Taking pride in our communities and town

Date of issue: Friday, 14 March 2014

MEETING:	**HEALTH SCRUTINY PANEL** (Councillors S K Dhaliwal (Chair), Chohan, Davis, Grewal, Plimmer, Sandhu, Shah, Small and Strutton) **NON-VOTING CO-OPTED MEMBERS** Healthwatch Representative Buckinghamshire Health and Adult Social Care Select Committee Representative
DATE AND TIME:	MONDAY, 24TH MARCH, 2014 AT 6.30 PM
VENUE:	MEETING ROOM 3, CHALVEY COMMUNITY CENTRE, THE GREEN, CHALVEY, SLOUGH, SL1 2SP
DEMOCRATIC SERVICES OFFICER: **(for all enquiries)**	GREG O'BRIEN 01753 875013

NOTICE OF MEETING

You are requested to attend the above Meeting at the time and date indicated to deal with the business set out in the following agenda.

RUTH BAGLEY
Chief Executive

AGENDA

PART I

AGENDA ITEM	REPORT TITLE	PAGE	WARD

Apologies for absence

CONSTITUTIONAL MATTERS

1.	Declarations of Interest *All Members who believe they have a Disclosable Pecuniary or other Pecuniary or non pecuniary Interest in any matter to be considered at the meeting must declare that interest and, having regard to the circumstances described in Section 3 paragraphs 3.25 – 3.27 of the Councillors' Code of Conduct, leave the meeting while the matter is discussed, save for exercising any right to speak in accordance with Paragraph 3.28 of the Code.* *The Chair will ask Members to confirm that they do not have a declarable interest.* *All Members making a declaration will be required to complete a Declaration of Interests at Meetings form detailing the nature of their interest.*		
2.	Minutes of the Last Meeting held on 13th January 2014	1 - 6	

SCRUTINY ISSUES

3.	Member Questions *(An opportunity for Panel Members to ask questions of the relevant Director/ Assistant Director, relating to pertinent, topical issues affecting their Directorate – maximum of 10 minutes allocated).*		
4.	Quality and Improvement at Heatherwood and Wexham Park Hospitals NHS Foundation Trust *(Maximum of 60 minutes allocated)*	7 - 40	
5.	Berkshire Healthcare NHS Foundation Trust Quality Account 2013/14 *(Maximum of 30 minutes allocated)*	41 - 90	

ITEMS TO NOTE

6.	Progress Report on Local Response to Winterbourne View	91 - 94	

AGENDA ITEM	REPORT TITLE	PAGE	WARD
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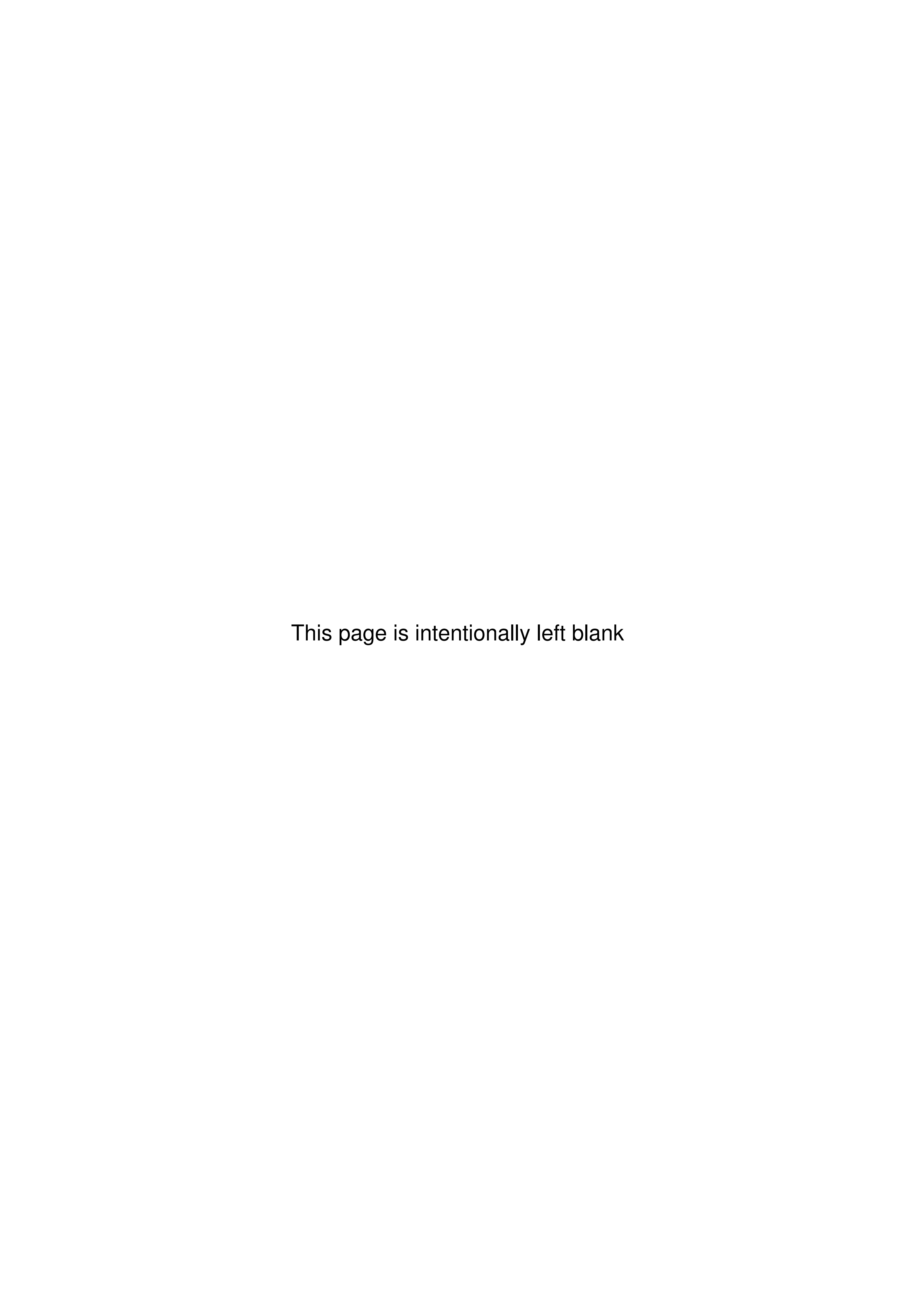
8.	Date of Next Meeting		
	Monday 30th June 2014		

Press and Public

You are welcome to attend this meeting which is open to the press and public, as an observer. You will however be asked to leave before the Committee considers any items in the Part II agenda. Special facilities may be made available for disabled or non-English speaking persons. Please contact the Democratic Services Officer shown above for furthers details.

Minicom Number for the hard of hearing – (01753) 875030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Health Scrutiny Panel – Meeting held on Monday, 13th January, 2014.

Present:- Councillors S K Dhaliwal (Chair), Chohan, Davis, Grewal, Mittal, Plimmer (from 6.33pm) and Strutton

Non-Voting Co-optee - Slough LINk representative, Mr Arvind Sharma

Also present:- Councillor Walsh

Apologies for Absence:- Councillor Small

PART I

40. Declarations of Interest

None.

41. Minutes of the Last Meeting held on 21st November 2013

Resolved – That the minutes of the last meeting held on 21st November 2013 be approved as a correct record.

42. Member Questions

There were no questions received from Members.

(Councillor Plimmer joined the meeting)

43. CQC Inspection Report - Wexham Park Hospital

The Chair confirmed that she had agreed the Panel should consider an urgent item on the Care Quality Commission (CQC) Inspection Report on Wexham Park Hospital which had been published on 8th January 2014 (after the agenda had been issued) following an unannounced inspection.

The Panel considered the Inspection Report and received a presentation from Philippa Slinger, Chief Executive of Heatherwood & Wexham Park Hospitals NHS Trust about the progress being made by the Trust in implementing the Action Plan to address the CQC warning notices. The latest Inspection Report related to a further unannounced CQC inspection in October 2013 which was a follow up to the first inspection in May 2013. A further new style CQC inspection was scheduled for February 2014.

The Panel noted the latest CQC findings which had stated that whilst the Trust had made 'significant improvements in some areas' the hospital was failing to meet the required standards in a number of significant respects and that a revised Action Plan had been produced to address the concerns raised. The key points made in the presentation are summarised as follows:

- The inspection report recognised that improvements had been made, notably that capacity issues had been addressed; A&E had 40% more capacity and services had been improved; a Surge Escalation Policy was in place; and there were 56 additional beds since May with a net gain in the number of doctors and nurses.
- Implementation of the Action Plans put in place in response to the first inspection in May 2013 were ongoing and the Trust had been clear in stating that some actions would take longer to implement.
- Whilst improvements had been recognised in a number of wards, issues remained in wards 4, 7 and 8 in particular and a further Action Plan had been sent to Monitor is response to concerns about the involvement and welfare of service users; cleanliness and infection control; safety and suitability of both premises and equipment; staffing; quality monitoring; records; and governance.
- It was not envisaged that the potential merger with Frimley Park Hospital had been effected by the latest inspection report.

Members made a number of comments and asked a wide range of questions during the ensuing discussion including whether the Trust had sufficient financial resources to bring about the require improvement in services. Philippa Slinger responded that sufficient resources were available; that the Trust had fully spent its £17.5m capital programme during the past year which had brought about major improvements, particularly in A&E with further investment due in upgraded the wards; and that the Trust's deficit had reduced from £13.8m to £6.9m. The Trust was approximately two years into a five year building programme of major improvements to premises and equipment. A number of new temporary support staff had joined the Trust, particularly to add project management capacity and to ensure existing clinical staff could focus on service delivery during winter.

The Panel also raised a number of issues in relation to impact of staff morale and the ways in which the problems of culture and practice identified during both inspections were being addressed. Members were informed that whilst a wide range of measures were in place to address these issues including training, communication and changes to working practices, it was recognised that cultural change was difficult to implement and took time. In terms of staff morale, Philippa Slinger recognised that the period of inspection and change had left some staff feeling 'under siege' with insufficient time to evaluate whether the changes implemented had brought about improved services for patients.

The Chair thanked Philippa Slinger for her progress report to the Panel and highlighted that a further update was scheduled for the meeting on 24th March.

Resolved – That the CQC Inspection Report be noted, and that the Panel consider further progress against the Action Plan at the meeting on 24th March 2014.

44. Care Bill 2013-14 and Better Care Fund

The Panel considered a report from the Assistant Director Adult Social Care, Commissioning and Partnerships, Alan Sinclair, regarding the progress of the Care Bill 2013-14 and the Better Care Fund.

Members were informed that the Care Bill brought together a number of existing laws into a single legal framework to reform care and support for adults, support for carers and adult safeguarding. It was anticipated that the Bill would become law in 2014 and would come into effect from April 2015. The Assistant Director advised the Panel of the key aspects of the Bill which included national eligibility criteria, clarity over service charges, a deferred payment scheme to ensure people did not have to sell their home and a cap on care costs of £72,000. Members raised a number of issues about the impact of the Bill, both for local residents and the Council, and asked about funding and eligibility criteria. In response, the Assistant Director clarified a number of points in relation to the implications of the Bill and reported that further guidance on issues such as assessment and eligibility was awaited.

The funding position was currently uncertain, particularly the revenue implications, although some capital had been made available to upgrade IT systems for the capped cost system. The Assistant Director reported that the funding of the Care Bill would also form part of the responsibilities of the Better Care Fund, the purpose of which was to create a pooled fund for health and adult social care. The Government had announced that £3.8bn would be available nationally of which Slough would have a minimum allocation of £8.7m from 2015/16. The Council was working closely with the Slough Clinical Commissioning Group (CCG) to develop the Better Care Fund delivery plan and it was anticipated that this would be signed off by the Slough Wellbeing Board in January and by the Cabinet at a later stage. Members discussed a number of issues including what could be learned from international experience on the transition from acute services to the community; the measures to reduce emergency admissions to A&E; and the timescale for developing the delivery plan.

The Chair thanked officers for their attendance.

Resolved –

(a) That the report and the appendices setting out the implications for the Council of the Care Bill, the actions taken so far, and the lead officers that will be responsible for implementing the legislation be noted.

(b) That the background to the Better Care Fund and current and future planned activity be noted.

(c) That the sign off timetable for the Better Care Fund Plan be noted.

45. Carers Caring for Others - Slough's Joint Commissioning Strategy Refresh 2014-17

The Panel considered the draft refreshed Joint Carers Commissioning Strategy 2014-17 for the Council and Slough Clinical Commissioning Group (CCG).

Alan Sinclair, Assistant Director Adult Social Care, Commissioning and Partnership and Sally Kitson, Commissioner, Wellbeing, informed Members that the Strategy had been updated following extensive consultation with carers and stakeholders to develop the six local priorities to support carers as follows:

- Improved health and wellbeing.
- Primary health care services.
- Hospital and carers.
- Improved support for young carers.
- Training and information for professionals.
- Involving carers.

The Strategy aimed to improve the support for carers and demonstrated the value of carers to the local community. Members were informed that census figures indicated that 11,300 people in Slough provided a caring function and that the Council and CCG were currently spending £3.6m to support carers. Members generally felt that awareness of the support available to carers could be raised. Officers recognised that this was a challenge and highlighted that the Strategy included measures to improve communication, for example through the appointment of a 'GP champion' to raise awareness with family doctors. Members also discussed issues such as the problems faced by young carers; the flexibility and choice of respite care; and the monitoring of the strategy to ensure effective delivery and value for money. The Assistant Director responded to these points and reported that improved support for young carers was clearly recognised as a key priority in the strategy; that steps were taken to try to provide flexibility for carers to choose the respite service provider which best met their needs; and that a range of measures were undertaken to assess services such as satisfaction surveys of clients.

The Panel agreed that it was important to recognise the vital contribution that carers made and requested that the Assistant Director consider further practical measures to recognise their role. Following due consideration, the Panel then endorsed the Strategy.

Resolved – That the draft Joint Carers' Commissioning Strategy 2014-2017, including resource allocation, be endorsed.

46. Tuberculosis (TB) in Slough

The Panel considered a report on Tuberculosis (TB) in Slough which set out the incidence and services of the condition as a public health issue.

Dr Angela Snowling, Consultant in Public Health, explained the background and patterns of TB as detailed in the report and Members noted that whilst the incidence of TB in Slough was high, 56.7 per 100,000 compared to 15.1 in England, the rate was significantly below some London Boroughs. They also noted that services available in Slough were contributing to the prevention, identification and treatment of the infection. The Panel discussed a number of issues relating to the provision of TB services in Slough, particularly TB screening services for new entrants. The Panel were informed that screening had recently changed from taking place at ports of entry to the country of origin; however the Panel felt that it was important that this was closely monitored to ensure it was effectively implemented.

The Chair thanked Dr Snowling for her report.

Resolved – That the report be noted.

47. Berkshire Health Clinical Services Reconfiguration - Progress with Mental Health In-patient Services Transfer

The Panel received an information report on the progress in transferring the mental health in-patient services from three sites, including Wexham Park Hospital, to Prospect Park Hospital. Members noted the report and agreed to follow up the matter at a later date should any significant concerns about the reconfiguration be raised.

Resolved –

(a) That the report be noted; and

(b) That the item be removed from the current work programme, but that it would be revisited should significant concerns regarding the provision be raised at a future date.

48. Accident & Emergency Review Report

The Panel considered the final report of the A&E Task and Finish Group review into accident and emergency provision at Wexham Park Hospital and agreed to endorse the recommendations.

Members were informed that only one practice in Slough currently used 0845 telephone numbers and they would move to local call rates within the next three months. It was also noted only 3% of A&E patients were not registered and that A&E admissions were stable.

Resolved – That the report and recommendations of the A&E Task & Finish Group review into accident and emergency provision at Wexham Park Hospital be endorsed.

49. Forward Work Programme

The Panel considered the work programme for 2013/14 and confirmed the items set out in Appendix A to the report. In relation to the additional workshop planned on the recommendations of the Francis Inquiry, it was proposed and agreed to hold a briefing session between 6.30pm-7.00pm followed by the Health Scrutiny Panel at 7.00pm on 6th March 2014.

Resolved –

(a) That the work programme be agreed.

(b) That a briefing session on the implications of the Francis Inquiry be held at 6.30pm on 6th March followed immediately by the Health Scrutiny Panel meeting at 7.00pm.

50. Attendance Record

Resolved – That the attendance record be noted.

51. Date of Next Meeting

Resolved – That the date of the next meeting be confirmed as 6th March 2014.

Chair

(Note: The Meeting opened at 6.30 pm and closed at 9.15 pm)

SLOUGH BOROUGH COUNCIL

REPORT TO: Health Scrutiny Panel **DATE:** 24 March 2014

CONTACT OFFICER: Sarah Forsyth – Scrutiny Officer
(For all enquiries) (01753) 875657

WARD(S): All

PORTFOLIO: Councillor Walsh – Commissioner, Health and Wellbeing

PART I
CONSIDERATION & COMMENT

QUALITY AND IMPROVEMENT AT HEATHERWOOD AND WEXHAM PARK HOSPITALS NHS FOUNDATION TRUST

1 **Purpose of Report**

To provide information on the latest position regarding the Action Plan at Heatherwood and Wexham Park Hospitals NHS Foundation Trust to address warning notices issued by the Care Quality Commission (CQC) and Monitor; and the roles played in this process by the Slough Clinical Commissioning Group and Healthwatch Slough in the improvement journey.

Note: The Slough Clinical Commissioning Group will provide a verbal update of the role it has undertaken in monitoring progress against the Action Plan at the meeting.

2 **Recommendation(s)/Proposed Action**

That the Panel consider the information provided in the report and through discussion at its meeting to assess the progress made in addressing the concerns raised by the CQC and Monitor, and the sustainability of the measures being put in place.

3 **Documents Attached**

A - Update to the Action Plan to address Warning Notices Issued by Care Quality Commission and Monitor Enforcement Actions (Heatherwood and Wexham Park Hospitals NHS Foundation Trust)

B - Healthwatch Slough’s Work Plan regarding Wexham Park Hospital

C - Healthwatch Slough’s Report Findings on Wexham Park Hospital

4 **Background Papers**

1 - Care Quality Commission: Inspection Reports (July 2013 and December 2013)

2 - Slough Health Scrutiny Panel Agendas and Minutes (17 September 2013 and 13 January 2014)

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Update to the Action Plan to address Warning Notices Issued by

Care Quality Commission and Monitor Enforcement Actions

1.1 Introduction

In response to the CQC warning notices received by the Trust in December 2013 and the Monitor enforcement undertakings, the Trust Board met to develop an Action Plan to return the organisation to compliance with CQC standards. The high level Action Plan and Detailed Milestone Plan have been presented to the Oversight and Assurance Group held on 3 February 2014.

The Trust has established a programme management function to co-ordinate, oversee and report on progress in achieving the Action Plan. A highlight report is produced by the programme management office lead on a weekly basis and discussed in detail at the Quality Programme Board.

Following the CQC inspection in February 2014 and reflecting on the progress made to date, the Trust has taken the opportunity to review and refresh the Action Plan. This document outlines the following:-

- Actions that are completed;
- A summary of actions that are ongoing with an outline of future plans; and
- New actions that the Trust Board considers necessary to drive and embed quality within the organisation.

The Trust recognises the importance of embedding qualitative changes into business as usual and demonstrating to key stakeholders that the actions are having the anticipated impact on quality. A template evidence document is attached at appendix 1 that outlines the actions taken by the Trust, the evidence base that demonstrates that the action has been implemented, the expected outcome and the ongoing mechanism for monitoring the impact.

2.1 Completed Actions

Through the weekly reporting and scrutiny at the Quality Programme Board, the Trust is satisfied that the following actions have been completed and that, where appropriate, a mechanism is in place to monitor the impact of the action on an ongoing basis.

Ref	Action	Response	Ongoing monitoring of the impact
1.9	Continue to engage with Sodexo to improve the food service.	Sodexo have introduced a new menu based on patient feedback. The menu makes it clear that the full choice (halal, kosher, vegetarian) is available to all.	Fortnightly monitoring of the take up of the new menu by Sodexo. Monthly reports to QPB. Performance against ward dashboards.
2.2	Make changes to nurse leadership roles in appropriate areas.	Changes have been made to matrons in some areas.	Ward quality rounds and safety thermometers will be used to monitor the effectiveness of nurse leaders.
3.1	Recruit a Hotel Services Director to drive improvement.	A Hotel Services Director has been appointed and commenced on 6 January 2014. His remit focuses on facilities, including cleaning, catering and portering.	None required.
3.2	Commission a review of cleanliness from an appropriate organisation and implement recommendations made.	A review of cleanliness was commissioned from Green and Kassab. The Trust has received the recommendations and has developed a plan to respond to areas of weakness (see ongoing action 3.3)	None required. QPB will monitor the cleaning plan included under action 3.3 to implement the recommendations.
3.6	Improve education of Hibiscrub.	Representatives from Hibiscrub visited the Trust to provide training to staff where required. Leaflets on how to use Hibiscrub have also been printed for use by staff on wards. Ward walks have confirmed a sound understanding by staff that Hibiscrub should be used undiluted and that each patient has their own bottle marked with their name.	Ward matron's audit tool.
5.3	Review the need and availability of hoists	Hoist requirements have been reviewed throughout the Trust.	An annual review of the working condition and availability of hoists will take place, led by Health and Safety.
6.3	Develop safe staffing metrics.	Safe staffing metrics have been agreed by the Executive Board. At a minimum, one registered nurse to 8 patients (day) and 10 patients (night) is required.	Monitored through the retrospective and prospective staffing levels report (see 6.2 above).
6.7	Conclude an agreement with a big 4 firm to enable a short term increase in senior management capacity to underpin the delivery of action plans and other organisational priorities.	The Trust has secured additional capacity to support senior management until 31 March 2014. This includes a PMO lead responsible for monitoring the delivery of the CQC Action Plan and reporting to the CEO and Quality Programme Board.	Not required.

Appendix A

Ref	Action	Response	Ongoing monitoring of the impact
7.1	External review of maternity cluster of incidents.	The review by Professor Draycott has been completed and fed back to the Trust. An initial action plan was implemented to address the recommendations. Further action plans to provide better management support have been developed with the set up of Division D.	Implementation of the obstetrics and gynaecology action plan and the successful set up of Division D. Review of SI tracker by Healthcare Governance Committee.
7.4	External review of falls.	The Trust invited Professor Adam Darowski, a consultant physician and experienced falls expert from John Radcliffe Hospital to review the falls data at the Trust. Having met with the Trust and reviewed the data, Professor Darowski recommended that FallSafe is implemented at the Trust and that regular audits take place. This mechanism is now in place.	The safety thermometer for each ward includes measurement of falls with harm. Ongoing audits of falls through implementation of the FallSafe programme. Falls will also be measured by the Falls Steering Group.
10.1	Establish and disseminate a single policy on the sharing of patient information with relatives. Policy to be based on good practice and shared learning from other organisations.	The Trust has provided clarity to staff on how to share information with relatives. A mythbusting e-mail has been sent to lead nurses and ward managers to highlight how to share information and what can be shared.	None required.
10.4	Remove first aid kits from wards.	Wards and other non-clinical areas have completed a risk assessment to determine if a first aid kit is required. Those areas that require first aid items have been provided with replenished kits.	The Health and Safety team will perform an annual audit and review of the risk assessments and first aid kits in all areas.
10.7	Review the usage of current red mark scorecards on the wards and provide clarity on what is being measured and why.	A standardised model has been developed. Safety crosses are being used for falls and pressure ulcers only. This has been communicated to staff and the safety crosses are displayed on the ward quality boards.	Ward quality rounds – includes requirement to check that the quality boards are up to date.

2.2 Ongoing Actions

The Trust is continuing to implement a number of other agreed actions. In some instances, the detailed work to develop and implement plans has identified that a different target date for implementation is required.

Ref	Action	Resp	Target completion	Revised completion	Progress to date	Future plans
1. Respecting and involving people who use services						
1.1	A technology enabled programme to continuously monitor patient satisfaction, with the intention of capturing feedback and using it to play it back to medical and nursing staff to identify their training needs and foster a greater understanding of the patient's needs.	DoN	February	February	Agreed a series of questions aligned to the Picker inpatient survey. Volunteers trained and arrangements in place to free up staff. First feedback collected.	Monthly reports to the Quality Programme Board. Inclusion of key metrics into the ward dashboard.
1.2	Build a customer care programme for all patient facing staff incorporating a set of basic "Always" themes.	DCEO	January	March Rollout (March – December)	Met with and understood programme from Frimley Park. Trainers have observed Frimley's training programme.	Customising the programme to fit with HWP. Roll out of initial training to managers followed by workshops with other staff. Evaluation process to be introduced.
1.3	Implement changes to a number of ward layouts to improve bed flexibility for patients whilst achieving single gender accommodation.	DoN	January	March	Switchable male/female toilet signs ordered and installed in ward areas with a focus on those where bays/beds are regularly switched between genders.	Assessment of the requirement for male / female signs for shower and wash rooms. Ordering and installation of any additional signs required. Monitor through ward quality rounds.
1.4	Implement a rolling programme for nurse leaders to ensure a sound knowledge of care standards that can be cascaded to others.	DoN	January	March	Task & Finish group established. Draft standards developed and sent to nursing staff for consultation.	Finalise and circulate agreed standards. Establish an ongoing mechanism to monitor compliance.
1.5	Set some common standards to enhance patient experience.	DoN	January	March	Rolling programme of 'did you knows' or mythbusters established to circulate to staff via the regular newsletter.	Drafting of content for newsletters and e-mail cascade.

Appendix A

Ref	Action	Resp	Target completion	Revised completion	Progress to date	Future plans
1.6	Raise staff engagement through ~~joining~~ membership of-the next "listening into action" programme	DCEO	January	January (2015)	Programme has commenced. Pulse survey issued and results used as Trust baseline. Sponsor group in place and lead appointed.	Invitations to every fifth member of staff on payroll to a 'Big Conversation'. Series of 'Small Conversations' to take place at ward level. Agreement of 3 areas of immediate focus by the sponsor group. Regular pulse surveys to track improvements.
1.7	~~Ensure that "Always" events are engrained in staff through a programme of communication with staff~~	DCEO	January	-	Reviewed Salford example of six always events. Focus group held to discuss HWP events.	Incorporated into action 1.2
1.8	Complete a programme of improving discharge planning. **(Safe discharges)**	COO	February	March	Policy drafted and circulated for comment. KPIs established. Mandatory discharge checklist developed and communicated to all staff.	Agreement of policy with internal and external stakeholders.
1.10a	Complete a rapid desktop review of MHPS cases	MD	January	March	NHS England report received which highlighted that some elements of the Trust policies were not fit for purpose. As a result of the finding, NHS England did not progress to undertake the desktop review of cases.	Recommendations of NHS England to be implemented (including update to policies, case manager / investigator training and appointment to Deputy MD position).

Appendix A

Ref	Action	Resp	Target completion	Revised completion	Progress to date	Future plans
1.10b	Secure support for a medical governance review.	MD	January	July	Agreed that KPMG will undertake a review of medical governance.	Finalise scope of the review. Provision of documentation requested. Review recommendations and develop an action plan for implementation.
1.11	Develop proxy indicators for measuring cultural change	DCEO	January	March	Agreed to use LiA pulse survey responses to track and measure staff attitude across the organisation. The patient experience tracker will be used to measure the impact upon patients.	Reporting mechanism to be agreed.
2. Care and welfare of people who use services						
2.1	Develop and implement a plan to drive higher standards on wards 4, 7, 8, to incorporate KPI's to demonstrate improvement.	DoN	February	February	KPIs have been developed for each of the wards.	KPIs to be reported to the Quality Programme Board on a monthly basis.
2.3	Implementation of the ward dashboard to highlight issues	CIO	January	March	Initial indicators have been developed and a format agreed.	IM&T to liaise with key staff to identify data requirements, format and timescales. Monthly dashboards to be produced and reported to the Quality Programme Board and divisional governance meetings.
2.4	Increase the number of staff trained to deliver intentional rounding and patient observations.	DoN	March	May	Standard Operating Procedure developed and communicated. Ward walks have taken place to assess level of compliance. 4 individuals certified to train HCAs.	Training plan to be developed. Ongoing compliance monitoring.

Appendix A

Ref	Action	Resp	Target completion	Revised completion	Progress to date	Future plans
2.5	Complete and evaluate pilot programme on open visiting and relatives assisting in providing appropriate care (e.g. meal times)	DoN	February	March	Pilot completed. Feedback analysed. Decision to roll out open visiting to all areas. Guidance materials developed.	Communication of the decision to launch open visiting to all staff. Circulation of guidance. Launch event.
3. Cleanliness and infection control						
3.3	Implement recommendations from the cleanliness review.	DoHS	July	July	Recommendations reviewed and milestone plan developed to implement change.	Implementation of the milestone plan. Ongoing compliance checks of cleanliness. Reporting of cleanliness in zones for the OPR.
3.4	Complete a deep clean of the Trust	DoHS	January	April	Deep clean of all ward areas completed.	Development of specification and costing of a substantive deep clean team. Recruitment of deep clean team.
3.5	Replace equipment that is identified as a significant barrier to achieving a clean and infection free hospital. (Free standing equipment)	DoEF	January	March	Free standing equipment reviewed and new items ordered. New equipment rolled out to wards.	Installation of new drug cabinets. Ongoing delivery of items with longer lead times. Review of non-condemned equipment held in storage to assess whether it can be repaired. Implementation of a policy and process for equipment inspections to take place on wards on a periodic basis.
4. Safety and suitability of premises						

Appendix A

Ref	Action	Resp	Target completion	Revised completion	Progress to date	Future plans
4.1	5 year prioritised plan to address £37m of estate issues identified in a 6 facet survey has been agreed with DoH. (Timeline as agreed with DoH)	DoEF	Various	Various	Immediate priorities addressed in advance of the CQC inspection. Capital business cases and plans have been refreshed to reflect completed works. 5 year capital plan consistent with OBC provided to FPH. 13/14 plan updated to reflect increase in capacity (eg. A&E) but expenditure on budget.	Drafting of 14/15 plan for April Board. Implementation of the capital plans.
4.2	Plan to address short term issues, such as toilet and shower facilities in ward 18 are being implemented. (Including storage issues)	DoEF	January	February	Ward action plans developed and prioritised. Short term issues such as ward 18 toilet and shower facilities addressed. 5 storage units now in place.	Longer term plan to be developed to cleanse the Planet FM system and use this for ongoing planned and reactive maintenance.
4.3	**Infection control** signage being installed	DoEF	January	February	Infection control signs with hand gel installed throughout the Trust. Domestic staff given responsibility for checking and replenishing hand gel.	Ongoing monitoring mechanism that hand gel is replenished to be established.
4.4	Trust signage plan to be completed **(Non-infection control)**	DoEF	July	July	Signage company engaged to undertake rolling audit of areas. Lead appointed to establish agreed names for areas in the Trust.	Small governance group to sign off plans and quality check proofs of signs. Installation of new signs.
4.5	Implementation of an adequate lockable security solution to secure site.	DoEF	March	March	Six requisitions placed for lockable security solutions. Installation plan agreed and has commenced.	Communication of clear policy on expectations re lockable areas. Compliance checking that appropriate areas are locked in accordance with the policy.
5. Safety availability and suitability of equipment						
5.1	Accelerate and re- prioritise the equipment replacement programme to ensure that everything is fit for purpose –	DoEF	January	March	Survey of macerators by Vernacare. 20 new items required. 9 new macerators installed. All macerators	EBME service to be reviewed. EBME equipment condition to be validated

Ref	Action	Resp	Target completion	Revised completion	Progress to date	Future plans
	e.g. all macerators to be under 5 years old.				over five years old are being replaced.	and reported back to medical electronics on a periodic basis.
5.2	Review the working condition of equipment (e.g. resuscitators).	DoEF	January	January	Ward action plans include a list of equipment required. Monthly audits of equipment take place to ensure that items are in working condition. EBME have reviewed all resusitaires and confirmed that they are in working order.	Ongoing monitoring of equipment through monthly audits, ward quality rounds and Planet FM.
6. Staffing						
6.1	Secure additional support to ensure that persistent workforce performance issues are resolved (eg. General Surgery)	MD	January	December	Fiona Reed and Associates appointed to address inter-personal issues within general surgery.	Meetings to take place with general surgeons.
6.2	Complete implementation of ward staffing system to ensure that safe staffing levels can be monitored at Senior Management level.	DoN	January	March	Daily report produced as a forward look and circulated to senior nurses daily. Weekly report identifying shifts that fell below expected levels produced and ADs asked to explain the actions for red shifts. Forward looking report produced to consider staffing over a 7 week period.	Upward reporting mechanism to be finalised – to be included within the ward compliance reports and discussed at Healthcare Governance Committee and Board.
6.4	Deliver programme to enable "real-time" understanding of staffing levels to include cleansing of ESR data	DoN	July	August	Plan for implementation developed and agreed.	Implementation of integrated nursing and medical rostering and interface with NHS Professionals. Development of a real time report on staffing levels.
6.5	Ensure that all "non uk" health professionals receive adequate acclimatisation support during induction	DCEO	January	March	Lead for overseas nurse induction identified. Feedback from current cohort of	Plan for updated induction procedure to be agreed and implemented.

Ref	Action	Resp	Target completion	Revised completion	Progress to date	Future plans
					overseas nurses collated.	
6.6	Organisational development review to include leadership development	CEO	June	June	See 1.2 – Customer care programme See 1.4 – Nurse leadership programme See 1.6 – Listening into Action See 1.7 – Always and Never events See 1.11 – Cultural indicators See 2.2 – Changes to nurse leadership roles See 6.1 – Addressing persistent workforce issues including general surgery See 7.1 and 7.2 – Review of maternity incidents and services	Ongoing actions to implement organisationalchanges.
7. Assessing and monitoring the quality of service provision						
7.2	External review of Maternity Services	MD	January	March	Royal College review commissioned and completed. Awaiting receipt of report and recommendations.	Develop actions in response to the findings.
7.3	Review of safeguarding with support to receive assurance	DoN	January	March	Training requirements assessed for children and adults. Training implemented for adults. Datix module for safeguarding reports implemented.	Training on childrens safeguarding. Quarterly reporting (first report to April Board).
7.5	Complete implementation of a ward dashboard to drive continuous improvement and reporting up through the Trust	CIO	January	March	Indicators agreed. Key stakeholders engaged on data requirements and timescales. First draft dashboards produced and feedback obtained.	Process review by IM&T. Monthly reporting.

Appendix A

Ref	Action	Resp	Target completion	Revised completion	Progress to date	Future plans
7.6	Complete implementation of ward quality rounds (with matron assessments peer reviewed against independent perspectives)	DoN	February	March	Guidance has been circulated to matrons, lead nurses and the Executive Team. Discussions held on revising the ward quality round questions to ensure that some of the CQC actions can be monitored through this mechanism.	Revised ward quality round questions to be finalised and included within the electronic survey. Summary report to Executive Team and Board to be developed (incorporate into action 11.21)
7.7	Ensure that approaches that have yielded improvement on wards 1, 3, 5, 17 and 18 are shared to enable a broad based change across the Trust.	DoN	January	June	Presentations to matrons meetings on what makes a good ward.	Shared learning to be incorporated into the Action Learning Sets. Future matrons meetings to include consideration of themes of Datix incidents, compliance reports and ward dashboards to facilitate awareness and shared learning.
8. Records						
8.1	Programme to review clinical records prior to automation	CIO	July	July	Patient records review complete and catalogue of documents developed. Recommendations developed.	Agree recommendations based on a cost-benefit analysis of storage vs scanning.
8.2	Retrieval and storage of records via funded EDM project	CIO	July	October	OJEU tender published. Work ongoing to establish scanning volumes.	Scanning volumes to be finalised. ITT to be published. Contractor to be appointed.
8.3	Review of nursing documentation complete	DoN	January	March	Policy, guidance and standard documentation developed and approved.	To be included as part of the ward quality round checklist to ensure that it is embedded within the organisation.
8.4	Reinforce and police the need for correct documentation	DoN	January	March	Ward walks have taken place to confirm that standard documentation is in use.	To be included as part of the ward quality round checklist to ensure that it is embedded within the organisation.
9. Governance						
9.1	Agree terms of reference with Monitor	DoCA	January	January	Terms of reference drafted and submitted to Monitor. Verbal agreement that Monitor is satisfied with the content.	Formal agreement from Monitor.

Ref	Action	Resp	Target completion	Revised completion	Progress to date	Future plans
9.2	Commission a governance review	DoCA	January	February	Desktop review of governance undertaken with key themes identified. Structural map re-designed and issued to Executive Board for comment. Standard operating procedure drafted. Good Governance Institute approached to review arrangements.	Agreement of structural map. Finalise Standard operating procedure. Formal agreement with the Good Governance Institute.
9.3	Review findings of governance review and develop an action plan	DoCA	February	July	-	Implement recommendations arising from the Good Governance Institute review.
10. Other						
10.2	Review staff training for individuals with learning disabilities	DoN	January	May	Identification of individuals who require training. Core principles developed and circulated to nurses.	Training plan to be developed and implemented.
10.3	Develop a system for marking equipment as "clean and ready for use"	DoN	January	March	Guidance issued on items that should be marked with an "I am clean" sticker.	Monitoring to take place through ward quality rounds.
10.5	Implement 8-8 working hours for staff on the reception desk	COO	January	February	Arrangements have been in place at Wexham Park since mid January.	Substantive posts to be appointed.
10.6	Review the policy on injectable medicines to determine whether one or two nurses are required. Update the policy as required.	DoN	January	February	Policy reviewed and considered appropriate. Reminder issued on medicines management to all staff.	Scheduled regular review of the policy.
10.8	Re-issue Datix passwords to ward managers, lead nurses and clinical leads	DoCA	January	February	Quick guide to Datix developed and distributed to staff. Ward walks have confirmed that appropriate staff have access to Datix, including the reporting features.	Further staff training to take place. Ongoing monitoring. Potential item to include in the ward quality rounds.

Appendix A

Ref	Action	Resp	Target completion	Revised completion	Progress to date	Future plans
10.9	Implement a system to identify and disseminate newly produced professional clinical guidelines (other than NICE)	MD	February	March	Terms of Reference mirroring NICE guidance dissemination prepared and circulated for comment.	Finalise and communicate the policy and mechanism to capture non NICE guidance.
10.10	Establish an assurance process to ensure that intentional ward rounding and care plans are in place.	DoN	January	-	Standard Operating Procedure developed and communicated. Ward walks have taken place to assess level of compliance.	Incorporated into action 2.4.

2.3 New Actions

The Trust's Executive Team has taken stock of the current challenges that it feels the organisation is facing, together with the informal feedback provided by the CQC in February 2014. This has led to the development of the following additional actions which will continue to be monitored by the programme management office lead and reported to the Quality Programme Board.

Ref	Action	Reason for the action	Intended outcome	Responsible	Completion date
11.1	Agree a review of sickness absence by internal audit.	CQC inspection queried the accuracy of the reported sickness absence figures.	Assurance that that the reporting of sickness absence is appropriate.	DCEO	March
11.2	Ensure that the boarding pass is used for all handovers to agency staff and that appropriate induction takes place.	Concerns over inadequate handovers with agency staff as noted in CQC 3.	Agency staff are familiar with basic ward facilities (such as the location of the crash trolley) and with the standard documentation used in the Trust.	DoN	March
11.3	Commission external resource to investigate bullying and harassment claims at the Trust and develop a programme of training to target bullying behaviour and to support managers to have difficult conversations/hold people to account.	Allegations of bullying and harassment from various sources together with feedback that the Trust is not holding people to account (staff survey and CQC feedback).	People are held to account without feeling that they are being bullied.	DCEO	April
11.4	Provide support to wards that require additional help to improve quality. This will include providing ongoing training to all lead nurses and matrons together with clarified job descriptions.	Trust and CQC concerns about Snowdrop, wards 2, 20 and 17. Other wards to be identified on an ongoing basis through the ward quality metrics (compliance, staffing and dashboards).	Improvements to quality demonstrated through the ward dashboards.	DoN	July
11.5	Review and deliver medical device training.	Some senior nurses do not have up to date medical device training which is compromising their ability to train more junior members of staff.	Improved training and records for medical devices.	DoN	June
11.6	Implement recommendations of the NHS England review of MHPS policies.	The NHS England report has identified that the MHPS policies within the Trust are inadequate. The policies require revision and approval by the LNC. Training for staff to enable them to manage MHPS cases is also required.	LNC approved policies and well-trained and supported staff able to manage case reviews.	MD	July

Appendix A

Ref	Action	Reason for the action	Intended outcome	Responsible	Completion date
11.7	Drive consistent use of the WHO checklist for all medical staff.	CQC review identified discrepancies between the checklist used in practice and the version published on the intranet.	Consistent and mandated use of the WHO checklist across both medical and surgical divisions.	MD	July
11.8	Set up division D with an appropriate governance structure.	The Trust has set up division D to split out the management of obstetrics and gynaecology from other services.	Division D is set up with a robust structure and clear knowledge and understanding of the expected governance mechanism.	MD	April
11.9	Establish a deep clean schedule and set up a team (internal or outsourced) to routinely cover all areas of the Trust on an annual basis.	A deep clean exercise has been undertaken and needs to form part of the Trust's business as usual.	Maintenance of the cleanliness of the hospitals.	DoHS	March
11.10	Develop RealTime as an operational tool.	The Trust has implemented RealTime but is not yet maximising the capabilities of the system.	RealTime to be used as an effective operational tool.	COO	TBC
11.11	Restructure the booking centre and outpatient process.	The Trust has identified that outpatient appointments are often cancelled at short notice or delayed.	Delivery of a more efficient outpatient service model to be measured using KPIs.	COO	TBC
11.12	Deliver improvements to the radiology service.	The CQC has expressed concern at a perceived radiology backlog that could cause clinical harm. The Trust has identified that a more robust capacity and demand plan is required and that further service improvements can be made.	A more efficient and planned radiology service that is able to cope with the projected demand.	COO	TBC
11.13	Review treatments and procedures to deliver a robust capacity plan informing operational planning for FY15. This will focus upon delivering internal professional standards.	The Trust and CQC have identified that patient flow is not as effective as it should be. Improved patient flow can be informed by a robust capacity plan and delivering to internal professional standards.	A robust capacity plan to facilitate improved patient flow. Clear expectations around internal professional standards (eg. Turnaround time for x-rays, scans, OT assessments etc).	COO	TBC
11.14	Review the elective access pathways and processes to deliver a more effective and efficient service.	The Trust and CQC have identified that patient flow is not as effective as it should be. In particular, there is a need to operate more cohesively across the related services to support the Trust in delivering better patient flow across the elective pathways.	Improved performance in particular to waiting list targets and a reduction in the backlog.	COO	TBC
11.15	Deliver improvements to the follow up appointments process.	The Trust has identified that booking procedures for follow up appointments should be reviewed.	An improved pathway for patients who require a follow up appointment.	COO	TBC
11.16	Perform a review of the emergency pathway, ambulatory care and hospital at night.	The Trust and CQC have identified that patient flow is not as effective as it should be. In particular, the CQC commented that the ambulatory care pathway is outdated.	Four ambulatory care pathways to be implemented with ongoing development of additional ambulatory care pathways and care at night.	COO	TBC

Ref	Action	Reason for the action	Intended outcome	Responsible	Completion date
11.17	Review of occupational and physical therapy.	Backlogs have been identified in the provision of these services, indicating that they could be planned and operated more effectively.	A recovery plan for the improvement of occupational and physical therapy services.	COO	TBC
11.18	Transition the management of estates jobs back onto Planet FM.	Planet FM has been used ineffectively and has resulted in an influx of additional immediate reactive jobs. Planet FM has been supplemented with wards using spreadsheet based action plans to identify and monitor progress of estates work required.	Use of Planet FM as the sole mechanism for identifying and prioritising estates work and for communicating progress to Ward staff. Maximise the system capabilities to effectively manage property, plant and equipment. To improve ward communications with estates	DoEF	June
11.19	Develop a monthly Estates newsletter.	The Trust has recognised that communication between estates and other staff has not been effective. In particular, there is a need to clearly communicate to the organisation estates performance, upcoming planned works and good news stories especially in terms and capital investments being made to improve the working environment for patients and staff.	Improved communication between estates and other staff within the Trust.	DoEF	June
11.20	Develop a clear reporting timetable for ward quality information to be collated and reported to the Executive Team and Board. This will include the ward dashboard information, ward quality round compliance reports and safe staffing metrics.	The Trust has developed several mechanisms for reporting quality at ward level which need to be collated, summarised and reported to give a clear picture of quality. This will improve the ward-to-Board reporting.	Clear picture of quality at ward level and clarity for Board members on where quality is not meeting expectations.	DoCA	March

Appendix 1: Template evidence document

Action:

Reason for the action

Action taken by the Trust

Evidence

Expected outcome

Ongoing monitoring

Healthwatch Slough:

- Independent consumer champion for health and social care services
- Provides services to individuals
- signpost people to inform consumer choices about health and care services
- Listens and gives citizens a stronger voice to influence and challenge health and social care services

The Slough community can contact Healthwatch Slough and share their experiences, views and stories good or bad about Wexham Park Hospital. This can be done by

- Visiting Citizens Advice Slough
- Calling Healthwatch Slough – 01753 325 333
- Logging on to the website to fill in a talk to us form – www.healthwatchslough.co.uk

August 2013

During August 2013 Healthwatch Slough under took a community engagement visit at Wexham Park Hospital. The visit consisted of informing patients and visitors of the role of Healthwatch Slough and carrying out intelligence gathering through a survey.

A number of patients and members of the public took part in the survey and issues were raised regarding:

- Waiting times and bed availability
- Comments relating to hospital staff
- Treatment and diagnosis
- Hospital services
- Cleanliness
- Car parking

The report regarding Healthwatch Slough's findings is attached as Appendix C.

Healthwatch Slough also met with Philippa Slinger and discussed a commissioned piece of work to make contact with patients and family members after their stay at Wexham Park Hospital. The project aim was to collect additional feedback about patient's experiences during their stay. To date this initial request has not progressed any further.

Healthwatch Slough will also be undertaking a piece of work around Initiative 1 of the Work Programme, looking at hospital discharge processes, details of which can be seen below.

Healthwatch Slough Objectives and Work Plan

Healthwatch Slough Key Information for Initiative 1

Communications Deliverable:	Objectives	Next steps:	Success Criteria
Initiative 1 **Wexham Park Hospital Discharge Project** **Timescale** **By 31/5/2013**	▪ Research and gathering data on patient discharge ▪ Engaging with patients and family members ▪ Observing the patient discharge system ▪ Meeting with key stakeholders	▪ Review existing research projects to ensure no overlap ▪ Update and liaise with the CEO WPH ▪ Scope project and agree approach/timeline with Board	▪ The consumer voices on the experience on patient discharge at WPH ▪ Increase of information on patient discharge ▪ Response to the report findings ▪ Changes in the patient discharge service services for the future ▪ Improvements to access and quality

The Healthwatch team will meet with key members of Wexham Park Hospital staff team to discuss the plans and engagement work identified for Wexham Park Hospital. Healthwatch will continue to meet with the Hospital Trust and update them with any planned work that Healthwatch Slough will carry out.

Colin Pill
Chair, Healthwatch Slough

Healthwatch Slough Report Findings on Wexham Park Hospital, Slough, SL2 4HL

Healthwatch Slough
1-1-2014

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Page 6 –7 **Comments received from the Wexham Park Hospital Survey**

Page 8 **Healthwatch Help Desk Data**

Page 9 **Healthwatch Walk In Data**

Page 10 **Contact Details & Healthwatch Chair Signature**

Healthwatch Slough Report on findings on Wexham Park Hospital, Slough, SL2 4HL
1.5.2013 – 31.12.2013

This report has been produced to provide a summary of the work and interactions that have been collated on Wexham Park Hospital by the Healthwatch Slough team.

The report will be shared with the Care Quality Commission and the Wexham Park Hospital Executive team.

Help and Care and Citizen Advice Slough are the delivery partners for Healthwatch Slough. Healthwatch Slough has an Independent Board with is made up of Executive Directors, Non-Executive Directors and soon to be appointed four lay members. The Healthwatch Board is responsible for the governance and the development of priorities and strategy of Healthwatch Slough

The Community Research and Engagement, and the Evidence, Insight and Influencing elements of the Contract are being delivered by the staff team of Help and Care led by Caris Thomas, Healthwatch Slough Manager and supported by Manvinder Sagoo, Healthwatch Officer.

The Information, Advice and Signposting element of the Contract is being delivered in two parts. Face to face information, advice and signposting is being delivered by Citizens Advice Slough. Arunjot Mushiana is the Healthwatch Advisor available every week day to talk to people about their experiences of health and social care.

Help and Care deliver the telephone, email and online Information, advice and signposting is. People can call the Healthwatch helpline number 01753 325 333 Monday – Friday.

Healthwatch Information & Recording

The data information has been collected from two data sources; Help and Care and Citizen Advice Slough.

Summary of a Survey conducted at Wexham Park Hospital by the Healthwatch Slough team.

As part of the Healthwatch community and engagement plan a visit to Wexham Park Hospital was planned. The aim of the visit to Wexham Park Hospital was to engage with patients and visitors at the hospital, distribute publicity material including leaflets, posters and post cards. To collect views of patients and visitors via the Healthwatch Speak Out Form or the Wexham Park Hospital survey which was planned by the Healthwatch Slough team. Prior to the visit the Healthwatch Chair Colin Pill and Healthwatch Manager Caris Thomas meet with the Chief Executive of Wexham Park Hospital Philippa Slinger Heatherwood and Wexham Park NHS Foundation Trust, to share the visit plan. Philippa acknowledge the plan, offered suggestions and agreed with the Healthwatch engagement plan. The Healthwatch team which included members of staff and volunteers visited Wexham Park hospital during the 20th – 22nd August 2013.

During the time of the visit the team took care and time to talk and listen to the patients and carers experiences and comments. After each conversation patients and carers were informed of what Healthwatch will do with the information received and then advised as to what the next steps could be.

During the visit the Healthwatch Team

- Communicated with 50 people
- Handed out 70 items of publicity material
- Distributed 40 surveys
- Received 33 completed surveys by patients at Wexham Park Hospital

Findings of Healthwatch Slough Survey at Wexham Park Hospital

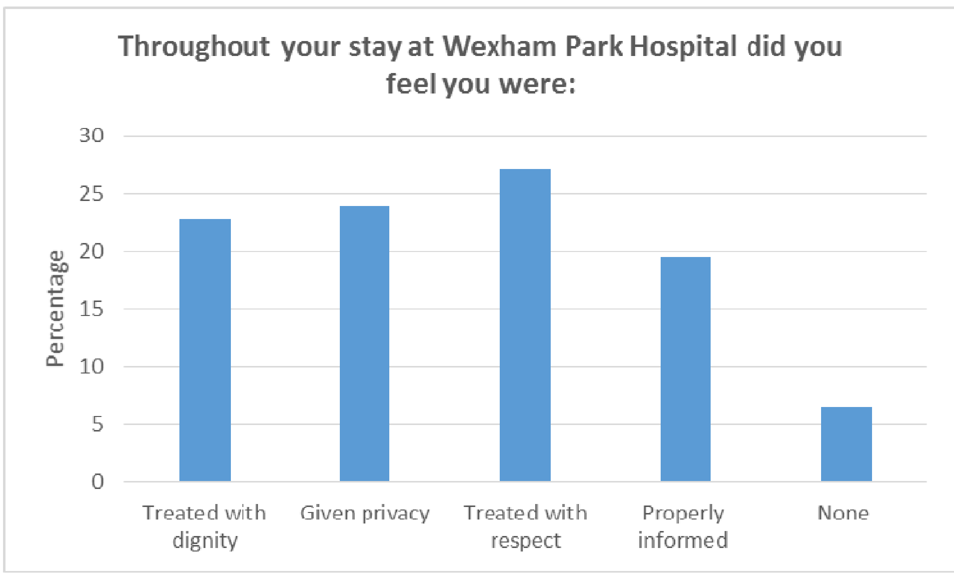

Figure 1.

The majority of patients that took part in the survey said they were treated with dignity, given privacy and treated with respect. Less patients felt they were properly informed and 6% of patients felt they experienced none of the aforementioned.

Patients were also asked whether the nurses/doctors explained their condition/treatment in a way they could understand, 73% of patients said they did.

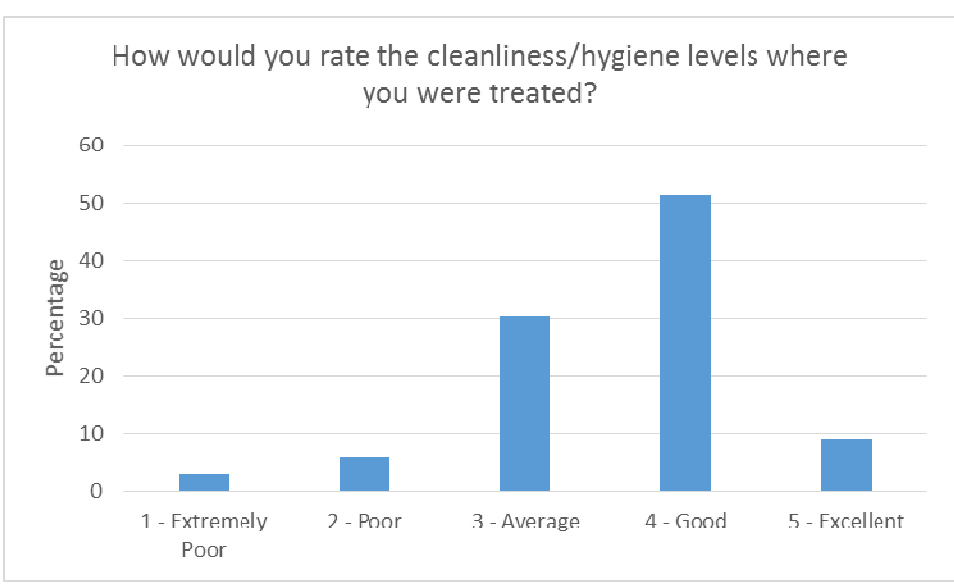

Figure 2.

Figure 2 shows that more than 50% of patients rated the cleanliness/hygiene levels of where they were treated as good. Only 3% rated the cleanliness/hygiene levels as extremely poor and 6% as poor.

Patients were also asked to rate their overall experience at Wexham Park Hospital. 52% of patients rated their experience as good and 15% of patients rated their experience as excellent. 6% of patient rated their experience as extremely poor.

Patients were asked whether they had any other issues relating to Wexham Park Hospital. The main themes that arose were: lack of car parking, long waiting times in Inpatients and A&E, lack of hygiene and rude staff.

Patients & Carers Comments from Wexham Park Hospital Survey

Comments on Hospital waiting times and bed availability (6 comments received)

- Waiting times are too long
- Waiting times should be shorter and seating should be more comfortable
- Had to wait for bed on ward, 3 and a half hours from A&E. Reduce waiting times. Cut waiting times.
- Patient found WPH to be overcrowded with no beds available
- Waiting times too long and had been sent to third place now in WPH for diagnosis.
- All an issue - appointments, time-keeping, record to follow patient, copies of information to patient.

Comments relating to Hospital staff (10 comments received)

- Not properly informed, only treated with respect depending on which surgeon. Some surgeons nice others were not. Surgeons were not helpful at all. Felt discriminated against, usually people don't ask what is wrong. There was no introduction from doctors or nurses to say who they were.
- Patient asked for results of tests which they did not get. Doctors would not tell patient what was wrong. Patient said they did not feel like a person anymore, let down by the system and.
- Only one doctor was efficient.
- Patient had bad experience when admitted. Said Asian doctor was shouting at patient and had no respect. Nurses were ok.

- GP felt patient needed to be admitted and gave letter to come straight to A&E. Waited in A&E for 3 hours to be told by a doctor that patient could not be admitted and that district nurse would deal with case, which they didn't. End result was patient being re-admitted and told they could now lose their toes. Patient's husband wrote letter to PALS to complain.
- Relative said he had heart surgery and surgeon left half way through operation, there were then complications and as a result only has a few months to live.
- Matron was brilliant
- Only 2 nurses to every 8 patients. Patient noticed another patient on their ward was left for 4 hours in a soaking wet bed, which nurses could have changed in 10 minutes. Patient had made attempts to leave and had 3 bad experiences with hospital security guards. Patient said another patient in same ward over 80 years old dropped bed control and there were no nurses in sight so patient had to pick and give back to other patient.
- Was not informed about discharge and patient's friend had to bring patient's own wheelchair in.
- Patient had broken hip, was given as much privacy as needed by ward staff, however had to ask for treatment/condition to be explained by doctors and nurses. Patient said main reason they enjoyed their stay in hospital was because they got on well with staff and other patients. Stay of 14 days – 3 days were upsetting, 11 days were excellent. Staff could do more, but nurses and doctors very respectful and have been brilliant.

Comments on treatment and diagnosis (two comments received)

- Patient sent home from hospital with no diagnosis to later be re-admitted, was disappointing. However since then had to use Urology department which was good, looked after well but still had to ask doctors/nurses about condition as they did not explain everything.
- There should be quicker diagnosis.

Comments on the Hospital Service (4 comments received)

- Patient said there was too much pressure on WPH after other hospital closed.
- Patient said treatment at hospital had been excellent and had no problems whatsoever, was treated very well.

- Overall experience has always been good at WPH.
- Ward 1 is great

Comments relating to the cleanliness and hygiene at the Hospital (4 comments received)

- Hospital is cleaner now but was not before.
- Bring back proper matrons.
- Not happy about staying on Ward 2 as patient noticed floor had not been cleaned for 2 days.
- Patient said cleanliness/hygiene levels were brilliant and it was absolutely spotless under beds.

Comments on car parking and travel arrangements (comments received 7)

- Parking at the hospital is always difficult, the parking is really bad. (Comments collected 4)
- Lack of car parking a problem, very bad as can miss appointments which then have to be waited months for. Usually have to be dropped off or use public transport to get to hospital appointments
- lack of transport
- Transport was an issue with appointments being missed.

Food Service (1 comment received)

- No quality of food.

Hospital Facilities (2 comments received)

- Ward 4 shower not working.
- Had problems with TV on ward, lost £60 by re-setting TV, no notice put up saying not to do this.

<u>Comments relating to other service – GPs and Social Care (2 comments received)</u>

- Very hard to see a GP, no appointments available.
- Problems in the community with carers, felt there was no respect and needs were not being met. Has since had another carer who is

looking after patient much better. Council was also supposed to help clear garden after patient had stroke but ruined garden instead.

Healthwatch Slough Helpdesk - 01753 325 333

By calling the Healthwatch number residents can speak to a member of the gateway team who are trained to record their information and signpost people to the correct agencies.

Since April 2013 to present, 12 patients have contacted Healthwatch Slough via the helpdesk expressing concerns about Wexham Park Hospital. Some have been signposted or referred to Care Quality Commission, PALS and SEAP to make formal complaints.

The themes that have arisen from these concerns include:

- Problems making appointments/Cancellation of appointments by WPH
- Misdiagnosis/Delayed diagnosis by WPH
- Alleged malpractice
- Lack of care
- Lack of privacy and dignity

Breakdown of telephone calls received about Wexham Park Hospital 1.4.13 – 31.12.13

Total Number of calls	**Number**	**TOTAL**
Safeguarding	2	**2**
Quality of treatment	6	**6**
Lack of care	3	**3**
Access to services	1	**1**
Hospital department breakdown for 12 calls		
A& E	1	**0**
Outpatients	1	**0**
Continuing Care	1	**0**
Psychiatry	1	**0**
Acute Care	1	**0**
Inpatients	7	**0**

Totals		**12**

Information collated from the Healthwatch CRM System

Healthwatch Slough, Walk in Citizens Advice Slough –

The Healthwatch Slough walk in service is delivered by Citizen Advice Slough, people can pop into the centre and speak to the Healthwatch Coordinator

Total Number of Healthwatch Walk ins to Citizen Advice Slough	**Number**
Complaints about the Urology Department	**3**
Complaints about disjointed services and lack of communication between departments	3
Alleged clinical negligence	4
Lack of support/care plan after heart attack	1
Complaint about resident having to travel overseas for an operation	1
Complaint about hygiene standards at Wexham Park	1

Hospital	
Complaint about alleged racism at Wexham Park Hospital	1
Issue about NHS charges for an overseas visitor	1
Issue about NHS charges for UK Citizen	1
Totals	16

Information collated from the Citizen Advice Slough Petra System

Healthwatch Slough 2014

- The Healthwatch Slough Board plan to meet with Phillpa Slinger (Chief Executive of Wexham Park Hospital) at the end of January 2014 to discuss the Healthwatch work stream for Wexham Park Hospital to carry out and identified piece of work on patient discharge.

For any further information please contact the Healthwatch Slough Manager. Caris Thomas

Healthwatch Slough Locality Manager & Officer, Help and Care

SCVS Office, 1st Floor

27 Church Street

Slough, Berks, SL1 1PL

Tel: 01753 219113 0r 07920 506403

Email: caris.thomas@helpandcare.org.uk

www.healthwatchslough.co.uk

Name – Mr Colin Pill

Title – Healthwatch Slough Chair

Date & signature of (Healthwatch Chair)

Contact Details Colin.pill@healthwatchslough.co.uk

Distributed to: Care Quality Commission (Hospital Inspection Team)

Wexham Park Hospital (Chief Executive Team)

End of report

AGENDA ITEM 5

SLOUGH BOROUGH COUNCIL

REPORT TO:	Health Scrutiny Panel **DATE:** 24 March 2014
CONTACT OFFICER:	Dr Justin Wilson - Medical Director, Berkshire Health NHS Foundation Trust
(For all enquiries)	01753 875 657
WARD(S):	All
PORTFOLIO:	Councillor Walsh – Commissioner for Health and Wellbeing

PART I
CONSIDERATION & COMMENT

Berkshire Healthcare NHS Foundation Trust – Quality Account 2014

1 Purpose of Report

1.1 The 2014 Quality Account is due to be published in June 2014. This report provides an update on progress with regard to Quality Account priorities and sets out the format for the final Quality Account.

2 Recommendation(s)/Proposed Action

2.1 That the Panel comment on the report and the quality priorities for 2014/15.

3 Slough Wellbeing Strategy Priorities

Priorities:

- Health and Wellbeing

4 Supporting Information

4.1 NHS Foundation Trusts are required, in legislation, to publish a Quality Account each year. The draft Berkshire Healthcare NHS Foundation Trust Quality Account 2014 is attached as Appendix A.

4.2 The Quality Account sets out the progress made against quality priorities for the year and the planned priorities for the next year with respect to clinical effectiveness, patient experience and patient safety. The Quality Account also includes information on other mandated areas for quality reporting such as research, clinical audit and board assurance statements, as well as additional quality performance data.

5 Appendices Attached

A - Draft Berkshire Healthcare NHS Foundation Trust Quality Account 2014

6 Background Papers

None.

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Document Control

Version	Date	Author	Comments
1.0	14.02.2014	Amanda Mollett Head of Clinical Effectiveness & Audit	
2.0	17.02.2014	Justin Wilson, Medical Director	
2.1	26.02.2014	Justin Wilson, Medical Director Following Trust Quality and Assurance Committee	

DRAFT

Quality Account 2014

Quarter 3 Report

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.

DRAFT

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Quality Account Summary 2014

To be added to and updated in Q4

97% of patients in community health wards rated the care as good or better 76% for mental health wards. This is an improvement

98% of community health inpatients and minor injuries unit patients would recommend the service to friends and family. 72% of mental health inpatients. This is an improvement.

Compliments recorded each month have doubled during the year.

Number of complaints per month have not altered significantly overall

69% of staff would agree or strongly agree that if a friend or relative needed treatment, they would be happy with the standard of care provided by the organisation (National average 59%). This is an improvement.

71% of staff agree or strongly agree that care of patients / service users is my organisation's top priority (National average 63%). This is an improvement.

Use of Recovery tools for patients on the Care Programme Approach have not improved in Q3. An action plan is being implemented to resolve this.

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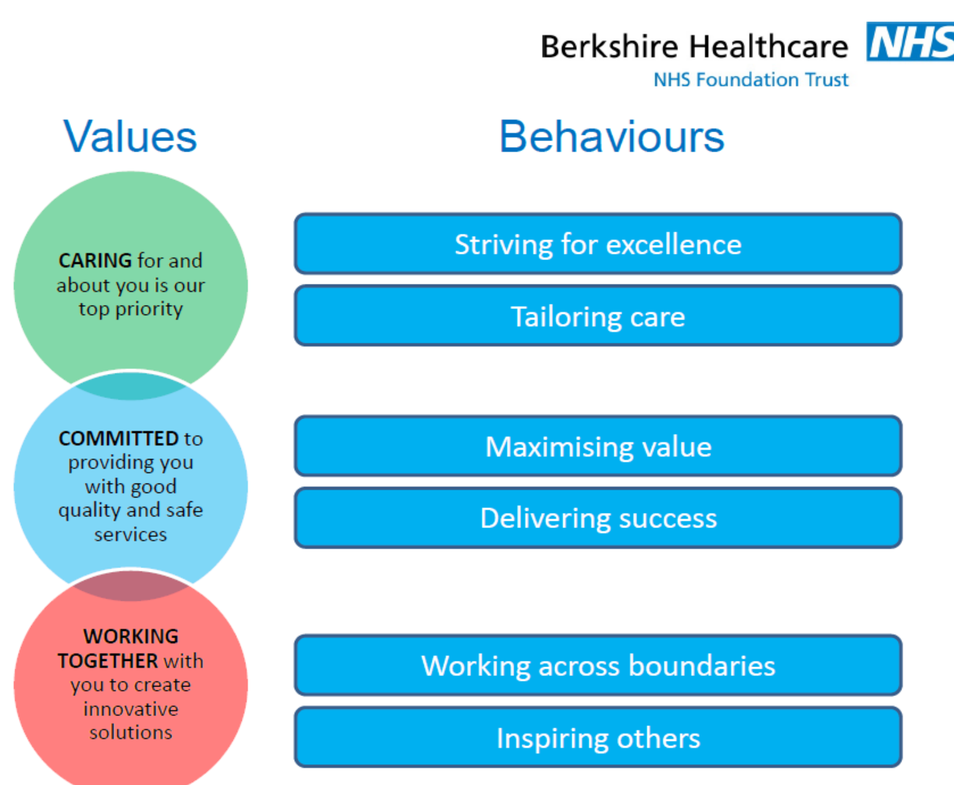

1. Statement on Quality from the Chief Executive (early draft)

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

The vast majority of the people we care for are supported in their own homes. We have 252 mental health inpatient beds and almost 200 community hospital beds in five locations and we employ more than 4,000 staff.

The health and social services in Berkshire face real challenges to maintain high quality care with increasing demands and limited resources. We are committed to working with others to develop innovative transformational solutions.

I want Berkshire Healthcare to deliver quality health services that work together to make a difference to individuals, their families and their communities. We can only do this by getting to know our communities and the people in them so we can deliver the best services to meet their health needs.

As Chief Executive I rely on patients, carers and their families to tell me when we are getting it right and when we get it wrong. I think that listening to the people we support and learning from them is the only way I can be sure that we are providing the best care. We will focus during the next year on further improving involvement of patients and carers to make the care we provide as good as possible.

Our staff are dedicated to ensuring the best outcomes for our patients their families, so I also rely on them to help me understand what the issues are and how we can improve our care. We have worked very hard to develop and listen to staff during the past year. They have come up with excellent solutions through our 'Listening into Action' programme to remove obstacles to providing the best care. I am very pleased that staff engagement levels are among the top 20% of similar Trusts in the country and we aim to build upon this success to further improve care for the people we serve.

Our vision

The best care in the right place: developing and delivering excellent services in local communities with people and their families to improve their health, well-being and independence.

The way we go about our work is defined by our values – which were developed after talking with our patients and their carers, our staff, our commissioners and our partners. These shared values are the foundation on which quality performance is built.

A theme running through our quality account and quality strategy is the achievement of improvements across both mental and physical health services. This means our community health services adopting a model of care similar to our mental health model, focused on early intervention, case management and admission avoidance.

Equally, our mental health services will align and integrate, where appropriate, with community health services, for example in providing better care for older people and for children. We are strengthening primary care partnerships in the provision of core services and integrating our services with social care and acute services, organised around patient need.

We are also working to use technology to drive quality and productivity improvements. We are building on our telehealth and mobile working initiatives to support clinicians and drive innovation.

This quality account is a vital tool in helping to support the delivery of high quality care. The information provided in this report is, to the best of my knowledge, accurate and gives a fair representation of the current services provided.

Julian Emms CEO

DRAFT

2.1 Priorities for Improvement 2013/14

This section of the Quality Account details our achievements to date against the 2013/14 priorities and information on the quality of services provided by the Trust during 2013/14.

2.1.1 Patient Experience

In 2013/14 we aimed to ensure patients and carers had a positive experience of care and were treated with dignity and respect

We asked patients:

1 “How likely are you to recommend our service /ward to friends and family if they needed care or treatment.”

2 How do you rate the service you received? Very Good, Good, Adequate, poor, very poor

Our goal was to show an increased rate of positive experience over time. Figure 1 below shows the percentage of patients who rated the service they received as very good or good. To date at Q3 a slight decrease in community services and a slight increase in hospital (inpatient) services rated as good or better.

Figures 2 show over 90% of patients who had stayed in a community hospital or visited the minor injuries unit (MIU) at West Berkshire Community Hospital would recommend the services they received to their friends or family.

Figure 3 shows that over 80% of people who had received either physical or mental health care in the community would recommend the service to their friends or family members. Over 70% of people who had been an inpatient and received care for their mental health would recommend the services they received.

Further details on the number or compliments and complaints we received together with actions we have taken can be found in part 3 (p33).

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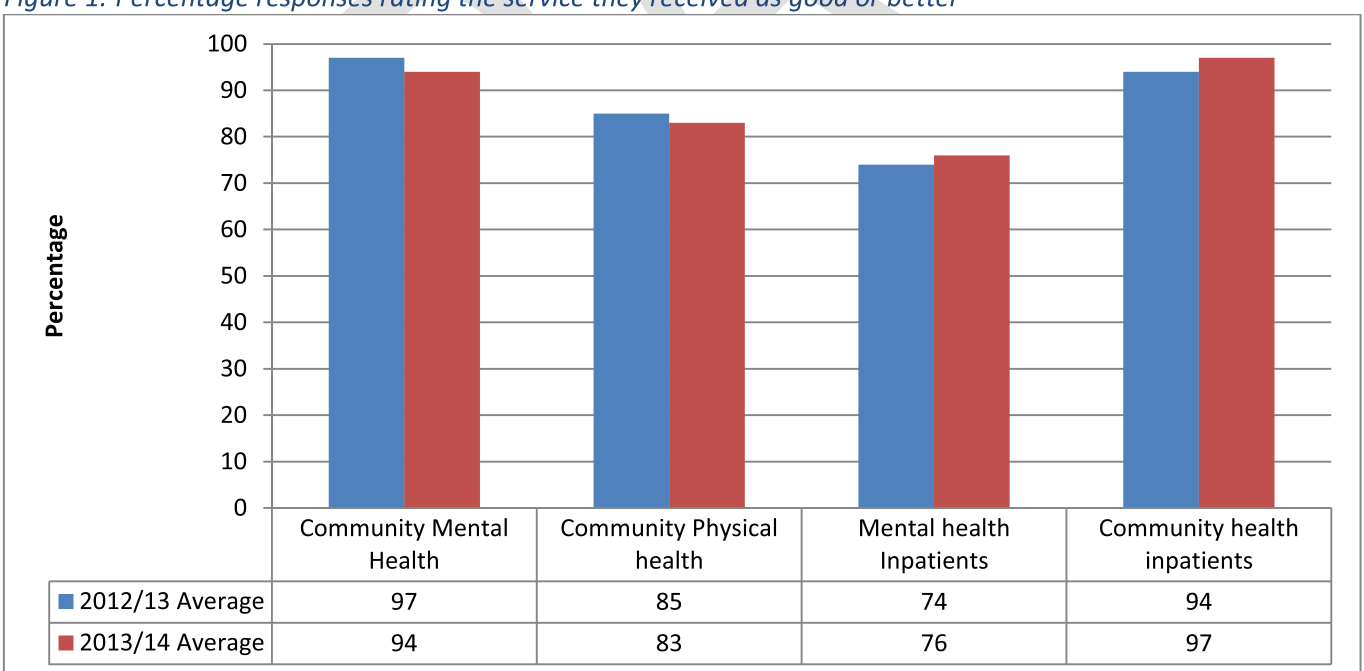
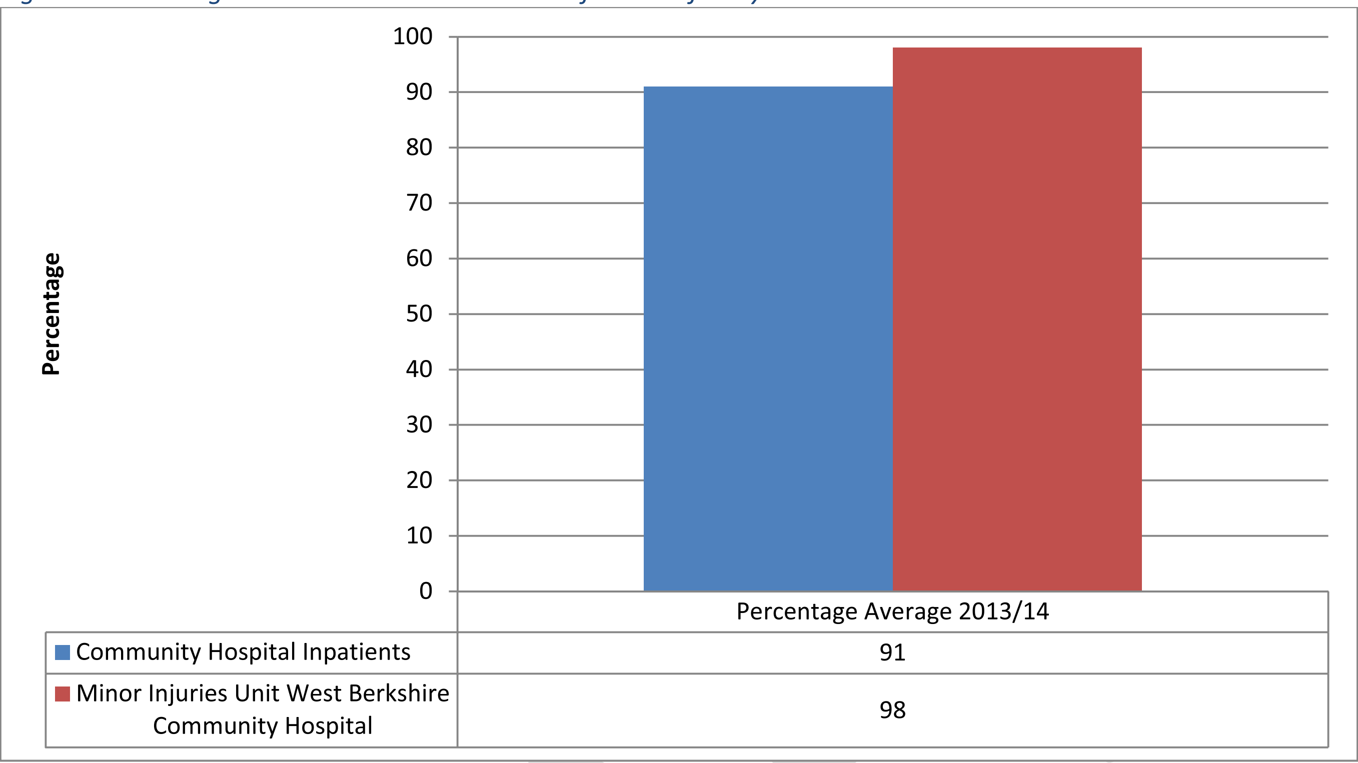
Figure 1. Percentage responses rating the service they received as good or better



	Community Mental Health	Community Physical health	Mental health Inpatients	Community health inpatients
2012/13 Average	97	85	74	94
2013/14 Average	94	83	76	97

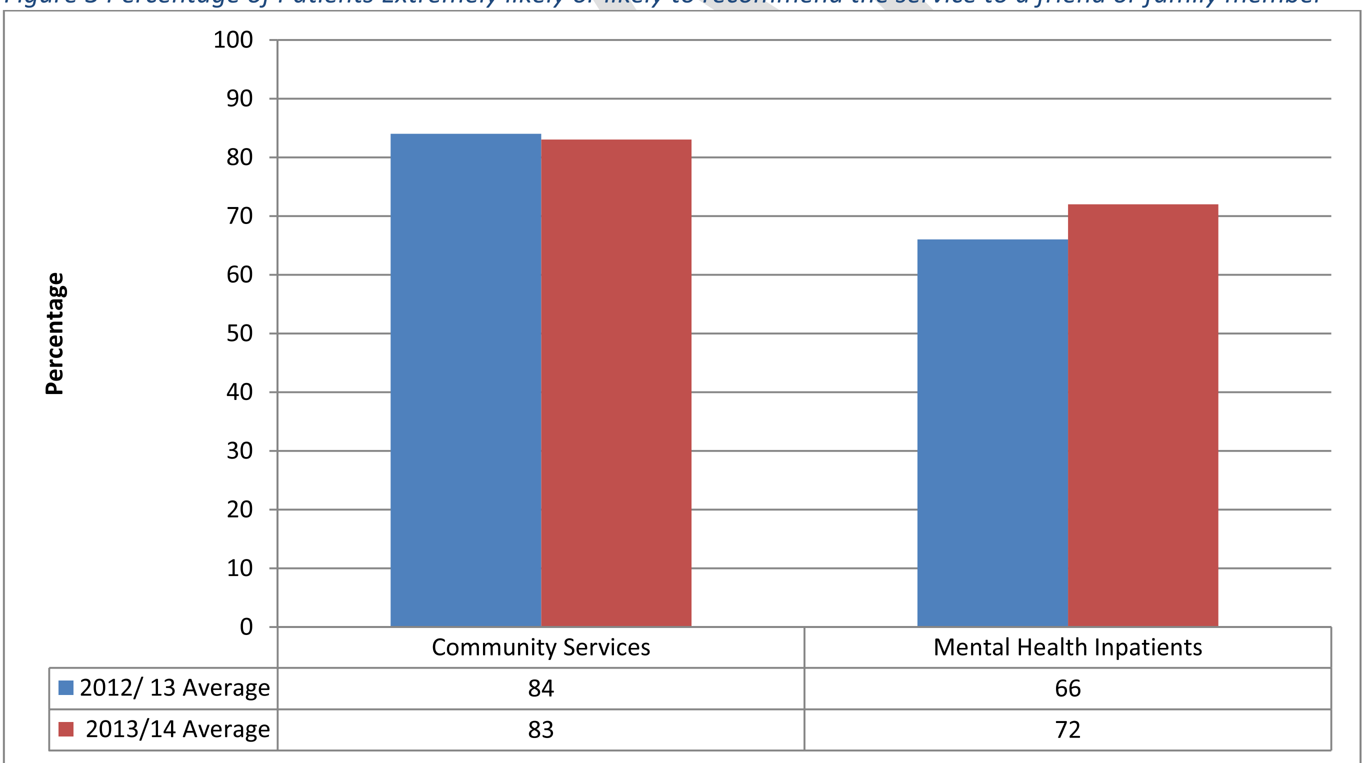
(Year end average rounded to nearest whole number. 2012/13 Community mental health results only include learning disability and older people’s services as data for adult and child services are unavailable. CMHT and ECT included for 2013/14)

*Figure 2 Percentage who would recommend to a friend or family member **



** Acute methodology used for Inpatients and MIU although not mandated for non-acute trusts.*

*Figure 3 Percentage of Patients Extremely likely or likely to recommend the service to a friend or family member ***



(Q1, 2 and 3 average (red) compared with full year average for 2012/13(blue)
***Increased number of both physical and mental health community services participated in 2014 compared to 2013*

National Community Mental Health Survey

The national report was published in September 2013 Service users aged 18 and over were eligible for the survey if they were receiving specialist care or treatment for a mental health condition and had been seen by the trust between 1 July 2012 and 30 September 2012. Responses were received from more than 13,000 service users nationally (29%).The Trust response rate was 31%.

The results of the survey show once again an improvement in performance, with the Trust demonstrating improvement in 13 areas, remaining the same in 32 areas and worsening in 2.

http://www.nhssurveys.org/Filestore/MH13/MH13_BM/MH13_Berkshire_Healthcare_NHS_Foundation_Trust_RWX.pdf

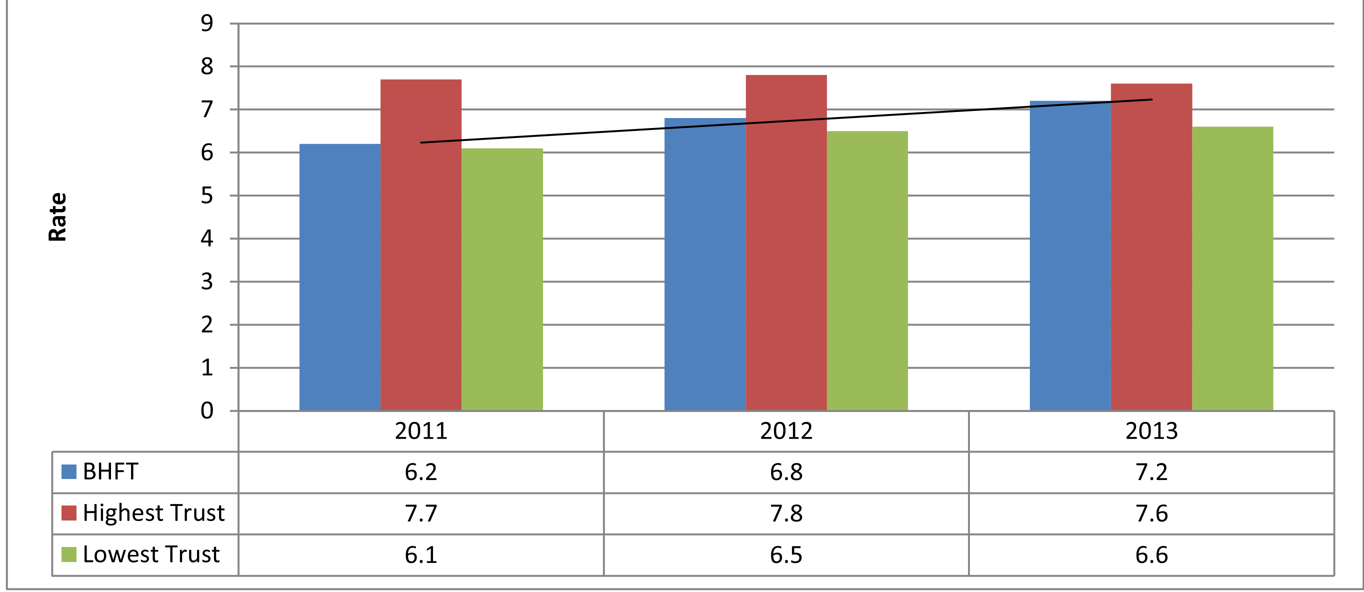
On review of our performance against trusts within NHS South of England we have moved our position significantly. For the overall experience section the Trust was 5th out of 16 regional trusts.

The Care Quality Commission (CQC) rate the Trust 'about the same' as most other trusts (Neither worse nor better).

Actions taken to improve quality:

- Results published across the trust
- Results to be shared with and disseminated into teams for information and discussion.
- Patients written to informing them who their Care Co-ordinator or Lead Professional is, enclosing a copy of the most current care plan
- Psychological skills training programme rolled out between September 13 and March 2014 to the Community Mental health workforce based on the Cognitive Behavioural Skills (CBT) training.
- Improved the advertisement of medicine information sources to staff, patients and their carers.

Figure 4 Overall, how would you rate the care you have received from the Trust in the last 12 months 1 (I had a very poor experience) - 10 (I had a very good experience)



	2011	2012	2013
BHFT	6.2	6.8	7.2
Highest Trust	7.7	7.8	7.6
Lowest Trust	6.1	6.5	6.6

Figure 5 Areas highlighted by the CQC as a significant increase in satisfaction

	2011 Score	2012 Score	2013 Score	2013 Lowest National Score	2013 Highest National Score
In the last 12 months, has a mental health or social care worker checked with you how you are getting on with your medication?	6.6	6.3	7.7 ↑	6.8	8.6
Do you know who your Care Co-ordinator (or lead professional) is?	7	5.4	6.8 ↑	5.5	8.2
Were you given a chance to express your views at the (care review) meeting?	8.5	7.7	8.6 ↑	7.5	9.1
In the last 12 months, did anyone in NHS mental health services ask you about any physical health needs you might have?	6	4.6	5.6 ↑	4.8	6.9
Have NHS mental health services involved a member of your family or someone else close to you, as much as you would like?	5.8	5.5	6.7 ↑	5.5	7.5

Whilst the CQC analysis did not identify any areas where there has been a significant decrease in satisfaction, upon reviewing the results in comparison with 2012 there are areas where satisfaction has decreased. These are shown in Figure 6.

Figure 6 Areas with a decrease in satisfaction in comparison with the 2012 survey

	2011 Score*	2012 Score	2013 Score	2013 Lowest National Score	2013 Highest National Score
Were the purposes of the medication explained to you?	8.3	8.2	7.7 ↓	6.1	9.1
Were you given information about the medication in a way that was easy to understand?	7.4	6.7	6.4 ↓	4.7	6.7
Section Score (Talking Therapies) *1	-	7	6.3 ↓	6.2	8.2
Did you find the NHS talking therapy you received in the last 12 months helpful?	6.6	7	6.3 ↓	6.2	8.2
Section Score (Day to Day living)*2	-	5.2	4.9 ↓	4	6.2

**calculations changed from percentage to scores *2 – the scoring methodology for a number of questions within this section has changed for the 2013 survey. The individual question scores for 2012 have been amended and updated however the 2012 section score results have not been revised*

These results suggest that the Trust has made significant improvements in care coordination, involving patients in care planning and in supporting mental health patients with physical health needs, although further improvement is required to be among the best Trusts in these areas. The organisation needs to work hard to maintain high standards with respect to providing accessible information about medicines for patients. There is a need to improve access to talking therapies for people with more severe mental health problems – those on a 'care programme approach'. The Trust is well positioned to respond positively to this as it provides very well regarded talking therapy services (improving access to psychological therapy) across Berkshire.

2013 National Staff Survey

The figure below shows how the Trust compares with other mental health/learning disability trusts on an overall indicator of staff engagement. Possible scores range from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, their team and their trust) and 5 indicating that staff are highly engaged.

Figure 7 shows the trust's score of 3.83 for overall staff engagement was in the highest (best) 20% when compared with trusts of a similar type.

These Key Findings relate to the following aspects of staff engagement:

- staff members' perceived ability to contribute to improvements at work
- their willingness to recommend the trust as a place to work or receive treatment
- the extent to which they feel motivated and engaged with their work

The trusts score for recommendation as a place to work or receive treatment (figure 9) was significantly higher than 2012 and in the highest (best) 20% when compared to other similar trusts.

Figure 7

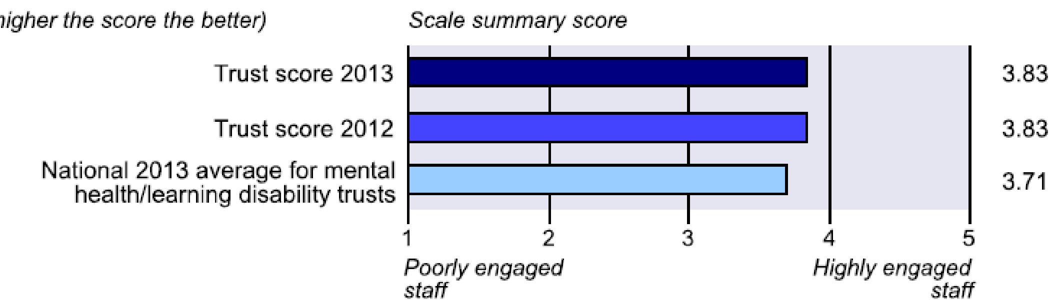
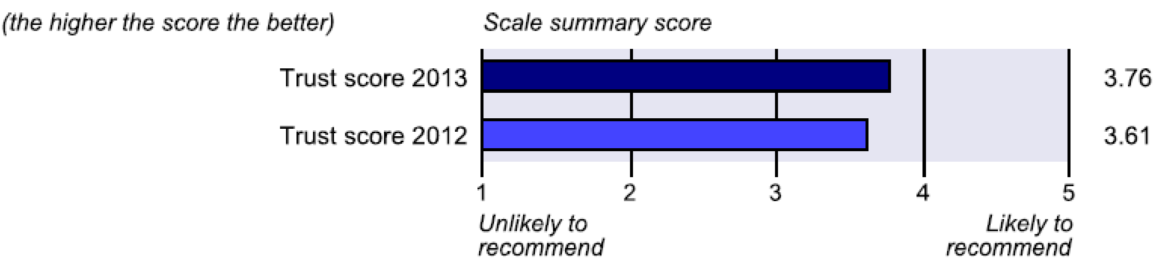


Figure 8

		Your Trust in 2013	Average (median) for mental health trusts	Your Trust in 2012
Q12a	"Care of patients / service users is my organisation's top priority"	71	63	62
Q12b	"My organisation acts on concerns raised by patients / service users"	75	71	69
Q12c	"I would recommend my organisation as a place to work"	62	53	58
Q12d	"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	69	59	64
KF24.	Staff recommendation of the trust as a place to work or receive treatment (Q12a, 12c-d)	3.75	3.54	3.61

Figure 9



Listening into Action LiA

Our Listening into action (LiA) programme is of central importance as a key means of engaging our staff. It aims to achieve a fundamental shift in the way the Trust works and leads, putting clinicians and staff at the centre of change for the benefit of our patients, staff and the Trust as a whole. It is all about:

- Changing the way we work for the benefit of our staff, patients and the organisation
- Connecting and bringing people together across the boundaries
- Empowering staff to get on and make the changes we all want to see
- Collaborating to come up with good ideas and then quickly turning them into action
- Celebrating our successes and using our stories to inspire others
- Sharing ownership and responsibility for improving care for our patients and working lives for ourselves

The LiA process is now becoming an accepted way of working together to solve issues in the organisation. The 'Big Conversations' between staff and the Chief Executive which identify issues requiring change, the action taken as a result and provision of prompt feedback to staff, all build confidence that concerns raised will be acted upon, and enable staff to get involved in making changes themselves.

We are able to measure the impact of our work to increase staff engagement through the in – house 'pulse' surveys, as well as the national staff survey. Our pulse surveys have shown us to be performing well – improving our scores on all questions asked since last year, with above average scores in comparison to the 24 other Trusts taking part in LiA. Our biggest improvements have been that more staff feel valued for the contribution they make and the work they do (up 21% on last year), and more staff believe we provide high quality services (up 22 %)

'Quick wins' and 'enabling our people schemes' have delivered improvements in key areas identified by staff such as communication, recruitment, care pathways, mobile working and protected reflective time for staff. The three waves of pioneer teams have introduced many high impact changes at team level which have made a real difference to patient care.

Excellent Manager Programme

Our organisational Development Strategy identified the requirement to support our managers in their development and performance – recognising the crucial importance of effective management at all levels.

In response to this, our own 'Excellent Manager' programme has been developed and is being implemented. It is important to emphasise that this programme was developed by talking to people about what they wanted and needed, and also by listening to what people said in the LiA Big Conversations. Through this programme we are aiming to align good management skills and practice with our new values based framework for appraisal. We firmly believe that designing the programme around the needs of our staff is the most significant factor in the success of the programme – which has received exceptional feedback from participants so far.

Talent Management

As part of our Organisation Development strategy the Trust identified Talent Management as a key priority, and we have subsequently become one of the organisations participating in a national talent management pilot, overseen by the NHS leadership academy.

This provides a way of identifying early potential, a mechanism for individuals to signal their intent, insight into where there are gaps in talent development and a way of ensuring business continuity and being prepared for unanticipated departures / absences. The process is aligned with and driven by the new values based appraisal system.

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2.1.2 Patient Safety

Aim: To protect patients from avoidable harm.

The NHS Safety Thermometer has been designed to be used by frontline healthcare professionals to measure a snapshot of harm once a month from;

1. Pressure ulcers
2. Falls
3. Urinary infection in patients with catheters
4. VTE (venous thromboembolism)

The trust wanted to reduce the amount of harm by identifying and learning from our incidents and to demonstrate continued improvement in relation to these important patient safety measures.

These four harms were selected as the focus by the Department of Health's Quality Innovation productivity prevention (QIPP) Safe Care programme because they are common, and because there is a clinical consensus that they are largely preventable through appropriate patient care.

The concept of Harm Free Care was designed to bring focus to the patient's overall experience. Data has been collected for all the eligible patients seen on one day of the month. Data is collected on a monthly basis from the inpatient community hospital wards, older people's mental health wards, learning disabilities units and community teams, and all community nursing and older people's mental health nursing. There has been significant improvement in the data accuracy with teams being challenged when the data submission sheet is not correctly completed

Figure 11 shows the percentage of harm free care per month compared to the national harm free figure.

On average during quarter 3, 91.96 % of patients received harm free care compared with 89.29% in Quarter 2.

There has been a gradual increase in the percentage of patients who receive harm free care. The national average is 93.5%. The Trust may have a lower number of harm free patients due to the significant number of old pressure ulcers. This means that patients have acquired the pressure ulcers in another setting before coming in to the care of the Trust.

The numbers of harm free care have increased since the training of staff on the correct definitions of the harms and the increase in the number of patients surveyed. The majority of patients only have one harm.

Appendix C details the individual charts depicting the level of harm from Pressure ulcers, Falls, Urinary infection in patients with catheters, and VTE (venous thromboembolism. The charts demonstrate the number of harms that each patient acquired.

The majority of patients who suffer a harm recorded for the month only have one harm

Pressure ulcers remain the highest harm. However since May there has been a reduction in the number of pressure ulcers reported.

There has been a reduction on the MEAN number of pressure ulcers which have developed on our wards over the last 6 months from the previous 6 months.

The Pressure Ulcer strategy is focused on zero tolerance of new pressure ulcers and the impact of this will be monitored at the pressure ulcer strategy group. There is new training for all clinical staff; all new pressure ulcers are reviewed by the ward and Deputy Director of Nursing at a monthly meeting. There is also to be a patient awareness raising campaign.

There have been 3 wards that have not had a developed pressure ulcer for 90.

The next 6 months will be monitored to assess whether the pressure damage prevention campaign had made a difference to the number of pressure ulcers across the trust. The trust compares favourably with other community trusts on their new harms.

Source: Berkshire HealthCare Foundation Trust Patient Safety Thermometer feedback Quarter 23 report 2013/14

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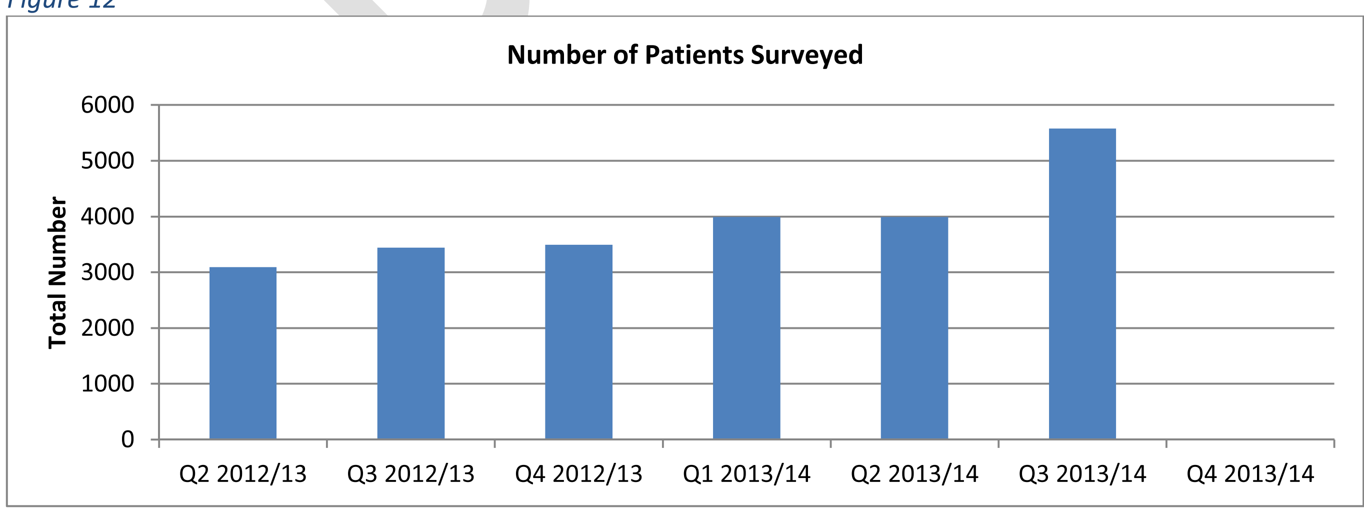
Figure 11 –Percentage of Harm free care

Percentage

	April	May	June	July	August	September	October	November	December	January	February	March
BHFT Harm Free 2013/14	89	89	90.4	87.85	89.61	90.42	92.2	92.4	92.5			
Harm free across all organisations 2013/2014	92.2	92.4	92.8	92.8	93	93.1	93.4	93.6	93.5			

Figure 12



2.1.3 Recovery

Mental Health

Aim: To enable people to recover from episodes of ill health and enhance their quality of life.

Primary Measures:

1. To continue to offer the mental health recovery star and Wellness Recovery Action Plans (WRAP) with improved uptake for people with enduring mental health problems.

During 2012/13 the Trust focussed on the training of staff in the use of the mental health Recovery Star and

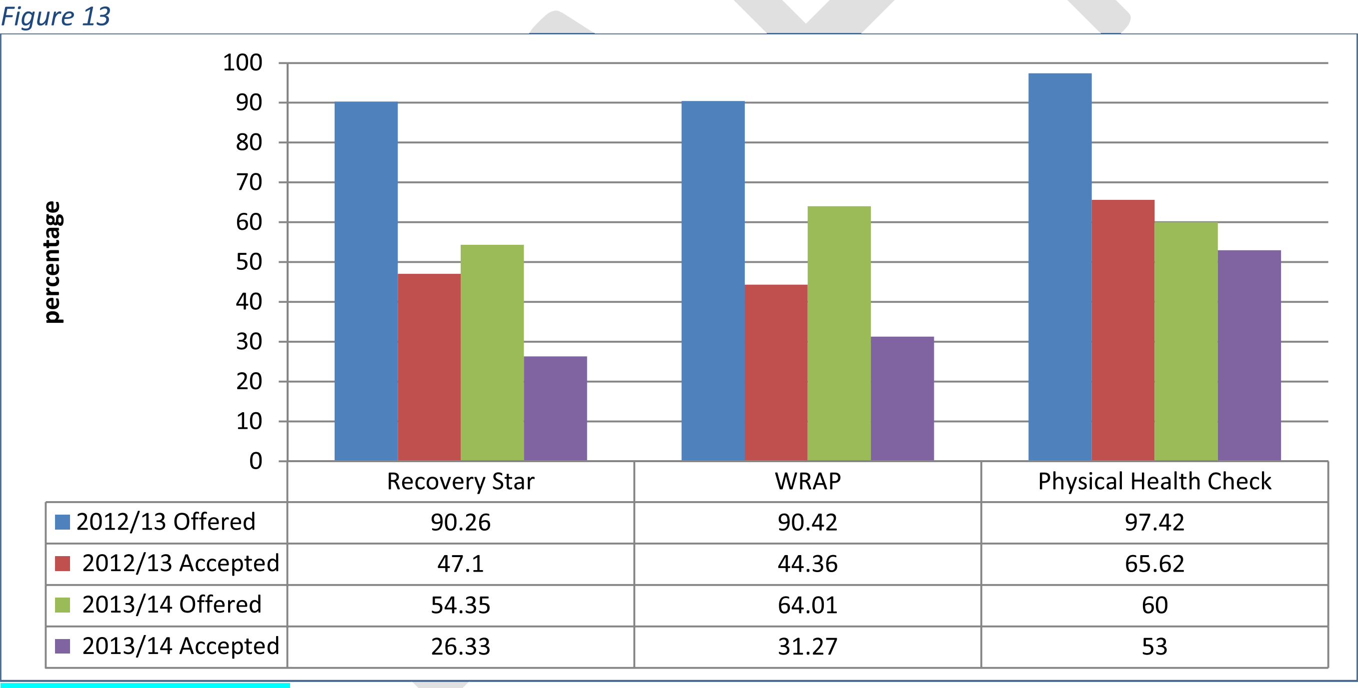
(CPA) are being offered the use of these tools in their care plans. The aim is to build on these metrics and seek ways to demonstrate improvements in the recovery outcomes for patients during the next year. Wellness Recovery Action Plans (WRAPs) and ensuring that patients on an enhanced Care Plan Approach

Figure 13 shows that there has been a decline in Q3 of the number who were offered and who accepted both Recovery star 54% and WRAP 64% of clients were offered the use of a Recovery Star and WRAP, of these26% (38% Q2) and 31% (42% Q2) retrospectively accepted the offer and proceeded to engage with the method of recovery. An action plan is being put in place led by the West Berkshire Locality Director to resolve this before the end of the year.

To be updated Q4

60% of clients have been offered a physical health check to date and of those 53% have accepted.

Figure 13



	Recovery Star	WRAP	Physical Health Check
2012/13 Offered	90.26	90.42	97.42
2012/13 Accepted	47.1	44.36	65.62
2013/14 Offered	54.35	64.01	60
2013/14 Accepted	26.33	31.27	53

* (Q3) to be updated Q4

Physical Health

The process of engaging people in their care, supporting them to take control and get the most out of life with a long term condition (LTC) is the central thread of the LTC strategy. Planning care in this way is more proactive and meets individuals' full range of needs. Patients who are better able to self-manage also have fewer contacts with health services.

Aim: To enable people to recover from episodes of ill health and enhance their quality of life.

Primary Measures:

1. To demonstrate for people with long term conditions that wellbeing outcomes are measured and associated plans implemented to help people make the most of their lives.

Three LTC which are reported on within this account are:

1. Heart Failure
2. Cardiac Rehabilitation
3. Neuro rehabilitation

Heart Failure

Heart failure affects over 1% of the population causing symptoms of breathlessness, oedema and fatigue and has a negative effect on quality of life worse than many long term conditions (Hobbs et al. 2002).

Treatments are led by physical symptoms and yet the National Institute for Health and Clinical Excellence and others state treatment plans need to be individualised and should consider all aspects of physical and psychological health (NICE, 2010).

The Heart Failure Service began to use an assessment tool to measure and monitor quality of life in heart failure patients from January 2012.

An internal audit of patients under the care of the Berkshire Healthcare NHS Foundation Trust Heart Failure Service showed that although asked if they have a history of depression, there was no evidence to illustrate quality of life had been assessed. Therefore a measurement tool was needed to assess and monitor quality of life in heart failure patients to meet key service outcomes of improving quality of life and developing patient centred plans of care.

Over the last year the tool has become established within the assessment process and is routinely used by all specialist nurses in the team. Analysis of scores revealed 41% of patients have a poor quality of life (Figure 14) and a breakdown of domains into physical and emotional components showed that those who had high sub scores also scored highly in their overall assessment.

420 patients have been assessed and these results and graphs remain fairly static. Although number are small, the team is are now beginning to record scores on discharge and it can be seen that there is a reduction in poor quality of life scores from 41% to 17% and 'good' quality of life has increased from 31% to 50% (Figure 15)

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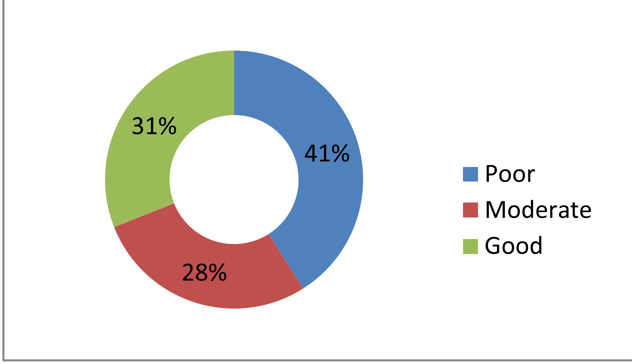
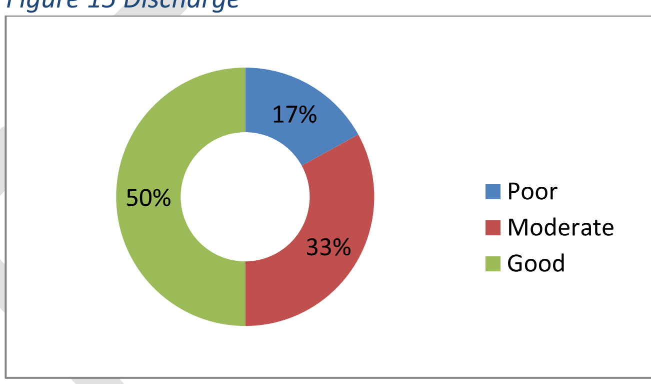
Figure 14 Baseline



Minnesota Living with heat Failure tool

Figure 15 Discharge



The results show that poor quality of life is an on-going issue for patients living with heart failure. In the next month our first Living Life with Heart Failure Course is starting, this is a new initiative with the IAPT Talking Health Team and as is open to all of our heart failure patients. The course is 6 weeks long and is intended to help them cope with their diagnosis. It will start in the Reading locality. Over the next year the service aims to address this with the following:

1. Enhancing the service to provide appropriate psychological support allowing the heart failure team to adhere to NICE guidelines of individualised care planning considering physical and psychological health, and meet local service outcomes of improving quality of life.
2. Heart failure nurses to complete appropriate IAPT training.
3. Work with local colleagues to develop pathways for onward referral where needed.
4. Ensure all patients have their quality of life assessment repeated on discharge from the service.
5. Long term patients to have their quality of life assessed every six months to monitor the effectiveness of interventions whether physical or psychological.

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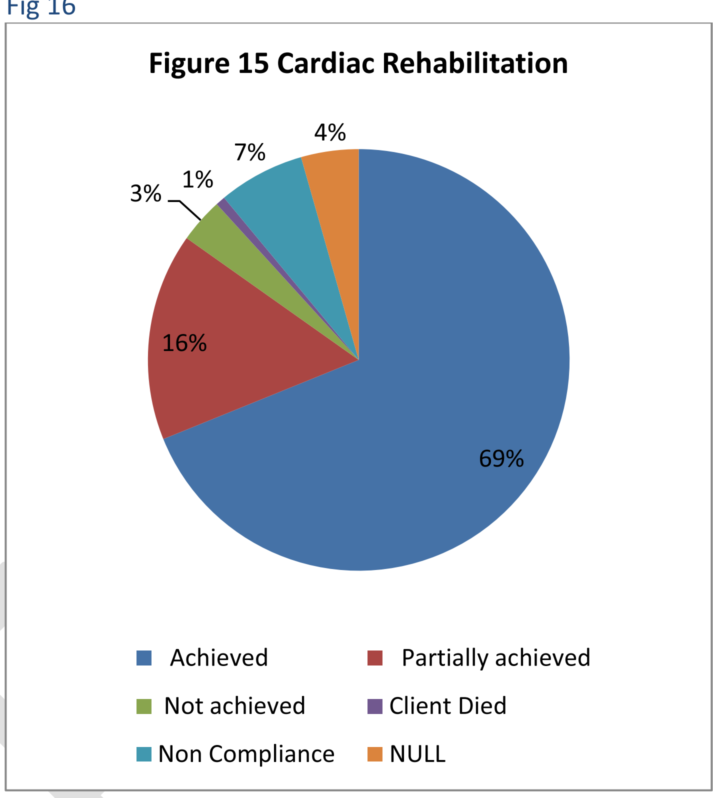
Cardiac Rehabilitation

There is evidence that exercise-based cardiac rehabilitation: is effective in reducing total and cardiovascular mortality and hospital admissions in people with coronary heart disease and reduces all-cause and cardiovascular mortality rates in patients after myocardial infarction (MI heart attack) when compared with usual care, provided it includes an exercise component significantly reduces hospitalisation for chronic heart failure and significantly improves quality of life and exercise tolerance for people with heart failure.

The aim of the programme is to reduce the risk of subsequent cardiac problems and to promote a return to a full and normal life. The Figure 16 (April 2013/Oct 2013) shows that 281 (69%) of patients achieved an increase in their level of fitness by at least 10% with a further 65 (16%) achieving a partial improvement (0-10%).Pre and post scores 'achieved' represents a 10% or more improvement in patients level of fitness after the intervention of cardiac rehab, Partially achieved means a 0-10% improvement in patients level of fitness after the intervention of cardiac rehab

Fig 16



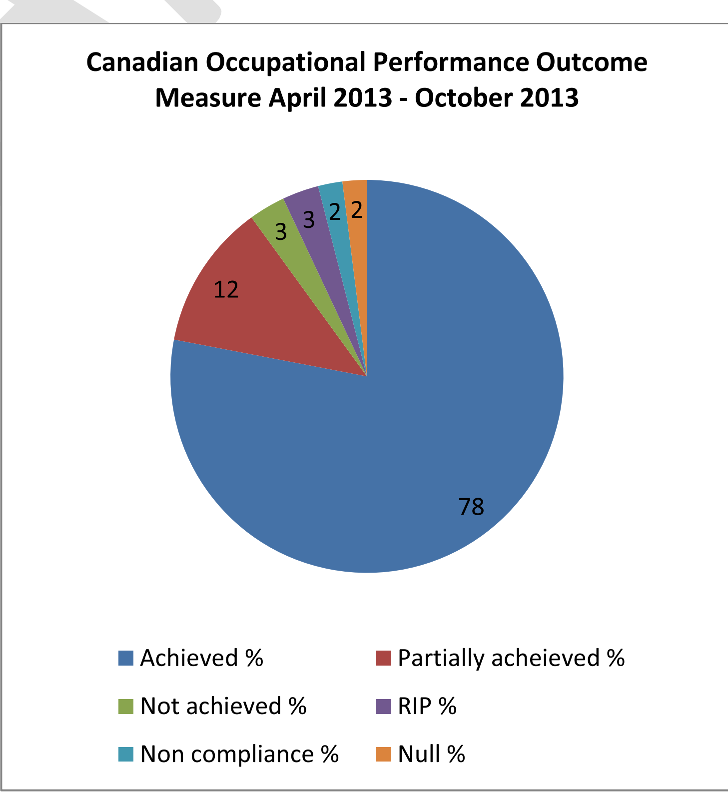
Neuro rehabilitation

The National Service Framework (NSF) for Long-term Neurological Conditions requires rehabilitation resources to be available at all stages in a neurological condition, in both community and hospital Settings. The Neuro-Rehabilitation team works with people aged 18 and above with acquired and long-term neurological conditions, helping them to achieve maximum independence in all aspects of daily life

The Neuro-Rehabilitation team works with people aged 18 and above with acquired and long-term neurological conditions, helping them to achieve maximum independence in all aspects of daily life

The Canadian Occupational Performance Measure (COPM) is an individualized, client-centred measure designed for use by occupational therapists to detect changes in a client's outcomes in areas of self-care productivity and leisure. The Figure 17 shows that 78% of patients achieved their outcome goals.

Figure 17



2.1.4 Dementia and Mental Health in acute hospitals

Aim: To improve dementia care and mental health liaison for people in acute hospitals in Berkshire.

Primary Measures:

1. Training of acute hospital staff across Berkshire to improve dementia awareness. To train 3000 staff (cumulative) to support admission avoidance and reduce length of stay as well as improving quality of care.

There has been progress on development of the older people's mental health liaison team in East Berkshire. There are regular ward rounds on care of the elderly wards in Wexham Park Hospital; which includes supporting those patients with:

- Self-harm and attempted suicide.
- Behavioural problems associated with dementia: aggression; agitation; wandering.
- Functional mental health disorders: mania; psychosis; psychotic depression and severe depression with poor food and fluid intake.
- Delirium
- Discharge planning for complicated delayed discharges.
- Complex capacity assessments requiring specialist second opinion

In addition to the improved management of dementia patients in the hospital. The referral rate has increased, with more referrals for functional psychiatric problems. Heatherwood and Wexham Park Foundation Trust have introduced dementia awareness training for their staff. Further outcomes will be available by year end (Q4)

In the West of the county Berkshire West Clinical Commissioning Groups (CCGs) have agreed to fund an expanded Hospital and Community based liaison services for 2014/15. The hospital based service will be located within the Royal Berkshire Foundation Trust Hospital and brings together the current older peoples health liaison team, A&E liaison and the children's and adolescents mental health self-harm post, which with additional investment will form an integrated Hospital liaison service.

The Community Liaison service will incorporate the Medically unexplained symptoms (MUS) service, and will focus on supporting timely discharge of patients from the Royal Berkshire Foundation Trust, and improving outcomes for people with long term conditions who are reviewed through integrated cluster teams. The East and West clinical commissioning groups have confirmed funding for 2014/15 to consolidate and further develop the liaison psychiatry initiatives in the community that began in 2012. The funding will enable the consultant liaison psychiatrist to continue collaborative working with primary care and acute trusts in Berkshire.

In brief, the community initiatives include:

- Providing specialist intervention for medically unexplained symptoms in collaboration with clinical health psychology, IAPT and general practitioners to reduce inappropriate healthcare utilisation. The project received 70 referrals in year 1 and 65 referrals (ongoing) in year 2.

- Outpatient assessment and management of patients with medically unexplained neurological symptoms (MUS). This weekly clinic at the Royal Berkshire Bracknell Clinic has received 70 referrals since it was set up in August 2012.

- Outpatient assessment and management of patients with respiratory long term conditions (LTC) and comorbid psychological distress. This weekly clinic at King Edward VII chest department has received 55 referrals since it was set up in February 2013.

- Primary care liaison in the form of assessment and management of complex patients with medically unexplained symptoms and physical/psychological comorbidity as part of the Common Point of Entry service. This initiative includes assessments in all 6 localities across Berkshire and has received 103 referrals since it was set up in June 2012.

- Education and training of general practitioners, acute care clinicians and mental health professionals in the management of complex conditions with physical and psychological overlay.

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2.1.5 Health Inequalities

The Trust is increasingly focussed on developing its contribution and commitment to tackling health inequalities. Ensuring fair access to services, enabling children and young people to maximise their capabilities and have control over their lives, contributing to fair employment and good work for all and strengthening ill health prevention.

Aim: To ensure that service provision is targeted to population need.

Primary Measure:

1. A baseline assessment to identify where action is required for adult services. It is anticipated that the focus will be within the Reading and Slough localities and the needs of diabetic patients
2. Allocation of further additional health visitor resources to reflect the population need and levels of deprivation.

Following a workshop in May, all localities within BHFT have set objectives. The following list highlights developments:

•**Slough** mapping of diabetes clinic attendance and other diabetes patients usage of services is on track. Data due in Quarter 4.

•**Reading** locality working jointly with Berkshire Diabetic Eye Screening service to improve awareness and ethnicity recording so that mapping of diabetes patients in Reading can be undertaken accurately in the future; the relationship between diabetes prevalence and disadvantage/ diabetes and ethnicity has been analysed. The locality is also developing a project to educate Reading based CMHT patients who are also diabetic about the management of their condition. Data due in Quarter 4.

•**Bracknell** seeking additional funding to provide young SHaRON (web-based peer support to young parents); recording of perinatal patient data on track, analysis against baseline delayed; scheduled IAPT support provided on monthly basis to children's centres; outstanding data reports requested for quarter 4.

•**Wokingham** specialist health visitor (HV) is making good progress engaging the local Gypsy, Roma and Traveller (GRT) community across a number of settlements; significant success reported by HV in tackling Measles, mumps and rubella (MMR) immunisation rates, and raising awareness of major health conditions and providing other support/equipment; outstanding data reports requested for quarter 4.

The 'Family First' initiative in Wokingham involves health visitors, school nurses, child, adolescent and adult mental health, social services and other partners working with troubled families. The group has worked with about 80 families so far with impressive outcomes:

Health: members of all but one of the families have underlying health needs, either physical or emotional, which were previously untreated.

Criminality and antisocial behaviour: All but two of the families identified for criminality and antisocial behaviour have stopped offending completely.

Education: School attendance for the young people of statutory school age has increased from an average of 20% to over 85%

Employment: 41% of families now have an adult who has entered employment (many for the first time)

•**Windsor and Maidenhead** are focussing on the physical health needs of mental health patients and are developing a web-based database to facilitate the monitoring of physical health care for this group.

Quote – 'Since being involved in the MH Forum I have learned more about the things I can get involved in. I enjoy working on Community Mapping. When I get out and about I feel I am doing something worthwhile. Sometimes you think life is a lump of coal, but if you chip away slowly you will find a glimmer of the nugget of gold'

•**West Berkshire** face-to-face Learning Disability training for clinicians on-going, Trust-wide training needs identified and roll out planned for November 2013; improvement in recording LD data evidenced; Easy read Podiatry information being piloted. Reports on LD patient satisfaction requested for quarter 4.

•**Mental Health Inpatients and Urgent Care** - Urgent care questionnaire on cultural competence being undertaken; tools being sourced for inpatient teams based on patient satisfaction data. Awareness raising conferences taking place in November 2013 (South Asian culture/mental health) and Spiritual care/mental health conference being planned for February 2014. Reports on patient data and patient satisfaction requested for quarter 4.

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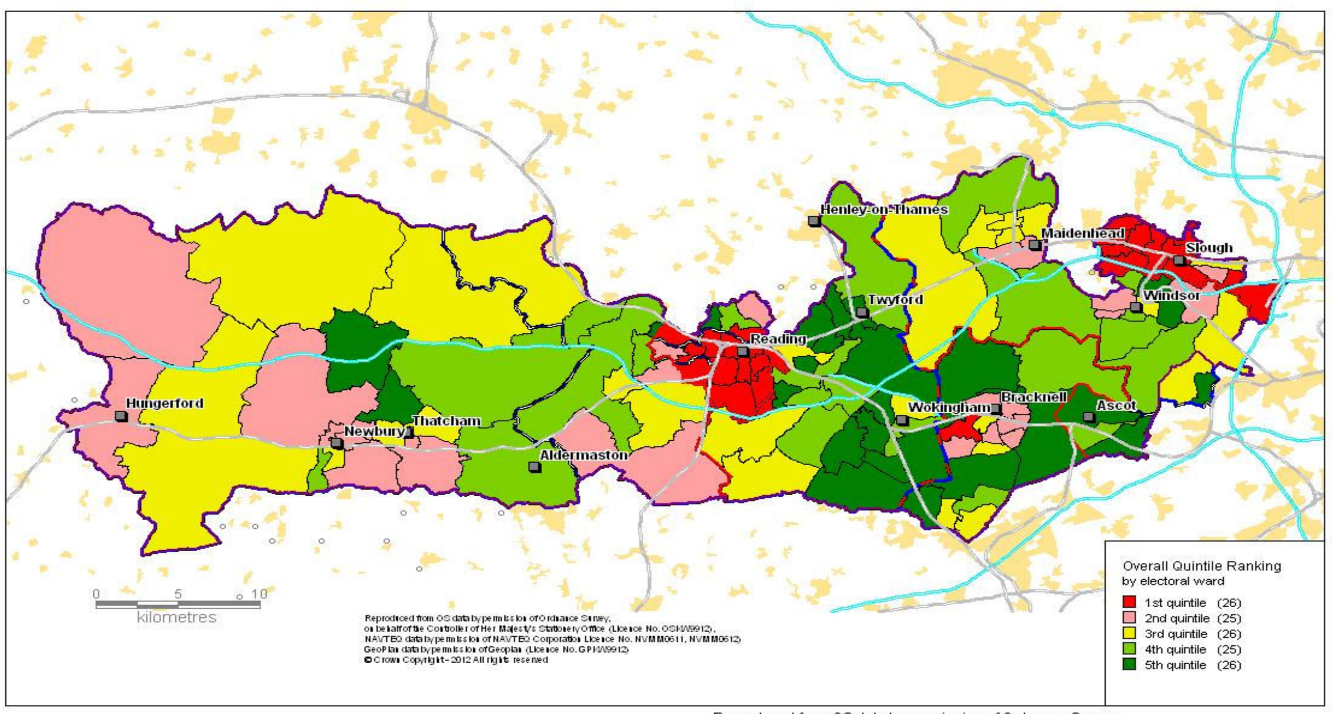
Health Visiting

The planned allocation of the 24 new health visitor posts for 2013/14 this year was based on the commissioner's decisions and the deprivation in each locality. However it became apparent in the year that the Trust was in danger of not meeting the target of recruitment so the decision was made to take on new staff to whichever area they wanted to work to ensure we did not lose them. This has been successful and we have retained the vast majority of staff trained and expect to meet the March 2014 target (some staff still in recruitment process so cannot finalise this yet.)

In 2014/15 we will be using this year's allocation of new staff to rectify any mismatch of staff to need arisen due to this change in recruitment using the overall deprivation and incorporating the version of the model below (Figure 18).This will be done following confirmation of posts for this year . The end result will be that by March 2015 the new HV posts will be allocated to ensure that all caseload sizes reflect the appropriate needs of the locality

Figure 18



Ward_Scores_HV_Allocation.wor 15/08/2012 Sid Beauchant BHISS/BPHN

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2.2 Priorities for Improvement 2014/15

The Trust's first goal is to provide accessible, safe and clinically effective services that improve patient experience and outcomes of care. In March 2014 (subject to ratification) the Trust is formally launching its Quality Strategy (Appendix A note) both the strategy and quality priorities linked to it will enable us to deliver this goal. Below are the 2013/14 priorities alongside the proposed development of the priority for 2014/15.

2.2.1 Patient Safety

In 2013/14 we aimed: To protect patients from avoidable harm

Primary Measure: The NHS Safety Thermometer.

1. Pressure ulcers
2. Falls
3. Urinary infection in patients with catheters
4. Treatment for VTE (Venous Thromo-Embolism)

Outcome: To reduce the amount of harm by identifying and learning from our incidents. To demonstrate continued improvement in relation to these important patient safety measures

Proposed for 2014/15

In 2013 we participated in the South of England Improving Safety in Mental Health Collaborative. This programme has been set up to improve safety in mental health. The aim of the programme is to develop and build a culture of patient safety and quality improvement with the support of a Patient Safety Faculty with expertise in Improvement Science. The programme focuses on four key areas to reduce harm to users of mental health services.

Aim: to continue to protect patients from avoidable harms

Primary Measure:

1. To have a positive patient safety culture within the trust.
2. Safe and reliable delivery of mental health care

Outcome:

1. Increased positive staff survey response to questions regarding incidents and learning.
2. Deaths as a result of self-harm in patients in receipt of care from community teams reduced to zero or greater than 300 days between such events by March 2015;
3. Severe harm in patients on inpatient wards reduced to zero or greater than 300 days between such events by March 2015;
4. Severe harm in patients in receipt of care from community teams reduced to zero or greater than 300 days between such events by March 2015;

Additional Option

For 2013/14 we reported on pressure ulcers within the patient safety thermometer. For 2014/15 we will focus particularly on Pressure ulcers, building on our pressure ulcer prevention campaign 'Under Pressure – our journey from inevitable to zero'. Pressure ulcer prevention champions have been appointed as part of this campaign. We will prioritise a clear outcome with respect to this.

Primary measure:

Our aim is to achieve no developed pressure ulcers on community and mental health wards. We will report on the number of days without a developed pressure ulcer on each of our wards and aim to exceed 120 days on all wards during 2014/15.

2.2.2 Clinical Effectiveness

In 2014 we aimed: To enable people to recover from episodes of ill health, enhance their quality of life and improve dementia care for people in acute hospitals in Berkshire.

Primary Measures:

1. To demonstrate for people with long term conditions that wellbeing outcomes are measured and associated plans implemented to help people make the most of their lives.
2. To continue to offer the mental health recovery star and Wellness Recovery Action Plans (WRAP) with improved uptake for people with enduring mental health problems.

Outcome: Increased rate of uptake over time for recovery star and WRAP

Primary Measures:

1. Training of acute hospital staff across Berkshire to improve dementia awareness.

Outcome: To train 3000 staff (cumulative) to support admission avoidance and reduce length of stay as well as improving quality of care.

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Proposed 2015

Aim: to provide services based on best practice

Primary Measures:

1. Implementation of the National Institute for Health and Care Excellence (NICE) Quality Standards to include but not exclusive to:
   a. Self-Harm
   b. ADHD
   c. Dementia
2. Implementation of PH48: Smoking cessation in secondary care: acute, maternity and mental health services.
3. Increasing access to psychological therapies in secondary care this will include mapping of skills within the workforce training and supervision of staff.

Outcomes: In line with NICE recommendations we will strive for 100% against quality measures within the quality standards and aim to fully implement smoke free services for 2015. Details of a CQUIN in relation to increasing access to psychological therapies are being negotiated with commissioners. The outcome will be included as a quality account priority in line with a request from Trust Governors.

2.2.3 Health Inequalities

In 2014 we aimed: To ensure that service provision is targeted to population need.

Primary Measure:

1. A baseline assessment to identify where action is required for adult services. It is anticipated that the focus will be within the Reading and Slough localities and the needs of diabetic patients
2. Allocation of additional health visitor resources to reflect the population need and of deprivation.

Proposed 2015

Aim: to ensure that services are based on need.

Primary Measure:

1. Following the identification of the baseline assessments by services in 2014 to ensure that the actions identified are implemented.
2. Local health inequalities initiatives will be reported on
3. Achievement against the target of 185 whole time equivalent health visitors by April 2015 allocated to best meet population need.

2.2.4 Patient Experience

In 2014 we aimed: To ensure patients and carers have a positive experience of care and are treated with dignity and respect

Primary Measure: Friends and Family test

1 “How likely are you to recommend our service /ward to friends and family if they needed care or treatment.”

Outcome: to show an increased rate of positive experience over time

Proposed 2015

Aim: To continue to ensure patients and carers have a positive experience of care and are treated with dignity and respect.

Primary Measures.

1. Friends and Family Test
2. Learning from compliments and complaints

Outcome: to show an increased rate of positive experience over time

As part of this we will also report on measures to demonstrate that people with learning disabilities, cognitive and memory problems are having a positive experience of care and treated with respect and dignity.

Improving patient Involvement will be a key theme for the Trust during 2014/15. Initiatives to further enhance this will be developed and implemented following a presentation to the Board at the start of the year. Examples being considered include:

1. ‘Listening into action’ events with staff to identify the best ways to remove barriers to better patient and carer involvement in their clinical areas.
2. ‘Listening into action’ events with patient and carer groups to improve care.
3. Closer association with key local and national patient representative groups and charities to help improve the development of services.
4. The employment of a patient involvement lead and champion reporting directly to the Chief Executive and sharing best practice across the Trust and beyond.
5. Increased involvement of experts through experience on key quality groups and committees.
6. Enhanced patient quality feedback systems to encourage and respond to suggestions for improvement.

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Monitoring of Priorities for Improvement.

By the end of June 2014 we will have agreed the detailed action plans and improvement targets that will deliver the priorities. They will be monitored on a quarterly basis by the Quality Assurance Committee as part of the Quality report and the Board of Directors will be informed of performance against agreed targets. We will report on our progress against these priorities in our Quality Account for 2015.

2.3 Statements of Assurance from the Board

During 2013/14 the Trust provided 72tbc NHS services. The Trust Board has reviewed all the data available to it on the quality of care in all 72 of these NHS services. The income generated by the NHS services reviewed in 2012/13 represents 100% of clinical services and 89% of the total income generated from the provision of NHS services by the Trust.

The data reviewed aims to cover the three dimensions of quality – patient safety, clinical effectiveness and patient experience. Improvements in the metrics used and processes in place to gather good quality data in these areas were implemented early in 2013/14. The key quality performance indicators presented to the Board have been further reviewed. 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.

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2.4 Clinical Audit (Q3 to be revised Q4)

During 2013/14, 10 national clinical audits and 1 national confidential enquiries covered relevant healthcare services which Berkshire Healthcare Trust provided.

During 2013/14 Berkshire Healthcare NHS Foundation Trust participated in 100% (n=8) national clinical audits and 100% (n=1) national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in (figure 20)

The reports of 3 (100%) national clinical audits were reviewed in 2013/14. This included 2 national audits that collected data in 2011/12 or 2012/13 that the report was issued for in 2013/14. (figure 20)

The national clinical audits and national confidential enquiries that Berkshire Healthcare Foundation Trust participated in, and for which data collection was completed during 2013/14, are listed in table 1 alongside the number of cases submitted to each audit or enquiry as a percentage of the number registered cases required by the terms of the audit or enquiry.

Local Audits

- Registered – 157
- Completed- 56 (may have started in previous year)
- Active – 159 (may have started in previous year)
- Awaiting action plan - 19

The reports of 51 local clinical audits were reviewed by the Trust in 2013/14 and Berkshire Healthcare Foundation Trust intends to take actions to improve the quality of healthcare. (NB: Projects are only noted as 'completed' after completion of the action plan implementation, which is why there are more local projects 'reviewed' than total 'completed').

The reports of all the national clinical audits were reviewed in 2013/14 and Berkshire Healthcare Foundation Trust intends to take actions to improve the quality of healthcare.

Full details Actions planned by the Trust, as a result of these national and local audits, will be included in the final Trust Quality Account for 2013/14.

2.5 Research (Q3 to be revised Q4)

The number of patients receiving NHS services provided or sub-contracted by the Trust that were recruited to end of December 2013/14 to participate in research approved by a research ethics committee was as follows:

241 patients were recruited from 61 active studies, of which 115 were recruited from studies included in the National Institute of Health Research (NIHR) Portfolio and 126 were from non-Portfolio studies.

Figure 19 R&D recruitment figures 2013/14 Q3

Type of Study	No of Participants Recruited	No of Studies
NIHR Portfolio	115	28
Student	111	26
Other Funded (not eligible for NIHR Portfolio & Own Account (Unfunded)	15	7

The Trust has been active in the development of the Oxford Academic Health Science Network (AHSN) and has been particularly focussed on ensuring that community and mental health services are prominent in the priorities of the network.

The Oxford AHSN incorporates a 'Best Care' programme which involves a series of clinical networks. Mental health networks have been developed within the AHSN with respect to dementia; improving access to psychological therapies for depression and anxiety; early intervention in mental health and physical/mental health comorbidities.

Linked to these developments there has been further close collaboration with the University of Reading including the opening of the Berkshire Memory and Cognition Research Centre.

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Figure 20

National Clinical Audit and Patient Outcomes Programme (NCAPOP) Audits	
National re-audit of schizophrenia (NAS) (2013)	Data collected October 2013 111 patients submitted, across adult and CAMHS
Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)	Data collected November 2013 – January 2014 Data submitted for 1 GP surgery, out of 1 relevant GP surgery (170 patients 100%)
Epilepsy 12 audit (Childhood Epilepsy)	No relevant patients –Nil return
Non-NCAPOP audits	
Prescribing for ADHD (March 2013)	Data collected March-April 2013 126 patients submitted, across adult and CAMHS
Prescribing anti dementia drugs	Data collected October 2013 88 patients submitted, across adult and CAMHS
Monitoring of patients prescribed lithium	Data collected June 2013 104 patients submitted.
Use of antipsychotic medication in CAMHS	January 2014 Data collection currently in progress. Minimum of 10 patients per locality to be submitted.
National Memory Clinics Audit	Data collected July-September 2013 6 clinics submitted, out of a relevant 6 (100%)
National Confidential Inquiries	
National Confidential Enquiry into Suicide and Homicide for people with Mental Illness (NCISH)	8 (100%)
Other audits reported on in-year (data collected in previous year(s)	
National Audit of Schizophrenia (2011)	Involved 80 patients in a case note review, with 30 service user responses and 22 carer responses to survey. Initial Trust level report received April 2012 and final national report December 2012. Reviewed April 2013
Prescribing antipsychotic medication for people with dementia	Data collected Sept 2012 1,016 patients submitted, across older adult teams east and west.

2.6 CQUIN

A proportion of the Trust's income in 2013/14 was conditional upon achieving quality improvement and innovation goals agreed between the Trust and the Primary Care Trusts, NHS Berkshire through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2013/14 and for the following 12 month period can be found in Appendix F and G

The income in 2013/14 conditional upon achieving quality improvement and innovation goals is £4,074,898. The associated payment received for 2012/13 was £4,100,918.

2.7 Care Quality Commission

The Trust is required to register with the Care Quality Commission and its current registration status is registered without conditions. The Care Quality Commission has not taken enforcement action against Berkshire Healthcare Foundation Trust during 2013/14. Berkshire Healthcare Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

The CQC inspected three of our services during 2013/14;

1. Sorrell Unit (Psychiatric Intensive Care Unit) at Prospect Park Hospital,
2. Ryeish Green Children's Respite Unit
3. Berkshire Adolescent Mental Health Unit (BAU) at Wokingham Community Hospital.

Sorrell Unit was assessed as being compliant with three of the five 'Outcomes' assessed, but received an improvement notice in respect of Outcome 1 (Respecting and involving people who use services), and Outcome 2 (Consent to care and treatment). For Outcome 1, the CQC said, "It was not clear if people's views and experiences were taken into account in the way the service was provided and delivered in relation to their care". For Outcome 2, the CQC said, "It was not clear that care and treatment was planned and delivered in a way that ensured people's safety and welfare". On this latter point, the CQC wanted to see improvement in the quality and triangulation of risk assessments, care planning and progress notes recorded on the Trust's clinical record keeping system. BHFT has put actions in place to address these issues.

Ryeish Green and BAU were assessed as meeting all of the Essential Standards inspected.

The Trust received a CQC Mental Health Act (1983) Monitoring Visit during the reporting period. This visit, the first of its kind involving BHFT, involved the CQC engaging multiple agencies and service users to evaluate standards of assessment and detention of mental health patients in accordance with the Act. The assessment identified areas of good practice and positive feedback, alongside developmental issues to be addressed by BHFT, its commissioners and partner agencies.

The Trust had an internal CQC inspection programme for 2013/14 which was delivered to provide assurance to the Executive and Board that CQC compliance with the essential standards is maintained across all services, and to highlight any risks to compliance.

The current CQC Quality & Risk Profile (Appendix D) published on 31st January 2014. Shows one change since the last profile published in November 2013. Outcome 11: (R16) Safety, availability, and suitability of equipment has improved from a high green to a low green rating.

2.8 Data Quality

Berkshire Healthcare Foundation Trust submitted records during 2013/14 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:
99.9% for admitted patient care
99.9% for outpatient care.

The percentage of records which included the patient's valid General Practitioner Registration Code was:
99.8% for admitted patient care
95.1% for outpatient care.
87.8% for emergency care (Minor Injuries Unit)

Information Governance

Berkshire Healthcare Trust Information Governance Assessment Report overall score for 2013/14 was (66%) and was graded (Amber).

The Information Governance Group is responsible for maintaining and improving the information governance

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Toolkit scores, with the aim of being satisfactory across all aspects of the IG toolkit for Version 11. An action plan is being agreed to achieve this for the Version 11 final response which is due March 2014. Progress against the actions is monitored by the Information Governance Group.

One aspect of information governance includes clinical coding. A clinical coding audit in December 2013 revealed correct primary diagnosis and secondary diagnosis coding of 86% and 72% respectively for mental health. This is a marked improvement on previous clinical coding audits.

Data Quality

Berkshire Healthcare Foundation Trust has taken the following actions to improve data quality.

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

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

The key measures for data quality scrutiny mandated by the Foundation Trust regulator Monitor and agreed by the Trust Governors are (Full descriptions Appendix X to be added):

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

BHFT was not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission

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3.1 Review of Quality Performance 2013/14 (Q3)

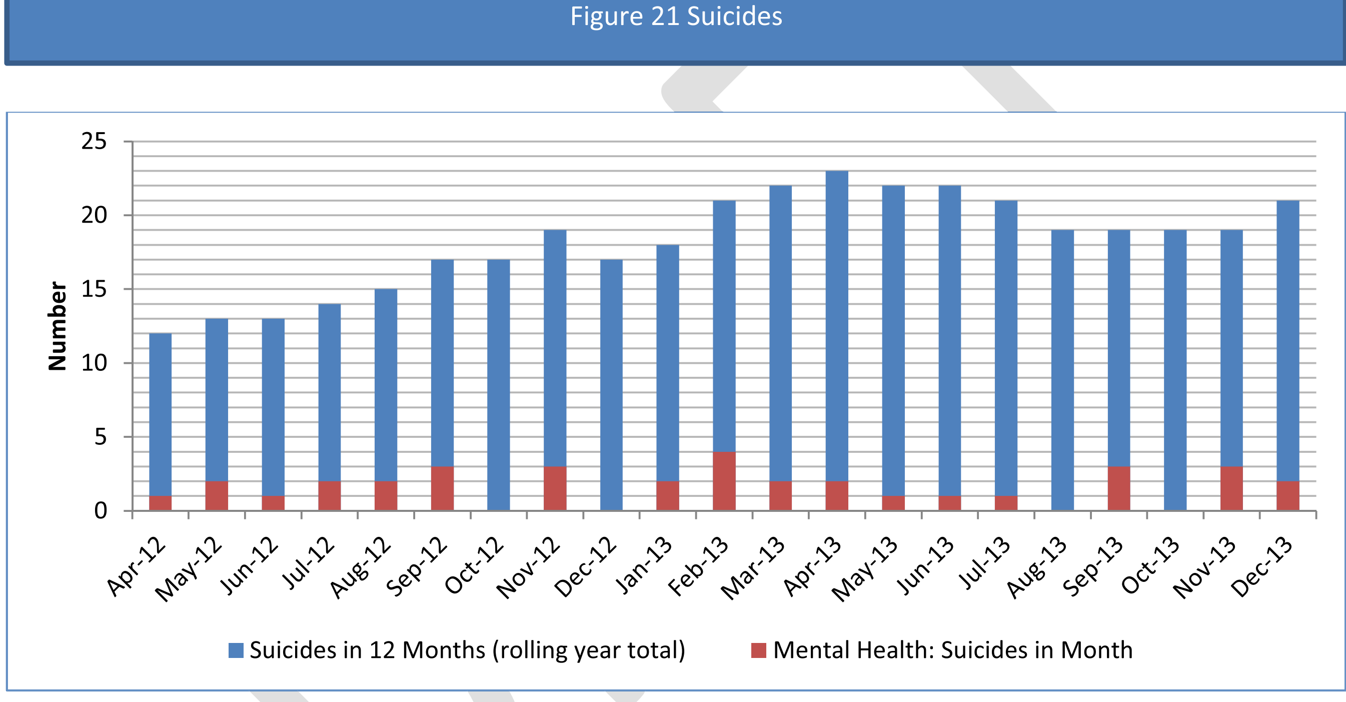
In addition to the key priorities detailed, the Trust Board receives monthly Performance Assurance Framework reports related to key areas of quality. These metrics are closely monitored through the Trust Quality Governance systems including the Quality Executive Group and the Board Audit Committee. They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

Patient Safety

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

Never Events

None reported at Q3



Suicide rates for those in contact with the Trust appear to have plateaued at around 19 per year. Clinicians have worked hard to improve processes for assessing and managing risks for patients in relation to suicide and self-harm. There have been no inpatient suicides during 2013/14. All suicides occurred in the community.

Absence Without Leave (AWOL)

There have been fluctuations in patients AWOL from the ward and in episodes of absconding. There has not, however been any clear trend in these areas. Three AWOL incidents relate to an older adult client on new Orchid Ward. One client was responsible for two awol incidents from Bluebell ward - On Bluebell ward there is a pilot project to see the impact of having the ward door unlocked for periods during each day, however in both these instance the client ran away from staff whilst on an escorted walks. This same client was also responsible for one of the absconsion from Bluebell ward in December 2013, by kicking open the fire door

AWOLS - information to add in here from the patient safety project Q4 Patient Safety Manager JG

Slips Trips and Falls

The number of slips, trips and falls across the Trust has remained stable at around 225 per quarter. 3 falls resulting in fracture have occurred during the first half of the year.

Figure 22 Absent Without Leave (AWOL) and Absconsions on a Mental Health Act (MHA) Section

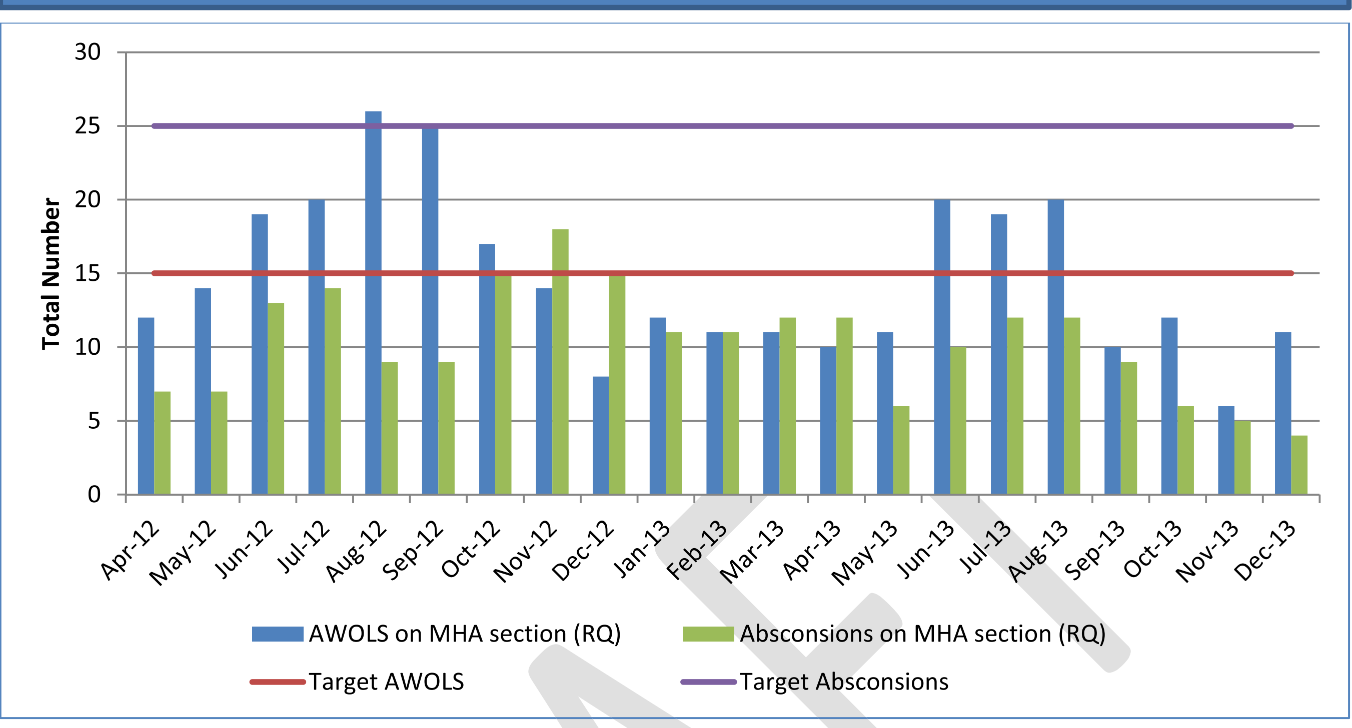
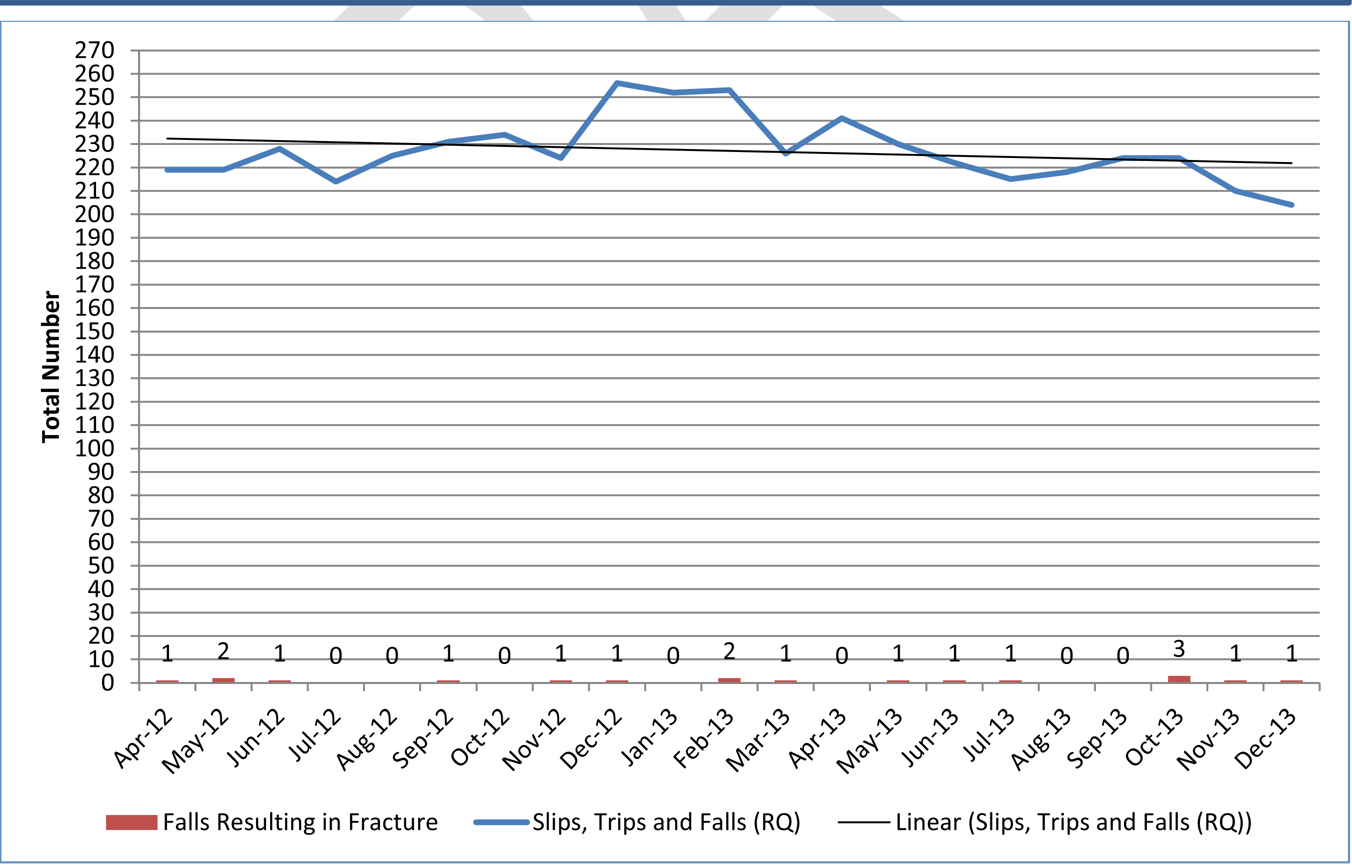


Figure 23 Total number of Slips Trips & Falls Incidents against those resulting in fracture



Medication errors
The number of medication errors reported has fluctuated on average around 140 (117 – 156) per quarter with no clear trend. The Trust aims to maximise the reporting of errors but reduce the occurrence of serious errors which cause harm to patients. To date 420 medication errors have been reported none of which have resulted in moderate or severe harm to patients.

Pressure Ulcers
The number of grade 3 and 4 Pressure Ulcers reported has increased in the first half of the year due to a change in reporting thresholds (including inherited pressure ulcers). – No new grade 3 pressure ulcers were reported in December 2013, Q1 55 in total, Q2 81 in total Q3 41in total [This will be revised to incorporate latest analysis of pressure ulcer data Q4].

Physical Assaults
There has been some reduction in physical assaults on staff by patients during the first half of the year with a slight increase in patient on patient assaults.

Figure 25 Newly Acquired Pressure Ulcers

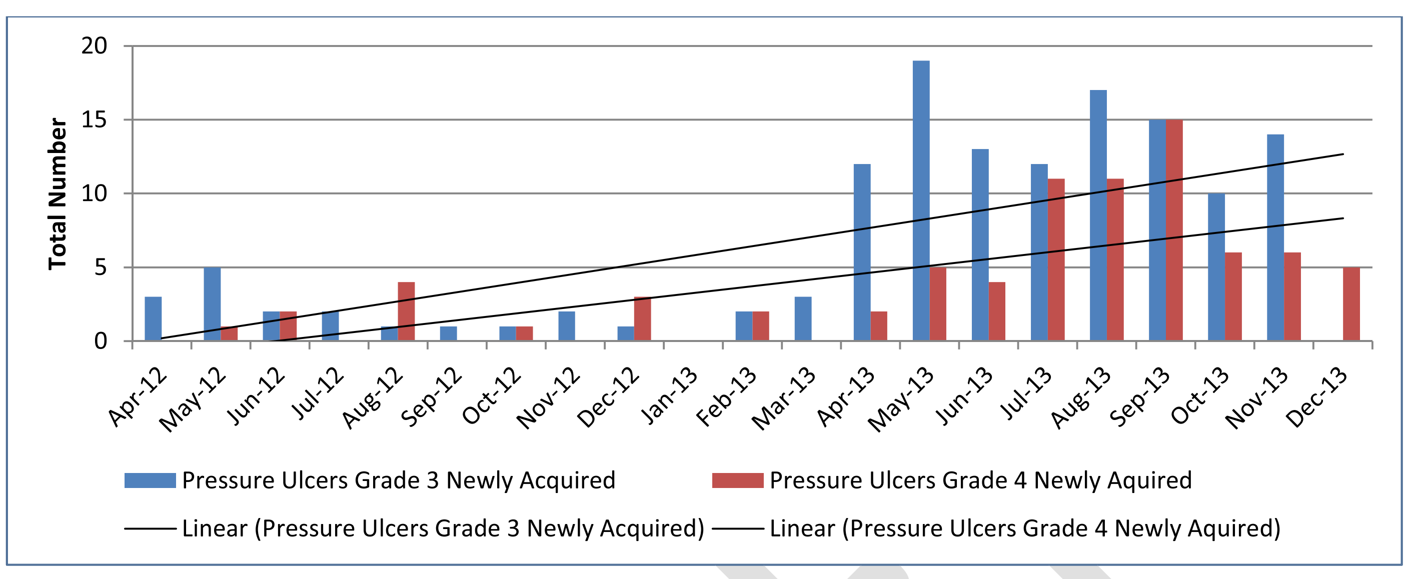
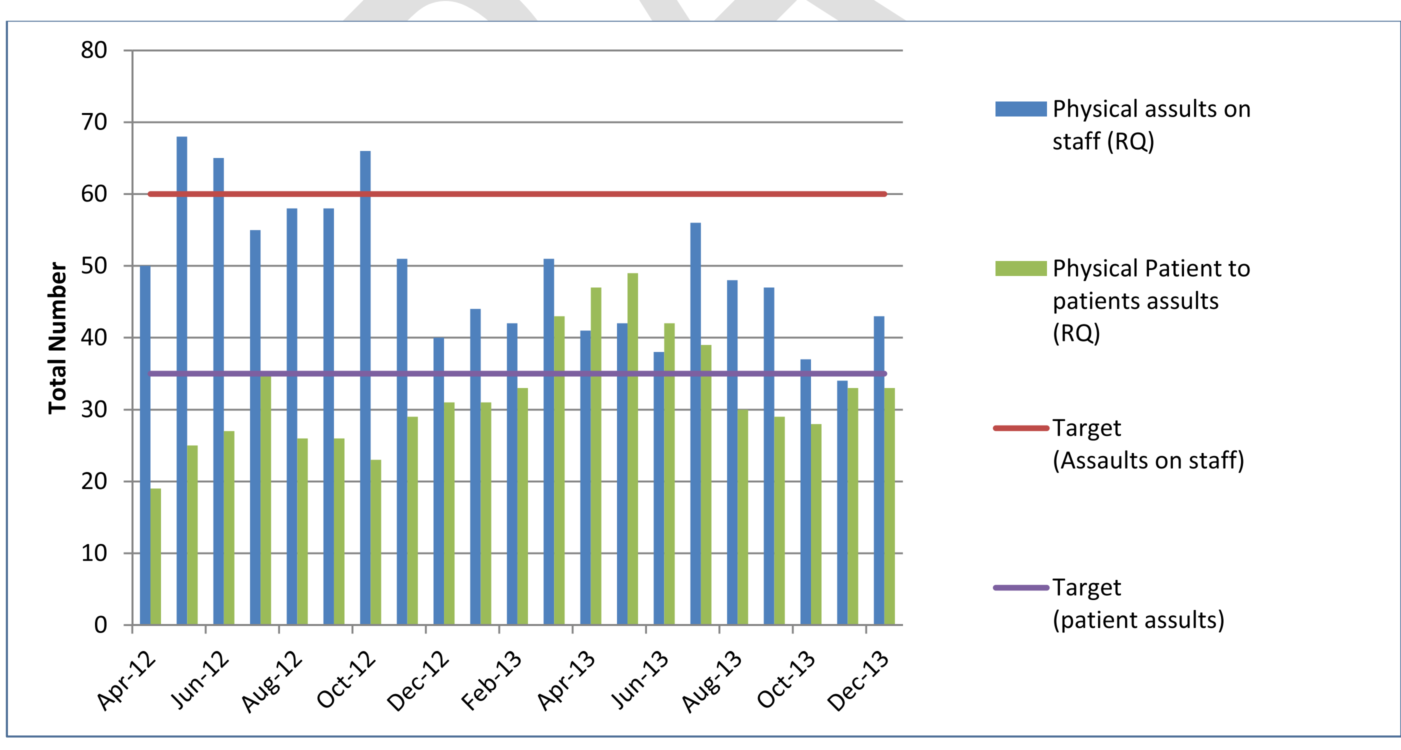


Figure 26 Patients to Patient and Patient to Staff Physical Assaults



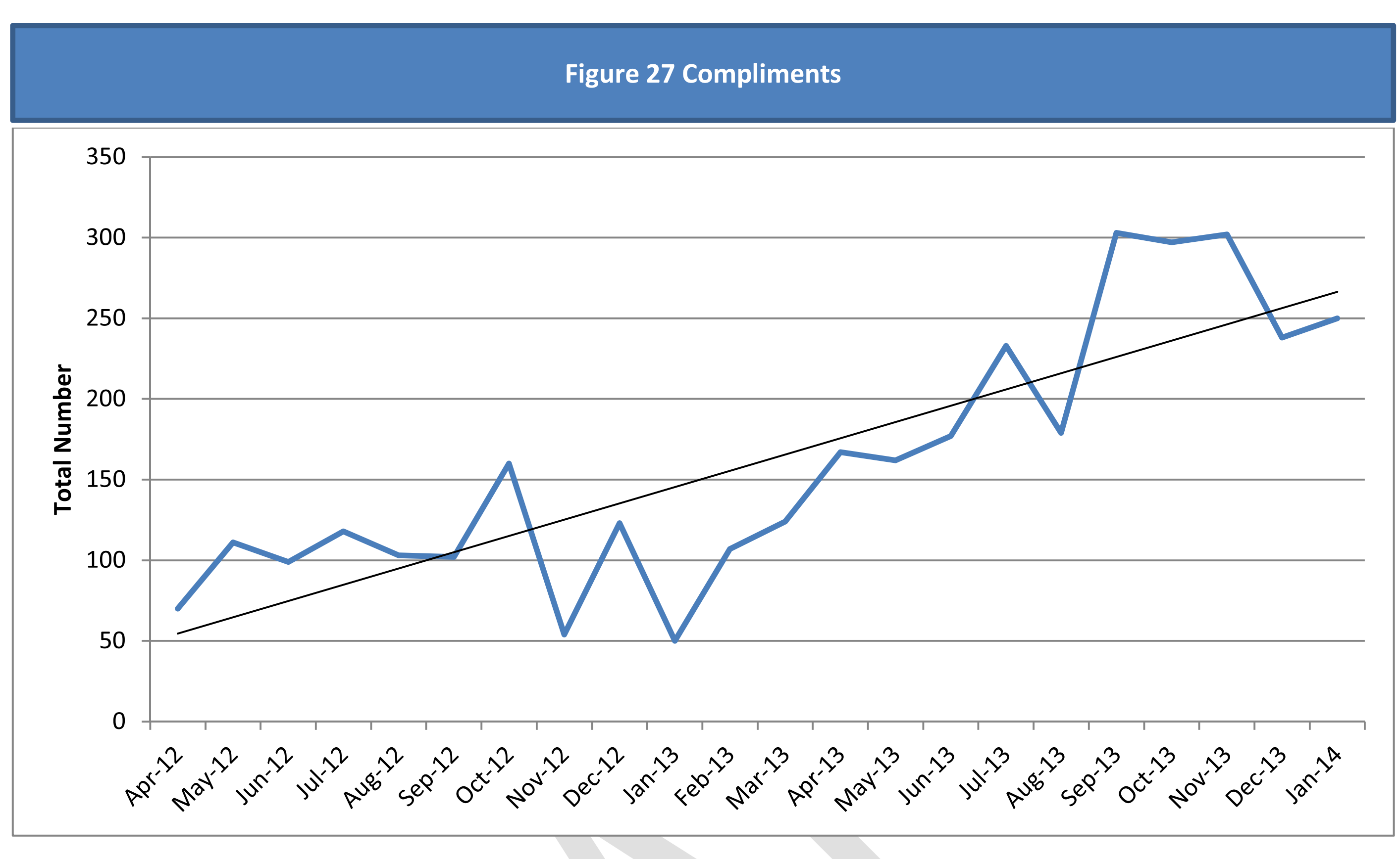


Figure 27 Compliments

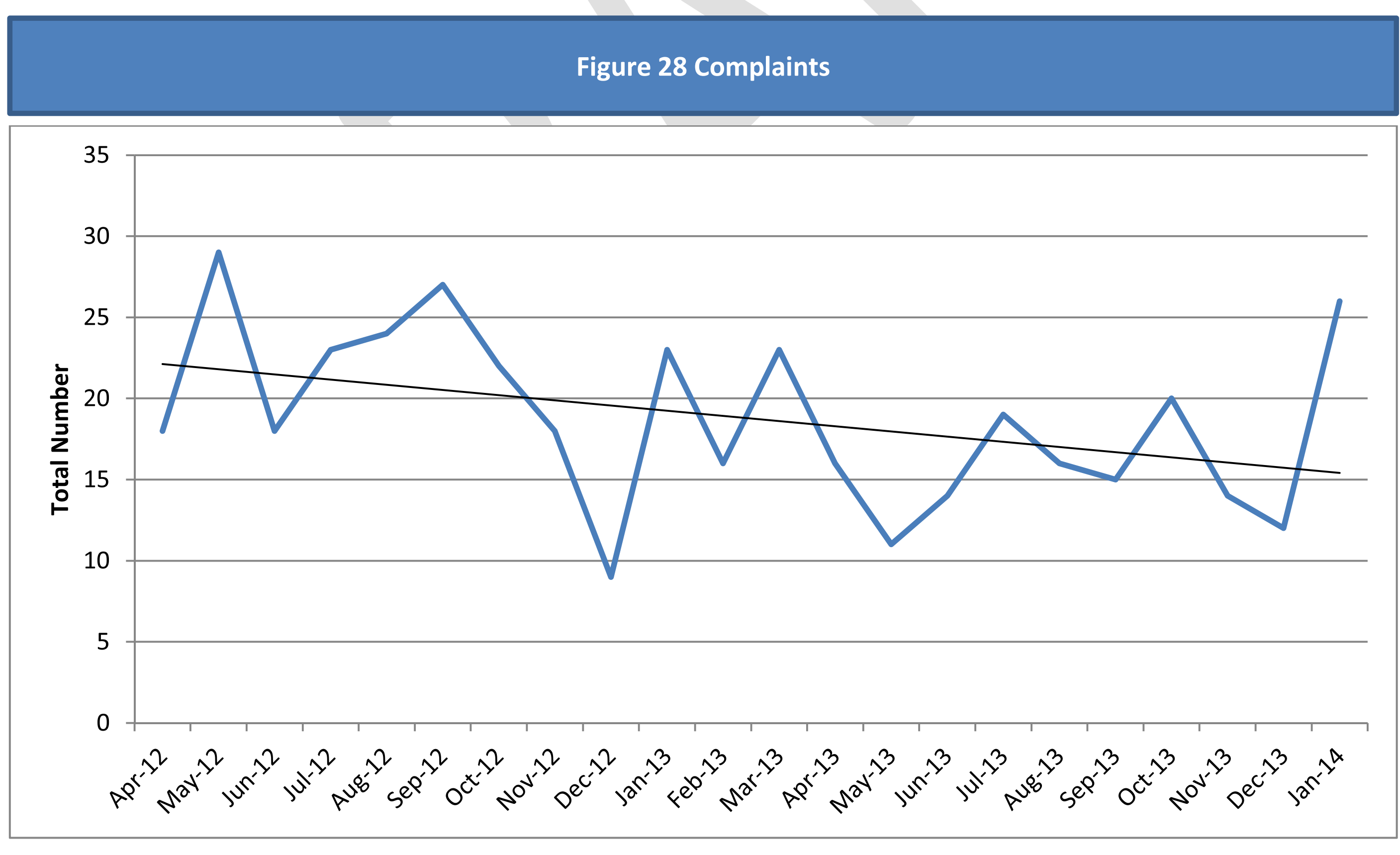


Figure 28 Complaints

Compliments and Complaints

The Trust is committed to improving patient experience, using complaints and other forms of feedback to better understand the areas where we perform well and those areas where we need to do better

The response rate within 25 working days for formal complaints is 51%. The response rate including those re-negotiated with complainants has increased to 75% for quarter three, and was 89% during December 2013. The average number of days to respond to a complaint was 29 days in November and 32 days in December2013.

The main themes from the complaints are care and treatment, communication and access to services.

Actions identified to improve the service we provide to our service users and their carers arising from complaints continue to be discussed at the Locality Patient Safety and Quality Groups. Whilst learning from individual complaints is led by the Service, it is recognised that themes need to be recognised and addressed by Localities.

You Said	We Did
Poor feedback around the general perspective of the service provided by the **Slough Walk-in Health Centre**.	This has been discussed in staff meetings and also on informal individual basis to encourage changes in approach to patients. The appointment booking system has been changed to allow a more structured approach. The times of Practice Nurse clinics have changed to include out of normal working hours. There has also been a change in the way people are surveyed in order to get more balanced feedback.
Many patients are not aware that the **Palliative Care Team** are available at the weekend.	This feedback was shared at the team meeting and agreed that there would be a concentrated effort to inform patients. This will also be monitored in future questionnaires.
On **Ward 12 (MH Inpatients)** there are constant issues with the remote control and it would be helpful to have some things to do.	Extra resources such as arts and crafts materials, games and TV remote controls have now been provided for the ward.
Quicker appointments needed on referral to **Community Dental**.	Service now contacting patients to explain long waits and offering appointments at different clinics if would like to be seen quicker.

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Monitor Authorisation

Performance in relation to metrics required by Monitor, the Foundation Trust regulator, has achieved the required targets. This relates to mental health 7 day follow up (97.07%), delayed transfer of care (2.2%), community referral to treatment compliance (98.3%), Care Programme Approach review within 12 months (96.4%) and new early intervention in psychosis cases 102 (154 12/13).

Figure 29	2010/11	2011/12	2012/13	2013/14	National Average	Highest and Lowest
The percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care during the reporting period	98%	96%	**95.8%**	**97.07% (Q3)**	**97.4% (12/13) to be updated March 14**	-

Berkshire Healthcare trust considers that this percentage is as described for the following reasons:

In line with national policy to reduce risk and social exclusion and improve care pathways (CQC 2008) we aim to ensure that all patients discharged from mental health in patient care are followed up (either face to face contact or by telephone) within 7 days of discharge, this is agreed and arranged with patients prior to discharge to facilitate our high level of compliance.

Berkshire Healthcare trust has taken the following actions to improve this percentage, and so the quality of services:

Berkshire Healthcare trust meets the minimum requirement set by Monitor of 95% follow up through the implementation of its Transfer and Discharge from Mental Health and learning Disability In-patient Care Policy. In addition the data is audited as part of the independent assurance process for the Quality Account and any actions identified through this are fully implemented to ensure that we maintain our percentage of compliance.

Figure 30	2010/11	2011/12	2012/13	2013/14	National Average	Highest and Lowest
The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period	100%	94%	97.6%	**97.7%(Q3)**	**98.2% (12/13) to be updated March 2014**	-

Berkshire Healthcare trust considers that this percentage is as described for the following reasons:

Crisis resolution and home treatment (CRHT) teams were introduced in England from 2000/01 with a view to providing intensive home-based care for individuals in crisis as an alternative to hospital treatment, acting as gatekeepers within the mental healthcare pathway, and allowing for a reduction in bed use and inappropriate in-patient admissions. An admission has been gate kept by the crisis resolution team if they have assessed the patient before admission and if the crisis resolution team was involved in the decision making-process, which resulted in an admission.

Berkshire Healthcare trust has taken the following actions to improve this percentage, and so the quality of services, by:

The Trust Admissions policy and procedures provides a clear framework to ensure that no admissions are accepted unless via the urgent care service and has increased our percentage compliance.

Figure 31	2011/12	2012/13	2013/14	National Average	Highest and Lowest
The percentage of 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 *The data presented here includes only emergency readmissions within 28 days (67) in the last 6 months as a percentage of discharges (527) in the same period and excludes any readmissions coded as planned.*	9%	12%	11.4% (Q3)	***To be published March 2014-***	***To be published March 2014-***

Berkshire Healthcare trust considers that this percentage is as described for the following reasons:
We have a lower bed base than average and this can cause the readmission rate to be higher than in other Trusts.

Berkshire Healthcare trust intends to take the following actions to improve this percentage, and so the quality of services:
Further work will be done by the relevant Service Improvement Group to work on the high level of readmissions, to identify why the trust has seen an increase and to identify actions to reduce it.

Figure 32	2011/12	2012/13	2013/14	National Average	Highest and Lowest
The indicator score of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends	3.55 65%	3.61 64%	**3.76** **69%**	**3.54** **59%**	

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

Figure 33(New section score for 2012/13)	2011/12	2012/13	2013/14	National Average	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	-	8.5	8.7	***Not published***	***8.0 Lowest*** ***9.0 Highest***

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

Figure 34	2011/12	2012/13	2013/14	National Average	Highest and Lowest
The number of patient safety incidents reported	**3995**	**3661**	**2789**	-	-
Rate of patient safety incidents reported within the trust during the reporting period per 1000 bed days	**19.7**	**30.2**	**TBC**	**26.8**	**TBC**
The number and percentage of such patient safety incidents that resulted in severe harm or death	**29 (0.7%)**	**42 (1%)**	**28 (1%)**	**1.3%**	-
*NRLS report 1st October 2012 – 31st March 2013**Trust figure					

Berkshire Healthcare Trust considers that this data is as described for the following reasons:
The percentage of incidents reported relating to severe harm or death is in line with national averages for similar Trusts, as set out in benchmarking reports published by the NHS Commissioning Board. Among these 28 cases were 13 suicides of people in the community who were either using mental health services or had been in contact within the previous six months. There were no inpatient suicides. The remaining 15 cases were unexpected deaths of community mental or physical health patients (including community wards) where suicide not suspected, an attempted suicide in the community, and two patient falls.
Berkshire Healthcare trust has taken the following actions to improve this percentage, and so the quality of services, by the following:
Promotes the reporting of all incidents, with an emphasis on learning from near misses and minor incidents in order to prevent more serious issues arising. Ensures that all serious incidents are thoroughly investigated and the findings used to create improvement plans to enhance the quality of its services. Serious incidents requiring investigation are also reported to commissioners and the Care Quality Commission to ensure transparency and external scrutiny of safety and quality. We have robust processes in place to capture incidents. However there are risks at every Trust relating to the completeness of data collected for all incidents (regardless of their severity) as it relies on every incident being reported. Whilst we have provided training to staff and there are various policies in place relating to incident reporting, this does not provide full assurance that all incidents are reported. We believe this is in line with all other Trusts. There is also clinical judgement in the classification of an incident as "severe harm" as it requires moderation and judgement against subjective criteria and processes. This can be evidenced as classifications can change once they are reviewed. Therefore, it could be expected that the number of severe incidents could change, so the figure reported could change from that shown here due to this review process.

Figure 35 Annual Comparators (Q3)	Target	2010/11	2011/12	2012/13	2013/14	Commentary
Patient Safety						
CPA review within 12 months	95%	-	97.6%	97.9%	**96.4%**	For patients discharged on CPA in year
Never Events	0	0	0	1	**0**	Full year
Infection Control (MRSA bacteraemia)	< 2 per annum	0	1	0	**0**	Full year
Infection Control (C.*difficile*)	<10 per annum (reduced from <19)	0	15	5	**3**	Full year
Medication errors	Increased reporting	179	574*	562	**420**	Cumulative total
Clinical Effectiveness						
Minimising delayed transfers of care	7.5%**	1.86%	3%	1.1%	**2.22%**	All delays in year
Mental Health: New Early Intervention cases	99	-	155	154	**102**	Year to date
A&E: maximum waiting time of four hours from arrival to admission/ transfer/ discharge	95%	N/A	99.6%	99.9%	**99.9%**	Year average
Completeness of MHMDS (Mental Health Minimum Data Set)	1) 97% 2) 50%	1) 99% 2) 86%	1) 99.6% 2) 97.9%	1)99.8 2)98.62	**1)99.8** **2)97.27**	New Monitor target for Identifiers 97% for 2012/13, target for 2011/12 was 99%. Year Average
Patient Experience						
Referral to treatment waiting times – non admitted -community	95%***	N/A	99.9%	99.9%	**98.33%**	Consultant led services in East CHS, Diabetes, and Consultant Led Paediatric services Year average
Access to healthcare for people with a learning disability	Score out of 24	22	22	22	**Green**	CM to confirm still 22 at Q4
Complaints received	<25 per month	134	232	250	**137**	Cumulative in year
Complaints	100% Acknowledged within 3 working days 80% Responded within 25 working days	100%	100%	91.3%		Final quarter

*Community Health services joined the Trust**Delayed transfers of care (Monitor target) is Mental Health delays only (Health & Social Care), calculation = number of days delayed in month divided by OBDs (Inc HL) in month. New calculation used from Apr-12***.Waits here are for consultant led services in what was East CHS, Diabetes, and Consultant Led Paediatric services from referral to treatment (stop clock). Notification has been received from NHS England to exclude Sexual Health services from RTT returns and so they have been excluded here (Included 2012/13).

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

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

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:
The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2013/14; The content of the Quality Report is not inconsistent with internal and external sources of information including:

1. Board minutes and papers for the period April 2013 to June 2014
2. Papers relating to Quality reported to the Board over the period April 2013 to June 2014
3. Feedback from the commissioners dated May 2014
4. Feedback from governors dated 02/02/13, 21/03/13, 16/05/2013
5. Feedback from Local Healthwatch organisations dated May 14
6. The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2014
7. The national patient survey 13/09/2013
8. The national staff survey 25/02/2014
9. The Head of Internal Audit's annual opinion over the trust's control environment dated xx/03/2014
10. CQC quality and risk profiles dated 31/01/2014

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

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
NB: sign and date in any colour ink except black

May 2014 Date **John Hedger Chairman**

May 2014 Date **Julian Emms Chief Executive**

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Appendix A National Clinical Audits Reported in 2013/14 and results received that were applicable to Berkshire Healthcare NHS Foundation Trust: Actions to Improve Quality

National Audits Reported in 2013/14	Recommendation	Actions to be Taken
Prescribing for ADHD	Under review to be added Q4	Action plan in development
National Audit of Schizophrenia (2011)	While there are many examples of good practice in this area, results from this audit suggest that more work needs to be done to improve communication between clinical teams if these basic requirements for keeping people well are to be delivered. The audit also shows that some patients are receiving more than one antipsychotic drug at a time, something for which there is no clear evidence of benefit except in the minority of situations. Others, whose health does not improve when they are offered standard treatment, do not appear to have been offered psychological and pharmacological treatments that could help them. Further attention needs to be paid to the needs of people who do not respond to the treatment they are initially offered, if the health and quality of life of all people with schizophrenia is to be improved.	Carry out spot check on Rio of documentation of initial assessment data for patients with schizophrenia /schizoaffective disorder being seen via community mental health teams (CMHTs) Emphasise the importance of clinical staff printing and handing out medicines related patient leaflets and discussing options with patient during appointment. Promote availability of medicines management training for doctors Remind clinical staff that they should have access to physical health test data. Circulate summary results and action plan to relevant clinicians Trust wide, in preparation for 2013 re-audit. Review the use of a medicines management algorithm.
Prescribing of antipsychotics for people with dementia	The audit demonstrates that the Trust has markedly reduced prescribing of antipsychotics for people with dementia during the past year and such prescribing occurs at a significantly lower level than in the national sample. The larger sample in 2012 reveals that, with respect to some audit standards, there is a lower level of achievement than indicated in the 2011 audit. Results for these standards, however, are still favourable when compared with national outcomes	Review within specialist old age teams of findings. Checklist implemented to ensure that compliance with best practice is assured with regards to risk benefit for antipsychotic prescriptions and medication review

Appendix B Local Clinical Audits Reported in 2013/14: Actions to Improve Quality Q4 Addition

Local Audits Reported in 2013/14	Recommendation	Actions to be Taken

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Appendix C Figure 1 Percentage of all Pressure Ulcers

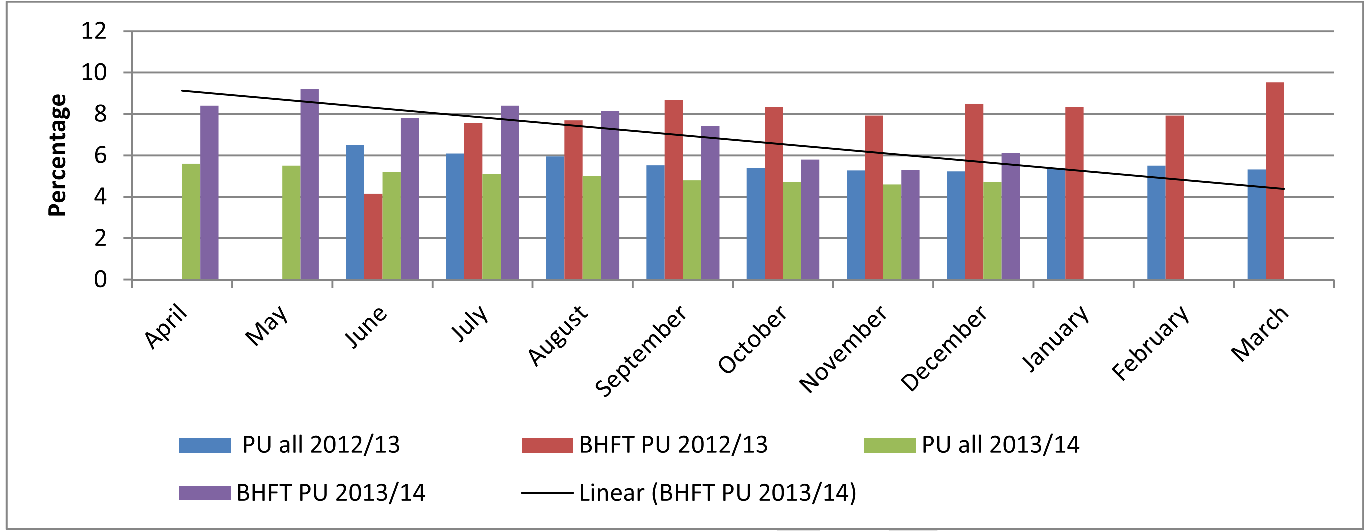
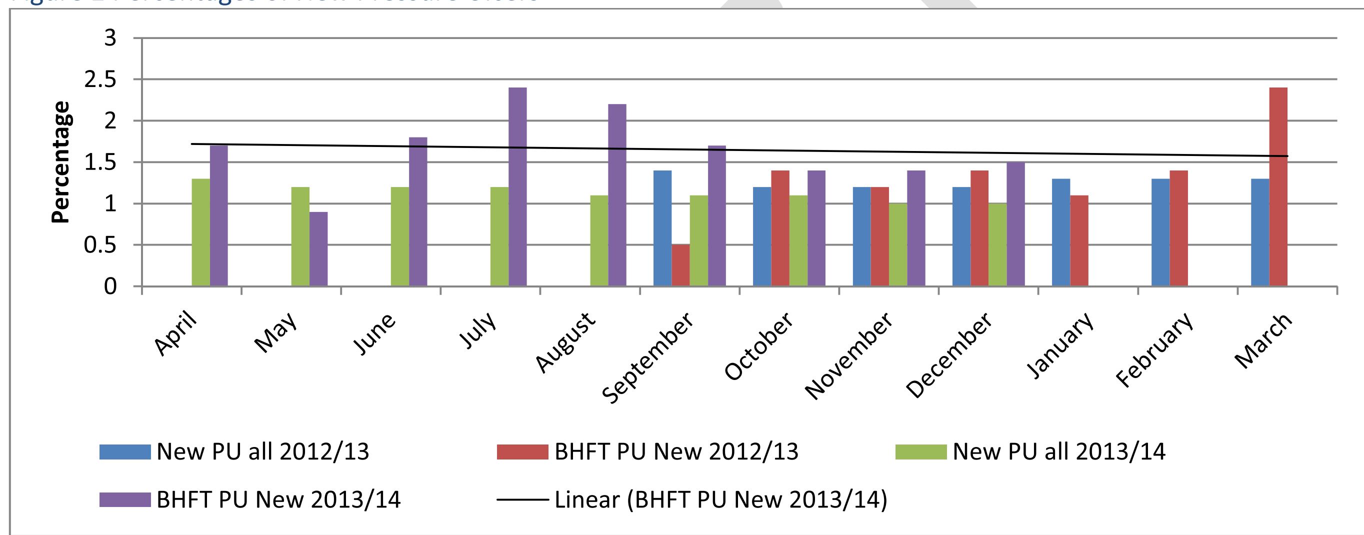


Figure 2 Percentages of New Pressure Ulcers



Note: reporting of new PU started September 2012/13

Figure 3 Percentage of Venous Thromboembolism (VTE)

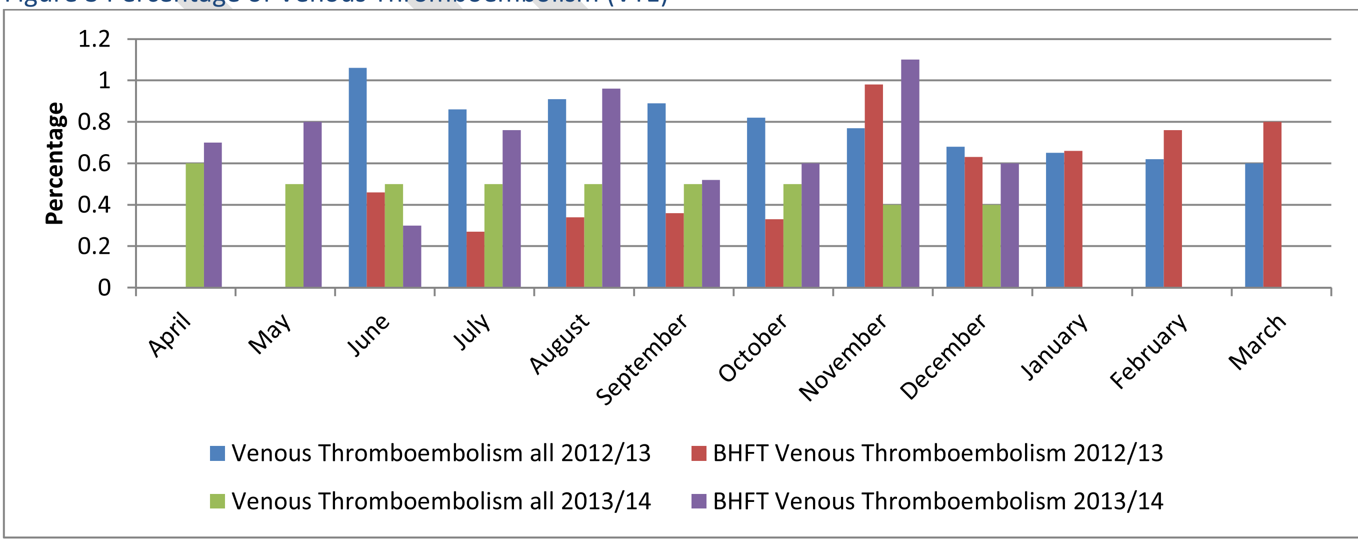


Figure 4 Percentage of Falls with harm

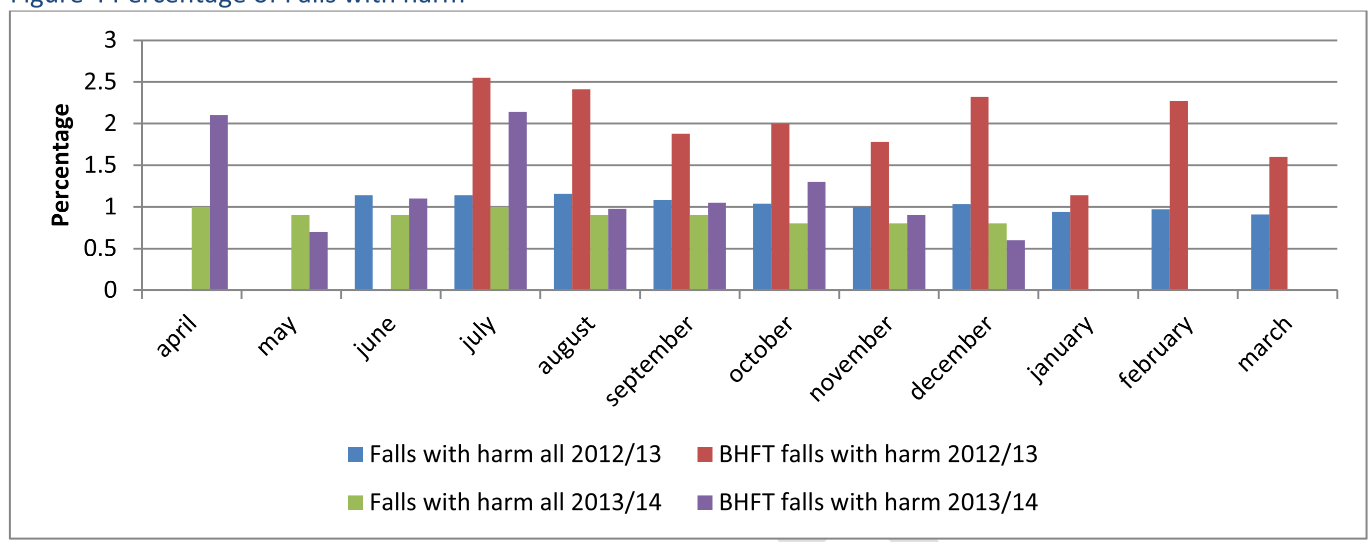
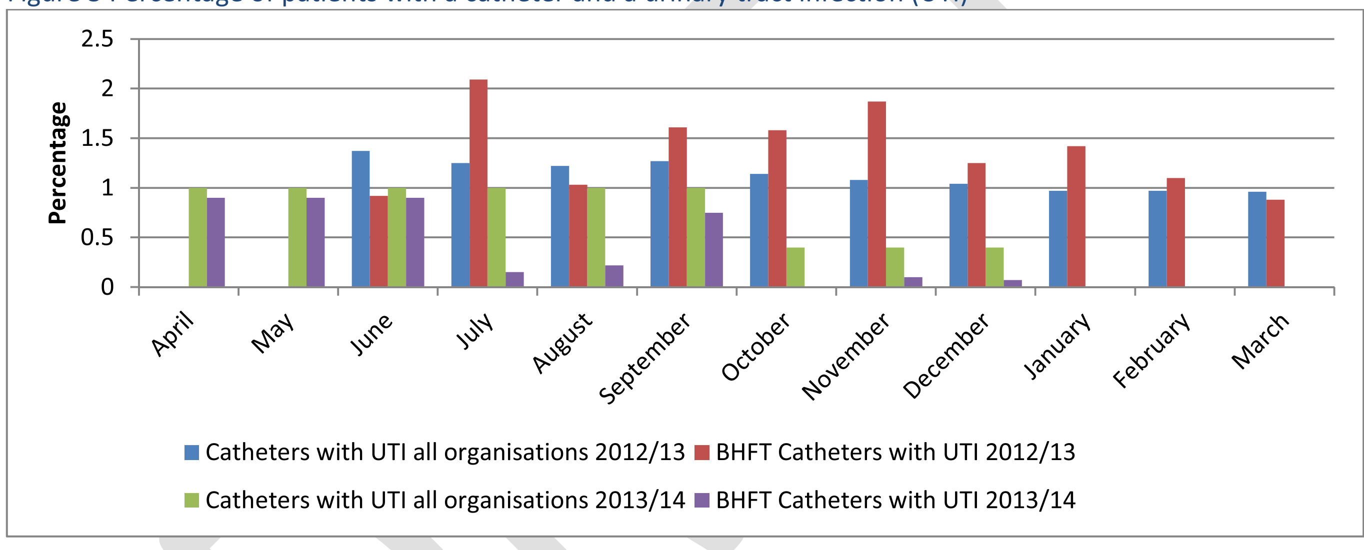


Figure 5 Percentage of patients with a catheter and a urinary tract infection (UTI)



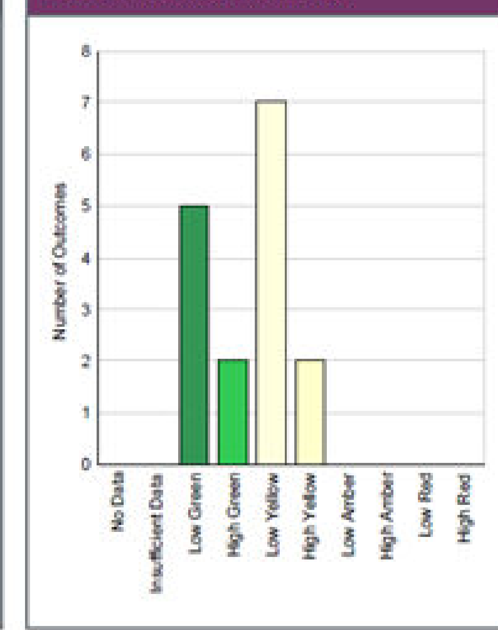
Appendix D

Trust Quality & Risk Profile v5.06 31.01.2014

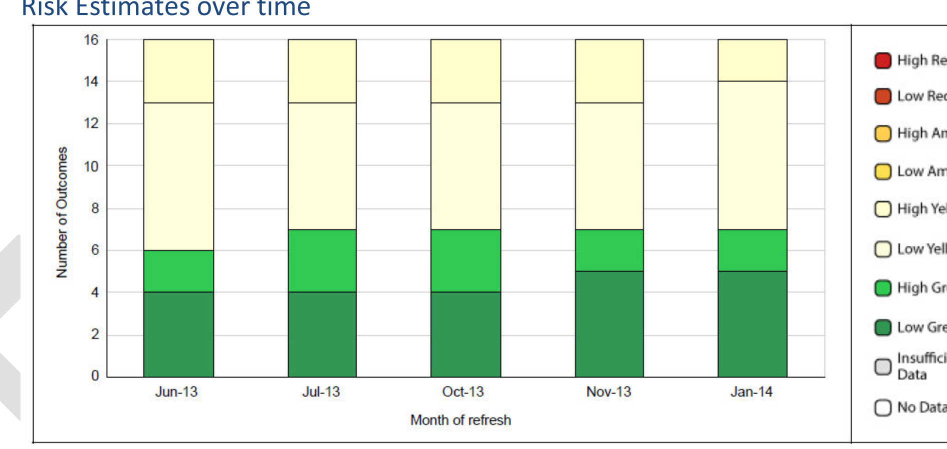
Quality and Risk Profiles (QRP) enable CQC to assess where risks lie and prompt front line regulatory activity, such as site visits. They do not direct front line regulatory activity. They support teams to make robust judgments about the quality of services. They are used alongside CQC's guidance about compliance, including the judgment framework, and additional information known to inspectors

Summary information

Provider type: NHS Healthcare Organisation	
Date registered with CQC	01/04/2010
Number of regulated activities	5
Number of locations	18
Total no. of data items in QRP	992
No. of qualitative data items	168
No. of quantitative data Items	824



Risk Estimates over time



The QRP has been relatively stable during the year and that there are no areas where the CQC considers there to be a high level of risk with regard to the quality of services delivered by the Trust.

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Appendix E CQUINs 2013/14 –Quarter 4 final achievements to be added at the beginning of May 2014 following agreement with commissioners.

CQUIN	Title	Indicator description	Value K	Achievement 2013/14
1				
2				
3				
4				
5				
6				
7a				
7b				

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Appendix F CQUIN 2014/15 to be added (Subject to final agreement

CQUIN	Title	Indicator description	Value K	Achievement 2013/14
1				
2				
3				
4				
5				
6				
7a				
7b				

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Appendix G Glossary to be added Q4

Appendix H Statements from Stakeholders to be added April 2014

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SLOUGH BOROUGH COUNCIL

REPORT TO:	Health Scrutiny Panel
DATE:	24th March 2014
CONTACT OFFICER: **(For all enquiries)**	Alan Sinclair, Assistant Director (01753) 875752
WARD(S):	All wards
PORTFOLIO:	Cllr James Walsh - Commissioner for Health & Wellbeing

PART I
TO NOTE

PROGRESS REPORT ON LOCAL RESPONSE TO WINTERBOURNE VIEW

1 Purpose of Report

In July 2013 every local area was required to undertake a stocktake on progress made locally in response to the Winterbourne View Concordat published by the Department of Health in December 2012. This required a number of actions from local health and social care economies.

This report provides an update on the local action in response to the concordat and stocktake.

2 Recommendation(s)/Proposed Action

That the Health Scrutiny Panel note the actions being taken locally to ensure delivery against the Winterbourne View requirements published in December 2012.

3 Slough Wellbeing Strategy Priorities

Priorities:

- Health and Wellbeing

Ensuring that the health of adults with learning disabilities is monitored and that they have access to a range of health professionals is a priority action for Slough.

4 Joint Strategic Needs Assessment (JSNA)

Slough's Joint Strategic Needs Assessment shows that people with learning disabilities are one of the most excluded groups in the community. They are much more likely to be socially excluded and to have significant health risks and major health problems including obesity, diabetes, heart and respiratory diseases. The number of young people with complex disabilities is rising, meaning that safeguards and quality assurance of care services for this group of people will remain highly important.

5 Other Implications

(a) Financial

There are no financial implications of proposed action.

(b) Risk Management

A failure to keep adults at risk of abuse safe from avoidable harm represents, not only a significant risk to residents, but also to the reputation of the Council, the NHS, Slough Clinical Commissioning Group and care providers. Although safeguarding must be the concern of all agencies working within adults at risk, the local authority is the lead agency and is responsible for the coordination of the multi agency Safeguarding Board.

Slough's Health Scrutiny Panel has a key leadership role to play in ensuring that the commitments made in the Winterbourne View Concordat are achieved.

(c) Human Rights Act and Other Legal Implications

The concordat is not a statutory document but sets out the values and actions to which various bodies, including Directors of Adult Social Services, have committed.

(d) Equalities Impact Assessment

There is no identified need for the completion of an Equalities Impact Assessment.

6 Supporting Information

6.1 The Concordat

The Concordat sets out some key actions for local implementation. This includes:

- Clinical Commissioning Groups to maintain a register of people with Learning Disabilities (LD) and autism who are in receipt of NHS funded packages of care.
- Completing multi-disciplinary reviews of people with LD and autism who are in receipt of NHS funded packages of care in hospital settings by the end of June 2013.
- Moving people to other local care settings by June 2014.

6.2 Progress to date

Other than those people detained under the Mental Health Act, Slough has 25 people either fully or partly funded by the NHS. Of these people only **two** are currently in a hospital setting. All other people are being supported in community settings.

Following regular reviews, plans are being developed with the people involved, families, carers, advocates, commissioners and providers for both of these people to move into community placements which can meet their needs and provide a stimulating environment to develop skills and greater independence whilst being safe. For one person this will be achieved by June 2014. For the other person the transitional period will need to undertaken at a pace which will not cause deterioration in behaviour and jeopardise the move.

6.3 The Stocktake

The Stocktake document was circulated to the Wellbeing Board in July 2013. The stocktake was signed off, as required, by the council and the Slough Clinical Commissioning Group (CCG). The stocktake was presented to the Slough Learning Disability Partnership Board in September 2013

Feedback from the Learning Disability Partnership Board was positive and it was recognised that robust systems were in place to ensure that regular reviews of adults with learning disabilities and challenging behaviour were taking place and independence, choice and control were central themes particularly regarding accommodation.

6.4 Commissioning

The stocktake highlights the need for the development of local care and support options for younger adults with complex needs. This is relevant to people placed in NHS settings but also the growing number of younger adults with complex needs.

Slough contributes to a Berkshire-wide Winterbourne View Project Group which is developing a joint commissioning strategy to map future demand and options for collaborative commissioning. A scoping exercise will be carried out by Children's Services, Adult Services and Berkshire East Clinical Commissioning Groups to develop proposals for planning for the future for young people with complex needs who are likely to require service interventions as they become adults.

6.5 Monitoring the care system

Part of the learning from the Winterbourne View scandal is that health and social care commissioners need to ensure that their systems for monitoring care quality are robust. This relates to individual care plans, care providers and the wider care system. To this end Slough hosts a monthly Care Governance Board with representation from health commissioners. The Board provides a governance framework for monitoring quality and concerns regarding health and social care provision. The Council works closely with the Care Quality Commission to identify and act in situations where there are concerns about social care providers locally and there are local multi-agency systems for raising concerns about providers.

The Council's Contracts and Commissioning Team undertakes unannounced monitoring visits of contracted social care providers and there is a programme of unannounced CQC inspections nationally. In addition, NHS England is establishing regional Quality Surveillance Groups which will review both qualitative and quantitative data on health care providers, in order to facilitate

early action where there are quality concerns. Slough CCG has a quality and safety programme which includes requiring providers to demonstrate their response to the Francis enquiry.

6.6 2012/13 Joint Health and Social Care Self-assessment Framework

The 2012/13 Learning Disability Joint Health and Social Care Self-assessment Framework (SAF) was launched in June 2013.

All areas are required to complete the SAF and involve people and their carers as well as stakeholders in the evaluation process. Task and Finish sub groups of the Learning Disability Partnership Board met to collate views. The completed SAF was submitted in December 2013

The Slough Learning Disability Partnership Board (LDPB), a multi-agency partnership bringing together people with learning disabilities (LD) and autism, family carers and professionals from the Council, NHS, voluntary sector and other services has played an important role in fostering a partnership approach to keeping people safe and in the development of learning disability commissioning priorities.

The LDPB is co-chaired by a person with a learning disability. Four members of the LDPB are people with learning disabilities. The Partnership is supporting the setting up of the Learning Disability Forum which is a key mechanism for engaging and consulting with people with learning disabilities in Slough. The Board is developing sub-groups of both family carers and people with learning disabilities who are full members of the board. The LDPB has taken an active interest in the Winterbourne View agenda and has scrutinised reports on this.

The Slough Safeguarding Adults Partnership Board (SSAPB) provides an inter-agency framework for coordinating actions in respect of safeguarding with representation from the Council, CCG, NHS Trusts, the voluntary sector, the Police and service users. The Board provides further additional scrutiny on the local response to Winterbourne.

7 Conclusion

7.1 There are very few numbers of Slough people currently living in hospital accommodation other than those people detained under the Mental Health Act. For the two people identified with need, there are plans in place to move one person into a community setting by June 2014, with a transition plan in place for the more complex needs of the other individual.

7.2 Provider monitoring arrangements are robust with a multi agency approach, and people with learning disabilities are reviewed on a regular basis.

8 Background Papers

1 - DH Winterbourne View Review – *Concordat: Programme of Action*

2 - Stocktake document

MEMBERS' ATTENDANCE RECORD 2013/14

HEALTH SCRUTINY PANEL

COUNCILLOR	12/06	24/07	17/09	21/11	13/01	24/03
Chohan	P	P	P	P	P	
Davis	P	P	P	P	P	
S K Dhaliwal	P	Ap	P	Ap	P	
Grewal	Ap	Ap	P	P	P	
Mittal	P	P	P	Ap	P	
Plimmer	P	P	P	P	P	
Sandhu	Ab	Ap	P	Ab	Ab	
Small	Ap	P	P	Ap	Ap	
Strutton	P	P	Ap	P	P	

P = Present for whole meeting
Ap = Apologies given

P* = Present for part of meeting
Ab = Absent, no apologies given

(Ext*- Extraordinary)

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