Berkshire Healthcare
NHS Foundation Trust

Quality Account 2019/20

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 Mental Health and Community Trust, providing a wide range of services to people of all ages living in Berkshire. 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 overall as 'Outstanding' by the Care Quality Commission.

We are also a digital pioneer, having been named by NHS England as a 'Global Digital Exemplar'. This allows us to transform patient care through use of technology.

We aim to deliver joined up physical and mental health services, helping people to remain independent at home for as long as possible and provide 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 regulates our financial stability and has placed us in segment 1, which reflects the highest level of performance for finance and use of resources

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Quality Account Positive Highlights and Overall Summary 2019/20

Care Quality Commission (CQC) Rating

The Trust is rated as 'Outstanding' overall. Our Community Physical Health services for adults and our End of Life service join our Learning Disability In-Patients and our Older Peoples Community Mental Health services in being rated as 'Outstanding'. All our services are now rated as either outstanding or good.

Patient Experience Priorities

- 95% or more of patients responding to the Friends and Family Test (FFT) stated that they were likely or extremely likely to recommend many of our services. 71% of respondents stated that they would recommend our mental health inpatient services.
- 95% of carers responding to the FFT stated that they were likely or extremely likely to recommend our services.
- The Trust continues working 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

1. We have met the following annual targets:
   - ≤4 medication errors resulting in moderate harm or above. Result: 1.
   - ≤18 grade 3 or 4 pressure ulcers due to a lapse in care by Trust staff. Result: 14.
   - ≤1 gram-negative bacteraemia per ward due to lapse in care by Trust staff. Current Result: 2 across all wards- each one on a different ward
   - The number of inappropriate Out of Area Mental Health placements.
2. We have continued implementing our Zero Suicide programme as well as embedding patient safety in clinical and support teams.

Clinical Effectiveness Priorities

- We have participated in all applicable national clinical audits, ensuring that appropriate actions are taken, and improvements made.
- We continue to have a robust system for reviewing NICE guidance to ensure that care is delivered in line with national best practice standards.
- We continue reviewing, reporting and learning from deaths in line with national guidance.

Supporting our Staff Priorities

We have reduced our staff vacancy rate to 5.9% and staff turnover rate to 14.7%. We continue promoting a compassionate culture with zero tolerance of aggression, bullying and exclusion.

2020/21 Trust Priorities

Harm-Free Care. To provide safe services by eliminating avoidable harm we will:

- Protect our patients and staff from getting COVID-19 by using appropriate infection control measures
- Ensure that we have safe levels of staffing to meet service demands
- Engage with all services over next six months to agree a plan to safely bring all services back to full operation
- Continue to reduce falls, pressure ulcers, self-harm in in-patient services and suicide across all our services
- Recognise and respond promptly to physical health deterioration on our in-patient wards
- Strengthen our safety culture to empower staff and patients to raise safety concerns without fear, and to facilitate learning from incidents

Clinical Effectiveness Priorities. We will demonstrate our delivery of evidence-based services by; reporting on implementing NICE guidance related to Trust priorities and continue learning from deaths in line with national guidance.

Patient Experience Priorities. To provide good outcomes from treatment and care we will:

- Use patient and carer feedback to drive improvements in our services, with specific engagement on proposed new ways of working
- Manage patient flow effectively, with minimum delays and make sure that patients stay within our services for no longer than is clinically appropriate
- Engage and communicate with patients and the public to make sure that they understand how to access the right help at the right time
- Support patients to manage any direct or indirect adverse impact of COVID-19

Supporting our Staff Priorities. To support our people and be a great place to work we will:

- Sustain and improve staff engagement
- Make sure all staff have the appropriate skills, training and support for their roles
- support staff to embed working remotely and to operate safely and effectively
- protect and sustain the health and wellbeing of our staff, reducing sickness absence
- increase numbers of staff feeling they can influence how we work and make decisions and those recommending the care and treatment of our services
- Improve staff recruitment, retention and satisfaction
- Have a zero tolerance to bullying and harassment and reduce violence and aggression towards our staff.

Figure 1- Summary of Trust achievement for the 2019/20 Quality Account

Indicator (Click on links to access the related main sections of the report)		2019/20 Target	Results 18/19	Results 19/20	Comment & Change from 18/19- 19/20
Patient Experience					
Patient Friends and Family Test- Response Rate		≥15%	15.2%	**10.6%**	**Target Not Met**
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	Community Services (Mental health and physical health combined).	≥95%	94%	**92%**	**Target Not Met**
	Mental Health Inpatients.	≥95%	71%	**71%**	**Target Not Met**
	Community Hospital Inpatients.	≥95%	96%	**96%**	**Target Met**
	Minor Injury Unit.	≥95%	98%	**97%**	**Target Met**
Carer Friends and Family Test (FFT) - % of carers likely or extremely likely to recommend the service to a friend or family member		No target set	96%	**95%**	**Change: -1%**
Staff report using service user feedback to make informed decisions in their department (National NHS Staff Survey)		≥60%	61%	**62.8%**	**Target Met**
Instances of prone restraint		≤2 per month	Not met	**3**	**Target Not met**
Delayed Transfers of Care		≤7.5%	9.0%	**6.8%**	**Target met**
National Community Mental Health Survey - Overall result out of 10		No target set	7.2	**7.3**	**Change: +0.1**
Patient Safety					
Self-harm incidents by Mental Health Inpatients by 30%		≤46 per month	N/A	**25**	**Target met**
Rate of inpatient falls on wards for older people	Older Peoples Mental Health Wards	≤4 falls per 1000 bed days	16.59	**10.57**	**Target Not Met**
	Community Health Wards		6.02	**5.34**	**Target Not Met**
Medication errors graded moderate and above		≤4 per year	N/A	**1**	**Target met**
Pressure ulcers (PU's) due to lapse in care by Trust staff	Number of Category 2 PUs due to lapse in care by Trust staff	≤19 per year	15	**30**	**Target Not Met**
	Number of Category 3&4 PUs due to lapse in care by Trust staff	≤18 per year	18	**14**	**Target met**
	Days between development of Category 3&4 PUs due to lapse in care by Trust staff	≥180 days between development	N/A	**Not met at end of Q4, but had been met earlier in the year**	
Gram negative bacteraemia due to lapse in care on community inpatient wards due to lapse in care by trust staff		≤1 per ward during year	N/A	**2 cases on different wards**	**Target Met**
Reported incidents that resulted in low or no harm to patients		≥95% per year	N/A	**89.7%***	**Target Not Met**
Urgent Admissions: Number of inappropriate out of area placements		As per NHSI (see main report)	Target Met	**Target Met**	**Target Met**
Clinical Effectiveness					
Compliance with recommendations contained in NICE Clinical Guidelines	Post-Traumatic Stress Disorder	≥80%	N/A	**88%**	**Target Met**
	Care and Support of People Growing Older with Learning Disabilities	≥80%	N/A	**96%**	**Target Met**
	Depression in Children and Young People	≥80%	N/A	**88%**	**Target Met**
Supporting our Staff					
Staff Engagement Score in the National Staff Survey		≥8 out of 10	7.3	**7.4**	**Target Not Met**
Staff report feeling they can make improvements at work (National NHS Staff Survey)		≥70%	64.5%	**65.7%**	**Target Not Met**
Staff agree or strongly agree they would recommend the Trust as a place to receive treatment (National NHS Staff Survey)		≥85%	73.6%	**74.4%**	**Target Not Met**
Staff vacancy level		<10%	8.6%	**5.9%**	**Target Met**
Staff turnover rate		<16%	N/A	**14.7%**	**Target Met**
Staff sickness level		<3.5%	N/A	**4.1%**	**Target Not Met**
Assaults on staff on Mental Health inpatient wards		≤44 per month	N/A	**57**	**Target Not Met**

* Please note that the incident data represents incidents between 1st April 2019 and 29th February 2020. Publication of data has been temporarily ceased at national level due to operational pressures

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 throughout 2019/20. This supports our vision to be recognised as the leading community and mental health provider by our patients, staff and partners.

The Trust is now rated as Outstanding by the Care Quality Commission, all our services are individually rated as either outstanding or good and I take great pride in congratulating our staff for this.

We are committed to the principles of system working and continue to be actively involved with our health and social care partners across Berkshire, including the third sector, to implement sustainable population-based solutions for meeting the physical and mental health needs of our patients and service users. We have also seen some expansion of our services outside of the Berkshire county borders, recognising the expertise of our teams in these areas.

It is essential that patients have a positive experience of our services and we continue to utilise Trust-wide systems to measure and learn from this experience. We prioritise learning from patient experience surveys, complaints and compliments and aim to continuously improve on and learn from this important 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. Robust governance, patient safety, incident and mortality reporting systems are maintained throughout the Trust, with these processes used to highlight areas for improvement in a timely manner allowing for learning. We have focused on improving safety in several areas this year, including self-harm and medication errors, and we will continue striving to improve in these areas.

Our clinical effectiveness systems help 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.

We are also a research-active organisation. 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.

This report details the breadth of improvement work that has been undertaken by Trust services throughout the year. Our staff have shown a commitment to improve their services and our Quality Improvement (QI) programme continues with more staff being trained in its methodology each year.

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

9th July 2020

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

2.1. Achievement of Priorities for Improvement for 2019/20

ⓘ This section details the Trust's achievements against its quality account priorities for 2019/20. These priorities were identified, agreed and published as part of the Trust's 2018/19 quality account.

These quality account priorities support the goals detailed in the Trust's 2019/20 True North Annual Plan (see Appendix A). The Trust's Quality 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.**

Although the areas of efficiency and equity do not have their own sub sections in this report, please note that they are covered in other sections of the report where it is relevant to do so.

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 2019/20.

Our 2019/20 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.

Trust performance in relation to complaints, compliments and the 2019 National Community Mental Health Survey is also detailed in this 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.

Please note that the Friends and Family Test was suspended nationally in Quarter 4 of 2019/20 due to the COVID-19 pandemic. Data presented here is accurate to the point of this suspension.

Response Rate - Target 15%

The Trust aims to achieve a response rate of at least 15%. Figure 2 below demonstrates the response rate for 2019/20 and shows that a rate of 10.6% was achieved during the year which is below target. The response rate has been impacted by the increase in the discharge data provided to the Patient Experience Team. We are now more assured on the accuracy of the data and this continues to be monitored on a monthly basis with a root cause and planning document being taken to the Trust Finance, Performance and Risk Committee meeting.

Satisfaction Rate - Target 95%

One of the Trust's targets for 2019/20 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 that they were extremely likely or likely to recommend services. The figures show that the 95% threshold has been achieved for community hospital inpatients and minor injuries services. Community services missed the target by 3%. Mental health inpatients scored 71% which is below the 95% threshold and equal to their 2018/19 annual figure.

Figure 2- Response Rate for Patient FFT - Target 15%

2019/20 Quarter	Q1	Q2	Q3	Q4	2019/20 Full Year
% Response Rate	12.2%	10.9%	10.7%	9.3%	10.6%

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 - Target 95%

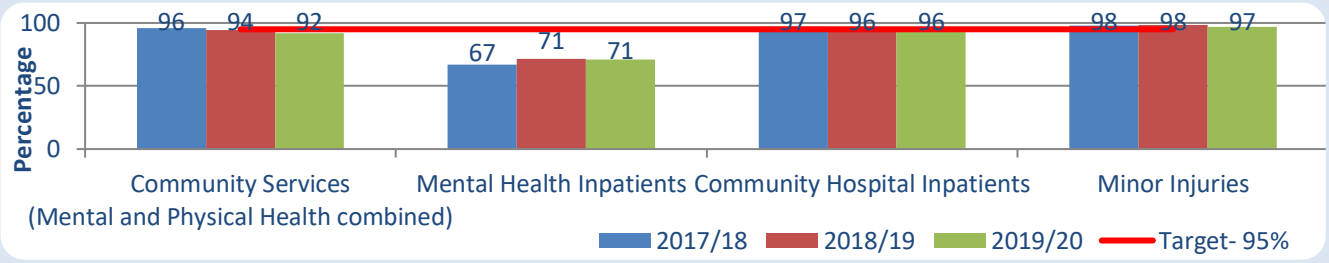


Figure 4- Patient Friends and Family Test- total number of responses

Survey and Service	2018/19 Total no. of respondents	2018/19 Respondents likely or extremely likely to recommend service No.	2018/19 Respondents likely or extremely likely to recommend service %	2019/20 Total no. of respondents	2019/20 Respondents likely or extremely likely to recommend service No.	2019/20 Respondents likely or extremely likely to recommend service %
Community Services- Mental Health & Physical Health Combined	30078	28321	94	44515	40828	92
Mental Health Inpatients	480	343	71	920	654	71
Community Hospital Inpatients	930	894	96	621	594	96
Minor Injuries Unit	2245	2209	98	715	694	97

Source for figures: Trust Patient Experience Reports. Please note that the 2017/18 figure for minor injuries also includes 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 that they were extremely likely or likely to recommend Trust services.

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

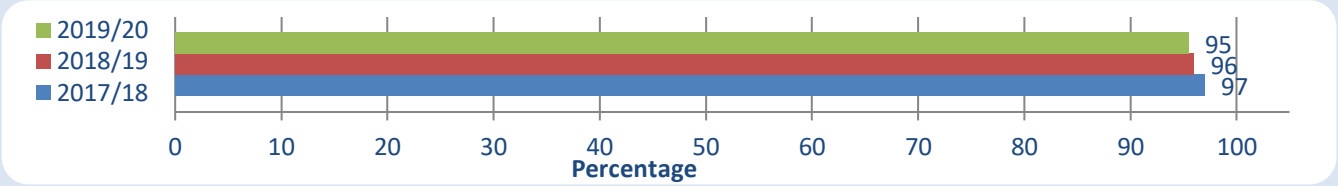


Figure 6- Carer Friends and Family Test- total number of responses

Survey and Service	2018/19			2019/20		
	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	849	815	96	1473	1404	95

Source for both figures: 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 performance in relation to this survey by showing the proportion of respondents that would rate services as good or very good.

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

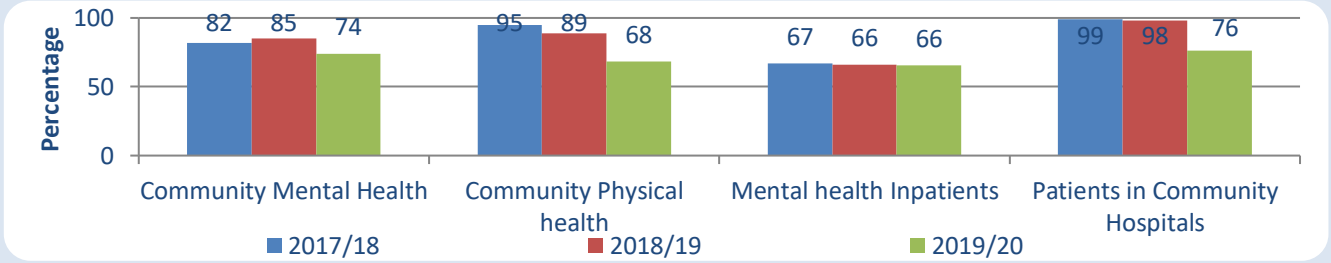


Figure 8- Trust Patient Survey- total number of responses

Survey and Service	2018/19			2019/20		
	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 MH	3197	2722	85	3321	2454	74
Community Phys H	7896	7062	89	11292	7725	68
MH Inpatients	417	274	66	937	615	66
Pts in Comm. Hosp.	53	52	98	1745	1330	76

Source for both figures: Trust Patient Experience Reports

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

ⓘ One of the Trust's targets for 2019/20 is that 60% of staff will report that they use service user feedback to make informed decisions about their department.

Performance against this target is measured with reference to Q22c in the 2019 National NHS Staff Survey, which asks whether ""Feedback from patients/service users is used to make informed decisions within my directorate/department".

From the results of the 2019 staff survey it is evident that 62.8% of our respondents agreed or strongly agreed with this statement. This finding is above the average result for other comparable trusts (55.5%) and above the Trust's 2018/19 result of 61%.

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 monthly number of complaints and compliments received by the Trust. A total of 231 complaints were received during 2019/20 compared with 230 in 2018/19.

During Quarter four 2019-20 there were 59 complaints received (including re-opened complaints), this is an increase compared to 2018-19 where there were 50 for the same period.

36 (61%) of these 59 complaints related to adult mental health service provision. Of these complaints:

- 13 related to Community Mental Health Teams (CMHT), with varied reasons for these.
- 6 related to mental health inpatient wards
- 6 related to the Crisis Resolution/ Home Treatment Team (CRHTT)

13 (22%) of the 59 complaints related to adult community health services. Of these complaints:

- 4 were received by adult physiotherapy services
- 4 related to community nursing services
- 3 related to community hospital inpatients

4 (7%) of the 59 complaints were about Child and Adolescent Mental Health Services (CAMHS), and 3 (5%) were about children's physical health services.

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

100% of complaints were acknowledged within three working days during Q4 of 2019/20, with 100% 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.

Examples of learning and changes made throughout the year as a result of feedback are detailed below:

Mental Health Inpatients:

- Better recording of patient property as a lack of documentation has resulted in the Trust needing to replace items.
- It is important to have a consistent approach to the clinical risk assessment of informal inpatients requesting leave from the ward

Mental Health Services East Division:

- When patients request a correction or amendment to clinical correspondence or records the change should be made as quickly as possible and confirmation sent to the patient.
- A timely and clear explanation should be provided to patients for discharge or when a treatment/service they have requested is not considered clinically appropriate. Patients' understanding of the rationale provided should be checked.
- It is important to keep patients informed regarding waiting times for assessment/ treatment/ decisions regarding their care.
- Clinicians should be careful about the language and tone of text messages sent to patients and make it clear that they will only be able to respond to patients' texts during working hours. Patients should be advised not to use texts for urgent communications.

Out of Hours GP (WestCall):

- Communication in the Urgent Care Medicines Bulletin reminding GPs of the correct mixing when reconstituting suspensions.

Children, Young People and Families Division:

- A reminder has been given to staff that they should provide clear context when communicating with patients/parents, as if patient/parent are not party to knowledge they cannot always deduce the correct context for their understanding/assessment to what is actually intended/meant.
- Ongoing work is happening to review processes, utilise technology, increase capacity and to work with commissioners as well as providing information, advice and review of risk regarding young people on waiting lists.
- Staff have been reminded that young people and their families should be asked about an observation happening prior to entering the clinic room and that they should be reassured that there choice will not impact on their treatment.

Community inpatient wards

- Introduce cognition reassessment prior to discharge
- MDT discharge checklist to be implemented
- Information Board for relatives now displays a poster re how the multi-disciplinary team makes decisions with regards length of stay
- Be aware of special days and plan with family
- Improve communication with relatives through Discharge coordinator & ward manage

Figure 9- ***Complaints received*** **(excluding re-opened complaints)**

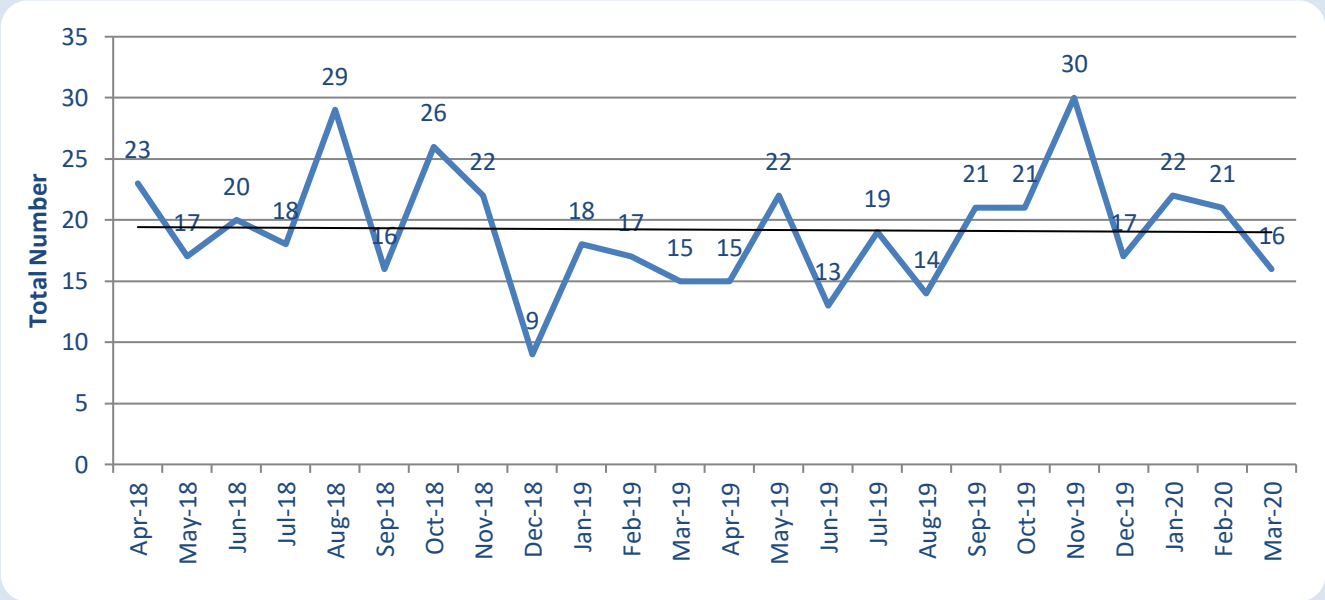
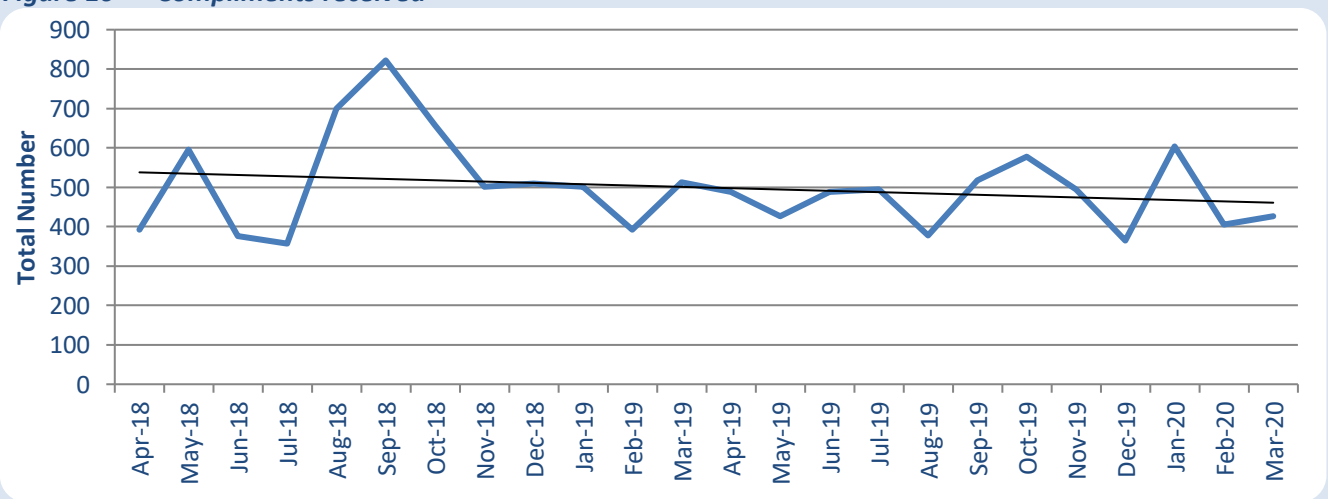


Figure 10- ***Compliments received***



Sources: Trust Complaints and Compliments Reports- this is based on compliments being submitted voluntarily by service

Understanding and Supporting Outcomes of Care that are Important to Patients

ⓘ One of the Trust's priorities for 2019/20 is to ensure that all services focus on understanding and supporting outcomes of care that are important to patients

Performance against this target is measured with reference to Q22c in the 2019 National NHS Staff Survey, which asks whether ""Feedback from patients/service users is used to make informed decisions within my directorate/department".

From the results of the 2019 staff survey it is evident that 62.8% of our respondents agreed or strongly agreed with this statement. This finding is above the average result for other comparable Trusts (55.5%) and above the Trust's 2018/19 result of 61%.

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 2019/20 is to reduce the use of prone restraint to no more than 2 per month during the year.

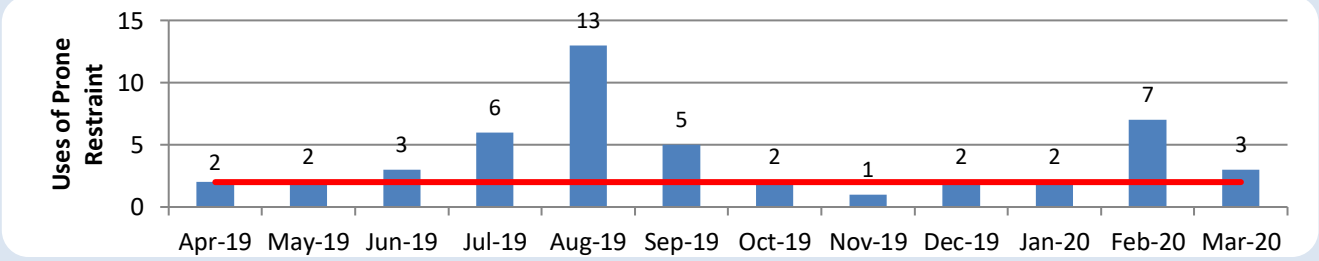
The monthly number of cases of prone restraint in Trust mental health care is detailed in Figure 11 below and shows that the target has been met in six of the months in 2019/20. The seven instances of prone restraint in December 2020 were for varying reasons including one undertaken by the police whilst bringing a patient into hospital.

Quality Improvement work continues on adult mental health inpatient wards. The service expects there to be peaks in data and these restraints are monitored on a monthly and weekly basis. The highest contributor to the need for a prone restraint is when giving Intramuscular (IM) medication to a patient. Staffing levels may also impact on this due to supine restraint requiring an extra member of staff.

The Clinical Director for adult mental health inpatients is working with the PMVA team to ensure that clear messages are given regarding the position to use when giving IM in supine restraint. The Clinical Director is also linking this with rapid tranquilisation training.

The use of prone restraint on Trust adult mental health inpatient wards has reduced by 61% during the last 18 months (exceeding their target of a 50% reduction). This service is now benchmarked below the mean line for prone restraint in national benchmarking data, having been above the mean line for this previously.

Figure 11- Monthly uses of prone restraint in Trust mental health services. Target- No more than 2 per month.



Source- Trust Tableau Dashboard

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 Integrated Care Systems (ICS):
Buckinghamshire, Oxfordshire and Berkshire West (BOB) Integrated Care System that covers a population of 1.8 million people, stretching from Banbury in the North to Wokingham/Riseley in the South, and from Hungerford in the West to Amersham in the East. As part of the BOB ICS Berkshire West is a key partner in the Berkshire West Integrated Care Partnership (ICP) covering a population of approximately 528,000 residents in Reading, West Berkshire and Wokingham. Berkshire West CCG and The Royal Berkshire NHS Foundation Trust are also part of this ICP, which is now aiming to align its work with the "Berkshire West 10 Integration Partnership", including Local Authority partners.

Frimley Health and Care ICS covers a population of approximately 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.

Berkshire West ICP

Project Prioritisation. The ICP Delivery Group took part in a quality improvement style workshop in August and September 2019 using a strategic filter process to identify the key projects for the ICP work programme. As part of this, all Programme Boards completed a key facts document for all their projects which then were presented to the Delivery Group for categorisation into mission critical, important, wait or needs more information. Projects that were prioritised as "mission critical" form the core ICP work programme with any resource requirements for these projects flagged for support. A further prioritisation workshop was held in February 2020 to test the 'long list' of projects and narrow the field of work, focusing on the projects that will have the most impact. This will be considered by the ICP Unified Executive in February 2020. Further work will continue. The ICP has a standardised approach to the development and governance of projects/programmes to ensure there is enough control over their identification and authorisation, thus increasing the likelihood of successful project delivery. The ICPs Digital Vision will be a key enabler for high-quality delivery of services.

The Trust has participated in several ICP work-streams to improve patient experience and outcome including: Urgent and Emergency Care (UEC) Strategy, Mental Health Crisis Care, Anticipatory Care Planning in Multi-disciplinary teams, Joint Health & Wellbeing Strategy, Community Reablement, Mental Health Act Section 117 Aftercare and Care Homes. Separately, there are also several work-streams that are redesigning pathways including respiratory, diabetes, CVD, dermatology and Musculoskeletal (MSK).

Frimley Health and Care ICS

Berkshire East has several work-streams improving patient care. Examples include the following:

Improving Diabetes Services. The Diabetes Structured Education Courses for East Berkshire have increased in number in 2019/20 and continue to be run during the day, evenings and at weekends. An online course is also available. An evaluation of people attending these education courses indicates that they have an average reduction in HbA1c of 9mmol/mol, with the largest reduction of 60mmol/mol. There was also an average reduction in weight of 6kg, with the largest weight reduction of 20kg. To improve the uptake of the education further we have proposed to the Primary Care Networks that more sessions are delivered in GP practices. The Diabetes Inpatient Specialist Nurse Team has increased from 1.6 to 4.8 whole time equivalent staff and is now running a 7-day service, with most patients seen within 5 hours of being referred. The service also provides regular diabetes education to ward staff.

Integrated Care Decision Making (ICDM). The ICDM approach enables teams from the health, social care and voluntary sectors to work together with much more flexibility, focused on a person's needs and not on organisational boundaries or responsibilities. By working together, services can best meet the needs of the local population and help them to remain in their

own homes for as long as possible. The model reduces duplication and effort across system partners and ensures patients get a coordinated, holistic response to meet their identified needs. There are five components within the model:

- An Anticipatory Care Planning approach (to support early identification of people with complex needs and allow the introduction of personalised and proactive Care and Support plans)
- Local Access points (between health and social care to jointly triage and assess people)
- Co-located community teams with primary and social care partners
- Multi-Disciplinary Team (MDT) / Clusters (to manage complex patients and reduce points of crisis)
- Hospital In-reach approach to proactively sign post people back into community services

The Trust is also the system leader on the Start Well Ambition included in the Frimley ICS five-year plan.

Reducing Mental Health Delayed Transfers of Care

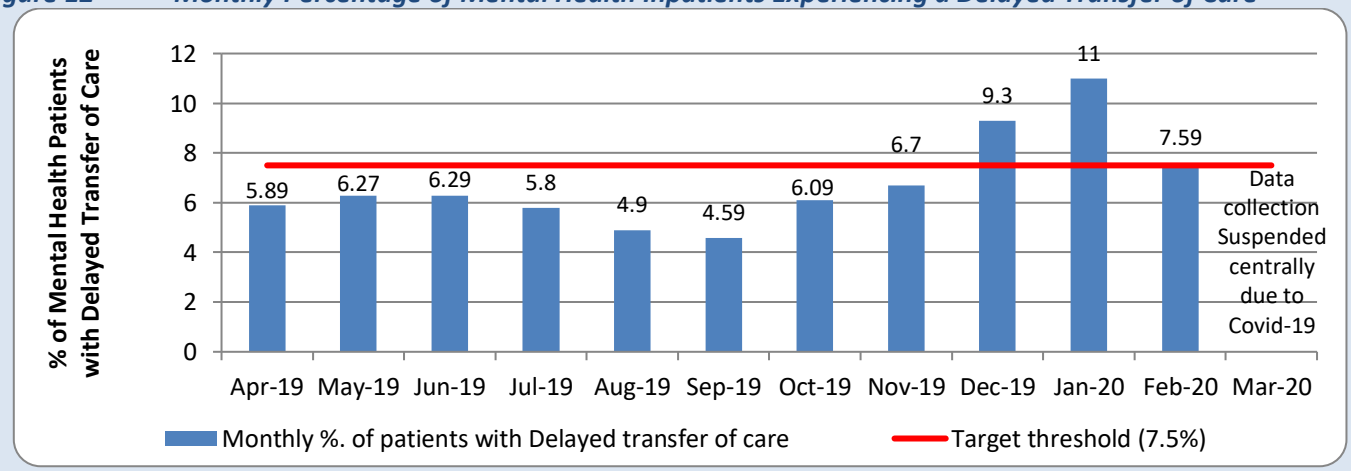
ⓘ A mental health delayed transfer of care occurs when a patient is ready for discharge and is still occupying a bed.

One of the Trust priorities for 2019/20 is to reduce the number of mental health delayed transfers of care against a target threshold of no more than 7.5%. 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 is had 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 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 for 2019/20. During Quarter 3, the mental health inpatient wards managed a few patients with a personality disorder diagnosis waiting to move to specialist placements and this increased their stay on the wards. In addition, some patients staying on Trust older adult mental health wards required discharge to specialist dementia care homes, of which there are only a few that will accept people with challenging behaviours or who are in their 60s. Waiting for these assessments to take place and then for a bed to become available in these care homes resulted in delays to transfer of care.

Figure 12- Monthly Percentage of Mental Health Inpatients Experiencing a Delayed Transfer of Care



Source- Trust Tableau Dashboard

National NHS Community Mental Health Survey 2019

ⓘ The National Community Mental Health Survey is undertaken annually to ascertain the experiences of people that receive specialist care or treatment for a mental health condition. Feedback from people about their experiences of these services is crucial in highlighting good care and in identifying risks to service quality

The Survey sample. People were eligible to receive the survey if they were aged 18+, were receiving specialist care or treatment for a mental health condition and had been seen by the Trust between 1 Sept and 30 Nov 2018. Responses were received from 197 (24%) people meeting these criteria. This is 9% below the Trust's 2018 response rate.

About the Survey and how it is scored. The survey contained several questions organised across 11 sections. Responses to each question and section were converted into scores from 0 to 10 (10 representing the best response). Each score was then benchmarked against 55 other English Providers of NHS Mental Health Services, resulting in a Trust rating of 'better', 'about the same' or 'worse' being given.

Summary of Trust results. The Trust was rated as 'better' than the other mental health service providers in two of the eleven sections:

- Reviewing care (8.2/10)
- Overall views of care and services (7.7/10)

The Trust was rated as 'about the same' as other providers for all the other nine sections.

The Trust achieved the highest score of all English mental health providers for the following questions:

- Reviewing your care: Did you feel that decisions were made together by you and the person you saw during this discussion? (Trust score: 8.4/10)
- Support and wellbeing:
  - In the last 12 months, has someone from NHS mental health services supported you in joining a group or taking part in an activity? (6.1/10)
  - Have NHS mental health services involved a member of your family or someone else close to you, as much as you would like? (7.7/10)
  - Have NHS mental health services given you information about getting support from people with experience of the same mental health needs? (4.6/10)

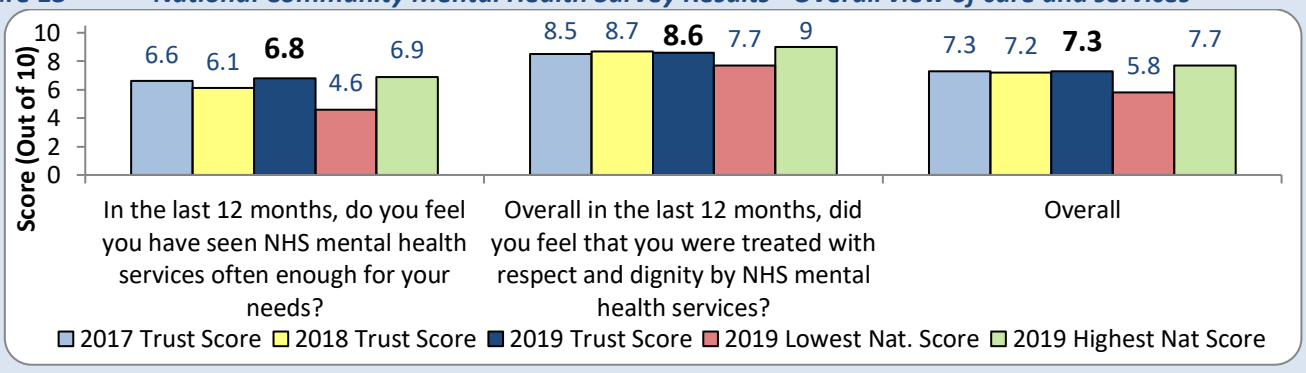
When compared with its 2018 results, the Trust scored the same or better in 2019 in all but four comparable questions:

- Organising care: Have you been told who is in charge of organising your care and services? -0.2 (2019- 7.6/10, 2018- 7.8/10)
- Medicines: Were you as involved as much as you wanted to be in decisions about which medicines you receive? -0.1 (2019- 7.1/10, 2018- 7.2/10)
- NHS Therapies: Were you as involved as much as you wanted to be in deciding what NHS Therapies to use? -0.3 (2019- 6.8/10, 2018- 7.1/10)
- Overall views of care and services: Overall in the last 12 months, did you feel that you were treated with respect and dignity by NHS mental health services? -0.1 (2019- 8.6/10, 2018 8.7/10)

Respondents' overall view of care and experience

Figure 13 gives an overview of Trust scores for overall experience. The 2019 Trust scores (shown by the dark blue bar in the middle of the chart) are compared with the highest and lowest scores achieved (the red and green bars), and with the Trust score in 2017 and 2018 (the light blue and yellow bars).

Figure 13- National Community Mental Health Survey Results - Overall view of care and services



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 2019/20 Patient Safety Priorities:

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

1. We will reduce harm to our patients by reducing:
   a. Self-harm incidents by 30%. Target: No more than 42 such incidents each month on mental health inpatient wards (excluding Learning Disability patients)
   b. Suicides of people under Trust mental health care by 10% by 2021
   c. The rate of falls on our community inpatient wards and older people's mental health inpatient wards to no more than 4 falls per 1000 bed days
   d. Medication errors graded moderate and above by 20%. Target: no more than 4 per year
   e. Pressure Ulcers:
      i. No more than 19 Category 2 pressure ulcers due to a lapse in care by Trust staff
      ii. No more than 18 Category 3 and 4 pressure ulcers due to a lapse in care by Trust staff
      iii. At least 180 days between the development of category 3 and 4 pressure ulcers due to a lapse in care by Trust staff
   f. Gram negative bacteraemia due to a lapse in care on our inpatient community wards by 50%. Target: No more than 1 per ward due to lapse in care by Trust staff.
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. Please note that delayed transfers of care are reported on in the patient experience section above

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 in Section 2.1.4- Supporting our staff

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.

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.

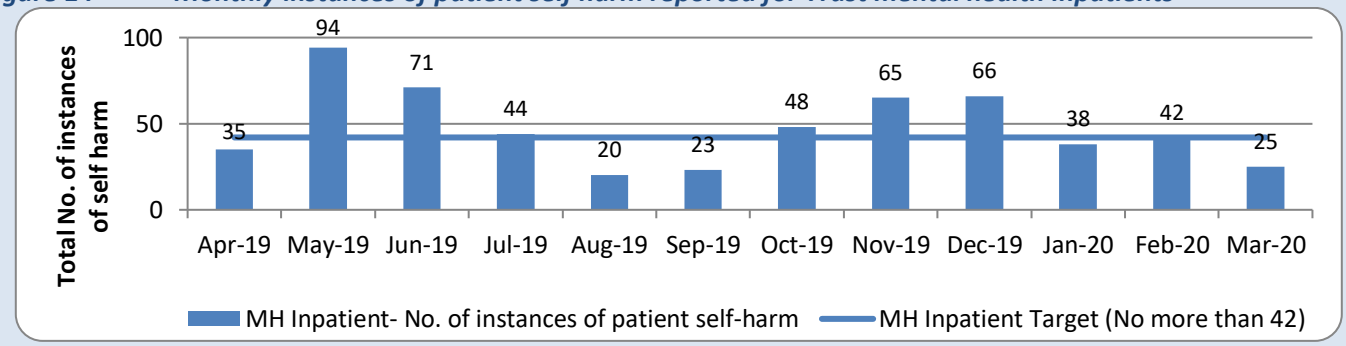
The Trust has set a priority to reduce self-harm incidents reported for patients under Trust care on mental health inpatient wards by 30%. The target is to have <42 such incidents each month on mental health inpatient wards (excluding Learning Disability patients).

A rapid improvement event was held in June 2019 to look at how quality improvement methods can be used to reduce these incidents. This is a complex problem, and the number of incidents may fluctuate depending on the service users presenting at any one time. At the improvement event some countermeasures (actions) were identified to be tested. One of these countermeasures is being used on the two highest contributing areas -Willow House Berkshire Adolescent Unit and Bluebell Ward at Prospect Park Hospital. It concerns the use of the safety plan in collaboration with the service user and displaying this on the observation board so staff can more easily identify things that the person has said can help. None of the self harm incidents reported for Bluebell Ward were as a result of a lapse in care by trust staff.

Willow House is continuing its Quality Improvement work on reducing self harm. It was recognised that there were clusters of incidents happening in the evening, particularly over the period during a shift change. As a result, a 'Sundown Meeting' has been introduced to keep patients engaged and to promote interaction between night staff and patients. A review of the number of bank vs substantive staff in place during that time is also being undertaken.

Figure 14 below shows monthly Trust performance during 2019/20 and shows that the target has been met in the last three months of the financial year.

Figure 14- Monthly instances of patient self harm reported for Trust mental health inpatients



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 Zero Suicide Project

This project commenced in 2016/17 in response to the Five-Year Forward View to reduce the rate of suicide by 10% by 2020. Every local authority was tasked with developing a multi-agency suicide prevention plan that demonstrated how they will implement interventions targeting high-risk locations and supporting high-risk groups.

In 2019, NHS England produced guidance recommending a specific focus on Mental Health Inpatient Services. The Trust has increased its Mental Health Inpatient focus as a result of this and is paying attention to those areas with higher rates of self harm. Suicide prevention work has continued across all localities and has moved to "Business as Usual' from August 2019.

Suicide Rates

In order to achieve the 10% reduction in the rate of suicide from 2016/17, there must be less than 8.4 suicides per 10,000 people under Trust mental health care by 2020. As can be seen in figure 15, the Trust is achieving this target so far, with a 2018/19 rate of 6.9 suicides per 10,000 people under mental health care. The 2019/20 figure will be available in the latter half of 2020/21.

There were 6,507 suicides registered in the UK in 2018, representing an age-standardised rate of 11.2 deaths per 100,000 population. This rate is significantly higher than that in 2017 and represents the first increase since 2013. The latest suicide statistics for England for the first half of 2019 indicate a rising picture with the reasons for this being complex. Recent changes in coronial law in England and Wales are in part a factor (prior to mid-2018, a higher standard of proof was used by coroners to determine whether a death was caused by suicide), but other factors are also important. Men are still at higher risk and there has been an overall increase in suicides of those aged under 25. Rates have increased, particularly in females aged 10–24 to 3.3 per 100,000, the highest level on record.

Outcomes and measurements against Trust Plan

Priority 1 - Zero Suicides in our Inpatient Units (measured by number of deaths)

- In quarter 3 there were zero inpatient deaths by suicide

Priority 2 - Safety planning will be a collaborative and individualised process and will focus on 4 key areas: means restriction, problem solving and coping skills (including distraction), enhancing social support and identifying emergency contacts

- An audit of risk documentation has been reviewed and moved onto an electronic Tableau dashboard to enable clinicians and managers to view compliance with the standards for safety planning in real time. This dashboard is currently being built and trialled.
- A Bucks, Oxon and Berkshire West Integrated Care System (BOB ICS) Trailblazer Project was presented to Public Health England, receiving positive feedback in this area.
- The Trust is on track to deliver a safety planning App for patients.

Priority 3- Staff will feel the organisation has a learning, not blaming, culture (measured by staff survey)

- The Trust Medical Director and Director of Nursing are leading a programme of work focusing on a "just culture" and restorative practice. The overall aim is to ensure that in our daily practice, our conduct and our dealings with each other is honest, kind and has an emphasis on learning rather than blaming. We are in the process of collecting data to establish a baseline of how staff perceive the organisation in these areas, and this will be utilised to inform the next steps for the programme.
- We are also undertaking a review of our Serious Incident process. This is currently in the planning stages and will be driven using our quality improvement expertise.
- The Head of Psychological Therapy is coordinating a stepped care model of staff support which will be presented to the Trust business and strategy group in February 2020.

Figure 15- Number of suicides per 10,000 people under Berkshire Healthcare Trust Mental Healthcare

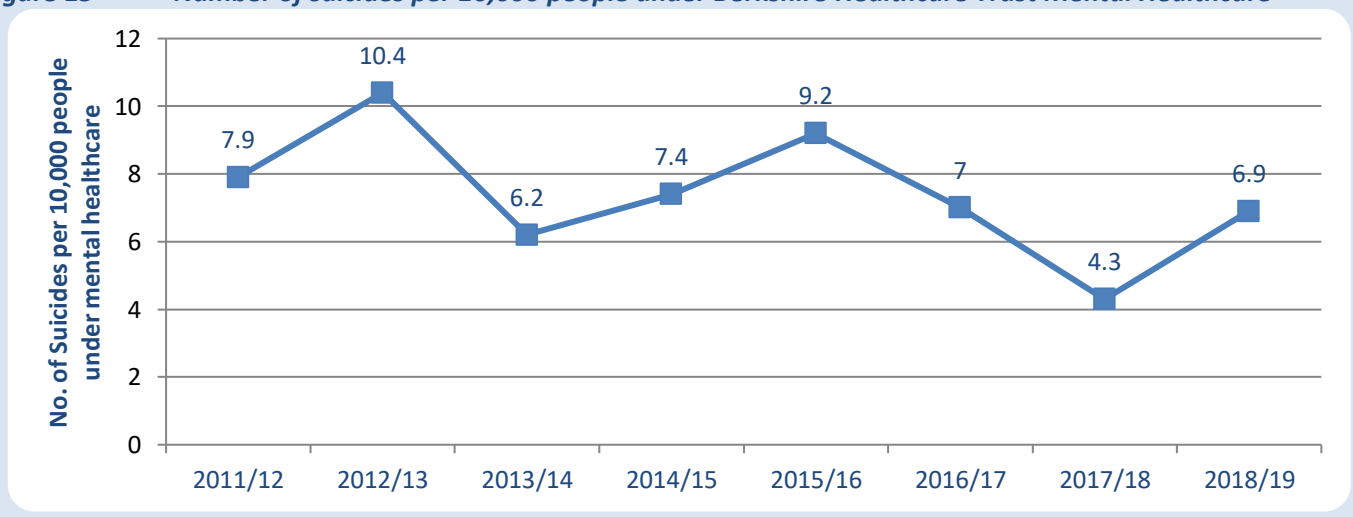
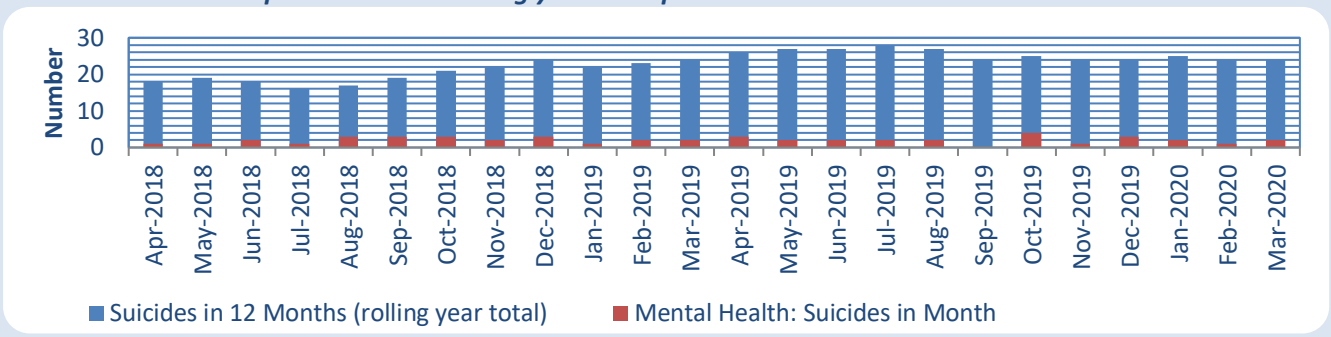


Figure 16- Suicides of patients under Berkshire Healthcare Trust mental healthcare
Number per month and rolling year total per month



Source- Trust Tableau Dashboard

Reducing Falls on Older People's Inpatient Wards

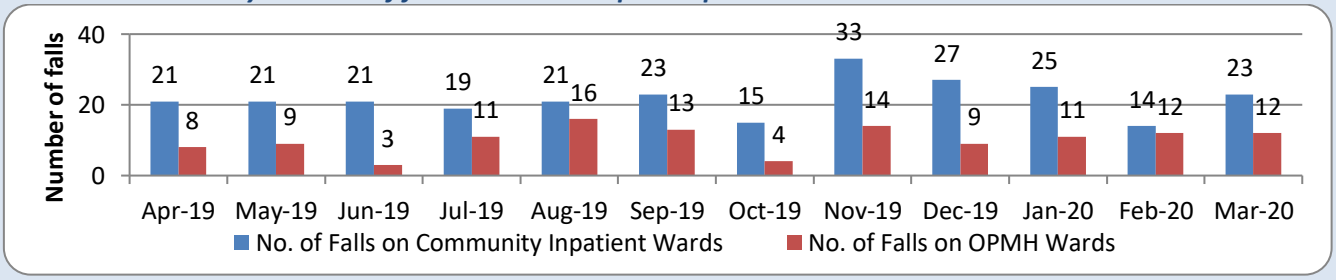
ⓘ The Trust considers prevention of falls a high priority. The Royal College of Physicians reports that falls are the most commonly reported type of patient safety incident in healthcare. Although most people falling in hospital experience no or low physical harm (such as minor cuts and bruises), others 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 to no more than 4 falls per 1000 bed days during 2019/20.

Figures 17 and 18 below detail the monthly number of falls on older people's inpatient wards and the rate of falls per 1000 bed days against the target rate. The figures show that the number of falls on both Trust community inpatient wards and Older People's Mental Health (OPMH) wards is above the target threshold of 4 per 1000 bed days during the year.

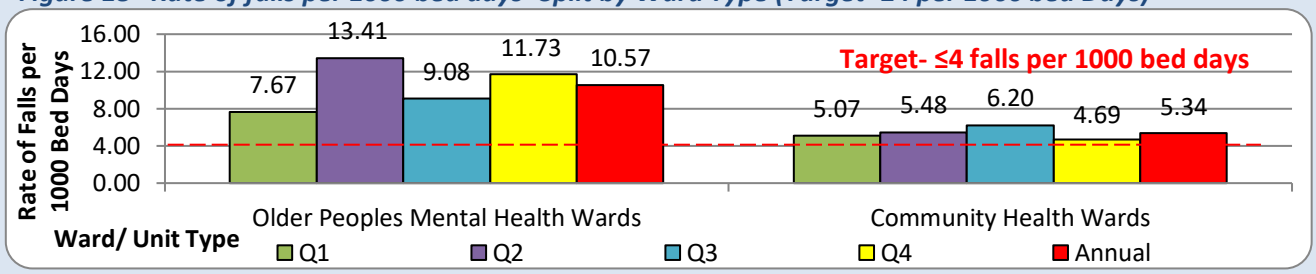
A new falls risk assessment was implemented on the community wards and mental health wards in December 2019 to support staff in identifying risks and putting in place individualised falls risk management plans. The older adult mental health wards and community wards continue to have falls as a driver for improvement. Orchid Ward at Prospect Park Hospital have implemented the Quality Management Improvement System (QMIS) to reduce falls. They identified that most falls were happening in patient bedrooms and at night time. Several measures have been implemented and tested, including a weekly 'staying steady' group for patients, increasing patient observations, use of call bells for high risk patients and a hydration station in the patient lounge area. This has resulted in a 41% reduction in falls from March 2019 – October 2019. Orchid and Rowan wards had 16.96 falls per 1000 bed days average for Q1-3 in 2018/2019 and this year that has reduced to 10.6 per 1000 bed days over the same period.

Figure 17- Monthly Number of falls on Older People's Inpatient Wards



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

Figure 18- Rate of falls per 1000 bed days- Split by Ward Type (Target- ≤4 per 1000 bed Days)



Source for both figures: Trust Tableau Dashboards

Reducing medication errors graded moderate and above

ⓘ 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).

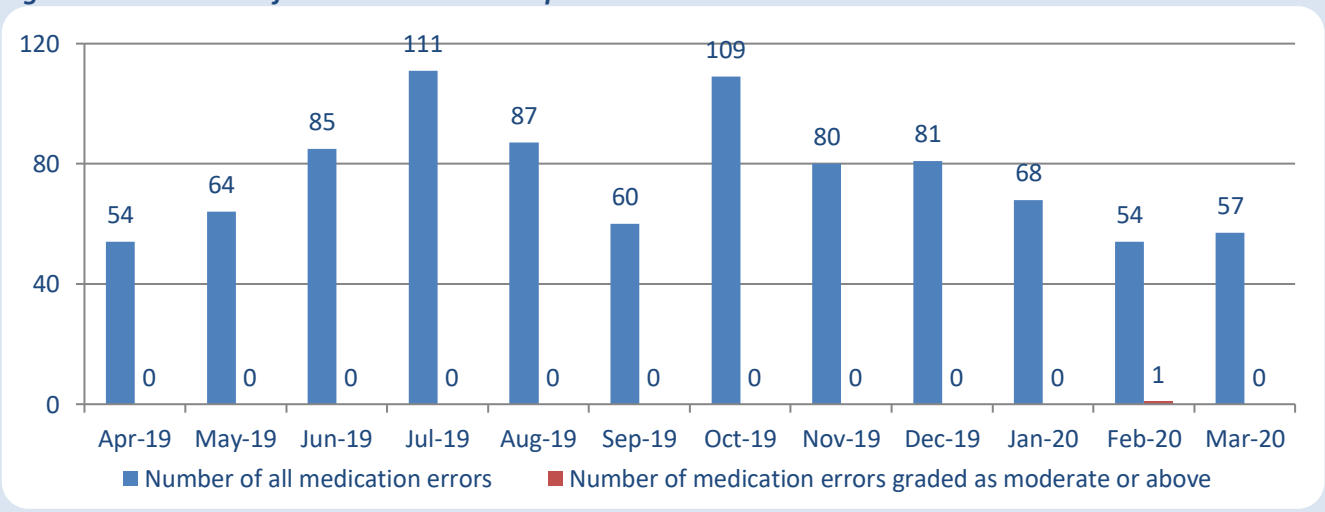
The Trust has set a priority to reduce the number of medication errors graded as moderate and above by 20%, with a target that there should be no more than four medication errors graded moderate or above during the year.

Figure 19 below details the total number of medication errors reported per month together with the number of these that were graded as moderate or above. 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 that 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.

The figure below shows that the Trust target has been met, with one moderate medication incidents reported during the year. This incident occurred in February 2020 and related to a patient who developed a proven DVT during admission due to not receiving appropriate prophylaxis. Policy and trust-wide training requirements are being reviewed in light of this.

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).

Figure 19: Number of Medication Errors Reported Each Month



Source: Medicines Safety Quarterly Report

Preventing Pressure Ulcers

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

The Trust has set three targets to prevent pressure ulcers in 2019/20:

1. To have no more than 19 grade 2 pressure ulcers due to a lapse in care by Trust staff
2. To have no more than 18 grade 3 or 4 pressure ulcers due to a lapse in care by Trust staff
3. At a service level, starting from 1st April 2019, having at least 180 days between the development of grade 3 and 4 pressure ulcers due to a lapse in care by Trust staff. This includes those that are unstageable or appear to be a Deep Tissue Injury (DTI) but further categorisation has not been achieved.

In pursuance of this target, the Trust has continued to ensure that all clinical staff have had relevant training in pressure ulcer prevention and management. All developed pressure ulcers of category 3 and 4 that are potentially due to a lapse in care by Trust staff are discussed at a learning summit with practitioners and managers to investigate whether there is anything that could have been done differently to help prevent the skin damage or to identify where improvements in the care we provide can be made. Actions are identified and taken forward by the teams and themes are reviewed at a strategic level to ensure training remains relevant and wider improvements can be made. Inpatient units review all developed pressure damage category 2 and above to ensure there are no opportunities for improvement missed.

Figures 20a, b and c below detail progress against these targets. Figures 19a and b show that the targets were met in relation to category 3 and 4 pressure ulcers, but not for category 2 pressure ulcers. This will be raised at the Pressure Ulcer Steering Group with a push for a renewed focus on prevention. Outside the Covid-19 period, we continue to undertake learning summits and action plans for all Category 2 PU's on the inpatient wards. Figure 19c shows that the 180-day target has not been achieved at the end of Q4, although it had been achieved earlier in the year.

Figure 19a- Developed Category 2 Pressure Ulcers due to a Lapse in Care

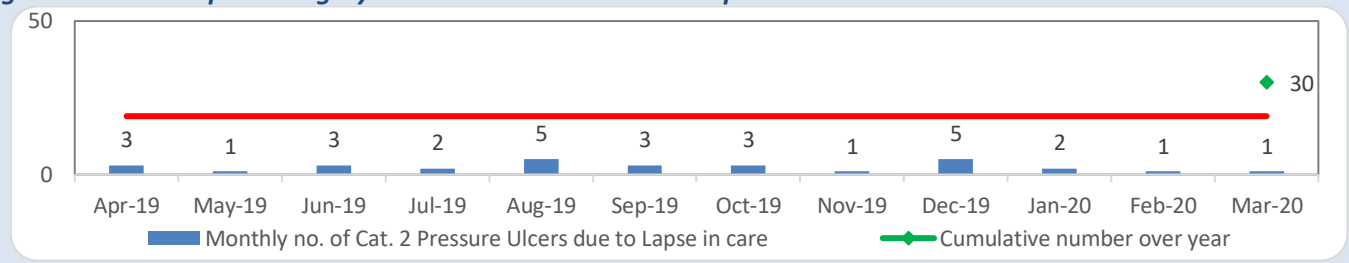


Figure 19b- Developed Category 3 and 4 Pressure Ulcers due to a Lapse in Care

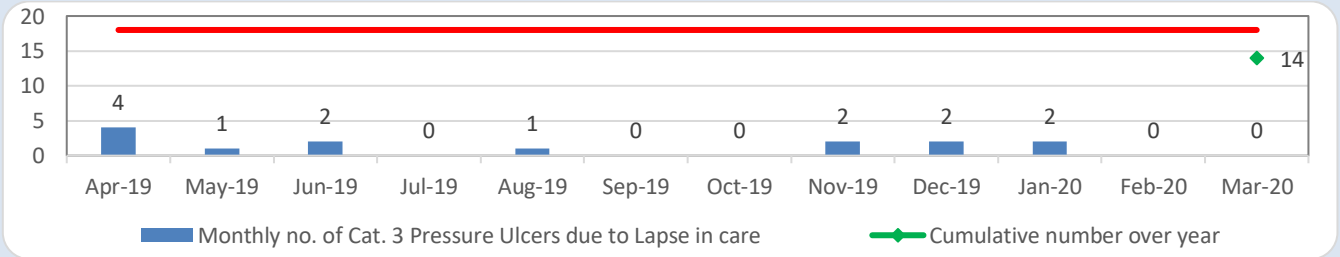


Figure 19c- Number of Days since last category 3 or 4 pressure ulcer due to lapse in care by Trust staff (as at 31st March 2020) target ≥180 days

Berkshire East Community	129 days
Berkshire West Community	84 days
Community Inpatient Units	101 days

Sources: Trust Quarterly Pressure Ulcer Report

Reducing Gram Negative Bacteraemia

Gram-negative bacteraemia cause infections including bloodstream infections and pneumonia. There is a national ambition to reduce healthcare associated Gram-negative bloodstream infections by 25% by 2021/2022 and by 50% by 2023/2024.

In pursuance of this target, the Trust has set itself a target of no more than one case of Gram-negative bacteraemia due to lapse in care by Trust staff per inpatient ward. Early identification and management of such cases can also be linked to a reduction in cases of sepsis.

During 2019/20, there were 21 cases of Gram-negative bacteraemia identified with two cases due to a lapse in care on the community inpatient wards. These cases were on different wards. Shared learning from post infection reviews are disseminated within the organisation.

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.

Preventing Harm to patients

For 2019/20, the Trust has set a target that at least 95% of its reported incidents will be of low or no harm to patients. Figure 20 below details the number of patient safety incidents reported by the Trust broken down by severity of harm to patients. Please note that publication of this data by the national team was temporarily ceased from April 2020 due to operational pressures. Therefore, the figures below present data between 1stApril 2019 and 29th February 2020. This will be updated with the March 2020 data when it becomes available nationally. The Trust continues to promote near-miss and no harm reporting.

Please note that the annual number of patient safety incidents reported by the Trust is also detailed in section 2.4 below as it is a core indicator.

Figure 20- Incidents reported by the Trust in 2019/20, by degree of harm

	Incidents Reported in 2019/20									
	Q1		Q2		Q3		1st Jan 20- 29th Feb 20*		1st April 2019- 29th Feb 2020*	
Degree of harm	No	%	No	%	No	%	No	%	No	%
No harm	636	61.7	863	63.7	792	50.3	442	38.8	2,909	53.9
Low	314	30.5	405	29.9	637	40.4	476	41.8	1,933	35.8
Moderate	68	6.6	75	5.5	133	8.4	210	18.4	507	9.4
Severe	2	0.2	1	0.1	0	0	0	0.0	3	0.1
Death	10	1.0	10	0.7	13	0.8	11	1.0	47	0.9
Total	1030	100	1354	100	1575	100	1,139	100	5,398	100.0
Low or no Harm	**950**	**92.2**	**1268**	**93.6**	**1429**	**90.1**	**918**	**80.6**	**4842**	**89.7**

Source: National Reporting and Learning System (NRLS) Monthly Report- England

** Please note that publication of this data by the national team was temporarily ceased from April 2020 due to operational pressures. Therefore, these represent incidents between 1st April 2019 and 29th February 2020.*

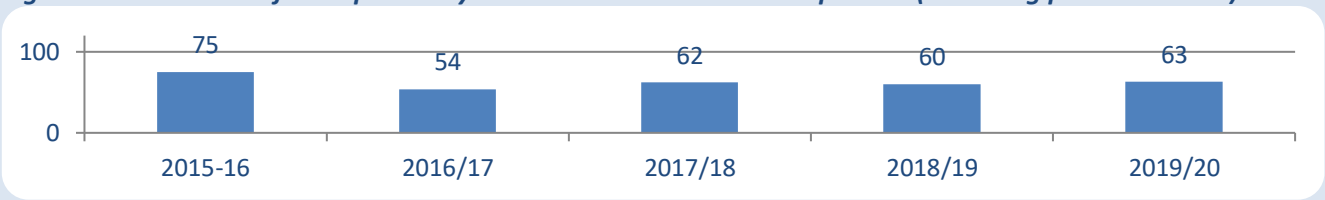
Never Events

ⓘ 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 2019/20

Serious Incidents (SIs) Figure 21 below shows the annual number of serious incidents reported by the Trust in comparison with the previous financial years.

Figure 21- Number of SIs reported by the Trust- Year on Year Comparison (excluding pressure ulcers)



Source: Trust Serious Incident Report

Summary of findings from Serious Incident (SI) reporting

In summary for the year; a total of 63 incidents were reported as serious incidents by the Trust. This compares to 60 for this previous year.

In 2019-2020, 86% of SIs have been reported by mental health services, 12% by community physical health services and 2% by children's services. Of the SIs reported by mental health, 56% were attributable to Mental Health West. Of the SIs reported by physical health, 88% were attributable to Community Health West. Serious incidents for unexpected deaths currently stand at 21 for 2019-2020 compared to 18 for 2018-2019 whilst suspected suicides are 19 for 2019-2020 compared to 22 for 2018-2019. Falls with harm has decreased from 5 in 2018-2019 (excluding downgrades) to 2 this year. The top 3 reporting categories in 2019-2020 were unexpected deaths (n=21), suspected suicides (n=19), pressure ulcers, IG breaches and attempted suicides (n=4). The top 3 reported categories in 2018-2019 were suspected suicides (n=22), unexpected deaths (n=18) and falls (n=5).

Inquest activity: In the year 2019-2020 the Trust provided evidence to 60 inquests which is an increase of 19 inquests from 2018-2019

Preventing Future Death (PFD) reports (Reg 28): The total number of PFDs issued to the Trust in 2019/2020 to 2. PFD evidence is still to be heard following an Article 2 inquest in December 2019

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

A review of the completed reports has identified that there were several investigations that did not identify specific care delivery problems in relation to the incident being investigated but identified broader system improvement opportunities and incidental learning as well as areas of good practice. Key themes identified from a review of good practice includes;

- Working with others – there is some good evidence of joint agency working with other partners as well as a multi-disciplinary approach to patient care.
- There were 2 deaths of patients approved, both of which identified similar recommendations including;
    - Leave process – to review how the leave process is being implemented which will include ensuring a conversation takes place about safety, whereabouts, searching process and the safeguarding considerations
    - Physical health monitoring – the need to continue to embed the work stream in relation to physical health assessments, monitoring and related documentation for patients admitted to a mental health inpatient setting.

Actions are being undertaken to address these main themes.

Embedding patient safety in clinical and support teams

ⓘ Patient safety is a top priority for the Trust, and it is important that this is embedded within its clinical and support teams. This will help minimise the risk of harm to patients and ensure that a safety culture is in place across the whole organisation

The Trust has set two objectives to help ensure that patient safety activity is embedded across both clinical and support teams:

1. All patient facing teams will have evidence-based objectives for reducing patient harm in their plans for 2019/20
2. All Trust support services will work with patient facing services to identify ways that they can support safety of patients.

To date, the following has been achieved in relation to these objectives. Many further examples can be seen in Section 2.1.5 of this report- 'Other Service Improvements'.

A new patient safety incident reporting form was implemented on 1st February 2020. This form is more intuitive and relevant to individual services and will improve the quality of patient safety incident reporting whilst reducing the time taken to complete incident reports. Divisional data will be available at the time of incident submission rather than at the time of incident approval, positively impacting on patient safety monitoring. The impact of the new form is currently being evaluated.

In line with CQC standards, a programme of work is underway looking at the use of restrictive practices. This programme is using quality improvement methodology to see how restrictive interventions can be reduced, and a reducing restrictive practice group has been set up to oversee this. Use of prone restraint is now below the national average. Quality improvement work continues on Sorrell Ward (our inpatient Psychiatric Intensive Care Unit) and we have seen the continued reduction in assaults on staff this quarter. Safety huddles are also becoming embedded on Sorrel, Snowdrop and Bluebell wards at Prospect Park Hospital.

Training now has an emphasis on de-escalation, with iPads being used to record the training, allowing staff to reflect on this. Safety planning work has been refreshed and a new dashboard has been implemented to monitor compliance against core standards in real time for use in supervision. Prevention Management of Violence and Aggression (PMVA) training for staff now includes Safewards, trauma informed care and the Human Rights Act. Videos of service user and staff views of restraint are also shown to give trainees this perspective. Regular monthly restrictive practice meetings are chaired by the Clinical Director. Finally, feedback is gathered from staff and service users to gauge what they understand about restrictive practices.

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

ⓘ An 'out of area placement' (OAP) for acute mental health inpatient 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.

One of the Trust's priorities for 2019/20 is to continue reducing the number of inappropriate out of area placements (OAPs) to below the targets set by NHS Improvement (NHSi) in the Single Oversight Framework (SoF).

To achieve this, the Trust has continued its focused approach on reducing the length of stay for inpatients, reducing occupancy in our acute inpatient wards at Prospect Park Hospital (PPH) and ensuring alternatives to admissions have been fully considered. We have continued to develop a Bed Management team to manage the flow of patients both in and out of the hospital, as well as Community Liaison workers to assist

the community and inpatient teams to expedite discharges.

An escalation process has been instigated which details a clearly defined process for when localities go above their allocated occupancy. We have also commenced work with our teams to look at extended lengths of stay, over 60 days, to assist with any issues that teams are finding difficult to resolve. The Psychiatric Intensive Care Unit (PICU) is also carrying out quality improvement work on the step-down process to facilitate more timely transfers to the acute wards. Overall, the approach to bed management has been changed, gatekeeping functionality has been enhanced and discharge planning improved to support both patient flow and experience.

Achievement against the target is measured with reference to the total number of occupied bed days that patients spend in Out of Area Placements. Figure 22 below demonstrates performance against this priority and shows that the Trust has over-achieved against target in each quarter during 2019/20.

In line with the national demand on Mental Health services, the Trust experienced variation in Inpatient Mental Health bed occupancy leading to the use of Inappropriate Beds in alternative providers. For example, for the majority of October and December 2019 we had zero patients out-of-area and this has been assisted by a clearer escalation procedure. The ongoing programme of work has resulted in a reduction of patients being treated away from home in the last financial year overall, with associated reduced costs. However, whilst numbers are significantly lower, this remains a fluctuating picture and continued focus is required to bring down occupancy to the benchmarked target of 85% and average Length of Stay (LoS) to 31 days, so that there is always available capacity.

Local ownership of this target is now well established. The OAPs indicator has been a challenging process to develop as it involves several complex steps, but significant progress continues to be made.

Figure 22- Quarterly and annual number of Inappropriate Out of Area Placements

	Out of Area Placement Occupied Bed Days in 2019/20								
	Q1		Q2		Q3		Q4		2019/20
	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
Occupied Bed Days	**288**	542	**412**	464	**177**	386	**149**	308	**1026**
Average Per Month	**96**		**137**		**59**		**50**		**86**

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.

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 services 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 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.

Duty of Candour (DOC)

ⓘ 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.

The 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 and advice.

The Trust Patient Safety Team monitors incidents reported on our incident reporting system (Datix) to ensure that where they 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 23 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 23- Incidents requiring formal Duty of Candour (DOC)

Month	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sept 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20
Incidents with formal DOC	50	43	54	38	16	21	9	28	38	51	33	43

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 2019/20 Clinical Effectiveness Priorities are as follows:

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 national guidance. Please note that this priority is detailed in section 2.3 of this report as it is also a required statement of assurance from the Board

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

ⓘ NICE provides 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.

Post-Traumatic Stress Disorder (PTSD). An assessment of compliance against NICE Clinical Guideline 116- Post Traumatic Stress Disorder (PTSD)- has been completed with input from clinical leads in both Adult Mental Health and Child and Adolescent Mental Health (CAMHS) Services. The assessment included a review of 52 NICE recommendations that were deemed to be applicable to the Trust, covering the areas of: recognition of PTSD, assessment and coordination of care, access to care, principles of care, language and culture, management of PTSD, care for people with PTSD and complex needs and disaster planning. The assessment found that the Trust was meeting 46 (88%) of the 52 recommendations.

Areas not meeting recommendations include:

- Waiting time for individual trauma- focused Cognitive Behavioural Therapy is greater than 1 month for children and young people aged under 18 years with a diagnosis of acute stress disorder or clinically important symptoms of PTSD- A substantial piece of work is being undertaken to address some of the underlying causes of this, as well as some specific process work to improve the current management of referrals
- An individual trauma-focused Cognitive Behavioural Therapy (CBT) intervention is not currently offered for children aged 5 to 6 years with a diagnosis of PTSD or clinically important symptoms of PTSD who have presented more than 1 month after a traumatic event- this is being looked at as part of a developing pathway project
- Eye Movement Desensitisation and Reprocessing (EMDR) therapy is not currently available in CAMHS – this is being looked at as part of a developing pathway project mentioned above.

Care and Support of people growing older with Learning Disabilities. An assessment of compliance against NICE Clinical Guideline 96- Care and Support of People Growing Older with Learning Disabilities- has been undertaken with input from the Trust Consultant Nurse for People with Learning Disabilities and the Health Lead for the Community Team for People with Learning Disabilities. The assessment included a review of 50 NICE recommendations that were deemed to be applicable to the Trust, covering the areas of: overarching principles, organising and delivering care and support, identifying and assessing care and support needs, planning and reviewing care and support, identifying and managing health needs, end of life care and staff skills and expertise.
The assessment found that the Trust was meeting 53 (96%) of the 55 recommendations.

Areas not meeting recommendations included: identifying a single lead practitioner as a point of contact for people with LD and their family members and ensuring staff in older people's services have expertise to support people growing older with LD. Discussions are ongoing on how to achieve these.

Depression in Children and Young People- Identification and Management. An assessment of compliance against NICE Clinical Guideline NG134- Depression in Children and Young People- Identification and Management- has been undertaken with input from Consultant Clinical Leads in the Child and Adolescent Mental Health Services. The assessment included a review of 102 NICE recommendations that were deemed to be applicable to the Trust, covering the areas of: care of all children and young people with depression, stepped care, detection, risk profiling and referral, recognition, managing mild depression, managing moderate to severe depression and transfer to adult services.
The assessment found that the Trust was meeting 90 (88%) of the 102 recommendations.

Areas not meeting recommendations included:

- Introducing primary mental health workers (or CAMHS link workers) into each secondary school and secondary pupil referral unit as part of Tier 2 provision- this is being looked at in relation to provision of new school's mental health teams in the east and west of the county
- The Trust team do not currently offer all the therapies recommended in the guideline. However, clinicians would like to be able to offer all of these and this is currently being evaluated as part of a clinical pathway project

- There are currently long waits for psychological therapy. To address this, patients that are already on medication are prioritised for psychological therapy, but the recommendation is that the two should be concurrent. This is also being addressed as part of current clinical pathway work
- Patients in remission that are on medication are followed up within the recommended 12 months, but those not on medication will not be. In addition, when a child or young person is in recurrent remission, they are not followed up within the recommended 24 months. Both issues are due to resource and is also being evaluated as part of current clinical pathway work.

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 has appointed two Consultant Psychiatrists who are jointly our 'Guardians of Safe Working' 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 quarterly to the Board on activity relating to Junior Doctor working hours, including rota gaps.

Figure 24 below details the Psychiatry rota gaps for NHS Doctors in training in the Trust during 2019/20. The gaps on the rota were a combination of Health Education England Thames Valley recruitment shortfalls, as they provide the trainees, and short-term sickness. The Trust continues to cover all rota gaps without the need for agency. Whilst the Trust continues to grow its medical bank to ensure continued coverage. We were only unable to cover one shift in the last quarter and that was short notice at a weekend. At present our system for cover is working as normal, with gaps being quickly filled

Figure 24- Rota Gaps for NHS Doctors in Training – Psychiatry – 1st April 2019 – 31st March 2020

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
	249	248	134	114	0	2294.5	2280.5	1319	961.5	0

Source- Trust Medical Staffing Team

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.

Our 2019/20 Supporting our Staff Priorities are as follows:

1. We will achieve high levels of staff engagement across all our services - scoring four or more (≥8/10) 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.

National NHS Staff Survey 2019

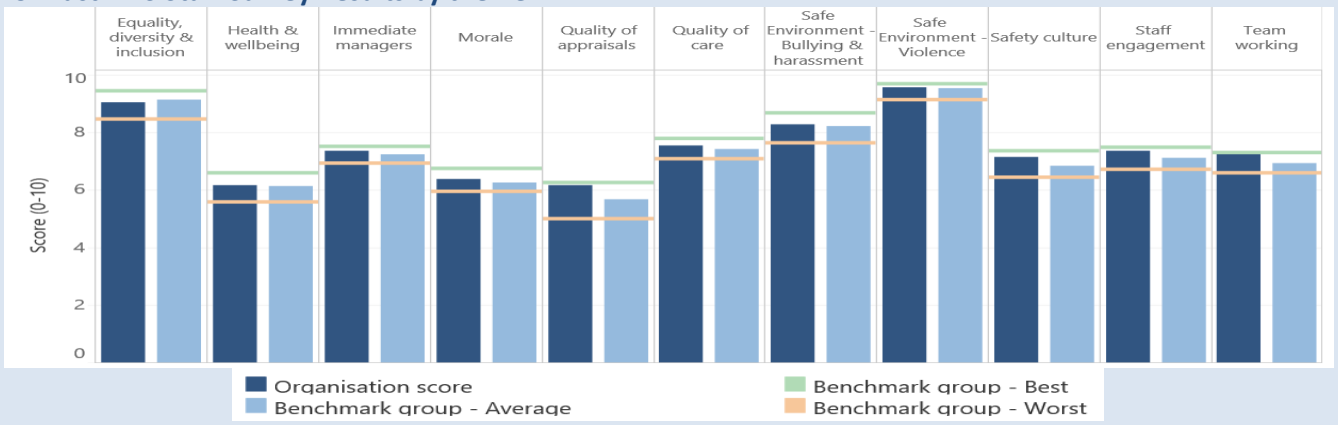
The results from the National NHS Staff Survey are used by the Trust to inform local improvements in staff experience and wellbeing. This is important as a positive staff experience plays an important part not only in staff welfare, but also in helping to maintain and improve on patient safety and experience.

The Trust participated in the 2019 NHS National Staff Survey between September and November 2019.

The Survey Sample.
The survey was conducted online, resulting in it being open to over 4000 of the Trust's employees. Our response rate for the 2019 National Staff Survey increased by 10% to 61% this year. This is our highest response rate ever and is also 10% higher than the average for all other Community and Mental Health Trusts.

Summary of Trust Results.
The figure below details the Trust results by theme.

2019 Trust NHS Staff Survey Results by theme



Source- 2019 NHS Staff Survey- Trust Benchmark Report

Staff engagement
One of the Trust's priorities for 2019/20 is to achieve a score of four or above (≥8/10) for staff engagement. The results of the survey show that the Trust has scored 7.4/10. This is 0.1 higher than our 2018/19 score.

Staff feeling they can make improvements at work
One of the Trust targets for 2019/20 is that at least 70% 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 results of the survey show that 65.7% of respondents answered 'yes' to this question. This is a 1.2% improvement on our score last year.

Staff recommending the Trust as a place to receive treatment
One of the Trust targets for 2019/20 is that at least 85% 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 results of the survey show that 74.4% of respondents agreed or strongly agreed to this question. This is a 0.7% improvement on our score last year.

The Workforce Race Equality Standard (WRES) requires organisations to demonstrate progress against a number of indicators of workforce equality, with some of these indicators based on the Trust's National Staff Survey results. The figure below details these findings for the Trust, separated into scores for white and black and minority ethnic (BME) staff. Work is ongoing to build on some of the things that are already have in place. 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.

Staff survey results relating to the Workforce Race Equality Standard

Indicator and Description	Race	Trust Scores (%) 2016 (%)	2017 (%)	2018 (%)	2019 (%)	2019 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	22	22	23	22	25
	BME	27	27	31	30	34
Ind.6- Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	White	18	18	20	20	20
	BME	26	21	26	25	25
Ind.7- Percentage of staff believing the Trust provides equal opportunities for career progression or promotion	White	90	89	89	91	87
	BME	68	74	68	76	72
Ind.8- In the last 12 months have you personally experienced discrimination at work from manager/team leader or other colleagues?	White	5	7	7	6	6
	BME	17	11	17	13	13

Source- 2019 National Staff Survey

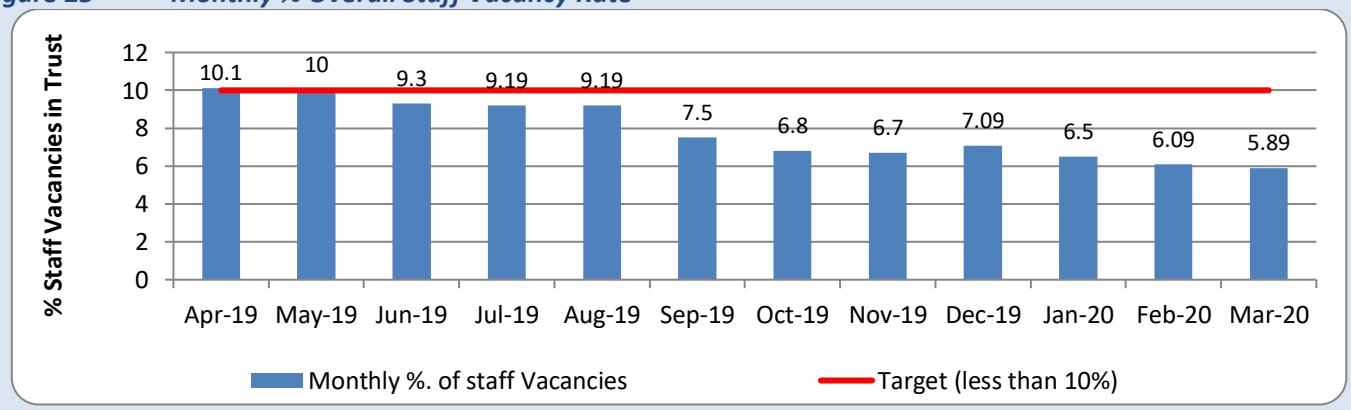
Reducing Staff Vacancies

ⓘ 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 has set a target in 2019/20 of maintaining its overall staff vacancy rate to below 10% through its recruitment and retention action plan.

Figure 25 below details monthly achievement against this target and shows that the target has been achieved each month since May 2019. This is attributable to our proactive recruitment work, specifically aimed at our hard to fill posts.

Figure 25- Monthly % Overall Staff Vacancy Rate



Source- Trust Tableau Dashboard

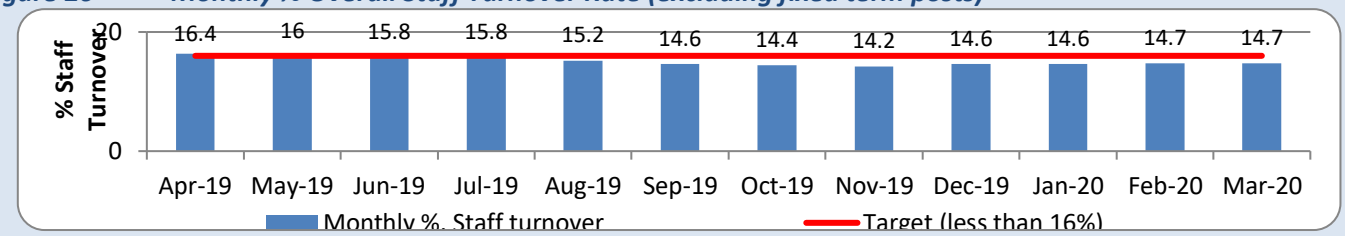
Reducing Staff Turnover

ⓘ It is important that the Trust works to retain skilled and experienced staff in order to deliver high quality care to patients. Where staff turnover is high, it can lead to difficulties in providing continuity of care and the ability to meet patient demand.

The Trust has set a target in 2019/20 of reducing its overall staff turnover rate to below 16%.

Figure 26 below details our monthly achievement against this target (excluding fixed term posts) and shows that the target has been achieved since July 2019.

Figure 26- Monthly % Overall Staff Turnover Rate (excluding fixed term posts)



Source- Trust Tableau Dashboard

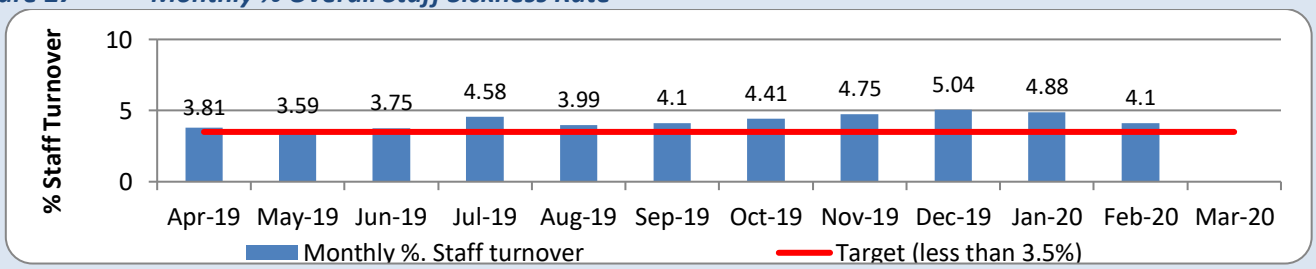
Reducing Staff Sickness

ⓘ The Trust cannot deliver quality and effective care to patients without staff who are well. The Trust has a policy and procedure on sickness absence that ensures sickness absence is managed in a timely, fair consistent and effective way.

The Trust has set a target in 2019/20 of reducing its overall staff sickness rate to below 3.5%

Figure 27 below details monthly achievement against this target and shows that the target has not been achieved to date. The sickness rate in the last quarter is showing a seasonal trend during the winter months which is consistent with previous years. Our sickness absence for anxiety/stress/depression continues to be proportionately high and the work associated with the reduction of this links in with some of our health and wellbeing activity.

Figure 27- Monthly % Overall Staff Sickness Rate



Source- Trust Tableau Dashboard

Zero Tolerance of Aggression, Bullying and Exclusion

ⓘ The Trust is committed to promoting and sustaining a working environment in which all members of staff feel valued and respected. Any kind of bullying, discrimination, harassment or acts of indignity at work are deemed as unacceptable and will be fully investigated in accordance with the Trust's Performance Management and Disciplinary Policy.

The Trust has a zero-tolerance policy for aggression, bullying and exclusion. Members of staff have the right to be treated with dignity and respect and any member of staff that raises a concern because they are subjected to behaviour or treatment that does not promote dignity and respect will be fully supported.

We will promote an inclusive and compassionate culture with zero tolerance of bullying and harassment and will achieve an increase in informal reporting and resolution of difficulties at the earliest opportunity. The number of formal disciplinary and grievance processes will be reduced, with no difference between the experience of BAME and white staff. We will increase the number of allies of people with protected characteristics, provide training and foster a 'just culture' where everyone is supported.

As well as encouraging people to speak up, we will also build our ability to 'listen up'. Further information on 'Freedom to Speak Up' is detailed later in this report.

Reducing Mental Health Patient Physical Assaults on Staff

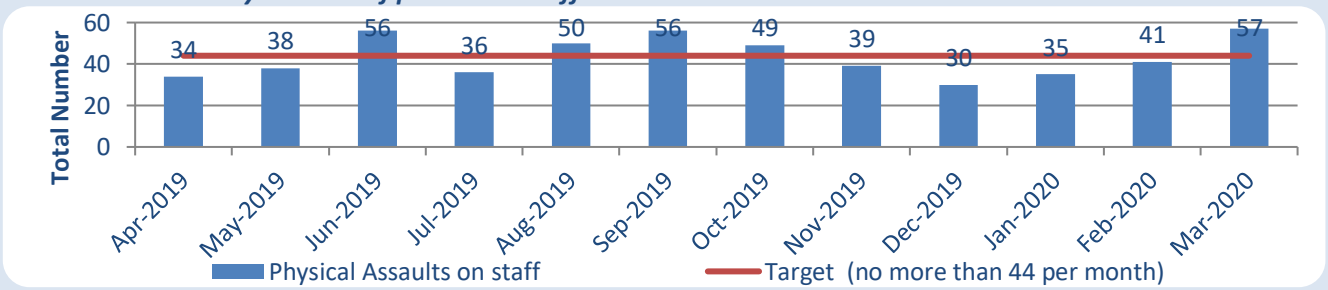
ⓘ The NHS has a 'zero tolerance' attitude towards violence, and NHS staff should be able to come to work without fear of violence, abuse or harassment from patients or their relatives.

The Trust has set a target of reducing the number of mental health assaults on staff by 20% in 2019/20. This equates to no more than 44 assaults per month.

Figure 28 below details the number of patient to staff assaults. The figure shows that the target has been met in six of the twelve months.

Sorrel Ward at Prospect Park Hospital continues its work on staff assaults. As occasional spikes in data are expected, the team look at the data over a longer period to decide if there has been improvement or whether further countermeasures need to be considered. They are currently working on introducing Safeward interventions to use, particularly when redirecting patients, as this has been identified as a highest contributor. Information on patient to patient assaults is included in part 3 of this report.

Figure 28- Monthly number of patient to staff assaults



Source- Trust Tableau Dashboard

Achieving Objectives for Equality of Opportunity

ⓘ 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.

We know that the most diverse teams and organisations are the most successful ones- where everyone feels welcome and included and is supported to achieve their own potential. We will be demonstrably explicit that we appreciate difference within our Trust.

Equality and inclusion are at the heart of our organisation – both in relation to our patients, service users and carers, and our staff – and we want to do the right thing by them for the right reasons.

The key areas of work have been developed in line with our vision, values and our overall strategy and informed by an analysis of our statutory and regulatory requirements, as well as national guidance.

We want to provide a simple message about equality and inclusion – that it is about respect for everyone, serving our population well, and building a fair and just culture within the organisation.

We will all work together to achieve this. Our BAME, Pride and Purple Staff Networks are a key part of our work - supporting us to achieve our objectives through a united approach that values and supports everyone.

Staff feedback from the 2018 Staff Survey give us an idea of some of the key areas we need to continue to focus on. We also know from our workforce data that we still have work to do to ensure our people represent our communities at all levels in the Trust and that all staff policies (training, flexible working, disciplinary, etc.) are applied equally and fairly across all staff groups.

Staff Wellbeing

ⓘ The Trust needs staff that are healthy, well and at work in order to deliver high quality patient care. Looking after the health and wellbeing of staff directly contributes to the delivery of quality patient care.

The Trust has set an objective to improve staff wellbeing. Our Health, Wellbeing and Staff Engagement Lead started in August 2019 and has established a Health & Wellbeing Corporate Group. This group, comprising senior managers from across the Trust and representatives from our networks and trade unions, has used the NHS Health & Wellbeing Framework to identify areas of focus for the Trust. These areas will be prioritised in Q4 and an action plan will be generated.

As part of our staff wellbeing work, support has been secured from our Quality Improvement team to undertake a green-belt project into reducing our high levels of anxiety/stress/depression related sickness absence. An audit has been conducted to identify the top 10 areas where there is workplace stress related absence. Targeted support will be provided to these areas.

Roles and structure of wellbeing and engagement champions and Mental Health First Aider champions are being (re)scoped with an aim of introducing this by the end of Quarter 1 next year. The champions will keep staff informed about what's happening, support available including signposting where relevant, and promoting healthy lifestyles.

We are focused on improving the communications around the support available for staff. January 2020 saw the launch of our 'RUOK?' campaign which is designed to raise the profile of the importance we place on the good health and well-being, including mental well-being to all our staff. Anyone can be directed to several workplace support options for their mental wellbeing. Other projects include a Health & Wellbeing Calendar with a different theme for each month of the year and the launch of a Staff Health & Wellbeing Teams group.

Participating in Integrated Care System Work Streams to enhance career development opportunities and improve workforce planning

ⓘ 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.

Following publication of the NHS Long Term Plan (LTP) Implementation Framework at the end of July 2019, and the draft NHS People Plan, STPs and ICSs were asked to develop system plans responding to the ambitions published within the LTP. A full Buckinghamshire, Oxfordshire and Berkshire West (BOB) LTP submission was made, with a chapter dedicated to workforce:

Deliverable 1 – Recruitment & Resourcing
Deliverable 2 – Productivity
Deliverable 3 – Workforce Planning & Change
Deliverable 4 – Supporting our Staff
Enabled by culture & leadership

Workstream leads will need to be identified within Berkshire Healthcare to work on these deliverables. The Frimley ICS will have similar requirements but have not yet finalised their People Plan.

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 several 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 Divisional, Clinical or Corporate Services Director, The Trust Freedom to Speak up Guardian, The Trust Executive Director with Responsibility for Whistleblowing (Currently the Director of Nursing and Therapies); 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 National Guardian's Office, relevant Registration bodies or Trade Unions, Health & Safety Executive, 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 1st April 2019 and 31st March 2020, 31 cases were brought to the Trust's Freedom to Speak up Guardian.

2.1.5. Other Service Improvement Highlights in 2019/20

ⓘ 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 section 2.1.6 to 2.1.11 relating to areas of improvement.

2.1.6. Improvements in Community Physical Health Services for Adults

The Dental Service implemented an initiative to reduce the waiting time from referral to consultation. This has resulted in a reduction in the number of people on the waiting list, with 91% of patients seen for initial consultation within 12 weeks. The service has also employed a part-time administration assistant to remind patients of their appointments, which has resulted in a reduction of their 'Did Not Attend' (DNA) rate.

The Community Dietetic Service has produced five patient videos on nutritional support and Home Enteral Nutrition (HEN). These videos have the potential to prevent hospital admissions and reduce the length of stay in hospital. The videos can be sent to patients before an appointment allowing them to start making changes at that point. This also allows the dietitian to focus on more complex areas at the patient's first appointment, potentially reducing the total number of appointments required. A Specialist Home Enteral Nutrition (HEN) Dietician has worked with the Motor Neurone Disease Multidisciplinary Team to enable early identification of patients suitable for enteral nutrition, leading to a planned and holistic approach to their tube placement. Three new Dietetic Assistant Practitioner roles have been developed to support prevention of malnutrition in nursing homes. An enhanced service is being offered for patients with Irritable Bowel Syndrome (IBS) living in the east of the county. This has resulted in quicker and easier access to information, with the potential of reducing the number of patient appointments. Finally, the service now offers a group intervention to help patients put their Type 2 diabetes into remission.

The Acute Dietetic Team have used Quality Management Improvement System (QMIS) methodology to improve their general adult clinic utilization by over 65% in both the Brants Bridge and Townlands sites. The team hopes to roll this out to more adult and paediatric dietetic led clinics.

The Integrated Hub now receive all routine referrals into a hub e-mail account using a specific referral form. This allows routine referrals to be pre-sifted, and phone lines to be available for urgent calls.

The Adult Speech and Language Therapy Service have undertaken a Rapid Improvement Event to reduce waiting times for patients with communication and swallowing difficulties. The wait time for these patients was 9 months before this project started. Several changes have been made as a result. For example, referrals are now made via the Health Hub, triaged by Speech and Language Therapy within two working days and identified as Swallowing/Dysphagia or Communication problem. This has resulted in a significant improvement in wait time, with all dysphagia referrals now offered an appointment within 3-4 working weeks, those with communication problems offered an appointment within 4-6 weeks and those requiring communication groups offered therapy in a group setting within 6-12 weeks.

The Podiatry Service have participated in a pilot project to understand the capacity and demands on the service. The focus of the project has been on providing a consistent and effective service to long term caseload patients.

The Hi Tec Care Team, have developed Peripherally Inserted Central Catheter (PICC) clinics in each of their localities, with the support of the Assessment and Rehabilitation Centre and Community Nursing.

The Continence Advisory Service have utilised a service rebate to develop the continence service for children, and to promote continence in this group. The service has purely provided products for management of incontinence in the past and is aware that these children can become lifelong users of the service. By investing in a range of staff, the service can support families with children who have disabilities, to reach greater potential by becoming toilet trained, resulting in improved outcomes for children and decreased expenditure on products

The Berkshire West Community Diabetes Service has expanded and developed their nurse led community clinics to support people with Type 1 Diabetes. These clinics are run three times a week in community venues across Berkshire West and bring specialist care, services and technologies to patients closer to home. The success of these clinics has contributed to Berkshire West having some of the best outcomes for people with Type 1 diabetes. The service is also involved in the redesign of the Type 1 diabetes pathway across Berkshire West which will see further change and expansion to current clinic provision. For the fifth year running, the service was a winner at the national XPERT awards for their delivery of Type 2 diabetes education and improving patient outcomes.

The East Berkshire Diabetes Service is improving their insulin pump service by training more Diabetes Specialist Nurses in pump therapy, running pump clinics and improving the insulin pump process and documentation. The team is also providing 'FreeStyle Libre' education sessions which enable eligible patients to access flash glucose monitoring. The service has seen a greater use of technology overall, with more people utilising continuous glucose monitoring systems to manage their diabetes.

The East Berkshire Musculoskeletal (MSK) Physiotherapy Service have introduced a new MSK triage service across the whole of East Berkshire. All referrals to Orthopaedics are triaged to ensure primary care options have been fulfilled, with 25% of them sent back to primary care. This reduces unnecessary first outpatient appointments and subsequent interventions. Analysis shows this has resulted in reductions of 20% on outpatient spend in Bracknell, 10% in Windsor and Maidenhead and 10% in acute spend for Hip/Knee surgery. The service has also developed several staff as First Contact Practitioners in GP surgeries. These practitioners see patients that would otherwise have to be seen by a GP. This has resulted in a positive patient response, as well as helping the GP workforce. As musculoskeletal pain and symptoms have a large psychological impact on patients, the service now works with the Mental Health team to deliver a Persistent Pain Programme. The service has introduced a paid 'open gym' for patients that have finished with rehabilitation classes, allowing them to keep up the momentum of exercising by using our gym equipment for a nominal fee. A new developmental post has also been introduced to facilitate staff moving from a Band 5 to a higher Band 6 position. A Band 4 rehabilitation post has also been introduced.

The Berkshire West Musculoskeletal (MSK) Physiotherapy Service currently runs 6 different joint/ condition specific classes in order to maximise a patient's recovery and return them to previous fitness levels. A pilot shoulder rehabilitation class was introduced in August 2019 with positive patient feedback and a significant positive improvement in patient specific functional goals. A full audit of this data will be undertaken in April 2020.

The Berkshire West Musculoskeletal Oncology Physiotherapy Team has given patients the opportunity to improve on their general fitness, exercise tolerance and gain confidence to manage their holistic wellbeing and health in relation to their condition after receiving medical oncology treatment. A 12-week programme called "Aiming High" was launched which focuses on upper limb strengthening in conjunction with cardiovascular exercise. This has received very positive feedback to date.

Rehabilitation Services in Berkshire West. All Berkshire West adult community physical health services that are under the banner of rehabilitation, are now managed collectively. These services include the community inpatient beds, intermediate care services

providing rehabilitation in a patient's own home, and a range of neuro-rehabilitation services which include both bed-based and home-based services. This has strengthened their links and helped them put the patient at the centre of their care. An inpatient governance role has been introduced to the service to support the ward teams in reviewing and auditing their work, leading to improved practice and sharing of learning across the wards. The service is also working with their health and social care partners to develop a post-stroke pathway to optimise resources and avoid duplication. Community Neurology services have always been well received by our patients but have experienced increased waiting lists due to increasing demand. In response, the service has undertaken some rapid improvement work, using quality improvement methodology that has led to an agreed plan for investment in community-based neuro rehabilitation. Additional staff have been successfully recruited, which will result in a reduction in the wait time for these patients. The community falls pathway has also been reviewed to ensure it is fit for purpose and consistent for all patients that are referred for a falls assessment. The inpatient wards have also embraced new technology to help reduce the incidence of falls in their areas.

The Berkshire West health and social care system has recognised the historical variation in the delivery of intermediate care rehabilitation/reablement pathways across the three West localities. In response, the Trust has led a system-wide review of this pathway, with its health and social care partners, to identify a consistent offer for patients regardless of where their home is situated. A range of resources have been produced to support this work and the new pathway should be fully in place by the end of 2019/2020. Work has also been undertaken to improve the flow of patients into services, to ensure that patients receive timely care and that acute partners can free up their beds for those acutely unwell patients who need their care. Home and community rehabilitation services and the acute Trust hold regular operational calls to secure the right service for each patient in a timely manner.

Reading Community Nursing Team have undertaken a quality improvement project to reduce the number of missed patient visits in their service. The project team found that staff had to stay late on 90% of days to complete their workload. This was delaying patient care and impacting on staff morale. Quality Management Improvement System (QMIS) A3 principles were followed, with several countermeasures implemented and tested that had a positive impact on patient care, reducing the average number of missed patient visits from nine before the project to six between August and December 2019.

The East Berkshire Community Nursing Team have reviewed their service and developed some core new roles to enhance care and support staff. Clinical Leads have been introduced to provide clinical expertise, support new staff in developing competencies, undertake joint complex visits and carry out formal six-monthly caseload reviews**.** The majority of Band 6 district nurses / sisters have undergone additional training to obtain a Specialist Practitioner Qualification. More Band 3 staff are undertaking Nursing Associate Training and Apprentice Degree training, leading to a more skilled workforce. Two new dedicated Wound Care nurses have been recruited to provide local training, support and assessment of complex wounds. Three new Continence Health Care Assistants have been introduced, resulting in quicker assessment of patients and more robust processes to ensure patients are receiving continence pads. 3.6 whole time equivalent new phlebotomy roles have also been introduced to undertake venepuncture for patients. A care home staff nurse position has been piloted in Bracknell to work with specific care homes on dedicated days to support their patients. This has resulted in a reduction in travel and a more efficient way of working. A new clinical governance role has been introduced to help review incidents across the team and share the learning. Finally, use of iPads has allowed staff to access and update patient information more easily.

Most staff in the East Berkshire Heart Function Team are now non-medical Prescribers, allowing them to

titrate medications immediately in clinic or within the home setting.

The East Berkshire Assessment and Rehabilitation Centre (ARC) team are a supportive discharge and In-reach service facilitating safe and faster admissions to services across integrated care**.** Weekly Consultant lead MDTs are in place across the community clinics**,** with catheter and PICC line clinics now supported across the community clinics. Frailty scores are now completed on each assessment and Community Matrons are working well in each locality. Nursing staff also facilitate educational updates for social care colleagues, with positive feedback received.

The East Berkshire Lower Limb Service is now a fully commissioned service offering patients expert and timely lower limb management in either a clinic or GP practice setting. Healing rates are well above the service target of 70% of patients with non-complex lower limb wounds healed within 12 weeks (the healing rate achieved by the service was 89% in October 2019). The service follows up all patients with healed leg ulcers every six months to reduce the risk of recurrence.

Henry Tudor Ward at St Marks Hospital- Maidenhead and Jubilee Ward at Upton Hospital- Slough are community inpatient wards in East Berkshire. They have introduced twice weekly consultant ward rounds with daily medical and Advanced Nurse Practitioner cover. Their weekly Multi-Disciplinary Team (MDT) meetings now have additional Community Nursing, Matron and Local Authority input. Two new clinical admission pathways have been introduced to support patient flow and the average length of stay on these wards is under 21 days- below the national target.

The East Berkshire Specialist Wheelchair Service has relocated to a more suitable premises at Abell Gardens in Maidenhead. This has provided an improved working environment, with better patient experience also reported due to the improved wheelchair access to the waiting area, larger clinic rooms and changing facilities. All powerchairs and tilt-in-space manual wheelchairs have been reviewed, with all those over 5 years old being replaced. A quarterly Patient Focus Group has also started.

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

The WestCall GP Out-Of-Hours Service

The process of managing the results of pathology tests (such as blood, urine, swabs, cultures) ordered by the service clinicians has been considerably refined this year and was noted as an area of excellent practice at the time of the CQC inspection. All results are seen by a doctor on the evening they are published, and patients are contacted by the WestCall doctor without delay if it is necessary to change any aspect of their treatment. Any actions taken are also entered into the Adastra patient record system and notified to the GP by resending the modified clinical details. This is a first-class service and it was noted that there are no other known examples of Out-of-Hours services in the country undertaking these important tests for their patients. An audit was also carried out on pathology results which found that of the 5,000 tests carried out in the year, significantly abnormal results were found in about 1,200 cases, thus emphasising the clinical importance of this work.

WestCall carry out a monthly audit of Advanced Care Plans entered by GPs onto the Adastra patient record system, for patients who have subsequently passed away. Results are reported back to the GP practices and Clinical Commissioning Groups (CCGs) as a measure of the quality of the information provided. Since this project began, the quality of the plans has improved so that 65% are now good compared with 40% in January 2019. This means that the information given to Out of Hours doctors and nurses looking after End of Life patients is better than before and their clinical management has improved.

An audit of antibiotic use in the management of urinary tract infections in out-of-hours patients found that the service was working effectively in this area but that specific improvements could be made. Efforts to achieve this will be measured by repeating the audit the following October.

Recording of learning points discussed at WestCall clinical meetings have received increased emphasis

and are clearly listed and sent out with the minutes of each meeting to all the WestCall doctors and clinicians. This was commented upon favourably by CQC.

A monthly publication containing a Medical Bulletin and Clinical Governance Newsletter are now produced by senior clinical staff in the WestCall office.

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

Participation in Special Educational Needs and Disability (SEND) Inspections. The CYPF division have participated in both the Wokingham area SEND inspection and the Royal Borough of Windsor and Maidenhead SEND reinspection. These inspections also involved the Care Quality Commission (CQC) and the Office for Standards in Education, Children's Services and Skills (Ofsted). Findings were broadly positive for the Trust, although concerns were raised about waiting times in specific areas such as autism assessment, the Attention Deficit Hyperactivity Disorder (ADHD) service and Occupational Therapy.

A West Berkshire Wellbeing Information Sharing Pop-Up event was attended by Trust staff in October 2019, who manned promotional stands to offer advice, written information and awareness on Childhood Immunisations, Health Visiting and Speech and Language services.

Over 400 members of staff attended three CYPF Division away days in June and July 2019. An ex-service-user, who had also been part of a young person's Child and Adolescent Mental Health Service (CAMHS) participation group, delivered an inspirational and thought-provoking talk to staff at each of these events, describing their early difficulties, experiences with professionals and services and their Autistic Spectrum Disorder (ASD) diagnosis. This helped staff reflect on the way they interact with service-users and deliver the service.

Identity and Transition. CYPF services are working with an increasing number of young people who are questioning their identity or have made the decision to transition. An introduction to trans awareness session was introduced to help staff better support these young people, explain to staff how transgender people experience the world and advise on the terminology that trans people prefer.

The school-aged immunisation service has once again exceeded expectations in their delivery of the annual childhood flu programme. As in prior years, this year saw an additional year group added to the programme, resulting in all children in primary school years (Reception to Year 6) being included in the programme. Since the beginning of October 2019, the service has vaccinated approximately 55,000 school aged children in 11 weeks at over 300 school and clinic settings. Some communities remain reluctant to vaccination, and the service has adapted and found that by offering an alternative to delivery in schools, many parents are willing to bring children to a clinic. Overall the service expects to once again exceed the national target of immunising 65% of the cohort.

A new Health Inequalities Nurse position has been developed to engage with, educate and empower families regarding immunisations. This nurse can administer immunisations for those aged 5-19 years that are hard to reach and/or vulnerable and struggle to access their GP surgery. The Nurse also focuses on empowering and educating the families of children aged under 5 about immunisations.

Health Visiting and School Nursing

Delivery of the Ages and Stages Questionnaire (ASQ) has been reviewed following feedback that it was extremely reliant on parents' perception of their child's development, with limited opportunity for professional input. A group format has been implemented that gives an opportunity for children and their parents to play together with age appropriate toys in a facilitated group, as well as an opportunity for a one-to-one conversation with a health practitioner. Parents experiencing both formats, expressed that they found the new format a better and more interactive experience.

Monthly Saturday appointments are being offered in Reading to support working parents.

A targeted massage group for mothers identified with low mood has been set up in Reading, in response to evidence supporting the benefits of baby massage for this group of mothers. Eligibility for this group is based on several risk factors around perinatal mental health which are assessed by Health Visitors. The Group is

facilitated by Community Nursery Nurses and Community Staff Nurses, with positive client feedback received so far.

Baby Friendly Initiative (BFI) accreditation. The Health Visiting Service continues to audit both staff knowledge and mothers' experiences on a regular basis as part of BFI accreditation. The service scored over the 80% pass mark for all BFI Standards in 2019, with results showing that staff knowledge around the importance of breastfeeding, helping to build a close and loving relationship and safe formula feeding is high. The service plans to re-accredit again in October 2020, with a view to achieving the next level of Gold accreditation 6 months after this date.

A peer to peer record keeping audit took place in July 2019 on the health visiting and school nursing RiO records. In total 403 records (284 health visiting 119 school nursing) from 89 staff (63 health visitors, 26 school nursing team members) were audited. The audit gave positive reassurance that records were of good quality. Some issues were identified and record keeping templates have been designed to ensure consistency in the way records are written up and to save time. Training and reminders regarding the expected high standard of record keeping have been given to all staff.

Health Visitor service user feedback has grown considerably, with significant increases in Friends and Family Test card submissions as well as an increase in the use of a new online App. Feedback from service users has supported change, including development of a specialist group for children with additional medical needs.

The Children and Young People's Integrated Therapy (CYPIT) Speech and Language Therapy Early Years team in Newbury are trialling some evening parent workshops. The aim is to provide parents and carers of children under five years of age with information about the importance of speech, language and communication skills, how to support their child's development and where to get further support and information if needed. The team have run five workshops so far with a total of 55 parents and carers attending. Each session has been interactive and verbal and written feedback from those who have attended has been overwhelmingly positive.

The Team Lead for the Specialist Dietetic Service won an award for Professional Lead for the year following a recommendation from a parent

Child and Adolescent Mental Health Services (CAMHS)

Psychological Perspectives in Education and Primary Care (PPEPCare) training has been delivered by CAMHS to professionals working with children and young people and their families/ carers. This training is designed to help staff in primary care and education to recognise and understand mental health difficulties and offer appropriate support and guidance using psychoeducation and evidence based psychological techniques and resources. Verbal and written feedback consistently shows a significant increase in peoples understanding of mental health issues, confidence in talking with young people and skill in applying the ideas to everyday interactions.

Supporting Children in Care. CAMHS are involved in a two-year national pilot project which aims to understand how to improve mental health and emotional wellbeing assessments for children and young people who are entering the care system. West Berkshire Council, in partnership with NHS Berkshire Clinical Commissioning Group (CCG), were successful in becoming one of nine national sites to pilot the development of a new assessment framework for these young people.

The Children and Young People in Care Teams have continued to work with the six children's services providers in Berkshire to improve the timeliness of initial health assessments. The work with Slough Children's Services Trust has produced a significant improvement in the timeliness of initial health assessments for children placed within a 20-mile radius of Berkshire.

CAMHS service user participation groups are being held on a monthly basis allowing young people and their families to give feedback on their experience of the CAMHS service, highlight their priorities, carry out actions to achieve the priorities and to give their views on various developments.

Neurodiversity

Online autism assessments are being offered by the Autism Assessment Team following a successful proof of concept pilot. These will be offered to families where it is appropriate to do so, with appointments

conducted from the family's own home. They can also be booked in the evening and at weekends.

Parent/carer workshops to support children with anxiety and autism and/or ADHD have been successfully piloted. Positive feedback has been received from parents attending the pilot workshops, with plans to run more sessions in the coming year.

A pioneering pilot of three trainee Children's Wellbeing Practitioners (CWP) has been successful across the autism and ADHD teams. These practitioners provide brief evidence-based interventions for children and young people with anxiety, low mood and emotional regulation difficulties. This has provided valuable support for children, young people and families while their child has been waiting for assessment or following a diagnosis. Placements will be offered again this year.

24/7 online support to families of children with an autism diagnosis or who are waiting for an autism assessment continues to be offered through the Trust's online 'SHaRON Jupiter' platform. The moderating team have increased in number this year with representatives from The Autism Group and Trust colleagues in the CAMHS Anxiety and Depression Team. The team aim to add peer moderators this year and are supporting colleagues in the Anxiety and Depression Team as they go live with their own SHaRON platform.

Training on adapting therapeutic interventions for autistic children, young people, adults and their families has been provided to Trust staff in CAMHS and adult mental health services, with positive feedback. Three linked CAMHS clinical effectiveness seminars on autism are also planned and two more members of the team have been trained to deliver autism training as part of Psychological Perspectives in Education and Primary Care (PPEPCare).

Digital Appointment Correspondence has been introduced resulting in families now having online access to their appointment information.

2.1.9. Improvements in Services for Adults with Learning Disabilities (LD)

Inpatient Services for People with Learning Disabilities

The Campion Unit at Prospect Park Hospital in Reading has continued to work on the Trust breakthrough objective to reduce patient assaults on staff. The team has been working together with the Intensive Support Team to increase the confidence of staff members, increase their competence in alternative communication skills and the development of individual Positive Behaviour Support Plans. These, together with other local measures, have resulted in a significant decrease in the frequency of assaults. The support provided to staff following an incident has also been improved and is now more consistently offered since adopting quality improvement methodologies supported by the Trust Quality Improvement Team.

Community Teams for People with Learning Disabilities (CTPLD)

Three GP education events were held in the east of the county. The topics presented included annual health checks for people with LD, dementia, challenging situations and Deprivation of Liberty Standards/Mental Capacity Act. The Clinical Commissioning Groups (CCGs) also presented on the LD mortality work that is being undertaken. People with LD and parents also attended the event to share their powerful health stories.

An LD screening tool has been implemented in Slough CTPLD. The aim of this tool is to help ascertain whether a new person being referred to the team was likely to have a Learning Disability and therefore be eligible for Trust LD services. Training has been given to staff in this area and changes made following feedback from staff. This is now being reviewed to consider the learning and potential for wider use.

A Health Checklist has been developed for out of county teams who are planning to move people with an LD from outside the county into the Berkshire area. This tool helps to facilitate the move and aids discussion of any concerns or additional help the person may require. It also ensures that all necessary risk assessments/legal reports go with the person.

Sepsis and Constipation Educational Group Work was undertaken for people with LD and paid carers. The signs and symptoms of each were highlighted and handouts on this area disseminated together with easy read information.

Compassionate Peer Support Groups have been set up as part of the Trust's compassionate leadership charter. This initiative also supports the Trust's 'Supporting our Staff' True North Goal and will be a space where staff can be mindful about issues happening at work and ways to maintain a healthy work life balance. The aim is to introduce the practice of self-soothing techniques, such as Mindfulness into the workplace setting. The session seeks to explore the emotions felt by team members during the previous week. People are given an opportunity to explore their feelings. This has resulted in discussion about bereavement and loss as well as more practical outcomes such as organising a presentation on how to chair a meeting.

A Transition initiative is planned in Bracknell with Child and Adolescent Mental Health Services (CAMHS) and other stakeholders. As part of this plan, a health member of the CTPLD will aim to attend the person's last review at 17 ½ years to ensure all health-related documents and reports are in place and to ensure there is a sufficient handover/transfer of care. In addition, Slough CTPLD plan to develop a health transition checklist.

The Provision of Therapy for Vulnerable Adult or Intimidated Adult Witnesses Prior to a Criminal Trial (2001) documentation was summarised to help therapists decide when and when not to offer therapy to vulnerable witnesses. The Practice Guidelines for the Learning Disability Service have been circulated to therapists within and outside of the Trust LD Service.

General Data Protection Regulations (GDPR) information has been developed into an easier to read format for people with Learning Disabilities.

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

Improving Access to Psychological Therapies (IAPT)- Talking Therapies

Video Consultations are now being offered by the IAPT Talking Therapies Service allowing clients access to treatment from their home or workplace. These consultations have: improved client experience, helped the service retain experienced staff, reduced the cost of accommodation, enabled the team to work more efficiently, enabled waitlist support across Berkshire and supported the wellbeing of the IAPT clinicians. There is a plan to continually increase the number of video sessions offered each month.

Using Virtual Reality (VR) in treating height phobias. For some mental health disorders (e.g. specific phobias) the use of virtual reality can be used to improve patient outcomes as it allows them to complete exposure work within their treatment session with the therapist, rather than undertaking this on their own. It also allows patients to face feared situations which they might otherwise find difficult to come across. The team have begun the roll-out and evaluation of VR for height phobias in conjunction with Oxford VR (an Oxford University spin-off company) and building upon the research of Professor Daniel Freeman. 40 patients have been successfully treated so far with positive feedback received. The team is looking forward to potential new VR applications in the future.

The Employment Advice Service has been funded to extend its provision of advice to clients receiving treatment in Talking Therapies. 459 referrals have been received between 1st March and 30th November 2019, with excellent feedback received from both clients and therapists.

Digital Innovations. As part of the Global Digital Exemplar (GDE) programme the service has developed programmes with Silver Cloud around long- term conditions and sleep. The team has increased the number of people with access to these programmes which now have a >70% recovery rate -an improvement of 10%. A resilience programme has also been introduced which also has a >70% recovery rate. The team were shortlisted for a Health Service Journal (HSJ) award in the 'Mental Health, Working Together' category for their digital work. The service is implementing a digital patient pathway and have also established an instant access to treatment pathway where a patient can use a link (URL) to sign up to Talking Therapies and get immediate access to Silver Cloud and the service.

A new website for IAPT Talking Therapies has been created as part of the Global Digital Exemplar (GDE) Programme. This will make information and referral forms easily accessible to their clients. 'Browsealoud' software will also be added to allow clients to translate

the website content into a variety of different languages. For those with sight impairment, the software can also read aloud the website content.

Adult Mental Health Services

Slough Community Mental Health Team (CMHT) has worked with Slough Borough Council to produce an award-winning initiative entitled 'Enabling Town Slough: Slough Mental Health Services'. This initiative, which includes projects to explore and reduce isolation, and promote inclusion across Slough, was shortlisted in two categories for National Awards in Positive Practice in Mental Health, winning the award in the 'Addressing Inequalities in Mental Health Through Coproduction and Inclusion' category, and receiving a commendation for positive practice in the 'Primary and Secondary Mental Health Services' category. 'Enabling Town Slough' will also feature in the National All Age Crisis Care Pathways Report which places it on a national map of positive examples of coproduction and asset-based mental health services.

Bracknell Community Mental Health Team (CMHT) have started a Quality Management Improvement System (QMIS) project to reduce the number of re-referrals to their service. 33.8% of total referrals into the service between March 2018 and February 2019 were re-referrals of patients within 6 months of discharge. The team utilised the A3 tool to explore this problem and test some countermeasures, resulting in a 7% reduction in re-referrals since March 2019.

Physical Health Lead- East Berkshire Mental Health teams have focused on recognising the importance of providing good physical health care to patients with severe mental illness (SMI), to tackle health inequality. The teams now have senior Physical Health clinicians working in each of their CMHTs. In Bracknell a weekly physical health clinic has been set up for SMI patients who are open to secondary care in Bracknell CMHT. This has improved the percentage of patients having annual cardiometabolic checks and those on long acting injectable medication having the correct physical health screens completed. Verbal feedback from patients has also been extremely positive and, due to the success of this clinic, a similar model is going to be piloted in Maidenhead in 2020.

East Berkshire Psychological Medicine Service (PMS) has successfully gained accreditation from the Psychiatric Liaison Accreditation Network through the Royal college of Psychiatrists. Accreditation requires stringent external evaluation against a comprehensive set of standards, and this provides assurance that the service is providing a high standard of care.

Individual Placement Support (IPS) – Employment support service for people with Severe Mental Illness – the service has continued to operate successfully in all CMHTs, EIP and IMPACTT, and has supported over 100 people with a severe mental illness to access paid employment in the first 9 months of the year**.**

Family Safeguarding – The Trust provides adult mental health services to the multi-agency Family Safeguarding Teams in Bracknell and West Berkshire, to support patients with a mental health need and thus improve outcomes for children subject to safeguarding. The adult mental health workers have become fully integrated into the team, working alongside domestic abuse, substance misuse workers and children's social care, and have demonstrated positive outcomes for families as well as increase in mental health awareness amongst colleagues.

West Berkshire Psychological Medicine Service (PMS) has applied lean improvement techniques to map the route patients take through their care pathway and implement a process whereby all patients requiring a PMS assessment in the Emergency Department can be seen within the 1-hour referral criteria. Lean tools have also been embedded in day-to-day working.

Berkshire Eating Disorders Service (BEDS). 100% of service users accessing the adult BEDs service said they were either likely or extremely likely to recommend the service to a friend or family member via the Friends and Family Tests. Service users are also being involved in the recruitment process.

The Intensive Management of Personality Disorders and Clinical Therapies Team (IMPACTT) is a specialist service providing 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), but who may also have comorbid Antisocial Personality traits. The team consists of specialist staff who are highly skilled and experienced in working with these patients. Two NICE recommended evidence-based treatments are offered: Dialectical Behavioural Therapy (DBT) and Mentalization-Based Treatment (MBT). The team has created a service user group and is working with North West Boroughs NHS Trust to arrange training for staff to deliver a comprehensive carers programme. The team has also been delivering training events across

the organisation to help staff working with patients with personality disorder. Psychologically Informed Consultation and Training (PICT) for secondary care has begun, with a weekly bite-size programme also in place for all ward staff. A successful bid was made for additional funding to develop PICT for primary care in the East of Berkshire. The service has helped develop coherent therapy interventions, and development of the Personality Disorder pathway has continued throughout the year.

Community Mental Health Transformation: in September 2019, Frimley Integrated Care System (ICS) was one of 12 who were awarded funding to develop primary care mental health services in line with the newly published Community MH Framework (September 2019). The new framework describes joined up care, which is responsive to individual strengths and needs, and is delivered in partnership with the voluntary and community sectors. Since September 2019, East Berkshire has worked closely with our counterparts in Surrey, as well as with local voluntary and statutory services in East Berkshire, to develop a service model which will provide mental health expertise to patients with Severe Mental Illness in primary care and reduce barriers between primary and secondary mental health services. The service is due to be launched in selected East Berkshire Primary Care Networks in Spring 2020.

The Early Intervention in Psychosis (EIP) Service have established peer support groups in the east and west of the county to allow service users to share their experiences. This has also led to the development of further groups, such as an art group. A rolling educational programme for carers has also been developed in co-production with a carer's peer support worker.

The Berkshire West Crisis Resolution and Home Treatment Team (CRHTT) now have a dedicated person collecting and collating patient and carer feedback. The carers group continues to go from strength to strength and the team has been piloting iPads for mobile working and a Mood App for patients to access their safety plans and record their mood.

The East Berkshire Crisis Resolution and Home Treatment Team (CRHTT) is one of 14 NHS England Pilot test sites that are allocating referrals into one of three response categories: Emergency- 1-2-hour response, Urgent- 4-6-hour response, and Routine- 24-hour response. The teams are also involved in a research project looking into the use of Brief Suicide-Specific Psychological Interventions within a CRHTT service. An additional Police Street Triage Practitioner will also be recruited which will place the service in a position of readiness in case they need to extend this service over a 7-day period.

Community Mental Health Team (CMHT)- West Berkshire has introduced a new pre-therapy, compassion focused group, known as the "OuR" group. This group has sustained 12 core members for 10 months. They have also started using a Structured Clinical Management Plan in June 2019 as part of a new Emotionally Unstable Personality Disorder (EUPD) pathway. The former short-term and long-term teams have been reconfigured into the Duty and the Intervention and Treatment team respectively. The wait list management system has recently been adapted to ensure a more rapid response and reduce the likelihood of service users falling through gaps. Finally, the team has increased their Friends and Family recommendation rate to 95% and are increasing requests for feedback from service users.

Berkshire Trauma Service has developed several resources, including a client booklet, facilitators manual for the compassionate resilience group and a 'living life after trauma therapy' booklet for clients. They are also developing the content of their psychoeducation group. A service user involvement group is in the process of being set up. New outcome measures that better reflect the primary presenting problem of clients have also been introduced. Finally, a clinician has been recruited to work on a birth trauma pathway, the evaluation of which is being written up for publication.

The Common Point of Entry (CPE) Team has introduced a new system to manage requests for reviews by the Psychiatry team. Use of this new system has resulted in their waitlist reducing from approximately 300 patients to 30 patients, with reviews regularly being booked for the following day. The new system also allows a "pre-assessment" review to be booked which can prevent unnecessary full mental health assessments. A CPE Pharmacy has been introduced to undertake medication reviews, greatly reducing wait times. A 'Duty Rota' has also been produced and made accessible on Microsoft Teams, resulting in there always being at least one psychiatrist on Duty. Virtual consultations are now being offered by the team as an alternative to the traditional face-to-face appointments. A small project was also

undertaken to update CPE administrative practices. MDT discussions have been increased due to implementation of multi-disciplinary Daily Referrals Meetings and psychiatry team changes. There is now greater transparency for MDT discussion and psychiatry reviews due to the visibility of every review, which also allows for a greater deep-dive analysis. Finally, one of the CPE Psychiatrists is undertaking research comparing the quality of telephone and face-to-face assessments, the results of which will guide future consultations and inform whether different approaches are necessary.

The Veterans Mental Health Transition, Intervention and Liaison Service (TILS) and Complex Treatment Service (CTS). TILS supports veterans and those about to leave military service and provides support and advice to support their mental health and emotional wellbeing. This may include, if appropriate, referring the veteran into the Complex Treatment Service (CTS), which provides specialist mental health support for those veterans who have complex mental health issues that are military attributable. These services are delivered across Berkshire, Buckinghamshire, Oxfordshire, Hampshire and the Isle of Wight. During 2019/20 both services have received additional funding to expand further and have successfully recruited more clinical staff to support this work. Monthly veterans drop-in support sessions have been introduced at the Royal British Legion in Reading, with a wide selection of veterans' charities and other support organisations also attending these. Both TILS and CTS have also successfully moved into a local hub in Portsmouth. Regular service user forums are in place to gather feedback and this has resulted in a series of short videos being produced that explain more about the service and what happens at an appointment. The CTS team has started the 'True Strength Group' for clients which facilitates a Compassion-Focused Therapy group approach to addressing issues with anger. It was developed by Russell Koltz, an American psychologist who uses it with American veterans, and has been adapted by CTS for use with our veterans. Finally, the Trust has signed the Armed Forces Covenant, supporting its principles that: the armed forces community should not face disadvantage compared to other citizens in the provision of public and commercial services; and special consideration is appropriate in some cases, especially for those who have given most such as the injured and the bereaved.

The Berkshire & Hampshire Liaison & Diversion (L&D) Service expanded its service footprint from April 2019 to include delivery of services across Hampshire and Isle of Wight in partnership with Nacro Organisation. An all age, extended hours delivery model is now delivered across all areas that the service covers to ensure consistent levels of delivery across each county. Following publication of the Ministry of Justices Female Offender Strategy, the L&D team have worked with partners across Criminal Justice to develop a female pathway. Armed Forces Veterans can encounter criminal justice agencies due to their needs and vulnerabilities. As a result, the Liaison and Diversion service, together with Thames Valley Police, the third sector, and a former serviceman, have worked together to create a system of identification, screening and assessment at custody, with pathways of support mapped out to the third sector and veterans' services. Additional funding has also been made available to extend the service into Winchester and Reading Crown Courts, where both services have been well received and established. A Lived Experience and Peer Support element has been added and the service has worked together with NHS England and the revolving door organisation to recruit volunteers and peer support workers with the lived experience of criminal justice and vulnerabilities. These workers will help engage those clients who are difficult to reach or entrenched with their difficulties and enable individuals to make positive changes to their health and social circumstances. The service has also developed apprenticeship opportunities for individuals with the lived experience. The feasibility of using Skype Technology to remotely assess clients detained within outlier suites is being looked into as a 'proof of concept'.

Older Peoples Mental Health Services (OPMH)

A Living with Mild Cognitive Impairment (MCI) support group has been initiated in Reading Memory Clinic to provide additional post-diagnostic support and treatment to clients diagnosed with MCI and their relatives. The aim is to offer interventions that go further than assessment, diagnosis and discharge, as difficulties (cognitive and psychosocial) can be significant and on-going. The group comprises three two-hour weekly sessions for 4/5 patients with MCI and their relatives or, sometimes a close friend. These MCI groups are currently being evaluated, with positive feedback from clients and their families alike.

Newbury Community Mental Health Service for Older Adults has initiated weekly peer supervision groups with all Community Psychiatric Nurses in the team

allocated into groups with the medics. This has resulted in regular discussion of patients on the caseload and has reduced the volume of email traffic to the medics. A West Berkshire Community Hospital liaison role has also been created to keep regularly contact and hold drop-in workshops with the ward staff about dementia specific support. Lastly, a 'priority patient' assignment has been created for new referrals that don't meet Home Treatment Team criteria but do need to be seen soon. This is a proactive approach to reduce the traffic into the Home Treatment Team.

Wokingham Memory Clinic has been working to reduce the wait time for medication prescribed in the clinic. Patients were waiting 14 days to receive the medication and a lot of waste was also identified in the process which impacted on the waiting time. Following root cause analysis and using the Plan Do Study Act (PDSA) approach, the team carried out a test using FP10 prescriptions. This method of prescribing has reduced steps in the process for patients receiving their medication and has enabled staff to have more time to spend delivering patient care. The new process has decreased wait time to an average of 3 days- a 76% reduction.

2.1.11. Improvements in Medicines Management

Patient safety.
Our Pharmacists and Pharmacy Technicians continue to play a vital role in ensuring the safe and effective use of medicines across the Trust. They work with multidisciplinary teams 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 three Trust Medication Safety Officers (we have a pharmacist, a nurse and a doctor) work to ensure that all medication incidents are reviewed, lessons learnt, and good practice shared and embedded across the Trust. They also 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 childbearing potential.

Pharmacists provide training to doctors to improve their knowledge of medicines safety, adverse incidents, and on several medication related topics e.g. Rapid Tranquillisation Medicines.

Antimicrobial Stewardship (AMS) has never been more important nationally and globally, and our antimicrobial lead pharmacist post is playing a key role in ensuring that Berkshire Healthcare is an exemplar for AMS at policy and patient level. We are collaborating with other Trusts across Berkshire and across the region to create an integrated network of AMS guidance and advice, to maintain effective antibiotic use and reduce widespread resistance, which if not countered could threaten the human race. Audits of antimicrobial use are part of the surveillance programme.

We have updated the Cold Chain Policy that underpins the correct storage of medicines that require refrigerated storage and have undertaken a full review of all drug fridges across the Trust, including their temperature calibration and new back-up thermometers (now replaced annually). Updated staff guidance has been produced and issued to Trust staff on how to handle situations where the recorded drug fridge temperature goes outside of range (2-8^{o}C), and where ambient temperature medicines storage (e.g. drug cupboards) goes above 25^{o}C.

Patient experience.
Our Pharmacists continue to review all medicines for effectiveness and adverse effects, 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. The patient medicines helpline, operated by our Medicines Information Service, continues to grow and supports patients and carers with medication guidance and advice.

Pharmacy Technicians regularly conduct medication reconciliation reviews with newly admitted patients, to ensure that the current and correct medication history is obtained – and to determine what patients are actually taking.

In line with the Carter Report (NHS Operational Productivity: unwarranted variations: Mental Health Services, Community Health Services, 2018), pharmacy staff are spending more time with patients and on medicines optimisation.

Pharmacy operate the Clozapine Clinics and in response to patient feedback we have recently introduced time bands to decrease patient waiting times and made improvements to the environment at the Prospect Park clinic. We are working to review the clozapine pathway, and to put it onto the Trust's electronic management system (RiO).

Electronic Prescribing and Medicines Administration (ePMA). Having implemented ePMA in all our mental health inpatient wards in 2017, and to the first mental health outpatient service, Windsor, Ascot and Maidenhead Depot Clinic in 2018, we have now developed plans to extend ePMA to the Community Health wards, and a full business case to support this development is currently being considered. We have introduced an ePMA Governance Group, a sub-committee of the Drug and Therapeutics Committee, to ensure that ePMA is well monitored and that all changes to ePMA are agreed and approved. The committee also monitors all safety concerns, risks and reported incidents, and works to improve the impact and benefits of ePMA on patient care, operational efficiency and user experience.

2.2. Setting Priorities for Improvement for 2020/2021

ⓘ This section details the Trust's priorities which reflect the Trust Annual Plan on a Page for 2020/21 (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 2019/20 have been rolled forward to 2020/21.

2.2.1. Harm-Free Care Priorities

To provide safe services by eliminating avoidable harm:

- We will protect our patients and staff from getting COVID-19 by using appropriate infection control measures
- We will make sure that we have safe levels of staffing to meet service demands
- We will engage with all services over the next six months and agree a plan to safely bring all services back to full operation
- We will continue to reduce falls, pressure ulcers, self-harm in in-patient services and suicide across all of our services
- We will recognise and respond promptly to physical health deterioration on our in-patient wards
- We will strengthen our safety culture to empower staff and patients to raise safety concerns without fear, and to facilitate learning from incidents

2.2.2. Clinical Effectiveness Priorities

- 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
- 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

- We will use patient and carer feedback to drive improvements in our services, with specific engagement on proposed new ways of working
- We will manage patient flow effectively, with minimum delays and make sure that patients stay within our services for no longer than is clinically appropriate
- We will engage and communicate with patients and the public to make sure that they understand how to access the right help at the right time
- Our services will support patients to manage any direct or indirect adverse impact of COVID-19

2.2.4. Supporting our Staff Priorities

To support our people and be a great place to work:

- We will sustain and improve staff engagement across all of our services
- We will make sure all staff have the appropriate skills, training and support for their roles
- We will support staff to embed working remotely and to operate safely and effectively

- We will protect and sustain the health and wellbeing of our staff, reducing sickness absence
- We will increase numbers of staff feeling they can influence how we work and make decisions
- We will increase numbers of staff recommending the care and treatment of our services
- We will improve staff recruitment, retention and satisfaction
- We will have a zero tolerance to bullying and harassment
- We will reduce violence and aggression towards our staff.

With our health and care partners: We will work in partnership with local systems to build Recovery and Restoration plans to build sustainable health and care that incorporate new ways of working.

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 2020/21.

2.3. Statements of Assurance from the Board

During 2019/20 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 these relevant health services.

The income generated by the relevant health services reviewed in 2019/20 represents 100% of the total income generated from the provision of relevant health services by Berkshire Healthcare NHS Foundation Trust for 2019/20.

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 2019/20, 12 national clinical audits and 2 national confidential enquiries covered relevant healthcare services which Berkshire Healthcare NHS Foundation Trust provides.

During that period Berkshire Healthcare NHS Foundation Trust participated in 100% (n=12/12) of national clinical audits and 100% (n=2/2) of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Berkshire Healthcare NHS Foundation Trust was eligible to participate in during 2019/20 are shown in the first column of Figure 29 below. This column also details the national clinical audits and national confidential enquiries that Berkshire Healthcare NHS Foundation Trust participated in during 2019/20.

The national clinical audits and national confidential enquiries that Berkshire Healthcare NHS Foundation Trust participated in and for which data collection was completed during 2019/20 are also listed below in Figure 29 alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry (detailed in the second column of Figure 29).

Figure 29- 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 2019/20	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=12)	
National Clinical Audit and Patient Outcomes Programme (NCAPOP)	
National Sentinel Stroke Audit (2019/20)	Data Collection: April 2019 to March 2020. 495 patients submitted, across 3 services, 187 six-month follow-ups. Report due: Annually
National Audit of Care at the End of Life- Round 2-2019-20	Data collection 3rd June 2019 - 11th October 2019. 17 (100%) patients submitted, across 1 service. Report due: July 2020
National Diabetes Footcare (Community Podiatry care) 2019/20	Data Collection: April 2019 to 31st July 2020. 524 patients submitted, across 1 service. Report due: Annually
National Clinical Audit of Psychosis 2019 - EIP Re-Audit	Data collection October 2019 to November 2019. 100 patients submitted, across 1 service. Report due: July 2020
National Asthma and COPD Audit Programme (NACAP): pulmonary rehabilitation	Data Collection: March 2019 to March 2020. 147 patients submitted, across 1 service. Report due: May 2020
National Audit of Inpatient Falls	Data Collection: January 2019-March 2020. 0 patients eligible for submission, across 3 services. Report due: Annually
National Diabetes Audit - Secondary care 2018/19	Data Collection: May 2019. 1880 patients submitted, across 1 service. Report due: July 2020
National Diabetes Audit - Secondary care 2019/20	Data Collection: April 2019 to March 2020. 2366 patients submitted, across 1 service. Report due: Annually
Non- NCAPOP Audits	
National Audit of Cardiac Rehabilitation (2019/20)	Data Collection: April 2019 to March 2020. 746 patients submitted, across 1 service. Report due: tbc 2021
POMH - Topic 19a: Prescribing for Depression in Adult Mental Health Services (May 2019)	Data Collected: May 2019 to June 2019 111 patients submitted, across 6 services. Reported: November 2019
POMH - Topic 17b - Use of depot/LA antipsychotic injections for relapse prevention (Oct 2019)	Data Collection: October 2019 to November 2019. 149 patients submitted, across 8 services. Reported: March 2020
POMH – 9d Antipsychotic prescribing in people with learning disability	Data Collection: February 2020 to March 2020. 135 patients submitted, across 1 service. Report due: July 2020
National Confidential Enquiries (N=2)	
NCEPOD Long term Ventilation Study	Data Collection: April 2019 to May 2019. 1 patient submitted, across 1 service. Reported: February 2020
Learning Disability Mortality Review Programme (LeDeR)	Data Collection: April 2019 to March 2020 Report due: Annually

Source: Trust Clinical Effectiveness Department

The reports of 9 (100%) national clinical audits were reviewed by the Trust in 2019/20. This included national audits for which data was collected in earlier years with the resultant report being published in 2019/20. 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 31 local clinical audits were reviewed by the Trust in 2019/20 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.

Clinical research involves gathering information from patients and healthy volunteers to improve the medications, therapies and services that we offer to patients. By participating in clinical research, patients may be able to access tests and treatments that are not available as routine NHS care.

Providing good outcomes from treatment and care and providing safe services are Trust priorities. Involvement in clinical research is one way that we demonstrate our commitment to actively improving the clinical treatments, care and outcomes for our patients.

Most of the research studies we invite our patients to participate in are National Institute of Health Research (NIHR) portfolio studies. The NIHR portfolio is a national list of high-quality studies which have received particular sources of funding. Our other high-quality research studies are conducted in part fulfilment of qualifications e.g. MSc or by a member of staff but will not have received funding from a relevant funding source. We have implemented a robust research governance system to ensure research is designed, conducted and delivered to the highest standards.

The number of patients receiving relevant health services provided or sub-contracted by Berkshire Healthcare NHS Foundation Trust to date in 2019/20 that were recruited during that period to participate in research approved by a Research Ethics Committee was 1407 from 44 NIHR portfolio studies. These figures include healthy volunteers involved in research.

Our aim is for all patients to have access to research opportunities which are relevant to them. Currently our patients can access research relating to bipolar disorder, dementia, eating disorders, autism, diabetes, schizophrenia, Chronic Obstructive Pulmonary Disease, Post Traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder, anxiety and depression.

We rank in the top ten out of 49 similar Trusts (Mental Health and Community) for the volume of NIHR portfolio studies which we have invited people to participate in.

As part of the NIHR Research Participant Experience Survey we have had feedback from 89 (11%) research participants in BHFT about their experience taking part in research, this is an increase from 2018/19 where 68 (6%) participants provided feedback. 98% of participants strongly agreed or agreed that they had had a good experience taking part in the research study. 85% of respondents also stated that they would be happy to take part in another research project.

Staff members have contributed to 65 journal publications to date in 2019/20. Discussing topics such as smoking cessation, technology use by older adults, information for families caring for people with dementia, treatments for childhood anxiety disorder and use of diabetes treatments for depression.

Research opportunities currently being offered to Berkshire Healthcare patients include:

- Eating Disorders- patients and carers in the study are provided with extra information on how to cope with the illness to see if it improves their wellbeing up to 18 months post-admission.
- Diabetes service (King Edwards VII Hospital)- patients are participating in a study aiming to achieve more accurate early classification of diabetes and identification of which patients will rapidly require insulin treatment.
- Child and Adolescent Mental Health Service- participants are helping to evaluate the clinical and cost effectiveness of a standardised diagnostic assessment tool as an adjunct to usual clinical care in children and adolescents presenting with emotional difficulties.

For each research project, it is the sponsor's responsibility to ensure peer-review. An internal peer review process has been implemented for all studies where the Trust is currently the sponsor.

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 2019/20 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 2019/20 conditional upon achieving quality improvement and innovation goals is TBC. This is the expected value at 100% achievement. The associated payment received for 2018/19 was £4,398,604.

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 2019/20.

Berkshire Healthcare NHS Foundation Trust is subject to periodic reviews by the Care Quality Commission. Following our CQC inspection of our core services in November 2019, and a "Well Led" inspection in December 2019 the Trust is now rated as Outstanding overall. Both our Community Physical Health services for adults and our End of Life service have been recognised as Outstanding. They join our Learning Disability In-Patients and our Older Peoples Community Mental Health services who also hold an outstanding rating. All our services are now either outstanding or good.

The CQC detailed the following actions that the Trust must take to improve:
Acute wards for adults of working age and psychiatric intensive care wards. The Trust must:

- Ensure that ligature risks are managed appropriately, ensure that patients are kept safe- for example promoting the sexual safety of people using the service, and ensure an alarm system is easily accessible to patients and visitors and that they are made aware of how to use them (Regulation 12)
- Ensure that the ward environment is always adequately furnished and maintained. (Regulation 15)
- Ensure restrictions are necessary and proportionate responses to risks identified for particular individuals (Regulation 13)

Specialist community mental health services for children and young people. The Trust must:

- Continue to work with commissioners to ensure waiting times are not excessive, thereby putting young people waiting to receive treatment at increased risk. Particular attention needs to be paid to ensuring timely access to services for those referred to the attention deficit hyperactivity disorder pathway and autism assessment pathway.

An action plan will be submitted to the CQC outlining how we plan to respond to these highlighted areas.

Berkshire Healthcare NHS Foundation Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2019/20:

- 3rd-7th June 2019- CQC Children Looked After and Safeguarding (CLAS) Review across Slough health providers

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

- A full multi-agency action plan has been developed to address suggested areas for improvement such as reinforcing safeguarding assessments and sharing referral information. The Trust is fully participating in this action plan.

Berkshire Healthcare NHS Foundation Trust has made the following progress by 31 March 2020 in taking such action:

- Several of the actions in the multi-agency action plan have been completed by the Trust, with others in progress.

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 2019/20 financial year at Prospect Park Hospital

- 2nd and 3rd October 2019- Sorrell Ward, Daisy Ward, Snowdrop Ward and Orchid Ward- all at Prospect Park Hospital, Reading
- 5th November 2019- Willow House Berkshire Adolescent Unit, Wokingham

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 2019/20 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
100% 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 Data Security and Protection Toolkit (DSPT) overall score for 2019/20 was 'Standards Exceeded'. The Information Governance Group is responsible for maintaining and improving standards in this area.

Data Quality

Berkshire Healthcare NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2019/20 by the Audit Commission.

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

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

Data Quality and Data Assurance audits are carried out throughout the year as part of the Information Assurance Framework (IAF) and where data issues are identified, internal action plans are put in place. The data is monitored until assurance is gained that the Trust can have a high confidence level in the data being reported. The assurance reports are included in the monthly Finance, Performance and Risk Executive Committee alongside the Performance Scorecard 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 December 2019, which showed that 100% of primary and 97.1% of secondary diagnoses were coded correctly. The clinical coding team carry out peer reviews on a quarterly basis.

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.

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 30 below details the number of deaths of Trust patients in 2019/20. 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 30- Deaths of Trust patients in 2019/20- case reviews and investigations carried out in 2019/20

	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 2019/20 the following number of Berkshire Healthcare NHS Foundation Trust patients died	By 31st March 2020, the following number of case record reviews and investigations have been carried out in relation to 301 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 19/20	**3884** ↓	**406**	**198** ↓	**198 (43)**	**3 representing 0.077%** ↓
Mandated Statement	This comprised of 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 19/20	**967**	**90**	**49**	**57 (8)**	**1 representing 0.103%- Oct 18 death**
Q2 19/20	**930**	**108**	**65**	**75 (10)**	**1 representing 0.108%**
Q3 19/20	**1150**	**103**	**39**	**57 (18)**	**0**
Q4 19/20	**837**	**106**	**46**	**53 (7)**	**1 representing 0.119%**

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 30 and Fig 31. This is because the death of the patient occurred in 2018/19, but the investigation was completed in 2019/20

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 31 below details the number of deaths of Trust patients in 2018/19 that had case note reviews and investigations carried out in 2019/20 (to be confirmed in Q4). 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 2019/20. Please note that the table contains statements that are mandated by NHS Improvement for inclusion in the Quality Account.

Figure 31- Deaths of Trust patients in 2018/19- case reviews and investigations carried out in 2019/20

	1. Reviews and investigations carried out		2.Deaths more likely than not due to problems in care	3. Revised estimate of deaths in 2018/19 that were more likely than not due to problems in care
Mandated Statement	The number of case record reviews and investigations completed after 31st March 2019 which related to deaths which took place before the start of the reporting period (deaths before 1st April 2019)		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 ascertained using either Initial Findings Report or Root Cause Analysis methodology)	The number and % of the patient deaths during 2018/19 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	**20**	**15**	**1**	**3, representing 0.076%**

**** 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 30 and Fig 31. This is because the death of the patient occurred in 2018/19, but the investigation was completed in 2019/20.***

2.3.7. Bolstering staffing in adult and older adult community mental health services

In East Berkshire Community Mental Health services, targeted work is being undertaken across the three locality teams to review skill mix and work with the recruitment team to fill vacancies in a timelier way. This work has started to deliver benefits. The Frimley Integrated Care System (ICS) has been successful in securing Transformation funding to introduce Mental Health Integrated Community Support teams who will work with the Primary Care Networks (PCN's) to deliver earlier intervention and support across primary and secondary Mental Health. The posts within these teams will offer exciting opportunities for new staff and will also assist the work of the core teams.

The Berkshire West region is leading a project addressing the function and workforce across all six locality CMHTs. This work is being undertaken to establish a standardised approach to providing support to people with mental health needs. This includes a further analysis of the offer and function of the community teams with a review of the skills required to develop primary care networks with mental health.

The Clinical Commissioning Groups (CCGs) are committing investment for 2020/21 to achieve the trajectory in Perinatal Mental Health.

In relation to the Berkshire West Psychological Medicine Service, the CCG investment standard has been met to comply with the 'Core 24' model for adult mental health liaison services.

There has been strong delivery of the Improving Access to Psychological Therapies (IAPT) constitutional and performance standards during the year, including national wait times standards and recovery rates. There is also system agreement to invest additional CCG baseline funding in order to recruit skilled staff.

Transformation investment has been used to enhance the crisis phone line aspect of the Berkshire West Crisis Resolution and Home Treatment Team (CRHTT) service. From late Q4 2019/20, this service will be accepting referrals from NHS111 for mental health crisis intervention. In addition, Police Street Triage is in place 7 nights a week.

A completed review of crisis service provision in Berkshire West contained 14 recommendations, and work is underway to prioritise and engage with partners to meet these. We are committed to delivering a sanctuary / safe haven as part of the long-term plan.

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 several inherent limitations in the preparation of quality reports which may impact the reliability or accuracy of the data reported.

- Data is derived from many 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 many 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 32	2017/18	2018/19	2019/20	National Average 2019/20	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	97.7%	98.7%	**96.5%**	National Analysis paused due to COVID-19	National Analysis paused due to COVID-19
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 33	2017/18	2018/19	2019/20	National Average 2019/20	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	99.2%	99.1%	**99.8%**	National Analysis paused due to COVID-19	National Analysis paused due to COVID-19
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 34	2017/18	2018/19	2019/20	National Average 2019/20	Highest and Lowest
The percentage of Mental Health patients aged— (i) 0 to 15; and (ii) 16 or over, readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period	7.9%	6.9%	**6.1%**	**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 35	2017/18	2018/19	2019/20	National Average 2019/20 For combined MH/LD and community Trusts	Highest and Lowest For combined MH/LD and community Trusts
The indicator score of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends *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."*	75.1%	73.6%	**74.4%**	**67.5%**	**57.3%-80.6%**
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 36	2017/18	2018/19	2019/20	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	7.3	7.2	**7.3**	**6.8** (median figure for all participating Trusts)	**5.8-7.7**
Berkshire Healthcare NHS Foundation Trust considers that this score 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 score, and so the quality of services, by: Being committed to improving the experience of all users of their services. Data is collected from a number of sources to show how our users feel about the service they have received. Actions are put in place through a number of initiatives to improve both an individual's experience and if required to change the service provision.					

Source: National Community Mental Health Survey

Figure 37	2017/18	2018/19	2019/20	National Figures 2019/20	Highest and Lowest
The number of patient safety incidents reported	**4824** *	**4518** *	**4842 (To 29th Feb 2020)** *	**TBC** **	**TBC** **
Rate of patient safety incidents reported within the Trust during the reporting period per 1000 bed days	**45.9** *	**46.2** *	**Figures for Mar 20 not yet available nationally** *	**TBC** ** **(Median)**	**TBC** **
The number and percentage of such patient safety incidents that resulted in severe harm or death	**44 (1.1%)** *	**40 (0.9%)** *	**50 (To 29th Feb 2020) (0.9%)***	**TBC** **	**TBC** **
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 X 2020, the median reporting rate for the Trust is given as X incidents per 1000 bed days (but please note this covers the 6-month period X-X)- Please note data analysis for this has been paused nationally due to COVID-19. 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 X- X relating to 50 Mental Health Organisations Only.*

Please note data analysis for this has been paused nationally due to COVID-19

Part 3. Review of Quality Performance in 2019/20

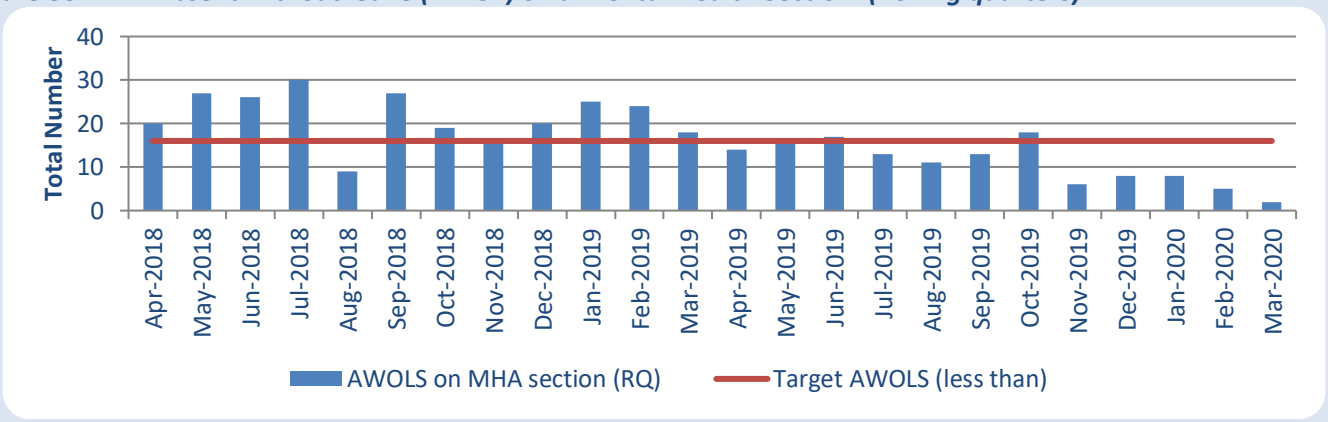
ⓘ In addition to the key priorities detailed in Part 2 of this report, the Trust Board receives monthly Performance Assurance Framework reports related to key areas of quality. The metrics in these reports are closely monitored through the Trust Quality Governance systems including the Quality Executive 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 2019/20 is detailed below.

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.

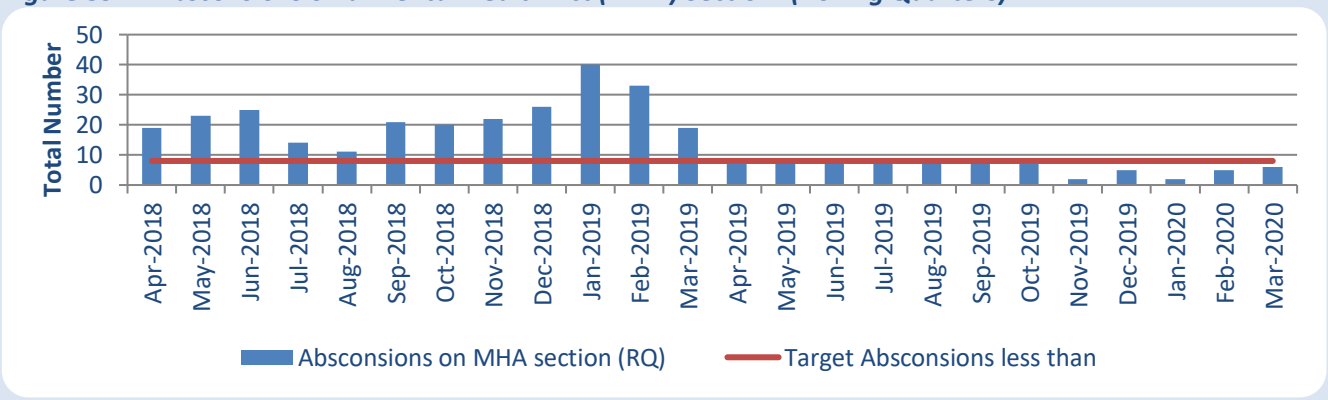
Figures 38 and 39 below detail the number of absconsions on a Mental Health Act Section and the number of patients absent without leave on a Mental Health section.

Figure 38- Absent without leave (AWOL) on a Mental Health Section- (Rolling quarters)



Source- Trust Tableau Dashboard

Figure 39- Absconsions on a Mental Health Act (MHA) Section- (Rolling Quarters)



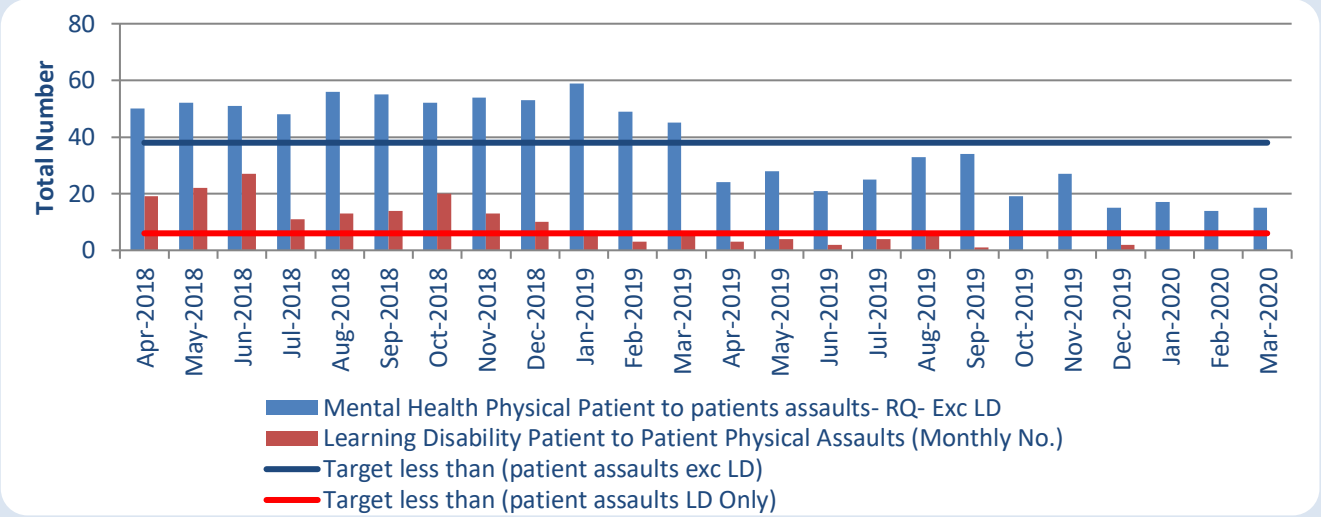
Source- Trust Tableau Dashboard

Mental Health and Learning Disability Patient to Patient Physical Assaults

Figure 40 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 40- Patient to Patient Physical Assaults- Rolling Quarters



Source- Trust Tableau Dashboard

Other Quality Indicators

Figure 41- Other Quality Indicators	Annual Target	2017/18	2018/19	2019/20	Commentary
Patient Safety					
Never Events	0	0	0	**0**	Total number of never events
Infection Control- MRSA bacteraemia	0	0	0	**0**	Total number of MRSA Cases *Source- Trust Inf. Control. Rept.*
Infection Control- C. difficile due to lapses in care	<6	3	1	**1**	Total number & rate per 1000 occupied bed days of C. Diff due to lapse in care by Trust. *Source- Trust Infection Control Reports*
Medication errors	Increase Reporting	N/A	830	**910**	Total number of medication errors reported. *Source- Trust Medicines Management Report*
Admissions to adult facilities of patients under 16 yrs. old	0	0	0	**0**	Total number of patients <16 years of age admitted to adult Mental Health Inpatient Facilities
Inappropriate out-of-area placements (OAP) for adult mental health services (Occupied Bed days as OAP)	Reduce as per NHSI Target	247 (Target Met)	185 (Target Met)	**86 (Target Met)**	Average monthly total bed days spent out of area
Mental Health minimising delayed transfers of care (Relates to Mental Health delays only- Health & Social Care).	<7.5%	12.38%	11.3%	**6.8%**	Average monthly %. 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%	84.5%	82.6%	**91.7%**	Average monthly %
Improving access to psychological therapies (IAPT): proportion of people completing treatment who move to recovery	50%	58.8%	57.4%	**56.7%**	Average Monthly %
Improving access to psychological therapies (IAPT): People with common mental health conditions referred to the IAPT programme will be treated within 6 weeks of referral	75%	98.9%	98.3%	**95.7%**	Average monthly %

Figure 41- Other Quality Indicators	Annual Target	2017/18	2018/19	2019/20	Commentary
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%	100%	100%	**100%**	Average monthly %
A&E: maximum waiting time of four hours from arrival to admission/ transfer/ discharge	95%	99.3%	99.8%	**98.1%**	Average monthly %
Data Quality Maturity Index (DQMI) – MHSDS dataset score (Revised Indicator)	95%	N/A	97.8%	**96.5%**	Average monthly %
Patient Experience					
Community Paediatric Service- Referral to Treatment waiting times (RTT)- Incomplete pathways- How many within 18 weeks (%)	95% <18 weeks	99.8%	99.4%	**99.8%**	Average monthly %
Diabetes Service- Referral to Treatment waiting times (RTT)- Incomplete pathways- How many within 18 weeks (%)	95% <18 weeks	98.9%	99.5%	**100%**	Average monthly %
Complaints received		209	230	**231**	Total number of complaints
1. Complaint acknowledged within 3 working days	100%	100%	100%	**100%**	% meeting requirement
2. Complaint resolved within timescale of complainant	90%	100%	100%	**99.5%**	% meeting requirement

Source- Trust Tableau Dashboard except where indicated in commentary

Please note that the cardio-metabolic assessment and treatment indicators were removed in 2019/20 in line with NHSI requirements.

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 2019/20 and supporting guidance detailed requirements for quality reports 2019/20
- 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 2019 to May 2020
  - papers relating to quality reported to the Board over the period April 2019 to May 2020
  - feedback from commissioners dated April 2020
  - feedback from governors dated April 2020
  - feedback from local Healthwatch organisations dated April 2020
  - feedback from Overview and Scrutiny Committees dated April 2020
  - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated April 2020
  - the 2019 national patient survey, November 2019
  - the 2019 national staff survey, February 2020
  - the Head of Internal Audit's annual opinion of the Trust's control environment dated May 2020
  - 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

9th July 2020  **Martin Earwicker** **Chairman**

9th July 2020  **Julian Emms** **Chief Executive**

Appendix A- Annual Plan on a Page

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

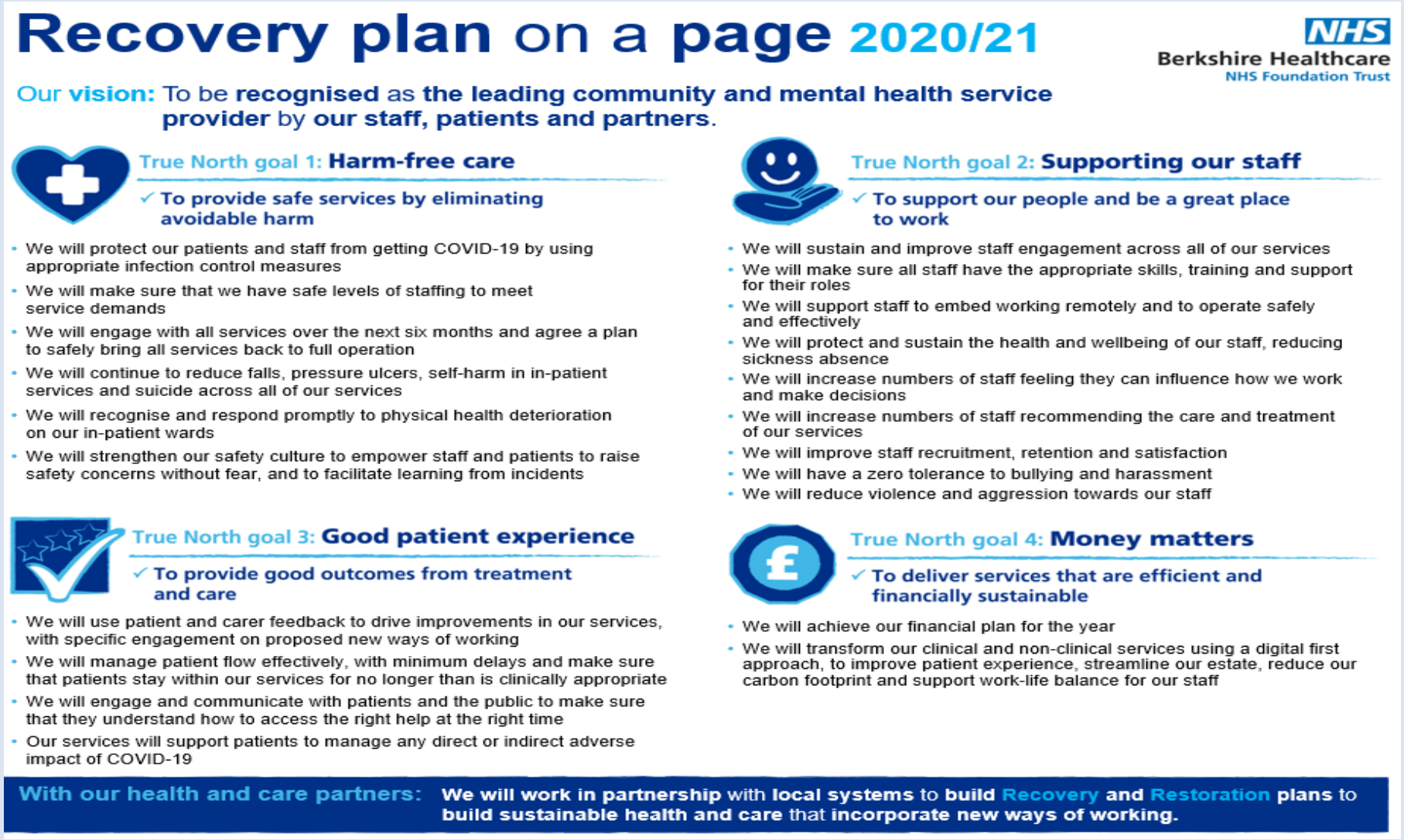
✓ **To deliver services that are efficient and financially sustainable**

- 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.

Annual Plan on a Page- 2020-21

Please note that the original 2020/21 Annual Plan was been updated in May 2020, in light of the COVID-19 pandemic, to become a Recovery plan on a page



Appendix B- National Clinical Audits- Actions to Improve Quality

National Clinical Audits Reported in 2019/20 and results received that were applicable to Berkshire Healthcare NHS Foundation Trust

National Audits Reported in 2019/20		Recommendation (taken from national report)	Actions to be Taken
NCAPOP Audits			
1	**The National Clinical Audit of Psychosis - EIP spotlight audit (4404)**	Early Intervention in Psychosis (EIP) services saw the introduction of an access and waiting time standard in 2016 (NHS England, NICE QS80 & QS102, NCCMH, 2016). This set targets for EIP services that require from 1st April 2016 more than 50% of those experiencing First Episode Psychosis (FEP) will be treated with a NICE-approved care package within two weeks of referral, and by 2020/21, more than 60% of people with FEP will be treated with this care package within two weeks of referral. A self-assessment exercise was conducted during 2017/18 led by the Early Intervention in Psychosis Network at the Royal College of Psychiatrists (RCPsych). In 2018/19, this became a spotlight audit by NCAP at the RCPsych and aimed to ensure that people with FEP received prompt assessment and access to the evidence-based interventions that are vital to improved mental health and recovery, including the monitoring of patient outcomes.	The EIP have been audited annually and at the time of the data collection the previous action plan had not been fully implemented and the following actions have since been implemented: 1. Full implementation of SHARON which includes and e-health education & support for carers and service users 2. A rolling education & support programme across Berkshire implemented in April 2019. 3. Ensuring 1 to 1 advice and information is captured as carer -focused education and support. Data collection has started on the next round of audit (1 October 2019). This audit also includes a service user survey, and these have been sent out to all 111 patients. The national report will be due to be published in Summer 2020. The service are planning a local analysis on the current data being submitted nationally to get a better picture of the effect of the previous action plan prior to summer 2020.
2	**National Diabetes Insulin Pump report (4330)**	The National Diabetes Insulin Pump Audit (NDA) collects information on the number and characteristics of people with diabetes using an insulin pump, the reasons for going on an insulin pump and the outcomes achieved since commencing insulin pump therapy. The National Institute for Care and Health Excellence (NICE) guidance states that Continuous Subcutaneous Insulin Infusion (CSII) or insulin pump therapy is recommended as a treatment option for adults, and children aged 12 years and over with Type 1 diabetes mellitus provided that the patient meets specific parameters.	- Discuss with Frimley ICS as to how we can ensure equity within the system for people with Type 1 Diabetes who require CSII. - To implement anxiety score for all people with Type 1 Diabetes who are under the care of the Diabetes Specialist Service. - Service due to transition from Diabetes Specific clinical database to RIO for recording of all clinical documentation. - Required data set has been added to Diabetes Assessment Sheet on RIO.
3	**National Clinical Audit of Anxiety and Depression -**	This is a new audit and it should be noted that the results reflect 2017 clinical activity. The National Clinical Audit of Anxiety and Depression (NCAAD) is a three-year quality improvement programme established to improve the quality of mental health care for people who are admitted to hospital for the treatment of anxiety and depression. This audit focuses on inpatient services, where	Two wards have countermeasures in place as part of quality improvement project, involving having a daily conversation with the service user around their safety plan. These countermeasures are: - Having a paper copy of safety plan in folder for ease of access. - Using admin to update folder.

National Audits Reported in 2019/20		Recommendation (taken from national report)	Actions to be Taken
	Core audit 2017 (53581)	people are admitted to hospital and stay overnight for a period of time. It has measured the performance of secondary care mental health services against thirteen quality standards. These standards are derived from national and professional guidance, including those from the National Institute for Health and Care Excellence (NICE), and guidance such as the 'triangle of care' published by the Carers Trust.	- Including a question in daily status exchange between ward manager and nurse in charge re whose safety plan needs further work today. - Mental health training lead and nurse consultant are working with individual clinicians and teams to improve their skills and understanding of safety planning. - Training will involve how to have a safety planning conversation and giving a copy to the service user and carer. - The nurse consultant for in-patients, crisis team and head of MH Urgent care plan to start and monthly training session using immersive theatre for skill development. - An app is being developed for service users to have on their phone and this is due to be trialled on Bluebell ward over the next few months. - The CQUIN requiring 72-hour reporting will be taken from the Mental Health Services Data Set and will be reported by NHS England to commissioners.

4	**(NCAAD) National Clinical Audit of Anxiety and Depression - Spotlight audit (Psychological Therapies) (4408)**	This audit was the second in the NCAAD quality improvement programme following on from the main Audit of Anxiety and Depression in 2017-18. It should be noted that the results reflect 2017-18 clinical activity.
		
		This audit focuses on the delivery of psychological therapies in secondary care adult mental health services with the aim to improve accessibility and psychological care and treatment for people with anxiety and depression. It has measured performance of secondary care mental health services against eight quality standards. These standards were derived from the National Institute for Health and Care Excellence (NICE) guidelines as well as other national and professional guidance.
		
		The national report presents the audit findings group into five themes: access and waiting times, appropriateness of therapy, service user involvement, outcome measurement, and therapist training and supervision.
			- Establish a trust-wide Psychological Therapies Committee (PTC)
			- Prompts for disability and sexuality to be added to the Demographics form, to be used by all AMH therapy services
			- Work across services to renew focus on waiting times:
			  ○ Refresh IPT Group Programme
			  ○ Utilise performance data from the Psychological Therapies Tableau
			  ○ Report performance and adherence to SoPs to PTS.
			- To identify and consider options and practical solutions to address skills gaps and capacity issues, duplication and post code/services variability, and differences in ability of AMH Psychological Therapy teams to deliver the MH Pathways consistently, equitably and effectively.
			- Proposed options to be considered by PTS.
			- Information leaflets to be updated with data management, treatments and treatment choices and utilised by all services.
			- Clinical Leads to remind all therapists of the need to develop a formulation of the presenting problem early in therapy, and to use this to inform goals for intervention that are agreed with the service user.
			- All AMH Psychological Therapists to be reminded to routinely complete HoNOS, ReQol, and CORE-OM pre- and post-intervention and record this on Rio where reports can inform learning.
			- Performance monitoring by Tableau to AMH Leads meeting and PTS.

National Audits Reported in 2019/20		Recommendation (taken from national report)	Actions to be Taken
			- The Supervision Task & Finish Group to review competency assessment requirements to ensure practising clinicians are sufficiently skilled in the therapies they deliver where accreditation is either not available or not an essential requirement for the level of practise.
5	**(NDA) National Diabetes audit (4912)**	The National Diabetes Audit is a major national clinical audit which measures the effectiveness of diabetes healthcare against NICE Clinical Guidelines and NICE Quality Standards in England and Wales. NICE Guidance and NICE Quality Standards for Diabetes: 1. Type 1diabetes in adults: Diagnosis and management (NG17) 2. Type 2 diabetes in adults: management (NG28) 3. Diabetes (Type 1 and Type 2) in children and young people: diagnosis and management (NG18) 4. Diabetes in adults (QS6) 5. Diabetes in children and young people (QS125)	- All staff including Diabetes Consultants are now using RIO and diabetes assessment sheet on RIO for all people with diabetes that are under the care of the Diabetes Specialist Service - All staff aware of the importance of entering data onto the diabetes assessment sheet. on RIO - Meet with analyst team to discuss process - Data inputted into RIO will be pulled into a tableau report against parameters for NDA data set
6	**National Audit of Care at end of Life (4870)**	The second round of The National Audit of Care at the End of Life (NACEL) is a nationally facilitated project that is mandated for participation by Trust community inpatient wards as part of the National Clinical Audit and Patient Outcome Programme (NCAPOP). Mental Health inpatient wards were excluded in this round of the audit but are expected to be included in round three. The audit focuses on expected hospital deaths and comprises three main parts; an organisational audit, a patient case note review and a 'Nominated Person' quality survey. Standards for the audit are derived from 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). A Trust bespoke dashboard for each participating organisation was released in February 2020 which benchmarked local findings against all participating UK acute and community trusts.	- Highlight the importance of fully completing and recording the Trust End of Life Care Plan on RiO with all staff at Ward meetings. - Emphasise where findings should be improved on and specify where these aspects should be recorded on the Trust End of Life Care Plan on RiO - Attend the Trust Ward Manager's meeting to present the findings of the report and highlight any areas requiring improvement, together with how these should be addressed - Meet with Business and Performance Manager to discuss feasibility of setting up reporting system with timescales - Launch automated EoL reporting system - Use automated reporting system to monitor completion of EoL care template and feed findings into governance meeting
Non-NCAPOP Audits			
7	**POMH - Topic 6d - Assessment of the side**	Clinical Guidelines recommend the use of LAIs as a strategy to tackle non-adherence where this is thought to be a clinical priority or where the patient expresses a preference to receive their medication as an LAI. They simplify treatment by providing a known	All medical staff reviewing patients under their care receiving LAI antipsychotic medication will perform a general physical examination to rule outside effects and document the findings.

National Audits Reported in 2019/20		Recommendation (taken from national report)	Actions to be Taken
	effects of depot antipsychotics (3584)	dose of medication at regular intervals, administered by a health professional that is alert to clinical change and to non-adherence by monitoring missed or delayed appointments. As with all medication, side effects are a major reason for non-adherence. For LAIs, these include the same range of effects as for the equivalent oral preparation. Side effects are particularly likely when the LAI is 'topped up' by other antipsychotic medication.	Existing GASS form already has movement disorder, menstruation, and sexual side-effects listed. Depot nurses or reception staff to hand GASS checklist to the patient on arrival and upload it to RIO on completion. Rapid Improvement Event to be led by physical health leads representing each of the divisions supported by the QI team executive sponsor of the project is the Director of Nursing.
8	**POMH – Topic 7f – Monitoring of patients prescribed Lithium (4527)**	Lithium is licensed for the treatment of bipolar affective disorder and depression and its use in these conditions is supported by NICE guidelines. Its side-effect profile is well established.	Link with the Clozapine pathway work stream to develop a Lithium pathway. Rapid Improvement Event to be led by physical health leads representing each of the divisions supported by the QI team executive sponsor of the project is the Director of Nursing.

9	**POMH – 19a: Prescribing for depression in adult mental health (4395)**	This is a new Prescribing observatory for mental health (POMH) audit, the practice standards for the audit are derived from NICE guideline CG90 depression in adults: recognition and management (NICE, 2009) and the British Association for Psychopharmacology (BAP) guideline for treating depressive disorders with antidepressants.
		Depressive symptoms are common in the population and there is a continuum in the number of symptoms and their severity. Depression is a syndromal diagnosis, and covers a range of clinical presentations, co-morbidities, and aetiologies. This translates into a wide range of treatment approaches, a lack of evidence for clear superiority for one approach over another, and a high rate of benefit from non-specific factors in any treatment given. The National Institute for Health and Care Excellence (NICE) guidelines for the management of depression propose a 'stepped-care' approach to the treatment of depression based on clinical criteria and treatment needs.
			- Improvement of the number and quality of Safety Plans is a Driver Metric for CMHTs. Psychiatrists to include:
			  - adherence,
			  - therapeutic response, substance misuse and comorbidities when documenting outpatient appointments
			- For patients not open to Psychiatry, Lead Healthcare professionals to fully complete progress note proforma which addresses all these points
			- If augmentation is indicated, Psychiatrist to be reminded to consider Lithium as an option.
			- Audit results to be shared at East and West Performance Meetings and progress against Safety Plan Driver to be monitored monthly.
			- To re-enforce the message that Lithium should be considered as an augmentation option through the results being shared at the MSC and for psychiatrists to be reminded to consider Lithium
			- Email reminder to be circulated to support this message

Appendix C- Local Clinical Audits- Actions to Improve Quality

Audit Title		Conclusion/Actions
1	Consent to ECT Re-audit (4568)	This is the fourth re-audit, Standards were developed from local guidance, Electro Convulsive Therapy (ECT) Policy and Guidelines CCRO, (section 8) and national standards for consent to ECT as produced by ECTAS (www.ectas.org.uk ECT accreditation, standards section). Repeated audits and sincere efforts from the ECT team have made compliance with consent for ECT National guidelines almost 100%. A bit more attention would probably be all that would be needed to reach the perfect score. We have managed to be 100% compliant in 11 out of 13 standards, the other 2 were between 90-99%
2	Mental Capacity Act Practice in clinical practice on inpatient units in Berkshire Healthcare (4700)	A new Mental Capacity Act and DoLS policy has been adopted by the Trust since April 2018 (CCR096), providing clearer direction and guidance for practitioners and a telephone helpline service has been implemented to support staff who require advice regarding specific clinical circumstances. An action plan has been devised, including: 1. Encourage champions to take a more active role in developing MCA practice on the wards encouraging their colleagues to consider circumstances when the framework is required and better documentation of Best Interest Meetings and decisions made. 2. Work on up-skilling and supporting mental health practitioners on the mental health wards to use the MCA framework where appropriate. 3. Review training and make it more practice based including assessment tools, a focus on Human Rights and requirements of documentation encouraging the correct use of the legal terminology and legal responsibility for the MCA framework.
3	JD - Audit of completion of VTE assessment, Audit C and ECG as per admission protocol (4701)	This project aimed to see if the admission protocol criteria were met and forms filled in, for ECG's, VTE, and AUDIT C in a timely manner. Circulation of findings to all psychiatrists through the academic meeting: achieved on 14.3.19. 1. Re-circulation of admission protocol to all psychiatrists, including trainees and SAS doctors, and nursing staff. This would provide clarification that both VTE and Audit C forms are now electronic and that paper copies must not be used. 2. Trainees to be reminded that any deviation from expected standards must be documented with clear rationale. 3. Findings to be shared with Physical Health Lead and Drug and Alcohol Lead for their awareness and appropriate actions (e.g. monthly audit of a random sample of admissions to check Audit C compliance; update from Physical Health Lead on ECG machines upgrade plans to improve accessibility).
4	Re-audit of Antimicrobial Prescribing on all Berkshire Healthcare NHS Foundation Trust Inpatient Wards Project 2018-19 (4788)	This audit is a re-audit of Project 3574. 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. Actions will be managed through the BHFTs AMS Group who will have overall responsibility for taking these actions forward. 1. Work towards increasing Trust compliance to documenting allergy severity for all inpatient drug charts. 2. Continue staff engagement through continued staff training and awareness of AMS principles. Propose that the ESR e Learning antimicrobial module is mandatory for all prescribers as a stand-alone module. This will ensure compliance to all standards is adhered to. It is expected, that further improvements will be observed as EPMA is embedded.

Audit Title		Conclusion/Actions
5	Speech and Language Therapy Referrals to the Mainstream School Service in Reading: Impact of the Early Years Service (3802)	Following a re-design of the Speech and Language Therapy (SLT) Early Years Service across Berkshire in 2014, service users have been required to attend a Drop-In clinic in order to access support from speech and language therapy between the ages of 0-5 years. There were concerns that some families were not accessing this new model and the needs of these children/young people weren't highlighted until they were in a mainstream placement. This may have been having a significant impact on the mainstream speech and language therapy service. 1. The SLT service may wish to develop greater links with Early Years services and educate others about the importance of early identification and intervention of speech, language and communication needs. 2. The SLT service may wish to increase the involvement of its users in ongoing service improvement to determine what challenges these families are facing and consider what reasonable adjustments could be made to the existing model.
6	The effectiveness of Group Cognitive Behaviour Therapies in Treating Adolescent Anxiety Disorders; A Service Evaluation (2018). (4228)	The study aimed to investigate the effectiveness, in terms of treatment gains, of three routinely delivered Cognitive Behavioural Therapy (CBT) groups within the CAMHS Anxiety and Depression Pathway, for adolescents (n=27) with a primary diagnosis of anxiety. One treatment group was for 13-15-year olds and two groups were for 15-17-year olds. Include further investigation into characteristics of adolescents who decline the offer of group treatment, and further investigation into whether the groups are effective, within the service, for adolescents with increased severity of symptoms could be beneficial. Future research could be undertaken within the service into whether adolescents are re-referred into the pathway, or to other adolescent or adult services after being discharged from the groups.
7	Re-audit of Risk Assessment and Record Keeping Audit of the Berkshire Eating Disorders Service, St. Mark's Hospital (4613): May 2019	The re-audit aimed to investigate the service's compliance with standards relating to risk assessments and record keeping. The standards were developed from the Trust's Risk Assessment Policy (CCR003) and the Record Keeping Policy (ORG096). The audit includes standards relating to documentation of appointments/progress notes on RiO; assessing and communicating risk to other professionals at triage, review and discharge; and responding appropriately to high-risk patients. In order to maintain good standard on record keeping the service needs to ensure that: Clinicians should update the risk summary on RiO at assessment and on discharge; Clinicians should document identified risks to GPs; The risk summary is reviewed and updated annually. The service team are to conduct twice yearly spot check audits to ensure that the above actions are in place and compliance is being met on all standards on record keeping and risk assessment.
8	Risk recording in letters from outpatient clinics to GP's (ID: 4624). Date of report: June 2019	Berkshire Healthcare Clinical Record Keeping Standards, Policies and Procedures (ORG 096) section 9, accuracy and content of clinical record and its subsection 9.8 states "there should be evidence of risk assessment of the patient and of analysis of their presenting problems". (Risk assessment/management of MH & LD Services Policy and Procedures, Berkshire Health, February 2018). It is advised to record risk of all non-Care Programme Approach covered patients twelve monthly. The aim of this audit was to review the extent to which risk assessment was recorded on patients that are not subject to the Care Programme Approach (CPA). A detailed risk analysis recording in the RIO notes should be attempted if risks existed. However, this can be time consuming and includes multi-disciplinary risk reduction strategies. This will be a big change in practice that needs training, education and coordination from several specialists in learning disability.

Audit Title		Conclusion/Actions
9	MIU X-Ray Diagnosing, Reporting and Follow Up Audit (4941): June 2019	As part of the learning from a Serious Incident (2017/19265) that occurred in the Minor Injuries Unit (MIU), whereby a patient's notes were not sent to the Virtual Fracture Clinic (VFC) leading to delayed treatment, the MIU has introduced a new procedure of checking X-Ray notes. Staff need to be aware of the impact on patients if their diagnosis is wrong. Referring patients to VFC if there is any doubt is an excellent way of ensuring patients get the correct treatment and this practice should continue. If the diagnosis is different this should be clearly documented in the notes. The patient should be informed unless it is clear that the patient is aware the treatment will not differ, and they are happy that the report will not be shared with them. X-ray reports should continue to be checked within two days of them reaching MIU to allow for timely implementation of any change in treatment Checking that the VFC referral has been made is an effective safety net and should continue. The documenting of this check needs to be consistent, so we are sure no referrals are being missed The results of this audit will be shared with RBH X-ray department X-rays requested by GP to be documented separately in future audits as the time scale for these reports do not fall under the Royal College of Emergency Medicine Management of Radiology Results in the Emergency Department best practice guidelines
10	Re-audit of prescribing for substance misuse: alcohol detoxification (4764)	This re-audit aimed to review clinical practice against national standards for the prescribing for substance misuse: alcohol detoxification. Equipment to test for breath alcohol is held on each ward, though it's possible that staff don't know where to find it. Liaison with staff regarding the whereabouts of equipment may improve the extent of testing carried out. AUDIT C form (along with other physical health forms) to be moved to an easier to find location on RIO. Some nurses may benefit from support/training in calculating accurately the units of alcohol drunk by patients. Consider including clotting and GGT to the blood form, to act as a reminder for staff to test patients.
11	Valproate prescribing for women of childbearing age (4602)	The purpose of this audit is to provide assurance to the Quality Assurance Committee of the Trust Board that, in the time period between national audits on this topic, the trust has reviewed clinical compliance with MHRA guidance for inpatient mental health wards at Prospect Park Hospital. Following feedback from medical staff it has been agreed to include a 'treatment reason' in ePMA to enable prescribers to document tapering dose prescriptions where the plan is to stop valproate. A POMH audit of the prescribing of Valproate is due to commence in 2020, the Royal College of Psychiatrists will be holding a planning meeting in January 2020 which will be attended by trust staff.
12	VTE re-audit (4759)	The purpose of this re-audit is to provide assurance to the Quality Assurance Committee of the Board and measure compliance on the older adult wards, against the standards listed below after the implementation of recommendations from the previous audit and the introduction of revised NICE guidance in 2018. VTE online form to be amended so that the prompt to save the form (before the risk factors have been considered) will be moved to the bottom of the form; this should improve bleeding risk assessment and result in more detailed VTE assessment. VTE e-learning should be considered for inclusion into essential training requirements for doctors and nurses working on inpatient wards--this should result in greater awareness around the need to consider repeating VTE risk assessment if clinical condition changes as well as overall awareness of VTE risk and its management.

Audit Title		Conclusion/Actions
13	OAP Service Evaluation of Personality Disorder Hospital Admissions Report (4565)	The Out of Area Placement (OAP) Team manages a number of referrals for out of area placements to Out of County Hospitals (Locked Rehab, and Specialist hospital placements), to the Cloisters (locked and open rehab in Newbury under block contract) and Rosebank House (open rehab in Reading with BHFT providing medical, pharmacy and MHA input). Historically the OAPs budget became overspent, and a lot of work has gone in to rationalising and making more robust and transparent the processes in OAPs. This service evaluation was carried out because the OAP team had limited outcome evidence on which to base the advice it gives or the decisions made in the OAP Funding Panel. 1. Discuss data within OAPs and IMPACTT services and share with Associate Medical Director (for inpatients) 2. Consider improving early work with emergent Personality Disorder in CAMHS 3. Develop a system for prospective data collection around patients in such placements 4. Share findings in upcoming personality disorder OAPs workshop 5. Reflect on what is offered to these patients prior to placement, arguably not sufficient or timely enough.
14	WestCall Antimicrobial Prescribing Audit 2018_Final Report (4643)	The audit looked to assess antimicrobial prescribing for patients seen in West Berkshire by the out of hours team - WestCall in accordance with Trust policy and AMx prescribing guidelines. Propose that an audit is carried out into how many patients had their treatment changed as a result of a urine culture and susceptibility (UC+S) result showing bacterial resistance to a prescribed AMx. Education and training for WestCall staff: 1. To increase compliance of documentation of patients' allergic status. 2. Trimethoprim is no longer a front-line treatment for UTI because of a resistance rate of 33% in Berkshire West. 3. Apply attention to detail when prescribing AMx in terms of using the correct dosage and frequency of medication. 4. The procedure for sending UC+S to increase number of processes sampled. 5. Wherever possible arrange UC+S for those patients who: a. Are 65 and over and may have a UTI. b. Have evidence of an upper urinary tract infection. c. Have a UTI that has not responded to a previous course of antibiotics. d. Children e. repeat UTI 6. Improve AMx prescribed in accordance with Trust guidance. 7. Document weight (estimated) used to calculate paediatric doses, where applicable. Change the order of nitrofurantoin formulations to place modified release at the top to reduce human error with medication selection on Adastra.
15	Identifying if clients with a cluster 10-15 are currently receiving any support for voice hearing – report - (4748)	This audit was completed as part of a final module on the Psychosocial Interventions for Psychosis (PSI), an innovation-based project. The CQC report highlighted that the Slough locality did not offer a hearing voices group. The audit took place to review whether any interventions were currently being offered for voice hearing or whether they had been offered to CMHT clients previously and the date that these were last offered. Hearing voices group to be planned, co-produced and facilitated with a peer mentor (individual with lived experience) at Slough CMHT. More interventions to be offered for those who hear voices.

Audit Title		Conclusion/Actions
16	10 day follow up by CAMHS RRT following discharge from acute hospital - report (May 2019) (4789)	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 aims to reduce, where possible, the risk of suicide and social exclusion. 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. A SOP has been agreed and a community follow up duty shift is now rotated evenly amongst the clinicians pro-rata to ensure 7-10 day follow up of patients.
17	Audit of Transition Practice from Child Services to Adult Learning Services Final Report Oct 19 (5024)	The aims of this audit are twofold: Firstly, to establish if all young people audited since the implementation of the protocol in August 2017 who were referred to the psychology service within the adult learning disability team were appropriately transitioned according to and in line with the local trust transitioning standard operating procedure. Secondly, to audit what happens to these transition referrals when they are held under the psychology team and what input is required. 1. To disseminate and provide teaching to Psychological Services and the broader CTPLD to increase awareness of local and national best practice standards. 2. To explore the use of a transition checklist for referring professionals to complete. 3. To increase opportunities for young people to meet clinicians from the CTPLD prior to transition from child services. 4. To routinely gather feedback on transition experience from referred young people with learning disabilities and their families. 5. To improve the functional use of the referral form to encourage improved quality of referrals to the service.
18	Re-audit of use of dementia assessment care pathway in LD (5053)	The aim of the project was to ascertain whether there had been an increase in the use of the Dementia Assessment Care Pathway tool, or the information provided by this tool, by health professionals in their dementia assessments of people with learning disabilities, since the initial audit in 2013. This is the fourth audit in relation to this topic. 1. Training for some health staff in certain teams regarding the tools that are available. 2. Annual training for staff teams to include how to use the Dementia Assessment Care Pathway, how to analyse data from the dementia assessments and how to report findings. 3. Consideration of the content of Dementia planning meetings to ensure it is consistent across teams as well as an agreed upon frequency and regularity.
19	Record Keeping Audit Health Visiting and School Nursing (4887)	Serious Case Reviews and complex investigations have identified occasions where record keeping was not comprehensive and failed to inform other professionals of holistic care needs. Aim to give quality assurance of the RIO record keeping completed by Health Visiting and School Nursing teams Objectives to enable consistency across all staff groups and ensure professional, Trust and service guidelines are being adhered too and findings to facilitate updates to service manuals including guidance and service specific standards on record keeping 1. Develop templates to facilitate progress note records. 2. Review abbreviations and update SOP accordingly. 3. Meet with safeguarding team to create protocol for vulnerable children on caseloads for over 4 months. 4. Contacts training reminders for all staff and guidance in service standards.

Audit Title		Conclusion/Actions
20	JD - Audit of lipid monitoring in WAM CMHT patients on antipsychotic medication (5061)	NICE Guideline CG178 (Psychosis and schizophrenia in adults: prevention and management), recommends that all patients should have blood lipid profile measured before starting an antipsychotic drug. It is also recommended the lipid profile is measured again at 12 weeks after starting the antipsychotic medications and then again at 1 year and then annually. This audit will specifically focus on the annual lipid monitoring of patients in WAM CMHT. Additionally, the audit will also look at whether the lipid profiles measured are within the normal parameters and if not, whether any lifestyle advice was given. Audit findings to be disseminated to psychiatrists and other clinicians. • Explore idea of leaflets or posters in patient waiting areas to raise awareness of dyslipidaemia, its risks and its management. • Patient information leaflets regarding reducing cholesterol to be circulated to doctors and other clinicians within the service to raise the profile of this issue.
21	(5165) Re-audit capacity assessment on Rose Ward (inpatient general adult ward) (5165)	Carrying out mental capacity assessment is extremely important regarding psychiatric patients who are admitted either informally or under the Mental Health Act. BHFT has clear standards for documenting capacity assessment for admission and for treatment. The aim was to re-assess how well we are adhering to the standards set by the trust and notice any improvement from the previous audit. An action plan has been drafted which includes guidance to be circulated to all the medical and nursing teams for documenting capacity assessment on admission.
22	JD - Assessing the management of diabetes amongst psychiatric adult inpatients (5004)	Correct management of patients with diabetes during acute adult psychiatric admissions is crucial in order to prevent severe harm through extreme hypoglycaemia or hyperglycaemia, identify worsening end organ damage and improve glycaemic control for long term benefit. NICE provides guidance for screening on admission for patients with diabetes, actions which must be undertaken based on HbA1c and hospital admissions. This audit aimed to identify whether best practice standards for patients with diabetes admitted as psychiatric inpatients in Berkshire Healthcare, were being met. Drafting of an admissions proforma for diabetic patients
23	NICE Lower Back Pain Audit (2016), MSK East in June 2019 (5527)	Previous informal audits against NICE Lower Back Pain (LBK) and sciatica guidelines have demonstrated an overall compliance of 62% and 69% in 2017 and 2018, respectively, in the Muscoskeletal (MSK) East service. The main purpose of this formal audit is to re-assess these areas and create an action plan to improve provided. Aim to improve compliance with NICE guidelines regarding lower back pain in the Musculoskeletal (MSK) East Service. Objectives to determine compliance against the NICE guidelines and create an action plan to improve areas requiring improvement. To liaise with admin to ensure all new patients with LBK given Start Back tool, to agree with clinical staff where to document score, education Service-wide education on importance of documenting advice given Locality led IST this year will be aimed at manual therapy practise and idea sharing and TNA to include courses to support increasing manual therapy consideration and idea sharing, TNA to include courses to support objective
24	Audit of Written Directive by Peer Vaccinators for the 2020 staff influenza vaccination campaign (5747)	For the 2019 staff influenza campaign, to allow peer vaccinators to vaccinate staff, a new national Written Directive replaced the former PGD. The Written Directive is an instruction for the supply or administration of the vaccine to staff who may not be individually identified before presentation for the vaccine. The Directive provides a legal framework that allows named, authorised, registered nurses, who are not prescribers in their own right, to supply or administer the vaccine to a pre-defined group of staff requiring the vaccine described without the need for a prescription or an instruction from a prescriber. This audit examined the use of the influenza vaccination Written Directive 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 Directive was used in accordance with agreed inclusion criteria and national recommendations. Documenting the brand on the consent form - add to training. Doses should be written in millilitres, not written as pre-filled syringe - add to training. Results to be shared with peer vaccinators.

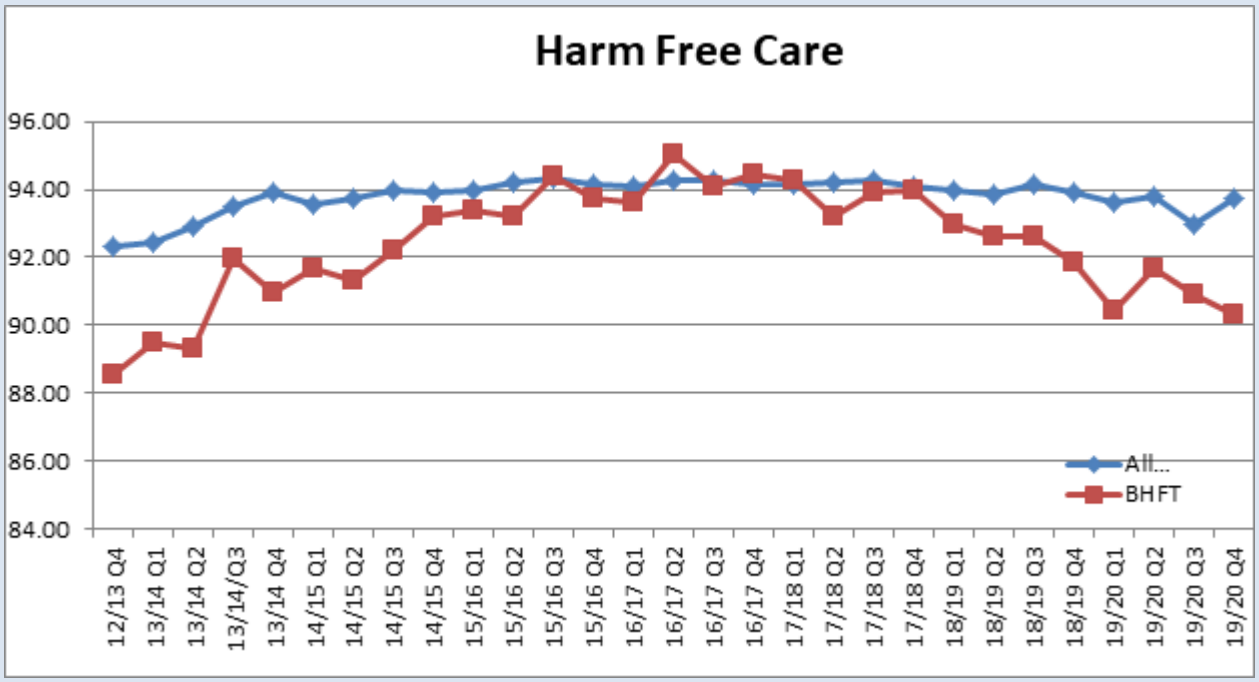
Audit Title		Conclusion/Actions
25	Junior Doctor project - Consent to Treatment with Psychotropic medications audit on Rowan and Orchid Wards (3945)	To compare how the current documentation for consent for psychotropic medications compares with the current GMC guidance "Consent: patients and doctors making decisions together on Rowan and Orchid wards. Aim to improve the consenting process for psychotropic medications on Rowan and Orchid wards Objective to determine the current extent to which documentation for consent for psychotropic medications compares with the current GMC guidance. To increase awareness of the importance of this documentation by presenting audit poster to the team during ward round. Improve availability of patient information leaflets that are clear for the patient demographic on Orchid and Rowan wards. Introduce easy template for Rio notes, to be used when a new psychotropic medication is being prescribed. Re-audit.
26	Junior Doctor project - Clinical audit - Informing PPH in-patients of DVLA guidelines (5297)	There are well established guidelines on giving patient advice in relation to driving and various physical illnesses. DVLA guidelines relating to mental health were updated in February 2019. However, the information is limited with regard to mental illness, even though mental illnesses can affect an individual's ability to drive. The aim was to assess how many patients were given this information during their admission at Prospect Park Hospital. Standards were based on the DVLA guidelines "Assessing fitness to drive – a guide for medical professions (September 2019, DVLA). A sample proforma provided to the patients admitted for them to inform the DVLA of the hospitalization voluntarily. Discussion with clinicians on the pros and cons of providing a DVLA form to every patient admitted to the hospital and either including the form in the patient admission pack or introducing it at the CPA meeting.
27	Junior Doctor project - Benzodiazepines prescription in an acute adult psychiatric setting, compared to best practice guidance. (5481)	Benzodiazepines may be required acutely in the short term for people with serious mental illness such as schizophrenia, bipolar disorder or depression. Despite all efforts to limit the risk for misuse and dependency of this class of medication, evidence suggests that this problem has been exponentially growing. An audit was required due to two recent Trust cases where patients died due to the combination of benzodiazepines with other psychotropic and pain relief medications. There was a need for an in-depth review of the size of this problem and how to better manage the way benzodiazepines are prescribed. A staff survey to gauge barriers to compliance. Identification of online learning modules. Liaison with pharmacy leads regarding potential for provision of up-to-date prescribing guide to benzodiazepines. Liaison with RIO team to identify potential for a template to aide regular medication reviews.
28	Audit of Gillick and Capacity assessments for Willow House on admission (5496)	Willow House is the Tier 4 unit for BHFT providing admission predominantly for Berkshire patients and the neighbouring counties; Buckinghamshire, Oxfordshire, Gloucestershire and Wiltshire. Willow House is composed of a full multidisciplinary team including medics. Assessment of competency (in under 16-year olds) and capacity (in over 16-year olds) are an essential part of admissions. This area in adolescent psychiatry may easily infringe upon human rights and deem admissions as unlawful if not clearly assessed and documented. Willow House needs to demonstrate compliance with the Mental Capacity Act 2005 code of practice. From the families' perspective, Willow House is keen to be understood as a law-abiding organisation which complies with regulations in addition to least restrictive practice. To revisit the knowledge of all junior doctors involved in the admission process and those new in post in Willow House. To include these assessments on the admission checklist and to print off the admission checklist in the nursing station for any junior doctor to be able to view. This would allow 100% compliance with the competency/capacity assessments. Establishing a more robust system of checking that all processes of admissions took place to the highest standards. Highlighting to the team the legal importance of these assessments will inform future practice.

Audit Title		Conclusion/Actions
29	Junior Doctor project - Study to evaluate patient risk management & safety planning for East Berks Psychological Medicine Adult Liaison Team at Wexham (5235)	East Berkshire Psychological Medicine (EBPM) Adult Liaison team is a 24/7 service based at Wexham Hospital which delivers mental health assessments and management for acutely unwell patients within an A&E setting and those admitted to acute wards with physical health issues presenting with psychiatric problems. The Royal College of Psychiatry Good Practice emphasizes the need for a high expected standard of care within a patient care-plan in which risk management and safety planning is mandatory. NICE states that a risk management plan can help people who self harm to reduce their risk of repeating. It should be based on a risk assessment and developed with the person who has self harmed, who should have joint ownership of the plan. The purpose of this audit was to detect the proportion of patients who were referred, assessed and discharged back to the community within the 2-week time frame; to evaluate whether they were actively informed of their care and signed the approved safety plan put in place; to identify the possible need for further safety planning for patients who may be admitted, referred back to the ward and reviewed for clinics. Increase staff awareness and education for the need to write up, discuss and log safety plans for all patients discharged back into the community. Type into 'progress notes' in RIO straight after FIRST contact with patient Provide same procedure of issuing a safety planning consultation for those even within wards and/or being reviewed for clinics.
30	Junior Doctor project - Driving in Dementia Re-Audit (5387)	People with early dementia may be fit to drive if sufficient skills are retained and progression is slow, however a license is issued that is subject to annual review. This audit aims to establish to what extent clinicians in the Memory Clinic are following GMC guidance. Objective to assess the quality of the clinical documentation in line with GMC guidance regarding DVLA assessments for fitness to drive. Documentation of driving status - regardless of obviousness of patients not driving, this should still be explicitly documented. Re-audit to maintain high standards of compliance.
31	Junior Doctor project - Assessment of the performance of Patient Observations undertaken on two older adult Mental Health Wards, PPH. (5401)	The existence of co-morbid chronic physical health conditions alongside mental health problems is common and the number of people living with two or more conditions is rising rapidly especially in the elderly. This audit aimed to assess the performance of regular physical observations as a means of screening for deterioration in physical health in Rowan and Orchid ward inpatients at Prospect Park Hospital. A 'Physical Health Observations – General Tips' poster was written, and five copies were distributed on each ward so that ward staff could be reminded to perform physical observations at least once a day. Increase awareness of the importance of this project's results by presenting to the team during ward round, briefly highlighting the need for better compliance. Use Datix to highlight missing physical health observations on RiO as per Trust's procedures. Raise the issue at one of the ePMA governance meetings and discuss the possibility of introducing a pop-up alert system which would alert the nurse accessing a patient's drug card on ePMA that physical health observations are required.

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'.

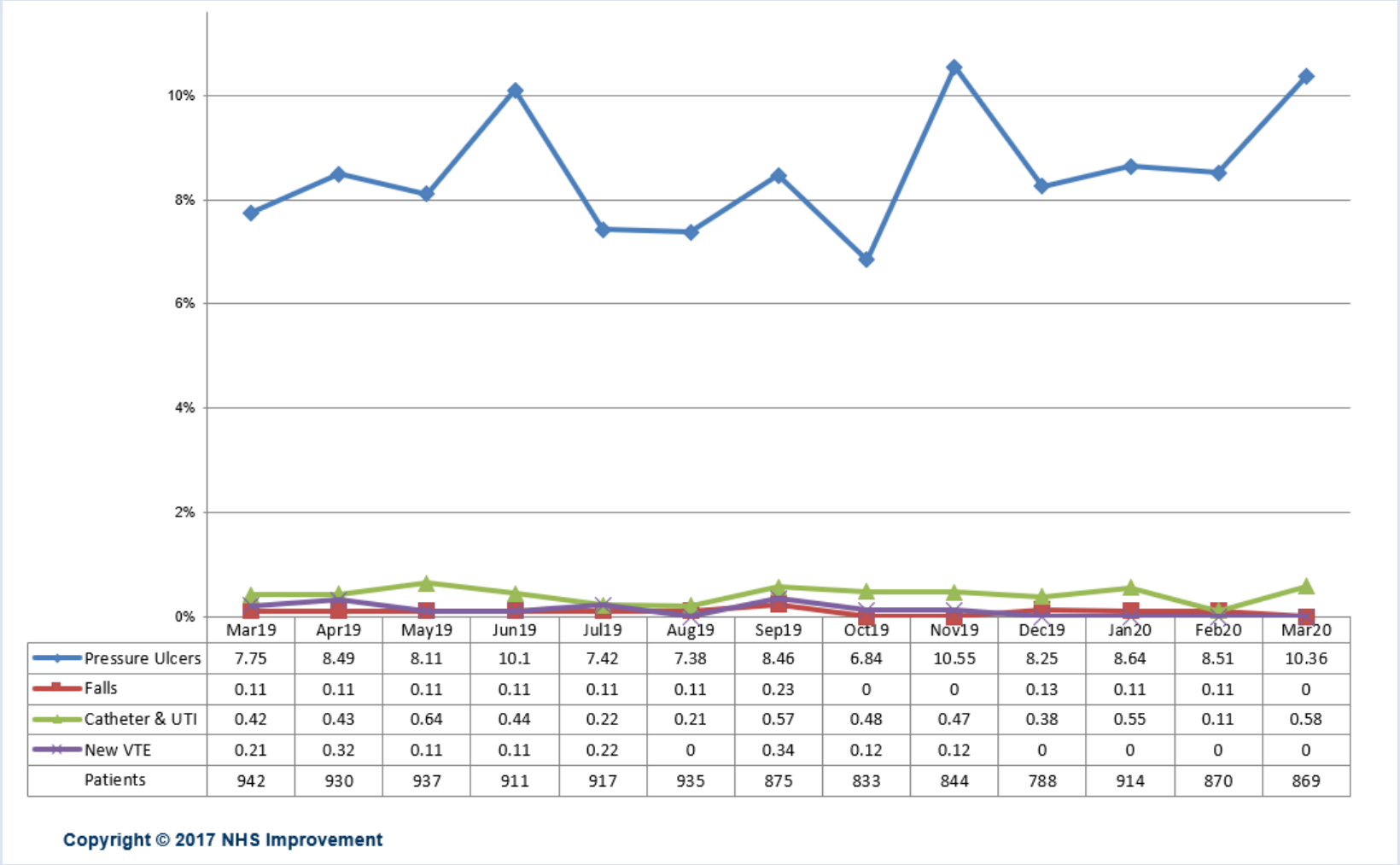
When interpreting the charts below, it should be noted that this Safety Thermometer data does not show the total number of each type of harm for the Trust, but only those that are recorded at a specific point in time each month. Old pressure ulcers and catheters with old UTIs are harms which we must own despite being inherited by the Trust and therefore largely beyond our influence.



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.



	Mar19	Apr19	May19	Jun19	Jul19	Aug19	Sep19	Oct19	Nov19	Dec19	Jan20	Feb20	Mar20
Pressure Ulcers	7.75	8.49	8.11	10.1	7.42	7.38	8.46	6.84	10.55	8.25	8.64	8.51	10.36
Falls	0.11	0.11	0.11	0.11	0.11	0.11	0.23	0	0	0.13	0.11	0.11	0
Catheter & UTI	0.42	0.43	0.64	0.44	0.22	0.21	0.57	0.48	0.47	0.38	0.55	0.11	0.58
New VTE	0.21	0.32	0.11	0.11	0.22	0	0.34	0.12	0.12	0	0	0	0
Patients	942	930	937	911	917	935	875	833	844	788	914	870	869

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

Appendix E- CQUIN 2019/20

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 F- CQUIN 2020/21

To be added when available

Appendix G- Statements from Stakeholders

Berkshire Healthcare NHS Foundation Trust – Quality Account 2019/20

Response from Council of Governors of the Trust

This report provides an excellent account of Berkshire Healthcare Foundation 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. We are pleased to see that the latest review from the Care Quality Commission rates the Trust as 'outstanding' and we believe this reflects a can-do attitude among staff and management. This has been profitably channelled through the 'QI Quality Improvement' initiative which is touching all staff in the Trust, as well as other initiative many of which are described in section 2.1 of the report.

Governors are pleased about the improving trends in the performance of the Trust in relation to many of their patients. We recognise however that a good level of care this year does not automatically mean that it will be the same next year and management vigilance and hard work is necessary to maintain a level of excellence. We also want recognition of the important role carers play in a patients' recovery, and we are pleased the Trust is taking a new initiative in this area.

We are interested in the well-being of staff without which Trust services could not operate. The NHS has a mixed reputation in relation to looking after employees, and we are pleased that management responds to issues that become apparent through the nationally mandated staff survey. This is an area where being rated highly among peers is not necessarily good enough!

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.

The Trust is developing a new measure of patient satisfaction. Governors are looking forward to seeing this in action, probably as a supplement to the nationally mandated measure known as the 'Friends and Family Test'. Unlike the latter, this new measure will enable patient feedback to be used as a both a prompt for change and a measure of improvement in the services delivered.

These comments are based on the Quality Account for the third quarter of 2019-2020. The draft report was circulated to the 32 members of the Council of Governors for the Trust in March 2020. All governors were given the opportunity to comment. There were a number of requests for clarification of figures and suggestions for improvement. All feedback is passed on to the team responsible for the report.

Paul Myerscough, Lead Governor.

Berkshire Healthcare NHS Foundation Trust Response:
The Trust welcomes this response from the Council of Governors to its 2019/20 Quality Account.

We thank Governors for the comments made and are grateful to those that have helped to contribute to the report during the year.

We are determined to continue providing a high level of care to our patients and acknowledge that vigilance and hard work is required to maintain this. The wellbeing of our staff is also one of our top priorities and we will continue to promote and monitor this throughout the year.

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 2019/20

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 2019/20 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 2019/20 and gives an overview of the quality of care provided by the Trust during this period. The priorities for 2020/21 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 2019/20 Quality Account were Patient Experience and Involvement, Patient Safety, Clinical Effectiveness and Supporting Staff.

Patient Experience and Involvement
It was disappointing that BHFT did not achieve the 15% response rate for the Friends and Family Test (FFT), but we can see that there has been a lot of work put in to trying to improve the uptake with an achievement of 11% over Q2 and Q3. Whilst it was really positive to see that the 95% satisfaction rate was achieved in Community Hospital Inpatients and Minor Injuries, it is also commendable to see that the Community Services (Mental and Physical Health combined) were just below the 95% target with 93%. Although there have been increases for the Mental Health Services from 2017/18 and 2018/19, it remains below the 95% target.
There are some great results from the Trust with regards to reducing their use of prone restraint; BHFT are below the mean line in national benchmarking data and they have exceeded their target of a 50% reduction by achieving 61%. It is however during the summer months that the target of 2 prone restraint occurrences in a month was exceeded. The CCG would like to commend the Trust on all of their hard work in this area.
The CCG's acknowledge the difficult position that the Trust is in with regards to working across two large Integrate Care Systems (ICS). The work streams that have been achieved across the Berkshire West ICP and the Frimley Health and Care ICS are admirable.

Patient Safety
The hard work already implemented into reducing the suicide rate is evident and is reflected in the data for the Trust in 2018/19. The Trust have further actions in progress to reduce this further.

Whilst it is disappointing to not see the rate of falls per 1000 bed days below the target, the work that is being implemented under the Quality Management Improvement System (QMIS) has shown a significant reduction already. It is really positive to see just one moderate medication error incident reported in the previous year and the CCG would like to congratulate the Trust on reducing the more serious medication error incidents.
We would also like to congratulate the Trust on reducing the number of category 3 and 4 pressure ulcers and the numbers are significantly below the target and although it is not the same picture for the category 2 pressure ulcers, it is positive to see that the focus will be increased into next year.

Clinical Effectiveness
It is reassuring to see that the Trust has reviewed their position against the Post-Traumatic Stress Disorder (PTSD), Care and Support of People Growing Older with Learning Disabilities and Depression in Children and Young People – Identification and Management NICE Guidance's and it is reassuring to see that actions are in place for those areas that are not quite being achieved.

Supporting Staff
The commissioners were very pleased to see the Trust has successfully achieved the target of having less than 10% of vacancies and have been below 8% since September 2019. The work that is being completed is very creditable to the Trust. This is also reflected in the staff turnover rate that has also been below the required target since September. Although there are fluctuations in the number of physicals assaults on staff, until the end of Q3 the Trust are achieving the overall target of reduction of 20% when averaged across the year.

The Quality Account does highlight a number of other service improvements that have been undertaken in 2019/20 and that this will be continued in 2020/21.

Priorities for 2020/21
The Trust has set out the priorities for 2020/21 which are as follows:

- Harm-Free Care
- Clinical Effectiveness
- Patient Experience
- Supporting Staff
- Monitoring of Priorities for Improvement

The Commissioners would like to continue to be informed of any new quality achievements or concerns identified during 2020/21 and 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.

Berkshire Healthcare NHS Foundation Trust Response:
The Trust welcomes this response to its 2019/20 Quality Account, prepared on behalf of East Berkshire and Berkshire West CCGs.

The Trust thanks the CCGs for the comments made in relation to achievements during the year and welcome the continuing support and partnership they offer to improve healthcare system-wide.

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.

Appendix H- Independent auditor's report to the Council of Governors of Berkshire Healthcare NHS Foundation Trust on the quality report

The requirement to gain external assurance for the Quality Account was removed in 2019/20 to the COVID-19 pandemic. As a result, there is no independent auditors report for this account this year.

Glossary of acronyms used in this report

Acronym	Full Name
ADHD	Attention Deficit/ Hyperactivity Disorder
ASQ	Ages and Stages Questionnaire
AMS	Anti-Microbial Stewardship
ARC	Assessment and Rehabilitation Centre
ASD	Autistic Spectrum Disorder
AWOL	Absent Without Leave
BAME	Black Asian and Minority Ethnic
BEDS	Berkshire Eating Disorder Service
BFI	Baby Friendly Initiative
BHFT	Berkshire Healthcare NHS Foundation Trust
BOB STP	Buckinghamshire, Oxfordshire and Berkshire Strategic Transformation Partnership
BPD	Borderline Personality Disorder
CAMHS	Child and Adolescent Mental Health Service
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
CDS	Commissioning Data Set
CDiff	Clostridium Difficile
CLAS	Children Looked After and Safeguarding
CMHT	Community Mental Health Team
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
CSII	Continuous Subcutaneous Insulin Infusion
CTPLD	Community Team for People with Learning Disabilities
CTS	Complex Treatment Service
CYPF	Children, Young People and Families
CYPIT	Children and Young People's Integrated Therapy Service
DBT	Dialectical Behavioural Therapy
DOC	Duty of Candour
DoLS	Deprivation of Liberty Standards
DQMI	Data Quality Maturity Index

Acronym	Full Name
DTC	Drugs and Therapeutics Committee
DTI	Deep Tissue Injury
ECG	Electrocardiogram
ECT	Electroconvulsive Therapy
ECTAS	Electroconvulsive Therapy Accreditation Service
EIP	Early Intervention in Psychosis
EMDR	Eye Movement Desensitisation and Reprocessing
EPMA	Electronic Prescribing and Medicines Administration
ESR	Electronic Staff Record
EUPD	Emotionally Unstable Personality Disorder
FFT	Friends and Family Test
GASS	Glasgow Antipsychotic Side-effect Scale
GDE	Global Digital Exemplar
GDPR	General Data Protection Regulations
GGT	Gamma-glutamyl transpeptidase
HCA	Healthcare Assistant
HEN	Home Enteral Nutrition
HV	Health Visitor
IAF	Information Assurance Framework
IAPT	Improving Access to Psychological Therapies
IBS	Irritable Bowel Syndrome
ICDM	Integrated Care Decision Making
ICP	Integrated Care Partnership
ICS	Integrated Care System
IFR	Initial Findings Report
IM	Intramuscular
IMPACTT	Intensive Management of Personality Disorders and Clinical Therapies Team
IPS	Individual Placement and support (Employment Service)
LAI	Long Acting Injectable
LD	Learning Disability
L&D	Liaison and Diversion
LeDeR	Learning Disability Mortality Review Programme
LIC	Lapse in Care
LoS	Length of Stay
MBT	Mentalization-Based Treatment
MCI	Mild Cognitive Impairment
MDT	Multi-Disciplinary Team
MH	Mental Health
MHA	Mental Health Act
MHRA	Medicines and Healthcare products Regulatory Agency
MHSDS	Mental Health Service Data Set
MIU	Minor Injuries Unit

Acronym	Full Name
MRSA	Methicillin-Resistant Staphylococcus Aureus
MSK	Musculoskeletal
NACAP	National Asthma and COPD Audit Programme
NCAP	National Clinical Audit of Psychosis
NCAPOP	National Clinical Audit and Patient Outcomes Programme
NCCMH	National Collaborating Centre for Mental Health
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NCISH	National Confidential Enquiry into Suicide and Homicide
NDA	National Diabetes Audit
NHSI	NHS Improvement
NICE	The National Institute of Health and Care Excellence
NIHR	National Institute of Health Research
NRLS	National Reporting and Learning System
OAP	Out of Area Placement
Ofsted	Office for Standards in Education, Children's Services and Skills
OPMH	Older Peoples Mental Health
PCN	Primary Care Network
PDSA	Plan, Do, Study, Act (A Quality Improvement methodology)
PFD	Preventing Future Deaths
PICC	Peripherally Inserted Central Catheter
PICT	Psychologically Informed Consultation and Training
PICU	Psychiatric Intensive Care Unit
PMS	Psychological Medicine Service
PMVA	Prevention Management of Violence and Aggression
POMH	Prescribing Observatory for Mental Health
PPEPCare	Psychological Perspectives in Education and Primary Care
PPH	Prospect Park Hospital
PTSD	Post-Traumatic Stress Disorder
PU	Pressure Ulcer
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
SEND	Special Educational Needs and Disability
SHARON	Support Hope & Recovery Online Network
SI	Serious Incident
SJR	Structured Judgement Review
SLT	Speech and Language Therapy
SMI	Severe Mental Illness

Acronym	Full Name
SOF	Single Oversight Framework
SOP	Standard Operating Procedure
SUS	Secondary Users Service
TILS	Transition, Intervention and Liaison Service
UC+S	Urine Culture and Susceptibility
UEC	Urgent and Emergency Care
UTI	Urinary Tract Infection
VFC	Virtual Fracture Clinic
VR	Virtual Reality
VTE	Venous Thromboembolism
WRES	Workforce Race Equality Standard