervisors.
48	Management of cases of early infectious syphilis in the Service. (3520)	The main aim of the audit is to assess performance against auditable outcomes specified in the guidelines. All services should ensure that an appropriate contact action is agreed and pursued for every contact of individuals with early syphilis, including documenting where no action is taken because a contact is deemed to be uncontactable. Caution is needed in recording and interpreting PN outcomes, especially as regards contact attendance reported by the index patient Consideration should be given to early follow-up HIV testing of individuals with syphilis, as an opportunity to diagnose seroconversion. The service is reviewing whether any actions are required from these results at present. No concerns have been highlighted.
49	Re-audit following audit of personal practice for autism diagnosis in children in 2015 (3534)	The primary aim of the audit is to compare clinical practice with the best practice criteria listed in NICE Clinical Guideline 128—Autism Diagnosis in Children and Young People. In response to the findings, further analysis of CDC data has been requested and a meeting to explore ways of working which could reduce the delays in the assessment process. The service has also been made aware of the NICE recommendation—'Start the autism diagnostic assessment within 3 months of the referral to the autism team'. A meeting is arranged (health and social care partners involved in the ASD referral and assessment pathway) to agree upon measures to improve waiting times.
50	Audit of discharge summary from Berkshire Perinatal Mental Health Services (3800)	The aim of this audit is to evaluate the quality of discharge summaries compared with standards from the Perinatal Community Mental Health Services of the Royal College of Psychiatrist Quality Network for Community Mental Health Perinatal Teams. There was variation in the format and content of the discharge summaries. Whilst for Initial Perinatal Assessments the perinatal team uses a standardised assessment form that collects the same data for all patients, this is not in place for Discharge Summaries. Standardised the discharge summary to be used by perinatal clinicians.
51	Access and Waiting Time for Berkshire community Perinatal Mental Health services (3833)	This audit aims to compare waiting times with the standards introduced by NICE in 2016 and aims to compare the waiting time with the standards introduced by NICE, 'Implementing the Perinatal Mental Health Evidence Based treatment Pathway. The result of this audit is excellent. Therefore, no action recommended for the practice.
52	Audit of use of Dementia Assessment Integrated Care Pathway in Learning Disability Services (3875)	The aim of the audit is to ensure the new care pathway had been fully implemented into practice. Lower rate of completion of some of these items may reflect omissions in documentation, rather than omissions in clinical practice a new assessment tool being introduced for a group of staff; uncertainties about when to upload documentation onto RiO as completing the Care Pathway can be a lengthy process; and turnover of staff meaning that the Care Pathway may not be familiar to all Community Team for People with Learning Disability (CTPLD) staff. Audit findings to be fed back to staff, dementia planning meetings to be undertaken in all teams, training provision for staff will include how to use the Dementia Assessment care pathway.

	Audit Title	Conclusion/Actions
53	Service evaluation of effectiveness of specialist Multi-Disciplinary Team (MDT) tics clinics for neurodevelopmental and psychoeducation in East Berks CAMHS (3339)	This service evaluation was undertaken after the decision was made within East Berkshire to group referrals for tics so that they could be seen together and as part of a joint assessment. This model was based on the National Tourette Service at Great Ormond Street Hospital and was put in place due to the identification of patients with tics being poorly triaged and waiting a long time for assessment. During the project, staff realised that it was appropriate to discharge almost half the sample with just education (and no CAMHS input). These earlier discharges were achieved due to the introduction of an Assistant Psychologist phoning patients to provide advice, thereby reducing unnecessary appointments. Earlier discharges freed up appointments, thereby reducing waiting times and the need for medication. During feedback of these results to CAMHS clinicians, it was suggested that current practice could be audited in other business units for comparison data. Other further models of care have been suggested, in line with the Anxiety and Depression Pathway model. It is possible that this service may be eligible to participate in the National Audit of Anxiety and Depression.
54	Evaluation process for the MAP pressure monitoring system (Sidhill) (3357)	The M.A.P™ system is a continuous bedside pressure monitoring tool that enables nurses and carers to monitor bed-bound patient's optimal pressure distribution in order to reduce the risk of pressure ulcers. It uses a pressure sensing mat to identify high and low pressure areas between the patient and the support surface. The mat is linked to a monitor displaying a real time, high resolution image defining at-risk pressure points, giving accurate data to enable staff to reposition patients so that optimal pressure distribution is achieved. This tool proved to be useful as a teaching resource. It was decided that due to cost, the tool would not be purchased for the Trust, but would be hired as and when required.
55	Management of Anogenital Warts (C11A) at first presentation (3565): March 2017	Anogenital warts caused by the Human Papilloma virus (HPV) are the second most common sexually transmitted infection (STI) in the UK and most common STI of viral aetiology. The aim of the project was to measure clinical practice against auditable standards both from the British Association of Sexual Health and HIV (BASHH) as well as internal standards so that improvements can be made in areas of poor compliance. Actions include replacing the Garden Clinic guidelines with current BASHH guidelines; to add additional features to Lilie and provide training to staff; to update female dynamic forms; and to improve documentation of discussions with patients.
56	Is the transfer of physically ill patients from and to Prospect Park Hospital (PPH) in accordance to Trust Guidelines? (3880): October 2017	The burden of physical health problems increases with age and this is of particular concern in those patients with a co-existing mental health disorder. Berkshire Healthcare and PPH have created guidance to enable efficiency when transferring patients out of and back to PPH for acute medical problems, Procedure for the transfer of mental health inpatients to and back from physical treatment. Discussions with clinical colleagues and observation of concurrent guidance (Royal Pharmaceutical Society, 2011; DH, 2017) led to some key recommendations for action. These relate to providing a laminated checklist including handover, drug chart, s17 leave, informing relatives and informing doctors of review. Other actions include reminding staff to print EPMA drug charts when transferring patients out, and to complete handovers, which will be discussed at staff induction. At daily handovers, staff will now be reminded to attempt daily contacts with relatives/carers.
57	Evaluation of the Lower Limb Class (3898): November 2017	The purpose of this service evaluation is to evaluate the effectiveness of the Lower Limb Exercise Classes (LL class) run across Wokingham and Newbury outpatient physiotherapy sites. Actions relating to: obtaining more pre- and post- class PSFS scores; standardising the number of sessions across both localities; routinely enquiring about maintaining physical activity post discharge; and adapting the audit tool at re-audit are being implemented.

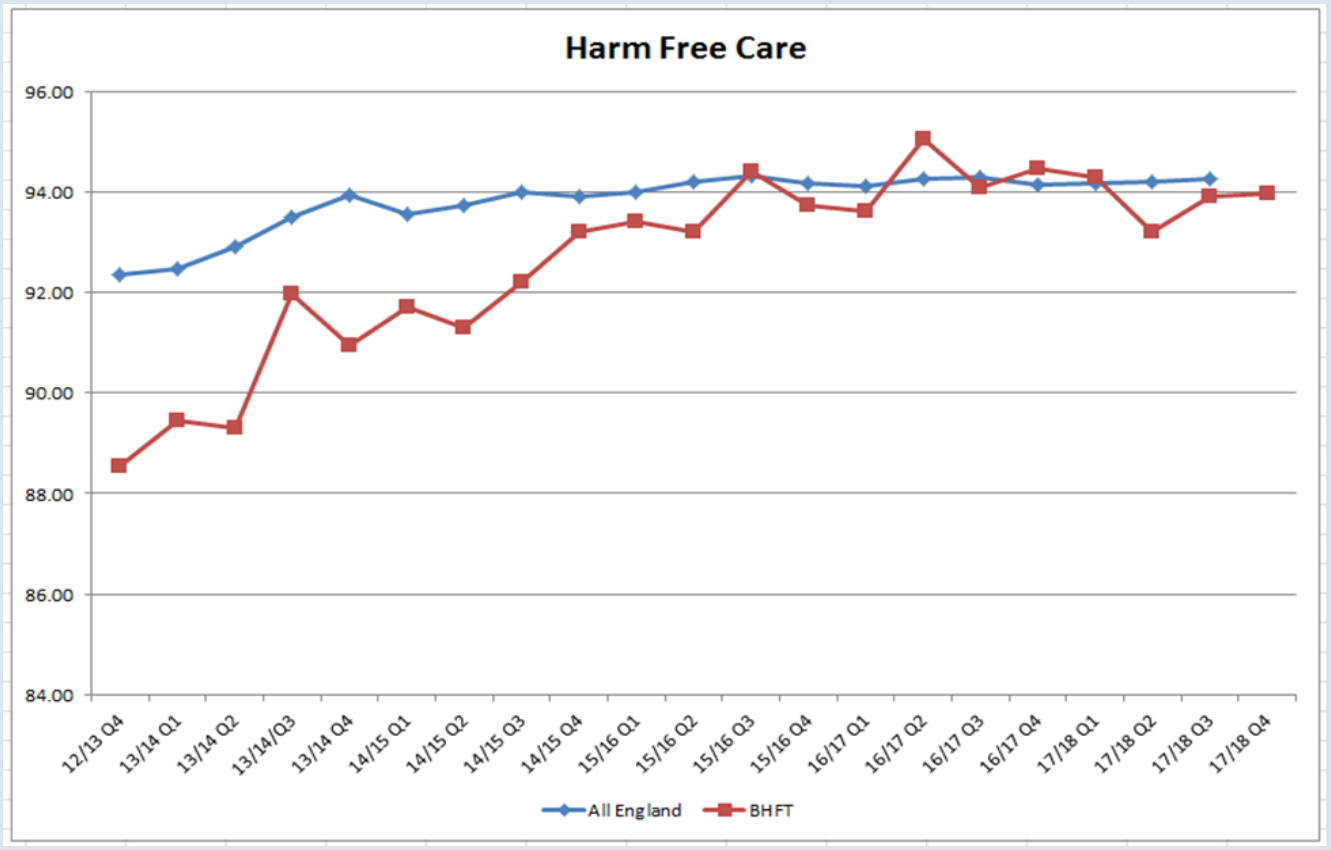
	Audit Title	Conclusion/Actions
58	Clinical Supervision Re-Audit -3943	The purpose of the re-audit of Clinical Supervision is to establish the level of compliance with the clinical supervision requirements outlined in policy CCR097 and to measure any changes in practice since the 2015/16 re-audit. Recommendations: Services across the Trust review their use of reflective diaries and actively encourage all clinical staff to complete them. Children's services review and formalise their protocols and arrangements for access to clinical supervision and provide clinical supervision training to supervisors and supervisees. Children's Services, East & West Physical Health Services and West Mental Health Services should make improvements with monitoring supervision attendance and non-attendances.
59	Re audit on the management of Gonorrhoea in the integrated sexual health service – 3279	The purpose of this re-audit is to measure current practice relating to management and treatment of gonorrhoea against standards developed from Public Health England's Gonococcal Resistance to Antimicrobials Surveillance Programme, BASHH Guidance for the Management of Gonorrhoea in Adults (2011) and Local Guidelines. Recommendations/actions: Development of an appointment system for TOC when given medications, fast track appointments and/or home tests. Improving documentation of information and health advice given during consultation –add a tick-box to the new IT system. Completing microscopy slides for all asymptomatic patients. To educate new staff as part of their induction.
60	Case Conference reports – 3562	The purpose of this audit is to re-audit the two standards which evidenced less than 90% compliance, and to also audit the quality of CAMHS Child Protection Case Conference Reports as recommended in the action plan. Actions: Named professionals for safeguarding children to discuss the findings with CAMHS practitioners at their management meetings and also to highlight the issue with the CAMHS management team. Main focus to be Trust safeguarding policy and procedure, the voice of the child, think family approach and the role of CAMHS in the safeguarding process. CAMHS to include safeguarding as part of induction. CAMHS staff to be reminded during supervision to use the Berkshire Healthcare template. Ensure child protection conference invites for CAMHS practitioners are being reviewed by CAMHS
61	Audit of Perinatal Mental Health Evidence (Amir Sam) Report-2017 – 3884	This audit aims to assess compliance with the standard outlined in Pathway 4: 75% of women with a perinatal mental health problem who are referred for psychological interventions, such as those provided by primary, secondary and tertiary care, start treatment within six weeks of referral. In relation to Pathway 4 which was the focus of the audit no actions were required as the standard was met in 100% of cases audited
62	JD/QIP - Clinical audit of the assessment of delirium at Wexham Park Hospital – 3927	This audit evaluated the proportion of medical admissions at Wexham Park Hospital, Slough, who were assessed for delirium. The tool mandates that the following group of patients must be assessed for delirium: age 75 and above or current confusion. Recommendations include: Increase of compliance of the 4AT tool through education. Creation of a standard question mandatory for all medical admissions, to capture patients at risk of delirium according to NICE but missed by hospital screening requirements. This may also prompt the user to complete the 4AT tool if 'yes' has been answered and can therefore increase compliance.
63	Qualitative Minor Injuries Unit notes audit 2017 – 3995	This audit was completed to ensure that certain criteria relating to note-taking were met. Standards were developed through discussions with staff to determine a consensus of opinion on minimum requirements for a set of clinical notes. The aim is to ensure that notes are high quality and that staff are able to easily understand notes written by other Practitioners. Member of staff incorrectly recording medical history on Adastra educated in correct procedure. Results and comments from audit disseminated to all staff through clinical governance newsletter. Continue audit on a bi-monthly rolling process. Involve other clinical staff in data collection as a way of sharing learning from practice by reviewing each other's notes.

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.

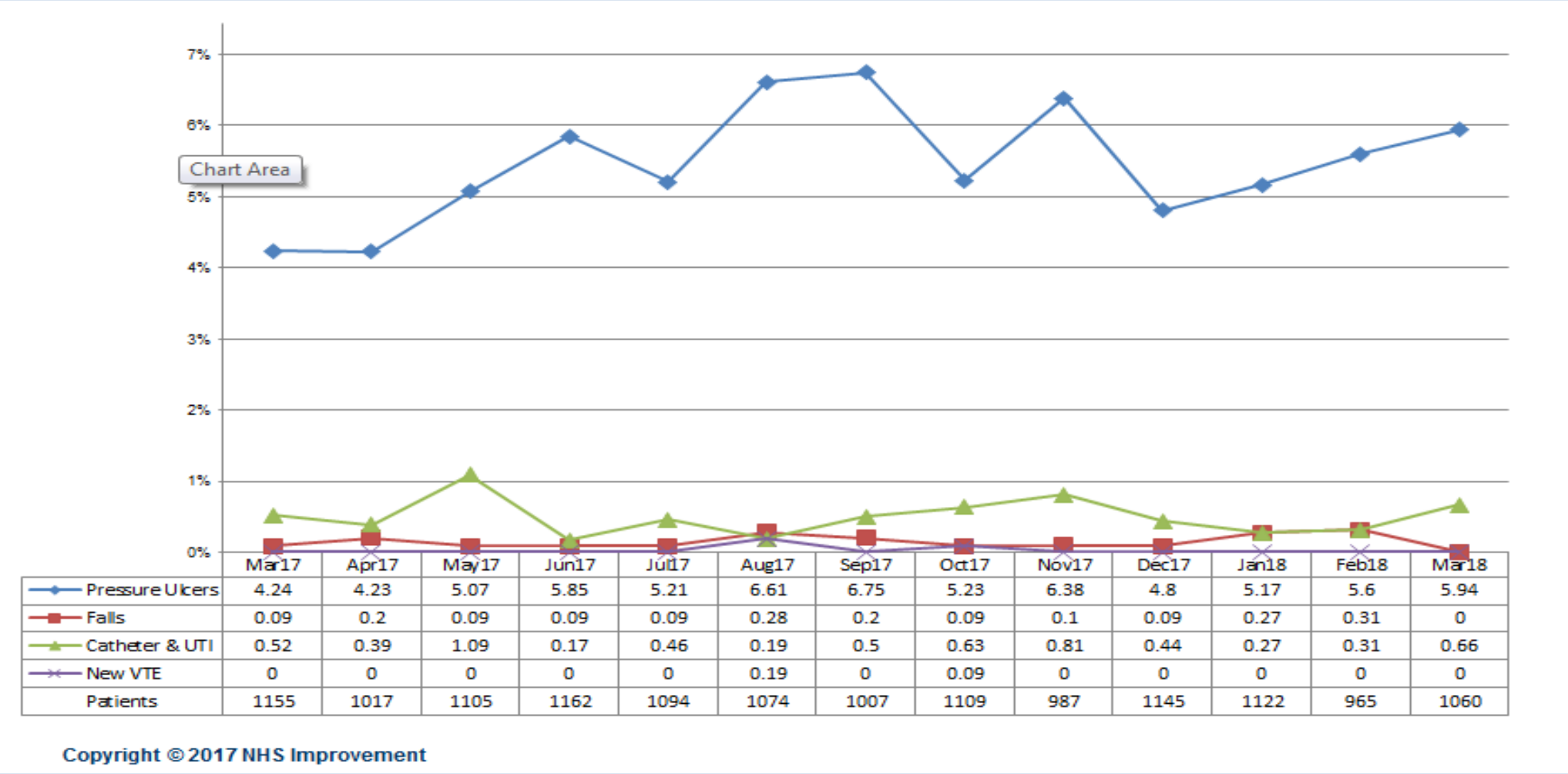
The figure below shows the percentage of harm-free care reported on the patient safety thermometer.
Harm Free care in Berkshire Healthcare has shown some improvement with 94% in Q4, 93.9% in Q3 and in Q2 it was 93.2%. These harms include those inherited to the Trust which are largely beyond our influence, such as old pressure ulcers and catheter and old urinary tract infections (UTI) which are almost three quarters of the harms we declare.



Source: Trust Safety Thermometer 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.



	Mar17	Apr17	May17	Jun17	Jul17	Aug17	Sep17	Oct17	Nov17	Dec17	Jan18	Feb18	Mar18
Pressure Ulcers	4.24	4.23	5.07	5.85	5.21	6.61	6.75	5.23	6.38	4.8	5.17	5.6	5.94
Falls	0.09	0.2	0.09	0.09	0.09	0.28	0.2	0.09	0.1	0.09	0.27	0.31	0
Catheter & UTI	0.52	0.39	1.09	0.17	0.46	0.19	0.5	0.63	0.81	0.44	0.27	0.31	0.66
New VTE	0	0	0	0	0	0.19	0	0.09	0	0	0	0	0
Patients	1155	1017	1105	1162	1094	1074	1007	1109	987	1145	1122	965	1060

Source- Safety Thermometer

UTI= Urinary Tract Infection VTE = venous thromboembolism

Appendix E CQUIN Achievement 2017/18 (anticipated)

CQUIN Number	CQUIN Indicator Name	Value
CQUIN 1a	Improvement of health and wellbeing of NHS staff	£427,006.40
CQUIN 1b	Healthy food for NHS staff, visitors and patients	
CQUIN 1c	Improving the uptake of flu vaccinations for front line staff within Providers	
CQUIN 3a	Improving physical healthcare to reduce premature mortality in people with Severe Mental Illness: Cardio metabolic assessment and treatment for patients with psychoses	£427,006.40
CQUIN 3b	Improving physical healthcare to reduce premature mortality in people with Severe Mental Illness: Collaborating with primary care clinicians	
CQUIN 4	Improving services for people with mental health needs who present to A&E.	£170, 802.56
CQUIN 5	Transitions out of Children and Young People's Mental Health Services (CYPMHS)	£170,802.56
CQUIN 8b	Supporting Proactive and Safe Discharge – Community Providers	£341,605.12
CQUIN 9a	Tobacco screening	£427,006.40
CQUIN 9b	Tobacco brief advice	
CQUIN 9c	Tobacco referral and medication offer	
CQUIN 9d	Alcohol screening	
CQUIN 9e	Alcohol brief advice or referral	
CQUIN 10	Improving the assessment of wounds	£256, 203.84
CQUIN 11	Personalised Care and Support Planning	£341,605.12

Appendix F- CQUIN 2018-2019

Please note that that this is part of a 2 year contract that started in 2017/18. The Trust is currently in discussion with Commissioners to finalise the 2018/2019 CQUIN and any changes will be adjusted under variation

CQUIN Number	CQUIN Indicator Name
CQUIN 1a	Improvement of health and wellbeing of NHS staff
CQUIN 1b	Healthy food for NHS staff, visitors and patients
CQUIN 1c	Improving the uptake of flu vaccinations for front line staff within Providers
CQUIN 3a	Improving physical healthcare to reduce premature mortality in people with Severe Mental Illness: Cardio metabolic assessment and treatment for patients with psychoses
CQUIN 3b	Improving physical healthcare to reduce premature mortality in people with Severe Mental Illness: Collaborating with primary care clinicians
CQUIN 5	Transitions out of Children and Young People's Mental Health Services (CYPMHS)
CQUIN 9a	Tobacco screening
CQUIN 9b	Tobacco brief advice
CQUIN 9c	Tobacco referral and medication offer
CQUIN 9d	Alcohol screening
CQUIN 9e	Alcohol brief advice or referral
CQUIN 10	Improving the assessment of wounds
CQUIN 11	Personalised Care and Support Planning

Appendix G- Trust Participation in Royal College of Psychiatrists Quality Improvement Programmes and Accreditation Schemes

Berkshire Healthcare NHS Foundation Trust			
Programmes	**Participating services in the Trust**	**Accreditation Status**	**Number of Services Participating Nationally**
ACOMHS: Accreditation for Community Mental Health Services	Bracknell Community Mental Health Team	Assessed – awaiting Accreditation Decision	8
	Wokingham Community Mental Health Team	Assessed – awaiting Accreditation Decision	8
AIMS-WA: AIMS-WA: Quality Network for Working-age Adult Wards	Bluebell Ward, Prospect Park Hospital	Accredited	145
	Snowdrop Ward, Prospect Park Hospital	Accredited	145
	Rose Ward, Prospect Park Hospital	Accredited	145
APPTS: Accreditation Programme for Psychological Therapies Services	Talking Therapies Berkshire	Accredited	32
C o C: Community of Communities	Slough Embrace	Participating but not yet undergoing accreditation	8
ECTAS: Electroconvulsive Therapy Accreditation Service	Prospect Park ECT Clinic	Participating in Accreditation renewal	83
EIPN: Early Intervention in Psychosis Network	Berkshire Early Intervention in Psychosis Service	Developmental Review	155
HTAS: Home Treatment Accreditation Scheme	Berkshire East Crisis Resolution Home Treatment Team	Accredited	54
MSNAP: Memory Services National Accreditation Programme	Bracknell Memory Clinic	Accredited	75
	Reading Memory Clinic	Accredited	75
	Wokingham Memory Clinic	Accredited	75
	OPMH Service Team (Beech Croft Newbury)	Accredited	75
	Slough Memory Clinic	Accredited until July 2018. Currently in review	75
	Windsor, Ascot & Maidenhead OPMH Memory Clinic	Accredited until October 2018. Currently in review	75

Berkshire Healthcare NHS Foundation Trust			
Programmes	**Participating services in the Trust**	**Accreditation Status**	**Number of Services Participating Nationally**
PLAN: Psychiatric Liaison Accreditation Network	Psychological Medicine Service (Royal Berkshire Hospital)	Accredited	81
QNIC: Quality Network for Inpatient CAMHS	Berkshire Adolescent Unit	Participating but not yet undergoing accreditation	130
QNLD: Quality Network for Inpatient Learning Disability Services	Campion Unit	Accredited	41
QNOAMHS: Quality Network for Older Adults Mental Health Services	Orchid Ward	Not accredited	86
	Rowan Ward	Not accredited	86

POMH-UK: Prescribing Observatory for Mental Health
Berkshire Healthcare NHS Foundation Trust – Topic 1g & 3d, Topic 17a and Topic 16a

Appendix H- Statements from Stakeholders

Berkshire Healthcare NHS Foundation Trust – Quality Account 2017/18
Response from the Council of Governors of the Trust

These comments are based on the Quality Account for the third quarter circulated to the 32 members of the Council of Governors for the Trust on the 6th March 2018. This summary is prepared by the Lead Governor, Paul Myerscough.

This report is a good account of the Trust, clearly expressed and with much of interest for all readers. The governors feel that the results shown in the report reflect the actual performance of the Trust.

There is general scepticism among governors about the nationally mandated measure known as the 'Friends and Family Test'. We would prefer that the effort expended on the collection and collating of this data is more focussed on areas of particular concern to patients and staff, where it could lead to a measurable improvement in the services delivered.

There some quality concerns mentioned which governors are aware of, and we appreciate regular updates from management. Several of these relate to staffing difficulties. This is an NHS-wide issue which puts pressure on management in most services.

Unfortunately the results from the staff survey were not available at the time this response was prepared. We would hope to see evidence of an improvement in staff well-being feeding through into the staff retention figures.

All governors were given the opportunity to comment. Much of the input was about format of information, with some requests for clarification of figures and, of course, concern expressed where it appears that performance is not getting better. All feedback is passed on to the team responsible for the report.

Berkshire Healthcare NHS Foundation Trust Response:

The Trust welcomes the feedback from Berkshire Healthcare NHS Foundation Council of Governors. We acknowledge that Members of the Council have contributed their views throughout the development of the account and we value this input.

The Friends and Family Test is a national measure that was originally introduced to support patient choice. We aim to achieve higher than a 15% response rate (this being the minimum for statistical relevance) and in some services, this is being exceeded. There are challenges in some services and the Patient Experience Team is working with the service and Clinical Transformation Team to look at different ways of collecting this feedback, such as via SMS text messaging.

The results of the most recent National Staff Survey have been included in the final version of the Quality Account, and the results generally shown an improvement.

Responses to individual queries have been included in a separate document and this has been sent to the Chair of the Council of Governors.

Commissioners Response – BHFT QUALITY ACCOUNT 2017/18

Prepared on behalf of East Berkshire and Berkshire West CCG's

Statement

The Clinical Commissioning Groups (CCGs) are providing a response to the Quality Account for Quarter 3 2017/18 submitted by Berkshire Healthcare Foundation Trust (BHFT.)

The Quality Account provides information and a review of the performance of the Trust against quality improvement priorities set for the year 2017/18 and gives an overview of the quality of care provided by the Trust during this period. The priorities for 2017/18 were detailed in the report and these were;

- Patient Experience and involvement
- Patient Safety
- Clinical effectiveness
- Organisational culture

All the priorities if successful will have an impact on patient care and staff satisfaction.

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

The Trust's Quality Priorities highlighted in the 2017/18 Quality Account were Patient Safety; Clinical Effectiveness; Patient Experience and Organisational Culture.

The Trust has implemented new processes which enable them to further learn from Complaints and Compliments, which is evidenced in the reduction of complaints in 2017/18.

The CCGs are very supportive of the Trusts project on zero suicides which was initiated in 2016. The programme focuses on challenging attitudes and behaviours and a new risk summary was implemented in 2017. There were a number of goals set for 2017/18 which included achieving a 10% reduction in the rate of suicides of people under BHFT care by 2020/21, demonstrating an increase in positive staff attitude and a having proactive approach to suicide prevention and ensuring families, carers and staff feel supported after a suicide.

The CCGs were pleased that the Trust has acknowledged the disappointing result of the 'Zero Suicide Workforce Survey' which showed that only 50% of the staff reported that they felt the organisation had supported them following their interaction with a patient that had committed suicide and the CCGs hope to see an improvement when the next survey is carried out.

The quality concerns that are raised within the quality account relate to acute adult mental health inpatient bed occupancy, locked wards and shortage of permanent nursing and therapy staff. The CCG echo the concerns that have been raised by the Trust and would like to see a more permanent workforce across all areas and therefore reducing the need to use agency staff and are pleased to see the efforts that are in place in order to achieve this.

It is important that the Trust participates with both National Clinical Audits and National Confidential Enquiries which they were eligible to take part in. This they have done and implemented actions to improve services.

The Trust continues to work on areas which have an impact on patient safety particularly around pressure ulcers and falls and the Trust has met its targets in quarter 3.

The Quality account also highlights other service improvements, which are all having a positive impact on patient care for example Family Safeguarding Service, and the Psychological Interventions in Nursing and Community (PINC) Services

Priorities for 2018/19

The Commissioners have reviewed the priorities that the Trust have set out for 2018/19 and support the Trust in achieving all aspects of the work streams in order for the Trust to be able to achieve an aspirational CQC rating of Outstanding. It is positive to see that the Trust have set some specific targets in order to measure against and acknowledge the hard work that will be undertaken in the following twelve months to achieve these targets. It is recognised that the zero suicide priority is a quality improvement initiative that will take a number of years to have an impact in the Trust as it is concerned with changing attitudes and behaviours.

The Commissioners would like to continue to be informed of any new quality concerns being identified during 2018/19 for the opportunity to support the Trust with these and working with BHFT with future Integrated Care system developments

---

Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

Berkshire Healthcare NHS Foundation Trust Response:

The Trust welcomes this response to its 2017/18 Quality Account, prepared on behalf of East Berkshire and Berkshire West CCGs

The Trust welcomes the CCGs support of its 2018/19 priorities and is grateful for the comments made in relation to our achievement in 2017/18.

In relation to the Zero Suicide programme, we value the support of the CCGs and will be carrying out the Zero Suicide Workforce survey again in May 2018. At this point we will measure progress in this area and hope to see an improvement in findings.

We look forward to continuing to work with you to achieve further improvements and successes in the areas identified within the Quality Account, and keeping you informed of progress.

Together we speak louder

healthwatch Wokingham Borough

Healthwatch Wokingham Borough response to Berkshire Healthcare Foundation Trust Quality Account 2018

As the independent voice for patients, Healthwatch Wokingham is committed to ensuring local people are involved in the improvement and development of health and social care services.

Local Healthwatch across the country are asked to read, digest and comment on the Quality Accounts, which are produced by every NHS Provider (excluding primary care and Continuing Healthcare providers). The Quality Account is a lengthy and detailed document (70 pages) containing lots of data, Healthwatch would welcome a summary version that members of the public could access.

Healthwatch Wokingham is still hearing regularly the frustrations of parents waiting to get a CAMHS (Child & Adolescent Mental Health Services) assessment for their child. The main theme appears to be lack of information available to guide them through this process and help manage expectations. We are pleased to see that you are implementing a project specifically exploring the transition from CAMHS into adult services.

With regards your patient experience priorities – Healthwatch Wokingham does not feel that the family and friends is not the best tool to provide good feedback with regards customer satisfaction.
Healthwatch Wokingham is pleased to hear that you wish to involve service users in plans and developments, we would be happy to support this, as we are still hearing frustrations, especially from those accessing Crisis Care and the Community Mental Health Team.

Healthwatch Wokingham has received comments recently about poor communication that creates confusion – things such as contact details on your website being incorrect and professionals being unclear about signposting and pathways.

Our Enter and View project which entailed 11 visits over a period of a week in October 2017. Patients were complimentary about staff attitude, care and friendliness; however the report highlighted the lack of connection between your inpatient services and community mental health services.
We found it a bit contradictory the Quality Account talking about Zero Suicide initiative but then having a goal to better support families after they have been bereaved by a suicide and seeing a "*Help is at Hand*" leaflet as a solution to this.

Our recent visit to Rowan Ward to test out how Dementia Friendly the environment was provides the Trust with some suggestions about how to improve the older adult ward.

Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

Berkshire Healthcare NHS Foundation Trust Response:

The Trust welcomes the feedback from Healthwatch Wokingham.

In relation to the suggestion of a summary version of the report, we currently include a "Quality Account Highlights" section towards the beginning of the document. This shows highlighted trust achievements for the year, followed by a table detailing the Trust's achievements against each of its priorities. We will look into re-naming this section to highlight that it is a summary.

In relation to comments about Child and Adolescent Mental Health Services (CAMHS), the service are constantly reviewing how they can better support families & young people who are waiting, balancing this with the need to

protect as much clinical time as possible to provide care and treatment. They have worked closely with service users and their families to develop all of the information on our on-line resource, available at https://cypf.berkshirehealthcare.nhs.uk/our-services/mental-health-services-camhs/. This provides information about the range of CAMH services provided by BHFT, how each of the services works, what to expect when you attend for an appointment and how to refer.

Referrals to CAMHS continue to increase and, as a consequence of this, although waiting times for the service had been decreasing, they are now starting to increase again. All teams have protocols in place to support people while they are waiting for an appointment. The Autism Assessment team, which has the longest waiting times, work collaboratively with other local services to run an on-line support network that all families referred to the service are given access too. The Anxiety & Depression team have been piloting a programme of workshops designed to help families understand the difficulties they're facing, consider the types of support available and understand what the therapy they offer involves. We are looking to develop this type of support across other teams. All teams have duty workers available several times per week to respond to calls from families. All send information out to families once a referral has been accepted, providing information about the team, self-help information if appropriate, guidance on how to contact the team if they are concerned that things are getting worse and information on what to do in the event of a crisis. The teams also try to give realistic information about waiting times however it is difficult to be accurate as we have to prioritise young people on the basis of their level and immediacy of clinical risk so waiting times vary greatly.

In addition, CAMHs have been reviewing their induction programmes for new staff. This now includes information about all BHFT children's services in order to ensure that all of our staff are informed about all of the services we provide, not just the team in which they work.

In relation to patient experience, The Friends and Family Test (FFT) is a national measure that was originally introduced to support patient choice, by using a standard measure that people could relate to when they give their feedback, and people could understand when they look at the results for different services and organisations. Within the Patient Experience Report, we include a comparison to other local Trusts which shows that we perform well. We aim to achieve higher than 15% response rate (this being the minimum for statistical relevance) and in some services, this is being exceeded. There are challenges in some services, and the Patient Experience Team is working with the services to look at different ways of collecting this feedback, such as via SMS text messaging. There are challenges with some of the client groups and services that we provide, such as Prospect Park Hospital, where historically there is a low response rate and there can be difficulty in separating the quality of the experience to the reason for their admission to hospital. The results of the FFT are available to services on our intranet each month and, importantly, these include not only the recommendation rate and response rate, but the comments which are really powerful. The Trust also undertakes other activity to evaluate patient experience, such as the trust patient survey, learning from compliments and complaints, deep dives and learning from the National Community Mental Health Survey.

Regarding updated information on the Trust Website- the Trust has an automated system in place for services to review their content on our main website twice a year. However, changes do happen in between. Based on your feedback, we will now take this opportunity to review the content update process for our main website to see what additional changes can be made to streamline this further.

In relation to the interface between Trust inpatient and community mental health services, a programme of work to improve interfaces is underway. The first workshop will be held in May 2018.
Zero Suicide is a long-term programme that also benefits from having a goal to support bereaved families. The 'Help at Hand' leaflet is only one element of the support we provide to bereaved families affected by suicide, and we also include face to face support.

The trust appreciates the visit made to Rowan Ward by Healthwatch to test how Dementia Friendly the environment was, and we appreciate the suggestions made for improvements in this area. Our new Modern Matron role, implemented in April 2018 will focus on this feedback.

Appendix I

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

Independent auditor's report to the council of governors of Berkshire Healthcare NHS Foundation Trust on the quality report

We have been engaged by the council of governors of Berkshire Healthcare NHS Foundation Trust to perform an independent assurance engagement in respect of Berkshire Healthcare NHS Foundation Trust's quality report for the year ended 31 March 2018 (the 'quality report') and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the council of governors of Berkshire Healthcare NHS Foundation Trust as a body, to assist the council of governors in reporting Berkshire Healthcare NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2018, to enable the council of governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the council of governors as a body and Berkshire Healthcare NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

- Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a National Institute for Health and Care Excellence (NICE)-approved care package within two weeks of referral.
- Inappropriate out-of-area placements for adult mental health services.

We refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the quality report in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual' issued by NHS Improvement.

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

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual' and supporting guidance;
- the quality report is not consistent in all material respects with the sources specified in section 2.1 of the NHS Improvement 2017/18 Detailed guidance for external assurance on quality reports; and
- the indicators in the quality report identified as having been the subject of limited assurance in the quality report are not reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual' and the six dimensions of data quality set out in the 'Detailed guidance for external assurance on quality reports'.

We read the quality report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual' and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

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

- board minutes for the period April 2017 to May 2018;
- papers relating to quality reported to the board over the period April 2017 to May 2018;
- feedback from Commissioners, dated April 2018;
- feedback from governors, dated April 2018;
- feedback from local Healthwatch organisations, dated April 2018;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated April 2018;
- the latest national patient survey, dated November 2017;
- the latest national staff survey, dated March 2018;
- Latest Care Quality Commission inspection report, dated May 2017; and

- the Head of Internal Audit's annual opinion over the trust's control environment, dated May 2018

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

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

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

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the 'NHS foundation trust annual reporting manual' to the categories reported in the quality report; and
- reading the documents.

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

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

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

The scope of our assurance work has not included testing of indicators other than the two selected mandated indicators, or consideration of quality governance.

Conclusion
Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual';
- the quality report is not consistent in all material respects with the sources specified in section 2.1 of the NHS Improvement 2017/18 Detailed guidance for external assurance on quality reports; and
- the indicators in the quality report subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual' and supporting guidance.

Deloitte LLP
St Albans
25 May 2018

Glossary of acronyms used in this report

Acronym	Full Name
ADHD	Attention Deficit/ Hyperactivity Disorder
ACG	Appropriate Care Given
AMS	Anti-Microbial Stewardship
ASD	Autistic Spectrum Disorder
ASSIST	Assertive Intervention Stabilisation Team
AWOL	Absent Without Leave
BAU	Berkshire Adolescent Unit
BHFT	Berkshire Healthcare NHS Foundation Trust
BME	Black and Minority Ethnic (also BAME- Black Asian and Minority Ethnic)
CAMHS	Child and Adolescent Mental Health Service
CCG	Clinical Commissioning Group
CDC	Centres for Disease Control and Prevention
CDS	Commissioning Data Set
CDiff	Clostridium Difficile
CEG	Clinical Effectiveness Group
CHS	Community Health Service
CMHT	Community Mental Health Team
CMHTOA	Community Mental Health Team for Older Adults
CNS	Clinical Nurse Specialist
CNT	Community Nursing Team(s)
COPD	Chronic Obstructive Pulmonary Disease
CPA	Care Programme Approach
CPE	Common Point of Entry
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CRHTT	Crisis Resolution and Home Treatment Team
CTO	Community Treatment Order
CTPLD	Community Team for People with Learning Disabilities
CYPF	Children, Young People and Families
CYPIT	Children and Young People's Integrated Therapy Service
CDS	Commissioning Data Set
DN	District Nursing
DNACPR	Do Not Attempt Cardiopulmonary Resuscitation
DQIP	Data Quality Improvement Plans
EIP	Early Intervention in Psychosis
EPMA	Electronic Prescribing and Medicines Administration
EPR	Electronic Patient Record
FFFAP	Falls and Fragility Fractures Audit Programme
FFT	Friends and Family Test
HEE	Health Education England
HoNOS	Health of the Nation Outcome Statistics
HOLT	Health Outreach Liaison Team
HTT	Home Treatment Teams

Acronym	Full Name
IAF	Information Assurance Framework
IAPT	Improving Access to Psychological Therapies
ICS	Integrated Care System
IFR	Initial Findings Review
IG	Information Governance
IMPACTT	Intensive Management of Personality Disorders and Clinical Therapies Team
IPS	Individual Placement and support (Employment Service)
IQIPS	Improving Quality in Psychological Services
KF	Key Finding
LD	Learning Disability
LeDeR	Learning Disability Mortality Review Programme
LIA	Listening Into Action
LIC	Lapse In Care
LSVT	Lee Silverman Voice Treatment
LTC	Long Term Conditions
MDT	Multi-Disciplinary Team
MDfT	Multi-Disciplinary Footcare Team
MH	Mental Health
MHA	Mental Health Act
MIU	Minor Injuries Unit
MRSA	Methicillin-Resistant Staphylococcus Aureus
MSK	Musculoskeletal
MSNAP	Memory Services National Accreditation Programme
MUS	Medically Unexplained Symptoms
MUST	Malnutrition Universal Screening Tool
NAAD	National Audit of Anxiety and Depression
NAIC	National Audit of Intermediate Care
NAP	National Audit of Psychosis
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
NDA	National Diabetes Audit
NDFA	National Diabetes Footcare Audit
NEOLCA	National End of Life Care Audit
NEWS	National Early Warning Score
NICE	The National Institute of Health and Care Excellence
NIHR	National Institute of Health Research
NSSA	National Sentinel Stroke Audit
OAHSN	Oxford Academic Health Science Network
OBD	Occupied Bed Days
OPMH	Older Peoples Mental Health
OT	Occupational Therapy
NRT	Nicotine Replacement Therapy
PAF	Performance Assurance Framework
PAPYRUS	Prevention of Young Suicide

Acronym	Full Name
PICU	Psychiatric Intensive Care Unit
PINC	Psychological interventions in nursing and community services
POMH	Prescribing Observatory for Mental Health
PPH	Prospect Park Hospital
PROMs	Patient Reported Outcome Measures
PU	Pressure Ulcer
QI	Quality Improvement
QMIS	Quality Management and Improvement System
QOF	Quality and Outcomes Framework
RBWM	Royal Borough of Windsor and Maidenhead
RiO	Not an acronym- the name of the Trust patient record system
RT	Rapid Tranquilisation
RTT	Referral to Treatment Time
RQ	Rolling Quarters
SALT	Speech and Language Therapy
SHARON	Support Hope & Recovery Online Network
SI	Serious Incident
SMI	Severe Mental Illness
SOP	Standard Operating Procedure
SSNAP	Sentinel Stroke National Audit Programme
SUS	Secondary Users Service
TVSCN	Thames Valley Strategic Clinical Network
UKAS	United Kingdom Accreditation Scheme
VTE	Venous Thromboembolism
WAM	Windsor Ascot and Maidenhead
WIC	Walk-In Centre
YPWD	Young People With Dementia