Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

Berkshire Healthcare NHS Foundation Trust

Quality Account 2018/19

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 around 4,500 staff who operate from our many sites as well as out in people's homes and in various community settings.

We are rated as 'Good' by the Care Quality Commission and our ambition is to achieve a CQC rating of 'Outstanding'. We are currently rated as 'outstanding' in the Well-Led domain.

We are also a digital pioneer, having been named by NHS England as a 'Global Digital Exemplar'. 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 have a major focus on the contribution we can make to the local population by working in collaboration with our commissioners and partner providers to identify new ways of working to benefit patients.

As a foundation Trust we are accountable to the community we support. NHS Improvement regulate our financial stability and have placed us in segment 1, which reflects the highest level of performance for finance and use of resources.

Table of Contents for Quality Account 2018/19

Quality Account Positive Highlights and Overall Summary 2018/19

Highlights

Patient Experience Priorities

- 95% or more of patients responding to the Friends and Family Test (FFT) stated they were likely or extremely likely to recommend many of our services. 71% of respondents stated they would recommend our mental health inpatient services.
- 96% of carers responding to the FFT stated that they were likely or extremely likely to recommend our services.
- The Trust worked with its health and social care partners to improve system-wide patient satisfaction and outcomes, as part of Integrated Care Systems (ICS).

Patient Safety Priorities

We have continued to implement our Quality Improvement and Zero Suicide programmes which have had specific impact on the following.

- Preventing patient falls on our community inpatient wards.
- Self-harm incidents continue to reduce and were below the target threshold.

Clinical Effectiveness Priorities

- We have participated in all applicable national clinical audits and ensured that appropriate actions are taken and improvements made.
- We have a robust system for reviewing NICE guidance to ensure that care is delivered in line with national standards.
- Ensuring patients can access care locally is a high priority and we remain below the local threshold for patients having to be treated elsewhere due to availability of beds.
- The Trust continues reviewing, reporting and learning from deaths in line with national guidance.

Supporting our Staff Priorities

We have met our target to reduce staff vacancies to below 10% in the year to date and to train an additional 24 services in our Quality Improvement System.

Care Quality Commission (CQC) Rating

The Trust continues to be rated as 'Good' overall and is rated as 'Outstanding' in the Well-Led Domain.

2019/20 Trust Priorities

Patient Safety Priorities

1. We will reduce harm to our patients by reducing: self harm and suicide, falls, medication errors, pressure ulcers and preventable deaths from septicaemia. Specific targets are detailed in main body of report
2. At least 95% of our reported incidents will be low or no harm to patients.
3. All patient facing teams will have evidence based objectives for reducing patient harm in their plans for 2019/20. All our support services will work with patient facing services to identify ways that they can support safety of patients.
4. With our health and social care partners, we will work to achieve reduced urgent admissions and delayed transfers of care.

Clinical Effectiveness Priorities

1. We will demonstrate our delivery of evidence-based services by reporting on the implementation of NICE guidance related to Trust priorities in this report.
2. We will continue to review, report and learn from deaths in line with new national guidance as published

Patient Experience Priorities

1. We will achieve a 95% satisfaction rate and 15% response rate in our FFT, with 60% of staff reporting use of patient feedback to make informed decisions
2. All our services will focus on delivery of outcomes of care that are important to our patients, based on a good understanding of our diverse population.
3. We will reduce instances of prone restraint to no more than 2 per month
4. With our health and social care partners: We will contribute to Integrated Care System (ICS) work streams to improve patient experience and outcomes.

Supporting our Staff Priorities

1. We will achieve high levels of staff engagement across all our services - scoring four or more in our staff survey. We will increase the numbers of staff feeling they can make improvements at work to above 70%, with more than 85% of staff recommending our Trust as a place to receive treatment.
2. We will aim to achieve a vacancy level of less than 10%, a staff turnover rate of less than 16% and a sickness level of less than 3.5%.
3. We will promote an inclusive and compassionate culture, with zero tolerance of aggression, bullying and exclusion, and reduce assaults on staff by 20%.
4. We will achieve our objectives for equality of opportunity and staff wellbeing.
5. With our health and social care partners we will enhance career development opportunities and improve our workforce planning.

Figure 1- Summary of Trust achievement against 2018/19 Quality Account

Priority, Indicator and target (Click on links to access related main sections of report)		Results 2017/18	Results 2018/19	Comment & Change from 17/18- 18/19
Patient Experience				
Patient Friends and Family Test (FFT) - % of patients stating they are likely or extremely likely to recommend the service to a friend or family member. (Target ≥95% of respondents)	Community Services (Mental health and physical health combined).	96%	**94%**	**Target Not Met**
	Mental Health Inpatients.	67%	**71%**	**Target Not Met**
	Community Hospital Inpatients.	97%	**96%**	**Target Met**
	Minor Injury Unit.	98%	**98%**	**Target Met**
Trust Patient Satisfaction Survey- % of Patients rating the service they received as good or very good	Community Mental Health.	85%	**85%**	**No Change**
	Community Physical Health.	93%	**89%**	**Change -4%**
	Mental Health Inpatients.	72%	**66%**	**Change -6%**
	Patients in Community Hospitals.	97%	**98%**	**Change +1%**
Carer Friends and Family Test (FFT) - % of carers likely or extremely likely to recommend the service to a friend or family member.		97%	**96%**	**Change -1%**
Staff report using service user feedback to make informed decisions in their department. (Target- ≥60% of staff, Source- National NHS Staff Survey).		57%	**61%**	**Target Met**
Reduce use of prone restraint by 90% (Target ≤2 cases by end of March 2019).		N/A	**3** in March 19	**Target Not Met**
The Trust will contribute to Integrated Care Systems (ICS) to improve patient experience and outcomes.		N/A	**Met**	**Target Met**
Reduce Delayed Transfers of Care across inpatient services. (Target <7.5%).		11.3%	**9.0%**	**Target Not Met**
National Community Mental Health Survey- Overall result (score out of 10).		7.3	**7.2**	**Change -0.1**
Patient Safety				
Continue Trust Quality Improvement (QI) Programme.		N/A	**Met**	**Target Met**
Continue Trust Zero Suicide Programme.		Met	**Met**	**Target Met**
Reduce patient falls on wards for older people (Target 50% reduction).		345	**468**	**Target Not Met**
Reduce the Rate of inpatient falls on wards for older people (Target ≤8 per 1000 bed days).	Older Peoples Mental Health Wards	9.66	**16.59**	**Target Not Met**
	Community Health Wards	4.65	**6.02**	**Target Met**
Reduce patient self-harm incidents by 30% (Target ≤87 per month)		N/A	**78**	**Target Met**
Achieve an 'Outstanding' overall Care Quality Commission (CQC) Rating		Good	**Good**	**Target Not Met**
Urgent Admissions- Reduce the total number of bed days patients spend in an Inappropriate Out of Area Mental Health Placement (OAP). (Targets set by Berkshire East CCG and Berkshire West CCG- see main report)		N/A	**Met**	**Target Met**
Clinical Effectiveness				
Compliance with NICE Guideline on long term management of Self Harm		N/A	**96%**	**Target Met**
Continue to review, report and learn from deaths in line with new national guidance as it is published		Met	**Met**	**Target Met**
Supporting our Staff (previously titled 'Organisational Culture)				
Staff report feeling they can make improvements at work (Target- ≥66% of staff, Source- National NHS Staff Survey)		N/A	**64.4%**	**Target Not Met**
Staff agree or strongly agree they would recommend the Trust as a place to receive treatment (Target- ≥75% of staff, Source- National NHS Staff Survey)		75%	**73.6%**	**Target Not Met**
Reduce assaults on staff by 20% (Target <36 per month)		N/A	**45**	**Target Not Met**
Reduce Staff Vacancies (Reduce to below 10%)		N/A	**Met**	**Target Met**
Train an additional 24 services in the Trust Quality Improvement System		N/A	**Met**	**Target Met**
Achieve objectives set out in equality plans for each area		N/A	**Met**	**Target Met**
Participate in Integrated Care System ICS) work streams to enhance job satisfaction and career development opportunities		N/A	**Met**	**Target Met**

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 2018/19. 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 has been awarded an 'Outstanding' rating in the Well-Led Domain. The Campion Unit, the trust's assessment and treatment unit for people with learning disabilities has also been rated as 'Outstanding' following assessment this year.

We continue to implement our Quality Improvement (QI) programme across the Trust, with more staff being trained in its methodology. This allows us to apply a consistent approach to continuous improvement, resulting in a better experience and outcome for patients and staff. Several of the improvements arising from this programme are included in this Quality Report.

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. Feedback from patient surveys has been largely positive this year and we aim to improve on and learn from this feedback.

Patient safety will always be 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. This year, we have focused on improving safety in a number of areas, including reducing prone restraint and self-harm, and we will continue striving to improve in these areas.

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 programmes allow us to measure our care against current best practice leading to improvement. This report details the work undertaken in this area.

Our programme of learning from deaths is important as it allows us to systematically and continuously review the care we have provided. 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 are not missed, together with learning from the review of the care provided and the experience in the period prior to the person's death. This work is scrutinised by our Board and reported publicly.

Following the publication of the report into the deaths at Gosport War Memorial Hospital, it is increasingly important that Trusts have robust systems in place that enable staff to 'speak up' about potential patient safety issues without fear of repercussions. This report outlines how we enable our staff to do this.

Our Trust 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 details some of our activity to achieve this with our partners during the year.

This Quality 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.

I would like to thank all staff for their hard work and commitment, and the vital contribution they make to the lives of our patients.

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

"My elderly relative was admitted to the care of Rowan Ward at the end of 2018. At which point she had hit crisis point and we were really shocked and distressed at her behaviour! She was diagnosed with dementia with Lewy bodies and was extremely poorly! The staff on Rowan Ward were unbelievably supportive and caring not only to her but to us as a family. They remained positive and provided endless encouragement, even though at times we found the situation extremely difficult! After nearly six weeks through their care, support and professionalism, my relative returned home with a support package! As a family we cannot thank these wonderful people enough, from the bottom of hearts we thank them all for giving us our relative back! Each and every one of them are an absolute credit to the NHS and they all went above and beyond the call of duty. It just goes to show with the right support and care miracles do happen!!"

From a relative of a patient- Rowan Ward, Prospect Park Hospital, Reading

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

2.1. Achievement of Priorities for Improvement for 2018/19

ⓘ This section details the Trust's achievements against its quality account priorities for 2018/19. These priorities were identified, agreed and published as part of the Trust's 2017/18 quality account.

These quality account priorities support the goals detailed in the Trust's 2018/19 True North Annual Plan (see Appendix A). The Trust's Clinical Effectiveness Strategy also supports this 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 respectful, responsive personal care. This sub-section details our performance against our patient experience priorities for 2018/19.

Our 2018/19 Patient Experience Priorities:

1. To achieve a 95% satisfaction rate in our Friends and Family Test (FFT) 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 (Target: ≤2 cases by the end of March 2019)
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 (ICS) work streams to improve patient experience and outcomes and reduce delayed transfers of care across our inpatient services, working in collaboration with provider partners and commissioners.

Trust performance in relation to complaints, compliments and the 2018 National Community Mental Health Survey is also detailed in this sub-section.

Patient Friends and Family Test (FFT)

ⓘ The Friends and Family Test (FFT) is used by most NHS funded services in England. It 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.

Response Rate

The Trust aims to achieve a response rate of at least 15%. It should be noted that in 2018/19 the Trust changed its methodology on how it reports the Friends and Family Test and therefore this year's performance should not be compared with that of last year. Figure 2 below demonstrates the response rate each quarter. During the whole of 2018/19 the overall response rate was above the 15% target at 15.2%.

Satisfaction Rate- Target 95%

One of the trust's targets for 2018/19 is to achieve a 95% satisfaction rate in the FFT. Figures 3 and 4 below demonstrate the Trust's achievement in relation to this target by showing the percentage of respondents stating they were extremely likely or likely to recommend services.

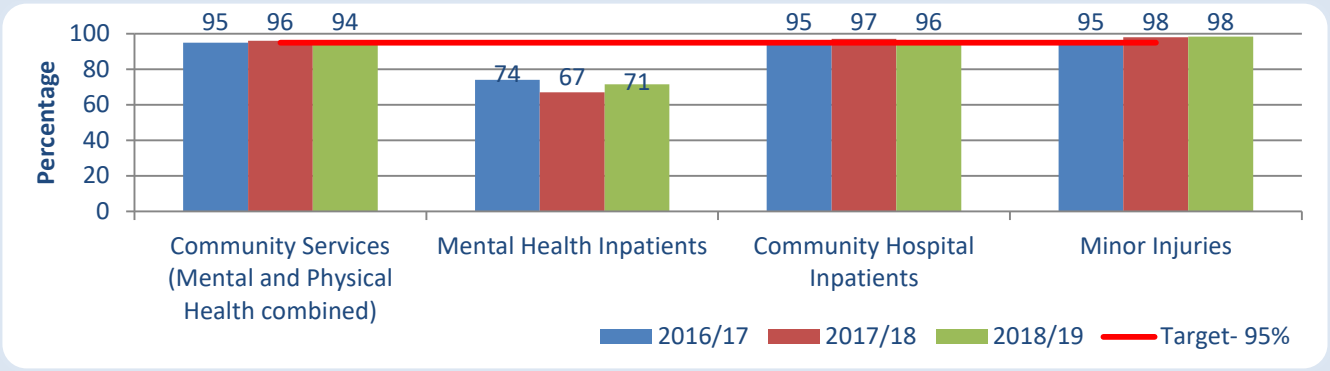
The figures show that the Trust's community inpatient services and minor Injury services met the target during 2018/19. Community services (mental health and physical health combined) were close to meeting the target with a rating of 94%. Mental Health inpatients were below target at 71%, but this is above the 2017/18 figure.

Figure 2- Response Rate for Patient FFT

2018/19 Quarter	Q1	Q2	Q3	Q4	2018/19 Full Year
% Response Rate	11.8	14.8	12.8	22.0	15.2

Source: Trust Patient Experience Reports

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



Source: Trust Patient Experience Reports. Please note that the figure for Minor Injuries previously also included data for Slough Walk-In Centre prior to its transfer to another organisation in September 2017

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

Survey and Service	2017/18			2018/19		
	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	15399	14718	96	**30078**	**28321**	**94**
Mental Health Inpatients	87	58	67	**480**	**343**	**71**
Community Hospital Inpatients	1057	1028	97	**930**	**894**	**96**
Minor Injuries Unit	3094	3035	98	**2245**	**2209**	**98**

Source: Trust Patient Experience Reports. Please note that the figure for Minor Injuries previously also included data for Slough Walk In Centre prior to its transfer to another organisation in September 2017

Carer Friends and Family Test (FFT)

ⓘ The Friends and Family Test for carers 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 and detail the percentage of respondents that stated they were extremely likely or likely to recommend Trust services. The figures show that the 2018/19 score (96%) is just below that of the 2017/18 full year finding, and is based on a greater number of respondents.

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

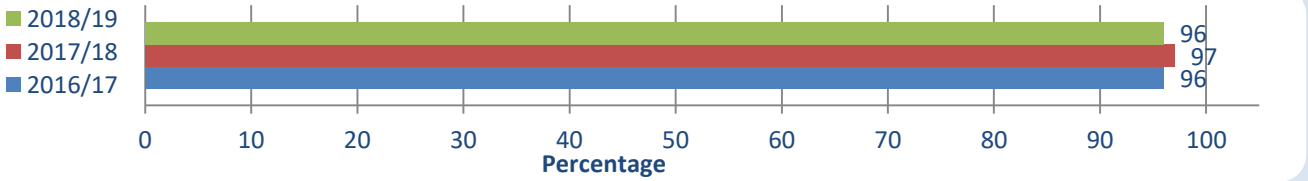


Figure 6- Carer Friends and Family Test- total number of responses

Survey and Service	2017/18			2018/19		
	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	269	261	97	**849**	**815**	**96**

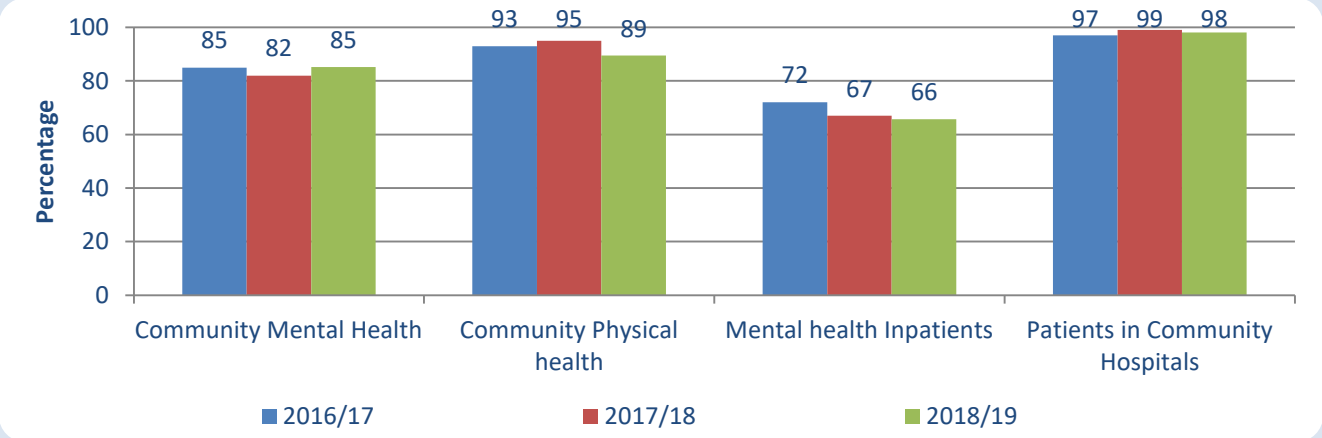
Source: Trust Patient Experience Reports Please note that the Trust does not have a response rate for this survey.

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 2018/19, 98% of respondents rated the care they received in community hospitals as good or very good, but this figure is based on a smaller number of respondents than in 2017/18. Community mental health and community physical health services were also highly rated. 66% of mental health inpatient respondents rated the service as good or very good in 2018/19, and this is based on a greater number of respondents when compared with the 2017/18 figures.

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	2017/18			2018/19		
	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	1203	985	82	**3197**	**2722**	**85**
Community Physical Health	12193	11559	95	**7896**	**7062**	**89**
Mental Health Inpatients	6	4	67	**417**	**274**	**66**
Patients in Comm. Hospitals	341	336	99	**53**	**52**	**98**

Source: Trust Patient Experience Reports

Staff Use of Service User Feedback to make Informed Decisions about their Department

ⓘ One of the Trust's targets for 2018/19 is that 60% of staff will report that they use service user feedback to make informed decisions about their department.

Performance against this target has been measured with reference to Question 22c in the 2018 National NHS Staff Survey, which asks whether ""Feedback from patients / service users is used to make informed decisions within my directorate / department". 60.6% of staff respondents answered "Yes" to this question and so this target has been met.

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 of 230 formal complaints received during 2018/19 compared with 209 in 2017/18.

During Quarter 4 of 2018/19, the trust received 50 formal complaints- a decrease compared with all other quarters during the year (60 in Q1, 63 in Q2 and 57 in Q3).

Of the 50 complaints reported in Q4 of 2018/19:

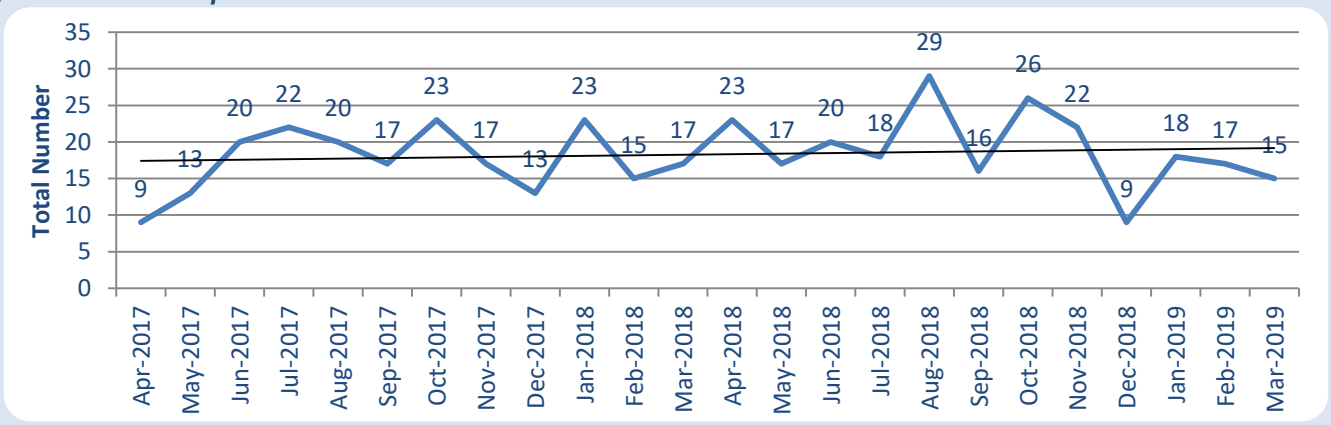
- 27 (54%) related to adult mental health service provision, of which:
  - 9 (18%) related to Community Mental Health Teams (CMHT), a reduction compared with Q1 (16), Q2 (11) and Q3 (10).
  - 5 (10%) related to Mental Health Inpatient services, a reduction compared with Q1 (9), Q2 (12) and Q3 (8).
  - 4 (8%) related to Crisis Resolution and Home Treatment Teams (CRHTT)- a similar number to those received in previous quarters.
- 14 (28%) related to community health service provision
- 6 (12%) related to Child and Adolescent Mental Health services (CAMHS) compared with 5 (Q1), 6 (Q2) and 8 (Q3).

Each service takes complaints seriously, with staff directly involved in the complaint asked to reflect on the issues raised and consider how they will change their practice.

100% of complaints were acknowledged within three working days during 2018/19, with 100% being resolved within the timescale agreed with the complainant.

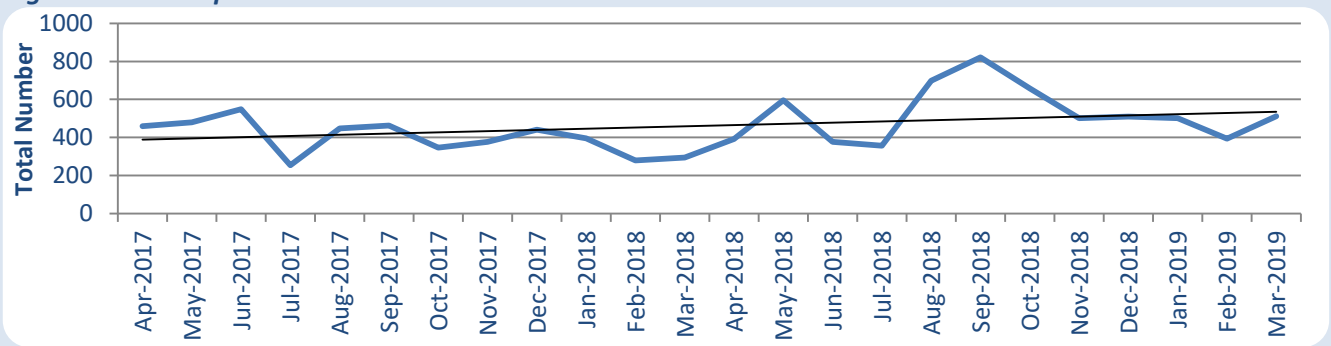
Please also note that the number of complaints, together with response and resolution times is included within section 3 of this report as they are indicators of quality.

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 service

Use of Prone (Face-Down) Restraint

ⓘ Prone restraint is a type of physical restraint where a person is held chest down, whether the patient placed themselves in this position or not, is resistive or not and whether the person has their face down or to the side. Guidance from the Department of Health, places an increasing focus on the use of preventive approaches and de-escalation for managing violent and aggressive behaviour. All restrictive interventions should be for the shortest time possible and use the least restrictive means to meet the immediate need.

All restraint positions have risks however with prone restraint there is a risk of positional asphyxia (difficulty breathing) which is why it is only to be used as a last resort.

One of the Trust's targets for 2018/19 is to reduce the use of prone restraint by 90% by the end of 2018/19. This means that there should be ≤2 cases reported by the end of March 2019.

A project group has been established at Prospect Park Hospital to address this target using Quality Improvement (QI) methodology. Following a rapid improvement event, the following measures were initiated in July 2018 and are being tested using the plan, do, study, act (PDSA) approach:

- Safety Huddle on Snowdrop Ward – this is still being tested
- A response/debrief role on Sorrel Ward- the hospital Psychiatric Intensive Care Unit (PICU). – this is still being tested
- Early warning signs forms on Sorrel Ward (PICU) – this is still being tested
- Use of a bean bag for seclusion exits- this has been tested and now implemented
- Training in the use of supine (face-up) restraint and how to administer Intramuscular (IM) medication in this position- This has also been tested and now implemented across all wards.

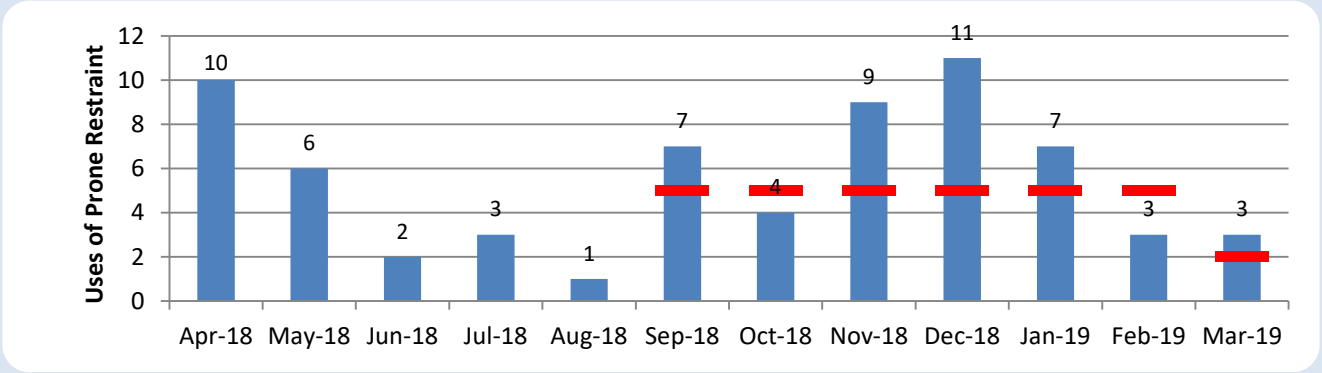
In addition to these measures, a number of other 'quick- win' measures have been implemented to address this target. These include:

- Public Health Model (PHM) management planning
- Introduction of post incident review meetings to support the PHM process of risk formulation and management.
- Detailed focus on and assessment of non-physical skills in Prevention Management of Violence and Aggression (PMVA).
- A poster highlighting the risks of prone restraint has been developed and now displayed in staff areas on the ward.
- Each episode of prone restraint is thoroughly reviewed by the nurse consultant to pick up themes and reasons for any use of prone restraint.
- Changes have been made to the Datix incident database structure to ensure accurate reporting and better understanding of the incidents.

The monthly number of cases of prone restraint in Trust mental health care is detailed in Figure 11 below and shows that the target of having no more than two cases of prone restraint in March 2019 was just missed, with three cases of prone restraint in this month.

The Trust will continue to prioritise reducing prone restraint in 2019/20.

Figure 11- Monthly uses of prone restraint in Trust mental health services
Target- 5 per month by September 2018 then 2 per month by March 2019



Source- Trust Tableau Dashboard

Understanding and Supporting Outcomes of Care that are Important to Patients

ⓘ One of the trusts priorities for 2018/19 is to ensure that all services focus on understanding and supporting outcomes of care that are important to patients

Performance against this target has been measured with reference to Question 22c in the 2018 National NHS Staff Survey, which asks whether ""'Feedback from patients / service users is used to make informed decisions within my directorate / department". 60.6% of staff respondents answered "Yes" to this question.

Contributing to Integrated Care Work Streams to Improve Patient Experience and Outcomes

ⓘ Integrated Care Systems (ICS) are partnerships between NHS Organisations, Local Authorities and other stakeholders which aim to improve the health and care of the population they serve. Organisations in each ICS take collective responsibility for managing resources and delivering NHS Standards across their population.

The Trust is a member of two ICS:

- Berkshire West ICS- covering covers a population of approx. 528,000 residents in Reading, West Berkshire and Wokingham. Berkshire West CCG and The Royal Berkshire NHS Foundation Trust are also part of this ICS, which is now aiming to align its work with the "Berkshire West 10 Integration Partnership", including Local Authority partners.
- Frimley Health and Care ICS cover a population of approx.726,000 residents in East Berkshire, North East Hampshire and Farnham and Surrey Heath. Berkshire East CCG, Frimley Health NHS Foundation Trust (including Wexham Park Hospital) and our Local Authority partners in Bracknell, Slough, Windsor and Maidenhead and Bracknell Forest County Council.

During 2018/19, the Trust has participated in the following workstreams to improve patient experience and outcomes:

- The ongoing development of the Berkshire-wide Connected Care programme which will deliver joined up care planning and delivery across health and social care through shared electronic records.
- The mental health priorities in Frimley Health and Care ICS are Out of Area Placements, Crisis Care, Perinatal Mental Health and access to Child and Adolescent Mental Health Services. A reference group, made up of service user and carer representatives, has been set up to inform our planning of services.
- Integrated Care Decision Making Hubs in Frimley Health and Care ICS are being developed to enable patients to receive more joined up out of hospital care, minimising non-elective admissions and delayed transfers of care.
- A Musculoskeletal (MSK) pathway in Berkshire West ICS is being developed to provide more treatment in community based services. This involves joint working between the Trust, Royal Berkshire Hospital Foundation NHS Trust, GPs and Physiotherapy Alliances

Reducing Mental Health Delayed Transfers of Care

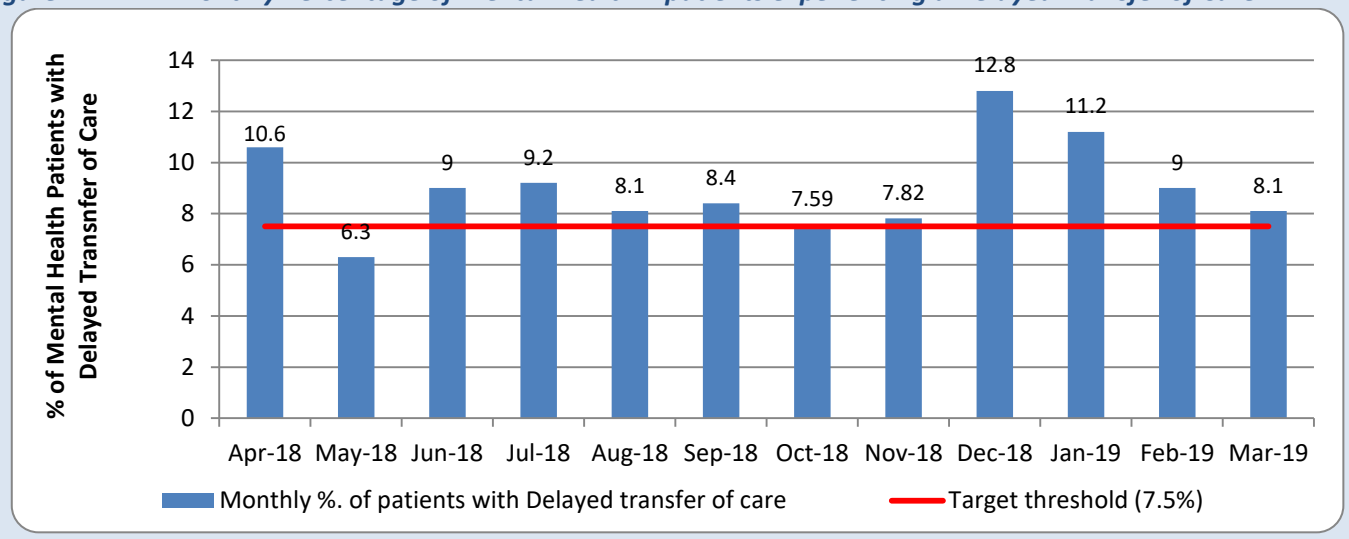
A mental health delayed transfer of care occurs when a patient is ready for discharge and is still occupying a bed.

One of the Trust priorities for 2018/19 is to reduce the number of mental health delayed transfers of care. This is achieved through:

- Closer monitoring and action to prevent potential delays for patients e.g. patients who may not have accommodation to return to.
- Weekly Reporting of actual delays (i.e. where a patient no longer needs to be in hospital for treatment, and daily discussion with clinical teams at the bed meeting).
- Close working with Local Authority and Clinical Commissioning Group (CCG) partners to minimise any delays that could be related to funding decisions.
- Setting an intended discharge date earlier in a patient's admission, so that they, their family members family and other parties have clear expectations to work towards
- Monthly review of delays and monitoring against targets to reach and sustain targets

Figure 12 below demonstrates performance against this priority. The chart shows that performance in this is in breach of the 7.5% target threshold, with a monthly average of 9.0% of mental health inpatients experiencing a delayed transfer of care in 2018/19.

Figure 12- Monthly Percentage of Mental Health inpatients experiencing a Delayed Transfer of Care



Source- Trust Tableau Dashboard

"My relative was rushed in for assessment - staff were amazing. The staff in the minor injuries department were exceptional at looking after my relative and I. We were advised to head straight there following a call with a 111 doctor. Once we arrived they saw my relative immediately, supported us both emotionally and looked after my relative's deteriorating physical health. They contacted the emergency ambulance service very quickly and did everything they could to make our experience as easy as possible. I was and am very impressed by the staff that we saw that evening. A huge thank you!

From a relative of a patient- Minor Injuries Unit, West Berkshire Community Hospital, Newbury

National NHS Community Mental Health Survey 2018

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 Survey Sample

People aged 18 and over were eligible for the survey if they were receiving specialist care or treatment for a mental health condition and had been seen by the Trust between 1 September 2017 and 30 November 2017. Responses were received from 270 people meeting these criteria, representing a 33% response rate. This is a 4% increase from the Trust response rate in 2017 and 5% above the 2018 national response rate.

About the Survey and how it is scored

The 2018 survey contained 37 questions organised across 11 sections. Individual survey responses were converted into scores on a scale from 0 to 10, with 10 representing the best and 0 the worst possible response. Each Trust score was then graded according to where it ranked against all participating trusts.

Summary of Trust results

The Trust scored about the same as other Trusts across all sections of the 2018 survey- the same as in the 2017 survey. The Trust also scored about the same as other Trusts across all questions in the 2018 survey, with the exception of two questions where the trust scored amongst the best performing trusts:

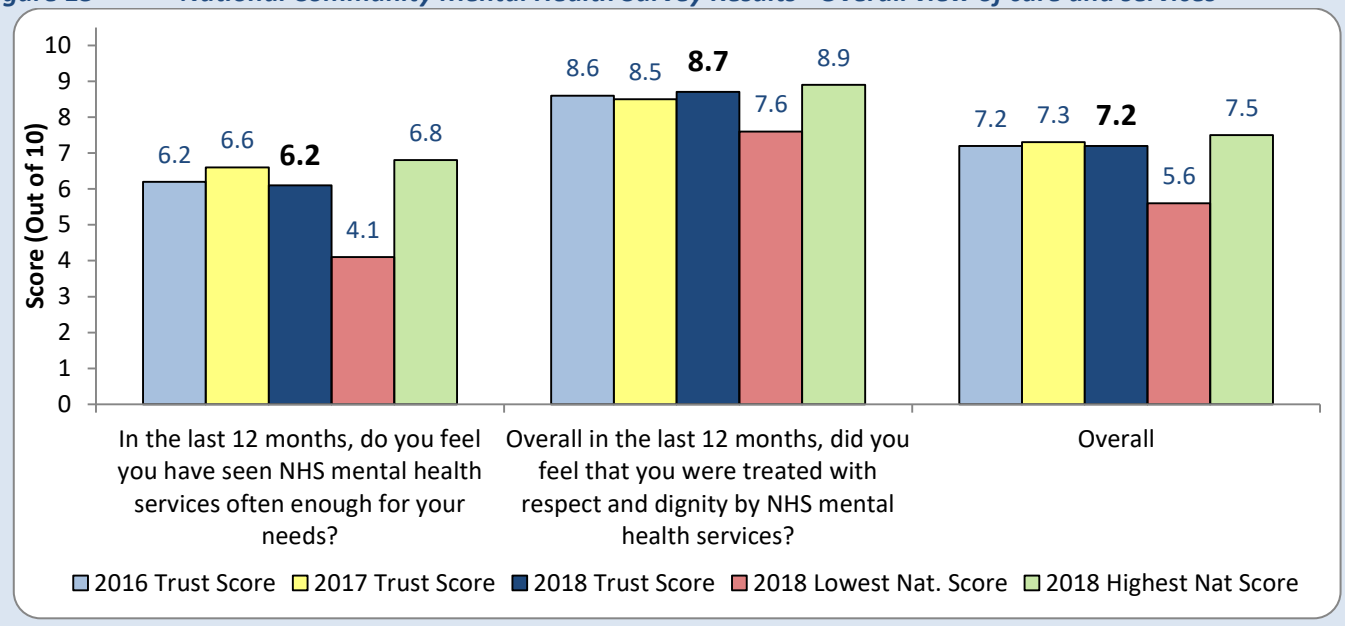
- Support and Wellbeing- Q36. Have you been given information by NHS mental health services about getting support from people who have experience of the same mental health needs as you?
- Overall views of care and services- Q38: Overall, in the last 12 months, did you feel that you were treated with respect and dignity by NHS mental health services?

Respondents' overall view of care and experience

Figure 13 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 2018 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 2018 (the red and green bars), and with the comparable Trust score in both 2016 and 2017 (the light blue and yellow bars).

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 13- 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. These errors 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 2018/19 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 on Older People's Inpatient Wards 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 towards achieving an "Outstanding" overall Care Quality Commission (CQC) rating. Please note that this priority is reported on in the CQC sub-section of the "Statements of Assurance from the Board" section later in this report
4. At a system level, to achieve reductions in urgent admissions (Inappropriate Out of Area Mental Health Placements).

The Trust's aim throughout the year has been to foster an environment where staff members can be confident to raise concerns about patient safety. In support of this, a 'Freedom to Speak Up' policy has been implemented, and this is described further Section 2.1.4- Organisational Culture

The Trust is 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.

Learning occurs across the organisation with respect to errors, incidents, near misses and complaints. The Trust has continued to engage with and contribute to cross organisational initiatives such as the regional patient safety collaborative.

Further information on Incidents is contained within section 3 of this report, with additional Trust patient safety thermometer metrics, including those relating to various types of harm included in Appendix D.

The Trust Quality Improvement Programme

ⓘ The Trust introduced an organisational Quality Improvement (QI) Programme in 2017/18. This programme enables a consistent approach to continuous improvement across the whole Trust. This is achieved by introducing new techniques, education, tools and training that focus on reducing waste and adding value for patients and staff.

The Trust ultimately 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.

The QI programme has four workstreams and a brief summary of progress with each is given below.

1. **The Quality Improvement (QI) Office-** *Ensuring structured accountability, support and dedicated resources are in place for improvement activity. Developing capabilities for improvement across the Organisation.*

The QI team and the Trust have been accredited as a Lean Organisation with the Lean Competency System (LCS) - the first NHS Trust in the UK to do so. This is a great achievement for both the Trust and the QI team and allows training to be run in-house, rather than relying on external consultancies. This will mean that bespoke Lean training can be delivered to meet specific Trust needs. 42 members of staff have been accredited by the Trust as Yellow Belt practitioners, with 20 members of staff due to qualify as Green Belt practitioners soon.

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

Waves 6 and 7 of QMIS training (with 7 teams in each wave) are now underway. Out of a total of 160 teams, 40 teams will have been trained once Wave 7 has been completed

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

True North is now well established in the Trust. The Annual Plan on a Page, showing the goals and metrics for each element of the Trust's True North, has been disseminated throughout the organisation.

4. **Improvement Projects:-** *Making improvements in areas that are too complex to be resolved through daily continuous improvement techniques*

The Emotionally Unstable Personality Disorder Pathway Project (EUPD) continues in its Implementation phase. This project aims to develop an end-to-end pathway for some of our most challenging mental health patients, including those with non-psychotic personality disorder. Roll out of implementation is taking place in Bracknell and Wokingham localities.

Reducing Falls on Older People's 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.

The Trust has set a priority to reduce falls on its older people's inpatient wards by 50% during 2018/19 compared with 2017/18.

Trust clinicians have worked closely with the Oxford Academic Health Science Network (OAHSN) across the Thames Valley to implement evidence-based ways of reducing falls in services. This has included 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.

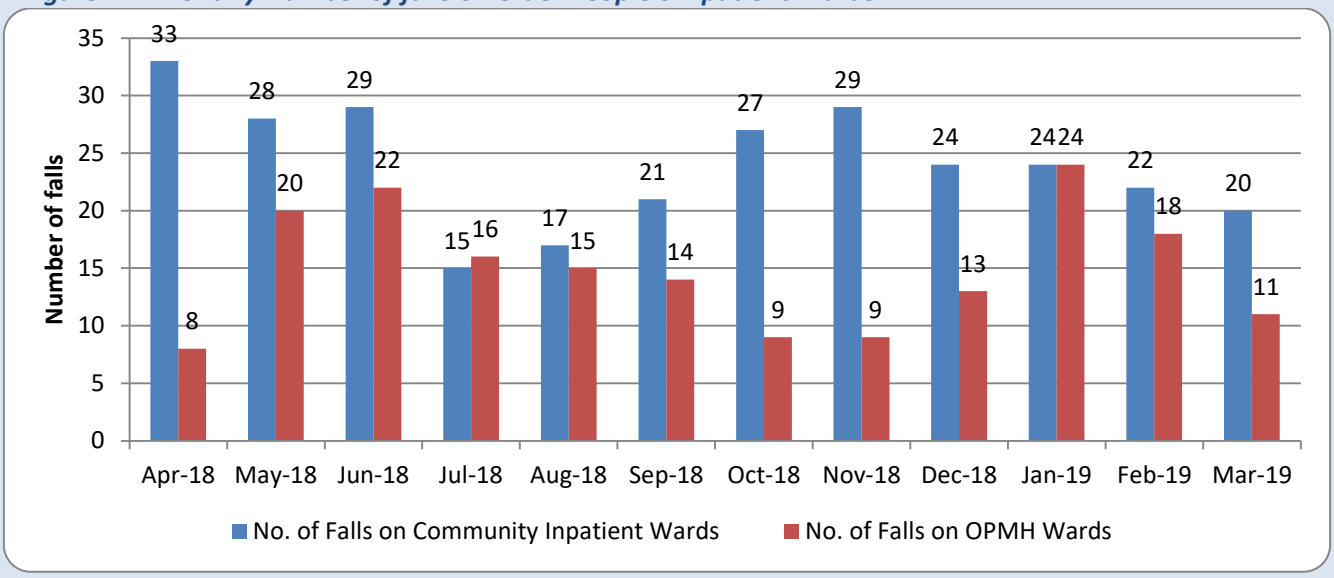
In order to address the target, both of the Trust's Older Peoples Mental Health (OPMH) wards at Prospect Park Hospital are working to reduce the number of falls as part of a Quality Improvement initiative during 2018/19. They will be analysing their falls data to understand why the falls occurred and then implement preventative measures using the Plan Do Study Act (PDSA) methodology. We continue to explore options for assistive technologies to help staff monitor patients at risk of falls. The risk of a patient falling and mitigation is recorded on the patients clinical record (RiO) used on the OPMH wards.

Progress against this priority will also be monitored against a target of no more than 8 falls per 1000 bed

days (taken from a National Patient Safety Agency target developed in 2007). Figures 14 and 15 below detail the number of falls and achievement against the target rate.

The figures show that Community Hospital inpatients have maintained achieved a rate of below 8 during the year, at 6.02 falls per 1000 bed days. Falls on OPMH wards were above the threshold at 16.59 falls per 1000 bed days for the year. OPMH wards cared for a number of patients who fell numerous times during the year. As a result, the falls assessment has been reviewed and is due to be incorporated in the risk summary on RIO. Patient specific care plans relating to falls management are also being reviewed together with the process that is carried out following a patient falling on one the older adult wards.

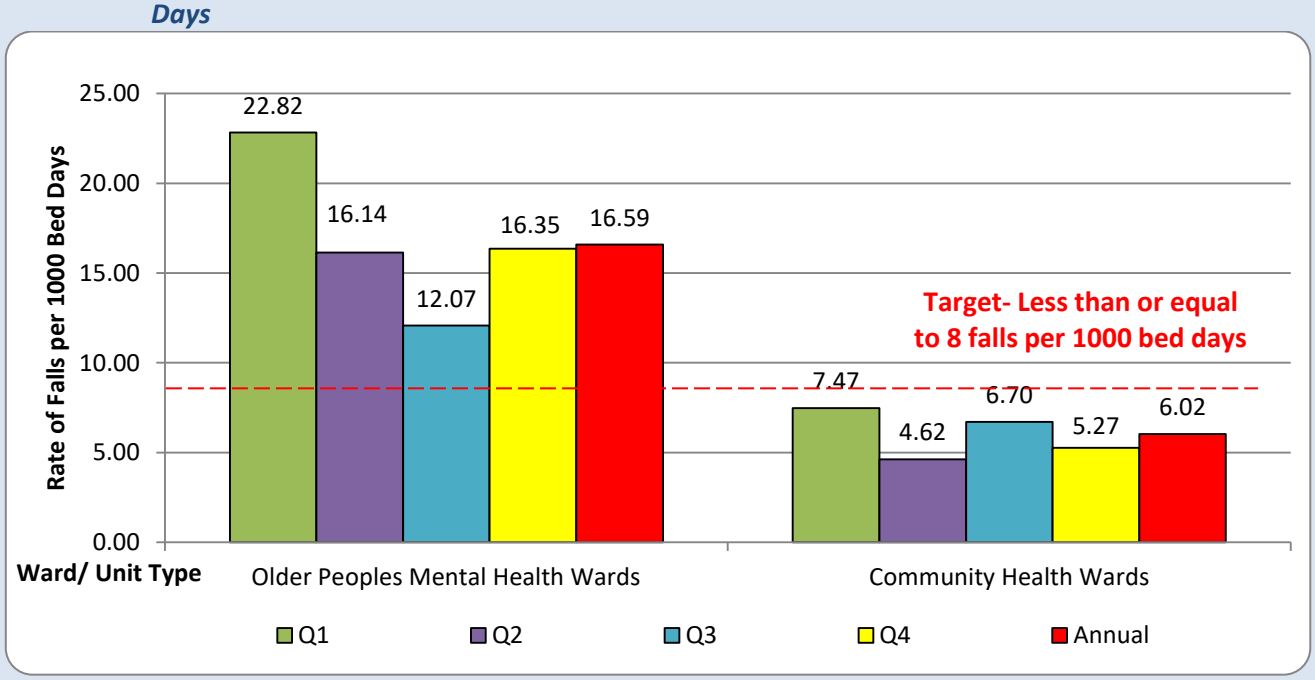
Figure 14- Monthly Number of falls on Older People's Inpatient Wards



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.

Source- Trust Tableau Dashboard

Figure 15- Rate of falls per 1000 bed days- Split by Ward Type (Target- less than or equal to 8 per 1000 bed Days



Sources- Trust Falls and Occupied Bed Days data provided on Tableau

Reducing Self-Harm Incidents

ⓘ Self-harm is when an individual intentionally injures themselves as a way of dealing with or expressing overwhelming emotional distress. It is sometimes carried out when individuals feel they have no other option

The Trust has set a priority to reduce patient self-harm incidents reported for patients under trust care by 30%. The target is to have ≤87 such incidents each month.

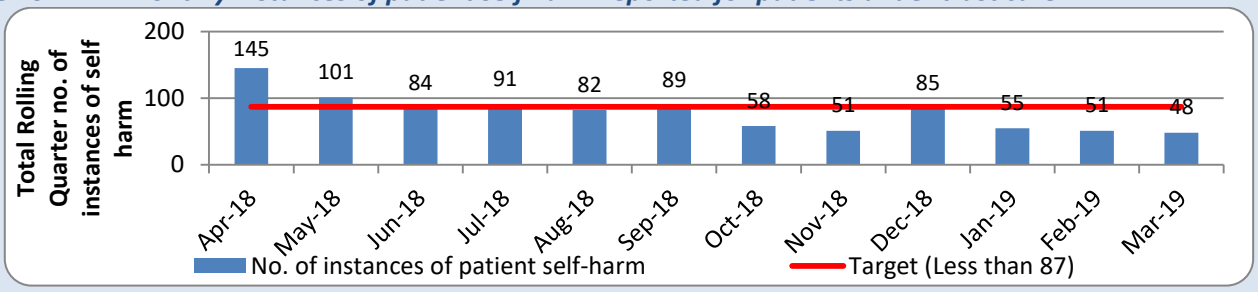
Using Quality Improvement methodology (QMIS), four of the adult mental health wards at Prospect Park Hospital and Willow House Adolescent Unit have identified the reduction of self-harm incidents as a priority. Each ward has developed actions in an attempt to reduce the number of such incidents on their units. Progress against this is reported.

The following factors have been identified as contributing to self-harm:

- Boredom in the evening (18.00-20.00)
  We are trialling an activity room approach in the early evening.
- Communication of distress in the early hours of the morning (01.00-02.00)
  We are investigating the case data on communication of distress and bad news mitigation with psychology colleagues to understand if this is a theme.
- Searches unable to detect contraband items
  Use of therapeutic searching.

Figure 16 below shows trust performance during 2018/19. As can be seen, the monthly number of self harm incidents reported was below target for 8 of the 12 months in the year, with an average number of 78 self-harm incidents reported per month which is below the threshold of 87.

Figure 16- Monthly instances of patient self harm reported for patients under trust care



Source- Trust Tableau Dashboard

Suicide Prevention- Zero Suicide

ⓘ The trust vision is to focus on suicide prevention by developing staff skill and knowledge, creating a no blame culture and supporting service users and their families through safety planning.

The Trust has set a target to maintain a 10% reduction from the 2015/16 baseline rate of suicides of people under Trust mental healthcare by 2020/21.

The 2018 "Zero Suicide" programme of work has focused on 4 main areas, with the following achieved in 2018/19:

1. Despite the increase in the numbers of suicide compared to 2017/18, the Trust is on target to see a reduction of 10% in the overall suicide rate compared to the 2016 baseline (9.2 deaths per 10,000 people under MH care) by April 2021. It has been repeatedly highlighted that suicide rates should be viewed over a 5-10 year period and we must be mindful that changes based on year-on-year data could be natural fluctuations rather than the beginning of a longer-term trend.
2. We have seen a decrease in the number of staff reporting they feel blamed when a suicide occurs compared to baseline data down to 8% from 16% (Zero Suicide Workforce Survey)
3. Leadership around communicating the key messages and expectations across the organization about suicide prevention being a priority for the Trust has been an important element of the project this year. 86% of staff reported that Leaders have explicitly communicated that suicide prevention is a priority.

4. Training - significant resource has been dedicated to the 3 day bespoke training, e- learning, ad-hoc training, workshops and a conference in December 2018 has seen staff reporting an increase in the skills and confidence compared to baseline (80% of staff admin and clinical compared to 62%).

Figures 17 and 18 below show the monthly number and yearly rate of suicides per 10,000 people under Trust mental healthcare. Figure 16a shows that the trust rate has again fallen to below the 10% reduction target rate (compared to the baseline 15/16 rate of 9.2 per 10,000 people under mental healthcare). However, it is important to continue to monitor the rate to determine if this can be sustained.

Figure 17- Number of suicides per 10,000 people under Berkshire Healthcare NHS Foundation Trust Mental Healthcare

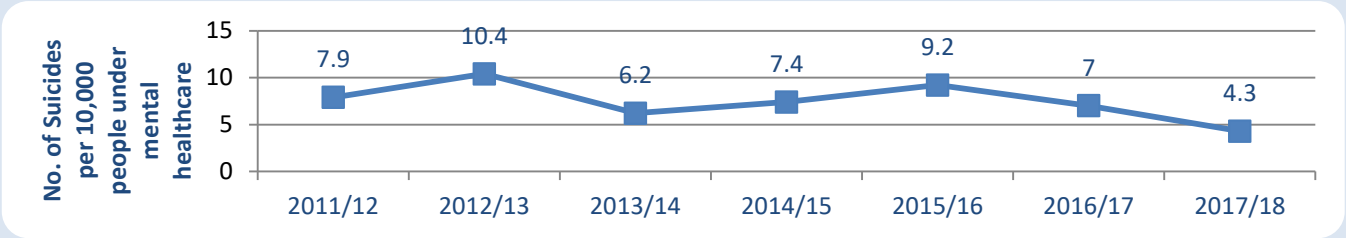
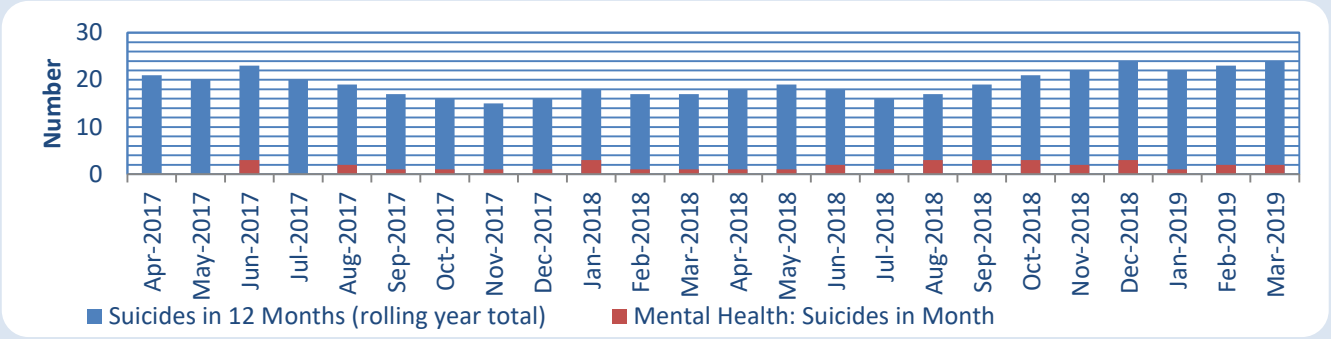


Figure 18- Suicides of patients under Berkshire Healthcare NHS Foundation Trust mental healthcare Number per month and rolling year total per month



Source- Trust Tableau Dashboard

Urgent Admissions- Reducing Inappropriate Out of Area Acute Mental Health Placements

ⓘ An 'out of area placement' (OAP) for acute mental health in-patient care occurs when a person with assessed acute mental health needs who requires adult mental health acute inpatient care is admitted to a unit that does not form part of the usual local network of services. There are circumstances where this may be appropriate (e.g. for safeguarding reasons), but where the OAP is due to a lack of capacity in the local inpatient unit then it will be inappropriate. The government has set a national ambition to eliminate such inappropriate OAPs by 2020/21.

In order to achieve this, the Trust is focused on reducing the length of stay for inpatients and ensuring alternatives to admissions have been fully considered. The approach to bed management has been changed, gatekeeping functionality has been enhanced and discharge planning improved to support patient flow and the experience.

Achievement against this target is measured with reference to the total number of occupied bed days that patients spend in Out of Area placements.
Figure 19 below demonstrates performance against this priority. The figure shows that the trust has achieved its target overall during 2018/19, with an average of 185 bed days spent as an OAP each month during the year. It should be noted that the number of OAPs was above the target set by NHS Berkshire West CCG in Q3 of 2018/19 and above the target set by NHS Berkshire East CCG in Q4. In line with the national demand on Mental Health services, the Trust continues to experience variation in Inpatient Mental Health bed occupancy leading to the use of Inappropriate Beds in alternative providers. The

ongoing programme of work has resulted in a reduction of patients being treated away from home in the last financial year, as well as reduced associated costs, however further improvement is required to eliminate this practice. The programme aims to achieve this by a reset of the programme which will look at the Prospect Park offer; local ownership of the initiatives to improve the use of inpatient beds; alongside an increased focus on Length of Stay to look to achieve a reduction in bed occupancy with the ideal being 85%, in order to offer the right care, in the right place, at the right time.

The OAPs indicator has been a challenging process to develop as there are a number of complex steps in the process. Significant progress has been made since the last audit of this indicator, but we still need to address the use of a spreadsheet to control part of the process and a programme of work is in place to address this. The trust is performing well against the Single Oversight Framework indicator and has achieved it quarterly target of reducing inappropriate OAPs throughout the year.

Figure 19- Quarterly and annual number of Inappropriate Out of Area Placements

CCG of patient	Out of Area Placement Occupied Bed Days in 2018/19									
	Q1		Q2		Q3		Q4		2018/19	
	No. of occupied bed days	Target (Less than)	No. of occupied bed days	Target (Less than)	No. of occupied bed days	Target (Less than)	No. of occupied bed days	Target (Less than)	No. of occupied bed days	Target (Less than)
NHS Berkshire West	**299**	436	**366**	396	**397**	356	**167**	316	**1229**	1504
NHS East Berkshire	**324**	418	**116**	380	**196**	342	**356**	304	**992**	1444
Grand Total	**623**	854	**482**	776	**593**	698	**523**	620	**2221**	2948
Average Per Month	**208**		**161**		**198**		**174**		**185**	

Source: Trust Out of Area Placement Report

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 was inspected by the Care Quality Commission (CQC) during June and July 2018. The Campion Unit, the trust's assessment and treatment unit for people with learning disabilities was rated 'outstanding' as a service. The trust was rated 'outstanding' for the well-led domain and continues to be rated overall 'good'.

Acute adult mental health inpatient bed occupancy is above 90% at Prospect Park Hospital

Bed occupancy continues to be consistently above 90% at Prospect Park Hospital which means that patients might not receive a good experience all the time. Delayed discharges have stabilised and the female wing of Sorrel Ward opened in December 2018. The new bed management system is working well and the number of out of area placements has reduced but the pressure remains on local beds.

Shortage of permanent nursing and therapy staff

Mental and physical health inpatient and West Berkshire 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. We have reduced the bed base by ten beds in West Berkshire Community Hospital and have invested in therapy and specialist roles. This will support an additional 3 dedicated neuro beds and provide additional therapy input to improve patient outcomes so that patients return back to their usual place of residence in a timely manner Prospect Park Hospital continues to have qualified nursing pressures. A recruitment and retention programme is being developed by the Director of People and further details of this and its achievements to date are included in the 'Reducing Staff vacancies' section of this report.

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. Figure 20 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.

Figure 20- Incidents requiring formal duty of candour (DOC)

Month	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19
Incidents with formal DOC	26	44	28	31	25	28	26	36	30	25	37	21

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 2018/19 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

   In addition, this section also includes a statement on rota gaps for NHS Doctors in Training, and the plan for improvement to reduce such gaps.

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

It had been intended to evaluate compliance against four pieces of NICE Guidance. However it was decided at the Trust Clinical effectiveness Group to concentrate on the self-harm NICE Guidance only.

To support the Trust's suicide prevention and self-harm priorities, an assessment of compliance against NICE Clinical Guideline 133 on self harm in over 8's has been undertaken. This exercise has been undertaken with the Clinical Directors for the Trust Adult Mental Health services and senior representatives of the Trust Child and Adolescent Mental Health Service (CAMHS).

An assessment of compliance has been produced and approved by the Trust Clinical Effectiveness Group in March 2019. The assessment concluded that the trust is meeting 53 (96%) of the 55 relevant recommendations in the NICE Guideline. The two unmet recommendations relate to:

1. Prompting clinicians to ask patients as part of a risk assessment whether they have access to family members', carers' or significant others' medications. Action is in place to add this.
2. If stopping self harm is unrealistic in the short term, advising the patient of less destructive techniques. This is not met as in all cases clinicians will try to stop the patient from self harming rather than advising them of a less destructive method. This would be undertaken as part of a risk assessment.

NHS Doctors in Training- Rota Gaps and Plans for Improvement

ⓘ The Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 requires NHS Trusts to make a statement in their Quality Report on rota gaps for NHS Doctors in Training, and the plan for improvement to reduce such gaps

The Trust appointed two 'Guardians of Safe Working' in February 2017. These guardians work within the Trust as Consultant Psychiatrists and have a duty to advocate for safe working hours for junior doctors and to hold the board to account for ensuring this. As part of this duty, the Guardians of Safe Working report to the Board on activity relating to Junior Doctor working hours, including rota gaps.

Figure 21 below details the Psychiatry rota gaps for NHS Doctors in training in the Trust between 1st April 2018 and 31st March 2019. The table shows that all but one of the requested gaps in shifts were covered and worked.

The gaps are the result of core training vacancies. To reduce rota gaps, the Trust has participated in the Medical Training Initiative (MTI) scheme. This brings experienced doctors from outside the European Union into the Trust for two years and, after an initial introduction to the NHS, they are then able to participate in the junior doctor's Out of Hours rota. This is the first year the Trust has participated in the scheme, and has received one doctor. Following the very positive feedback, the Trust will be looking to increase its number of MTI Drs and will always try and recruit doctors into the gaps.

The Trust has also increased, and continues to increase, its number of bank doctors to ensure that the rota is always covered and patient safety is not compromised.

Figure 21- Rota Gaps for NHS Doctors in Training – Psychiatry – 1st April 2018 – 31st March 2019

Rota Gaps	Number of shifts requested	Number of shifts worked	Number of shifts worked by:			Number of hours requested	Number of hours worked	Number of hours worked by:		
			Bank	Trainee	Agency			Bank	Trainee	Agency
	258	257	206	51	0	2561	2548.5	2087	461.5	0

Source- Trust Guardians of Safe Working Board Reports

2.1.4. Supporting our Staff

ⓘ 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. This section was titled 'Organisational Culture' in previous Trust Quality Reports

Our 2018/19 Supporting our Staff Priorities are as follows:

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 to below 10%.

* Please note that the original target set by the Trust had been to reduce vacancies by 10% against the previous year's levels. However, following further analysis and establishment of the Trust People Dashboard this year a clearer ambition was set to reduce vacancies to below 10% overall.

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

2018 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 participated in the 2018 NHS National Staff Survey between September and November 2018.

Differences between the 2017 and 2018 Survey

For the 2018 survey, the 32 Key Findings seen in the 2017 survey have been replaced by 10 themes. These themes cover ten areas of staff experience and present results in these areas in a clear and consistent way. All of the ten themes are scored on a 0-10 scale, where a higher score is more positive than a lower score. These theme scores are created by scoring question results and grouping these results together.

The Survey Sample.

The survey was conducted online, resulting in it being open to over 4000 of the Trust's employees, 2,067 (51%) of whom responded. This is higher than the Trust's 2017 response rate of 44% and the 2018 national response rate of 45% for similar Trusts (31 combined mental health, learning disability and community health services Trusts).

Summary of Trust Results.

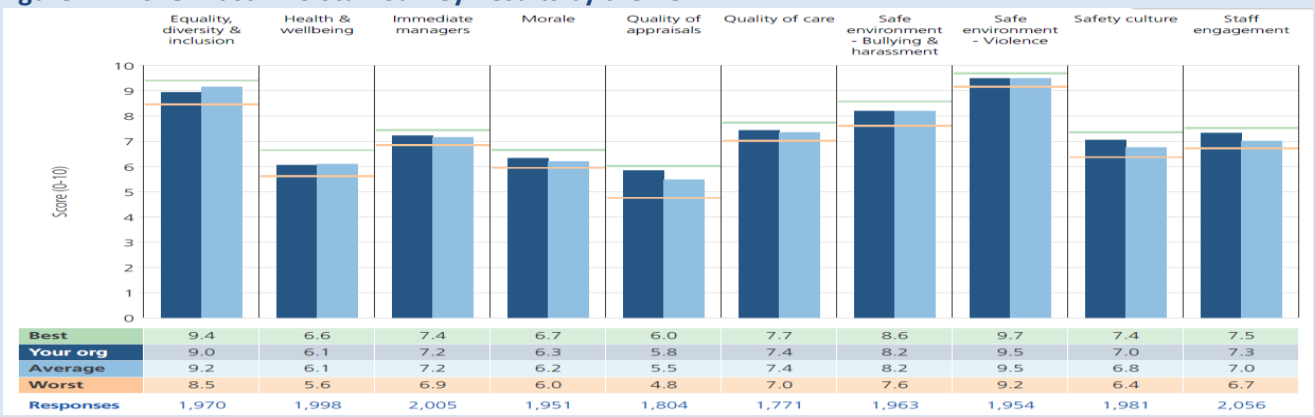
The Trust results were benchmarked against the other 31 similar Trusts and showed:

- Better than average scores for 4 of the 10 themes
- Equal to the average scores for 5 of the 10 themes
- Worse than average scores for 1 of the 10 themes

Figure 22 below details the Trust results by theme and shows that there is more work to do in areas such as health and wellbeing, and in creating an environment free from discrimination and bullying. An analysis of individual questions shows that 82% of responding staff said that 'care of service users is the organisation's top priority', which is well above the NHS average of 70%. In addition, 80% of responding staff said that 'my organisation acts on concerns raised by service users' (NHS average 76%).

The staff engagement score for the Trust in the 2018 survey was 7.3 out of 10 which is the third highest engagement score for all mental health, community and learning disability trusts and puts us in the top 20% of all trusts. This is important due to the link between staff engagement and the provision of good quality, safe services.

Figure 22- 2018 Trust NHS Staff Survey Results by theme



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Best	9.4	6.6	7.4	6.7	6.0	7.7	8.6	9.7	7.4	7.5
Your org	9.0	6.1	7.2	6.3	5.8	7.4	8.2	9.5	7.0	7.3
Average	9.2	6.1	7.2	6.2	5.5	7.4	8.2	9.5	6.8	7.0
Worst	8.5	5.6	6.9	6.0	4.8	7.0	7.6	9.2	6.4	6.7
Responses	1,970	1,998	2,005	1,951	1,804	1,771	1,963	1,954	1,981	2,056

Source- 2018 NHS Staff Survey- Trust benchmark Report

Staff feeling they can make improvements at work

One of the Trust targets for 2018/19 was that at least 66% of staff responding to the staff survey state 'yes' to Question 4d, 'I am able to make improvements happen in my area of work'. The survey results show that 64.4% of responding staff answered yes to this question, and so the target was just missed.

Staff recommending the trust as a place to receive treatment

One of the Trust targets for 2018/19 was that at least 75% of staff responding to the staff survey state 'yes' to Question 21d of the survey, 'If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation. The survey results show that 73.6% of responding staff answered yes to this question, and so the target was just missed.

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 recognise there are concerns here that need addressing, and work is underway to build on some of the things that are already have in place, such as the Making it Right programme. The Trust will make 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

Indicator and Description	Race	Trust Scores (%) 2015 (%)	2016 (%)	2017 (%)	2018 (%)	2018 Average (median) for combined MH/LD and community Trusts (32 Trusts)
Ind.5- Percentage of staff experiencing harassment or bullying from patients / public in the last 12 months	White	23	22	22	23	26
	BME	25	27	27	31	31
Ind.6- Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	White	19	18	18	20	21
	BME	27	26	21	26	26
Ind.7- Percentage of staff believing the Trust provides equal opportunities for career progression or promotion	White	91	90	89	89	88
	BME	74	68	74	68	76
Ind.8- In the last 12 months have you personally experienced discrimination at work from manager/team leader or other colleagues	White	5	5	7	7	6
	BME	14	17	11	17	13

Source- 2018 National Staff Survey

Reducing Mental Health Patient Physical Assaults on Staff

ⓘ The NHS has had a 'zero tolerance' attitude towards violence since 1999, and NHS staff should be able to come to work without fear of violence, abuse or harassment from patients or their relatives.

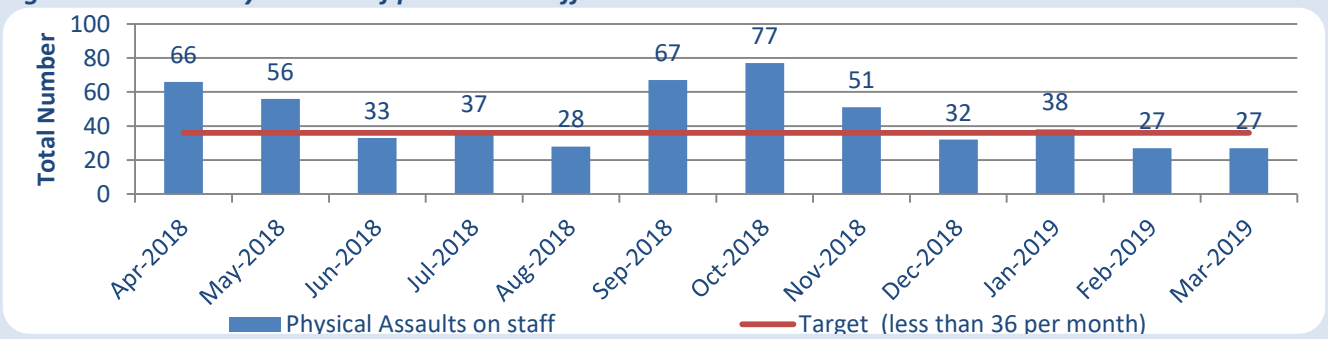
The trust has set a target of reducing the number of assaults on staff by 20% in 2018/19.

Figure 24 below details the number of patient to staff assaults. The figure shows that the number of patient physical assaults on staff was above the threshold of 36 in 7 of the 12 months in 2018/19 with an average number of 45 assaults per month during the year.

Sorrel Ward, the Psychiatric Intensive Care Unit (PICU) at Prospect Park Hospital is focusing on completing Datix incidents reports accurately to help them fully understand the situation. They are also using a key worker board so that patients can clearly see who their allocated person is for that shift to avoid any communication breakdowns. Work is also being undertaken on Sorrel Ward to standardise the level 4 (general) observations. These actions have been reviewed in light of the Q3 findings and will be further reviewed at the end of March 2019 to ensure they are meeting objectives.

Information on patient to patient assaults is included in part 3 of this report.

Figure 24- Monthly number of patient to staff assaults



Source- Trust Tableau Dashboard

Reducing Staff Vacancies

ⓘ Ensuring the Trust is staffed with the appropriate number and mix of clinical professionals is vital to the delivery of quality care and in keeping patients safe from avoidable harm. It is also important that both new and existing staff are supported and encouraged to remain with the Trust.

The trust set a target of reducing its staff vacancies to below 10% through its recruitment and retention action plan. The original target set by the Trust had been to reduce vacancies by 10% against the previous year's levels. However, following further analysis and establishment of the Trust People Dashboard this year a clearer ambition was set to reduce vacancies to below 10% overall.

From April to November 2018 the Trust recruited 516 new starters and 450 staff left the organisation, a positive variance of 66 Full Time Equivalent (FTE).

The Trust has a Recruitment and Retention working group which meets once per month to deliver the action plan. In addition we have developed action plans for District Nursing, Prospect Park Hospital and West Berkshire Community Hospital. One significant action is an advertising campaign to attract new recruits to vacancies now and planned for the months ahead. This campaign covers radio, buses, newspapers and social media advertising, plus open days and school and university fair attendance.

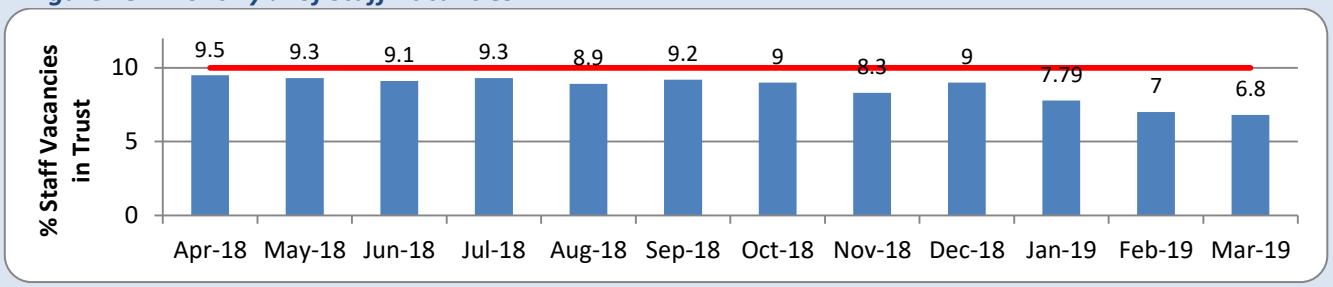
West Berkshire Community Hospital held a recruitment open day in April 2019 attended by 90 potential applicants. The trust will hold another open day in May 2019 at Prospect Park Hospital with the aim of recruiting band 5 nurses.

The Trust has decided to fund a three year project to improve the health and wellbeing offer and improve employee engagement with the aim of making this a great place to work. Over the longer term it is anticipated that this work will have a positive impact on recruitment and retention.

The operational, clinical education team and HR are working together to build better data for workforce planning and a new People Hub has been set up with an increased focus on recruitment and retention. The People Hub allows the recruitment team to review the data for all teams, professions and priorities the recruitment and retention activity. The team have, developed the use of social media to target applicants, redrafted job descriptions and adverts, streamlined elements of the recruitment process, designed new advertising material, improved the school and university fair offer and set up a contract with an agency to recruit community nurses.

Figure 25 below details monthly achievement against this target and shows that a staff vacancy rate of below 10% was met throughout 2018/19. The trust continues to focus on strategies to reduce the vacancy rate for substantive band 5 nurses, which was at nearly 35% (full time equivalent) as at 1 January 2019. This vacancy factor is managed through use of temporary nursing staff in addition to staff from a different nursing band.

Figure 25- Monthly % of Staff Vacancies



Source- Trust Tableau Dashboard

Training Staff in Quality Improvement

ⓘ 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 set a target to train 24 teams in its Quality Improvement System (QMIS) in 2018/19. 26 teams have been trained in QMIS during this period and so the target has been met.

Achieving Objectives in Trust Equality Plans

ⓘ At Berkshire Healthcare we passionately believe that being inclusive in our service provision and fair in our employment practice is integral to providing excellent customer service and is the backbone of our staff recruitment, retention and engagement. Delivery of objectives set out in our Trust Equality Plans will help us meet this goal.

Examples of work undertaken so far this year to meet objectives include the following:

As of the end of December 2018 the first and second cohort of staff have successfully completed the 'Making it Right' (MIR) Programme for BAME staff. The third cohort is due to begin in May 2019. A MIR mentor's workshop was conducted in November 2018 to up-skill mentors with the knowledge and requirement of being a MIR mentor.

In the last quarter we have employed a new member of the equality team to help support the staff networks. This role is able to publicise events, share

information, and ensure that there is administration support for all the activity we try to deliver.

The Learning and Development team in collaboration with staff, managers and the networks, have developed a new course called 'Making it Right for Managers'. The aim is to share the data about our workforce (national staff survey, recruitment, turnover, sickness) and provide a forum for discussion about the actions that are required by all managers to improve how it feels to be a member of staff with a protected characteristic.

In March 2019 the Trust's Purple Network hosted a disability symposium, entitled 'Maximising our Ability,' with guest speakers and attendance by more than 100 members of staff. The event allowed attendees to be involved in finding solutions to some of the challenges our staff, managers and carers face. As a result of this a number of the actions will be taken forward during 2019, specifically developing our managers and improving how we support staff needing a reasonable adjustment.

The NHS national staff survey took place in October 2018 and the results were published in February 2019. A team of managers have reviewed the data to look at themes and priority areas of focus. The results were shared at the Diversity Steering Group and the Director of People took an action to review the feedback in detail with the lead for each staff network and the Executive sponsor for that network. The aim is to have an agreed understanding of the key messages, next steps and to ensure actions are in place to make a significant improvement over the coming months.

Following the submission of the Workforce Race Equality Standard report and the accompanying action the board agreed the following actions:

- Review local population data and consider whether a target above our current level of 20% BAME staff in bands 8a-d is achievable
- Review the actions set out in the current action plan and determine how we engage white managers in the conversation about why there is an over-representation of BAME staff in disciplines and grievance
- Develop talent pools and improve our external advertising and ensure all band 8a and above roles are advertised
- Set up focus groups with non-BAME managers, unions, black and minority staff and develop learning and development interventions, communication tools and new ways of working that create a new Berkshire Healthcare way of working to shift from 'Making It Right' to 'It Being Right'

The finance team are ensuring that all staff members have a work place assessment and that wellbeing is asked about and explored as part of the appraisal process. The team have also been openly discussing types of disabilities to help people declare a disability if they so wish.

Staff Networks

The Trust has three staff inclusion networks that play a vital role in delivering workplace equality and advising on service inclusion issues. They are open to interested members of staff from any background.

The Black, Asian and Minority Ethnic (BAME) Network was formed in 2016 to help the trust meet its statutory duty to promote racial equality and eliminate discrimination in line with the Workforce Race Equality Standard (WRES). The network's mission is "to create equal career prospects and advancement opportunities for BAME staff by enriching their working lives through caring for the individual, being committed to providing quality patient care and working together to develop innovative solutions". During the year 2018/19, the network continued to support the delivery of the Making It Right (MIR) Programme and hosted a high profile conference to celebrate Black History month. Additionally, members of the network organised road shows and local networking events to foster dialogue, advance cohesion and raise awareness of issues that may affect BAME staff members. The network has identified key priorities for 2019/20 which include continued support for the MIR Programme, Reverse Mentoring, Working with Equality and Diversity lead on inclusion strategies, supporting the Freedom To Speak Up initiative and celebrating events and achievements.

The LGB&T and Friends Network provide focused advice and assistance to the Trust to ensure sexual orientation equality in employment and service delivery. The network has three new co-chairs who have agreed the 10 priority areas to work on including improving membership, building the allies network, taking actions on the feedback from Stonewall, and ensuring the staff survey feedback is reviewed and actions taken. The network also engages with the

local LGB&T community and is a supportive network for LGB&T staff, providing personal support and mentoring where required. The LGB&T network is open to LGBT staff as well as heterosexual staff as there are a great many heterosexual staff members who are very supportive of this work. The network aims to make issues of sexual orientation and transgender open and visible within the organisation ensuring all members of staff feel able to bring their whole self to work.

The Purple Network was formed in 2018 to support trust staff with disabilities, impairments, physical disabilities, neuro-diverse conditions, mental health conditions and caring responsibilities. The network supports the trust to increase its disability confidence, address barriers and promote a culture of openness in line with the new Workforce Disability Equality Standard (WDES). During the year 2018/19, the network celebrated and raised awareness of a number of national events including; persons with disability day, purple light-up day, and Time to Talk. In addition, the network undertook a survey of 'purple staff'. This activity culminated in a successful and well-attended conference in March 2019 entitled 'Maximising our Ability'. The network has identified key priorities for 2019/20 which include; producing blogs to raise awareness of the experiences of purple staff, promoting the voices of purple staff, celebrating equality days both in the trust and on social media, attending the 2019 disability summit, supporting the introduction in the trust of the WDES and implementing suggestions from the 'Maximising our Ability' conference.

Participating in Integrated Care System Work Streams to enhance job satisfaction and career development opportunities

ⓘ Integrated Care Systems (ICS) are partnerships between NHS Organisations, Local Authorities and other stakeholders which aim to improve the health and care of the population they serve. Organisations in each ICS take collective responsibility for managing resources, delivering NHS Standards across their population.

The Trust is a member of both West Berkshire ICS and Frimley Health and Care ICS, the make-up of which is described in the Patient Experience Section earlier in this report. The Trust is involved in activity that covers the following areas with the aim of delivering best practice:

- Occupational health
- Medical staffing
- Statutory and Mandatory training
- Recruitment

The outcomes should ensure that NHS staff who move between trusts are able to do so more easily, at pace and more efficiently.
In addition, organisations are working together to improve the capability of the workforce to ensure that enough staff are trained to undertake roles following remodelling of services. For example we offer advanced history taking and prescribing courses. The ICS are also working together to improve workforce modelling data and capability.

All Human Resources Directors of Trusts in the Buckinghamshire, Oxfordshire and Berkshire Strategic Transformation Partnership (BOB STP) have met and drafted a new People Strategy with the aim of having a single agreed document and joint working teams finding solutions aligned to priorities. The development process included a day with local authorities, social care providers and the CCG to ensure the People Strategy covers all providers' concerns and to build consensus on priorities and focus areas. The strategy will then work at ICS and individual trust level too. The group now meets weekly to progress this work on behalf of the Local Workforce Action Board.

The Trust are currently looking at good practice in statutory and mandatory training across the country with the aim of finding a better solution for the Strategic Transformation Partnership (STP) that also works for our staff. The recruitment streamline project is progressing and changes have been made by us to align to other STP providers, which will speed up our recruitment processes. There are issues with Electronic Staff Record usage and functionality as all providers use the system differently and therefore ICS or STP data is difficult to produce.

Freedom to Speak Up

ⓘ Following a review by Sir Robert Francis in 2015, a national standard 'Freedom to Speak up' policy was published by NHS Improvement and NHS England. This policy has the aim of developing a more open and supportive culture for staff to raise any issues of patient care, quality or safety. The Trust has subsequently adopted this standard policy in its own policy.

The Trust's policy and procedure in relation to this area is contained within ORG013- Freedom to Speak Up: Raising Concerns (Whistleblowing). This policy emphasises the importance of staff being able to speak up about any concern in order to ensure the safety and effectiveness of our services.

Under the policy, trust staff members are encouraged to raise concerns (confidentially, unless required to disclose by law) about risk, malpractice or wrongdoing that they may think is harming the services the trust delivers. Such examples may include, amongst others, unsafe patient care, unsafe working conditions, inadequate training or a culture of bullying.

How does the Trust ensure that staff do not suffer detriment from speaking up?
If a member of staff raises a genuine concern then they will not be at risk of losing their job or suffering from any form of reprisal as a result. The trust will not tolerate any harassment or victimisation of anyone raising a concern. In addition, providing that the staff member is acting honestly, it will not matter if the staff member is mistaken or if there is an innocent explanation for the concern.

How can staff speak up?
Staff are encouraged to raise concerns in a number of ways:

1. By raising the concern with their line manager, lead clinician or tutor (for students). This may be raised orally or in writing and advice can be sought from a trade union if the employee is a member.
2. If the member of staff does not feel they can raise the issue with their line manager, or they feel the line manager has not addressed their concerns, then it can be raised with any of the following; their Locality or Corporate Services Director, The Trust Freedom to Speak up Guardian, The Trust Executive Director with Responsibility for Whistleblowing (Currently the Director of Nursing); the Risk Management Team; through a dedicated confidential external telephone line or e-mail service, or through the local Counter Fraud Specialist.
3. If the above channels have been followed, and the member of staff still has concerns, then the Trust Chief Executive or nominated Non-Executive Director can be contacted via e-mail or by letter about the concern.
4. Alternatively, concerns can be raised formally with external bodies such as NHS Improvement, the Care Quality Commission and NHS England

How is feedback given to staff raising a concern?
Feedback is given as appropriate to each case and would depend on the concern raised and if the information is confidential or not. The aim is to share learning from concerns raised.

The role of the Freedom to Speak Up Guardian
The Trust Freedom to Speak Up Guardian helps to protect patient safety and the quality of care, improve the experience of workers and promote learning and improvement. This is achieved by ensuring that; workers are supported in speaking up, barriers to speaking up are addressed, a positive culture of speaking up is fostered and Issues raised are used as opportunities for learning and improvement. This role is now fully embedded in the Trust and awareness of this facility is very well publicised Trust-wide. Between April 2018 and March 2019 44 cases where brought to the Trust's Freedom to Speak up Guardian.

Whistleblowing Cases
A total of 14 concerns were raised using the Trust whistleblowing process during 2018/19. All of these whistleblowing cases have been fully investigated and closed. All parties have received feedback and the appropriate action has been taken and is on-going. Four of the concerns raised included a patient safety element.

2.1.5. Other Service Improvement Highlights in 2018/19

ⓘ 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

West Berkshire Community Hospital Inpatient Unit in Newbury has implemented daily board rounds involving trust and social care staff. These occur around each ward base PSAG board (Patient Status at a Glance). All members of the Multi-Disciplinary Team (MDT) are present and the meetings on each ward last approx. 30 minutes. Only patients designated as medically fit have their discharge plan reviewed and tasks are assigned daily and reviewed daily. As a result, the average length of stay on the wards is below the trust target. Patient discharge plans are discussed on a daily basis to facilitate this and a Development Lead role has also been introduced to the Unit. The unit plan to increase therapist input this further.

Oakwood Community Inpatient Unit at Prospect Park Hospital in Reading has achieved a falls target of less than three falls per months for three consecutive months. They have also introduced board rounds to improve patient flow and introduced a weekly staff support group.

Wokingham Community Hospital Inpatient Wards have introduced a number of improvements including; board rounds (see above), focusing on improvements in early warning system escalation (NEWS), induction and pressure ulcer prevention.

Wokingham Intermediate Care Service achieved a 'Good' rating in their recent CQC inspection and has introduced a Units based system which has enabled to them to better manage their demand. A robust Lone working procedure has been introduced for Therapists with better monitoring systems. Service provision has been expanded to include mobility visits (rehab visits) at the weekend and the team also raised funds in Wokingham as part of the NHS70 celebrations.

West Berkshire Intermediate Care Service undertook a green belt project to produce a single pathway for all community therapy patients so that patients are seen at the right time by the right clinician. This involved; merging three existing pathways into one, clearing a backlog of patients, re-designing patient triage and developing a standard work process for all staff to follow. After eight months of intensive work, the new pathway became operational resulting in the waiting list reducing from 11 months to 1 week. The new pathway is allowing more focused, quality time with patients on visits.

The Community Podiatry Service participated in a Rapid improvement Event (RIE) to address their capacity and demand. The event identified quick wins and longer term action which focused around collecting and using data to improve capacity. This work is still ongoing. The service has also implemented a new 0300 telephone number for East Berkshire (St Marks, King Edward and Upton sites). This new system includes a call queuing system and informs patients that their calls will be answered within a certain time.

The Nutrition and Dietetics Service has been involved in the development of a new Irritable Bowel Syndrome (IBS) service within Frimley Integrated Care System (ICS). In addition, the service continues to work with the Daisy Garland charity to provide a full time dietician that supports the Paediatric team at the Royal Berkshire Hospital in running a Ketogenic Diet service. This is a service for children with a confirmed diagnosis of epilepsy who have been identified by a Paediatrician as suitable to move to a ketogenic diet. Such a change in diet can reduce the number of seizures the child has and the impact of them on the child's quality of life. In addition, the dietetics service at The Royal Berkshire Hospital (RBH) undertook a

pilot of the Low Calorie Liquid Diet (LCLD) approach for diabetes remission using a group model, the first known of its kind in the UK. The outcomes were highly successful resulting in a remission in diabetes of 46% and a mean weight loss of 10kg after 1 year. Discussions are being held with commissioners as a result of these findings.

The Musculoskeletal (MSK) Physiotherapy Service has introduced a GP helpline so that advice can be sought from the service via e-mail on a daily basis.

The Integrated Pain and Spinal Service (IPASS) have introduced an 'opt in' system that has helped reduce their waiting list for initial assessment of pain management to within target. The 'Did Not Attend' (DNA) rate for spinal assessment has also reduced from between 7-11.5% to 5%. Pain clinicians have introduced a detailed pathway to ensure consistency in practice and more effective triaging of patients into the correct part of the service. In addition, 'Cauda Equina' cards have been developed and distributed. These are small cards with essential advice for patients who are at risk of having a spinal medical emergency.

The Community Speech and Language Therapy (SLT) Service have introduced 'soaking solutions' for puree snacks on community inpatient wards. Patients on these wards that require a modified diet now have improved access to suitably appropriate snacks and this has led to increased nutritional intake, greater patient choice and an increased sense of dignity and inclusion at snack time. The team have also been working collaboratively Berkshire wide to produce a 'feeding with acknowledged risk' policy. When finalised and adopted, this policy will ensure clear communication and continuity of care across settings for clients with identified eating and drinking issues. In collaboration with the Dietetics Service, the team have also started the International Dysphagia Diet Standardisation Initiative (IDDSI). This extensive piece of work has involved delivering training and changing leaflets, ward signage, ward menus and notation used in record keeping etc. The team will be fully compliant with this initiative by April 2019.

The Adult Acute Speech and Language Therapy (SLT) Service completed a service review in October 2018 that resulted in the development of a new team structure and new SLT posts. The team have worked with other hospital staff at the Royal Berkshire Hospital (RBH) to introduce the International Dysphagia Diet Standardisation Initiative (IDDSI) fluid descriptors. These descriptors are global and provide a standard framework for everyone to work from. A full time head and neck cancer post has also been created which allows the RBH to provide an outreach service/satellite service to head and neck cancer patients at Wexham Park Hospital in Slough so they do not need to travel to Reading. Finally, a Quality improvement project was undertaken with the aim of improving the SLT service for patients with Parkinson's disease. The poster for this work won First Prize in the Royal Berkshire Hospital NHS Foundation Trust Audit Competition.

The Continence Advisory Service has started paediatric group sessions for parents of children with underlying constipation**.** This has empowered parents to help manage their children's constipation, as well as reducing waiting times for input from continence services for families. In addition, a pilot specialist catheter clinic was instigated to re-catheterise mobile patients within the Wokingham community, rather than being added to the District Nursing caseloads.

The Phlebotomy Service now have access to the Royal Berkshire Hospital Pathology (ICE) system, allowing staff to print blood request forms for patients that have been referred for a blood tests by their GP.

The Berkshire Integrated Hub has reduced their process time for routine referrals from 7 days to 3 days. A revised training programme has been introduced for new staff, and staff and user surveys have been introduced.

East Berkshire Community Nursing Services have been involved in developing standard work processes to improve consistency across the service. Catheter clinics have commenced in Bracknell and Maidenhead, and are planned for Slough. Staffing-skill mix has been reviewed, with a phlebotomy role introduced and extension of the health carer role**.** The use of I-pads is being trialled to support mobile working and a community nursing video has been filmed for sharing with patients.

Wokingham Community Nursing Services have consolidated their community teams into larger, more effective teams located within GP surgeries. A restructure of team resources has been undertaken to take account of the skill mix of staff and the need to provide a better visible governance and support structure for the teams.

Nurse Led Do Not Attempt Cardio–Pulmonary Resuscitation (DNACPR). A training and competency programme has been developed for senior nurses, Advanced Nurse Practitioners and specialist nurses relating to DNACPR conversations and the completion of the relevant paperwork to record the DNACPR decision. Previously, these senior experienced nurses may have had DNACPR conversations with patients where this was appropriate, but would then need to request that a GP or senior medic have a further conversation to complete the paperwork. The new DNACPR programme is facilitated by Trust Geriatricians, a Hospice consultant and a senior Trust nurse. To date, the training has been well evaluated, with 60 nurses completing the programme.

Community Cardiac and Respiratory Specialist Service (CARSS). The Cardiac Rehabilitation team has been certified as an accredited service, have improved their home exercise programme and updated their education sessions. The Heart Function Team has established a cardio-renal Multidisciplinary Team (MDT) with a consultant at the Royal Berkshire Hospital. They have also strengthened their relationship with The Great Western Hospital in Swindon allowing better sharing of information for patients who have a GP in Berkshire West**.** The Respiratory Team have introduced phone-call assessments for patients with sickle cell anaemia requiring home oxygen review. These assessments have saved patient time and travelling. The Pulmonary Rehabilitation Team have updated their education sessions and introduced coffee mornings/afternoons where specific topics can be discussed. In 2019/20, the team plan to further integrate the various teams to ensure a streamlined approach for service delivery and less repetition for patients (e.g. by initiating joint visits).

Integrated Care Home Service (ICHS). The Rapid Response and Treatment Teams (RRAT) and Care Home Support Team (CHST) across Reading, Wokingham and West Berkshire localities have now merged to become the Integrated Care Home Service (ICHS) with one service manager. The team now functions in an integrated way which enhances the quality of service delivered. The ICHS Occupational Therapist and Physiotherapist have worked with the care homes and the ambulance trust to; review care home falls policies, train falls champions, implement telecare and analyse falls incident data. This has resulted in; a 55% reduction in falls over 6 months in one care home, a 90% reduction in 999 calls with an associated 41% reduction in falls in another care home, and a 66% reduction in another care home that now has falls champions. The ICHS Specialist Nurse Practitioners have delivered the 'Six Steps' programme to the care homes with the aim of enhancing end of life care through facilitating organisational change and supporting staff to develop their roles around end of life care. The ICHS Speech and Language Therapist set a challenge for care home staff to help residents enjoy their puree meals and snacks and stop residents losing weight. The chefs in the care homes rose to the challenge and designed some very appetising dishes which they have shared with each other. The winner went on to win a national competition 'Care Dine with Me'.

The Home First Rapid Response Service participated in in the first Green Belt project to be completed by the Trust QI team. The Length of Stay (LoS) on their caseload was in a breach of the service specification which stated that patients should be on the pathway for up to 14 days. The project group designed a new patient pathway and standard work for staff to follow, which they rolled out and continuously reviewed over a 6 month period. The outcomes have been positive for the service and patients and have seen the Length of Stay (LoS) on caseload reduced to 1-15 days.

The High Tech Care Service has sourced a venue for a new Peripherally Inserted Central Catheter (PICC) clinic in Reading to support District Nursing. The team are also working with The Rosemary Appeal, a Dialysis and Cancer care Charity in West Berkshire, to ensure the team have suitable treatment rooms when they move to their new premises based at West Berkshire Community Hospital (WBCH). This move has the potential to realise other benefits such as increasing the number of patients that can be seen at the WBCH IV clinic.

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

Urgent Care Services, including Westcall GP Out- of-Hours Service, Emergency Department (ED) Streaming and the Thames Valley 111 (TV111) Clinical Advisory Service

A new process for management of controlled drugs (CDs) has been put in place. Previously CDs were issued to individual GPs for them to use and record in their own registration books and on the Adastra patient system. When a doctor had used all their CDs they would return to WestCall to collect more or return expired medications. Under the new system CDs are much more tightly controlled with clear Standard Operating Procedures issued to doctors, nurses and drivers. The ordering, stock control, management and reconciliation of these medicines are tightly audited and controlled in order to reduce incidents and waste.

A new and improved process for non-answered calls to patients has been put in place and this has resulted in increased safety-netting and visibility of cases that are not answered upon call back.
Pathology results are now checked by a named GP on a daily basis at 1900hrs. This improves care by ensuring that all pathology requests made by WestCall GPs are both audited and followed up in a timely way

The Urgent Care administration team has been restructured to ensure named individuals have delegated responsibilities. A team leader has also been introduced to the team.

Nurse and paramedic practitioners have been introduced onto the clinical rotas. This has improved the skill mix of the team, enabling it to be more responsive and effective.

An experienced Urgent Care Matron specialising in out of hours care has been added to the senior leadership team. This ensures that non-medical practitioners and clinical support staff are well led.

A Clinical Governance Lead post has been introduced, and the service governance structure improved. This was undertaken in response to CQC feedback and ensures that clinical governance and quality standards remain robust, well embedded and audited.

The WestCall GP out-of-hours service has introduced the ability for 111 call centres to book patients directly into the service if appropriate to do so. This represents an improvement in the patient journey as, prior to this change, patients had to await call back from the service before being given an appointment. WestCall GP out of hours also now accepts patient self-referrals through 111 online.

The GPs in the TV111 Clinical Advisory Service are focusing on re-triaging patients who would otherwise have been told to attend the Emergency Department (ED) or be sent a 999 ambulance. This has resulted in less ambulances being dispatched and less patients attending ED which improves the whole system.
The Westcall GP out-of-hours service has introduced a new home triage role. This role supports clinicians to manage patients remotely using equipment provided by the service.

The service have introduced a FastTrack GP recruitment procedure and can now move a GP from enquiry to employed in the space of only a few hours if required.

Minor Injuries Unit (MIU), West Berkshire Community Hospital, Newbury
The service have trained two of their reception staff as Healthcare Assistants (HCAs) to support the practitioners doing initial assessments on patients as they arrive, as well as other tasks.

An office has been converted into a treatment room, allowing staff to do observations on patients there rather than in the waiting room. A new treatment room has been equipped with a Bariatric trolley with pressure relieving mattress. In addition, the staff toilet has been converted into a specimen toilet which allows patients to do their specimen in the toilet and leave it there to be tested rather than it being tested in a clinical room.

An appointment system has been introduced via 111, which allows patients to be seen at a suitable time, with the team endeavouring to see these patients within 30mins of this set time regardless of the wait time for walk-in patients. It is hoped this will become more popular with patients and allow workload to be spread throughout the day. In addition, a direct referral pathway has been set up with Podiatry

The service has developed a working relationship with a local GP Surgery to allow their staff to work with the duty GP and the Nurse Practitioners to develop their

minor illness skills. The Service has made a reciprocal offer to the GP Surgery.

Three members of staff are attending a Masters level course on Minor Illness to allow the service to see more patients that present with medical problems. In addition, a member of staff is attending a Non-Medical prescribing course to enhance patient treatment plans.

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

Participation Champions. Service users are crucial to the development of feedback mechanisms to ensure services meet needs. CYPF services have a vibrant network of participation champions who promote participation and the collection and analysis of service user feedback within the service. They meet on a quarterly basis to share ideas and good practice.

The Looked after Children Nursing Teams have been working with children and young people in care in order to develop their young person's feedback form. Team members have linked in with children in Care Youth Councils across Berkshire, where young people who are in Local Authority care or who are care leavers are able to meet and discuss their views. Having the involvement of young people at the earliest opportunity ensures the team are able to ask the right questions about the service they deliver and how it can be improved.

Child and Adolescent Mental Health Services (CAMHS) have produced a mini report on the findings of recent service user feedback. This is available for children, young people and their families to read when accessing our services. Whilst there are multiple ways to collect feedback and involve young people and families in participation activities, reporting back the outcomes of their input is essential. This helps ensure service users know that their contribution has been heard, that it is valued and that changes have been made as a result.

The Children and Young People Integrated Therapies (CYPIT) Service have developed a form that captures feedback gathered at parent groups. The form enables the facilitator to detail actions that are needed in response to parent feedback, who is responsible and when this will happen. This not only ensures that the service is collecting qualitative feedback, but makes sure that SMART actions are put in place and assigns responsibility.

Reading School Nursing Team is commissioned to deliver health promotion within the Reading locality, with one of the areas of focus being substance misuse. Following a scoping exercise and consultation with children and teachers, it was agreed that the best way to address this would be through a film made by the young people in Reading, for the young people of Reading. As a result, the team have been working in partnership with schools in Reading to develop a film called 'Taylors' Story'. The film will form the centrepiece of a health promotion session and contains three scenarios that are designed to be paused to allow for discussion about what Taylor's choices are and what the consequences might be. Filming has now taken place and the team are awaiting the edited version.

A new model of delivery has also been developed by Reading School Nursing Team. By separating the roles of School Nurses within the team into two areas of focus, Safeguarding and Public Health, they hoped that their safeguarding commitments would be managed effectively whilst allowing half of the School Nurses in the team to focus on their Public Health/early intervention role, which had historically received less attention. The pilot of this new approach commenced on 5th September 2017 and completed in August 2018. Evaluation of the pilot found a number of benefits including; a significant increase in face-to-face and telephone contact with families, a significant reduction in the number of safeguarding meetings which needed to be attended and an increased amount of health promotion being delivered.

The Berkshire School-Aged Immunisation Team continues to successfully carry out their core work of delivering immunisations in primary and secondary schools across Berkshire. In addition, the team have embraced additional work to deliver timely responses to outbreaks of disease amongst children and adults within Berkshire. In the spring of 2018/19 the team responded to a small outbreak of Hepatitis B at a school. This required the service to mobilise a small team of nurses, engage with the Health Protection Agency and Public Health Teams and provide a rapid

response to an outbreak, usually within 48 hours. The team was called upon again in the summer to provide a rapid response to an outbreak of Meningitis B at a nursery school of 3 – 4 year old children during the height of the summer holiday. The service rose to the challenge, with staff coming in from their summer break to deliver prophylactic antibiotics and injections to children and staff.

Reading Health Visiting (HV) Team and Reading Community Nursery Nurse (CNN) Team are trialling two innovative solutions to improve uptake of the Healthy Child Programme scheduled development reviews. Firstly, the CNN team are working in partnership with a number of local nurseries to improve uptake of the 27 month development review. When a nursery identifies a child that has not had their 27 month review then, with the consent of the parent, this review can be arranged to be undertaken with a CNN at a convenient date. This has resulted in 60 reviews to date within a Nursery setting. Secondly, the team have started a number of health promotion sessions in local supermarkets in an attempt to identify children that have either missed a scheduled development review or are due one soon, and also to identify expectant mothers/parents to be that have not accessed an Antenatal contact.

Transition from Child to Adult Mental Health Services- Commissioning for Quality and Innovation (CQUIN) This relates to improving the quality of transition from children's mental health services to adult mental health services and requires the audit of four aspects:

1. The percentage of young people who've undergone Joint Agency Transition Planning if transitioning into a receiving provider
2. The percentage of young people who've undergone Joint Agency Transition Planning if transitioning into a receiving provider: Young people are meant to have a discharge plan and this must be shared with the young person
3. The percentage of young people who in their pre-transition survey reported feeling prepared at point of discharge
4. The percentage of young people who in their post-transition survey reported that they met their transition goals

An audit has found that all four of these aspects have been met by the Trust for the year April 2018 to end of March 2019.

2.1.9. Improvements in Services for Adults with Learning Disabilities

Campion Unit Learning Disability Inpatient Unit at Prospect Park Hospital in Reading has undertaken several service improvements during the year. These include training all staff on the ward on the use of active communication and active support to ensure that patients have adequate social and emotional stimulation during their stay on the ward. Work has been undertaken looking at the skill mix on the ward, with staff feeling more confident and up-skilled to undertake their new roles. This in turn has resulted in reduced delayed transfers of care and improved quality of care for our patients. Work has also been undertaken to reduce the numbers of people in out-of-area placements and this has also resulted in reduced rates of admission to the ward. The unit are currently using Quality Management Information System (QMIS) methodology to focus on reducing the number of assaults on their staff.

Community Teams for People with Learning Disabilities (CTPLD)

CTPLD Team Slough. Over the past 18 months the team have developed some innovative quality improvements. This has included translating an epilepsy care plan into the persons preferred language and translating hospital passports into three languages; Urdu, Punjabi and Polish. This enables the team to address the needs of the local community and promotes diversity and inclusion.

The team have also worked closely with Public Health to run a successful 16 week weight loss programme in line with national obesity targets. There is little evidence of implemented programmes which include reasonable adjustments to address the needs of people with LD and obesity, and encouraging people with a learning disability to attend and commit can be challenging. Individual easy read diaries were also developed by the team to enable people with LD and their carers to record tips during the session, to use when they return home to maintain their weight loss. All educational material was also developed by the team, and at the end of the 16 weeks 6 out of 9 attendees lost weight.

A pilot screening tool has also been developed due to the number of inappropriate referrals received by the CTPLD Slough team. This project is ongoing and has

the aim of using the psychologists time more effectively.

Alongside the CTPLD in Bracknell, the Slough team have started a Postural Management Clinic for people with Profound and Multiple Learning Disability (PMLD). People with PMLD are highly vulnerable to the adverse effects of poor positioning, and are often unable to communicate their concerns. The physiotherapist is able to carry out a full assessment of their multiple and complex needs at this clinic with the aim of maintaining, protecting and restoring body shape, maximising comfort and promoting health and wellbeing in addition to other benefits.

CTPLD Team Bracknell. There is a national drive to promote annual health checks by GPs for people with LD and the Bracknell and Slough Health Lead has worked hard to build relationships with the GP's in those localities. There is still some distance to go with this, but improvement has been seen over the years. Initiatives have included the development of GP LD registers and LD training being delivered to some GPs and practice staff by the LD Lead. This has resulted in improved healthcare and preventative healthcare for people with LD.

The team have recently delivered LD training to the Parapet Breast Screening Unit staff at King Edward VII Hospital in Windsor. This has raised awareness of LD and the required reasonable adjustments amongst the Parapet team and it is intended that this will be delivered every year.

The Occupational Therapists have been working with the 'Dogs for Good' charity to introduce a community dog as an aid to improve independent life skills for people with LD. A pilot of 8 clients for 8 sessions ran from March 2017 to November 2018. Due to the success of the pilot, a new branch in the service was created with a full time dog handler with a dog and a full time Occupational Therapy Assistant to meet the needs of people with a LD. The new service has developed a waiting list and a second dog should be allocated to a dog handler in the next 6 months to address this.

The team have also facilitated a Relationship/Sexual Health programme for final year students at a school over a period of 4 weeks. The feedback was extremely positive from the school and the students.

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

Talking Therapies- Improving Access to Psychological Therapies (IAPT). The service has introduced the 'Our Space' cafés to offer support to patients following treatment in order to stay well and prevent relapse. These cafes take place at St Mark's hospital in Maidenhead, Reading University, Wokingham Hospital, Upton Hospital, West Berkshire Community Hospital and Bracknell Open Learning Centre. The service also initiated a Black, Asian and Minority Ethnic (BAME) access and recovery project in slough that has led to an increase in BAME referrals from 2014/15 to 2017/18. The IAPT Post Traumatic Stress Disorder (PTSD) pathway has been extended to treat more patients with a single complex trauma. Access to the service has also been increased for patients with anxiety and depression alongside other long term conditions (LTC) as part of the service's IAPT-LTC pathway.

East Berkshire: Admiral Nurse for Young People with Dementia. Admiral Nurses are registered nurses with specific knowledge of dementia care. They provide support to individuals and families living with dementia as well as education, leadership, development and support to other colleagues and service providers. The Trust was commissioned by East Berkshire CCG to provide a part time (3 days per week) Admiral Nurse for younger people with dementia. This represents a new partnership in east Berks between BHFT and the national charity Dementia UK. The nurse has worked with approximately 30 families this year, as well as signposting others to appropriate sources of support. Satisfaction and impact has been high with reported reductions in visits to other services such as GPs, and delayed need for more intensive care and support.

Trust Memory Clinic Services successfully in achieved reaccreditation for the next two years and, as part of this, have been awarded a sustainable Mental Health Service Commendation by the Royal College of Psychiatrists Sustainability Committee.

Individual Placement and Support Employment Service (IPS). Following a successful bid for funding

from NHS England, the Trust has increased the size of its IPS Employment Service team from five staff to eleven, so that the service now covers the whole of Berkshire. This service provides one to one support to active clients of secondary mental health services helping clients into work. The focus is on competitive paid work and works closely to ensure the job matches with the client's preferences, skills and ambitions. Employment Specialists are now integrated into all Community Mental Health Teams (CMHTs) and Early Intervention in Psychosis clinical teams and use a person centred, strengths based approach to identify work goals. Collectively, the service has worked with approximately 100 service users this year, and is beginning to show promising job outcomes for people under the care of CMHTs.

Improving the physical health of people with severe mental illness. People with severe mental illness have significantly poorer physical health than the general population and can have a reduced life expectancy of up to 20 years. The Trust has been working with their local Clinical Commissioning Groups, Public Health teams and voluntary sector partners to address this issue in Berkshire. In East Berkshire, the Trust introduced a physical health lead in mental health services to oversee the initiatives**.** Physical Health CQUIN targets for 2017/18 were met and work is progressing to support achievement for 18/19.

Recovery Colleges in East Berkshire. The Trust is commissioned to provide Recovery Colleges in Windsor, Ascot and Maidenhead (WAM), and in Slough. In WAM, Opportunity Recovery College is in its second year of operation, and in Slough Hope College has been operating for 4 years. One of the key principles of these colleges is to offer an education based route to recovery, with peer-led education and training programmes as a partnership within mental health services. The colleges continue to offer wide range of courses, including courses aimed at promoting wellbeing, physical health, employment related initiatives, and leisure.

Family Safeguarding Service. The Trust is a partner in the Family Safeguarding model which is being implemented in the Bracknell and West Berkshire localities. This model adopts a whole system approach to Child Protection Services, focusing on risk due to Domestic Abuse, Mental Health and Substance Misuse. The Trust provides six expert adult mental health practitioners to work in a multi-agency service, alongside child protection social workers, domestic abuse workers and drug and alcohol specialists. The mental health interventions provided to parents, together with the formulations and insights provided to colleagues are beginning to show a positive impact.

Community Mental Health Team (CMHT) accreditation. Bracknell CMHT is one of the first teams to undertake accreditation with the Royal College of Psychiatrists. This programme works with staff to assure and improve the quality of community mental health services. A final accreditation decision is due in March 2019.

Structured Clinical Management. The Trust is introducing Structured Clinical Management as part of the newly emerging pathway for people with personality disorder. This is a new evidence based intervention which can be delivered to trained practitioners working within CMHTs. Training has now been provided to 90 practitioners across all Trust CMHTs, and implementation is now in the early stages across all teams.

Reading Community Mental Health Team (CMHT) has started a project to build its resilience following its uncoupling from Reading Adult Social Care Team. This focused on four areas that the team found challenging; supervision, team culture, team organisation and team development. Each identified area has team members allocated to it and priorities identified. This work is ongoing, but some actions have already been undertaken and the team are presenting as stronger and more resilient as a result.

Wokingham Community Mental Health Team recruited a psychology lead in October 2018 which has led to reductions in waiting lists and waiting time for therapy.

East Berkshire Crisis Resolution and Home Treatment Team (CRHTT) identified their response time as their main area of improvement. There is a national expectation that by 2020/21 all areas within the UK will offer a 24 hour crisis service which will be truly responsive. The team aspiration is to see all referrals within 4 hours or even faster and develop a rapid response element within the service. However, historically such "4 hour crisis referrals" were only available to GPs making a referral to the service via the Common Point of Entry (CPE). The service has now opened up these "4 hour crisis referrals" to all referrers, resulting in an increase in assessments being completed within 4 hours.

East Berkshire Psychological Medicine Service formed in January 2018 and comprises a specialist dedicated team of Nurses, Social Workers and Psychologists delivering a 'Core 24' service to the A&E Department and wards at Wexham Park Hospital (WPH). The team work with WPH staff to ensure patients with mental health needs receive the best possible care in the acute hospital setting. The service is consistently meeting their performance targets

The Early Intervention in Psychosis Service (EiP) has implemented an online support forum called 'SHARON for EiP' for carers. This forum has received good uptake and information is being developed to increase the resources available. SHARON for EiP Service users is due to go live in February 2019.

Hillcroft House shares a site with West Berkshire Community Hospital in Thatcham and houses multiple teams, including primary and secondary mental health services, Community Health Services and partners such as Adult Social care. Work began on the building in November 2018 to better meet the needs of service users and staff. These include significant changes to the reception and waiting room areas, increasing the usable clinical space and improving the safety of the building. Office space has also been upgraded to include more breakout and meeting space, a more comfortable climate and upgrade of staff rest areas.

Thames Valley Criminal Justice Liaison and Diversion (CJLD) Service were awarded a commendation for Service of the Year at the Howard League for Penal Reform Awards in October 2018. The service was also awarded the tender for the Hampshire and Isle of Wight Liaison & Diversion Service from 1st April 2019.

Intensive Management of Personality Disorders and Clinical Therapies Team (IMPACTT). IMPACTT is a specialist service which provides comprehensive assessment and evidence-based treatments for individuals aged 18 and over with a diagnosed personality disorder, primarily Borderline Personality Disorder/Emotionally Unstable Personality Disorder (BPD/EUPD). The service offers two evidence-based treatments: Dialectical Behavioural Therapy (DBT) and Mentalization-Based Treatment (MBT), as recommended by the NICE guidelines. The service has been rolling out training events across the organisation on working with personality disorder and these have been very well received. A new initiative known as Psychologically Informed Consultation and Training (PICT) is currently in development. This which will continue to grow the consultation and training arm of IMPACTT and further support the organisation in working with patients with personality disorder.

Adult Mental Health Inpatient Services at Prospect Park Hospital have been involved in numerous quality improvement projects during the year, many of which are listed in earlier sections of this quality report. In addition a Green Belt Project has been undertaken to increase the number of Friends and Family Test (FFT) responses received for this service. This has resulted in 140 responses to the FFT in the 7 months since the start of the project compared to 22 responses in previous 7 months. The Project is ongoing with work concentrating on sustaining changes and reporting back to service users.

2.1.11. Improvements in Medicines Management

Patient safety

Our Pharmacists play a vital role in ensuring the safe and effective use of medicines. They work with the multidisciplinary team to ensure systems and processes are in place to support medication safety. Our drive to improve the safer use of medicines includes the use of short memos to increase awareness around medication safety initiatives.

Our Medication Safety Officer is a member of the National Medication Safety Network and ensures that good practice is shared and embedded across the Trust.

Our Pharmacists ensure that we respond to, and take appropriate action, on national medication safety alerts. This includes sharing medication safety information through publication of regular Medication Safety Bulletins (shared trust-wide), and producing posters, for example, on the safe supply of valproate to females of child bearing potential.

The Pharmacists provide training to doctors to improve their knowledge of medicines safety. Pharmacists provide in-house teaching to doctors on a number of medication related topics, including Medication Safety and Rapid Tranquillisation Medicines.

The Deputy Chief Pharmacist has developed a Pharmacy Improvement and Innovation Programme to facilitate the embedding of a rolling, annual programme of medicines-related audits, and timely follow up of actions arising out of the findings of these audits. This shall improve patient safety and ensure compliance with national standards.

Patient experience

Our Pharmacists shall continue to review all medicines for effectiveness and adverse effects, and provide support to service users. Pharmacists continue to offer 1:1 sessions for inpatients, facilitate patient education sessions in inpatient units, support inpatient carer sessions, and contribute to patient and carer Recovery College workshops.

Pharmacy has continued to invest in staff development to ensure, that staff have the skills required to work effectively and efficiently.

In line with the Carter Report (NHS Operational Productivity: unwarranted variations: Mental Health Services, Community Health Services, 2018), our Pharmacy Department ensures pharmacists and other pharmacy staff spend more time with patients and on medicines optimisation. We are committed to increasing specialist pharmacy professionals including ACP qualified pharmacists and pharmacist prescribers to add capacity, expertise and value to patient care.

Electronic Prescribing and Medicines Administration (ePMA)

The Trust is a Mental Health Global Digital Exemplar site. We have implemented Electronic Prescribing and Medicines Administration (ePMA) at all our mental health inpatient wards, and in November 2018, ePMA was rolled out to the first mental health outpatient service, namely Windsor, Ascot and Maidenhead Depot Clinic. The introduction of ePMA in the outpatient clinic has enabled depot antipsychotic injections to be prescribed and ordered electronically, facilitating a seamless link to the dispensing and supply system within Pharmacy.

Our Specialist Informatics Pharmacist supports all aspects of technical configuration, and clinical content relating to medicines management within the ePMA system. ePMA has been effectively used to support the national valproate Pregnancy Prevention Programme for women and girls of child bearing potential

2.2. Setting Priorities for Improvement for 2019/2020

ⓘ This section details the Trust's priorities which reflect the Trust Annual Plan on a Page for 2019/20 (see Appendix A). 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. Several of the priorities from 2018/19 have been rolled forward to 2019/20.

2.2.1. Patient Safety Priorities

To provide safe services, prevent self harm and harm to others

1. We will reduce harm to our patients by reducing:
   - Self harm incidents by 30%. Target: no more than 61 per month.
   - Suicides of people under trust mental health care by 10% by 2021
   - Falls on our community inpatient wards and older adult inpatient wards by 50%. Target: no more than 4 per 1000 bed days
   - Medication errors graded moderate and above by 20%. Target: fewer than 4 per year
   - Category 3 and 4 pressure ulcers due to a lapse in care by trust staff. Target: At least 180 days between the development of these ulcers. In areas where this target is already being met, a 10% improvement against current baseline is to be applied.
   - Gram negative bacteraemia due to a lapse in care on our inpatient community wards by 50%. Target: No more than 1 per ward.
2. At least 95% of our reported incidents will be low or no harm to patients

3. All patient facing teams will have evidence based objectives for reducing patient harm in their plans for 2019/20
4. All our support services will work with patient facing services to identify ways that they can support safety of patients
5. With our health and social care partners: We will work to achieve reduced urgent admissions and delayed transfers of care.

2.2.2. Clinical Effectiveness Priorities

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

2.2.3. Patient Experience Priorities

To provide good outcomes from treatment and care

1. We will achieve a 95% satisfaction rate with a minimum 15% response rate in our Friends and Family Test (FFT) and 60% of staff reporting use of patient feedback to make informed decisions in their department
2. All our services will focus on delivery of outcomes of care that are important to our patients, based on a good understanding of our diverse population
3. To reduce instances of prone restraint to no more than 2 per month
4. With our health and social care partners: We will contribute to Integrated Care System (ICS) work streams to improve patient experience and outcomes.

2.2.4. Supporting our Staff Priorities

To strengthen our highly skilled and engaged workforce and provide a safe working environment

1. We will achieve high levels of staff engagement across all our services - scoring four or more in our staff survey. We will increase the numbers of our staff feeling they can make improvements at work to more than 70%, and aim to achieve more than 85% of staff recommending our Trust as a place to receive treatment
2. We will aim to achieve a vacancy level of less than 10%, a staff turnover rate of less than 16% and a sickness level of less than 3.5%
3. We will promote an inclusive and compassionate culture, with zero tolerance of aggression, bullying and exclusion, and reduce assaults on staff by 20%
4. We will achieve our objectives for equality of opportunity and staff wellbeing
5. With our health and social care partners: We will enhance career development opportunities and improve our workforce planning.

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 2019/20.

2.3. Statements of Assurance from the Board

During 2018/19 Berkshire Healthcare NHS Foundation Trust provided and/or sub-contracted 49 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 2018/19 represents 100% of the total income generated from the provision of relevant health services by Berkshire Healthcare NHS Foundation Trust for 2018/19.

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 2018/19, 16 national clinical audits and 0 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=16/16) national clinical audits 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 2018/19 are shown in the first column of Figure 26 below. This column also details the national clinical audits and national confidential enquiries that Berkshire Healthcare NHS Foundation Trust participated in during 2018/19.

The national clinical audits and national confidential enquiries that Berkshire Healthcare NHS Foundation Trust participated in and for which data collection was completed during 2018-19 are also listed below in Figure 26 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. 26).

Figure 26- 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 2018/19	Data collection status, number of cases submitted as a percentage of the number of cases required by the terms of each audit and other comments
1. National Clinical Audits (N=16)	
National Clinical Audit and Patient Outcomes Programme (NCAPOP)	
National audit of Anxiety and Depression 2017	Data Collection: June 2018 – September 2018. 73 (100%) patient's submitted across, 1 service. Report due: August 2019
National audit of Anxiety and Depression 2017 - Spotlight 1 - Psychological Therapies	Data Collection: October 2018 – January 2018. 150 (100%) patient's submitted across, 5 services. Report due: TBC 2019
National Sentinel Stroke Audit (2018/19)	Data Collection: 1st April 2018 – 31st March 2019 (Continuous). 571 (99%) patients submitted for 2018/19, across 3 services, 185 6-month follow-ups. Report due: TBC 2020
National Audit of Care at the End of Life (2018/19)	Data Collection: June 2018 – October 2018 33 (100%) patient's submitted, across 1 service. Report due: May 2019
National Diabetes Audit - Secondary care 2018	Data Collection: May 2018 (data 2017/18). 1747 (100%) patients submitted, across 1 service. Report due: June 2019. Insulin Pump Report Due: July 19
Learning Disability Mortality Review Programme (LeDeR) (2018/19)	Data collection: 1st April 2018 – 31st March 2019 Report due: Annually
National Diabetes Footcare (Community Podiatry care) (2018/19)	Data Collection: 1st Jul 18 – 31st Mar 19 (Continuous). 64 patients submitted across 1 service (Final figure not yet available). Report due: TBC 2020
The National Clinical Audit of Psychosis - EIP spotlight audit	Data Collection: October 2018 – November 2018. 86 (100%) patient's submitted, across 1 service. Report due: August 2019
National Asthma and COPD Audit Programme (NACAP): pulmonary rehabilitation	Data Collection: 1st Mar 19 – 31st Mar 20 Continuous. xx patient's submitted, across 1 service (Final figure not yet available) Report due: TBC 2021
National Audit of Inpatient Falls	Data Collection: Continuous, starts 1st Jan 19. Organisational audit completed Jan 19. No Submissions required for core data collection during 2018/19. Report due: TBC
Non- NCAPOP Audits	
POMH Topic 16b - Rapid Tranquilisation re-audit (May 2018)	Data Collection: March 2018 – May 2018. 41 (100%) patient's submitted, across 5 services. Report published: November 2018

National Clinical Audits and Confidential Enquiries that the Trust was eligible to participate in and did participate in during 2018/19	Data collection status, number of cases submitted as a percentage of the number of cases required by the terms of each audit and other comments
POMH Topic 18a Prescribing clozapine (June 2018)	Data Collection: June 2018 – July 2018. 106 (100%) patient's submitted, across 3 services. Report published: February 2019
POMH - Topic 6d - Assessment of the side effects of depot antipsychotics- Sept-Oct 18	Data Collection: September 2018 – November 2018. 151 (100%) patient's submitted, across 6 services. Report due: June 2019
POMH Topic 7f – Monitoring of patients prescribed Lithium	Data Collection: February 2019 – March 2019. 108 (100%) patient's submitted, across 10 services. Report due: July 2019
National Audit of Cardiac Rehabilitation (2018/19)	Data Collection: Continuous, 1st April 2018 – 31st March 2019 Number of patients submitted (100%) 314 event records; 376 initial assessments; 313 post assessments. Report due: January 2020
National Audit of Intermediate Care (2018)	Data Collection: 21st May 2018 – 31st August 2018 Data submitted across 4 Intermediate care service types. Crisis response, home based intermediate care, bed based intermediate care and re-ablement services. Benchmarking Project. Reported: Jan 2019
National Confidential Enquiries (N=0)	

Source: Trust Clinical Effectiveness Department

The reports of 9 (100%) national clinical audits were reviewed by the Trust in 2018-19. This included national audits for which data was collected in earlier years with the resultant report being published in 2018/19. 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 48 local clinical audits were reviewed by the Trust in 2018/19 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 and Development (R&D)

ⓘ 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 2018/19 that were recruited during that period to participate in research approved by Health Research Authority was 1209 from 45 active NIHR Portfolio studies.

As part of the Clinical Research Network Trust Patient Research Ambassador initiative, we now recruited 6 research ambassadors in 2018/19. These are patients who have taken part in research and help us promote research by, for example, presenting at our various research events telling their story about how and why they got involved in research and giving their thoughts about research participation.

Our research activity reflects that we are now a mental health and community Trust; our portfolio of research whilst dominated by mental health research also incorporates research in other non-mental health services such as Diabetes Centre at King Edward VII Hospital in Windsor, the Community Cardiac and Respiratory Specialist Service (CARSS) and Health Visiting service.

The trust held its inaugural research conference in May 2018. This provided the opportunity to celebrate the Trust's contribution to research and to raise awareness locally. Entitled 'Research Collaborations for Better Patient Care' – guest speakers included, amongst others, Keynote speaker Dr Jonathan Sheffield, Chief Executive Officer, NIHR Clinical Research Network (CRN), Professor Belinda Lennox, Clinical Senior Lecturer, Honorary Consultant Psychiatrist, Clinical Director NIHR CRN, Oxford University Hospitals, Professor Adrian Williams, Research Dean, University of Reading and Jennifer Harrison, HRA Approval Change Manager, Health Research Authority. Everyone who completed an evaluation form on the day gave positive

feedback about the event and for a first event it was a fantastic to have 121 delegates attend.

The Trust also publishes the Department of Health mandated "Performance in Initiating and Delivering" (PID) research data on a quarterly basis. This allows the trust to benchmark its performance nationally with some of this data also published on the R&D pages of the Trust's Internet site; the data is available on the following link.
https://www.berkshirehealthcare.nhs.uk/get-involved/our-research-and-development

The Care Quality Commission (CQC) has now included key research related questions in its inspection framework as part of the "well-led" domain. Further information is available at https://www.nihr.ac.uk/news/support-for-clinical-research-further-recognised-in-the-cqc-inspection-framework/9497?diaryentryid=36923

The Trust Research and Development department registered 19 publications by Trust Staff during 2018/19. Publications of Trust Staff research indicate a growing number and diversity of clinician involvement in health research in the Trust. This helps demonstrate the growth of research awareness.

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 2018/19 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 2018/19 and for the following 12 month period can be found in Appendix E & F.

The income in 2018/19 conditional upon achieving quality improvement and innovation goals is £4,398,604. This is the expected value at 100% achievement, and is to be confirmed in June 2019. The associated payment received for 2017/18 was £2,135,032 against named CQUINs with a further £1,708.000 against STP conditions.

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 2018/19.

Berkshire Healthcare NHS Foundation Trust is subject to periodic reviews by the Care Quality Commission. The Trust was inspected by the Care Quality Commission during June and July 2018. The Campion Unit, the trust's assessment and treatment unit for people with learning disabilities was rated 'outstanding' as a service. The trust was rated 'outstanding' for the well-led domain and continues to be rated overall 'good'.

Berkshire Healthcare NHS Foundation Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2018/19:

1. How older people move through the health and social care system in Reading, with a focus on how services work together. The reviews looked at how hospitals, community health services, GP practices, care homes and home care agencies work together to provide seamless care for people aged 65 and over living in a local area. Review dates- 29th October 2018- 2nd November 2018
2. Joint targeted area inspection of the multi-agency response to sexual abuse in the family in Bracknell Forest. Review Dates 21-25 January 2019.

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

1. An action plan has been developed as a system response through the Berkshire West Integrated Care System. Leads have been identified for each of the actions.
2. A multi-agency response including actions is to be produced by the Director of Children's Services in the Local Authority by 20th June 2019.

Berkshire Healthcare NHS Foundation Trust has made the following progress by 31 March 2019 in taking such action:

1. Actions have been developed and progressed as a system response through the Berkshire West Integrated Care System
2. Progress to be detailed following production of action plan.

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 2018/19 financial year at Prospect Park Hospital

- 17th October 2018- Bluebell Ward
- 23rd January 2019- Rose Ward
- 5th February 2019- Rowan Ward

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 2018/19 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:
99.7% 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 Information Governance Assessment Report overall score for 2018/19 was 'Standards Met'

The Information Governance Group is responsible for maintaining and improving standards in this area with the aim of being satisfactory across all aspects.

Data Quality

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 full detailed audit took place in November 2018, which showed that 90% of primary and 92.8% of secondary diagnoses were coded correctly

Indicators chosen for external testing

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 National Institute for Health and Care Excellence (NICE)-approved care package within two weeks of referral- *Mandated indicator*
2. Inappropriate out-of-area placements for adult mental health services- *Mandated indicator*
3. 100% enhanced Care Programme Approach (CPA) patients receiving follow-up contact within seven days of discharge from hospital- *Governors' Choice*

In March and April 2019 Deloitte LLP carried out testing on these areas. For each indicator Deloitte met with a relevant staff member of staff to understand how the data is used and collected to calculate the indicator. A sample of items was selected from the data set for the auditor to carry out the testing with the designated clinician for each indicator.

"Absolutely delighted with the care and respect that was shown to my relative at an ENT Consultant Outpatients appointment - lovely staff, professional, courteous and an outstanding service, thank you.

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

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.

Figure 27 below details the number of deaths of trust patients in 2018/19. This is presented alongside the number of case record reviews and investigations of these deaths that were undertaken over the same period, as well as an assessment of the number of deaths that were more likely than not to have been due to problems in care provided. Please note that the table contains statements that are mandated by NHS Improvement for inclusion.

Figure 27- Deaths of trust patients in 2018/19- case reviews and investigations carried out in 2018/19

	1. Total number of Deaths	2. Total number of reviews and investigations carried out			3.Deaths more likely than not due to problems in care
Mandated Statement	During 2018/19 the following number of Berkshire Healthcare NHS Foundation Trust patients died	By 31st March 2019, the following number of case record reviews and investigations have been carried out in relation to 3474 of the deaths included above.			The number and percentage of the patient deaths during the reporting period that are judged to be more likely than not to have been due to problems in the care provided to the patient are detailed below. (These numbers have been estimated using either Initial Findings Report or Root Cause Analysis methodology)
		1st Line Case Record Reviews (Datix)	2nd Line Review (IFR/ SJR)	Case Record Review & Investigation (SI)	
Total 18/19	**3474** ↓	**320**	**134** ↓	**40**	**3, representing 0.08%*** ↓
Mandated Statement	This comprised the following number of deaths which occurred in each quarter of that reporting period:	The number of deaths in each quarter for which a case record review or an investigation was carried out was:			In relation to each quarter, this consisted of:
Q1 18/19	**812**	**73**	**42**	**6**	**1, representing 0.12%**
Q2 18/19	**788**	**77**	**25**	**14**	**0**
Q3 18/19	**983**	**95**	**28**	**14**	**1, representing 0.10%**
Q4 18/19	**891**	**75**	**39**	**6**	**1, representing 0.11%**

Source- Trust Learning from Deaths Reports

**** Please note that 1 death judged more likely than not due to a problem in care has been reported in both the figures in Fig 27 and Fig 28. This is because the death of the patient occurred in 2017/18, but the investigation was completed in 2018/19***

A number of learning points were identified from the review and actions arising from the learning points have been completed and monitored through the trust mortality review group. The impact of actions is monitored through the Serious Incident process.

Figure 28 below details the number of deaths of trust patients in 2017/18 that had case note reviews and investigations carried out in 2018/19. This is presented alongside an assessment of the number of these deaths that were more likely than not to have been due to problems in care provided and, as a result, a revised estimate of the number of deaths that were more likely than not due to problems in care in 2017/18 Please note that the table contains statements that are mandated by NHS Improvement for inclusion in the Quality Account.

Figure 28- Deaths of trust patients in 2017/18- case reviews and investigations carried out in 2018/19

	1. Reviews and investigations carried out		**2.Deaths more likely than not due to problems in care**	**3. Revised estimate of deaths in 2017/18 that were more likely than not due to problems in care**
Mandated Statement	The number of case record reviews and investigations completed after 1st April 2018 which related to deaths which took place before the start of the reporting period (deaths before 1st April 2018)		The number and percentage of patient deaths before the reporting period that are judged to be more likely than not to have been due to problems in the care provided to the patient. (These numbers have been estimated using either Initial Findings Report or Root Cause Analysis methodology)	The number and % of the patient deaths during 2017/18 that are judged to be more likely than not to have been due to problems in the care provided to the patient.
	Case Record Reviews	Investigations		
Total	**34**	**9**	1 (representing 0.03%) lapse of care has been identified and reported subsequently as an SI in May 2018 following review of the report by the Trust Mortality Review Group: The death occurred in 2017/18. Included in Table 27 above. *	**2, representing 0.05%***

Source- Trust Learning from Deaths Reports

**** Please note that 1 death judged more likely than not due to a problem in care has been reported in both the figures in Fig 27 and Fig 28. This is because the death of the patient occurred in 2017/18, but the investigation was completed in 2018/19***

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.

It is important to note, as in previous years, that there are a number of inherent limitations in the preparation of quality reports which may impact the reliability or accuracy of the data reported.

- Data is derived from a large number of different systems and processes. Only some of these are subject to external assurance or included in internal audit's programme of work each year.
- Data is collected by a large number of teams across the Trust alongside their main responsibilities, which may lead to differences in how policies are applied or interpreted.
- In many cases, data reported reflects clinical judgement about individual cases, where another clinician might have reasonably classified a case differently.
- National data definitions do not necessarily cover all circumstances, and local interpretations may differ.
- Data collection practices and data definitions are evolving, which may lead to differences over time, both within and between years.

Figure 29	2016/17	2017/18	2018/19	National Average 2018/19	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	97.8%	97.7%	**98.7% (Average Monthly %)**	**95.8%**	**83.5%-100%**
Data relates to all patients discharged from psychiatric inpatient care on Care Programme Approach (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 Tableau Dashboard

Figure 30	2016/17	2017/18	2018/19	National Average 2018/19	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	99.1%	99.2%	**99.1% (12M Average Percentage)**	**98.1%**	**88.2%-100%**
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 Tableau Dashboard

Figure 31	2016/17	2017/18	2018/19	National Average 2018/19	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	6.2%	7.9%	**6.9% (Average Monthly %)**	**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. A Post Admission Review (PAR) is now in place and embedded which takes place within 72 hours (wherever possible) and produces an intended discharge date (IDD). This is monitored at the daily bed management team so that plans are checked and any concerns escalated.					

Source- Trust Tableau Dashboard

Figure 32	2016/17	2017/18	2018/19	National Average 2018/19 For combined MH/LD and community Trusts	Highest and Lowest
The indicator score of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends *This finding has been taken from the % of staff respondents answering 'yes' to Question 21d of the National NHS Staff Survey: If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation*	74.8%	75.1%	**73.6%**	**66.2%**	**55.9%-79.1%**
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.					
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. In addition, the Trust runs a compassionate Leadership course and excellent manager programme which are well attended with positive feedback. Several interventions are also in place to help make it a better place to work despite the challenges around recruiting and retaining staff.					

Source- National Staff Survey

Figure 33	2016/17	2017/18	2018/19	National Figures 2018/19	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	7.2	7.3	7.2	**6.8** (median figure for all participating trusts)	**5.6- 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 34	2016/17	2017/18	2018/19	National Figures 2018/19	Highest and Lowest
The number of patient safety incidents reported	3195 *	4824 *	4518 *	169,041 **	16-9,204 **
Rate of patient safety incidents reported within the Trust during the reporting period per 1000 bed days	29.1 *	45.9 *	46.2 *	48.8 ** (Median)	24.9-114.3 **
The number and percentage of such patient safety incidents that resulted in severe harm or death	35 (1.1%) *	44 (1.1%) *	40 (0.9%) *	1834 (1%) **	1-239 **
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 reported to the NRLS. In the NRLS/ NHSI most recent organisational report published in March 2019, the median reporting rate for the Trust is given as 75.2 incidents per 1000 bed days (but please note this covers the 6-month period April 2018-Sept 2018). 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 reported to the NRLS. Please note that these figures are representative of the number of incidents reported at the time the report is sent and are subject to change over time.*

*** NRLS/ NHSI Organisation Patient Safety Incident Report covering 6 months between April 18- Sept 2018 relating to 50 Mental Health Organisations Only*

Part 3. Review of Quality Performance in 2018/19

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 2018/19 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 section 2.4 above.

Never Events

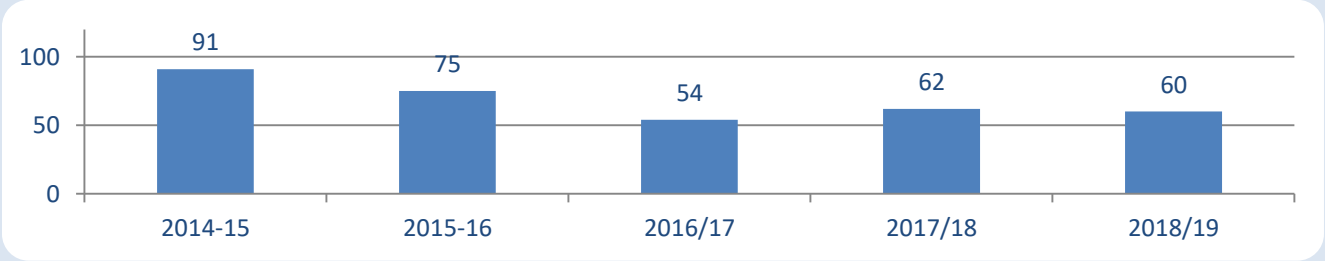
Never events are a sub-set of Serious Incidents and are defined as 'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.

The Trust has reported 0 never events in 2018/19.

Figure 35 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 35- Number of SIs- Year on Year Comparison (excluding pressure ulcers)



Source: Trust Serious Incident Report

Summary of findings from Serious Incident (SI) reporting

During Q4 there were a total of 13 serious incidents originally reported. At the time of writing, 2 have been downgraded and therefore 11 serious incidents have been included. This is a reduction on the number reported in the previous quarters (18 in both Q3 and Q2 of 2018/19). All 11 of the serious incidents reported were related to mental health services; 5 to Community Mental Health West, 3 to Community

Mental Health East and 3 to Mental Health Inpatient Services. There were no serious incidents reported for Community Physical Health or Children's Services.

The serious incidents reported during Q4 were:

- **Suspected Suicide Cases:** 5 cases were reported in Q4- 3 fewer than in Q3 of 2018/19.
- **Unexpected Deaths:** 1 case was reported- significantly fewer than the 6 reported in Q3.
- **Falls:** 1 fall resulting in moderate harm met the SI reporting threshold as it required surgical repair.
- **Patient on Staff Assault:** 1 case was reported in Q4 of a serious assault by a patient on a doctor during an inpatient Mental Health Managers meeting.
- **Patient on Family Member Assault:** 1 case was reported in Q4 of a patient attempting to murder a family member who was critically injured.
- **Allegation of Sexual Assault by a Member of Staff:** During Q2 of 2018/19, a female patient made an allegation of sexual assault against a member of staff on one of the Trust's mental health inpatient wards. The patient was appropriately safeguarded and the police were contacted at the time who informed the Trust that there would be no further investigation. The Police subsequently contacted the Trust again in March 2019 to inform them that the investigation was active and that additional evidence had been established. This was logged by the Trust as a Serious Incident at this point.
- **Other:** 1 reported serious incident in Q4 related to a serious alleged non-accidental injury to a baby whose mother was in receipt of a targeted health visiting service.
- **Pressure Ulcers:** In Q4 no pressure ulcers were reported as serious incidents. There were 6 learning events held for incidents of category 2, 3 and 4 pressure damage that developed in our care and where there was a potential lapse in that care that may have contributed to the development. Following the learning events, 4 pressure ulcers were agreed to be as a result of a lapse in care in community settings. There were no learning events for Inpatient Units for developed pressure ulcers where a lapse in care was concluded.
- **Preventing Future Death reports (Reg. 28):** The Trust had input into 17 inquests during Q4- 10 more than in Q3. No Regulation 28s were issued but the Trust did receive criticism at two inquests in which a narrative outcome was delivered. Both of these were for deaths which occurred in Prospect Park Hospital and were in relation to a death by natural causes and also a suicide of a person detained under the Mental Health Act. Action plans were already in place to address concerns raised by Coroner.

Comparison to 2017/18: There have been 60 SIs reported in 2018/19 compared with 62 reported in 2017/18 (excluding downgrades). 18 of the SIs reported in 2017/18 were information governance (IG) breaches, whereas only 1 IG SI has been reported in 2018/19 due to a change in reporting requirements. SIs for unexpected deaths have increased from 13 in 2017/18 to 16 in 2018/19 whilst SIs for suspected suicides have increased from 13 to 24. At the time of writing the Trust do not know what percentage this is of secondary care contacts. Falls with harm SIs have decreased from 7 in 2017/18 to 6 in 2018/19. The 3 top reporting categories in 2017/18 were information governance breaches, suspected suicides, and unexpected deaths. The top 3 reported categories in 2018/19 were suspected suicides, unexpected deaths and falls.

Key themes identified in SI investigation reports together with actions taken to improve services:

- **Communications with family / carers:** Failings in communication with families and carers and the documentation of such communication are a common finding in serious incident investigations.
- **Management of hydration**: This has been raised as an issue in some investigations with regards to the assessment and management for signs and symptoms of dehydration on Inpatient Units (both physical and mental health). It is important to intervene early and act on this information. At times the tools available to staff are not being robustly completed and monitoring is not being effectively carried out.
- **Multidisciplinary Team (MDT) Meetings**: The robustness and completeness of documenting what is discussed and planned in MDT meetings has been highlighted as a theme in a previous quarterly report but continues to be identified as an issue in relation to mental health MDTs.
- **Lack of robust safety** planning – whilst safety plans are now in place ongoing work is required to ensure that the quality of interventions, particularly to mitigate the likelihood of suicide, are always explored and documented clearly.

Actions are being undertaken to address these main themes.

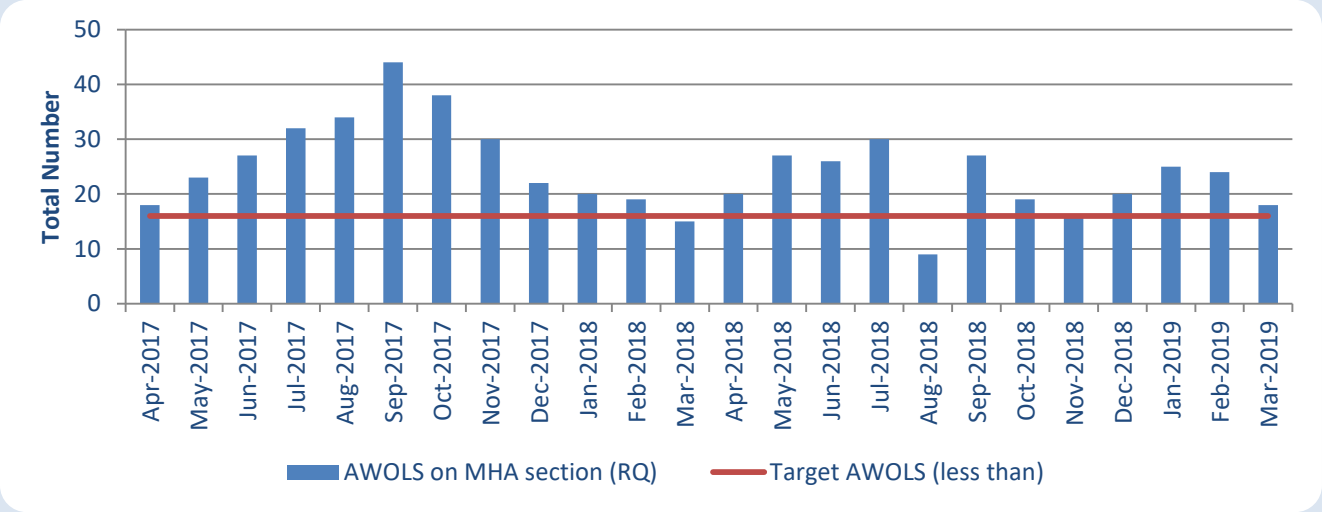
Absent without leave (AWOL) and absconsions

ⓘ 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 36 and 37 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.

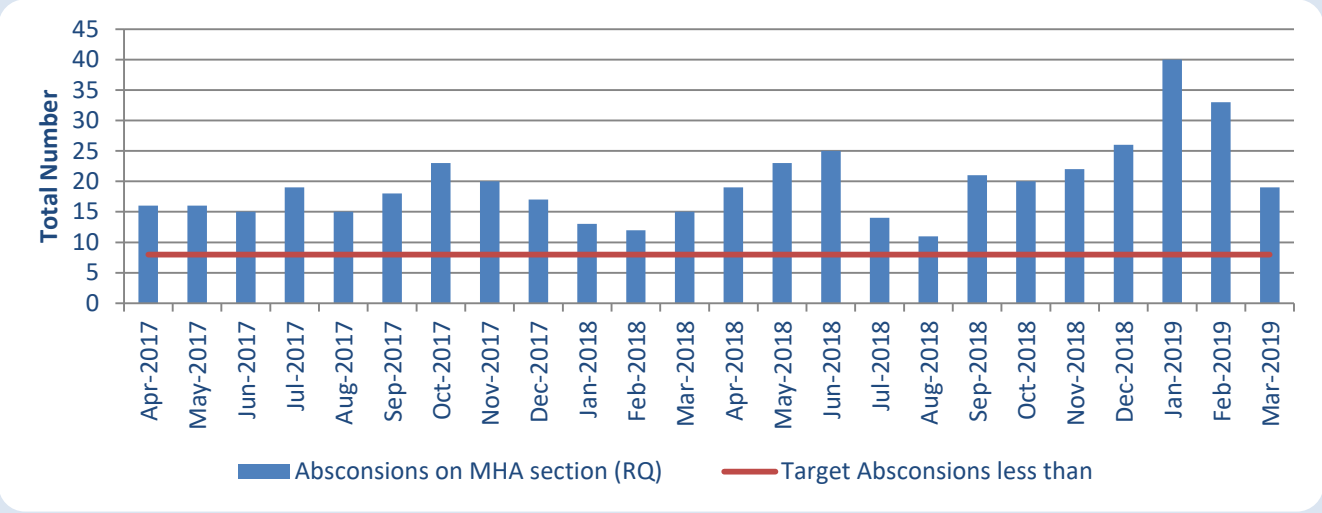
To address this target, the wards are Prospect Park Hospital are running a 'failure to return' project which aims to reduce the number of AWOLs and absconsions.

Figure 36- Absent without leave (AWOL) on a Mental Health Section- (Rolling quarters)



Source- Trust Tableau Dashboard

Figure 37- Absconsions on a Mental Health Act (MHA) Section- (Rolling Quarters)



Source- Trust Tableau Dashboard

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).

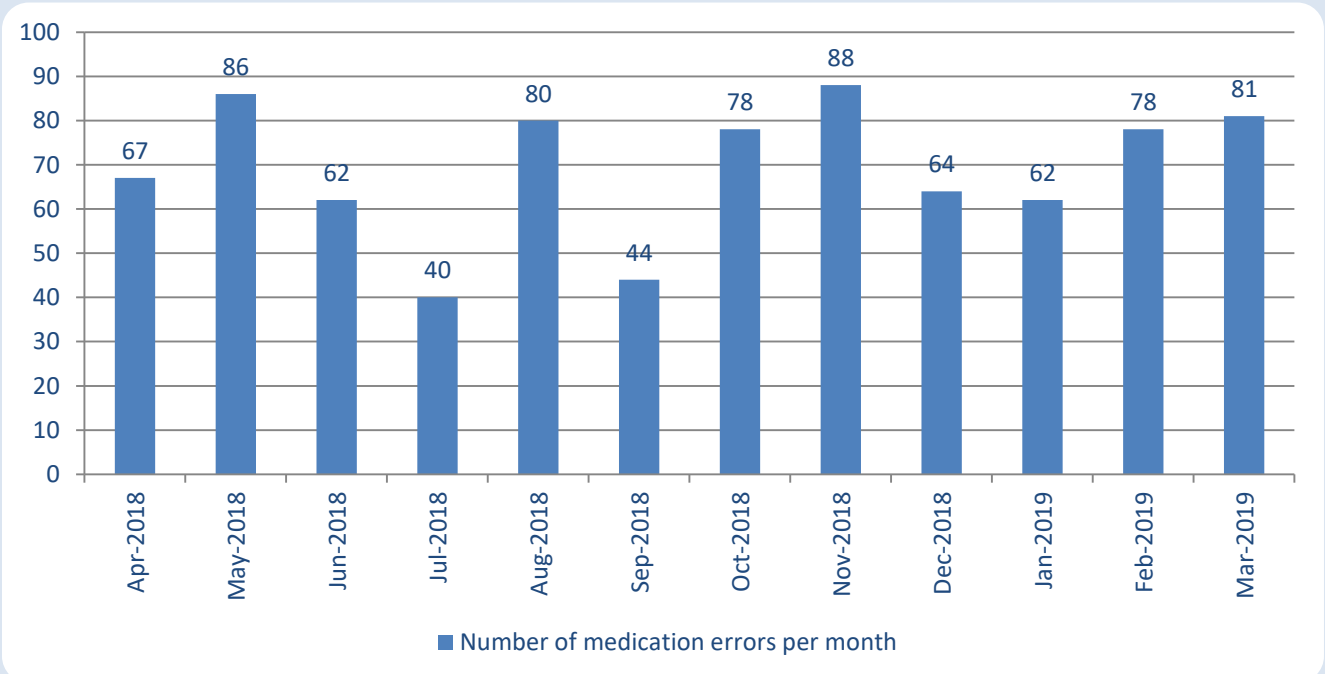
Figure 38 below details the total number of medication errors reported per month. There were a total of 830 medication errors reported in 2018/19. When interpreting this figure, it should be noted that a high and increasing rate of medication error reporting is a sign of a healthy learning culture in the organisation and that reporting of such errors is being encouraged as the first step in ensuring a robust safety culture exists. The data reported also includes all the near misses and documentation errors, so they are not all actual incidents. There is also evidence to suggest that not all incidents and near misses that staff acted upon were reported so any increase may be due to better reporting culture rather than a less safe organisation.

Local processes in this area are being updated by line managers. Trust-wide, there is much activity in overseeing this area including; sharing learning from incidents with summaries sent to locality Patient Quality and Safety Groups, Standardising practices around insulin doses in the community, Treatment to Take Out (TTO) tracking stickers, review of medicines management training, resolving EPMA system errors and standardising and streamlining technology to support medicines management.

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).

One moderate medication error was reported during the year (during Quarter 1). This error related to Insulin and other medicines being given to an incorrect patient on a Community Health Ward. There was no harm reported for the patient.

Figure 38: Number of Medication Errors Reported Each Month



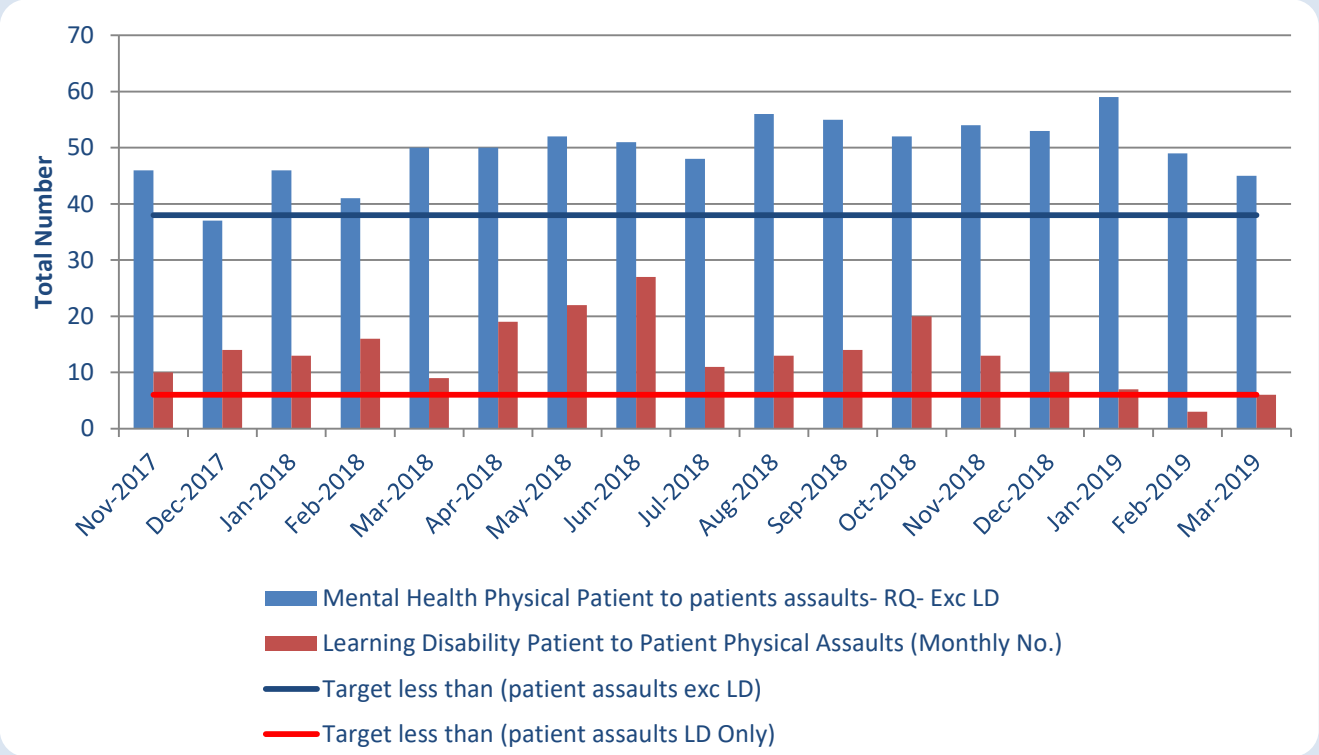
Source: Medicines Management Quarterly Report

Mental Health and Learning Disability Patient to Patient Physical Assaults

Figure 39 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.

Information on patient assaults on staff is included in part 1 of this report.

Figure 39- Patient to Patient Physical Assaults- Rolling Quarters (RQ)



Source- Trust Tableau Dashboard

"Excellent emergency care. My relative was visited on a daily basis by the team when he became suicidal. They were diligent and persistent, even when he was reluctant to engage, and when he needed to see the team psychiatrists the appointments were given promptly and he was seen on time. I cannot fault the follow up, and we couldn't have managed without their support and advice."

From a relative of a patient- Crisis Resolution and Home Treatment Team (CRHTT), West Berkshire

Other Quality Indicators

Please note that the following indicators have been removed from this section of the Quality Account as they are not in the Single Oversight Framework:

- CPA review within 12 months
- Completeness of Community service data
- Referral to treatment (RTT) waiting times – non-admitted –community.
- Access to healthcare score for people with a learning disability

Figure 40	Annual Target	2016/17	2017/18	2018/19	Commentary
Patient Safety					
Never Events	0	0	0	**0**	Total number of never events in year
Infection Control- MRSA bacteraemia	0	0	0	**0**	Total number of MRSA Cases in year *Source- Trust Inf. Control. Rept.*
Infection Control- C. difficile due to lapses in care	<6	2	3	**1 (0.01 per 1000 occupied bed days)**	Total number & rate per 1000 occupied bed days of C. Diff due to lapse in care by Trust in year. *Source- Trust Infection Control Reports*
Developed Category 2 Pressure Ulcers due to Lapse in Care by Trust Staff	<19	N/A	14	**15**	Total number of Cat 2 pressure ulcers due to lapse in care by Trust in year. *Source- Trust Pressure Ulcer Reports*
Developed Category 3 and 4 Pressure Ulcers due to Lapse in Care by Trust Staff	<18	N/A	18	**17**	Total number of Cat 3 and 4 pressure ulcers due to lapse in care by Trust in year. *Source- Trust Pressure Ulcer Reports*
Medication errors	Increase Report.	N/A	N/A	**830**	Total number of medication errors reported in year. *Source- Trust Medicines Management Report*
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	a) 87.5% b) 88.5% c) 100%	**TBC when data available**	Percentage of patients with psychosis where cardio-metabolic assessment requirements were met. *Source- Trust CQUIN Report*
Admissions to adult facilities of patients under 16 yrs. old	0	N/A	0	**0**	Total number of patients <16 years of age admitted to adult MH Inpatient Facilities in year

Figure 40	Annual Target	2016/17	2017/ 18	2018/19	Commentary
Inappropriate out-of-area placements (OAP) for adult mental health services (Occupied Bed days as OAP)	Reduce as per CCG Targets	N/A	247	**185 (Target met)**	Average monthly total bed days spent out of area in year
Mental Health minimising delayed transfers of care (Relates to Mental Health delays only-Health & Social Care).	<7.5%	12.38%	11.3%	**9.0%**	Average monthly % in year. Calculation = number of days delayed in month divided by Occupied Bed Days in month.
Clinical Effectiveness					
Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral	53%	85.8%	84.5%	**82.6%**	Annual Percentage
Improving access to psychological therapies (IAPT): proportion of people completing treatment who move to recovery	50%	N/A	58.8%	**57.4%**	Average Monthly % in Year
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%	98.4%	98.9%	**98.3%**	Average monthly % in year
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%	99.9%	100%	**100%**	Average monthly % in year
A&E: maximum waiting time of four hours from arrival to admission/ transfer/ disch.	95%	99.5%	99.3%	**99.8%**	Average monthly % in year
Data Quality Maturity Index (DQMI) – MHSDS dataset score (Revised Indicator)	95%	N/A	N/A	**97.8%**	Average monthly % in year
Patient Experience					
RTT waiting times Community: Incomplete pathways	92% <18 weeks	99.9%	99.8%	**99.4%**	Average monthly % in year
Complaints received		209	209	**230**	Total number of complaints in year
1. Complaint acknowledged within 3 working days 2. Complaint resolved within timescale of complainant	100% 90%	100% 100%	100% 100%	**100%** **100%**	Total % in year.

Source- Trust Tableau Dashboard 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 2018/19 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 2018 to May 2019
  - papers relating to quality reported to the board over the period April 2018 to May 2019
  - feedback from commissioners dated April 2019
  - feedback from governors dated April 2019
  - feedback from local Healthwatch organisations dated April 2019
  - feedback from Overview and Scrutiny Committees dated April 2019
  - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated April 2019
  - the 2018 national patient survey November 2018
  - the 2018 national staff survey March 2019
  - the Head of Internal Audit's annual opinion of the Trust's control environment dated May 2019
  - CQC inspection report dated October 2018
- 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

14th May 2019  **Martin Earwicker** **Chairman**

14th May 2019  **Julian Emms** **Chief Executive**

Appendix A:
Annual Plan on a Page- 2018-19

True North: Annual plan on a page 2018-2019

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

NHS
Berkshire Healthcare
NHS Foundation Trust

True North: goal 1 - Harm-free care

✓ **To provide safe services, prevent self-harm and harm to others**

- We will align our efforts and work to deliver our 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
- All our services will contribute to an Outstanding Care Quality Commission rating

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

True North: goal 2 - Supporting our staff

✓ **To strengthen our highly skilled and engaged workforce and provide a safe working environment**

- We will achieve improvements in key areas:
  - 66% of our staff feeling they can make improvements at work
  - 75% of our staff recommending Berkshire Healthcare as a place to receive treatment
  - 20% reduction in assaults on staff
- Our recruitment and retention plans will reduce vacancies by 10%
- An additional 24 services will be trained in our Quality Improvement System
- We will achieve the objectives set out in the Equality Plans for each area

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

True North: goal 3 - Good patient experience

✓ **To provide good outcomes from treatment and care**

- We will 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
- We will reduce our use of prone restraint by 90% by the end of 2018/19
- All our services will focus on understanding and supporting outcomes of care that are important to patients

At a system level: We will contribute to Integrated Care System work streams to improve patient experience and outcomes.

True North: goal 4 - Money matters

✓ **To deliver services that are efficient and financially sustainable**

- We will deliver our financial plan for the year and achieve £5m internal savings
- We will continue to improve our efficiency in the way we buy goods and services and further reducing our use of agency staff
- People needing acute mental health inpatient care will be able to access it locally, eliminating the need for acute out of area treatment by 2021
- We will achieve our environmental targets, reducing our use of fuel and water

At a system level: We will contribute to the achievement of the financial targets in 'Berkshire West' and 'Frimley Health and Care' Integrated Care Systems.

Quality Improvement programme

Annual Plan on a Page- 2019-20

Annual plan on a page 2019/20

NHS
Berkshire Healthcare
NHS Foundation Trust

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

True North goal 1: Harm-free care

✓ **To provide safe services, prevent self harm and harm to others**

- We will reduce harm to our patients by reducing: self harm and suicide, falls, medication errors, pressure ulcers and preventable deaths from septicaemia
- At least 95% of our reported incidents will be low or no harm to patients
- All patient facing teams will have evidence based objectives for reducing patient harm in their plans for 2019/20
- All our support services will work with patient facing services to identify ways that they can support safety of patients

With our health and social care partners:
We will work to achieve reduced urgent admissions and delayed transfers of care.

True North goal 2: Supporting our staff

✓ **To strengthen our highly skilled and engaged workforce and provide a safe working environment**

- We will achieve high levels of staff engagement across all our services - scoring four or more in our staff survey. We will increase the numbers of our staff feeling they can make improvements at work to more than 70%, and aim to achieve more than 85% of staff recommending our Trust as a place to receive treatment
- We will aim to achieve a vacancy level of less than 10%, a staff turnover rate of less than 16% and a sickness level of less than 3.5%
- We will promote an inclusive and compassionate culture, with zero tolerance of aggression, bullying and exclusion, and reduce assaults on staff by 20%
- We will achieve our objectives for equality of opportunity and staff wellbeing

With our health and social care partners: We will enhance career development opportunities and improve our workforce planning.

True North goal 3: Good patient experience

✓ **To provide good outcomes from treatment and care**

- We will achieve a 95% satisfaction rate in our Friends and Family Test (FFT) and 60% of staff reporting use of patient feedback to make informed decisions in their department
- All our services will focus on delivery of outcomes of care that are important to our patients, based on a good understanding of our diverse population

With our health and social care partners: We will contribute to Integrated Care System (ICS) work streams to improve patient experience and outcomes.

True North goal 4: Money matters

✓ **To deliver services that are efficient and financially sustainable**

- We will achieve our financial target of a £1.9m surplus so that we can continue to invest in improving our services, buildings and equipment
- All our teams will work on achieving a 2% efficiency or productivity improvement to benefit patients and staff
- We will continue to achieve reduced use of agency staff and deliver an additional 1% reduction in corporate costs

With our health and social care partners: We will play our part to achieve the financial targets in Berkshire West and Frimley Health and Care Integrated Care Systems.

Appendix B- National Clinical Audits- Actions to Improve Quality

National Clinical Audits Reported in 2018/19 and results received that were applicable to Berkshire Healthcare NHS Foundation Trust

National audit		Description	Actions to be taken to meet recommendations
NCAPOP Audits			
1	National Clinical Audit of Psychosis (3582) (including MH CQUIN3 for community & Inpatients)	National Clinical Audit of Psychosis (NCAP) was previously known as the National Audit of Schizophrenia (NAS) from which two reports were previously published: NAS1 in December 2012 and NAS2 in November 2014. The audit has focused on four issues relating to the quality of care provided for people with psychotic disorders: management of physical health, prescribing practice, access to psychological therapies and outcomes. Twelve audit standards and two outcome measures were developed to address these issues which were measured using 29 individual metrics	The audit highlighted that we have the lowest proportion of patients on CPA when benchmarked with other The proportion of patients on CPA is wider than the NCAP and has been highlighted previously in other benchmarking reports. This is being addressed across BHFT, each locality led by the locality directors has an operational action plan in place, to ensure appropriate review of patients who should be on CPA and that specific actions required are implemented within that locality to support the compliance with the CPA policy. Assessments of carers needs: The audit identifies that we have the lowest number of patients with carers identified and that assessment of their needs is not completed when benchmarked against other similar organisations. There is a specific focus on Carers within the trust which the Clinical Director for Children's Services leads on, all mental health services have an action plan in place to specifically address the needs of carers which is being monitored through this programme of work. In addition for those patients on CPA the crisis plan specifically reviews carer's involvement. Locality risk audits are completed and reviewed quarterly by the locality through the patient safety and quality meetings. The audit looks at the service user view, carer view and safety plan (in addition to other areas), any areas of concern are raised to the Quality Executive Group (QEG), and actions are taken within the specific localities to improve compliance. The August risk assessments give assurance that appropriate carer involvement is being completed for patients on CPA. Interventions for when glucose and lipid results which are outside of the Lester tool parameters are often lifestyle and diet advice and in some cases onward referral to an appropriate specialist. In previous audits we have identified that documentation of this is not always easy to find on RiO and this can lead to inaccurate audit data submissions. There is a significant focus on physical health of mental health patients within the trust and documentation of interventions is an area they are aware of and reviewing.
2	National Diabetes Footcare audit (3586)	The National Diabetes Footcare audit (NDFA) is a measurement system of care structures, patient management and the outcomes of care for people with active diabetic foot ulcers. The NDFA is a continuous data collection audit and is part of the National Diabetes Audit (NDA) portfolio within the National Clinical Audit and Patient Outcomes Programme (NCAPOP), commissioned by the Healthcare Quality Improvement Partnership (HQIP)	There has been an increase year on year of the proportion of patients who are being seen more than 2 months after initial presentation, increasing from 12.8% to 24.6% To improve time from first being assessed by any Healthcare Professional (HCP) to referral into the MDfT the part time Foot Protection Lead role (community role) continues to support community Podiatry woundcare clinics in this process along with changing referral guidelines to the MDfT. Podiatry local investigation to be carried out for all major amputations from April 2018. From July 18 the community Podiatry service will be collecting data which will give more comparable data across the CCGs.

National audit		Description	Actions to be taken to meet recommendations
3	National Diabetes Secondary Care & Insulin Pump audit (3751)	The National Diabetes Audit (NDA) provides a comprehensive view of Diabetes Care in England and Wales, measuring the effectiveness of diabetes healthcare against NICE Clinical Guidelines and NICE Quality Standards. GP Practices and secondary care services were also involved in the audit to give a full picture of the diabetes care pathway. The NDA is part of the National Diabetes Audit portfolio within the National Clinical Audit and Patient Outcomes Programme (NCAPOP), commissioned by the Healthcare Quality Improvement Partnership (HQIP).	Significant work has been done since 2016/17 the timeframe in which these audits review, and detailed below is the improvements and actions which have been taken and are in progress. The Diabetes Service is a core member of the Frimley Health and Care Diabetes Programme Board who make recommendations for improvement in diabetes care across the whole Frimley ICS. The Board was set up in April 2017 to help support the transformational bids across the whole Frimley ICS. The Diabetes Service is also a key member of the Berkshire East Clinical Leads Group where local needs are reviewed and addressed. The service is also represented at the Thames Valley Diabetes Clinical Reference Group which looks to improve diabetes services across Thames Valley. The service is currently working as part of the Frimley ICS and is looking to redesign by moving to a more integrated diabetes service. This will include Consultant support in Primary Care and an increase in WTE of Diabetes Specialist Nurses based in the Community to up-skill Primary Care. The Diabetes service is working with the supplier of their Diabetes Database, HICOM so that that more functionality can be utilised to obtain more accurate data. The system may be able to link with RIO and ICE (the pathology system) to ensure that relevant data is entered onto the system automatically. The Specialist Service is in discussion with East Berkshire CCG in respect of commissioning more dietary interventions for people with diabetes as healthy eating and associated weight loss plus physical activity still remains the best treatment for people diagnosed with type-2 diabetes. Structured education Provide more education session including evening and weekend sessions. Sessions in other languages to meet the needs of the local population. Working in partnership with a local GP practice by piloting a locally developed type 2 education programme in Punjabi. An on-line offering of structured education for those people who do not want to attend a face to face course. The service is working in partnership with Talking Therapies to help support uptake of structured education as part of an education hub initiative. The ICS is reviewing how to engage this group of people in their care and how to improve uptake to the services available. Slough are currently recruiting Diabetes Community Champions supported by Diabetes UK to work in the local community to provide support and signposting to Diabetes Care as well as highlighting the risk factors and complications related to the condition Insulin Pump All people with Type 1 Diabetes who are referred for an insulin pump and meet NICE criteria for Insulin Pump Therapy are offered Insulin Pump Therapy. A pathway is in place and agreed with East Berkshire CCG.
4	National Audit of Care at the End of Life (3588)	The National Audit of Care at the End of Life (NACEL) is a nationally-facilitated project that is mandated for Trust participation by our trust community inpatient wards and mental health inpatient wards as part of the National Clinical Audit and Patient Outcome	Review and update the Trust Individualised End of Life Care Plan template to ensure that it meets all of the current best practice requirements, and ensure all patients that require them have an end of life care plan. Ensure that all patients that require them have an End of Life Care Plan. Ensure patients have their capacity to be involved in their end of life care decisions both assessed and documented. Where mental incapacity is not suspected, ensure that this is also documented. Ensure that a senior clinician (a senior doctor or recognised competent nurse) carries out a documented

National audit		Description	Actions to be taken to meet recommendations
		Programme (NCAPOP). The audit focuses on expected hospital deaths and comprises three main aspects; an organisational audit, a patient case note audit and a 'Nominated Person' quality survey. All three parts of the audit were analysed against best practice as defined in "One Chance to get it Right (2014) and NICE Quality Standard 144 -Care of Dying Adults in the Last Days of Life (2017). This is the first time that this audit has been open to services that the Trust provides. In February 2019, the national team running the project (The NHS Benchmarking Network) released a Trust Bespoke Dashboard detailing trust findings benchmarked against all Trusts. It is the findings from this Bespoke Dashboard that are presented in this report.	discussion about CPR with both the patient and the nominated person (unless the patient does not consent to this, in which case this should also be documented). Ensure that the possibility that the patient may die is discussed and documented with the patient. Ensure that the need for routine tests (such as vital signs and blood tests) and non-routine tests is reviewed and documented in light of the patients deteriorating condition. Ensure that the recorded contact details for the nominated person include their address. Ensure that the potential side effects of medications are discussed and documented with both the patient (where possible) and the nominated person. Ensure that the patient's hydration and nutrition status are reviewed regularly (daily in the case of hydration) and that conversations are held and documented with both the patient and nominated person about the risks and benefits of hydration and nutrition options. Review the processes, support and information available immediately prior to, at the time and immediately after the patient's death. Review this interim analysis once the national report for the project is published in May 2019. Implement standardised process for sending condolence letters including BHFT Information for families following a bereavement leaflet Update trust end-of-life guidelines to include a guideline for viewing the body in the immediate time after death and a guideline for enabling rapid discharge home to die if that is the person's preference Investigate whether it would be possible to have an adult and child psychologist available to be consulted by patients, relatives and carers for trust community inpatient wards Investigate the possibility of including End-Of-Life care on trust induction & mandatory training programme
5	National Diabetes Secondary care – Care Process and Treatment Targets report (4330)	The National Diabetes Audit (NDA) provides a comprehensive view of Diabetes Care in England and Wales, measuring the effectiveness of diabetes healthcare against NICE Clinical Guidelines & Quality Standards. It reviews both Primary & Secondary Care services to give a full picture of care provided across the whole diabetes care pathway. It is a requirement of the NDA for secondary care services to participate. In East Berks we are commissioned to provide a Specialist Secondary Care Diabetes Service which supports both people with diabetes primary care in the management of the condition.	The Diabetes Service is a core member of the Frimley Health and Care Diabetes Programme Board who make recommendations for improvement in diabetes care across the whole Frimley ICS. The Service has received extra non –recurrent funding in 2018 in respect of structured education to provide more education session including evening and weekend sessions, sessions in other languages as well as an on-line offering. The service is also working with a local GP practice by piloting an Asian type 2 education programme The service is working in partnership with Talking Therapies to help support uptake of structured education as part of an education hub initiative . Over 70% of people who did not respond to an invitation to attend structured education when questioned felt that they did not need to attend as they had sufficient education and or another family member with type 2 diabetes.

National audit		Description	Actions to be taken to meet recommendations
Non-NCAPOP audits			
6	POMH Topic 15b: Prescribing valproate for bipolar disorder (2017) (3583)	The Prescribing Observatory for Mental Health (POMH-UK) runs clinical audit based quality improvement programmes that focus on discrete areas of prescribing practice. This report focuses on the first re-audit for POMH 15b: Prescribing valproate for bipolar disorder. The standards are derived from NICE Clinical Guideline CG185: Bipolar disorder (update): the management of bipolar disorder in adults, children and adolescents in primary and secondary care, September 2014.	Trust Medical Director to email all psychiatrists including trainees in the trust advising them of the MHRA drug safety alert, that valproate should no longer be used in women of child bearing age unless a pregnancy prevention plan is in place. Medical Director to further communicate advice to doctors at the medical staff committee (MSC) Medication Safety update to be sent to all Patient Safety and Quality Meetings across the Trust The consultant checklist to be replaced by the Annual Risk Acknowledgement Form which is required to be completed by the specialist prescriber and the patient. This form must be completed at initiation and yearly thereafter with copies sent to the GP. Valproate Screensaver 'Stop' 'think' detailing link to pharmacy resources on all Trust computers A prompt has been added to the new CPA template and also the risk aide memoir to provide a further reminder to staff. EPMA text reminder to appear when sodium valproate is clicked on. A request has been put into EMIS for EPMA as currently there is no "alerting" functionality within EPMA unlike other systems that could remind staff at point of prescribing. Audits of prescribing for this cohort both 6 monthly and annually through FP10 and electronic systems to be undertaken and reviewed at the MSG. Trust Medical Director to email all psychiatrists including trainees in the trust advising them of the trust audit results, reminding them of their responsibilities when prescribing valproate to patients. A programme of work is already underway to improve physical health screening for those with SMI. This will be extended to include all patients with a bipolar diagnosis prescribed valproate. Physical health leads will ensure education and information provided captures the findings from this audit and the areas to improve on in terms of physical health monitoring. This group should also be included in the shared care protocols for physical health monitoring that are underway
7	Review of the Early Intervention in Psychosis Network's (EIPN) self-assessment report on Berkshire Healthcare's EIP Service 2017/18 (3589): May 2018	The Early Intervention in Psychosis Network (EIPN), an initiative of the Royal College of Psychiatrists' College Centre for Quality Improvement (CCQI), provides supportive quality improvement reviews for EIP services. Services are reviewed against EIPN quality standards through a process of self-review and a peer-review visit. The aim of the self-assessment tool was to provide services with the opportunity to review their practice against a core set of	EIP Service to link in with the Physical Health monitoring work to identify how baseline data can be identified easier at start of being prescribed antipsychotic medication To add documenting baseline measures to the risk register To link in with Cardio-metabolic Assessment QI work. To meet with Inpatient Physical Health Leads to plan raising awareness of the need to document baseline physical health measures at start of antipsychotic medication whenever antipsychotic medication is initiated during an admission. The outcome measure forms are to be accessed online via electronic means such as RiO, iPhones, tablets and available through SHARON if possible A meeting with IT to establish what is possible electronically around forms on RiO, tablets and whether e-forms can be incorporated electronically onto clinician devices and accessed via SHARON.

National audit		Description	Actions to be taken to meet recommendations
		standards which included an assessment of their ability to offer NICE recommended interventions, deliver timely assessment and collect appropriate outcome measures. This is the second time the EIP self-assessment has been undertaken and included data relating to expectations laid out in the 'Implementing the Early Intervention in Psychosis Access and Waiting Time Standard'. The previous EIPN self-assessment was conducted in 2016/17. This National audit also included the CQUIN EIP 2017/18	To have forms created electronically. To meet with IT again to make a plan for developing the electronic forms by the end of October as part of the GDE project
8	POMH Topic 16b: Rapid tranquillisation in the context of the pharmacological management of acutely-disturbed behaviour (3975)	This report focuses on the first re-audit for POMH 16b: Rapid tranquillisation in the context of the pharmacological management of acutely-disturbed behaviour. The standards are derived from NICE Guideline NG10: Violence and aggression: short-term management in mental health, health and community settings.	Three standards have been highlighted as areas which require improvement: A prompt debrief is completed and recorded on the patients RiO record within 24 hours (Trust policy requirement) Physical health monitoring and recording in the hour post rapid tranquilisation Physical health monitoring for at risk patients (15 minute observations). In addition to the actions which have been completed since September 2018 there are a number of other actions which have been implemented or are in the progress of being implemented. Staff training continues to be a focus of development and in the last 6 months we have introduced e-Observations which allows' staff to directly input physical observations onto an i-pad and this information goes directly into the patient management system. One of its functions is to be able to set the frequency of physical observations and this is able to serve as a reminder to staff that observations are due.
9	POMH Topic 18a Prescribing clozapine (June 2018) (3996)	This baseline audit aimed to review clinical practice against national standards for prescribing clozapine. Wherever current practice diverges from best practice, as outlined in NICE Clinical Guideline CG178, Berkshire Healthcare aims to take action to make improvements and reduce risks related to prescribing clozapine. There were seven standards and a treatment target based on the NICE guidance.	Comprehensive standardised approach to physical health monitoring. Review alongside physical health monitoring for BHFT patients through physical health group and agree standards Trust wide. Defined Clozapine pathway in line with other care pathways with consistent approach to record interventions on RIO system. Develop pathway through BHFT pathway project team and transformation team. Evidence based agreed standards for prescribing and monitoring of Clozapine within BHFT. Review of guidance and consideration of side effect monitoring tool (GASS).

Appendix C- Local Clinical Audits- Actions to Improve Quality

	Audit Title	Conclusion/Actions
1	High dose or multiple antipsychotic medication use in Wokingham CMHT 4170)	This audit aimed to review whether Wokingham CMHT was meeting national NICE Guidance (NICE Schizophrenia Guideline: Clinical Guideline CG178, 2014, Psychosis and schizophrenia in adults. Although majority of the data documented in their notes CPA, clinic letters, or Clozapine clinic follow up charts it would be ideal to have an agreement to document those in one place on the system so it can be easily checked when required. Also, although it is documented somewhere on case notes that the patient is on high or multiple dose of medication, it would be ideal if it is written as a separate statement in clinic letters, therefore they can be monitored more carefully in primary care settings with given advice. Capacity and consent to treatment is also documented in all of their notes, however, a statement about patients being informed about risks of multiple or high dose of antipsychotic medication, about the risks of combining those with other medications when applicable and obtaining informed consent specifically for that can be considered and would be a better practice.
2	Audit of PGD use by Peer Vaccinators for the 2017 staff influenza vaccination campaign (4227)	The purpose of this audit was to examine the use of the influenza vaccination PGD used by peer vaccinators to administer the vaccine to Berkshire Healthcare staff and partner organisations staff, working alongside Berkshire Healthcare staff, as part of the annual flu vaccination campaign. It focussed on whether the PGD for the administration of flu vaccine to staff has been used in accordance with agreed inclusion criteria and whether documentation was in line with the national recommendations. An action plan has been devised and includes: PGD to be updated and to include people who work in trust clinical areas on a voluntary basis in the inclusion criteria. Issues identified with standards: 5, 8, 11 & 15 to be clarified and re-enforced. Consent form to be updated and the questions re-ordered in order to avoid staff missing questions. Only the most up to date consent forms to be used and available on Teamnet.
3	East Berkshire audit of assessment and investigation of newly diagnosed HIV patients (3649): December 2017	BHIVA has produced extensive guidance on the initial assessment and baseline investigations for newly diagnosed HIV patients. Each patient should have a full medical history and examination plus documentation of 14 factors. Recommended investigations cover a broad range of tests. Slough Sexual Health Clinic serves East Berkshire and cares for approximately 600 people living with HIV. The audit highlighted several areas requiring improvement including the need to include DA, travel, vaccination and mental health history in the clinic proforma. Patients may not report mental health issues unless asked and, as it could affect engagement with services, medication choice and adherence, it should be recorded. Improved recording of travel histories will facilitate targeted TB and parasite testing. MSM patients should be offered the vaccine if non-immune. PHI-testing is not currently available at our local laboratory but would be useful for targeted partner notification. The findings from this audit have been reported back to the clinic and plans to update the proforma should act as an aide memoire and improve documentation. An action plan was fully completed in 2017, which involved updating proformas and presenting the findings to staff to improve compliance with physical examinations.
4	Health Visitor New Birth Assessment Audit (3855): February 2018	This re-audit had two main aims. Firstly, to identify good practice in recording of HV assessments and to establish if the RIO version of the Family Health Needs Assessment (FHNA) New Birth, had been safely embedded in practice and secondly to identify any possible areas for improvement and actions required. The template for the FHNA had been developed within RiO as recommended in the previous audits action plan. Health Visitors need to continue using the RiO CYPF New Birth FHNA template, need to improve on the recording of the outcome of the new birth FHNA in the mother's progress notes, the recording of fathers details using the personal contacts link, to improve on the synchronising of RiO details with the National Spine and need to complete their records within 24 hours, in keeping with the trust business rules. Reminders to be given at all team meetings and followed up via review of records during management supervision, All localities/managers to confirm actions completed at service improvement group. Audit tool needs to be adapt for next audit to fit with the 24hr standard not 48hr.

	Audit Title	Conclusion/Actions
5	Consent to ECT Audit (4092): January 2018	The aim of this re-audit is to ensure that Berkshire Healthcare ECT Department comply with national guidelines for consent to ECT and, in order to ensure that consent is valid, for all patients to have a robust capacity assessment with relevant documentation prior to ECT. Standards were developed from the ECT Care Pathway and the Berkshire Healthcare ECT Policy and Guidelines (CCRO). The re-audit included one additional standard when compared to the baseline: the mental capacity form is completed on RiO. Clear documentation is the best way of evidencing that the trust is meeting the standards set by its policy and the ECTAS guidelines. Therefore, we must aim to improve and reach the previous 100% compliance with re-checking capacity on the day of the ECT and recording it in the patient's notes. In addition, although lack of the RiO form being completed, does not mean that capacity was not checked on the day prior to ECT, it should be utilised more to ensure clear and detailed documentation of a capacity assessment does take place prior to each ECT treatment. Raise awareness with ward doctors about the importance of completing the capacity forms on the day prior to each ECT treatment – this can be emphasised at the junior doctor induction. To provide immediate feedback to ward doctors on the day of ECT if they have failed to complete the capacity form prior to treatment. Raise awareness with posters about the consenting process for ECT. These can be placed in office areas on the wards.
6	Blood Transfusion Audit 2018 West Infusion Clinics (4177): March 2018	There is an MHRA requirement for all clinical areas where blood transfusion occurs to undertake the British Society of Haematology national bed side audit. The audit was undertaken in the High Tech Care Team to comply with BHFT's transfusion policy (CCR133) requirement to undertake an annual audit of transfusion practice. An action plan has been developed and action has already been taken to inform blood banks that the service works alongside, about the audit results. Further action is being taken to ensure that prescribers are aware of the need to document special requirements.
7	Lurasidone (Latuda®) Evaluation within BHFT (2715)	Purpose: To evaluate the prescribing of Lurasidone to patients referred to inpatient ward Psychiatrists (BHFT) where one of the treatment goals is to manage schizophrenia and psychoses with minimal risk of weight gain and metabolic side effects. Consider treatment with Lurasidone for Berkshire patients admitted as inpatients, experiencing relapse for the following reasons: Non-adherence of current treatment due to side effects and/or weight gain or other metabolic adverse effects from current treatment. Lack of efficacy of one antipsychotic. -The formulary position of Lurasidone should be reviewed as a result of this audit within CCGs - BHFT has added this drug to its formulary but this will not be taken over by GP's.
8	10 day follow up rates by Berkshire CAMHS Rapid Response Team following discharge of a CYP from acute hospital (3863)	For all children and young people who present to an acute hospital in a mental health crisis, our standard operating procedure recommends a "7-10 day follow up either by a telephone or face to face contact". This project aimed to measure the 10 day follow up rates by Berkshire CAMHS Rapid Response Team following discharge of a CYP from acute hospital and an evaluation of the reasons where this has not been possible. Community 7-10 FU appointment is determined before the patient is seen in acute hospitals and offered to the patient at the crisis appointment in acute hospital. Review operational process for handovers of CYP who have out of hour assessments by engagement with PMS services and with PPH/APOS – Protocols in practice meeting. The handover protocol to be incorporated in standard work/SOP for CAMHS RR. Review operational process for handovers of CYP out of hour assessments in out of area hospitals (Basingstoke and FPH) Induction protocol embedded in standard operational procedures for new starters. Operational causes will be evaluated and we expect to implement actions to improve the compliance rate for re-audit in one year.
9	Prescribing psychotropic medication in individuals with intellectual disability (4054)	The aim of this audit is to determine the level of compliance with the current standards of practice for the prescribing of psychotropic medication in patients with intellectual disability as outlined by the report of the Faculty of Psychiatry of Intellectual Disability, Royal College of Psychiatrists, alongside the NICE guidelines for challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges. Make the admitting and ward doctors aware of current standards for prescribing psychotropic medication in intellectual disability, with focus on the recording of off-label medication. Inform admitting and ward doctors of the off-label use of antipsychotics for challenging behaviour and the NICE conditions. Push for clear documentation in patient notes for the rationale behind changes in medication.

	Audit Title	Conclusion/Actions
10	Re-Audit of Antimicrobial Prescribing on all Berkshire Healthcare Inpatient Wards (3574)	This audit is a re-audit of Project 3494. The audit aimed to determine how compliant the Trust was with nationally recognised standards of good antimicrobial stewardship (AMS) and practice, and whether local Trust prescribing guidelines for antimicrobial prescribing is followed by prescribers. Recommendations will be managed through the BHFTs AMS Group who will have overall responsibility for taking these actions forward. Continue the wide spread use and regular update via AMSG of Trust guidelines through The Microguide app. Doctor's induction pack. Inpatient bulletin. Continue staff engagement through continued staff training and awareness of AMS principles. Annual AMx Guardian campaign. Review e-learning to incorporate ongoing pertinent AMS points. Raise staff awareness for full completion of allergy box on EPMA charts across all healthcare professionals. Inpatient bulletin. Continue system working. Joint collaboration to streamline Trusts and CCG guidelines within the County It is expected that further improvements will be observed as EPMA is embedded. The AMS group are due to discuss the action plan at their next meeting on 16th July 2018; they will lead on this going forwards.
11	Re-Audit of compliance with sepsis early recognition tool in community health inpatient units (3713): April 2018	The NICE sepsis guidelines were published in July 2016 and a quality standard published in September 2017. An initial audit was undertaken in 2016-17 to establish baseline compliance in inpatient units following the implementation of the sepsis early recognition tool. Targeted training to continue including eLearning. HIPC to continue to provide support for staff in compliance with the sepsis early recognition tool. The sepsis page on Teamnet is to be regularly reviewed and updated, new resources and guidelines to be communicated to clinical staff. Infection Prevention and Control post infection reviews to be monitored for compliance with the early recognition of sepsis tool. Learning is to be disseminated to clinical teams via relevant post infection review reports and quarterly shared learning reports disseminated by the IPCT. Involvement with individual QMIS projects to review the use of the early sepsis recognition tool.
12	Fragility Fractures Audit Programme (FFFAP) - CSP Hip Sprint Audit 2017 (3630)	Although this was a national audit, it is not mandated (quality account reportable) or on the NCAPOP Programme. Following a review of the national report's recommendations, the following actions were devised for BHFT: Evidence based exercise programme including strength, balance, mobility and endurance in place for all hip fracture patients on Jubilee. Health coaching and goal setting used to increase adherence to programme. Continuity post discharge by referral to other ARC services – ICR, Community Physio, ARC
13	School Nursing Nocturnal Enuresis Service Audit (4118): December 2017	The school nursing service undertakes the record keeping audit on an annual basis in order to measure compliance against the CCR153 'School Nursing: Nocturnal Enuresis Policy. Compliance against this policy is required to be monitored via the annual audit using the national enuresis service monitoring tool. An action plan was developed which includes key actions for all localities to ensure that the enuresis assessment tool is used in all cases. Further education and development of staff through pan-Berkshire staff nurse meeting and the use of the school nursing letter to distribute, findings, recommendations and further information. New automatic waiting list set up on RIO with an alert after 42days if client not yet seen, which will prompt review of clinic availability
14	Safeguarding Record Keeping Audit, School Nursing 2017 (4119): December 2017	An in-depth audit of child protection records and health assessment was conducted by the school nursing service. Spot checks will be conducted half termly via management supervision, to include reviewing whether safeguarding children's risk forms are fully completed and whether the progress notes summaries the key information including risk to the child. IT training has been provided in uploading documents and the Health assessment form is being Built into RIO.

	Audit Title	Conclusion/Actions
15	Audit of Risk Summary Documentation for all Patients in the Slough Pathways Outreach Team (4318)	The purpose of the audit was to establish if all eligible patients under the care of the Slough Pathways Outreach Team (SPOT) have had risk summaries completed. In particular, whether their last risk summary update was in line with the time frame required (either 6-monthly or 12-monthly depending on necessity to have CPA meetings). There is nowhere on RiO which prompts staff that a risk summary is overdue; it is possible that this would improve compliance. Team to be made aware that risk summaries can be updated despite not having seen the patient in the case (as one of ours) when they are in a different region of the country. If there has been any contact with the patient, family or other healthcare professionals this can be documented and as long as clearly stated that the patient has not been seen and assessed, this is valid. Discussion with the MDT surrounding adding a column on the MDT handover sheet. The current form includes patient details, their last CPA, next CPA, cluster number, details of outpatients appointments and CTOs. Two columns could easily be added to include date of last risk summary and date next risk summary is due.
16	Lithium use in Wokingham CMHT: Audit of safety and quality of monitoring in the last year (4349)	Wokingham CMHT previously participated in the national POMH Lithium re-audit in June 2016. This audit measures using NICE Clinical Guideline (CG185) for Bipolar disorder: assessment and management (published September 2014). Whilst compliance with all standards prior to starting Lithium are excellent, some measures conducted during maintenance treatment could be improved upon, particularly serum calcium 6 monthly. It should not be assumed that requests for U&E's will also mean that calcium would be checked as an electrolyte; it should be requested separately.
17	Audit on use of hypnotics for insomnia in West CRHTTs in comparison with NICE guidelines (4331)	The aim of the audit was to identify patients under West CRHTT who were started hypnotics (Zopiclone, Zolpidem and Zaleplon) and to assess whether NICE guidance was followed. Patient's literature on sleep hygiene should be readily available to clinicians. Patients should be provided with information and followed up on sleep hygiene plan. MDT collaboration to review ongoing hypnotic's use. Improve awareness of NICE guidance of management of insomnia.
18	ADHD Shared Care Clinic Annual Review Audit (4094)	Adult ADHD is treated with medication and managed locally by the Adult ADHD Shared Care Clinic. Both the new and previous NICE Guidelines recommend an annual review of the condition and treatment: NICE CG 72 (2008) and NICE NG 87 (2018) respectively. . The aim of this audit was to demonstrate whether we are meeting the standards. All annual reviews should lead to communication to GP's on the pro forma. Where there is no available previous weight, a BMI should be calculated, anyway. We need to ask about sexual side effects on atomoxetine and record the outcome. We should ensure that we record comments on mental wellbeing, physical health and substance misuse at every annual review.
19	A direct observation study of medication administration errors in a community and mental health setting (2733)	In response to a 2010 NPSA alert on omitted and delayed medicines, repeated audits of 'blank boxes' on medication administration charts have been completed; however action plans have had either a temporary or little effect (blank boxes are unsigned administration records when a medication was due, leading to uncertainty whether the medication was administered or not). In response, we completed this wide scale audit of all medication administration errors across BHFT. This aimed to document the rate of medication administration errors (MAE's) across all inpatient wards in a community and mental-health Trust, and to investigate the interrelationship between error rates and possible contributing factors. Additional information to be added to the mandatory medicines management training. Medication administration processes to be discussed at Medicines Safety Group with actions to be identified.
20	Evaluation of a Transdiagnostic Cognitive Behavioural Therapy Group in a Secondary Care Adult Mental Health Service (4088): May-18	The aim of this project was to evaluate the effectiveness and acceptability of the tCBT group. No issues were raised as a result of completing this service-evaluation and therefore no action is necessary. The evaluation demonstrated that running the tCBT group is effective and acceptable.

	Audit Title	Conclusion/Actions
21	Audit of Care Pathway: People Whose Behaviour Challenges - Pre and Post Outcomes (4206)	This audit is completed every year to ensure that the LD service delivers an excellent quality of care to people following the People Whose Behaviour Challenges Care Pathway. The audit is based upon good practice standards set out in two documents: Challenging Behaviour: a unified approach (2007); and Challenging Behaviour and Learning Disabilities: Prevention and Interventions for People with Learning Disabilities Whose Behaviour Challenges (NICE 2015). Present findings to the Learning Disability Governance meeting (November 23rd, 2018). Re-audit in April 2019 to ensure progress is maintained and improved. The Intensive Support Team (IST), Occupational and Speech and Language therapists will be asked to contribute specialist assessments as pre and post outcome measures. A three monthly follow up, repeating outcomes measures used, will be completed as per guidelines, to enable measurement of whether the gains have been maintained following closure. This guideline will be added to the care pathway.
22	Re-audit Berkshire Perinatal Community Mental Health Service Discharge Summaries (4458): 09/08/2018	This re-audit aims to measure improvements since last years' audit. One standard relating to timeliness of reporting to the GP was added to the 2018 re-audit, while all other standards remained the same as in 2017. To discuss with the team the importance of documenting a plan for future pregnancies. Standardised Discharge Summary to be used by all perinatal clinicians
23	Better understanding of the interplay between hyperactivity, inattention and impulsiveness in the clinical assessment of ADHD (2732)	The standard assessment of ADHD in BHFT CAMHS includes the use of screening questionnaires (Conners rating scales) and neurocognitive testing combined with infrared motion analysis (QBTest). This project tried to assess whether distinct neurocognitive profiles can also be distinguished in the scoring of the Conners rating scales & what the degree of correlation will be. In order to improve the interpretation of clinical data and investigations for the benefit of making more reliable diagnoses and raising the standard of the diagnostic assessment, thus leading to better treatment plans, the following have been implemented: Results were presented at the Specialist CAMHS ADHD Team Meeting on 10.10.2017. Attention was drawn towards the careful analysis of activity levels in relation to neurocognitive profiles. Clinical advice was given with regards to the integration of investigations, i.e. clinical observation, screening questionnaires and objective measurements when assessing for a diagnosis of ADHD. Standard Assessment was introduced with aids as to how to analyse neurocognitive profiles and how to complete an ADHD assessment that will meet Bolam/Bolitho criteria.
24	Improving Multidisciplinary Rounds on an acute Psychiatry inpatient ward (4211)	Multidisciplinary ward rounds (MDR) are an important forum wherein patients, carers and inpatient teams share information about patient's care. The outcomes were expected to aid enhanced patient engagement, service user safety, improve communication between inpatient team, carers and community mental health teams and to reduce unnecessary delays in discharges. A further review is needed to assess the views of carers and community staff, to gain a full understanding of how MDR rounds can be improved on an inpatient ward, but this is likely to be part of a separate piece of work.
25	Audit on the documentation and appropriate review of blood investigations in the inpatient services (4249)	The audit aimed to review the proportion of new admissions that had blood tests taken, whether these were documented in RiO, if documentation was timely, and if an appropriate plan was documented. Phlebotomy to be consulted as to how they can best/most easily communicate with clinicians. Mention the need to document bloods on RiO to new trainees at induction. Consultants to be made aware by email of findings of audit in order to pass the message on to the team.

	Audit Title	Conclusion/Actions
26	Covert Administration Audit on Rowan Ward (4362): May 2018	. The main aim of the audit was to measure the level of adherence that healthcare professionals on Rowan Ward had to Berkshire Healthcare's SOP on covert administration. Training on where to specifically store and how to use the MRSOP; 4009 Covert Administration of Medicines forms. Nurses to be given additional training on covert administration and the importance of signing the covert administration form with their agreement. Training for pharmacists on how to use ePMA to input specific endorsements for the method of administration. Improve the covert administration process by ensuring that covert administration forms are all uploaded to RiO, to make accessible to all. Reduce the maximum official review date for covert medication from 3 months to 2 months and ensure review includes looking at if medications are still essential. Repeat audit using a regular member of the team to complete the audit prospectively over a longer period when recommendations have been implemented.
27	Parkinson's Audit (3656)	The objective of the Parkinson's patient management audit is to ascertain if the assessment and management of patients with an established diagnosis of Parkinson's complies with national guidelines including the Parkinson's NICE guideline and the National Service Framework for Long Term Neurological Conditions (NSF LTNC).
28	Frequent attenders at the emergency department (2839)	The CCG asked the Psychological Medicine Service (PMS) to create a system to address the problems for individuals and services associated with people who repeatedly present to A&E at the RBH. The aim of this project was to identify the 'top 20' repeat attenders aged 16+ to RBH A&E each quarter and to implement appropriate indirect / direct interventions with the aim of reducing attendances in the following quarter(s). No specific actions are required as part of this project, though further related work will include: Continuing with CQUIN until 2020, Increasing frequent attenders pathway (requires resources). Continuing to develop the work regionally – benchmarking and networking with other Emergency Departments
29	Audit of transition practice for young persons with ADHD (3803): June 2018	Berkshire Healthcare Trust implemented a policy on the ADHD Transition Pathway from CAMHS to Adult Services in 2015 based on NICE guidelines and recommendations. Effective and thorough transition from CAMHS to adult services in patients with ADHD is crucial to minimise the impact to patients in what can be a challenging and anxiety-provoking period for both the patients and their families. The audit sought to assess, whether the transition process was being followed by services across Berkshire in line with BHFTs transitioning tool, and to make changes where required improving the service provision for patients. The audit demonstrated that the current policy is in line with national standards and guidance. However, there are some gaps within the service based on the recommendations made: • ADHD Transition from CAMHS to Adult Services Policy should be made more widely available on the intranet by discussing with IT and appropriate professionals involved in these services. • Results of the audit to be presented at the CAMHS academic seminar, ensuring relevant professionals are informed & made aware of change. • Results of the audit presented during team meetings in each area of BHFT e.g. Maidenhead / Wokingham / Reading etc. • The ADHD transition from CAMHS to Adult Services Policy to be presented at team meetings in each area locality in order for people to become more familiar with the standards and expectations of the transition process. • Whilst this audit primarily highlights changes which can be made by CAMHS, this audit needs to be passed to the adult ADHD team in order for them to be made aware of areas for improvement including them sending receipt of referrals and sending appointments. • A proposed checklist to be created outlining in brief what needs to be completed prior to transition and during the transition process including deadlines; to be distributed amongst the teams. • In the longer-term, to consider having a prompt on RiO to ask whether clinicians are considering referral may be a helpful as a reminder.

	Audit Title	Conclusion/Actions
30	An audit of current practice of Partner Notification for patients with a new diagnosis of HIV presenting 2016-17 at the Garden Clinic (4184): July 2018	Partner Notification (PN) is an important outcome to be evaluated in the commissioning of sexual health services and is also important from a public health perspective as it enables services to identify those at risk of HIV infection, particularly those at risk of primary HIV infection, who will be most at risk of transmitting the virus to new sexual partners. The HIV Partner Notification for Adults: Definitions, Outcomes and Standards published by BASHH/BHIVA in 2014 define the process whereby contacts of those with HIV are identified and offered HIV testing. The aim of this audit was to compare performance at the Garden Clinic in Slough with national results and with results of the 2012/13 PN audit. This audit highlights the need for local review of the PN process as PN information was often difficult to access and information was documented differently depending on the clinician who saw the patient. Following the audit, it became apparent that Health Advisors in the team could input PN information that was not available to other members of staff. The action plan tackles the issues of access and, through training, will ensure a consistent process if followed using the sexual contacts tab on Lille.
31	Re-Audit on the Management of Gonorrhoea in the Sexual Health Service (4186): September 2018	Antimicrobial resistance is on the rise worldwide, GRASP surveillance has issued warning regarding resistance to the currently used Cephalosporin antibiotics. Though the incidence of Gonorrhoea infection is on the rise especially in high risk individuals, is also an indication of HIV transmission. The purpose of this audit is to audit the investigation and treatment of gonorrhoea positive patients. Standards were taken from the UK National Guideline for the Management of Gonorrhoea in Adults (2011; BASHH). An audit against the same standards was conducted a year prior to the re-audit. Recommendations include: Improving attendance rates of men, such as by having clinics for men or online testing. NAATS and culture plates should be taken from all appropriate sites. Full sexual history must be taken from both men and women. If first line of treatment is not given, continue to document reasons. Written information to be given out to patients and documented on Lille. An action has been developed to set up a texting system on Lille to provide a link with patient information leaflets.
32	Audit of the Safeguarding Children Risk Form on the RIO record (4375): April 2018	The safeguarding children at risk form was designed to enable practitioners to see at a glance the safeguarding issues for the child, whilst at the same time holding important information about the contact details for the social worker and details of the next safeguarding meetings. The form allows for all of this important information to be accessed from one place and be viewed at a glance. The purpose of this audit was to review if the safeguarding children risk forms were being used since their introduction two years ago. The initial reason for developing the form was so that the information around safeguarding was instantly accessible. The audit sought to highlight if the forms were being completed correctly. Overall, the findings of the audit were positive, the children risk forms are being used as designed for their intended purpose. Therefore, no further actions required
33	A QIP on the Physical Health Monitoring of Inpatients on Bluebell Ward (4024): June 2018	This project was carried out as it was identified that although, there was a robust monitoring system in place to assess the physical healthcare of patients on admission, there was no process where a patient's physical health examination, bloods, ECGs or other general physical health was discussed as part of the weekly MDT meetings whilst they were an inpatient. The audit sought to address the impact of this and improve this with the objective of being able to review the processes involved and identify gaps in care. The key recommendations proposed are: The physical examination, results of blood tests and ECG should be documented in the patient's electronic records. Medical aspects of the patient's clinical presentation should be adequately documented during weekly MDT discussions summarising the physical health status of the patients during the review and their treatment. The monitoring of NEWS should be consistent with the Trusts NEWS monitoring policy CCR 116 in terms of the frequency of the monitoring and contacting relevant medical professionals. 24-hour physical monitoring forms on RIO should be completed to include all parameters such as hearing, sight, dentition, bowel problems and fluid balance. The nutrition monitoring forms on RIO should be completed with eating and swallowing problems being recorded. Propose to re-audit in a years' time. All doctors on the inpatient wards will use the check list during the MDT meetings and the use of the check list will be periodically reviewed.

	Audit Title	Conclusion/Actions
34	Effective Use of Anticoagulation Use in Atrial Fibrillation (4218): July 2018	Atrial Fibrillation is associated with increased risk of strokes; effective anticoagulation can minimize patients having strokes. The primary objective of this audit was to see whether all patients who need anticoagulation are on either warfarin or NOACs. Further also to find out the reasons, if patients have not been started on anticoagulants or if they are on Aspirin or Clopidogrel. To increase the awareness among GPs on CHA2DS2-VASc by arranging lectures, posters and sending emails. Display CHA2DS2-VAS score guidelines in clinical areas. To investigate if the system can have periodic pop ups of CHA2DS2-VASc score as reminder.
35	MIU X-ray Diagnosing, Reporting and Follow Up Audit (4279): August 2018	The purpose of this audit is to review the Minor Injuries Unit's (MIU) practice relating to diagnosing, reporting and following up on patients who have x-rays. Similar audits have been completed during 2016 and 2017; however this audit has been updated (following a SIRI 2017/19265) to include two additional standards relating to follow up processes when a patient requires referral to the Virtual Fracture Clinic (VFC). The radiology department at WBCH should be printing the RBH x-ray reports and delivering them to MIU in a timely manner. Differences in diagnosis and report should be clearly documented in the notes regardless of whether it affects treatment. Patients with fractures to the proximal and middle phalanx of the fingers should be referred to VFC as per VFC recommendations. Documentation of what the x-ray report stated should be recorded correctly in the patient notes. Delay between the time a patient has their x-ray and in the checking of the x-ray report should be reduced. Checking the VFC referral has been made needs to continue and must be documented.
36	To establish, improve and maintain a personal folder for inpatients. Audit to check items in patient folders against a checklist (June 2017 to December 2017) (3701): October 2018	Campion Unit is an acute inpatient service providing intensive multidisciplinary assessment, formulation and treatment in a controlled setting. Service users have complex needs, often with multiple diagnoses. Standards have been developed based on Transforming Care Programme, which was developed by NHS England, the Association of Adult Social Services, the CQC, Dep of Health and RPsych. Action was taken throughout the 6 month period based on the findings of the audit. Completion of these actions has resulted in improvements for patients: - Full and complete care plans and section 17 leave documentation, which evidence patient involvement, have given clarity to the patients and their families about leave opportunities for patients to maintain contact with their families as well as leisure activities. - T2 and T3 forms were not clearly understood by all of the patients and the Responsible Clinician has since developed an easy read explanation of the SOAD process and T3 certification. Including communication passports in the patient folders has helped to embed the need for all staff to individualise communication with patients. Staff have reported that this has increased their use of, and confidence in using non-verbal methods of communication including sign supported English such as Makaton. - Storage of documentation relating to healthcare appointments at Royal Berkshire Hospital (and other healthcare sites) has been a challenge. The Responsible Clinician has devised a system for copying information related to the patient into their folder to improve practice in this area. - The CTR leaflet is being given to the patient and completed during the Mental Capacity Act process. This is documented in the progress notes.
37	First Prescription of Combined Oral Contraceptive (COC) Audit (4535): October 2018	This re-audit aims to measure compliance (and any improvements since the 2011 audit) with the following auditable outcomes: - Prior to first prescription of COC, all women attending the service have a Body Mass Index (BMI) and blood pressure documented - Before first prescription of COC, all women attending the service have a documented record showing assessment of cardiovascular risk factors, including migraine. Key recommendations from this re-audit include: Filling out physical health details electronically while the patient is in the room so as not to forget to document results on the electronic system. Further development of the contraception proforma, including a banner at the top with a box for blood pressure, height and weight to be documented. The proforma and physical details tab should be linked if possible so that it can self-populate. Feed results back to staff, including issues relating to incorrect coding of prescriptions on SRHAD.

	Audit Title	Conclusion/Actions
38	Neuro-imaging in dementia patients (4570): November 2018	Neuroimaging is an essential part of investigations in dementia patients. NICE Guidelines exist for this aspect of investigation for dementia (NICE Guidelines: 1.2.13: offer structural imaging to rule out reversible causes of cognitive decline and to assist with subtype diagnosis, unless dementia is well established and the subtype). Although full compliance was found, an action plan will be considered based on the following recommendation: create a recommended time in the local policy in which a previous scan would be acceptable. Ideally this should be within one year in order to rule out reversible causes.
39	Audit on testing Vitamin D level in elderly patients admitted to Henry Tudor Ward after falls, as per NICE Guidelines in Falls and Vitamin D (4532): December 2018	The standard for this audit was: All patients presenting on admission with a clinical problem of falls will have a vitamin D test completed within 1 month. The purpose of the current audit was to evaluate how compliant Henry Tudor Ward is with NICE recommendations, specifically recommendation 7 which relates to testing vitamin D levels on patients presenting with a clinical problem of falls, with the aim of starting vitamin D treatment earlier for applicable patients. There have not been any recent audits on this topic in Berkshire Healthcare. The results were presented to the Clinical Governance Group on 19th December 2018, where the recommendations and action plan were agreed. Recommendations include: - Educating ward and rehab doctors on the Vitamin D NICE Guideline during weekly teaching meetings, clinical governance meetings and weekly multi-disciplinary team meetings about the need to add a vitamin D request in routine blood for all patients who have falls. - Designing a notice based on NICE Guidelines around falls and displaying the notice on notice boards in doctors' rooms and clinical rooms. - Adding a pop-up notice to computer desktops on vitamin D and falls. - If nurses are unable to book vitamin D blood tests, their ICE login should be updated. - Doctors' ICE login can be set to default to the endocrine panel where vitamin D is displayed. - Discussing any limitations to testing vitamin D with the biochemistry lab.
40	Review of patients on anti-dementia medication (ID 4276): January 2019	This audit set out to evaluate the current prescribing practice in the Bracknell Community Mental Health Team for Older People (CMHTOA). Based on the 2011 guidelines BHFT participated in a POMH (Prescribing Observatory for Mental Health) audit in 2013 on prescribing anti-dementia drugs. An action plan is being devised. Recommendations: - Clear recording of information: A standardised form to adequately record the review. - The results of the audit will be presented and discussed at a Bracknell memory clinic and CMHT business meeting.

	Audit Title	Conclusion/Actions
41	An Audit of the Antipsychotic Drugs prescribed for management of Behavioural and Psychological Symptoms of Dementia (BPSD) in Older Adult Community Patients (4357): June 2018	The current audit uses standards developed from NICE Guideline CG42 (2016) and NG97 (2018) to audit antipsychotic prescribing for management of BPSD in patients from Slough Older Adults Community Mental Health Team (CMHT) who have dementia, with the aim of making improvements to practice where necessary. The findings of the audit were presented to the multi-disciplinary team for further discussion and analysis. At this meeting it became apparent that not all staff were aware of the timescales for completing assessments and that another reason why the three-month follow up is not always being completed is due to patients presenting as too disturbed for cognitive re-testing. The decision was made to develop an action plan for improvement and review these standards on an annual basis as per the guidelines. The action plan includes actions relating to: - Using the pain score tool to identify the severity of pain when reviewing patients prescribed antipsychotic medication. - Using medication information and leaflets to present medication effects, risks and benefits and to improve compliance with prescribed medication. - Documenting reported effects, CVA risks & risks & benefits of antipsychotic treatment in the Psychotropic Medication section in RiO progress notes. - Using the MSE template and Physical Health section on RiO progress notes to document the Behavioural and Functional Analysis and CVA risk. - Including timescales of assessments in staff inductions and training. - Staff education via clinical supervision, appraisals and MDT meetings to highlight importance of re-assessment of cognitive function for patients' prescribed antipsychotic medication. - Identifying and recording social needs using functional tools such as Bristol Activities of Daily Living, Face Overview Assessment. - Considering referrals to Occ. Therapy / Physiotherapy / Podiatry / Falls Clinic when identifying needs and deficits with living conditions and mobility. - Discussing possible psychosis in clinical meetings and adhering to NICE guidelines for management of psychosis for patients with dementia. - Reviewing after 3m and 6 m subsequently, per CQUIN requirements & Royal College of Psychiatry Guidelines on prescribing psychotropic medication.
42	Capacity and Consent Issues (ID 4666): May 2018	Mental capacity is an important issue regarding patients with mental health problems. This is relevant for the psychiatric patients who are admitted informally or under the Mental Health Act. This audit aimed to review whether mental capacity was recorded on RIO for admission and treatment purposes for patients who were admitted on Rose Ward, PPH. An action plan is being devised. A recommendation includes: • Capacity for treatment is documented in three different places which make it a challenge and time consuming to pull out specific aspects of care. The medical team aim to assess capacity for treatment and admission at the first patient review or at the MDT.
43	Audit of Physical Activities in patients with learning disabilities (ID 4166): February 2019	People with Learning Disability (PWLD) are at higher risk of developing mental illnesses and dying prematurely due to poor physical health. Reducing premature death and increasing the general well-being of PWLD is a national and organisational priority. This audit used an adaptation of IPAQ-SF, specifically designed and tested for PWLD, to quantify the level of physical activities in PWLD. • Raise awareness amongst healthcare professionals e.g. GPs, social workers, members of MDTs and carers/relatives about the current guidelines and recommended level of physical activities. This can be achieved by designing and distributing easy-read leaflets, running educational sessions and publishing papers in journals/mass media. • Develop the current audit tool (LDPAQ) in collaboration with our physio/OT colleagues to elaborate further on different vigorous activities in people with severe learning and physical disabilities. • Undertake further studies and surveys to explore the impact of different factors such as level of learning disabilities, mental and/or physical co-morbidities and presence or absence of capacity on preferred life style and level of physical activities. • Explore the possibility of using technology to measure the intensity of physical activities in a more objective way such as recoding the heart rate. • Seek advice and recommendation from a specialist about the recommended physical activity plan for complex individuals with mental and physical health co-morbidities.

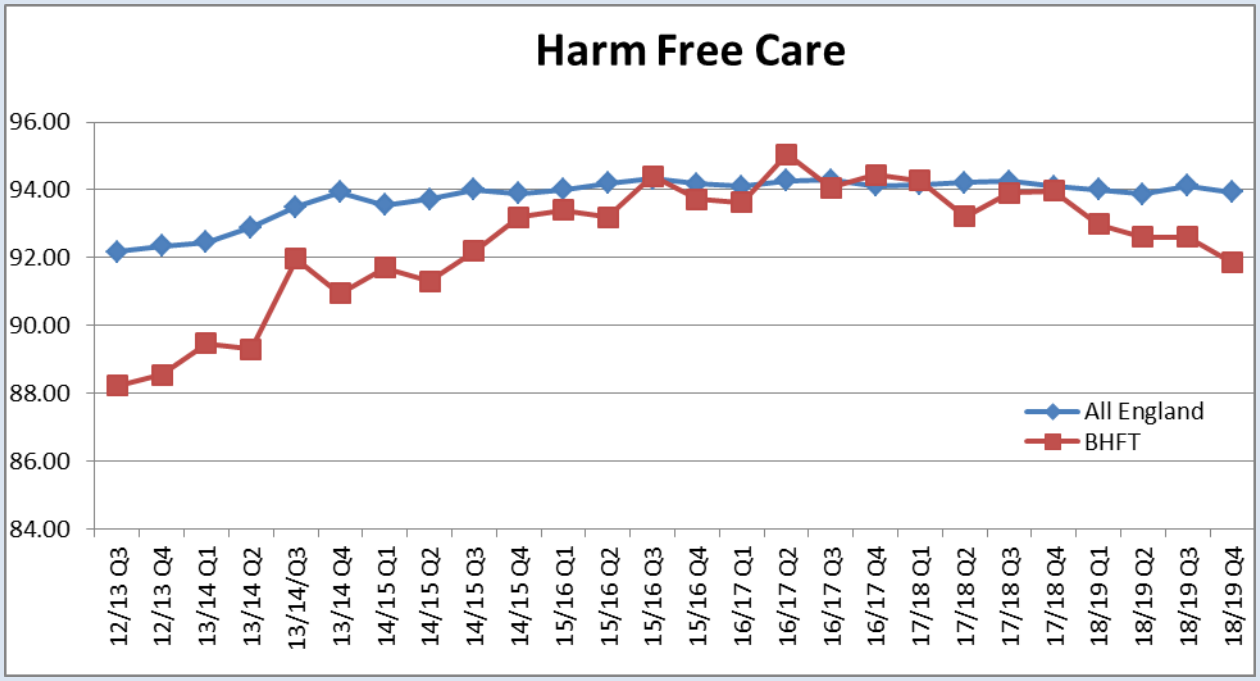
	Audit Title	Conclusion/Actions
44	Audit of use of Dementia Intervention Care Pathway in Learning Disability Services (ID 4471): January 2019	The aim of the project was to ascertain whether the Dementia Intervention Care Pathway tool or the information provided by this tool, has been used by health professionals to support PWLD who have a diagnosis of dementia. An action plan is in place and includes the following recommendations: 1. Audit findings to be fed back to the six community health teams/localities for PWLD within Berkshire. 2. The Intervention Care Pathway is to be more widely publicised within the service. 3. Health teams are to be supported to develop their Dementia Planning Meetings. 4. Liaison with the End of Life Care Pathway regarding resources and appropriate tools that may be available for use when considering Future Planning when someone has a diagnosis of dementia.
45	Waiting Time Standards for CBT Treatment in Berkshire Perinatal Community Mental Health Service (ID 4483): November 2018	This audit aimed to examine the compliance of the current service provided against Pathway 4 of the perinatal EBTP, i.e. the waiting time of women with a perinatal mental health problem who are referred for psychological interventions to our team and whether they start treatment within six weeks of referral. An action plan will be devised. Recommendations include: • To repeat this audit in 12 months' time to include a longer data collection period to identify if the results are replicated. The next audit should seek to identify reasons why clients may not be offered CBT treatment within the recommended 6 week window i.e. client not ready to engage. • To further identify reasons for clinician and client cancellation across both West and East Berkshire. To identify if this is a system or administrative error that can be resolved. • To continue to explore recovery rates through psychological tools and patient feedback. To have a larger, complete data set.
46	UNICEF Baby Friendly Initiative Annual Audit 2018 - Health Visiting Services (4531): September 2018	The UNICEF Baby Friendly Initiative aims to provide women and their families with evidence based, sound knowledge and advice to support them with their feeding choices for their baby and to promote a close and loving relationship with their child. To maintain its level 3 accreditation, the Trust has to submit annual audit figures based on staff knowledge and mothers feedback for both breastfeeding and bottle-feeding mothers to ensure that the four standards set by the Baby Friendly Initiative have been embedded into practice. To explore other ways of contact with mothers to address the issue of informing them about continued breastfeeding once they have returned to work. This could be via text messages or use of email, the inclusion of relevant information in the 'Introduction to family foods' session and the documenting of visit conversations in the Personal Child Health Record.
47	Clinical Audit of Electro-Convulsive Therapy (ECT) Outcomes: Using the Clinical Global Impression (CGI) and Hamilton Depression Scale (HAM-D) to evaluate ECT treatment (ID 4692): January 2019	Electro-convulsive therapy (ECT) is one way of treating depression, mania, schizophrenia and catatonia (NICE Guidelines, 2009). It is recommended to achieve rapid and short-term improvement of severe symptoms after inadequate trial of other treatment options has proven to be ineffective and/or the mental illness is considered to be potentially life threatening. The purpose of this project was to evaluate the ECT service provided by Prospect Park Hospital by studying who receives ECT treatment and looking at the ECT response rate. An action plan is being finalised. Recommendations: • Future audits may consider broadening the standard to include more stringent criteria for standards of patients who receive ECT treatment. • A separate audit to address the issue of increasing numbers of people having ECT and the poor post-ECT Efficacy Index rate. This could look at the quality of referrals for ECT and the appropriateness of those who receive treatment.
48	Audit of PGD use by Peer Vaccinators for the 2018 staff influenza vaccination campaign (ID: 4731): February 2019	The purpose of this audit was to examine the use of the influenza vaccination PGD (Patient Group Direction) used by peer vaccinators to administer the vaccine to Berkshire Healthcare staff and partner organisations staff working alongside Berkshire Healthcare staff, as part of the annual flu vaccination campaign. An action plan has been devised: 1. Update of PGD, including staff that are over 65 and the new egg free vaccine that will be available in 2019. 2. Quality issues identified with standards: 6, 8, 11, 13, 14 & 15 to be clarified and re-enforced at update training, prior to commencing the 2019 flu vaccination campaign. 3. Consent forms to continue to be returned to Peer Vaccinators for signing if returned unsigned. 4. Only the most up to date consent forms to be used, this will require re-iteration at training.

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.

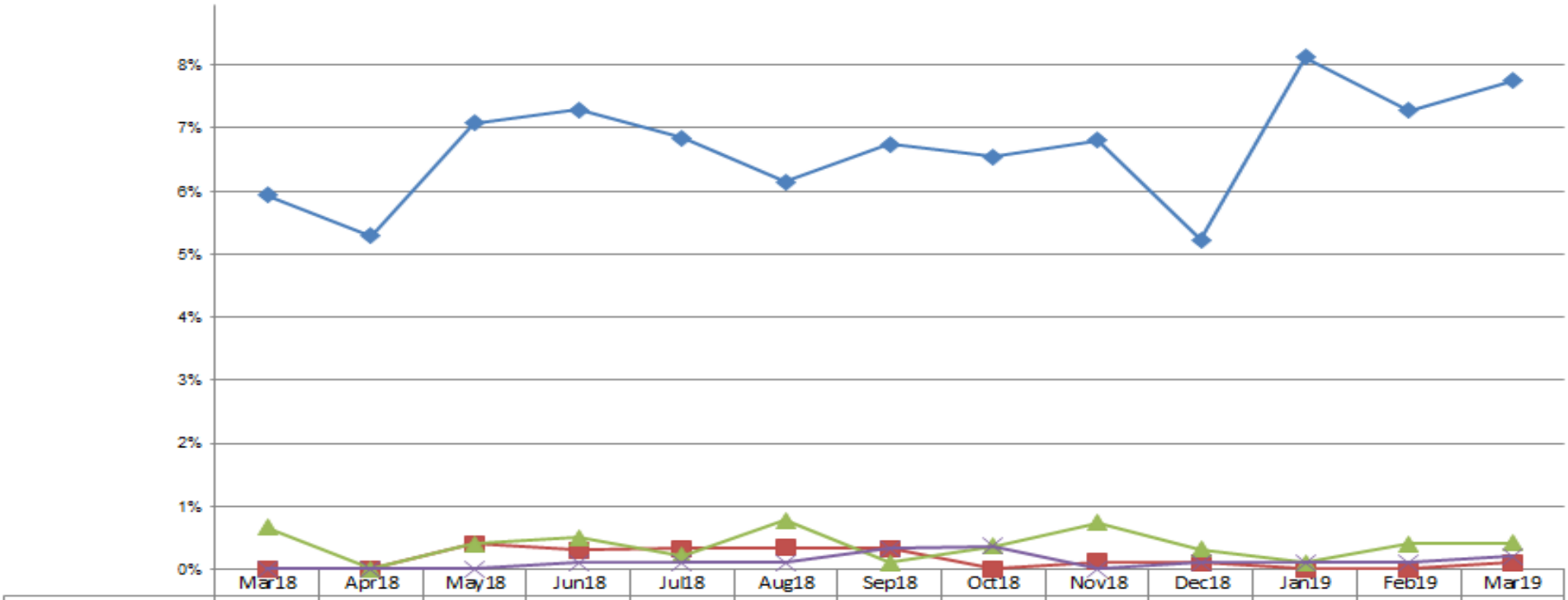
The percentage of Harm Free patients for all England in Q4 was 93.93%. The Harm Free care in Q4 for Berkshire Healthcare has dropped slightly to 91.86%. Old pressure ulcers and catheter with old UTIs, are harms which we must own despite being inherited to the Trust and therefore largely beyond our influence. In Q4 of 2018/19 these old harms made up 78.39% of our total harms.



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.



	Mar18	Apr18	May18	Jun18	Jul18	Aug18	Sep18	Oct18	Nov18	Dec18	Jan19	Feb19	Mar19
Pressure Ulcers	5.94	5.29	7.08	7.29	6.84	6.15	6.75	6.55	6.81	5.23	8.13	7.28	7.75
Falls	0	0	0.4	0.3	0.33	0.34	0.33	0	0.12	0.1	0	0	0.11
Catheter & UTI	0.66	0	0.4	0.5	0.22	0.78	0.11	0.36	0.74	0.31	0.11	0.4	0.42
New VTE	0	0	0	0.1	0.11	0.11	0.33	0.36	0	0.1	0.11	0.1	0.21
Patients	1060	1002	989	1001	921	895	904	840	808	975	935	1003	942

Source- Safety Thermometer
UTI= Urinary Tract Infection VTE = venous thromboembolism

Appendix E CQUIN 2018/19

Please note that that this is part of a 2 year contract that started in 2017/18.

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 4	Improving services for people with mental health needs who present to A&E
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 F- CQUIN 2019-2020

Please note that at the time of writing specific milestones and values have yet to be agreed

CQUIN Indicator Name
Staff Flu Vaccinations – All Staff
Alcohol and Tobacco – Mental Health Services and Community Health Services
72 Hours follow up following Discharge – Mental Health Services
Use of Anxiety Disorder Specific Measurements in IAPT
CCG5 MHSDS Data Quality

Appendix G- Statements from Stakeholders

Berkshire Healthcare NHS Foundation Trust – Quality Account 2018/19
Response from 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 2019. This summary is prepared by the Lead Governor, Paul Myerscough.

This report provides a good account of the Trust. The information is 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.

Governors are interested in trends which show year on year improvement in Trust performance. Whole year figures were not available at the time of the review. We were pleased however to see the many improvement initiatives described in section 2.1 and look forwards to seeing the evidence that new processes are effective as planned and the benefit is being felt at the frontline.

Governors continue to be concerned about the well-being of staff and the level of vacancies in some parts of the service. We are pleased that management efforts are producing results in many areas and we look forward to seeing the results from the latest staff survey which was not available at review time.

We are happy that management keeps governors up-to-date on the rare occasions when service quality concerns are raised. Governors are free to question the executive in Governor Council meetings some of which are also open to the public.

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 focused on areas of particular concern to patients and staff, where it could lead to a measurable improvement in the services delivered.

All governors were given the opportunity to comment. There were a number of requests for clarification of figures. Some concerns were expressed on understanding the significance of the statistics when throughput figures (number of patients seen in a service) are generally not available. All feedback is passed on to the team responsible for the report.

We recognise the dichotomy between a desired culture of reporting faults and problems and consequential learning and a 'blame and shame' culture which leads to suppression of information. We feel that Berkshire Healthcare have promoted a learning culture through encouraging staff to record incidents and problems in the 'Datix' system which provides useful input to Quality Improvement initiatives throughout the Trust.

Healthcare from the heart of your community
Berkshire Healthcare NHS
NHS Foundation Trust

Berkshire Healthcare NHS Foundation Trust Response:

The Trust welcomes this response from the Council of Governors to its 2018/19 Quality Account.

We thank Governors for the comments made in relation to the content of the report and are pleased that it is both clear and of interest. We also wish to convey our thanks to those that have taken time to help contribute to the document throughout the year.

In relation to the Friends and Family Test (FFT), we are mandated to participate in this survey and endeavour to achieve a 15% response rate. We are also working to revise our patient experience measure and will ensure that the FFT is considered with this to avoid duplication for staff.

Responses to individual queries have been included in a separate document and sent to the Chair of the Council of Governors. We look forward to working with our Council of Governors in the future.

Commissioners Response – BHFT Quality Account 2018/19

This statement has been prepared on behalf of East Berkshire CCG and Berkshire West CCG.

The Clinical Commissioning Groups (CCGs) are providing a response to the Quality Account for Quarter 3 2018/19 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 2018/19 and gives an overview of the quality of care provided by the Trust during this period. The priorities for 2019/20 are also detailed in the report.
The CCGs are committed to working with the Trust to achieve further improvements and successes in the areas identified within this Quality Account.

The Trust's Quality Priorities highlighted in the 2018/19 Quality Account were Care Quality Commission (CQC) Rating; Clinical Effectiveness; Patient Experience; Patient Safety and Organisational Culture.

Care Quality Commission (CQC) Rating

The CCGs were very pleased to receive the news that the Trust maintained an overall rating of Good at the CQC inspection in June and July 2018 with the report being published in October 2018. The CCGs wish to express their congratulations to the Trust for achieving a rating of Outstanding in the Well-Led domain.
There were examples of outstanding practice in the core service inspections for; Wards for older people with mental health problems; Acute wards for adults of working age and psychiatric intensive care units; Mental health crisis services and health based places of safety and wards for people with a learning disability or autism; Urgent care and community health services for adults.
It is also very positive to see that all of the services have now received a minimum rating of Good and no areas were identified as Requiring Improvement.

Clinical Effectiveness

It is reassuring to see that the Trust has participated in all applicable national clinical audits and that improvements have been implemented from the action plans that were identified.
The CCGs are also satisfied that the Trust review NICE guidance and provide the standard of care that is line with the national standard.

Patient Experience

The Trust continues to encourage patient and carer feedback either through the Friends and Family Test, Carers Friends and Family Test and the Trust's patient satisfaction survey. Whilst the response rate is lower than both the CCGs and the Trust would like to see, there are positive results for Community Health Services with regards to the recommended rate from patients and from carers. This remains above the 95% target. The CCGs acknowledge that there is further work to be completed within the Mental Health Services to improve this.
It is disappointing to see that the Trust did not achieve the 90% reduction in the use of prone restraint but recognise the hard work that the Trust has already done and acknowledge the work that will need to be implemented in order to achieve a reduction in 2019/20. Though this is not identified in the 2019/20 priorities the CCGs will continue to monitor progress. However from the Quality Account, the CCGs can see that there are occasions when prone restraint is used because this is the choice of the patient and that other patients have been turned very quickly when it has been necessary to restrain them prone. The CCGs would like to see the instances of prone restraint used on the dementia older adult ward are as a result of necessity rather than a lack of staff training.
The Trust did not achieve the target of reducing mental health delayed transfer of care by over 2%. The commissioners can see the effort that has been put in by the staff to bring this down and can see that the Trust are not far from being able to achieve this going forward.

Patient Safety

It is very promising to see the reduction in the self-harm incidents that are being reported by the Trust and should be commended on the work that has taken place in order to achieve this.

The CCGs would like to commend BHFT on continuing to stay below the rate of 8 falls per 1000 bed days on their Community Hospital inpatient wards and although the rate has not been achieved for those patients on the older people's mental health wards, there has been a significant reduction in the rate when compared with Q1 and Q2.
A key target to reduce is the inappropriate out of area acute mental health placements and the CCGs are reassured that the Trust has met the target for the year meaning that fewer patients are being treated away from home and reducing the amount of bed days spent away from home.
The CCGs would like to acknowledge the dedication from the staff that has been involved in all of the Quality Improvement (QI) projects and whilst we recognise that further work is required to complete the objectives set out in the 2018/19 Quality Account, the QI projects have had a very powerful impact on many other areas across the Trust.

Organisational Culture
The CCGs look forward to seeing the result of the National Staff Survey, expected in Q4.
The commissioners were very pleased to see the Trust has successfully achieved the target of having less than 10% of vacancies and have been maintaining around 9% each month throughout 2018/19. The work that is being implemented is very encouraging to see and hope that the vacancy rate continues to improve.
The Trust did not meet the target for reducing the number of physical assaults against staff. The CCGs can see the work that is being done in order to ensure that this target can be reached but recognise that this is can be a very challenging target to achieve.

The Quality Account does highlight a number of other service improvements that have been undertaken in 2018/19 and that this will be continued in 2019/20.

Priorities for 2019/20
The Trust has set out the priorities for 2019/20 which are as follows:

- Patient Safety
- Clinical Effectiveness
- Patient Experience
- Organisational Culture
- Monitoring of Priorities for Improvement

The Commissioners would like to continue to be informed of any new quality concerns being identified during 2019/20 for the opportunity to support the Trust with these. The Commissioners would like to continue to work with the Trust on service redesign to improve patient outcomes.

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 2018/19 Quality Account, prepared on behalf of East Berkshire and Berkshire West CCGs

The Trust welcomes the CCGs support of its 2019/20 priorities and is grateful for the comments made in relation to our achievement in 2018/19.

In relation to use of prone restraint on older adult mental health wards, staff on these wards have been trained in new techniques but are using them less frequently as these wards generally have fewer restraints as a whole meaning they have less opportunity to practice them. A plan is in place to address this.

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.

16 April 2019

West Berkshire COUNCIL

Jason Hibbitt
Clinical Effectiveness Facilitator- NICE
Clinical Audit Department,
Berkshire Healthcare NHS Foundation Trust

Adult Social Care (Communities)
West Berkshire Council
West Street House, West Street,
Newbury, Berkshire RG14 1BZ

Please ask for: Tandra Forster
Direct Line: (01635) 519736
e-mail:
tandra.forster@westberks.gov.uk

Dear Jason,

Berkshire Healthcare Foundation Trust Quality Account : West Berkshire Health and Wellbeing Board Response

Thank you for sharing the Quality Account with the West Berkshire Health Wellbeing Board and inviting comment. The Board acknowledge the broad range of priority indicators and welcome particularly the patient focus, with a clear commitment to improve service quality and safety for patients across Berkshire. Whilst the performance reporting relates to quarter 3 it is notable that the targets for a number of areas have already been met which is an indication of strong performance. However, there are number of areas where we would welcome reassurance:

- Patient safety – it is disappointing that the target to reduce falls for patients on the Older Peoples Mental wards has not been met. Whilst we appreciate that these patients will have more complex needs we would urge you to do everything possible to address this.
- Mental Health Delayed Transfers of Care – again we recognise the complexity of working with mental health patients, particularly the challenge to find appropriate ongoing support where it is required. However, we also feel that there is more that could be done to start planning discharge at an earlier point and would welcome closer working to enable this.
- Friends and Family Test – whilst the overall feedback was very positive it is notable that this is not the case for mental health in-patients and that the position has worsened compared to 2017/18. The Board feels that this needs closer attention and engagement with families so that it is clearer what actions are required to address it.

We support the priorities for 19/20 and note in particular your commitment to working with partners across the system. We feel that there are many opportunities to continue this and in particular would welcome greater progress on joint working around recruitment and retention given our shared challenge.

Yours sincerely

Tandra Forster

Tandra Forster
Acting Corporate Director (Adult Social Care)

Berkshire Healthcare NHS Foundation Trust Response:
The Trust welcomes this response from West Berkshire Health and Wellbeing Board to its 2018/19 Quality Account.

The Trust welcomes the Wellbeing Board's support of its 2019/20 priorities and is grateful for the comments made in relation to our patient focus and commitment to improve quality and safety.

In relation to falls, the Trust acknowledges that we have not met our target in relation to our older peoples' Mental Health Inpatient wards. As a result, the reduction of falls will again be a priority for us during 2019/20.

In relation to delayed transfers of care, a Post Admission Review (PAR) is now in place and embedded which takes place within 72 hours (wherever possible) and produces an intended discharge date (IDD). This is monitored at the daily bed management team so that plans are checked and any concerns escalated. The trust will continue to monitor this area.

In relation to the Friends and Family Test, the Trust acknowledges the lower satisfaction rate achieved for mental health inpatients. The satisfaction level reported for this group has historically been lower than for other groups, and is also based on smaller numbers of respondents. The trust is committed to ensuring its patients have the best possible experience of the care we provide and will strive to improve this satisfaction rating where possible.

We look forward to continuing to work with you to achieve system-wide improvements and successes during the following year.

Appendix H

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

We have been engaged by the council of governors of Berkshire Healthcare NHS Foundation Trust to perform an independent assurance engagement in respect of Berkshire Healthcare NHS Foundation Trust's quality report for the year ended 31 March 2019 (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 2019, 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 2019 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

- Early intervention in psychosis, and
- 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 2018/19 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 2018 to the date of signing of the limited assurance opinion;
- papers relating to quality reported to the board over the period April 2018 to the date of signing of the limited assurance opinion;
- feedback from Commissioners, dated April 2019;
- feedback from governors, dated April 2019;
- feedback from local Healthwatch organisations, dated April 2019;
- feedback from Overview and Scrutiny Committee, dated April 2019;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated April 2019;
- the latest national patient survey, dated November 2018;
- the latest national staff survey, dated March 2019;

- Care Quality Commission inspection report, dated October 2018; and
- the Head of Internal Audit's annual opinion over the trust's control environment, dated May 2019.

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' and supporting guidance.

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 2019:

- 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 2018/19 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

Glossary of acronyms used in this report

Acronym	Full Name
ADHD	Attention Deficit/ Hyperactivity Disorder
AMS	Anti-Microbial Stewardship
AWOL	Absent Without Leave
BAME	Black Asian and Minority Ethnic
BHFT	Berkshire Healthcare NHS Foundation Trust
BMI	Body Mass Index
BOB STP	Buckinghamshire, Oxfordshire and Berkshire Strategic Transformation Partnership
CAMHS	Child and Adolescent Mental Health Service
CARRS	Community Cardiac and Respiratory Specialist Service
CCG	Clinical Commissioning Group
CCQI	College Centre for Quality Improvement
CD	Controlled Drug
CDS	Commissioning Data Set
CDiff	Clostridium Difficile
CHST	Care Home Support Team
CMHT	Community Mental Health Team
CNN	Community Nursery Nurse
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
CTPLD	Community Team for People with Learning Disabilities
CYPF	Children, Young People and Families
CYPIT	Children and Young People's Integrated Therapy Service
CYPMHS	Children and Young People's Mental Health Services
DBT	Dialectical Behavioural Therapy
DNACPR	Do Not Attempt Cardiopulmonary Resuscitation
DOC	Duty of Candour
DQMI	Data Quality Maturity Index
DTC	Drugs and Therapeutics Committee
ECG	Electrocardiogram
ECT	Electroconvulsive Therapy
ED	Emergency Department
EIP	Early Intervention in Psychosis
EIPN	Early Intervention in Psychosis Network
EPMA	Electronic Prescribing and Medicines Administration
EUPD	Emotionally Unstable Personality Disorder
FFFAP	Falls and Fragility Fractures Audit Programme
FFT	Friends and Family Test
FHNA	Family Health Needs Assessment
FTE	Full Time Equivalent

Acronym	Full Name
GDE	Global Digital Exemplar
HCA	Healthcare Assistant
HQIP	Healthcare Quality Improvement Partnership
HR	Human Resources
HV	Health Visitor
IAF	Information Assurance Framework
IAPT	Improving Access to Psychological Therapies
IBS	Irritable Bowel Syndrome
ICHS	Integrated Care Home Service
ICS	Integrated Care System
IDDSI	International Dysphagia Diet Standardisation Initiative
IM	Intramuscular
IMPACTT	Intensive Management of Personality Disorders and Clinical Therapies Team
IPCT	Infection Prevention and Control Committee
IPASS	Integrated Pain and Spinal Service
IPS	Individual Placement and support (Employment Service)
IST	Intensive Support Team
KF	Key Finding
LCLD	Low Calorie Liquid Diet
LCS	Lean Competency System
LD	Learning Disability
LeDeR	Learning Disability Mortality Review Programme
LIC	Lapse In Care
LoS	Length of Stay
LTC	Long Term Conditions
MBT	Mentalization-Based Treatment
MDT	Multi-Disciplinary Team
MDfT	Multi-Disciplinary Footcare Team
MDR	Multi-Disciplinary Round
MH	Mental Health
MHA	Mental Health Act
MHSDS	Mental Health Service Data Set
MIR	Making it Right
MIU	Minor Injuries Unit
MRSA	Methicillin-Resistant Staphylococcus Aureus
MSG	Medication Safety Group
MSK	Musculoskeletal
MTI	Medical Training Initiative
NACAD	National Asthma and COPD Audit Programme
NAS	National Audit of Schizophrenia
NCAP	National Clinical Audit of Psychosis
NCAPOP	National Clinical Audit and Patient Outcomes Programme
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NDA	National Diabetes Audit
NDFA	National Diabetes Footcare Audit

Acronym	Full Name
NEWS	National Early Warning Score
NHSI	NHS Improvement
NICE	The National Institute of Health and Care Excellence
NIHR	National Institute of Health Research
NPSA	National Patient Safety Alert
NRLS	National Reporting and Learning System
NSF LTNC	National Service Framework on Long Term Neurological Conditions
OAHSN	Oxford Academic Health Science Network
OAP	Out of Area Placement
OPMH	Older Peoples Mental Health
PAF	Performance Assurance Framework
PDSA	Plan, Do, Study, Act (A Quality Improvement methodology)
PGD	Practice Group Direction
PHM	Public Health Model
PICC	Peripherally Inserted Central Catheter
PICT	Psychologically Informed Consultation and Training
PICU	Psychiatric Intensive Care Unit
PID	Performance in Initiating and Delivering
PMLD	Profound and Multiple Learning Disability
PMS	Psychological Medicine Service
PMVA	Prevention Management of Violence and Aggression
PN	Partner Notification
POMH	Prescribing Observatory for Mental Health
PPH	Prospect Park Hospital
PSAG	Patient Status at a Glance
PTSD	Post-Traumatic Stress Disorder
QEG	Quality Executive Group
QI	Quality Improvement
QMIS	Quality Management and Improvement System
R&D	Research and Development
RBH	Royal Berkshire Hospital
RIE	Rapid Improvement Event
RiO	Not an acronym- the name of the Trust patient record system
RTT	Referral to Treatment Time
RQ	Rolling Quarters
RRAT	Rapid Response and Treatment Team
SHARON	Support Hope & Recovery Online Network
SI	Serious Incident
SJR	Structured Judgement Review
SLT	Speech and Language Therapy
SMART	Specific, Measurable, Achievable, Relevant, Time-Bound (in relation to objectives and actions)
SMI	Severe Mental Illness
SOP	Standard Operating Procedure
STP	Strategic Transformation Partnership
SUS	Secondary Users Service

Acronym	Full Name
TCBT	Transdiagnostic Cognitive Behavioural Therapy
TV111	Thames Valley 111 Clinical Advisory Service
UTI	Urinary Tract Infection
VFC	Virtual Fracture Clinic
VTE	Venous Thromboembolism
WAM	Windsor Ascot and Maidenhead
WBCH	West Berkshire Community Hospital
WPH	Wexham Park Hospital
WRES	Workforce Race Equality Standard