Taking pride in our communities and town

Date of issue: Friday, 11 March 2016

MEETING:	**HEALTH SCRUTINY PANEL** (Councillors Ajaib (Chair), Strutton (Vice-Chair), Chahal, Chaudhry, Cheema, Chohan, M Holledge, Pantelic and Shah) **NON-VOTING CO-OPTED MEMBERS** Healthwatch Representative Buckinghamshire Health and Adult Social Care Select Committee Representative
DATE AND TIME:	MONDAY, 21ST MARCH, 2016 AT 6.30 PM
VENUE:	VENUS SUITE 2, ST MARTINS PLACE, 51 BATH ROAD, SLOUGH, BERKSHIRE, SL1 3UF
DEMOCRATIC SERVICES OFFICER: **(for all enquiries)**	NICHOLAS PONTONE 01753 875120

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

AGENDA ITEM	REPORT TITLE	PAGE	WARD

PART I

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.*		
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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).*		
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10.	Date of Next Meeting - 4th April 2016 (Extraordinary)		

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. Please contact the Democratic Services Officer shown above for further details.

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Health Scrutiny Panel – Meeting held on Thursday, 14th January, 2016.

Present:- Councillors Ajaib (Chair), Strutton (Vice-Chair), Chahal, Chaudhry, Cheema, Chohan, M Holledge, Pantelic (from 6.35pm) and Shah

Also present:- Councillor Carter

Apologies for Absence:- Colin Pill

PART I

40. Declarations of Interest

No declarations were made.

41. Minutes of the Last Meeting held on 18th November 2015

Resolved – That the minutes of the last meeting held on 18th November 2015 be approved as a correct record.

42. Member Questions

There were no questions from Members.

The Chair varied the order of the agenda to consider Item 6: Slough Walk In Centre first.

43. Slough Walk In Centre

The Panel received a report from Slough Clinical Commissioning Group (CCG) on the current activity and review of future provision of Slough Walk In Centre at Upton Hospital. The contract had been extended for 18 months to June 2017 and this provided an opportunity for NHS England and the CCGs to review the current service and consider how the service could be developed in the future. This work would be aligned with the strategic 5-year plan for primary care including providing seven day access to services.

(Councillor Pantelic joined the meeting)

Slough Walk In Centre opened in 2009 and the current services included walk in provision which had 42,470 attendances in 2014/15 and a GP practice with 6,409 registered patients. The current walk in service was for minor illnesses such as colds, fever and dressings, and it did not cater for minor injuries. 66% of attenders were from the Slough CCG area, and following a question from a Member it was indicated that the high level of use was mainly due to the geographic proximity rather than any specific health related issues.

Members discussed various issues and asked a number of questions which can be summarised as follows:

- The national GP survey revealed only 47% of patients in Slough said they found it ‘easy to get someone on the phone’ compared to 71% nationally. The CCG were asked what steps were being taken to improve this position and it was responded that improving telephone access had been identified as a key priority and actions were being undertaken to respond to patient demands including increased online access.

- Had there been any significant impact on Walk In Centre attendance arising from recent improvements at Wexham Park Hospital systems? There was some evidence that hospital admissions had started to come down but attendance at the Walk In Centre had increased.

- Why didn’t the Walk In Centre deal with minor injuries? It was noted that there were no x-ray facilities at Upton Hospital which was required to deliver minor injury services. Future provision could include such services, however, there would a significant additional cost to consider and Wexham Park Hospital was already relatively close. Discussions were taking place with Wexham Park Hospital about an integrated offer.

- What areas of development had been identified? The CCG were not looking at the future options for the Walk In Centre in isolation, and were looking to encourage further integration with normal primary care provision, promote self care and information; and complement the offer at Wexham Park Hospital.

The review of the current services offered an opportunity to shape future provision to meet patients primary care needs, provide a hub for services such as dressings and blood tests and avoid unnecessary use of Accident & Emergency. A steering group had been established, which included the Commissioner for Health & Wellbeing, and consultation and data collection had taken place to inform the future options. A further workshop would be held on 26th January and the Panel requested that the Chair be invited to represent the scrutiny panel. Members also expressed a strong interest in the emerging proposals of the review. It was therefore agreed that the Chair be invited to the workshop on 26th January and that a further report be brought to the Panel, at an extraordinary meeting in February if required or at the next scheduled meeting.

Resolved –

(a) That the update on the review of the current Walk In Centre service at Upton Hospital be noted.

(b) That the CCG invite the Chair of the Panel to the second stakeholder workshop to be held on 26th January 2016.

(c) That a further report on the emerging proposals be considered at a future meeting with an extraordinary meeting of the Panel arranged in February or early March 2016 if required.

44. Adult Social Care Budget and Adult Social Care Reform Programme 2015-19

A report was considered that updated Members on the in-year adult social care budget, future budget plans and the progress of the implementation of the reform programme.

An overspend of approximately £0.6m was projected for 2015/16 primarily due to the slippage on the delivery of savings and the increasing demand and complexity of needs of individuals. Efficiency savings of £2.714m would be delivered during the current year with further planned savings of £5.14m to be delivered by March 2019 as part of the reform programme. In addition to the major reductions in the government grant for local authorities in recent years, the provisional Local Government Finance Settlement had brought forward further reductions and this would put pressure on service budgets. The Government had announced that local authorities could introduce a new precept of 2% on Council Tax (in addition to the existing 2% referendum cap), providing this was used to support adult social care. If introduced in Slough, this would raise circa £0.9m and would be considered as part of the budget setting process. The Panel asked a number of questions about how the precept would operate and how it could be demonstrated that the additional revenue would support adult social care. It was noted that further detail of how the scheme would work was awaited and the Members would be provided with further information when available.

The Panel also noted that a further £1.5bn nationally had been announced for the Better Care Fund from 2018-19 although the detail of this was not yet known. Details of the main savings in adult social care up to 2019 and progress on implementing the portfolio of projects in the reform programme were summarised. The Panel highlighted the importance of ensuring the necessary controls and procedures were in place to provide assurance that the Council met the standards required by the Care Act despite the funding reductions. The Panel were informed that the delivery of the reform programme incorporated the Care Act requirements and the authority would remain compliant with statutory requirements after implementing the proposed savings proposed.

Members asked what approach was being taken to balance the competing pressures of rising demand, a relatively unhealthy population and budget reductions. It was responded that a system wide approach was needed and the reform programme had been designed to address these pressures. A more preventative approach would be taken to delay or avoid care needs, however, it was recognised that implementing the programme would be challenging. The level of budget reductions was unprecedented and involved carefully renegotiating contracts and recommissioning such as the new community and voluntary sector SPACE alliance.

The possibility of further devolution of social care in the future and potential funding opportunities was raised. The devolution deal in Manchester was being observed by local authorities across the country and the department were exploring any additional funding opportunities such as Smart Cities. The Panel discussed the status and options for introducing new technology, for example to promote flexible working for staff, and it was noted that a pilot had taken place and all available options had been reviewed in making a recommendation that would meet the future needs of the service.

At the conclusion of the discussion, the Panel noted the report.

Resolved –

(a) That the financial position facing the Adult Social Care service and progress being made in the reform programme be noted.

(b) That the Panel receive further information on the mechanism of the option for the Council to introduce a 2% Adult Social Care precept on the Council Tax.

45. Get Active Slough: A Five Year Leisure Strategy for Slough

The Commissioner for Community & Leisure gave the Panel an update on the progress of implementing the Slough Leisure Strategy, “Get Active Slough” that was designed to get “more people, more active, more often”. The report provided further information on the investment in major capital development of core facilities – a new leisure centre to replace Montem Leisure Centre, refurbishment of the ice arena and the Arbour Park community sports facility – however, the main focus was on progress of the ‘Get Active’ targeted activity programme and the neighbourhood capital programme.

The cost of physical activity in Slough was estimated to be £24m per annum and was a major contributing factor in a range of health conditions contributing to premature death. Activity was also recognised to have major social and economic benefits and could contribute to community safety. Promoting activity could play a major role in achieving a wide range of strategic objectives and the Commissioner stated that 2016 would be the ‘year of delivery’ to make a major step forward in implementing the strategy. Examples included five multi-use games areas that had been developed so far in strategic locations and capital funding had been committed to provide a series of new outdoor gyms, trim trails and improvements to existing sports provision in parks and neighbourhoods. The early evidence from the ‘Get Active’ programme and Active People Survey was that there had been a decrease in inactivity levels and an increase in participation. The Commissioner emphasised the importance of raising awareness of the opportunities for people to become more active in neighbourhoods across Slough and he invited the Panel to submit their ideas to him about how to most effectively communicate the key message and engage local residents in Members’ wards.

The Panel were very supportive of the work being done to implement the strategy at a local and neighbourhood level. Members raised the following points during the discussion:

- Attitudes and behaviours were formed early, so what work was being done with schools and in early years settings? It had been initially difficult to engage schools, but the team were working with the School Sports Network and advising on the most effective use of the premium available to primary schools for PE. Links were also being made with Public Health on childhood obesity programmes.

- A Member expressed the view that the cycle hire scheme had primarily been targeted at commuters and businesses rather than residents. It was suggest siting stations in neighbourhoods with links and routes to the Jubilee River and Burnham Beeches. The Commissioner agreed that more could be done to extend and promote the scheme to residents in this way to take advantage of the excellent provision of cycle routes available locally.

- Was support to access leisure facilities available to Looked After Children? A scheme was in place previously to provide free access to leisure facilities for Looked After Children but the scheme had not been well used. However, it could be reconsidered in the future and promoted to ensure it was effective.

- What role could councillors play in promoting neighbourhood level activity? The Panel felt that ward Members were well placed to support and raise awareness of local leisure opportunities. A number of suggestions about how this could be done were discussed and it was agreed ward Members would be provided with further information on the facilities and activities in their areas to promote appropriately. A communications plan was suggested for each councillor to help them promote the fun and engaging activities available in their ward. Members were encouraged to provide their views to the Commissioner on how such opportunities could be effectively communicated. The Panel felt more generally that more visible and proactive communications activity led by the communications team would assist in promoting the key messages of the campaign.

- A Member expressed disappointment that the play park in Bloom Park had recently been lost and residents were concerned about anti-social behaviour. It was noted that there was a trim trail in Bloom Park and emerging proposals for a football pitch and walking track. The leisure strategy therefore needed to be closely linked to other services such as parks and community safety. Issues were also highlighted at other local facilities such as the play area in the Lynch Hill area. The Commissioner commented that barriers to using particular play areas, parks and open spaces for informal activity often needed to be

addressed locally by involving ward members, residents etc. to find the right solution.

- Would the increase in pitch fees negatively impact on levels of activity? The Commissioner explained the rationale for the change and commented that at a time of significant pressure on the revenue budget it was important to strike a balance that still made pitches available at with attractive fees. Pitch fees in Slough had previously been very low compared to neighbouring areas. There was also an important role for the CCG, police and other public sector partners with an interest in promoting healthy lifestyles to actively support the strategy.

At the conclusion of the discussion, the Panel expressed its support for the aims of the community leisure strategy and noted the progress that had been made.

Resolved –

(a) That the progress report on the implementation of the Leisure Strategy, ‘Get Active Slough’, be noted.

(b) That communication plan including a list of events, activities and programmes in each ward across the Borough be provided to each councillor to enable them take ownership in promoting local opportunities through surgeries, canvassing and general engagement with residents.

(c) That Members of the Panel submit any further ideas to the Commissioner for Community & Leisure on how local activity could be delivered and communicated to Slough residents.

(d) That the communications department take an active role in promoting the ‘Get Active Slough’ programme to help raise awareness in the local media and publications.

46. Service changes arising from the in year reduction to the Public Health Grant and the Comprehensive Spending Review

The Panel considered a report on the implications of the in year reduction to the public health grant and the comprehensive spending review. It built on the report to the Panel in October 2015.

The proposed 6.2% in year cut to the public health budget had been confirmed in the November Spending Review which had also included a further 9% reduction to 2019. The baseline public health grant for 2016/17 would not be confirmed until later in January but significant activity had been undertaken to review services and where possible to reduce services in line with the funding reductions. However, the Panel noted that the cut would have a severe impact, particularly as Slough was already the lowest funded in the country amongst authorities with equivalent levels of deprivation and

because of the difficulty of implementing in year cuts when the vast majority of spend was committed in contracted services. Details of the service reviews were set out in paragraph 5.2 of the report and the Panel were informed that the risks were being mitigated by integrating services and working with partners such as the CCG and Children's Trust.

The Panel asked about the overall approach being taken and it was responded that there remained considerable uncertainty about the profile of the grant reduction over the next three years and the Council was therefore working on the 'worst case scenario'. A three-year plan was being put in place and the Council would fund mandated services by 2019 with a greater need to align with Slough CCG and NHS England. A Member commented on the good progress being made with the drug and alcohol misuse strategy presented at the last meeting, and asked how other funding could be attracted to protect services. It was responded that income generation was part of the approach being taken and the redesign of services could also achieve savings without negatively impacting on health outcomes. The Panel commented that cuts to public health services was likely to increase pressures on other parts of the health system and that partners therefore needed to work closely together to maximise the value for money of the 'public pound'.

Members discussed a number of other issues including the impact of staffing cost reduction this year and plans for recruitment from April 2016; the protection provided to mandated services; and the joint commissioning arrangements across Berkshire. At the conclusion of the discussion the Panel noted the report.

Resolved – That the report be noted.

47. Forward Work Programme

The Panel considered the work programme for 2015/16 and agreed the following additions/amendments:

- An additional meeting to be arranged, if required, in February or early March to discuss the emerging options for the future of the Slough Walk In service and the CQC inspection of Wexham Park Hospital be considered at the extraordinary meeting.

Resolved – That the Forward Work Programme for 2015/16 be endorsed, subject to the possibility of an additional meeting if required.

48. Attendance Record

Resolved – That the record of Member's attendance in 2015/16 be noted.

49. Date of Next Meeting - 21st March 2016

The date of the next meeting was confirmed as 21st March 2016, noting the possibility of an additional meeting in February 2016 if required to further discuss the proposals for the Slough Walk In Centre.

Chair

(Note: The Meeting opened at 6.30 pm and closed at 8.30 pm)

Frimley Health NHS Foundation Trust

Wexham Park Hospital

Quality Report

Wexham Park Hospital
NHS Foundation Trust
Wexham Street
Wexham
Slough
SL2 4HL
Tel:01753 633000
Website:www.frimleyhealth.nhs.uk

Date of inspection visit: 13, 14 and 15 October 2015.
We also carried out three unannounced visits, on the 21 and 22 October and 31 October 2015.
Date of publication: 02/02/2016

This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital	Good
Urgent and emergency services	Outstanding
Medical care (including older people's care)	Good
Surgery	Good
Critical care	Outstanding
Maternity and gynaecology	Good
Services for children and young people	Good
End of life care	Good
Outpatients and diagnostic imaging	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

Wexham Park Hospital is a district general hospital serving a population of around 465,000 people with approximately 3,400 staff and around 700 beds. Since October 2014 it has formed part of Frimley Health NHS Foundation Trust (FT), when Frimley Health NHS FT acquired Heatherwood and Wexham Park Hospital. Wexham Park Hospital was the main acute site of the previous trust.

The previous Heatherwood and Wexham Park NHS FT was inspected by CQC in February 2014. The trust was rated as Inadequate. At that time 3 of the 8 core services at Wexham Park were individually rated as inadequate (Medicine, Surgery and Maternity) with a further 3 core services being rated as Requires Improvement (Urgent and Emergency Care, End of Life Care and Outpatients). Critical Care and Children's and Young People's services were the only services to be rated as good at that time. Consequently Heatherwood and Wexham Park NHS FT was placed in special measures.

Following the acquisition by Frimley Park special measures were lifted. This was because Frimley Park NHS FT had been rated as Outstanding in September 2014. This was the first trust in England to be rated as Outstanding with 5 of the 8 core services being individually rated as Outstanding and 3 of the 5 key questions being rated as Outstanding including the key question relating to the trust being Well Led. However, following the acquisition a number of requirement notices related to the Wexham Park location were issued in respect of aspects of care that had been of particular concern.

CQC reinspected the Wexham Park location in October 2015, just over a year after the acquisition and formation of Frimley Health NHS FT. This was a comprehensive inspection of the hospital/location to assess the current quality and safety of care. We did not reinspect the Heatherwood location as this had been rated as Good following the inspection in February 2014.

This report demonstrates that remarkable progress has been made since our previous inspection. Indeed this is undoubtedly the most impressive example of improvement that CQC has observed since our new approach to inspection started in September 2013.

All the external stakeholders we spoke with as part of this inspection were very positive about the progress that has been made over the past year. These included Monitor, NHS England, local CCGs, local HealthWatch and the Health Overview and Scrutiny Committee. We heard from staff working at Wexham Park that the culture in the hospital had improved markedly with a greater degree of openness at all levels. Governance had been completely revised, major improvements had been made with regard to handling of complaints and incident reporting. The number of student nurses who have opted to stay at Wexham Park Hospital following qualification has increased substantially over the past year.

Staff were much more positive about Wexham Park as a place to work than previously and a much higher proportion of staff would now recommend the hospital as a place to be treated. Key measures of performance such as the 4 hour A&E target, cancer waiting times targets and referral to treatment targets have improved markedly.

In relation to individual services, both the Urgent & Emergency Care service and Critical Care have now been rated as Outstanding with all other services being rated as Good. Three services were rated as Outstanding for being well led. This, together with the overall leadership at Wexham Park Hospital has resulted in the Well Led key question being rated as Outstanding for this location. This has been achieved by a team of experienced clinical leaders, mainly but not exclusively from Frimley Park, working with Wexham Park Hospital staff to deliver much better care for patients.

Our key findings were as follows:

Safe

Summary of findings

There were effective and robust systems and protocols in place to protect patients from harm, and staff contributed positively to an incident-reporting culture that provided opportunities for continual learning. We found learning from incident investigations was disseminated to staff in a timely fashion and they were able to tell us in detail about improvements in practice that had occurred as a result.

A culture of openness was found in the trust. However, there was room for improvement with the policy and application of policy around Duty of Candour.

Staff contributed to the NHS Safety Thermometer programme. Information was collected on a weekly basis and clear, easy-to-read information was displayed for staff, patients and visitors across the hospital site.

The hospital was clean. However, the auditing of cleaning was not being managed in line with best practice guidance.

Medicines management had improved since our last inspection. Regular medicines audits took place; such as audits of the management of controlled drugs and antibiotic prescribing. Actions were taken where issues were identified such as a change in the antibiotic prescribing policy.

Staff attendance at mandatory training had improved since our last inspection. Mandatory training was monitored and all staff expected to attend on an annual basis. Staff told us that there was less 'e-learning' since joining with Frimley Heath NHS Trust and the quality of training had improved. They also told us they now received relevant training specific to their role.

Patients were protected from the risks associated with the unsafe use of equipment because staff maintained a reliable and documented programme of checks, including portable appliance testing (PAT).

The trust had identified that improvements in the management of deteriorating patients was a priority. A lead nurse for the management of deteriorating patients had recently been appointed and a work stream was in place to drive improvement across the trust. Actions included ensuring the availability of the resuscitation team, training for newly qualified staff and a review of early warning systems used across the NHS.

At this inspection we found nurse staffing had improved although there were still a number of staff vacancies. Providing safe staffing was an acknowledged risk for the hospital and there were appropriate action plans in place to monitor and address the risk on a daily basis.

Effective

Throughout our inspection we observed patient care carried out in accordance with national guidelines and best practice recommendations.

National clinical audits were completed. Mortality and morbidity trends were monitored monthly through SHIMI (Summary Hospital-level Mortality Indicator) and CRAB (Copeland's Risk Adjusted Barometer) scores. Reviews of mortality and morbidity took place at local, speciality and directorate level within a quality dashboard framework to highlight concerns and actions to resolve issues.

There was a consistent and standardised approach to multidisciplinary meetings and morbidity and mortality meetings trust-wide. The trust told us that attendance was good and learning identified with monthly updates and reports to the Trust's Quality Committee. The trust had considered the results from national reviews such as the review into mortality and morbidity, and action had been taken to implement the findings and recommendations.

The trust had a range of clinical governance groups who were responsible for reviewing best practice guidelines and changes to legislation. Audits took place against national guidelines with changes to practice shared where appropriate.

Summary of findings

The trust identified that not all policies and procedures at Wexham Park Hospital were in date or reflected current best practice. An action plan was in place to prioritise the policies to be updated and the resources required to undertake this. In the meantime the chiefs of service were reviewing policies and procedures to make sure patients were safeguarded. Staff were able to access national and local guidelines through the trust's intranet, which was readily available to all staff.

Caring

Patients' told us that they were treated with dignity and respect and had their care needs met by caring and compassionate staff. We also received positive feedback from patients who had received care at Wexham Park Hospital over the past few months. This positive feedback was reflected in the Family and Friends feedback and patient survey results.

During our inspection we observed patients being treated in a professional and considerate manner by staff. All staff we were enthusiastic about the service they provided and gave examples of 'going the extra mile' to ensure patients received good-quality care that they would want their own families to receive.

Responsive

There had been an improvement in patient flow through all departments of the hospital. The Emergency Department (ED) had re-designed the service to improve patient flow through the department. Wards and departments across all directorates had also made improvements in patient flow through the hospital. Improvements were reflected in data throughout the hospital and the in the ED despite an increased number of people accessing the service the proportion of patients being seen within four hours had improved from 93% to 95% (meeting the national standard) and was being sustained consistently.

At the last inspection, we found complaints were not dealt with in a timely fashion and a backlog had developed. These had now been dealt with and any new complaints were being managed more effectively. Specialist staff were now managing complaints centrally.

We heard of the positive initiatives in place to support patients living with dementia. Dementia Leads were reviewing the care of patients living with dementia across all the trust's sites against the trust's Dementia Strategy.

Staff had access to resource folders for patients admitted with special needs such as a learning disability. There was an email 'in-box' for staff to raise any queries, referrals or concerns.

Well led

Following the acquisition of Wexham Park Hospital by Frimley Health NHS Foundation Trust in 2014, the trust's values, vision and strategic plan were reviewed and revised.

At this inspection we spoke with a positive and ambitious workforce. Staff told us that they felt valued and felt able to put excellent patient care and experience at the heart of their work.

Staff across the hospital told us how the trust's values were now embedded throughout their directorates and were monitored through local work and the appraisal system.

Since the last inspection the executive team had taken action to ensure they were visible on the wards and in the departments and ensured they engaged with front line staff, listening to feedback and acting promptly on any concerns raised. Senior staff walkabouts were undertaken to engage with staff and obtain direct feedback.

The trust implemented a new governance and committee structure with Board level quality assurance informed by new quality committees. Clinical governance was now embedded at local level with structured standard agendas complete with minutes and action logs. The local groups reported to the quality committee and to the Board via the Trust's Clinical Governance Committee.

Summary of findings

Since the last inspection the trust had established a clear set of values together with the expected standards of behaviour expected from all staff employed by the trust. Direct action had been taken to address the behaviour of individuals who did not demonstrate the professional standards of behaviour expected.

The quarterly Family and Friends Test included additional questions regarding values and leadership. The most recent results (April 2014 to September 2015) showed improvements in staff recommending the Trust as a place to work up 17% to 57% and in staff recommending the trust as a place to have treatment up 25% to 69%.

New central directorates had been established to manage complaints, patient safety and quality assurance.

The Family and Friends Test had been expanded to include questions, which gave a baseline on the patient safety culture within the trust.

A Patient Safety Committee had been established at Wexham Park Hospital and met monthly to share outcomes and take pro-active actions taken to improve safety.

We saw several areas of outstanding practice including:

- Leadership in the trust had inspired a culture shift since our last inspection that was evident across the hospital in all of the staff groups we spoke with. Staff were proud to work in the hospital, and were committed to delivering care that met with the trusts values and vision.
- The improvements to patient flow through the ED meant that patients being seen within four hours had improved from 93% to 95% (meeting the national standard) and was being sustained consistently despite an increased number of people accessing the service.
- In critical care staff showed considerable innovation in meeting the individual needs of patients under exceptional circumstances.
- Staff engagement throughout outpatients and diagnostic imaging departments was outstanding. All staff were working towards common values, both clinicians, administrative and support staff, at all levels.
- The achievement of the radiology department to reduce and maintain their waiting times, in view of reduced staffing levels and equipment issues showed an outstanding commitment to improve patient experience.
- The improved booking centre processes in outpatients and radiology which involved multidisciplinary team members and ensured patients got the right appointment at the right time.
- Medical records were available more than 99% of the time, over the past 12 months.
- The roles of the five practice and development midwives were split between 50% clinical work and 50% administration and teaching workshops. One midwife worked every day in the labour ward to provide on the spot guidance and support to midwives.
- We observed outstanding prompt, appropriate and sensitive care and treatment provided for a woman in the labour ward who had complex and sensitive needs. Staff adhered to the comprehensive care plan they had developed to ensure the woman did not experience unnecessary distress.
- The hospital had comprehensive guidelines for staff in regards to female genital mutilation (FGM). The trust's safeguarding children annual report 2014/15 recorded that the identification of FGM had been an area of development for the trust. The trust had a policy of addressing FGM when booking women for maternity care.
- The hospital had a Deputy Director for Clinical Education who had developed a comprehensive preceptorship programme for newly qualified nurses. This was a structured period of transition for the newly qualified nurses when they started their employment at the hospital. We viewed comments from newly qualified nurses' evaluation forms from their learning and found these to be consistently positive.
- The matron on children and young people's ward had received a trust recognition award for leadership.
- A senior nurse in critical care had been seconded into a research post for the year before returning to full time clinical duties. They had contributed to the application of the good clinical practice (GCP) guidance of the NIHR Clinical Research Network, which had been used to prepare a research working book for other nurses to use as a benchmark

for research processes, from screening to final data analysis. The research was quality assessed by Monitor through site visits to check that research protocols adhered to gold standard clinical and ethical requirements. The lead research nurse had attended a GCP training course and had successfully been certified against national standards including ethics, legislation and application of the Mental Capacity Act (2005).

- One of the key research projects, VANISH (Vasopressin versus Noradrenaline as Initial therapy in Septic shock), had resulted in specialised one-to-one training packages for staff and an invitation for staff to present their findings at the European Intensive Care Society Conference in 2015. The study had looked at the avoidance of acute kidney injury through the use of steroids with inotropes and the results were presented to staff in the unit on completion of the study. Other projects included a study of the effectiveness of emergency laparotomies and a study of the translocation of bacteria in abdominal sepsis to consider specific antibiotic therapy. The impact on nurses had been very positive and for three consecutive years, research-active staff had attended the European Intensive Care Society Meeting as recognition of their efforts towards establishing an active programme of testing best practice and treatment.

However, there were also areas of poor practice where the trust needs to make improvements. Importantly, the trust must:

- The cleanliness of the hospital must be audited in line with standards set out in the national specifications for cleanliness in the NHS (NSC). This includes the correct classification of high risk and very high risk areas and the frequency of auditing in these areas. Audit processes should include a re-audit where areas are found to be less than 100% compliant. If the hospital chooses not to audit to NSC standards they must provide evidence of an equally robust auditing programme.
- Ensure their policy around Candour (DoC) includes incidents resulting in 'psychological harm'. The provider must also ensure the policy is followed when managing incidents that come under this regulation.
- Continue with its delivery and the risk priorities associated with the backlog program. Fire risks associated with backlog need to be addressed as a priority.
- Improve Estates governance and ensure that up to date and approved policies and standard operating procedures (SOP's) are in place.
- Ensure that monitoring of weekly medicine stock checks in critical care is consistently applied and must ensure that the system in place to make sure out of date medicine is disposed of is audited.
- Ensure that resuscitation equipment is always checked according to the trust policy. The auditing system must include a visual check of the expiry dates of batteries.
- Cleaning and storage materials in critical care must be stored in locked facilities and the lock for the cleaning cupboard must be replaced.
- Recruit to the three vacant consultant posts in ED. Although consultant cover in ED had improved since our last inspection the department still fell short of national standards.
- Ensure that all oxygen cylinders have an expiry date displayed, and system in place for staff to check that cylinders are within date.
- Continue to improve staffing recruitment and retention.

In addition the trust should:

- Ensure all staff in outpatients have development opportunities and training as agreed in their personal development plans.
- Ensure that regular and routine checks are made of the temperature of medication fridges.
- Consider plans for an additional CT scanner and integrated x-ray within the new emergency centre development planned for 2016.
- Improve pharmacy support for the emergency department and the decision unit (EDDU) in particular.
- Explore an effective means of explaining to patients why they have to wait to be treated in the ED.
- Consider testing the major incident plan which had recently been re-written.

Summary of findings

- Consider the size and organisation of paper health records.
- Ensure the audit trail of medications delivered to wards is completed including the signature of the staff member receiving the medications on the ward.
- Consider the safety of Aria e prescribing system which is not available to staff in the ED and the patient risks associated with this.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating		Why have we given this rating?
Urgent and emergency services	Outstanding		Overall we rated the emergency service at Wexham Park hospital as 'Outstanding' because: Since our last inspection in 2014, a new leadership structure had been developed. Consultant medical staff now provided leadership for some aspects of the service, such as clinical safety and patient experience, clinical governance, education and training. There had also been changes to the senior nursing team with the appointment of matrons who now oversaw the quality of the service being provided in the department on a daily basis, ensuring patients were being well cared for. We found these changes had resulted in sustained improvements in the quality of care patients received. At our last inspection we were concerned that some patients spent a long time in the ED waiting to be seen. The service had difficulty meeting the national quality standard for 95% of patients being seen in less than four hours. At this inspection, we found the trust had met the four hour quality standard since February 2015. Patients were assessed quickly and the service had met the national quality standard for 95% of patients being seen in less than four hours since February 2015. Consultant medical staff provided effective leadership of the service such as clinical safety and patient experience, clinical governance, education and training. Senior nurses took responsibility for the quality of the service being provided in the department on a daily basis, ensuring patients were being well cared for. The service was well co-ordinated through board rounds held four times a day and clinical practice was audited against the standards set by the College of Emergency Medicine (CEM). Guidelines were accessible and followed by staff. The ED audited clinical practice against the standards set by the College of Emergency Medicine (CEM). The college of emergency medicine is a body which sets national standards for emergency services. The department was also part of the Thames Valley Trauma Network, which aimed to develop high-quality trauma care across all the hospitals in the area. This involves the ED service being reviewed against a set of national quality standards and undergoing a quality review by clinicians providing similar services in other hospitals.

The ED had a system in place for monitoring changes in a patient's condition. The Detection of Deterioration (EDOD) scoring system was used when patients were first assessed and to monitor their condition during their stay in the ED. Similar systems were in place for both adults and children. Staff monitored each patient's condition and were able to reduce the risk of unsafe care if they deteriorated.

When we last visited the hospital we found the number of patients waiting between four and 12 hours and longer than 12 hours for admission was much worse than the England average. At this inspection we found that the number of people waiting longer than 12 hours for admission had reduced steadily from 23 in April 2015 to five in June 2015. This reduction may reflect a difference between the seasons with fewer admissions required during the summer months. However, the hospital had also been working on a range of ways of improving the movement of patients from the ED to other departments which had contributed to this reduction.

At our previous inspection we found that patients who were waiting a long time for admission did not have the condition of their skin checked and were not offered anything to eat or drink, both of which are good practice. At this inspection we found staff had improved the care provided and now monitored the condition of patient's skin and provided food and drink to those waiting.

Staff delivered care based on best practice national guidelines. At our last inspection we found staff had good knowledge about the guidelines and audits in place, but were less clear about how improvements were going to be implemented. At this inspection we found the hospital had strengthened the structures for overseeing the implementation of guidelines and there were effective, clear written information accessible on the computer for all staff working in the department.

Staff spoke positively about the considerable changes that had taken place over the last 12 months and the pace at which this had been achieved. They told us the leadership of the department provided clarity about the vision for the service and senior medical and nursing staff provided support and direction. Consultant medical staff had highly visible leadership responsibilities for improving the quality of service

which staff believed was making a positive difference. Staff told us they felt more motivated, supported and energised. They were proud to work in the ED because the leadership and culture had improved.
The ED had worked with other departments to reduce the length of time patients waited to be admitted. Three additional consultants had been appointed, which enabled senior staff to have a greater presence in overseeing the work of the department. Senior nursing staff also spent more time supervising the quality of patient care.
However, we found some areas had scope for improvement. We considered that existing mitigating strategies and the expertise of clinical staff meant that risks to patients were minimised.
The need to improve access to CT scanning. There is currently only one scanner on site. Patients were diverted to another hospital when the CT scanner was out of action. The trust planned to provide a second scanner when the new emergency department is built, however the trust should seek to ensure all patients requiring a CT scan were able to receive one, at the earliest opportunity.
Pharmacy support for the department was limited to 16 hours a week. Patients in emergency department decision unit (EDDU) needed their medicines reviewed before they could return home, the lack of pharmacy support sometimes led to delays in patients being discharged.
A new major incident plan had been developed but not all staff were aware of it. The plan had not yet been rehearsed or tested but a simulation was planned.

Medical care (including older people's care) — **Good**

Overall we rated medical care (including elderly care) at Wexham Park Hospital 'Good' because:
We found medical care at the hospital was evidenced based and adhered to national and best practice guidance. The trust's policies and guidance were readily available to staff through the trust's intranet. The care delivered was routinely measured to ensure quality and adherence to national guidance and to improve quality and patient outcomes. The hospital was able to demonstrate that it mostly met national quality indicators.
Patients' medical outcomes were monitored and reviewed through formal national and local audits. Consultants led on patient care and there were

arrangements for supporting the delivery of treatment and care through multidisciplinary teams and specialists. We found that training for staff was good with newly qualified staff being well supported. Staff caring for patients had undertaken training relevant to their roles and completed competence assessments to ensure patient safety.

The hospital was working towards offering a full seven-day service. Although some medical patients were treated in other areas of the hospital when beds were not available, systems had been put in place to ensure the consistent quality of their care. Staff responded to individual patient needs for those living with dementia.

The hospital had systems in place to allow patients to feedback their experience of care on the medical wards. The results of the surveys indicated the department provided excellent, compassionate care by friendly and approachable staff. Patients we spoke with during the inspection confirmed that staff were kind, considerate and respectful. Complaints processes had been improved since our last inspection. Complaints were acknowledged, investigated and responded to appropriately.

However, we found some areas had scope for improvement. We considered that existing mitigating strategies and the expertise of clinical staff meant that risks to patients were minimised.

We found some paper health records to be large in size and documentation was hard to locate in these records.

The electronic prescribing system used for patients requiring chemotherapy could not be accessed by staff working in Emergency Department (ED). Although staff had put in measures to mitigate this risk the trust may wish to reassess the risks associated with these measures.

There was an overdependence on agency staff to support permanent staff to ensure safe staffing levels during the delivery of chemotherapy.

Surgery **Good**

Overall we rated surgical services at Wexham Park Hospital as 'Good'. This was because:

The majority of issues identified in the previous report had been addressed. The trust had action plans for areas of concern that remained, such as staffing. Staff continuously monitored these plans and took appropriate actions in a timely manner.

Summary of findings

We found that leadership in all areas had improved. Senior staff were visible, available and supportive to all staff. We foundimprovements throughout the surgical division meant patients experienced safe, effective and appropriate care and treatment that met their individual needs and protected their rights. Staff provided care that was compassionate and all patients were treated with respect and dignity. Patients had their individual risks identified, monitored and managed. There were systems to regularly monitor and review the quality of service provided.

Staff were competent and knowledgeable about their specialties on both the surgical wards and in the theatre units. Mandatory training was generally up to date with further staff training and development available and encouraged.

Outcomes for patients were good and the surgical departments followed national guidelines. The clinical environments, including the equipment available, were clean and well maintained. Departments undertook frequent audits such as environmental, theatre checklist, infection control and hand hygiene. Clinical governance teams analysed the audits and fed the results back to staff. Where risks were identified there were action plans to resolve or manage them in a timely fashion.

Incidents and complaints were investigated and handled in line with trust policy. There were systems to feedback to staff any learning from incidents and complaints.

The trust had recognised that improvements were needed to address the culture within the surgical division and had taken robust action to address the bullying issues. Staff were enthusiastic about the initiatives taken to address the concerns raised at the last inspection and were passionate about the quality of care they delivered.

However, we found some areas had scope for improvement. We considered that existing mitigating strategies and the expertise of clinical staff meant that risks to patients were minimised.

There was a degree of underreporting of incidents. The trust was aware of this issue and had strengthened governance systems and improved training and development in reporting and managing incidents and complaints.

			Although we noted an improvement in medicine management, there were still some practices that did not meet current best practice or comply with national guidelines. Issues included insufficient monitoring of temperatures and security.
Critical care	**Outstanding**		Overall we rated the critical care unit (CCU) at Wexham Park Hospital as 'Outstanding' this was because: We found significant areas of good practice through our review of clinical audits, staff training, patient notes, clinical outcomes and other indicators such as an exemplary programme to promote independence and person-centred care. Leadership in the unit was coherent, robust and respected by staff. This leadership contributed to a team that continually challenged existing practice to identify new and improved ways of working. Innovation was very much part of the culture in the unit and staff spoke positively about the development opportunities available to them as a result. Clinical practice was benchmarked against national guidance from organisations such as the National Institute for Health and Care Excellence (NICE), the Royal College of Physicians and the Intensive Care Society (ICS). Such guidance was embedded into the work culture and staff used it to evaluate and improve their practice. For example, an extensive programme of audits was used to update policies and procedures. Staff contributed to national audits compiled by the Intensive Care National Audit and Research Centre (ICNARC). They then used the national audit results alongside local studies to inform the planning of staff study days. The CCU team had access to multidisciplinary specialists who contributed to decision-making and ward rounds to ensure best care for patients. An established critical care outreach team supported patients across the hospital and provided bereavement and emotional support. The CCU appeared clean, hygienic and well maintained. Staff demonstrated good infection control practices but there was room for improvement in some areas of housekeeping. Equipment was serviced regularly and staff were competent in its use with regular training updates. We found one area of non-compliance with the trust's medication management policy but there were safeguards in place to ensure that this would not affect patient safety.

A robust incident reporting system was in place that staff confidently used to investigate incidents and errors. There was evidence that learning from investigations had taken place consistently with an effective system in place to ensure all staff were aware of updates to practice. These measures contributed to an environment in which safety was prioritised and patients received individualised care.

We observed numerous instances of significant commitment to personalised care. Staff were competent, passionate and driven, and their efforts included supporting a patient to return home safely to their garden during an extended CCU stay and a programme to promote independence in patients' in the middle of their recovery. Staff were active in clinical research and were supported in this by a senior team of nurses and doctors who understood the need for continued innovation in care and treatment. One relative told us, “I am overwhelmed by the attention of all of the people looking after [relative].”

Staffing levels were reviewed continually using an established nursing acuity tool and there were enough staff to provide care and treatment in accordance with Royal College of Nursing (RCN) guidance. The use of agency staff was consistently below the maximum acceptable level set by the trust and temporary staff underwent stringent induction and background checks before working on the unit. Without exception staff told us they were supported and valued by the senior team and they felt proud to work in the unit.

At our last inspection of Wexham Park Hospital, we found critical care services for responsiveness to require improvement. This was because admissions and discharges were often delayed and patients were sometimes transferred out of hours because of a lack of capacity elsewhere in the hospital. At this inspection we found a significant and sustained improvement in these areas, with an acute commitment from the senior team to improve the unit's responsiveness to patient needs that had been highly successful. In areas we previously found to be good, staff had worked hard to build on their existing practice and explore innovation in patient care and treatment.

Maternity and gynaecology	**Good**		Overall we rated maternity and gynaecology services at Wexham Park Hospital as 'Good'. This was because:

Summary of findings

At our last inspection carried out in February 2014 we found the maternity and gynaecology services to be inadequate. This was because of failure to report incidents and reliance on bank and agency staff to maintain the services. Governance arrangements were poor with inadequate systems for monitoring staff performance and dealing with an inappropriate staff culture. We evidenced that the majority of issues identified in the previous report had been identified and addressed.

Patients were protected from the risk of avoidable harm and, when concerns were identified staff had the knowledge and skills to take appropriate action. Incidents were recorded, investigated and, where necessary, actions were taken to prevent recurrences. Medical, midwifery and nursing staff provided safe care; staffing levels were in line with national averages and were regularly reviewed.

Staff delivered evidence-based care and treatment and followed NHS England and the National Institute for Health and Care Excellence (NICE) national guidelines. There was multidisciplinary working that promoted integral care. The audit programme monitored whether staff followed guidelines and good practice standards. The previously high caesarean section rate was now in line with the national average. Staff were caring and thoughtful, and treated women with respect. Patients' confidentiality and privacy were protected. All patients and relatives we spoke with gave positive feedback about their care and how staff treated them. Women and their partners felt involved with their care and appropriate explanations were given to them.

Policies and procedures were available on the hospital's intranet for all staff to access. Appropriate arrangements were in place for patients who could not make informed decisions about their care. Systems were in place to support patients with a learning disability. Complaints were dealt with effectively and improvements made where necessary. There had been a decrease in the number of complaints made since the previous inspection.

There were established local governance arrangements and risk management identified risks to patients and service delivery through the risk reporting process. This is a process for dealing with risks, actions taken to minimise them and recognising those that required reporting to NHS England. Staff demonstrated a strong

desire to develop the services and efforts had been made to gain the views of patients and the public. The widespread poor culture found during the previous inspection had almost gone. Senior managers were working towards eliminating poor practices. Many improvements had been made and staff had an open and motivated attitude that had strengthened the culture throughout. Senior managers had developed a plan to sustain the improvements and continue improving the quality of the services.

Services for children and young people	**Good**		Overall we rated services for children and young people at Wexham Park Hospital 'Good' because: The treatment and care needs of children and infants were assessed and planned from referral to discharge, taking into account their individual needs. The health and wellbeing of children, young people and infants was monitored using recognised assessment tools. Arrangements were in place for looking after vulnerable children. Staff responded compassionately when children and young people needed help and supported them to meet their basic personal needs as and when required. Children said that the staff were kind and caring and that they received information that helped them understand what treatment and care they were receiving. Staff helped children and young people and those close to them to cope emotionally with their care and treatment. Comprehensive safeguarding policies and procedures were in place. This included referral pathways for children's safeguarding. The service had systems in place to ensure that incidents were reported and investigated appropriately. Children and young people's services were well-led by a very enthusiastic and committed staff team. The leadership, governance and culture promoted the delivery of high quality child-centred care. There was a clear statement of vision and values, driven by quality and safety, with defined objectives. Staff were aware of best practice guidance for the safe and effective care of children and infants. The service had experienced nursing staff shortages, but were actively recruiting nurses by advertising the vacancies.
End of life care	**Good**		Overall we rated the EOLC services at Wexham Park Hospital as 'Good' this was because:

Summary of findings

National guidance determines precisely what end of life care (EOLC) should look like for adults diagnosed with a life limiting condition in all care settings. EOLC is defined as a patient with less than 12 months to live no matter what the diagnosis.

Overall we found the EOLC service provided by Wexham Park Hospital was good. The duty of the inspection was to determine if the hospital had policies, guidelines and training in place to ensure that all staff delivered suitable care and treatment for a patient in the last year of their life. The hospital provided mandatory EOLC training for staff which was attended, a current End of Life Care Policy was evident and a steering group met regularly to ensure that a multidisciplinary approach was maintained.

Staff at Wexham Park Hospital provided focused care for dying and deceased patients and their relatives. Facilities were provided for relatives of patients and patient's cultural, religious and spiritual needs were respected. Further supplies of syringe drivers were purchased to enable a dying patient to receive prompt, adequate and appropriate medication.

The palliative care team had a high level of evidence based specialist knowledge. They worked well with the local hospice and other departments involved in providing EOLC. The team were well thought of throughout the hospital. They supported, trained and gave advice to other staff.

There was evidence that systems were in place for the referral of patients to the palliative care team for assessment and review to ensure patients received appropriate care and support. Through education and acknowledgement of national guidance the number of referrals to the palliative care team had increased since the last inspection and these referrals were seen and acted upon within 24 hours.

At our last inspection of Wexham Park Hospital we found the EOLC service to require improvement. This was because the service relied on the drive and vision of the EOLC team and not through any trust wide strategy. EOLC did not appear to be a priority for the trust.

Since the hospital's acquisition by Frimley Health NHS Foundation Trust the service had board representation and a dedicated clinical lead. This had resulted in a well led trust wide service that had a clear vision and strategy.

Summary of findings

Outpatients and diagnostic imaging

Good

Overall we rated the outpatients and diagnostic imaging departments at Wexham Park Hospital as 'Good' this was because:

The hospital consistently met waiting and treatment times in line with national standards. Professional staff treated patients with kindness, dignity and respect. The outpatient and radiology departments followed best practise guidelines and there were regular audits taking place to maintain quality.

The booking centres had processes to ensure patients received appointments within the appropriate timeframe. There were fail-safes in place and medical staff assisted management if required. Medical record management enabled clinicians in outpatients to have access to patients' records more than 99% of the time. The radiology department had worked to reduce waiting times in the past year.

Staff were competent , professional and treated patients with dignity and respect. The outpatient and diagnostic imaging department appeared clean and well maintained. Staff demonstrated good infection control practices . Equipment was serviced and maintained regularly.

Every member of every team contributed positively to patient care. All staff shared the vision and values of the hospital and good leadership was visible at all levels. Staff worked hard to deliver improvements in their departments. They were proud of their achievements and had the vision and energy to continue with improvements and develop services further.

Berkshire Healthcare NHS Foundation Trust

Quality Account 2016- Q3 Update 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.

About the Trust

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 171 mental health inpatient beds and almost 200 community hospital beds in five locations and we employ more than 4,000 staff.

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Quality Account Highlights 2016

Trust community Services (both physical and mental health) are highly valued by our patients. Results from the patient Friends and Family Test during the past year indicate that greater than 95% of respondents are either extremely likely or very likely to recommend these services to a friend or family member.
It is also evident that Trust community inpatient services, minor injury services and walk-in centres are highly valued with that than 90% of respondents stating they are likely to recommend these services during the year.

The Trust has delivered on its commitment to become smoke free across all of its sites.

The Care Quality Commission undertook a planned inspection of the Trust in December 2015. During this time, we hosted 120 CQC inspectors from a wide range of professions as well as experts by experience. Inspectors visited a vast range of our services in mental health, community services, learning disability and the Trust out of hours service-Westcall. The Trust is awaiting the final CQC report following the inspection.

The Trust has demonstrated that 100% of NICE Technology Appraisals and greater than 80% of all NICE Guidance have been implemented across the Trust.

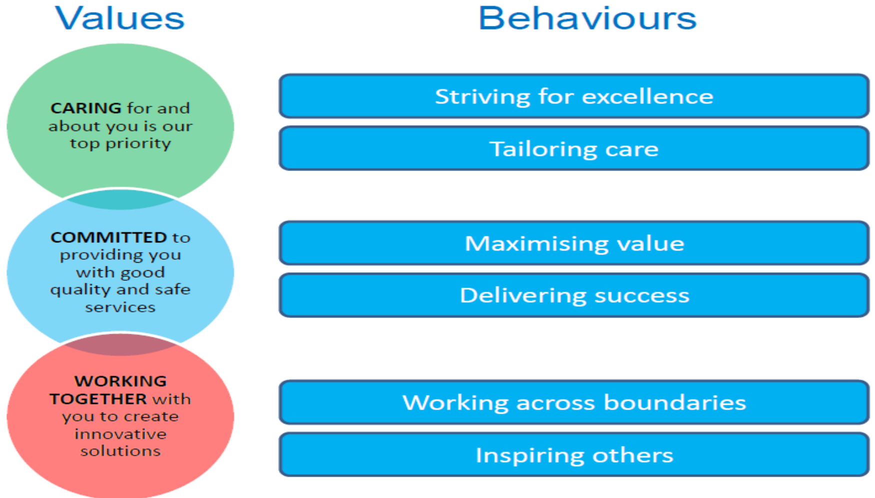
The Trust has introduced a more systematic and detailed method for logging information about and investigating whistleblowing concerns.

Many successful improvements have been implemented by services throughout the Trust, examples of which are included in this report.

The Trust has set quality priorities for 2016/17 relating to the following areas:

- Reducing patient falls
- Pressure ulcer prevention
- Implementation of NICE guidance and guidelines
- Patient experience priorities relating to the Friends and Family Test, learning from complaints and the Patient Leadership Programme
- Suicide prevention

To be updated in Q4 with latest data, and following results of the National Staff survey



1. Statement on Quality

The Trust has continued to deliver highly effective, safe, efficient and equitable care for its patients throughout the year. Such care is reinforced by an organisational culture that embraces the Trust's values- *caring, committed and working together*- all of which are embedded within the Trust appraisal system for staff. Additionally, the principle of working together is extended through collaboration with external health, social care and third sector organisations to enable the delivery of practical solutions to complex health and social care challenges.

Evidence available from patient Friends and Family Test results and the Trust's own patient satisfaction survey demonstrate that the services we provide are highly valued by our patients. This enforces our commitment to ensure that the care we provide is not only of a high clinical quality, but also that patients have a positive experience of our services. We aim to maintain and improve on these results and have set an ongoing priority in this area for the 2016/17 year.

Patient safety remains of paramount importance to the Trust. Throughout the year, the Board has received reports on a variety of patient safety metrics, several of which are shared in this report. Trusts must also learn from experience when things go wrong and we now have increasingly robust governance, patient safety, incident reporting and patient experience systems that highlight areas for learning and improvement. In addition, the trust have implemented a policy encouraging a culture of openness when things go wrong (the Duty of Candour) as well as a more systematic and detailed method for logging information on and investigating whistleblowing concerns (Freedom to Speak Up). The Trust will continue striving to deliver safe care, with priorities relating to the reduction in falls and reduction of pressure ulcers set for the following year.

The clinical effectiveness agenda for the trust has increased during this year with progress being made in the areas of clinical audit and research. Clinical audit has allowed us to measure our care against current best practice leading to improvement, whilst our involvement in research has helped to inform future treatment and management of patients. In addition, the Trust has met its target of implementing 100% of relevant NICE Technology Appraisal Guidance and greater than 80% of all relevant NICE Guidance and Guidelines. We will aim to maintain this level of compliance and have set a further priority target for this.

In October 2015, the trust became smoke free across all of its sites. A staff smoke free policy has been implemented with many staff also taking the opportunity to reduce their tobacco intake or quit smoking altogether. Patients in the community are now asked to abstain from smoking whilst we provide their treatment, with staff helping to ensure that our grounds are smoke free. Our final milestone was realised when we became smoke free on our mental health wards at Prospect Park Hospital. Patients are being supported through this by being offered nicotine replacement therapy whilst on the wards and are given access to stop smoking services if they would like to be supported in making a serious quit attempt during their stay.

The year has also seen numerous other service improvement projects being initiated throughout the Trust. Improvements have been evident across the board, with cross-service and multi-agency improvement work also being undertaken. This report highlights some of the improvements that have been made and demonstrates our commitment to improve services across the whole of the Trust.

Our involvement in primary care management has proven successful during the year. Following our management intervention last year, the Priory Avenue GP Practice was taken out of special measures by the CQC. Resultant improvements to patient care and the processes adapted to enhance the delivery of primary care have been noticeable and highly commended by the Patient Participation Group.

Finally, the Care Quality Commission (CQC) undertook a planned inspection of the Trust in December 2015 during which time we hosted 120 CQC inspectors from a wide range of professions as well as experts by experience. We are awaiting the final inspection report from the CQC.

We are committed to continue ensuring that the people of Berkshire receive amongst the best care in the country for physical and mental health problems. At Berkshire Healthcare NHS Foundation Trust we are determined to play our part in making sure that this is the case.

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
SIGNATURE OF CEO

To be updated in Q4 to take account of latest data, CQC report and results from national patient survey

2. Priorities for Improvement

2.1 Priorities for Improvement 2015/16

This section of the Quality Account details Trust achievements against the 2015/16 priorities and information on the quality of services provided during 2015/16. The priorities support the Trust's quality strategy (Appendix A) to provide accessible, safe, and clinically effective community and mental health services that improve patient experience and outcomes of care through the following six elements:

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

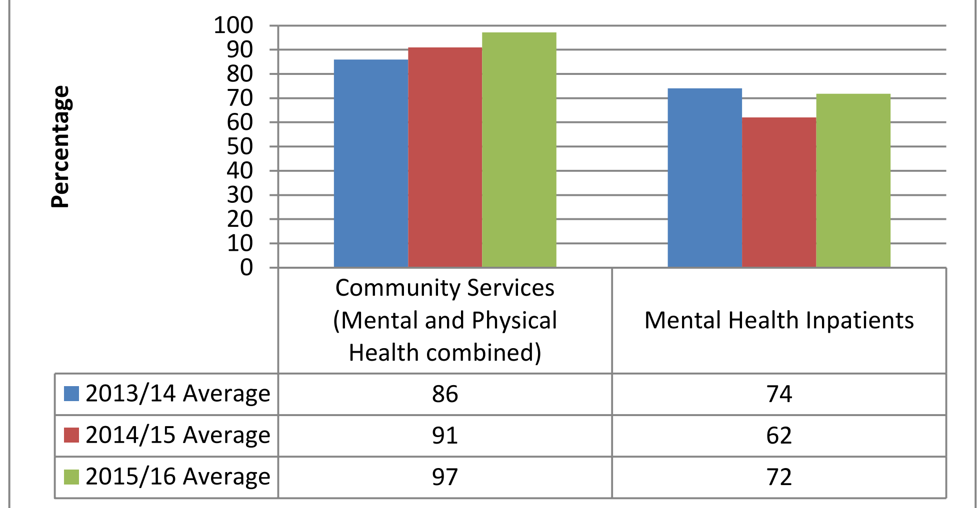
2.1.1 Patient Experience

The Trust has continued to report on the Friends and Family test results and on the Trust's own internal patient satisfaction survey throughout the year. By doing so, the Trust aims to demonstrate continuing improvement. Learning from complaints and improving national survey results also remains a priority for the Trust. Achievement in relation to each of these areas is detailed further below.

Patient Friends and Family Test (FFT)

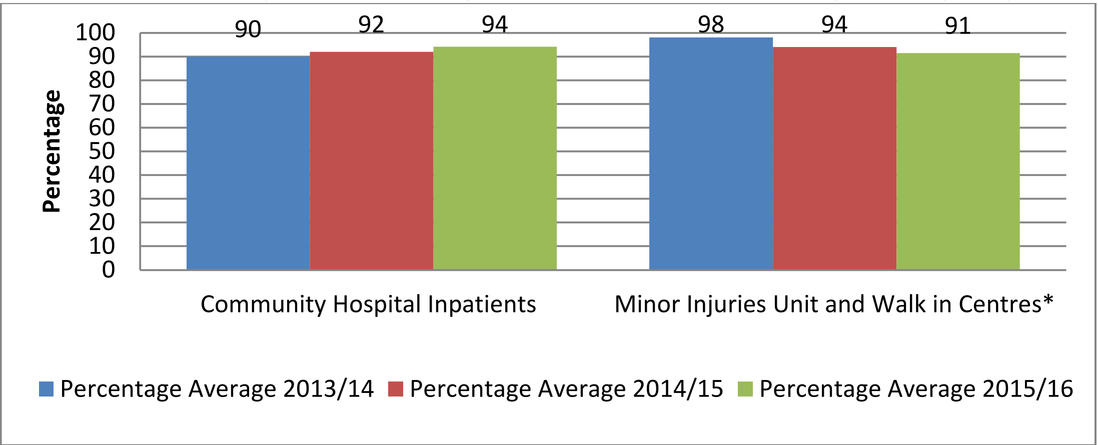
Figures 1 and 2 below demonstrate the Trust's achievement in relation to the patient Friends and Family Test. The figures demonstrate that Trust community services (both physical and mental health) are highly valued with over 95% of people surveyed likely to recommend them. Additionally, Trust community inpatient services, minor injury services and walk-in centres are valued with over 90% of respondents recommending such services. For mental health inpatients, the percentage recommending services has reduced in the third quarter following increases in the first and second quarters of the year.

Figure 1- Patient Friends and Family Test: Percentage of Patients Extremely likely or very likely to recommend the service to a friend or family member



**MH figures for 2014/15 are for Nov 2014-March 2015 due to the change in national methodology. 2015/16 figure is for Q1- Q3. Source: Trust Patient Experience Reports*

Figure 2- Patient Friends and Family Test: Percentage who would recommend to a friend or family member.

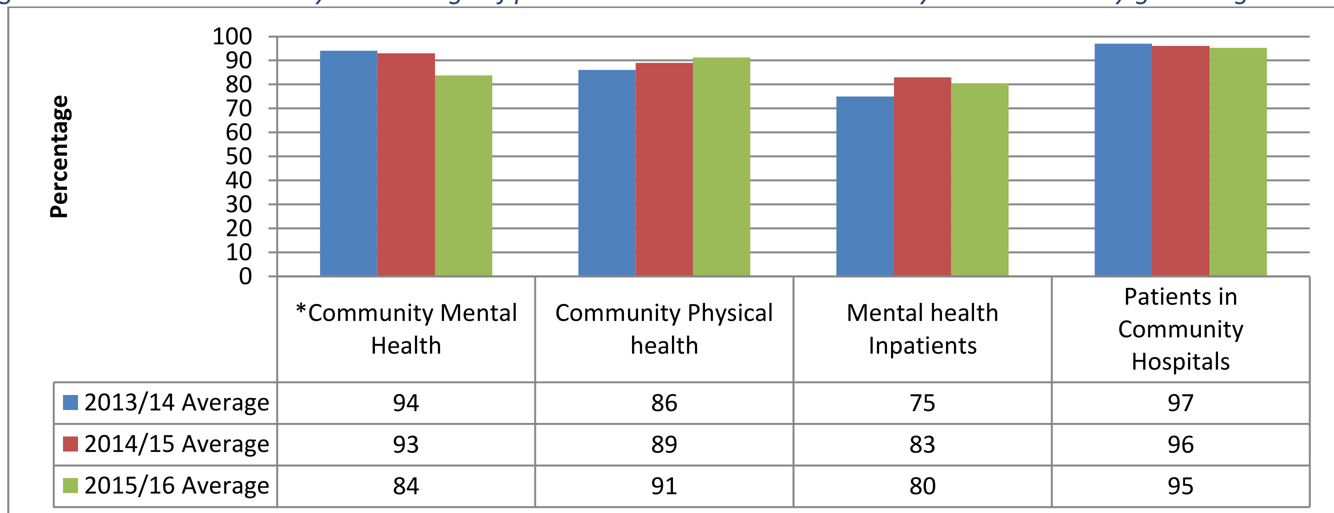


** 2013/14 figures are for Minor Injuries Centre only. 2014/15 figures onward include Slough Walk in Health Clinic. There has also been some change in the methodology to ensure visitors report in higher numbers and anonymously. 2015/16 Figure is for Q1- Q3. Source: Trust Patient Experience Reports*

Trust Patient Satisfaction Survey

In addition to the patient Friends and Family Test, the Trust has also carried out its own internal patient satisfaction survey throughout the year to further ascertain and assure levels of patient satisfaction. Figures 3 and 4 below demonstrate the Trust's performance in relation to this survey. It can be seen that during the 2015/16 financial year, a total of 9244 service users and carers have provided feedback through this survey programme, with 90% of people giving a good or better than good rating of the care they received.

Figure 3- Trust Patient Survey: Percentage of patients who rated the service they received as very good or good.



	*Community Mental Health	Community Physical health	Mental health Inpatients	Patients in Community Hospitals
2013/14 Average	94	86	75	97
2014/15 Average	93	89	83	96
2015/16 Average	84	91	80	95

**2012/13 Community mental health results only include learning disability and older people's services as data for adult and children services are unavailable. Community Mental Health Teams and Electroconvulsive therapy included for 2013/14. 2015/16 Figure is for Q1- Q3. Source: Trust Patient Experience Reports.*

Figure 4- Trust Patient survey: Total number of responses to internal patient survey over the year. (2015/16 YTD)

	Total Number of Responses	Total Number of Good or Better Responses
Community Mental health	1114	934
Community physical health	7641	6972
Mental Health Inpatients	450	362
Community Inpatients	1025	976

Source: Trust Patient Experience Reports.

Carer Friends and Family Test (FFT)

A Friends and Family Test for Carers has been created and has been distributed to services from February 2015. This allows carers the opportunity to share their experience with us in a dedicated way. Whilst this is not mandated within the Friends and Family national guidance, the Trust recognises the crucial role that carers have and the value of their feedback.

In Quarter 3, the Trust received a total of 15 Carer FFT responses (73 in Q2) from all services. All 15 respondents replied that they were either very likely or likely to recommend the Trust services

Learning from Complaints

The Trust has continued to respond to and learn from complaints during the year. Figures 23 and 24, shown in part 3 of this report, show the number of complaints and compliments received by the Trust.

During quarter three we achieved a response rate of 85% within the agreed timescale with the complainant. This is a drop from quarters one and two. The complaints team have worked with the clinical directors to improve this situation and are hopeful that quarter four will show improvement. Services on average took 32 days to investigate and respond to complaints. Many complaints are responded to much quicker if they are less complex. This is a slight increase in our responsiveness. Of complaints closed during quarter three, just under 52% were upheld or partially upheld.

The highest numbers of complaints during this financial year have been received by mental health inpatients, child and adolescent mental health services (CAMHS) and community mental health teams.

Services receiving the highest number of complaints in quarter three were:

- Mental health inpatient services where there are no trends identified currently
- Community nursing is starting to feature within complaints more frequently so this is being monitored more closely. The service is far exceeding its commissioned levels of activity and is experiencing difficulties in recruitment. The trust is in discussions with commissioners about reviewing this service.
- Crisis response and home treatment team have received 11 complaints within this financial year. In 2014/15 the service received 19 in total. The Trust is hopeful that at the end of this financial year we will see fewer complaints overall for the service because of the focused work led by the Chief Operating Officer in light of the additional funding agreed by commissioners this year. East of Berkshire services still receive more complaints that the west of Berkshire services.

CAMHS services have been highlighted this quarter because they have received 23 complaints so far this year compared with 21 for the whole of 2014/15. This means that CAMHs is the service with the highest number of complaints for this year however of the 23 complaints received 19 were for West of Berkshire services whereas in 2014/15 the two localities, Bracknell and Reading, received the highest number of complaints. The Director of Nursing has asked the management team to investigate what is happening in the West of Berkshire because we are seeing a change that requires action. Access to treatment and waiting times continue to be the greatest reasons for complaint.

The main themes from the formal complaints received were care and treatment, attitude of staff and waiting times for treatment and communication. This continues the trend we have seen in previous quarters. Each service takes complaints seriously and implements new ways of working if appropriate. If a staff member has been directly named, they are involved in the investigation and its findings and action taken if required. The service and staff directly involved in the complaint are asked to reflect on the issues raised and consider how they will change their practice.

The number of posts placed on NHS Choices about our services continues to increase with 12 negative and 8 positive comments during the quarter. The negative comments cover staff attitude, communication and service capacity so very similar to complaint trends. It is good to see positive comments as well being placed though. The system the trust has in place means that we are able to respond quickly to each post.

It is good to note that the trust has not received notifications from the Parliamentary Health Ombudsman Service (PHSO) that they intend to investigate any new complaints; one complaint is open to investigation and another with an action plan requiring completion.

2015 National Community Mental Health Survey

The Trust uses national surveys to find out about the experiences of people who receive care and treatment. The results of the annual National Community Mental Health Survey were published in October 2015.

This year's survey allowed for comparisons to be made with the 2014 results as there were only minor amendments made. The survey contained 33 questions (the same number as in 2014) which were categorized within ten Sections. Each question was scored out of a total mark of 10.

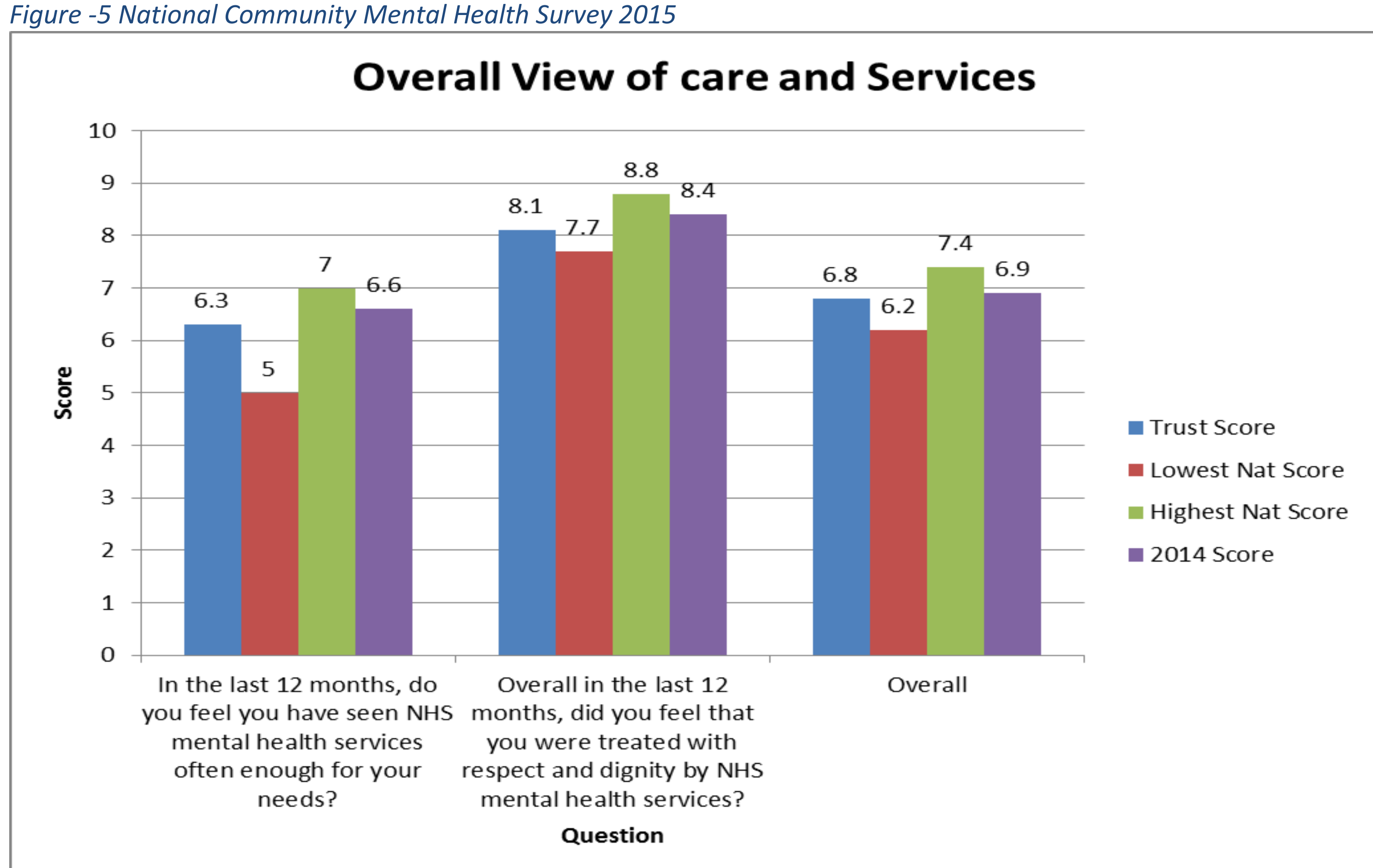
Patients were eligible to receive the 2015 survey if they had been seen by community mental health services between 1 September 2014 and 30 November 2014. Surveys were sent out to 850 patients meeting this requirement between February and July 2015, with responses received from 245 people (30%).

Out of the available 43 scores (including section scores), the Trust achieved 42 results that were ranked as about the same as the majority of other participating trusts.

For one question, the Trust received the lowest score: 'In the last 12 months, did NHS mental health services give you any help or advice with finding support for finding or keeping accommodation?'
These results are consistent with a deep-dive survey that was undertaken in the last financial year and an ongoing action plan is being implemented as a result.

Figure 5 below gives an overview of scores for the Trust in relation to respondents' overall views of the care and service they received and their overall experience. The 2015 Trust scores are compared with the highest and lowest scores achieved by other trusts this year, and with the comparable Trust score for the equivalent question in 2014

Figure -5 National Community Mental Health Survey 2015



Source: Trust Results from National Community Mental Health Survey 2015

2015 National Staff Survey

One of the Trust's patient safety priorities for 2015/16 was to achieve staff survey results that were amongst the best 20% of similar Trusts in relation to relation to errors, near misses, incidents and concerns (Questions 18 and 19 of the survey). Figure 6 below details the results of the 2015 staff survey in relation the stated priorities, together with other results including those relating to the staff experiencing harassment, bullying or abuse from staff in the last 12 months and those believing that trust provides equal opportunities for career progression or promotion.

Results are due for publication on 23rd February 2016, and will be published in the Q4 update report.

Figure 6- 2015 National Staff Survey

Question ref.	Question	Trust 2013 %	Trust 2014 %	Trust 2015 %	National average for all mental health trusts 2015 %
Q12a	*Care of patients / service users is my organisations top priority (agree or strongly agree)*	71	73	**TBC**	
Q12b	*My organisation acts on concerns raised by patients and service users (agree or strongly agree)*	75	78	**TBC**	
Q12c	*I would recommend my organisation as a place to work (agree or strongly agree)*	62	62	**TBC**	
Q12d	*If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation (agree or strongly agree)*	69	71	**TBC**	
Q5a	*I look forward to going to work (often or always)*	58	59	**TBC**	
Q5b	*I am enthusiastic about my job (often or always)*	71	74	**TBC**	
Q8g	*How satisfied am I that the organisation values my work (Satisfied or very satisfied)*	44	47	**TBC**	
Q11c	*Senior managers try to involve staff in important decisions (agree or strongly agree)*	41	41	**TBC**	
Q11d	*Senior managers act on staff feedback (agree or strongly agree)*	38	41	**TBC**	
Q18a	*My organisation treats staff who are involved in an error, near miss or incident fairly (agree or strongly agree)*	54	51	**TBC**	
Q18b	*My organisation encourages us to report errors, near misses or incidents(agree or strongly agree)*	90	88	**TBC**	
Q18d	*My organisation blames or punishes people who are involved in errors, near misses or incidents (agree or strongly agree*	9	10	**TBC**	
Q18e	*When errors, near misses or incidents are reported my organisation takes action to ensure that they do not happen again (agree or strongly agree)*	67	67	**TBC**	
Q18f	*We are informed about errors, near misses or incidents that happen in the organisation (agree or strongly agree)*	48	51	**TBC**	
Q18g	*We are given feedback about changes made in response to reported errors, near misses and incidents (agree or strongly agree)*	48	51	**TBC**	
Q19b	*I would feel secure raising concerns about unsafe clinical practice (agree or strongly agree)*	71	78	**TBC**	
Q19c	*I am confident that my organisation would address my concern (agree or strongly agree)*	55	65	**TBC**	

Source: 2015 National Staff Survey Table A3.2: Survey questions benchmarked against other mental health/learning disability Trusts

2.1.2 Patient Safety

Throughout the year, the Trust's aim has been to foster an environment where staff are confident to raise concerns about patient safety. Learning occurs with respect to errors, incidents, near misses and complaints across the organisation. Initiatives to achieve this have been implemented during 2015/16. The Trust has continued to engage with and contribute to cross organisational initiatives such as the patient safety collaborative.
The Trust has also signed up to the 'Sign up to Safety' pledges and through this has committed to put safety first, continually learn, be honest and transparent, collaborate in learning and support staff to help them understand and improve on when things go wrong.

In order to assure patient safety, the Trust has continued to monitor a range of quality indicators on a monthly basis alongside the daily staffing levels. Progress is reported on the following indicators:

1. Community wards
   - Developed Pressure sores
   - Falls where the patient is found on the floor
   - Medication related incidents (Detailed in part 3 of this report)
2. Mental health wards
   -AWOL (Absent without leave) and absconsion (Detailed in Part 3 of this report)
   -Patient on patient physical assaults (Detailed in Part 3 of this report)
   -Seclusion of patients
   -Use of prone restraint on patients

   Further information on Trust patient safety thermometer metrics, including the number of patients surveyed and the incidence of various types of harm are included in Appendix D.

Pressure Ulcers

The Trust collects data on pressure ulcers data to measure its incidence and to make improvements in this area. Figures 7 and 8 below give an overview of the number of developed pressure ulcers on inpatient wards and in the community during the last twelve months. In addition, the rate of new pressure ulcers across the Trust, detailed against the national rate, is shown in Appendix D.

Figure 7 shows that, in the twelve months to the end of December 2015, there have been 21 Category 2 and 1 avoidable category 3&4 pressure ulcer on Trust inpatient wards. This compares with 39 category 2 and 5 avoidable category 3&4 pressure ulcers during the whole of the 2014/15 financial year.

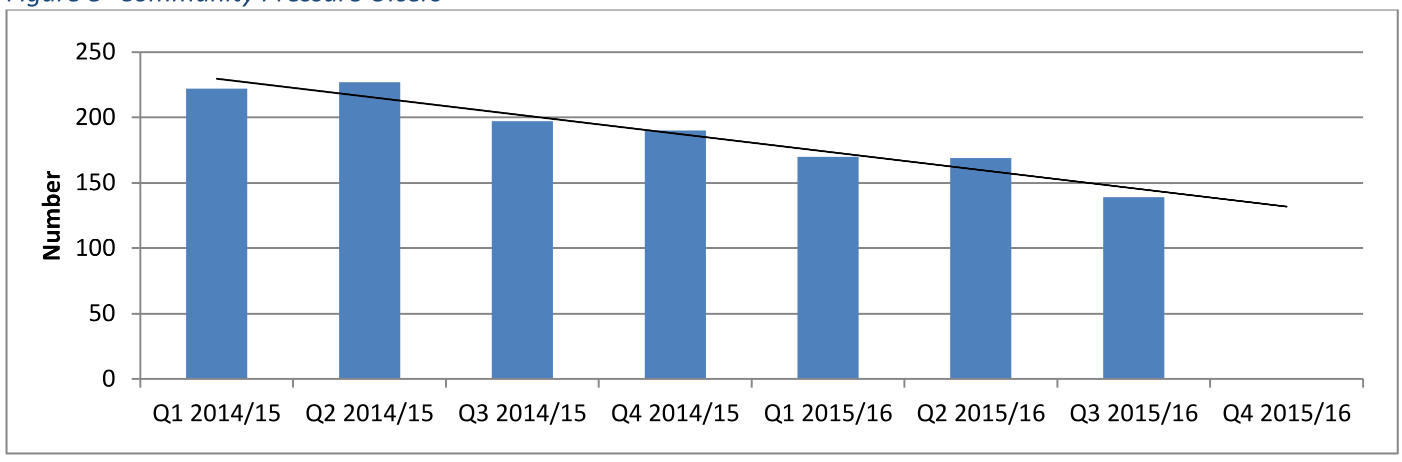
Figure 8 show a reduction in the trend of number of community pressure ulcers since April 2014/15.

Figure 7- Overview of Developed Pressure Ulcers on inpatient wards during the last 12 months.

	2014 - 2015			2015-2016									
Developed Pressure Ulcers	Q4			Q1			Q2			Q3			Total
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
Category 2 PU	4	4	3	0	3	3	1	1	0	1	0	1	**21**
Cat 3 & 4 PU Avoidable	0	0	0	0	0	0	1	0	0	0	0	0	**1**
Cat 3 & 4 PU Unavoidable	1	0	0	0	0	0	1	1	1	1	0	0	**5**
Grand Total	**5**	**4**	**3**	**0**	**3**	**3**	**3**	**2**	**1**	**2**	**0**	**1**	**21**

**This is not all the PU events on the wards as we separate developed within our services and those inherited from other services. These are just the developed. We currently do not investigate developed category 2s so these cannot be identified as avoidable or unavoidable. Source: Trust Pressure Ulcer Reports.*

Figure 8- Community Pressure Ulcers

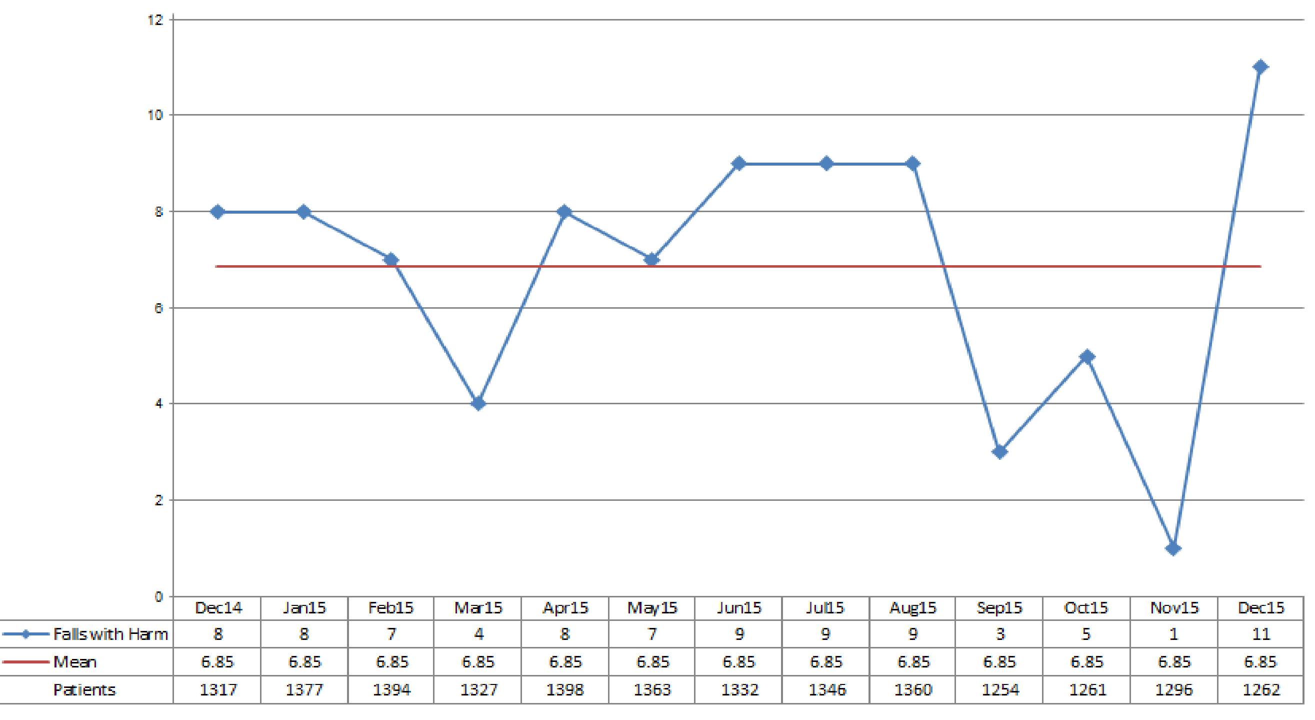


Source: Safety Thermometer

Falls

Figure 9 below details the number of falls that have resulted in harm for the Trust during the last 12 months. This data has been obtained from the Trust Safety Thermometer data. Five falls resulting in harm occurred in October 2015, with one in November 2015. However, eleven falls resulting in harm were recorded in December 2015. The Trust mean number of falls resulting in harm per month is 6.8. The number of falls calculated per 1000 bed days is contained within part 3 of this report.

Figure 9- Falls resulting in harm: All services, inpatients and community.



	Dec14	Jan15	Feb15	Mar15	Apr15	May15	Jun15	Jul15	Aug15	Sep15	Oct15	Nov15	Dec15
Falls with Harm	8	8	7	4	8	7	9	9	9	3	5	1	11
Mean	6.85	6.85	6.85	6.85	6.85	6.85	6.85	6.85	6.85	6.85	6.85	6.85	6.85
Patients	1317	1377	1394	1327	1398	1363	1332	1346	1360	1254	1261	1296	1262

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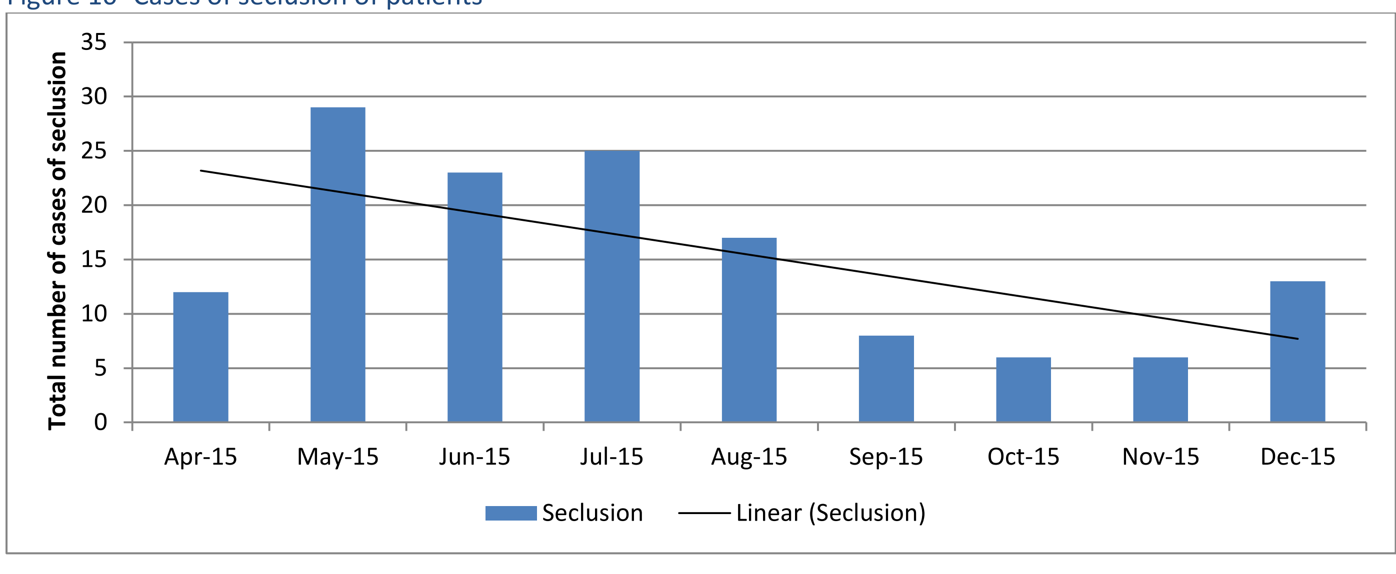
Seclusion of patients

Figure 10 below shows the monthly number of cases of seclusion of patients during the year. As can be seen, there is a general downwards trend in the monthly number of secluded patients between April 2015 and December 2015.

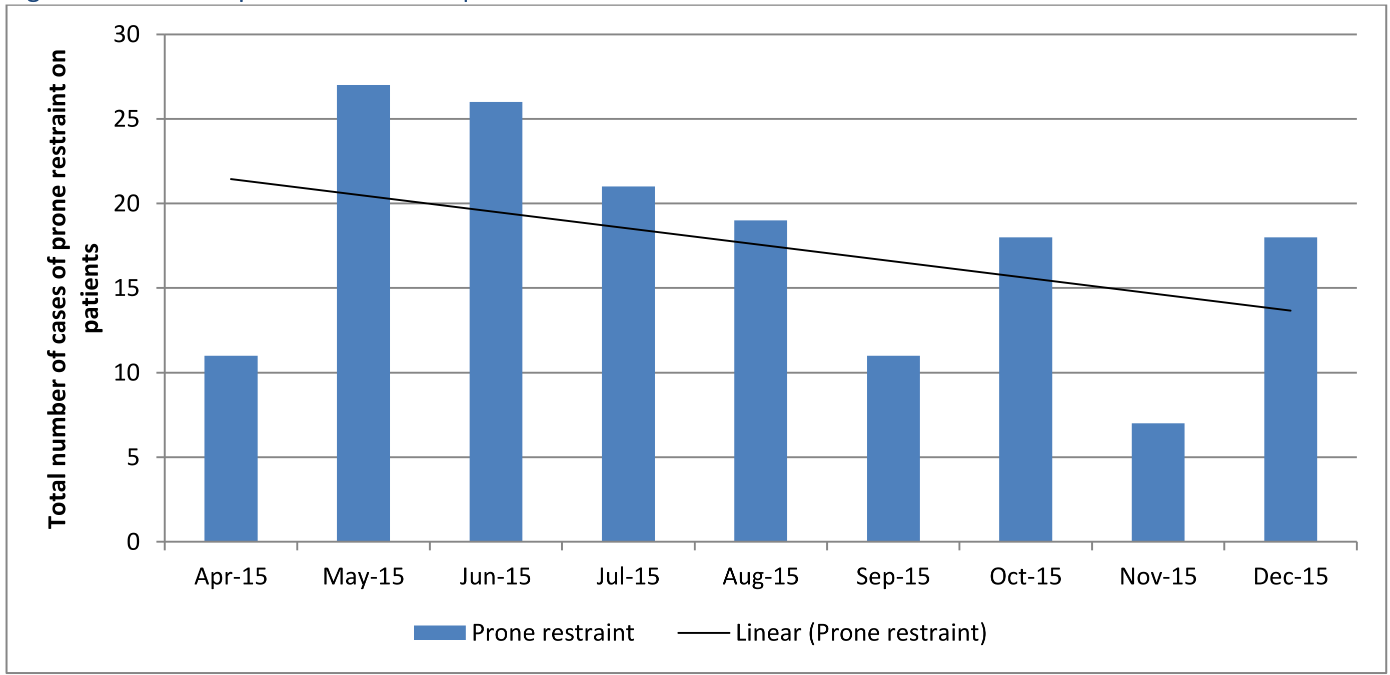
Figure 10- Cases of seclusion of patients



Use of prone restraint on patients

Figure 11 below shows the monthly number of cases of prone restraint on patients during the year. As can be seen, there is a general downwards trend in the monthly number of cases of prone restraint between April 2015 and December 2015.

Figure 11- Cases of prone restraint on patients



Quality Concerns

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

Our quality record is good and the trust has recently undergone a CQC comprehensive inspection with the results due to be received by the trust in February and published towards the end of March 2016.

CQC

In January 2016 a CQC warning notice was received regarding our High Dependency Unit (two beds) on Sorrel Ward at Prospect Park Hospital. This related to not meeting the standards required in trust policy regarding long time segregation and the Mental Health Act Code of Practice 1983, patient care plans and gender separation. Actions are in progress to rectify these issues by the end of February 2016.

Locked Wards

Our inpatient assessment and treatment unit for people with learning disabilities and psychiatric intensive care unit are both locked units managing very challenging and vulnerable patients, who frequently assault staff. Both of these units continue to experience high turnover of staff and agency use and therefore potentially provide a poor patient experience. Regular supervision is in place along with recruitment plans. Professional leads are working closely with staff to ensure standards of practice are maintained. Both wards are robustly monitored by Executive Directors.

Shortage of adult nursing and therapy staff

Mental and physical health inpatient and community services are now affected by shortages of nursing and therapy staff, which has resulted in increased agency staff use. This has a potential impact on the quality of patient care and experience, and increases our costs. A variety of mitigations are in place including 'over recruitment' and workforce redesign. Our plans to increase the use of framework agencies and develop an internal bank along with the embedding of e-rostering will also help us with effective distribution of resources.

Berkshire Adolescent Unit (BAU)

The BAU has provided tier 4 child and adolescent mental health services since July 2015. The unit has struggled to recruit permanent staff and has had a number of challenges implementing new ways of working and adapting the environment. A comprehensive action plan has been developed and implemented with the number of beds open reduced currently. New nursing and medical ward leadership has recently been appointed.

Interface between CRHTT, Common Point of Entry and Community Mental Health Teams.

Ensuring a smooth transition between components of our mental health services is a high priority, as we recognise the level of risk that this presents, particularly when services are busy. Short term initiatives to address this issue are being led by Executive Directors, alongside medium to longer term work to improve our understanding of and response to demand and capacity risks.

Mental Health Act (MHA) Code of Practice Compliance

The CQC comprehensive inspection and previous CQC MHA inspections has shown that our staff do not always adhere to the Code of Practice which may result in patients not knowing their rights and therefore potentially receive harm as a consequence. A training and audit programme is underway and plans for a MHA inspector role within the trust are in development.

Acute Adult Mental Health Inpatient Bed Occupancy

Bed occupancy has been consistently above 90% since August 2015. Patients have high acuity, there is disruption for patients who are on leave with concerns about where they will go on their return and patients are being placed out of area (this increases suicide risk on their discharge). There are clear weekly processes in place to mitigate risks.

Freedom to Speak UP

Whistleblowing cases are defined as cases where the member of staff has raised a concern under the Trust Whistleblowing policy or have referred to the complaint as 'blowing the whistle'.

In the period January to November 2015, the trust has received 11 whistleblowing concerns raised by staff of Berkshire Healthcare NHS Foundation Trust. All but one was raised anonymously. All were received in writing. The number of cases in 2015 appears to be higher than the previous years, which is expected following the introduction in December 2013 of the new approach and policy on raising concerns, where staff were encouraged to do so and the mechanisms For voicing issues was clarified and widely communicated.

Of the 11 concerns raised, seven have been investigated and closed. The remaining 4 are still open, and are being investigated. The time taken to investigate and close a case varies considerably. This is to be expected bearing in mind that most are raised anonymously and this generally entails a wider group of people being interviewed.

Following recommendations from our internal auditors, the Trust has introduced a more systematic detailed method for logging information centrally about whistleblowing concerns. The challenge continues to be ensuring that information about all cases is communicated centrally whilst keeping management of the issues at the appropriate level

2.1.3 Clinical Effectiveness

During 2015/16, the Trust prioritised the implementation of NICE Guidance to ensure that the services it provides were in line with best practice.

NICE Guidance

NICE guidelines, technology appraisals and quality standards provide valuable evidenced-based information on clinically effective and cost-effective services. The Trust has continued to demonstrate 100% compliance with technology appraisals and the performance target of 80% of all relevant guidance being implemented is now also being met.

At the end of Quarter 3 2015/16, progress against these targets was as follows:

Figure 12 NICE compliance December 2015

Trust Performance Target	Target (%)	Score (%)
1. Compliance with NICE Technology Appraisals	100	**100**
2. Compliance with all NICE Guidance	80	**83**

Source: Trust NICE Guidance Compliance Update Reports

Other clinical effectiveness activity, including that relating to service improvements, clinical audit and research, is reported later in this report

2.1.4 Health Promotion

The Trust has committed to deliver on its priorities to become smoke free, to increase awareness of diabetes amongst patient and staff and to improve monitoring of physical health risk factors amongst patients with mental health problems. An update on each of these priority areas is detailed below.

Smoke Free

On 1st March 2015 our first major milestone was achieved and the staff smoke free policy came into effect, many staff have used this as an opportunity to reduce their tobacco intake or quit smoking and we are hoping to publish some of their positive stories onto the smoke free teamnet intranet pages.

To support the staff smoke free policy we have updated the job description template, there is now reference to this in all adverts and the interview checklist now includes a reminder to advise applicants of the smoke free policy. A new paragraph will be included in terms and conditions.

Any staff with queries about going smoke free can contact a dedicated Trust e-mail address for advice. Business cards have been printed for staff and managers to give to colleagues as a reminder of the key elements of the policy and where to get support if required.

On 1st July 2015 we achieved our second milestone and all staff should now be asking our community patients to abstain from smoking whilst we provide

their treatment/ care and will also be ensuring that our grounds are smoke free. To achieve smoke free in our grounds we are asking staff to advise their patients, and anyone that they see smoking that we do not allow this on our sites. We have leaflets / business cards to support any conversations that staff will have with patients, carers and visitors. To support the campaign new signage has been put up on the main Trust sites and posters designed. The policy is available on the intranet.

Smoke Free Life Berkshire have been working very hard to support our campaign and have ever increasing visibility with new clinics for staff, patients and the public being held at various Trust locations.

On 1st October 2015 we reached our final milestone and became smoke free on our mental health wards at Prospect Park Hospital. Patients are being supported with this by being offered Nicotine replacement therapy whilst on the wards and access to Smoke Free Life Berkshire if they would like to be supported in making a serious quit attempt during their stay. Outcomes from this project will be reported in the Q4 report.

Diabetes Awareness

Several initiatives have been undertaken during the year to raise awareness of diabetes amongst patients and staff.

For patients, awareness Initiatives in East Berkshire includes:

- Diabetes Education & Awareness for Life (DEAL) structured group education for people newly diagnosed with Diabetes. These run regularly across East Berkshire and are facilitated by Diabetes Specialist Nurses and Dietitians.
- DEAL PLUS. These group sessions run once/twice a month and are for people who have had diabetes for greater than 1 year
- CHOICE. Group diabetes education for people with type 1 diabetes (run quarterly)
- Weekly Gestational Diabetes Education Group sessions

In West Berkshire Xpert Diabetes Group Education Sessions are run for type 2 diabetes.

The Diabetes Project Group have also been running initiatives for Trust staff during the year, including:

- Production of awareness posters
- Information on the Trust intranet and payslip leaflets helping staff to 'know your risk' of diabetes and signposting them to other resources.
- Diabetes education sessions for healthcare and social care professionals to help raise their awareness of diabetes.

Monitoring of physical Health Risk Factors amongst patients with mental health problems

There has been an increased focus on ensuring that patients with mental health problems also have their physical health risk factors monitored. This focus has been enhanced through delivery of a related CQUIN.

In Trust mental health inpatient settings, training has been disseminated on the importance of monitoring physical health symptoms. The CQUIN slide show has been circulated, with training also being delivered by request. This has been sent out for teams to utilise in their staff meetings.

Training focuses on where assessment and interventions should be recorded and for each of the following:

- Smoking status;
- Lifestyle (including exercise, diet alcohol and drugs);
- Body Mass Index;
- Blood pressure;
- Glucose regulation (HbA1c or fasting glucose or random glucose as appropriate);
- Blood lipids.

Importance has also been placed on recording where the assessment has been refused and that it is important to continue attempting to collect the information. CQUIN results are published In Q4.

2.1.5. Service Improvements

In addition to improvements resulting from the priorities detailed above, services have undertaken additional initiatives to improve the quality, safety and experience of care provided to patients. Details of some of these improvements are detailed below.

1. Community Health Services for Adults

The End of Life Care Team have undertaken a full service review against the new recommendations relating to caring for dying adults detailed within 'One Chance to Get it Right'. As a result, the trust Individualised End of Life Care Plan was launched across community services, with monthly audit in place to review its usage and implementation. Policies related to this area have also been revised, and End of Life Awareness Training has been delivered.

The Diabetes Centre/ Teams have been involved in several initiatives to improve the quality of the service provided. Some of these are included within the Health Promotion section of this report above, with additional initiatives undertaken as follows:

- The West Berkshire Diabetes Team implemented the 'Optimisation of Insulin' programme. This is a bespoke package of education and one-to-one advice for patients with high HbA1c results putting them at further risk of complications
- Trust Inpatient Diabetes Specialist Nurses in East Berkshire have:
  - Introduced Hypoglycaemia boxes for use in the acute trust (Frimley Healthcare NHS Foundation Trust)
  - Supported the preceptorship programme for newly qualified staff nurses at Frimley Healthcare NHS Foundation Trust.
- The time and location of the Gestational Diabetes Mellitus (GDM) education sessions have been changed in line with patient and staff feedback.
- The development of the hypo-ambulance project will mean that patients will automatically be referred to Diabetes Specialist Nurses following paramedic callout/ A&E admission for hypoglycaemia.
- The Update on Glucometer Project has informed staff and patients of what glucometers to use based on patient and staff feedback, the clinical evidence base and cost.
- In addition, services continue to be updated in line with the latest NICE Guidance in this area.

The Podiatry Service has introduced wound care sandals to the community teams so that patients have quick access to them. These sandals aim to improve off-loading of forefoot wounds and reduce wound healing times. The team have also fully implemented a wound care template across the service to support clinicians with monitoring wounds, thus leading to better wound outcomes for patients. In addition, new guidance has been devised for clinicians regarding the admission process/ home visits for patients with acute foot conditions. This will support emergency admission and access to appropriate care for the condition.

The Berkshire Community Dental Service has held regular locality meetings throughout the year which include service improvement. One resulting improvement has been the introduction of designated members of staff with responsibility for specific areas such as cross-infection control, radiology, referral waiting lists and audits. The Service have also been able to reduce the costs of using agency dental staff at weekends by implementing a rota for permanent staff to work at Dental Access Centres on Sundays and bank holidays. Finally two articles have been published which have raised the profile of the team in a positive way.

The East Berkshire Mobility Service has been working hard throughout the year to maintain a successful service and have held group meetings addressing service improvements. The team also monitor the delivery of the wheelchair service by a provider organisation. This is achieved by receiving regular updates, monitoring delivery times and submitting incident reports if patients' appointments have to be cancelled due to non-delivery of wheelchairs.

The East Berkshire Musculoskeletal (MSK) Physio Service have launched an additional service offering appointment times on Saturday mornings and also extending clinic hours to 7pm at some sites. Patients are also now able to book their appointment online and chose the time and site of their appointment. Rehabilitation classes are now more varied and allow for better access to and types of rehabilitation. An antenatal class is also being planned to allow the service to respond more quickly to that patient group.

The West Berkshire Integrated Pain and Spinal Service was launched in September 2015 and consists of specialist physiotherapists and physiotherapists in the community receiving regular support from the Royal Berkshire Hospital pain and spinal consultants. Patients with acute spinal pain or long standing pain which has been fully investigated can be referred by their GP to the service. Following assessment, there are a range of options available for the patient including; MRI and direct listing for injections, psychology treatment, physiotherapy treatment, pain management classes and education sessions. Initial feedback from patients has been very positive with patients attending the pain programme showing an improvement in their outcome scores, and feeling more confident in dealing with their pain.
In addition, the service has won the British Society of Rheumatology's 2016 Emerging Best Practice Award for its work in helping people with musculoskeletal and chronic pain problems. The British Society of Rheumatology highlighted the project's success as a result of the collaborative approach taken through engaging with a wide range of stakeholders in its development, as well as its co-ordinated MSK, rheumatology and pain service on a large scale.

The Bracknell Leg Ulcer Service was commissioned as a pilot in September 2014 as it was identified that there was a lack of equity in service provision across the CCG. The aim was that the district nursing service and primary care would work together to improve quality of life for people with or at risk of recurrence of venous leg ulcers through the delivery of clinically effective care and advice. The service worked with practices that chose to provide their own leg ulcer management within the service specification in order to secure the best possible outcomes for patients and their carers.
After a challenging start during which time many lessons were learned, the pilot became a commissioned service in April 2015. Four GP surgeries have opted to manage their own leg ulcer services and these are supported by the clinical lead who offers advice regarding assessments and treatment plans as well as ensuring that required competencies are assessed and met.
The remaining surgeries refer their patients with straightforward non-healing leg wounds to the tier 2 leg ulcer service.
The Trust runs five leg clinics per week in the CCG area across 2 sites (Great Hollands Health Centre and Skimped Hill Health Centre). A timely and individualised wound management and healing service is delivered with a maximum wait of 10 working days for initial assessment and commencement of treatment. The target of 50% of patients being seen within 5 working days is currently being met. All patients are contacted within 3 working days of receipt of referral; GPs are also sent acknowledgement of referrals within that time framework. Onward referrals are made if required to the specialist leg ulcer clinic or to secondary care. Since the start of the pilot only one patient has been admitted to hospital as a direct result of his leg ulcer.

Patients undergoing treatment for their leg ulcers report the improvement of symptoms such as pain, exudate and odour. This is achieved through the provision of "best practice" treatment in accordance with clinical evidence and guidance which is delivered by appropriately trained and experienced clinicians who are able to demonstrate high rates of wound healing through skilled care and advice. Care is always patient-centred from initial assessment through to discharge to promote long term care and reduce the risk of recurrence.
The service aim is that a minimum 70% of venous ulcers should be healed within a 12 week period across the service. In November 2015 the average healing time was 9 weeks across both local Trust and practice nurse led clinics.
To ensure requirements are met monthly reports also monitor the total number of referrals, patient satisfaction on discharge, the rates of recurrence, infection rates and PROMs (Quality of life)

Reading Community Health Services. A key feature of work for these services has been the development of integrated working across a range of services and organisations to improve the patient experience:

- Care Coordinators amalgamated with the Community Matron Service in June 2015 with the aim of combining their respective resources and experience to develop and deliver an improved MDT format to South Reading CCG surgeries. MDT meetings are held weekly, new assessments are presented and current patients reviewed. Core members of the group are Community Matrons, Case Co-ordinators, Social Workers and Age Concern (Wellbeing Project), representing the voluntary sector. The data produced from the first three months of MDT activity demonstrates the significant positive impact this type of intervention has generated. Next steps will be to develop the

MDT group to include the patient, family, significant other and carers in the process and expand partnership working with a wider range of voluntary groups.
- The Care Homes Support Team has delivered a number of training sessions to care homes across the West of Berkshire to improve the quality of life for people. The team was expanded to respond to needs identified with the care homes resulting in an Occupational Therapist, Physiotherapist and Speech and Language Therapist being recruited to the team in June 2015. The therapists have been addressing ways to enhance the current support provided by focussing on key areas to improve patient experience. These include; falls audit to reduce falls within care homes, seating and positioning for comfort, contracture prevention and promoting appropriate posture for eating drinking and swallowing and advising staff on correct diet and fluids to reduce the risk of aspiration.

The West Berkshire Locality Intermediate Care Team, together with the West Berkshire Local Authority Maximising Independence Team have embarked on a journey to help facilitate a simpler, more efficient and safer discharge process for patients requiring any type of personal care at home. The guiding principles of this pathway were that; there should be only one referral to a joint pathway with no need to decide between health and social care, the pathway should allow the team to work with patients at home to achieve their full potential, the team can accept care plans from the assessor in hospital, joint commissioning of care is in place and social workers in hospital can be used for fine-tuning if needed.
The team have now started using this new process and have a joint health and social care administration team to process all referrals from any hospital. The team continue to work in joining up other areas of staffing to enable joint working across organisations.

Highclere and Donnington Inpatient Units at West Berkshire Community Hospital have been working towards the development of a single inpatient unit. Historically, Donnington Ward provided care for patients requiring rehabilitation with Highclere ward providing sub-acute medical care and end of life care. This resulted in the skill sets of both sets of nursing teams being very different. Each ward housed a vast amount of experience and knowledge but this was not disseminated throughout the unit which in turn was not conducive to effective bed management when placing patients. In January 2015 all staff commenced a rotation programme giving them experience of working in areas of nursing that were new to them. This has resulted in a workforce with extended skills and has provided a more flexible option for patients being admitted to the unit. Feedback from staff has also been positive. In addition, following patient feedback indicating that patients did not always understand what different medications were specifically for, the wards have implemented the MAPPS system allowing them to share medication-related information with the patient. This has resulted in very positive feedback from patients.

2. Primary Care, Minor Injuries Unit and Walk-in Centre

The Slough Walk In Health Centre has consistently achieved over 85% in the Quality and Outcomes Framework (QOF). Action plans are also in place with Trust community services to support patients with mental health problems, those that misuse alcohol and drugs, those with long term conditions and also children.

Priory Avenue GP Surgery. The Trust entered into a contract with NHS England to manage this primary care service out of Special Measures. With the right leadership and support to showcase the skills within the practice, the journey has taken Priory Avenue out of Special Measures and from 'Requires Improvement' to a 'Good' CQC rating within 9 months of the Trust being awarded the interim contract. The improvements to patient care and the processes adapted to enhance the delivery of primary care have been noticeable and highly commended by the Patient Participation Group.

The Minor Injuries Unit (MIU) based at the West Berkshire Community Hospital has worked with the Royal Berkshire Hospital (RBH) to establish a Virtual Fracture Clinic to offer patients a safe and effective process in the assessment of fractures. Using secure technology, patient notes can be sent securely to the RBH trauma team. Every week day morning a consultant orthopaedic surgeon and two specialist orthopaedic nurses at the RBH review all the notes and X-rays received since the previous clinic and telephone the patient to give them advice on their injury, arrange follow with the most appropriate clinic

or arrange admission of surgery. This stops the need for patients to travel to a clinic only to find they need to return to see a particular specialist or have surgery. It also reduces the number of missed appointments and provides a safety net for any patients who may, under the old system, have waited several days to see a specialist only to find they needed urgent intervention or a change in treatment.

The MIU has also introduced a Telemedicine Referral Image Portal System (TRIPS), allowing for a secure way to make referrals with photographic evidence to the Burns Unit at Stoke Mandeville Hospital. Once the referrals and photographs are received and reviewed, the team at Stoke Mandeville will phone back the MIU practitioner with advice on whether the patient needs to be seen by them at once at Stoke Mandeville, in clinic, or to suggest a dressing that the patient can have that would prevent them needing to travel to Stoke Mandeville.

3. Community Health Services for Children, Young People and Families

The Children and Young People's Integrated Therapy Service (CYPIT) have continued to design, implement and evaluate the Speech and Language Therapy model of service throughout Berkshire.

Pre-school children and their families are now able to access drop in clinic sessions locally if they have concerns or queries regarding their child's speech and language development, without the need for a referral or pre-arranged appointment. These children and families no longer have to wait to access this service as they had to in the past.

The service also provide a school offer across mainstream schools in Berkshire, where the needs of the children in each school are jointly discussed with education staff and the therapist and a joint action plan is created to meet the ongoing needs of the school population as a whole.

In line with the success of these service developments, CYPIT are now focusing on aligning occupational therapy and physiotherapy services across Berkshire. The service has also created and implemented an integrated report and therapy plan template on RIO and is developing a clinical outcome measure to enable them to demonstrate the impact of CYPIT intervention moving forward.

The School Immunisation Team was established following the changes to and separation of commissioning of immunisations and school nursing. In addition, the Trust won the tender to deliver the seasonal childhood flu programme to children in years 1 and 2 in all primary care schools across Berkshire. As a result, teams were established in East and West Berkshire, with both reporting into an Immunisation Service Lead

The team have recruited a number of new staff, and have given them the supervision and the mandated NHS England approved training to deliver immunisations. Alongside the pre-existing immunisation schedule, the team have delivered flu vaccinations across almost 300 schools in Berkshire over a period of 40 school days. This was a mammoth task undertaken by committed staff, resulting in the team surpassing the uptake target they were set.

Health Visiting and School Nursing Teams have continued to implement service improvements throughout the year.

In Slough, improved health assessments have been introduced for both Health Visiting and School Nursing teams. Improvements have been made to include the voice of the child as well as strengthening the family and environmental factors, helping the practitioner work with the family. Preceptorship has also been implemented for newly qualified Health Visitors and School Nurses to help develop the knowledge and skills acquired during the formal training process.

Health visiting teams in Slough have also been trained to use the Solihull Approach in their work with children and families. This approach supports parents in understanding their child and promotes emotional health and wellbeing in children and families. In addition a new health visitor bloodspot screening service has been embedded for babies under the age of 1 year who have moved into the area and have no written record of screening for the nine conditions.

Reading Health Visiting service have developed an intranet message book that enables administrative staff to add messages which other staff can then access remotely. The method offers a clear audit trail and means that if staff are absent from work their messages can still be actioned by other members of the team. This has reduced the need for staff to return to base and has quickened the process for responding to messages. The message book has been adopted and rolled out across Berkshire in all children's services. In addition, the Reading Admin Support Team (RAST) has been developed. As a result,

the clinic clerks working across Reading have been bought together on the Whitley site to enhance the reception and improve the basic admin support to the Health Visiting teams. This team required up- skilling to be able to offer the Health Visiting teams consistent practical support to ensure that the service was able to meet their needs. A training package consisting of basic IT and customer care skills was also developed, has been further enhanced in Wokingham and is now a Learning and Development package for admin staff. This service is fundamental to the smooth running of the Health Visiting service in Reading and gives the Health Visitors more clinical time.

Health Visiting teams in West Berkshire have changed the way that parents can book their infant/child into developmental clinics. This change was introduced due to the wide geographical area covered by West Berkshire and lower than expected uptake on developmental checks. The system for parents has now been centralised with one number to call. Depending on personal circumstances, parents and children now have a greater choice of when and where to attend appointments.

The Berkshire School Nursing Service have launched a Facebook page providing current health and wellbeing information for young people and sharing information on local services and public health events.

School nursing teams in Slough have implemented a School Nursing Service Manual that covers the Healthy Child Programme 5-19 years and locally commissioned services. It also includes up-to-date information on the management of medical conditions in schools

4. Services for People with Learning Disabilities

Services for people with learning disabilities continue to be focused on ensuring the best care is provided in the right place.
As a result, during this year we have been rolling out our easy read care plan and outcome measure to help ensure that we are focussing on the right things for people and that our service is making a difference. This has been particularly challenging in our inpatient services as we need to be able to support people with a wide range of needs and circumstances, but the team have been developing their skills and confidence in using the new documentation and this is helping us to improve how we involve people using our services and their families more in their care.
Meanwhile, our staff working in the community have broadened their opportunities to connect with people by working together with existing community groups and activities and providing specific training sessions and clinics to promote healthy choices. An example of this is the "Fit for Life" event in Wokingham where 61 people with learning disabilities attended a joint event hosted by Wokingham Partnership Board and supported by our Learning Disability Dieticians to learn about how small changes can make a positive difference.

5. Mental Health Services for Adults

Slough Community Mental Health Team (CMHT) and Slough Borough Council have worked together to provide a new service called Hope College.

Hope College is a new way of delivering educational courses and activities to people with mental health difficulties, using the Recovery College model approach. The model is primarily a group of values which aims to move away from medicalising mental illness into symptoms and problems and helps the client focus on their strengths and goals. It is very much led by the client rather than traditionally a clinical team leading the care.

Hope is a very important element to embed within the recovery model which emphasises the importance of motivation and managing expectations of the client and their families. Self-management and personal discovery is encouraged and techniques to empower the client to learn how to manage their own wellbeing are very important (Shepherd et al, 2008). Students' friends and family are also welcome to participate in the courses and activities available through the college.

The purpose of the college is to provide hope, opportunity and control for every student as they embark on their recovery journey. We are now in the second term of the college and we ensured that we thoroughly evaluated the first term to continue to improve.
"I much prefer the College and the courses which are on offer. Before I would go to the drop in (day centre) once a week but wasn't really going anywhere. Now I

feel that I am achieving and learning something which is great". (Service User)

A volunteer peer support programme is also in place. This programme offers a unique service for past service users to use their own experiences of mental health problems to support others. If clients feel able to manage their mental health and feel ready for the challenge, they can apply to attend a ten-week volunteer induction course. Each week covers a topic to prepare for the role as a peer mentor. Topics include communication skills, boundaries and safeguarding. Once they have completed the course, they are invited to become a peer mentor. This role includes:

- Providing support and encouragement to others attending Hope College
- Helping to develop ideas for new services – co development
- Facilitating or co-facilitating groups and courses.

As a one-to-one volunteer peer mentor, clients will feel ready to use their experiences to support other service users, attend meetings once a week to offer emotional and practical support, share experiences, and support the clients to meet their objectives and personal goals.

A monthly 'open space' mental health forum is also offered. This forum is co-facilitated by peer mentors and the ethos of the forum is that everyone is equal and everyone is heard and listened to. The forum uses different ways to engage the client group which often includes breaking off into smaller groups to answer questions and generate ideas.

Hope College is being thoroughly evaluated and each and every course or workshop run is evaluated using several different methods including; Warwick Edinburgh Mental Wellbeing Scale (WEMWS), anonymous questionnaire style feedback forms and verbal feedback as a group using flipcharts. We feel that by having various mediums of feedback this caters to all the needs and level of functioning within the client group.

Reading Community Mental Health Team (CMHT) have reviewed their model of care during the past year to ensure timely allocation with a focus on early intervention and treatment for people newly referred into the service. A multidisciplinary focus on new referrals has enabled quicker access to the right type of treatment using most relevant interventions by the best placed practitioner to provide this treatment. The team have integrated their resettlement and reablement team with the main CMHT to support enhancing recovery focused work for people with longer term mental health problems and are working with the local authority and health colleagues across the whole of West Berkshire to develop a Recovery College. This exciting development is being led by IMROC (Implementing Recovery through Organisational Change), a nationally recognised group who have supported a number of organisations in the UK to co-produce more recovery focused services with people who have experienced mental health difficulties. We are looking forward to developing this further in the coming year.

The team have been particularly successful in delivering a co-produced carer support programme. This has been designed and delivered by staff and carers who have experience of supporting people with mental health problems and has been of real benefit to the loved ones of people receiving mental health services within the CMHT. We intend to continue this programme in the coming year.

Another success has been the introduction of the Individual Employment and Support Employment Service (IPS). This national model aims to support people with a mental health diagnosis into paid work and already this dedicated service is proving to be successful in the Reading locality with 60 people being referred into the service in the first six months of it starting, way above target figures set at the start of the project.

Trust Older Peoples Mental Health Services. The Trust was awarded a grant by Health Education Thames Valley and Health Education England to develop and deliver Tier 1 Dementia Awareness Training for all staff. From a starting point of 5%, greater than 50% of all staff have now completed one of the Tier 1 training options.

Health Education Thames Valley and Reading University are also developing an App of an abridged version of the Trust's Dementia Handbook for Carers suitable for use on mobile phones and tablets. The handbook is also available freely on the Trust website. In addition, Dr Jacqui Hussey, Consultant- Old Age Psychiatry, has won the TVWLA Inspirational Leader of the Year and has been progressed through to the national final (National result due in March 2016)

Memory Clinics in the trust have been working towards accreditation/ reaccreditation with the Memory Services National Accreditation Programme (MSNAP).

- Reading Memory Clinic was awarded an 'Excellent' accreditation rating by MSNAP this year and has also received an Outstanding Achievement Award.
- Wokingham Memory Clinic was accredited two years ago and retained its excellent rating for assessment and diagnosis and psychosocial interventions. They are preparing for their next peer review.
- Bracknell Memory Clinic was also accredited two years ago and retained its excellent rating for diagnosis and assessment. They are also preparing for their next peer review.
- Windsor and Maidenhead Memory Clinic and Newbury Memory Clinic are both due an accreditation visit in the next financial year, and preparations are well underway for this.
- Slough Memory Clinic will have their accreditation visit on 7th April 2016. In addition, following service user requests, a culturally adapted version of Cognitive Stimulation Therapy (CST) was delivered in Punjabi at Slough Memory Clinic between May and August 2014. To our knowledge, this was the first time CST had been delivered in a non-English language within a UK memory clinic. In a live, symbiotic manner, Punjabi group members led the adaptation process of the CST programme to suit their cultural requirements. Following on from Punjabi CST, we have run a set of Dementia Information Groups, culturally and linguistically tailored to our Punjabi community, in order to raise awareness about the illness.

Windsor Ascot and Maidenhead Older Peoples Mental Health Team and Windsor and Maidenhead CCG (WAM CCG) have undertaken a highly successful improvement project with the aim of improving care for people living with dementia and their carers. The aim of this project was to:

- Re-design services for patients with dementia and their carers in line with NICE guidance and other best practice
- Develop a dementia strategy for agreement between the Trust, WAM CCG, The Royal Borough of Windsor and Maidenhead and all other stakeholders including patient consultation
- Improve recognition of dementia in all settings, and ensure appropriate services and support once dementia is recognised
- Improve dementia care in care homes, increasing knowledge by staff of psychological based approaches, reducing use of antipsychotics, decreasing hospital admissions and using NICE Quality Standards to guide the aims of care.

Windsor Ascot and Maidenhead did have traditional services of three day hospitals and little community development which resulted in little access to services for people with dementia and a disincentive for primary care services to identify dementia.

As a result of the project the following improvements have been achieved:

1. The new services have identified more people with dementia earlier. This has resulted in improved rates of diagnosis of dementia, going from third worst national rates to better than average rates in two years. The work led to the service becoming a finalist for a Health Service Journal award in 2014.
2. Services for people with dementia across all care sectors have been re-designed with the emphasis of care shifted to community settings.
3. More support has been offered to patients with dementia and their carers. An innovation grant was awarded by Windsor and Maidenhead CCG for the establishment of Cognitive Behavioural Therapy for carers groups. A further grant has been awarded to continue this work.
4. A fund was awarded to improve dementia services in 17 care homes. This has resulted in new state of art facilities and many homes have seen such positive results for residents, families and staff, that additional investments are now being made
5. A separate programme was initiated with the aim of reducing the use of anti-psychotics in care homes by reviewing all individuals on such medication. This was linked to a pilot in three care homes of staff training in the use of psychological based approaches. The pilot led to reductions in the use of anti-psychotics, increase in staff knowledge and reduced admissions to hospital. This was presented at the National Faculty for the Psychology of Older People and Royal College of General Practitioners conferences in 2014, and is being rolled out to all 48 care homes in the area this year as part of a "Harm Free" programme.

The success of the project has resulted in it being listed on the National Institute of Health and Care Excellence (NICE) website as an example of shared learning.
http://www.nice.org.uk/sharedlearning/living-with-dementia-%E2%80%93-improving-care-home-care

As a result, Dr Chris Allen, Joint WAM CCG Lead Dementia/Consultant Clinical Psychologist BHFT was asked to present the project to the NICE Conference and Patient Safety Conference in 2015. The work has also been shortlisted for a National Patient safety Award in 2015.

The team is also implementing a project to help community nursing staff in Windsor and Maidenhead manage patients with physical and psychological problems. This will involve three elements:

- An Increasing Access to Psychological Therapies (IAPT) Older People Specialist and Assistant Psychologists working one day a week for three months with more complex clients, using a Cognitive Behavioural Therapy transdiagnostic manual developed by Professor Jan Mohlmann specifically for older people.
- A training workshop with community nurses about identifying psychological problems, assessment and approaches that can be used.
- A referral pathway to IAPT and Trust Psychology services for patients for whom our community nurses require input.

Bracknell Community Mental Health Team for Older Adults (CMHTOA) have reconfigured and integrated the CMHTOA and the Home Treatment Teams (HTT) following a formal consultation process. This integration has enabled the delivery of a model by one team resulting in significant benefits in the patient experience and continuity of care, as their care and treatment is delivered by one team over a seven day period.
Following implementation in March 2015, monthly meetings were arranged to discuss any issues arising with most of the feedback being positive. This has included; more staff to share the weekends, dedicated Community Psychiatric Nurse (CPN)/ Duty/ HTT, increased use of diary, morning handover meetings, easier allocation to CPN from HTT caseload, team working/support, continuity of care and positive patient feedback. Overall, the team has done very well with adopting the new way of working and have been very supportive of each other.

West Berkshire Older Peoples Mental Health Team, based at Beechcroft have embedded pilot projects from 2014 into their best practice service model. These include the addition of a sixth session to their Understanding Dementia Course for Carers that concentrates on the wellbeing of the carer themselves, and four dates per year when carers can attend a discussion session on end of life care planning. In addition, the team's weekly memory clinic accreditation meetings throughout the year have generated multiple service improvements including aligning clinic schedules and admin team roles, sound proofing of consulting rooms and stream-lining the role of the memory clinic nurse to support timely reviews and more efficient recording of information. Current pilot programmes include offering the carer an opportunity to be heard prior to the client appointment and initiating a two-week post-diagnostic follow-up carer support phone call when required. Ideas from 2015 will be further developed in 2016.

Younger People with Dementia. In the west of the county, commissioners have approved a joint business case presented by the Trust and Younger People with Dementia Charity (YPWD) to fund a model of care for these patients and their carers. The funding has allowed for the Trust to recruit an Admiral Nurse for this group of patients. Admiral nurses are specialist dementia nurses who give expert practical, clinical and emotional support to families living with dementia to help them cope. Funding was also made available through this business case for the YPWD charity to deliver age-appropriate workshops for younger people with dementia and their carers in the west of the county. In support of this, an engaging workshop was delivered to the 'Get Physical' half day interactive event, in which Dr Jacqui Hussey described her experiences starting new enterprises like psycho-education groups for patients and carers.
A pilot rollout for this project in East Berkshire is also underway with the aim of demonstrating the need for such a service in this area of the county and funding has been approved by the East Berkshire CCGs to continue this beyond the pilot stage.
The project has achieved national recognition as a model of best practice and the Royal College of Psychiatrists have recently awarded the service the award for 'Team of the Year: Older Age adults'.

Older Adult Mental Health wards, following successful and internationally recognised implementation of the Safe wards programme, have commenced data collection in pursuance of accreditation from the Royal College of Psychiatrists.
In reducing falls, Assistive technology has been introduced into the older adult wards including alarms and high/low beds and looking to implement the Fall

safe programme as part of the falls prevention best care group (Oxford Academic Health Science Network).

In-patient Mental health services have developed and are running a bespoke focused in-patient preceptorship programme for newly qualified nurses. The programme was developed and is facilitated by the Nurse consultant. The programme runs over a period of a year and it helps to support nurses in their first year of qualifying as mental health nurses. The programme also tackles dilemmas and ethical issues for nurses whilst educating them about quality and wider trust strategies. It focuses on developing nurses' skills and focuses on building the resilience needed for in-patient wards. The programme also educates and develops important modern nursing skills such as service improvement skills and introduction to models of improvement (patient safety collaborative work). As part of the programme the preceptees are supported and encouraged to deliver a service improvement project which they present to senior leaders in May 2016. The programme also aims to retain staff on in-patient wards and mostly attracts newly qualified nurses to come and work in Prospect Park Hospital. It tackles the difficult aspects of in-patient nursing and the emotional impact and burn out working on busy in-patient wards potentially can have on nurses. Reflective practice and the use of action learning sets are at the centre of the programme to develop skills, resilience and emotional intelligence. The programme also focuses on leadership and empowerment skills that each nurse needs in today's ever changing NHS.

Safe Wards is a project driven by 16 years of research creating a dynamic model of what drives conflict and containment on acute mental health wards. Researchers investigated the ways staff can act so as to produce an environment which will reduce the frequency of these events, and make wards safer place (Bowers et al 2013).

All in-patient wards in Prospect Park Hospital have successfully implemented the Safe Wards initiative. In addition to this Prospect Park Hospital have been recognized for the progress they have made with Safe wards by the Department of Health, and safe wards official website. Both older adults' wards, Rowan and Orchid, continue to excel with embedding interventions. They are both presenting their work to many conferences across the country and continue to have both national and International visitors. On the official safe wards website both older adult wards continue to be presented as excellent wards to visits for safe wards implementation. A lot of positive feedback is gathered by both service users and carers.

The Occupational Therapy Team, Mental Health Inpatients have expanded their service to span 7 days a week. One Occupational Therapist and an Occupational Therapy Assistant provide a variety of meaningful, therapeutic group activities across all 7 mental health wards at Prospect Park Hospital. Therapeutic activities are planned and facilitated following suggestion and feedback from patients in morning meetings and community meetings and individual therapy sessions. Activities that are provided for patients either take place in the ward environment, therapy centre, or hospital gym. Group sessions have included; reminiscence therapy, cooking, creative activities, physical activities such as yoga and gym sessions.

This service improvement has received overwhelming positive feedback from patients and therefore has contributed to improving the overall patient experience during inpatient admissions at Prospect Park Hospital. It has also impacted out-of-hours safety as there has been a reduction in incidents occurring on weekends. Although there are many contributing factors to the occurrence of incidents, this data provides further evidence that engagement in meaningful activity, and routine and structure plays a positive role in preventing and reducing them.

Sport in Mind/Sport England- Get Health Get Active Project. The Trust is working collaboratively with local charity Sport in Mind who have received funding from Sport England for their 'Get Healthy Get Active' Project in 2015. The project, currently in its infancy, aims to set up and facilitate up to 33 weekly sporting sessions; 5 sessions per Berkshire locality, and 3 for mental health inpatient services. The project spans over 3 years and aims to improve the well-being of participants; psychologically, physically and socially. The programme will be delivered in a safe and supported environment where participants' mental health conditions will not pose a barrier to participation. Sporting sessions will include; yoga, badminton, football, walking and tai chi. The service evaluation aims to measure whether physical activity participation has a positive impact on participants' overall activity levels and mental wellbeing.

Drama Sessions, Pilot on Orchid Ward at Prospect Park Hospital. In January 2016, Occupational Therapy staff at Prospect Park Hospital started a pilot of drama

sessions with local theatre, Reading Repertory. 10 weeks of drama sessions are being delivered to the patients on Orchid Ward by Reading Repertory staff, collaboratively with the Occupational Therapist and Occupational Therapy Assistant on the ward. If successful, we are looking to increase the amount of drama sessions offered to inpatients at Prospect Park Hospital. There is increasing literature available which supports the positive role the arts, including music, dance, theatre, visual arts and writing plays, has in supporting health and wellbeing, and because of this the inpatient therapy team at Prospect Park Hospital are looking to maximise the opportunities to engage in activities such as these in the near future.

The Reader Organisation, Tea and Tales, Prospect Park Hospital. For the past three years we have been working with The Reader Organisation to deliver reading aloud sessions for patients at Prospect Park Hospital. The Reader Organisation's mission is to 'create environments where personal responses to books are freely shared in reading communities in every area of life'. Our patients commonly state that due to their mental health, they have been too unwell to be able to open a book, yet finish reading one, which is one of the reasons why these sessions are viewed as of high importance within the multidisciplinary interventions offered to patients during their treatment and recovery at Prospect Park.
Over the last year the 'Tea and Tales' reading sessions have been delivered for the patients on the four acute wards, and Rowan Ward at Prospect Park Hospital. These shared aloud reading groups provide a place for participants to find their own thought as stories and poems are read aloud in a friendly, relaxed and informal environment. Participants can listen, or take turn to read and there is no pressure either way. Everybody is welcome, readers and non-readers alike, it certainly is not an English lesson! People are encouraged to come along and relax and enjoy the words. Excitingly, we have been able to train some staff at Prospect Park Hospital to 'read to lead' and deliver reading aloud sessions themselves, this means that all seven inpatient mental health wards at Prospect Park Hospital will now have the sessions delivered, including on the intensive care unit. We have received vast amounts of feedback from patients on how the sessions have positively impacted their lives and care they have received, including;
'I have not been able to read alone for several years. Since attending the group I am able to follow text now. Please continue – it is invaluable to our health and well-being as it offers friendship, which is missing in lives of some of the members'
Another patient stated that when they were in hospital it didn't feel right somehow, but here in the group with all of us she feels she can say anything and she won't be judged.

Reducing Failures to Return project on Bluebell Ward
This quality improvement work on Bluebell ward aims to decrease "failure to return" from agreed leave.
The project work sits within the patient safety collaborative work lead by the Director of Nursing and reduces risks associated with failing to return from agreed leave. As a result of this work, Bluebell Ward have now sustained 90% of patients returning back on time to the ward from a start of 20% before starting the work- an impressive improvement.

The Mental Health Crisis Resolution and Home Team (CRHTT) have been running weekly Carers Support groups in the evening both in the east and west of Berkshire. They run 4 sessions as follows:
Week 1: Mental Health – Services and sign-posting
Week 2: How you can help in a CRISIS?
Week 3: Promoting Recovery and Independence
Week 4: Promoting Recovery and Independence
The feedback from carers has been excellent. The service is currently running the 4th Cohort which is proving to be very popular with improved outcome for both Carers and Service Users.

Rowan Ward Staff Supervision Pilot Project. The Ward Manager and Deputy Ward Managers on Rowan Ward are undertaking a pilot project to improve the quality and consistency of staff supervision, and to embed peer review of documentation within the supervision process. Work has been started to ensure that the ward supervision structures and key individual tasks are clearly identified within the Deputy Ward Managers Supervision sessions and to ensure that there is a consistent approach to what is required in terms of peer review of documentation, specifically with the registered nurses on Rowan Ward. This work is being supported through governance meetings which run every other week, alongside Orchid Ward senior nurses. The peer review process will focus on the quality of the risk summaries, care planning and progress notes for each registered nurse's key Patients.
This project is still in its infancy, however, the ground work has commenced and this will continue over the coming months

2.2 Priorities for Improvement 2016/17

The Trust has set the following priorities for 2016/17 in the areas of patient safety, clinical effectiveness, patient experience and health promotion:

2.2.1 Patient Safety

Falls

During 2016/17, the trust will aim to reduce the number of falls experienced by patients. The Trust Falls Strategy was written and ratified in the autumn of 2015. This was in response to the recognition that our falls focus and assessments were not standardised across all our wards and that numbers were at times high both in the mental health and community wards with no real understanding as to why that was. Before the strategy there was no action plan to remedy this. As a result, quarterly meetings of a trust wide falls group are now held, keeping falls high on the agenda across mental health and community services as well as defined falls champions on each in -patient ward.

Patients admitted to Trust inpatient wards have complex needs, both physically and mentally, and it is well recognised that there is no one solution that will reduce the amount of falls. Many of the reasons people fall are out of our control (comorbidity) but equally many of the reasons people fall can be learnt about and practice changed. We know from data collected that the peak times that people fall are soon after breakfast, lunch and supper as well as in the middle of the night. Most falls occur in the toilet or bathroom. Fewer falls happen at the weekend (families are around to help).

In order address this priority, the Trust will take the following action:

1. In 2016 we plan to introduce bespoke assistive technology equipment into all our inpatient wards that will alert nursing staff when at risk patients are moving around so enabling staff to assist as required. This will be in the form of bed, chair and movement sensors as well as a new sensor for the WC (being developed for the Trust) maintaining patient dignity but alerting staff.
2. We are also working closely with the Oxford Academic Health Science Network (OAHSN) across the Thames Valley to implement evidenced-based ways of reducing falls in our services. This may be as simple as:
   - Replacing bins with push pedals with open topped bins, thus reducing the need for the patient to stand on one leg to dispose of paper towels
   - Leaving the light on/ putting a light sensor in the WC, so that the patient does not become confused with the pull cords or embarrassed they will pull the wrong cord and resulting in them using the WC in the dark.

   There is unfortunately not one easy answer to this challenge.

Progress against this priority will be monitored as follows:

1. We will evaluate the use of the assistive technology after 3 months of use, adapting as required.
2. We will monitor and work to maintain the number of falls to under the set required per 1000 bed days metric and also be able to accurately understand why there are peaks in the numbers through close monitoring of patients who are at higher risk.
3. We will continue to link with the OAHSN and review what our neighbours are doing and implement changes as appropriate.

Pressure Ulcer Prevention

The aim of the Pressure Ulcer Prevention priority is to provide the best care to patients through prompt and thorough risk assessment, education of patients and carers, and early intervention to ensure prevention of pressure damage in the first instance.

In pursuance of this aim, the Trust will demonstrate continuing improvement during the year, maintaining the level of performance against current indicators on avoidable developed pressure ulcers and improving the quality of the reporting of tissue damage.

When people in our care develop pressure ulcers this is considered to be a harm. Pressure damage can have an enormous impact on the individual, causing discomfort or pain and delaying rehabilitation or discharge. In some cases this can be severe and have lasting effects. Since the launch of our 'Under Pressure' campaign and strategy in September 2013 there has been a sustained reduction in the development of unavoidable pressure ulcers across the trust and the Trust aims to ensure continued provision of the best and safest care to patients.

Current interventions to ensure sustained best practice include completion of the Waterlow risk assessment and MUST scores on admission and development of an appropriate action plan where a risk is identified.

The Trust currently monitors all developed pressure ulcer incidences of category 2 and above. Category 3s and 4s (and category 2s on inpatient wards) are investigated as serious incidents and deemed either avoidable or unavoidable, to ensure a root cause is identified and lessons are learnt. The Trust currently uses 90 days as a target for celebrating the achievement of being free from any developed pressure damage on the wards. This has proven very successful in embedding the Trust goal of embedding a change of attitude towards pressure ulcers. Nearly all community health service inpatient wards have achieved at least 90 days free from developed pressure ulcers.

Current quality schedule indicators with reductions of 15% and 20% have been challenging following on from the significant improvements already made and mostly these are on target for 2015/16 where they are achievable. However, as part of this priority, the Trust would like to see these targets maintained and this will require continued improvement work.

In order address this priority, the Trust will take the following further actions.

1. The Pressure Ulcer Prevention Champion network will continue to be supported by the tissue viability team with four educational days through the year providing an effective resource, continuing to undertake small improvement projects linking to the safety collaborative and the work of the Oxford Academic Health Science Network.
2. Improvement projects will be undertaken and include the piloting of a 'MOPS' tool to assist with distinguishing between moisture and pressure, and closer monitoring of Category 1 pressure ulcers, which is expected to impact on the development of category 2s.

Progress against this priority will be monitored as follows:

1. The number of pressure ulcers will be monitored against Quality Schedule targets
2. Pressure ulcers will also be monitored through the Classic Safety Thermometer with a focus on harm-free care. Work is almost complete with the rollout of the eHealth system which is an easier method for clinicians to collect data and the Trust expects that improved validation using this system will be demonstrated through an increase in Harm Free care.

2.2.2 Clinical Effectiveness

NICE Guidance

The aim of the NICE Guidance priority is to maintain the Trust achievement of 100% compliance with technology appraisals and greater than 80% compliance with all NICE Guidance during the year.

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

In order address this priority, the Trust will take the following actions.

1. The Trust will continue promoting the implementation of NICE Guidance by ensuring that it is identified, assessed and implemented in a timely manner. All guidance will be prioritised and assurance will be sought through expert opinion and clinical audit.

Progress against this priority will be monitored as follows:

1. The level of compliance with NICE guidance will be reported at the Trust Clinical Effectiveness Committee meetings.

2.2.3 Patient Experience

The Trust patient experience priority will focus on the Friends and Family Test, learning from complaints and participation in the Patient Leadership Programme. Further information on each of these priorities is detailed below.

Friends and Family Tests

We will continue to promote and encourage the Friends and Family Test, integrating this wherever possible into our existing internal patient survey programme. We introduced the Friends and Family Test for Carers in 2015 and will continue to promote

this throughout the year because we recognise the crucial role that carers have and value the feedback that they can provide.

Progress against this priority will be monitored as follows:
1. Monthly monitoring of patient friends and family Test results
2. Monthly monitoring of carer's friends and family test results

Learning from Complaints
Sharing learning from complaints will remain a priority for the Trust.

Progress against this priority will be monitored as follows:
1. Monthly monitoring of the number of complaints and compliments received
2. Monthly monitoring of the number of complaints that have been acknowledged within 3 days
3. Monthly monitoring of the number of complaints that have been resolved within an agreed timescale of the complainant
4. Quarterly patient experience reports to share learning from complaints

Patient Leadership Programme
The Trust will continue to improve on how we involve patients and carers in the development of our services. In pursuance of this, the Trust are going to take part in the Patient Leader Programme collaboratively with the Royal Berkshire Hospital NHS Foundation Trust with the aim of establishing a group of people that have received training and support to work with us to design and change patient services for the better.

Progress against this priority will be monitored as follows:
1. Recruit to the role and to engage patient leaders in developing services

2.2.4 Health Promotion

Suicide Prevention:
The aim of this priority will be to work with staff to prevent suicide through enhancing skills in assessment, interventions, and recording of risk for people who are managed within secondary mental health services.

In order address this priority, the Trust will take the following further actions.
1. A training programme will be developed to complement current generic risk training and will focus specifically on suicide prevention and skills development in this area. The programme will focus specifically on clinical engagement with people who express suicidal feelings and behaviours, management of risk, and documentation of risk assessment.
2. During 2016/17 all staff working in secondary mental health services that have not undertaken additional training will have access to this additional suicide training.
3. A robust audit process will be implemented to monitor risk record keeping

Progress against this priority will be monitored as follows:
1. Uptake of training on suicide prevention by staff
2. Results of the audit of risk record keeping to be reported through the Trust Suicide Steering Group chaired by the Director of Nursing
3. Monthly suicide numbers with associated rolling 12month figures will be reported.

2.2.5. Monitoring of Priorities for Improvement

All priorities detailed above will be monitored on a quarterly basis by the Trust Quality Assurance Committee as part of the Quality Report and the Board of Directors will be informed of performance against agreed targets. We will report on our progress against these priorities in our Quality Account for 2017.

2.3 Statements of Assurance from the Board

During 2015/16 the Trust provided 61 NHS services. The Trust Board has reviewed all the data available to it on the quality of care in all 61 of these NHS services. The income generated by the NHS services reviewed in 2015/16 represents 100% of clinical services and 92% 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. Details of a selection of the measures monitored monthly by the Board which are considered to be most important for quality accounting purposes are included in Part 3. These incorporate more than three indicators in each to the key areas of quality.

2.4 Clinical Audit

The Trust uses clinical audit to systematically review the care that it is providing to patients against best practice standards. Based upon the findings of audits, the Trust makes improvements to practice where necessary, to improve patient care. Such audits are undertaken at both national and local level, and a summary of progress during this year is detailed below.

National Clinical Audits and Confidential Enquiries

During 2015/16, 10 national clinical audits and 2 national confidential enquiries covered NHS services that Berkshire Healthcare Trust provided.

During 2015/16 Berkshire Healthcare NHS Foundation Trust participated (or is due to participate) in 90% (n=9/10) national clinical audits and 100% (n=2) national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Berkshire Healthcare NHS Foundation Trust was eligible to participate in during 2015/16 are as follows:

1. National Clinical Audit and Patient Outcomes Programme (NCAPOP) - Long Term Conditions (LTC) 009 Chronic Kidney Disease in Primary Care
2. NCAPOP - LTC002 Diabetes (Adult)
   a. Includes National Diabetes Primary Care (2013/14 & 2014/15),
   b. Includes Diabetes in Secondary care (2013/14 & 2014/15),
   c. Includes Diabetic foot care
3. NCAPOP- Older People (OLP) 008 Sentinel Stroke National Audit Programme (SSNAP)
4. NCAPOP - OLP009 Falls and Fragility Fractures Audit Programme (FFFAP)
   a. Includes Fracture Liaison Service Database
5. NCAPOP - National Audit - National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme
   a. Includes COPD Rehab
6. Non- NCAPOP - National Audit - Prescribing Observatory for Mental Health (POMH) - Topic 13b: Prescribing for ADHD in children, adolescents and adults
7. Non- NCAPOP - National Audit - Prescribing Observatory for Mental Health (POMH) - Topic 14b: Prescribing for substance misuse: alcohol detoxification.
8. Non- NCAPOP - National Audit - Prescribing Observatory for Mental Health (POMH) - Topic 15a: Prescribing for bipolar disorder.
9. Non-NCAPOP - National Audit of Intermediate Care

1. NCAPOP - MTH003 Mental health clinical outcome review programme: National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH)
2. NCAPOP - WCH005 Child health clinical outcome review programme:
   a. Includes Children with chronic neurodisability
   b. Includes Adolescent Mental Health (tbc)

Did not participate in:

1. National Audit - UK Parkinson’s Audit (previously known as National Parkinson's Audit).
   a. A decision was taken not to participate in this audit, due to the fact that previous audits had shown 100% compliance in all areas of relevance.

The reports of 4 (100%) national clinical audits were reviewed in 2015/16. This included 2 national audits that collected data in 2012/13, 2013/14, 2014/15 that the report was issued for in 2015/16.

- POMH – Topic 12: Prescribing for people with a personality disorder
- National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (In-Patient Suicide under observation) (2014)
- National Confidential Inquiry into Suicide and Homicide by people with Mental Illness (Annual Report) (2015)
- POMH - Topic 9c: Antipsychotic prescribing for people with a learning disability

The national clinical audits and national confidential enquiries that Berkshire Healthcare NHS Foundation Trust participated in, and for which data collection was completed during 2015/16, are listed below (in Figure 13) alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of the audit or enquiry.

The reports of all the national clinical audits were reviewed in 2015/16 and Berkshire Healthcare Foundation Trust intends to take actions to improve the quality of healthcare which are detailed in Appendix B.

Local Audits

The following gives a summary of the number of local clinical audits registered with the Trust and a comparison during this financial year, and compares this with the previous financial year.

- Registered – (106 last year) 118
- Completed- (87 last year) 102 (may have started in previous year)
- Active – (170 last year) 143 (may have started in previous year)
- Awaiting action plan – (21 last year) 10

The reports of 57 local clinical audits were reviewed by the Trust in 2015/16 and Berkshire Healthcare NHS Foundation Trust intends to take actions to improve the quality of healthcare provided which are detailed in Appendix C.
(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').

Figure 13- National Clinical Audits and Confidential Enquiries Undertaken by the Trust

NCAPOP Audits		
Diabetes (Adult) ND(A), a. Includes National Diabetes Primary Care, b. Includes Diabetes in Secondary care, c. Includes Diabetic foot care.	a.	2013/14 audit Data collected February – June 2015 191 patients submitted, across 1 teams. Report due December 2015 (delayed) 2014/15 audit Data collected July - September 2015 218 patients submitted, across 1 team. Report due December 2015 (delayed)
	b.	2013/14 audit Data collected May – June 2015 1519 patients submitted, across 1 team. Report due December 2015 (delayed) 2014/15 audit Data collected July - September 2015 1534 patients submitted, across 1 team. Report due December 2015 (delayed)
	c.	Data collection continuous 46 patients submitted, across 1 teams. 23 with 1st assessments before 10th April, data uploaded by 31st July 1st Report due March 2016 23 patients submitted with 1st assessments after 10th April, data upload deadline tbc.
Sentinel Stroke National Audit Programme (SSNAP)	Data collection continuous 339 patients submitted for January –December 2015, across 1 service. 1st Report due March 2016	

NCAPOP Audits	
Falls and Fragility Fractures Audit Programme (FFFAP) a. Includes Fracture Liaison Service Database	a. Facilities audit - Data collected September – October 2015 across 1 service Report due March 2016 Patient Audit due to collect January – September 2016
Chronic kidney disease in primary care	*Project noted as relevant to primary care – to be confirmed for SWIC, etc. (TBC when audit to start)*
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme a. Includes COPD Rehab	Data collected January – July 2015 77 patients submitted, across 2 services Report due February 2016
1. NCAPOP - MTH003 Mental health clinical outcome review programme: National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH)	Data collection continuous
2. NCAPOP - WCH005 Child health clinical outcome review programme: a. Includes Children with chronic neurodisability b. Includes Adolescent Mental Health (tbc)	a. Registration only at this stage b. Registration only at this stage
Non-NCAPOP audits	
Prescribing Observatory for Mental Health (POMH) - Topic 13b: Prescribing for ADHD in children, adolescents and adults	Data collected May 2015 219 patients submitted, across 7 teams. Report due in October 2015
Prescribing Observatory for Mental Health (POMH) - Topic 14b: Prescribing for substance misuse: alcohol detoxification.	Data due for collection January 2016 Unknown number of patients to be submitted, across unknown number of teams. Report due August 2016
Prescribing Observatory for Mental Health (POMH) - Topic 15a: Prescribing for bipolar disorder.	Data collected October 2015 137 patients currently submitted, across 6 teams. Report due March 2016
National Audit of Intermediate Care	Data collected June-July 2015 12 service elements included. Report received December 2015.
Other audits reported on in-year (data collected in previous year(s)	
Prescribing Observatory for Mental Health (POMH): Topic 9: Antipsychotic Prescribing for people with Learning Disability	Data collected March 2015 Report received August 2015
Prescribing Observatory for Mental Health (POMH): Topic 12: Prescribing for people with personality disorder	Data collected June-July 2014 Report received January 2015
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (In-Patient Suicide under observation) (2014)	Data collected ongoing Report received July 2015
National Confidential Inquiry into Suicide and Homicide by people with Mental Illness (Annual Report) (2015)	Data collected ongoing Report received August 2015
Did not participate in.	
National Audit - UK Parkinson's Audit (previously known as National Parkinson's Audit)	Decision made January 2015 Clinical Effectiveness Group

Source: Trust Clinical Audit Team

2.5 Research

The number of patients receiving NHS services provided or sub-contracted by Berkshire Healthcare NHS Foundation Trust in 2015/16 that were recruited during that period to participate in research approved by a research ethics committee was as follows:

703 patients were recruited from 78 active studies, of which 588 were recruited from studies included in the National Institute of Health Research (NIHR) Portfolio and 115 were from non-Portfolio studies.

Figure 14- R&D recruitment figures 2015/16

Type of Study	No of Participants Recruited	No of Studies
NIHR Portfolio	588	47 (of which 12 are PICs)
Student	97	20
Other Funded (not eligible for NIHR Portfolio & Own Account (Unfunded)	18	11

Source: Trust R&D department

2.6 CQUIN

A proportion of the Trust's income in 2015/16 was conditional upon achieving quality improvement and innovation goals agreed between the Trust and the Clinical Commissioning Groups (CCGs) through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2015/16 and for the following 12 month period can be found in Appendix E & F.

The income in 2015/16 conditional upon achieving quality improvement and innovation goals is £3,716,110 The associated payment received for 2014/15 was £3,549,929.

2.7 Care Quality Commission

Berkshire Healthcare NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is registered without conditions.

The Care Quality Commission has not taken enforcement action against Berkshire Healthcare Foundation Trust during 2015/16.

The current quality intelligence draft report which has replaced the CQC Quality & Risk Profile can be found at: **http://www.cqc.org.uk/Provider/RWX**.

Berkshire Healthcare NHS Foundation Trust is subject to periodic reviews by the Care Quality Commission and the last review was in 7th-11th December 2015. We are awaiting the final report from this visit which we anticipate will be available for the public and our staff at the end of February 2016 /beginning of March 2016 following finalisation of the quality assurance process between the CQC and the Trust. Once finalised, the trust's CQC rating grid will be published, alongside how the Trust plans to address any areas that require improvement or are inadequate, and by when we expect it to improve.

As mentioned in the quality concerns section above, In January 2016 a CQC warning notice was received regarding our High Dependency Unit (two beds) on Sorrel Ward. This related to not meeting the standards required in trust policy regarding long time segregation and the Mental Health Act Code of Practice 1983, patient care plans and gender separation. Actions are in progress to rectify these issues by the end of February 2015 with the action plan being monitored by the Director of Nursing. Some actions have already been completed, with the remainder in progress.

During the planned visit in December 2015, the Trust hosted 120 CQC inspectors from a wide range of professions as well as experts by experience. Inspectors visited a vast range of our services in mental health, community services, learning disability and the Trust out of hours service- Westcall. There were also a few unannounced visits during that week as well as the following week, when the inspectors went to sites, wards and teams to clarify their thinking and check up on changes they had asked us to make the previous week. There was some very positive feedback given by the lead inspectors to the Trust executive board about the engagement of our staff with them and the organisation of the inspection.

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

In addition to the announced inspection in December 2015, the CQC has carried out two unannounced Mental Health Act (MHA) monitoring visits on Trust wards during 2015/16. The CQC is required by law to make such visits to provide a safeguard for individual patients whose rights are restricted by law. These MHA monitoring visits were carried out on Sorell Unit (a psychiatric intensive care inpatient unit at Prospect Park Hospital) in August 2015 and on the Campion Unit (a learning disabilities inpatient unit at Prospect Park Hospital) in September 2015. There was no enforcement action taken against the Trust as a result of either of these visits.

The Care Quality Commission also visited the GP practice Priory Avenue on 29th July 2015 which was taken on by the Trust when in 'special measures'. The practice was taken out of 'special measures' following this inspection.

2.8 Data Quality and Information Governance

The Trust submitted records during 2015/16 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data which included the patient's valid NHS Number was:
100% for admitted patient care
100% for outpatient care

The percentage of records which included the patient's valid General Practitioner Registration Code was:
100% for admitted patient care
100% for outpatient care
100% for emergency care (Minor Injuries Unit)

Information Governance

The Trust score for 2015/16 for information quality and records management assessed using the Information Governance Toolkit was 66% and was graded as satisfactory (Green). To be updated in Q4
The Information Governance Group is responsible for maintaining and improving the information governance Toolkit scores, with the aim of being satisfactory across all aspects of the IG toolkit for Version 13.

Data Quality

The Trust was not subject to the Payment by Results clinical coding audit during 2015/16 by the Audit Commission

The 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:

- 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
- Delayed transfers of care

2.9. Duty of Candour

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

The patient Safety Team monitor incidents reported on our incident reporting system (Datix) to ensure that where incidents meet the requirement for formal Duty of Candour that this is undertaken. Our process for formal Duty of Candour include meeting with patients and families, apologising for their experience , explaining the investigation process, inviting them to be involved in the investigation and then sharing the report and findings when the investigation is complete. We also ensure that support is offered to patients, family and carers as appropriate.

3. Review of Performance

3.1 Review of Quality Performance 2015/16

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. The data source for all information within this section is the Trust Performance Assurance Framework unless otherwise stated.

Patient Safety

The Trust 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.

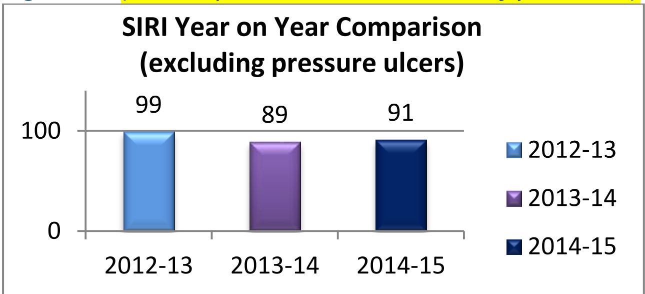
Never Events

Never events are a sub-set of Serious Incidents and are defined as 'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers'. The Trust has not reported any never events between Q1 and Q3 2015/16.

Incidents and Serious incidents requiring investigation (SIRI)

Figure 15 below shows the numbers of SIRIs reported in comparison with the previous two financial years. The chart shows that the overall annual numbers of SIRIs have remained fairly consistent.

Figure 15 (To be updated in Q4 with end of year data)



Source: Trust Patient Safety Team

The significant features represented in Q3 2015/16 Serious Incident (SI) reporting are:

- Suicide cases: 2015/16 continues to have a high rate of suicide and suspected suicide cases, comparable with national trends. By the end of Q2, the trust had equaled the number of suicides reported in total during 2014/15. In Q3, there were a further 7 SIs reported as suspected suicides. There have been no inpatient suicides although a patient who was informally admitted to Daisy ward at Prospect Park Hospital was found dead at home after failing to return from an agreed 4 hour period of Section 17 leave. The suspected suicide cases have occurred across localities and services. 43% of them were SIs reported by Mental Health Inpatient and CRHTT and 29% were reported by WAM CMHT.
- Unexpected Deaths: 35% of all SIs reported in Q3 (excluding pressure ulcers) were unexpected deaths (7 in total).
- Falls: There were 2 SIs relating to patient falls in Q3. They both occurred on Rowan Ward.
- Pressure Ulcers: 3 pressure ulcer SIs were reported in Q3, which is a reduction on the 4 reported in Q2. All were Grade 4 and reported by Community Nursing Services from West Berkshire, Reading and Bracknell. There continues to be a reduced trend compared with overall reporting in 2014/15.
- Inpatient Pressure Ulcers: There were no inpatient pressure ulcers meeting SI criteria in Q3.

Key themes identified in SI investigation reports approved in Q3 are as follows (Note: this is a discussion of learning from investigations completed and approved by commissioners in Q3)

The main theme that has been identified following completed investigations in Q3 is:

- Documenting complete risk assessments using the appropriate tool in Rio – more than one investigation has highlighted that risk assessments are not always reflected in the Rio risk assessment tool; in many but not all cases the risks and the management plan are documented within the progress notes but there is a varying degree of detail within the progress notes and where the risk is not documented in the tool it is not always easy for clinicians to find.

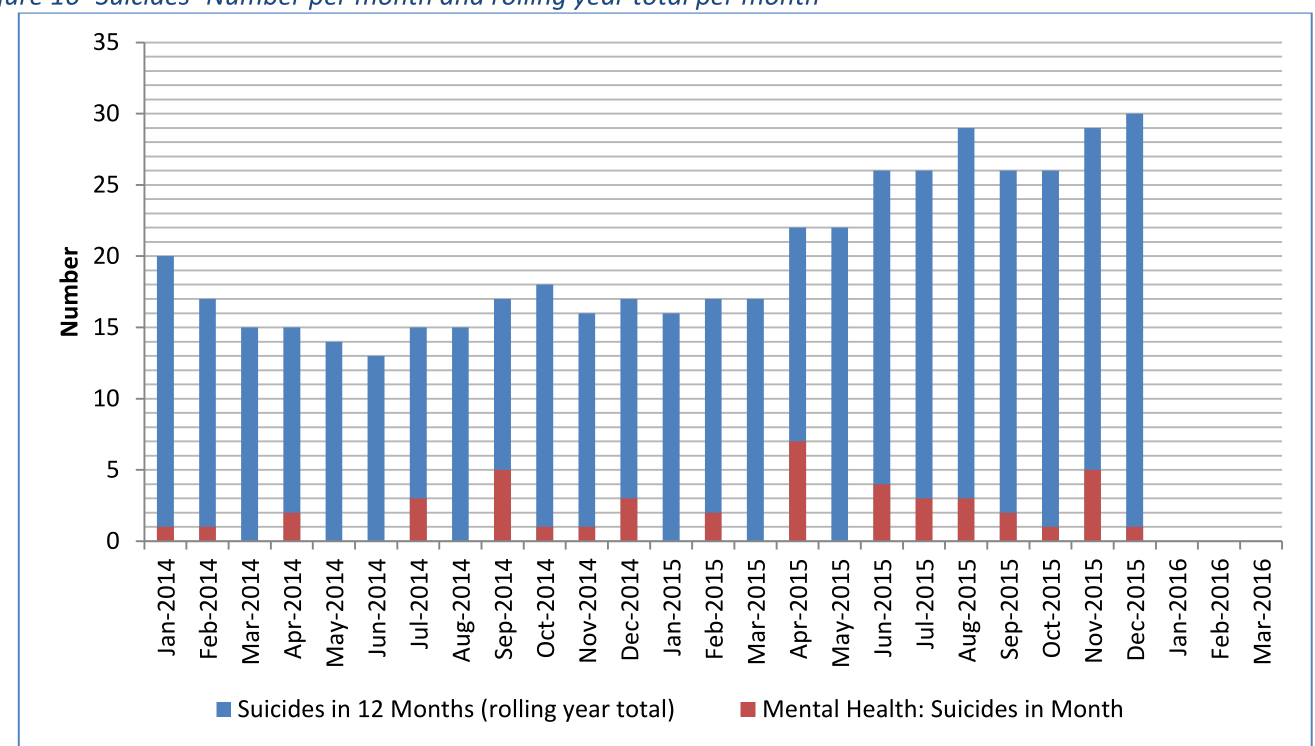
The following areas, some of which have been seen previously and discussed in earlier reports, are highlighted in SI cases from Q3:

- Clinical decision making regarding discharge – patients are being discharged from mental health services without review/discussion from a wider Multi-Disciplinary Team (MDT) or a senior member of staff.
- Communication with GPs especially on discharge - full discharge letters are not being sent in a timely manner to the GP. GPs are also not being consistently informed of changes in treatment/responsibility of care.
- Patients who are difficult to engage – this continues to be a theme. There needs to be improved communication between the GP, other health professionals and other services when a patient appears to be disengaging so that a greater understanding of their situation is obtained and appropriate risk mitigation / crisis contingency plans are agreed.
- Carer / Family Involvement – this continues to be a theme. Some carers/next of kin report a lack of support for themselves when their family member is receiving mental health services. There needs to be quicker signposting of carers into support structures and a review of the arrangements of the carers' assessments.
- Risk Assessment – increased levels of risk are not always being discussed or escalated with a supervisor
- Interface between BHFT services – psychiatry outpatient appointments are managed and processed differently across different localities resulting in an inconsistent approach to how and when patients receive an appointment.

Suicides

Figure 16 below shows the number of suicides reported per month, together with the rolling 12 month figure. In 2014/15 there were 17 suicides during the year. During the third quarter of 2015/16 there have been 7 suicides, compared with 8 in Q2 and 11 in Q1. All recorded suicides have occurred in the community and there have been no suicides in any of our inpatient facilities.

Figure 16- Suicides- Number per month and rolling year total per month



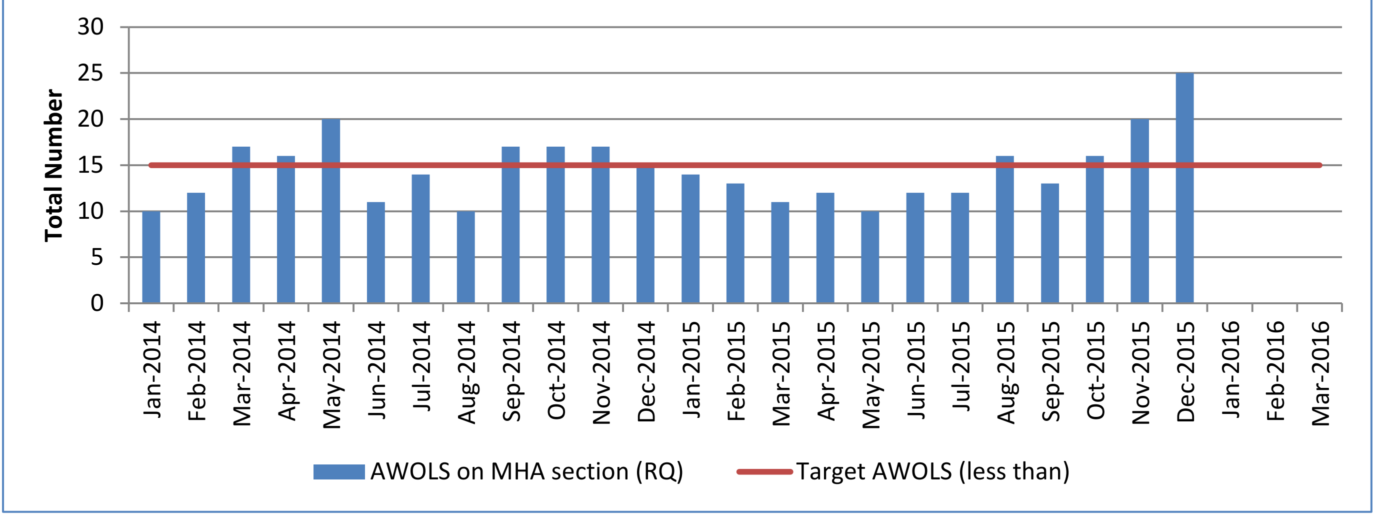
Source: Trust Performance Assurance Framework

Absent without Leave (AWOL) and Absconsions

Figures 17 and 18 below detail the number of absconsions on a Mental Health Act Section and the number of patients absent without leave on a Mental Health section. The definition of absconding used in the Trust is different than AWOL, in that this refers to the patients who are usually within a ward environment and are able to leave the ward without permission. There appears to be a correlation with the occupancy levels on the wards.

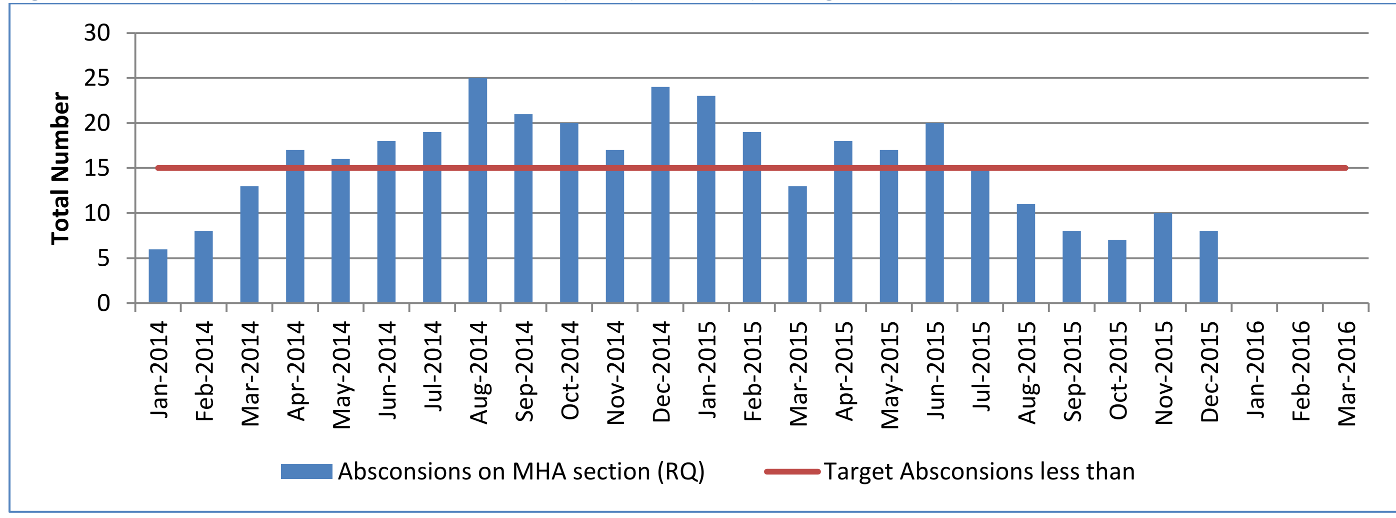
As can be seen there have been fluctuations in patients AWOL from the ward and in episodes of absconding. There has not been any clear trend in these areas although there were increases in numbers AWOL for November and December 2015. (The figures shown for each month are rolling quarters)

Figure 17- Absent Without Leave (AWOL) on a Mental Health Section- (Rolling quarters)



Source: Trust Performance Assurance Framework

Figure 18 Absconsions on a Mental Health Act (MHA) Section- (Rolling Quarters)



Source: Trust Performance Assurance Framework

A number of initiatives have been considered to help reduce the number of absconsions;

1. To make sure all the fences were in good repair, bolt down garden benches away from fences [so that they could not be moved to the fence to assist with absconding and instigate a regular checking programme of the fences / garden areas.
2. Tighten the function and process for having a dedicated member of staff out on the ward at all times. This person must be additional to the member of staff doing intermittent and general observations.

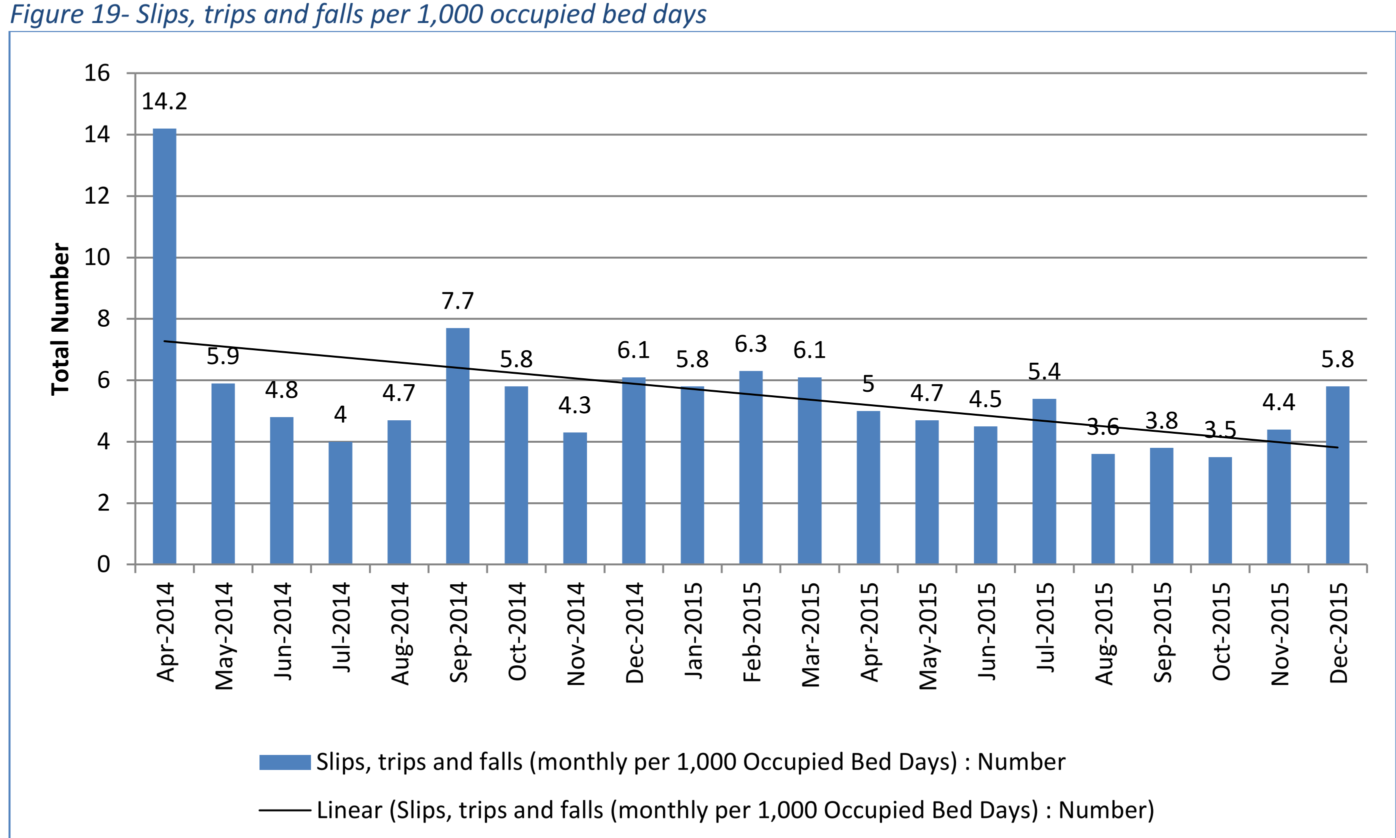
3. Extra vigilance within outside areas [garden/courtyard].
4. Implement regular slot in staff meetings where staff discuss and reflect on physical and relational security issues. This includes as a minimum: discussion of boundaries, therapy, patient mix, patient dynamic, patient's personal world, physical environment, visitors and other external communication and may be facilitated by the See, Think, Act Relational Security Explorer
5. Robust risk assessment and management plan on admission to focus on AWOL and Absconsions.

Implement anti-absconding interventions - all staff to complete the workbook training sessions on: rule clarity; signing in and out book; identification of those at high risk of absconding (targeted nursing time for those at high risk); promoting contact with family and friends; promotion of controlled access to home; careful breaking of bad news; contact cards; post incident debriefing; MDT review following two absconding episodes.

Slips, Trips and Falls

The number of slips, trips and falls per 1,000 occupied bed days is detailed in figure 19. As can be seen, the trend in falls is generally on the decline. However, falls continue to be above the target per 1,000 bed days on a number of our mental health and physical health wards. The 'Falls Safe Plan' is in place on all wards. Actions have included examining whether further assistive technologies may reduce the number of falls and changes to staff working hours as falls on the ward tend to occur between the hours of 6pm to 10pm. Since February 2015, the wards have been monitoring cognitive impairment of clients who have experienced a fall and whether the fall was witnessed. Future monitoring will include when the patient was last checked prior to the fall.

Figure 19- Slips, trips and falls per 1,000 occupied bed days



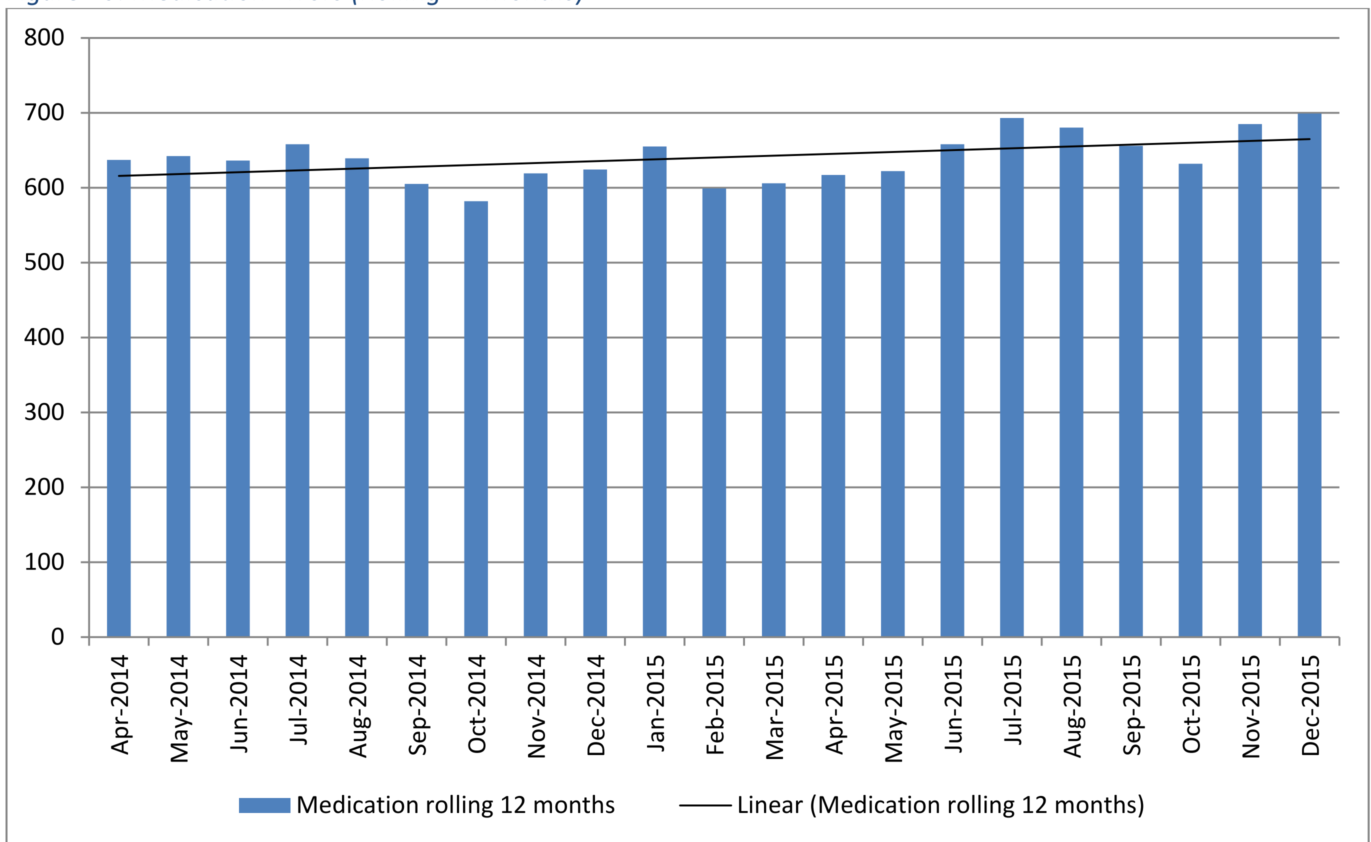
Source: Trust Performance Assurance Framework

Medication errors

699 medication errors were reported in the 12 months to the end of Q3 2015/16. In the course of Q3 there were 239 medication errors reported.

There were two incidents reported as moderate. Both of these incidents were inherited from outside of the Trust. Figure 20 below details the total number of medication errors reported in rolling twelve month intervals

Figure 20: Medication Errors (Rolling 12 Months)

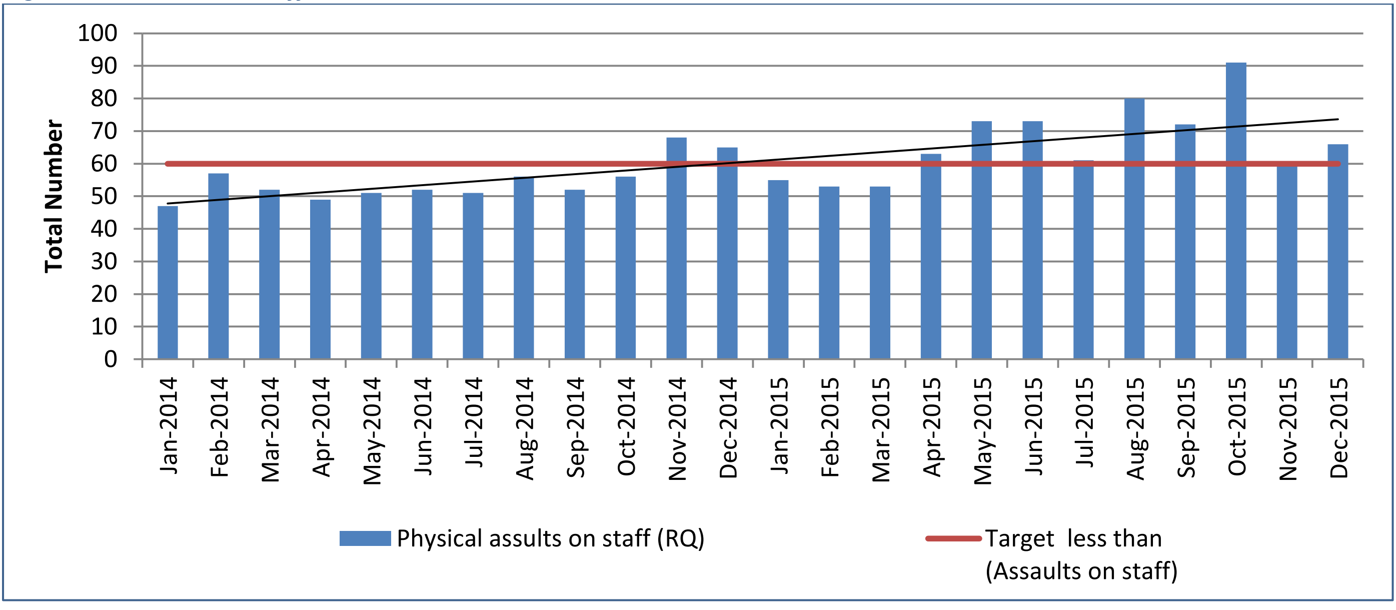


Source: Trust Performance Assurance Framework

Patient to Staff assaults

Figure 21 below details the number of patient to staff assaults recorded in the Trust each month. There have been fluctuations in the level of physical assaults on staff by patients with an increase in trend over time. Often these changes reflect the presentation of a small number of individual inpatients.

Figure 21- Patient to staff assaults

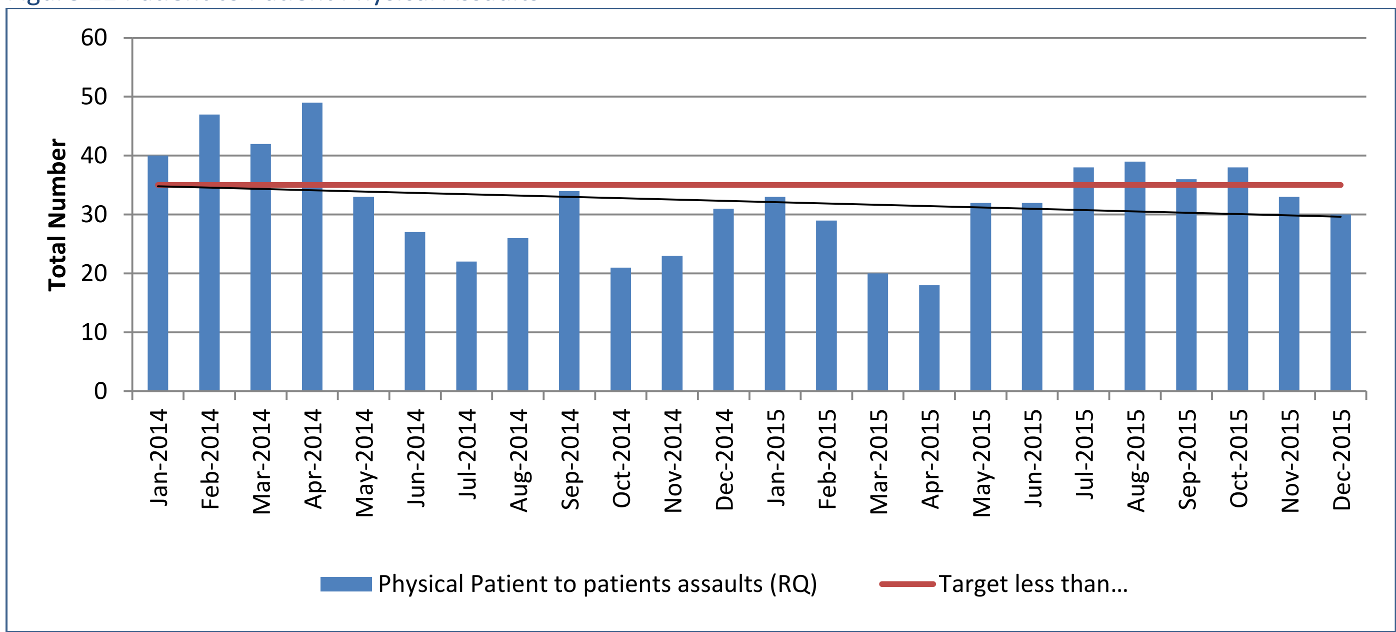


Source: Trust Performance Assurance Framework

Patient to patient physical assaults

Figure 22 below details the number of patient to patient physical assaults recorded in the trust each month. As can be seen, the level of patient on patient assaults appears to fluctuate with a slight downward trend in the past two years.

Figure 22 Patient to Patient Physical Assaults

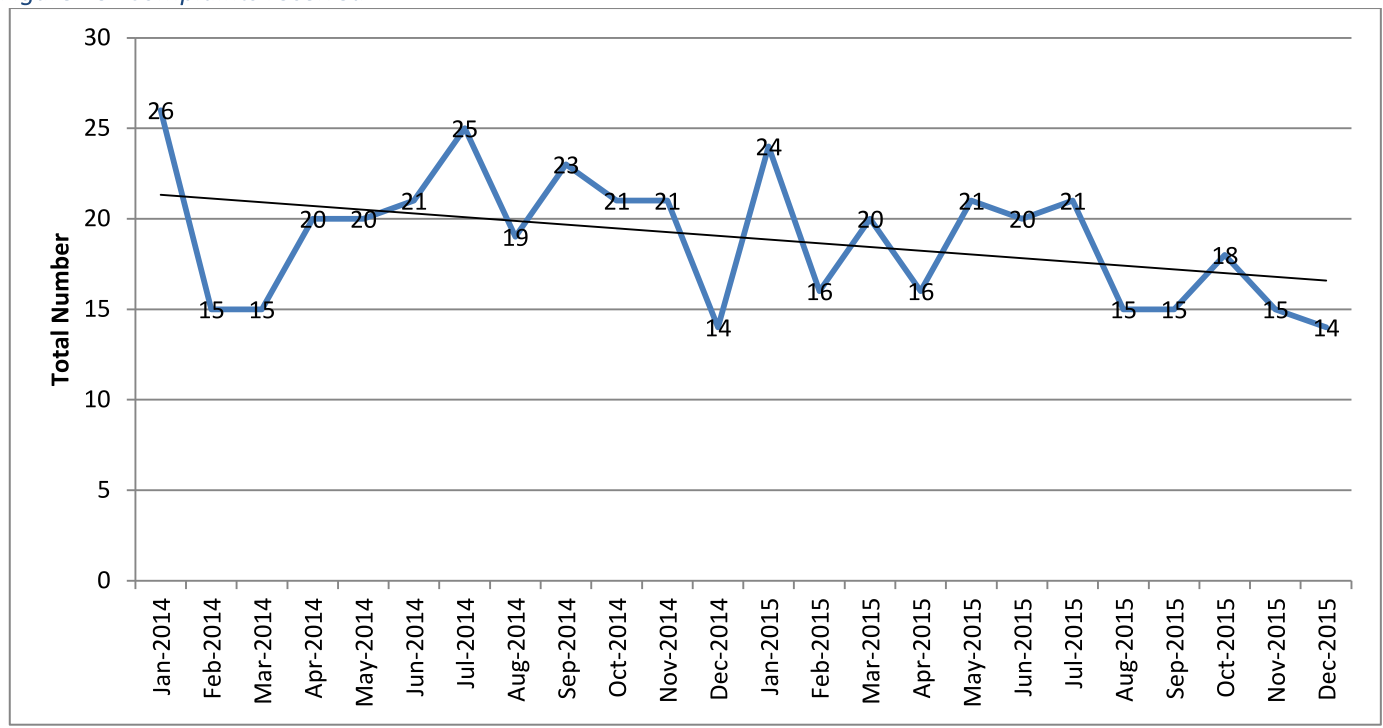


Source: Trust Performance Assurance Framework

Complaints and compliments

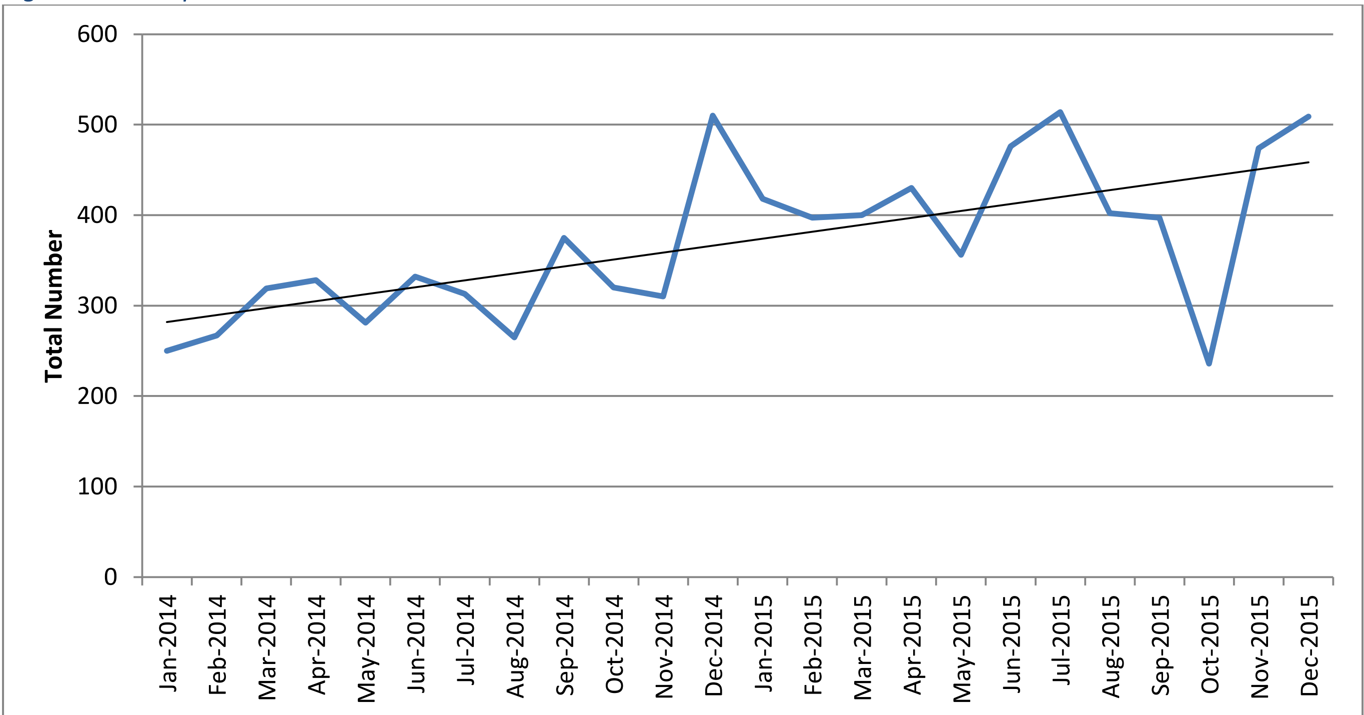
Figures 23 and 24 below detail the number of complaints and compliments received by the Trust throughout the year. As can be seen, there is a downward trend in the number of complaints received since January 2014, and an upwards trend in the corresponding number of compliments. Information on learning from complaints is recorded in Section 2 above.

Figure 23- Complaints received



Source: Trust Performance Assurance Framework

Figure 24- Compliments received



Source: Trust Compliments Reports

3.2 Monitor Authorisation

Performance in relation to metrics required by Monitor, the Foundation Trust regulator, has achieved the required targets for Q3. This relates to mental health 7 day follow up (98.5%), delayed transfer of care (1.4%), community referral to treatment compliance (99.6%), Care Programme Approach review within 12 months (96.3%) and new early intervention in psychosis cases (99 YTD).

Figure 25	2011/ 12	2012/ 13	2013/ 14	2014/ 15	2015/16 Q1	2015/16 Q2	2015/16 Q3	National Average 2015/16	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%	98.2%	98.7%	99.3%	**98.5%**	**Not yet published**	**Not yet published**

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.

Source: Trust Performance Assurance Framework

Figure 26	2011/ 12	2012/ 13	2013/ 14	2014/ 15	2015/16 Q1	2015/16 Q2	2015/16 Q3	National Average 2015/16	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%	96.7%	97.5%	**97.6%**	**Not yet published**	**Not yet published**

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 27	2011/ 12	2012/ 13	2013/ 14	2014/ 15	2015/16 Q1	2015/16 Q1	2015/16 Q3	National Average 2015/16	Highest and Lowest
The percentage of MH patients aged— (i) 0 to 15; and (ii) 15 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	9%	12%	13.3%	11.1%	8%	8.2%	**8.1%**	**Not yet published**	**Not yet published**

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

The Trust focusses on managing patients at home wherever possible and has fewer mental health beds for the population than in most areas. Sometimes the judgement to send a patient home may be made prematurely or there may be deterioration in the patient's presentation at home due to unexpected events.

Berkshire Healthcare trust 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.

Source: Trust Performance Assurance Framework

Figure 28	2011/ 12	2012/ 13	2013/ 14	2014/ 15	2015/16	National Average 2015/16	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%	3.79	**Not yet published**	**Not yet published**	**Not yet published**

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.

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.

Source: National Staff Survey

Figure 29	2011/ 12	2012/ 13	2013/ 14	2014/ 15	2015/16	National Average 2015/16	Highest and Lowest
Patient experience of community mental health services indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period	-	6.8	7.2	6.9	**6.8**	**About the same as similar Trusts**	**6.2-7.4**

Berkshire Healthcare trust considers that this data is as described for the following reasons: The Trusts score is in line with other similar Trusts
Berkshire Healthcare trust has taken the following actions to improve this 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 through a number of initiatives to improve both an individual's experience and if required to change the service provision.

Source: National Community Mental Health Survey

Figure 30	2011/ 12	2012/ 13	2013/ 14	2014/ 15	2015/16 Q1	2015/16 Q2	2015/16 Q3	National Average 2015/16	Highest and Lowest
The number of patient safety incidents reported *	**3995**	**3661**	**3754**	**3642**	**881 ***	**940 ***	**944 ***	**N/A**	**N/A**
Rate of patient safety incidents reported within the trust during the reporting period per 1000 bed days *	**19.7**	**30.2**	**32.7**	**31.4**	**32.3 ***	**30.9 ***	**23.0 ***	**Not yet published (**)**	**Not yet published**
The number and percentage of such patient safety incidents that resulted in severe harm or death *	**29 (0.7%)**	**42 (1%)**	**33 (0.9%) ***	**49 (1.3%)**	16 (1.8%) *	7 (0.7%) *	**14 (1.5%) ***	**Not yet published (**)**	**Not yet published**

Sources: *= Trust Figures **= NRLS report published MONTH 2016, covering DATES

Berkshire Healthcare Trust considers that this data is as described for the following reasons:
The above data shows the reported incidents per 1,000 bed days with the targets set based on average reporting for the year. In the NRLS most recent report published in April 2015, the median reporting rate for the cluster nationally was 32.82 incidents per 1,000 bed days (but please note this covers the 6-month period April-September 2014, for which period the NRLS gives the BHFT rate as 53.97 incidents per 1,000 bed days). High levels of incident reporting are encouraged as learning from low level incidents is thought to reduce the likelihood of more serious incidents.
Overall Incident reporting volume is in line with previous years.
The percentage of such incidents resulting in severe harm or death is slightly higher than in previous years, but is proximal to the national rate for the cluster of 1.0% shown in the most recent NRLS report, published in April 2015.
Berkshire Healthcare Trust has taken the following actions to improve this percentage, and so the quality of services, by the following:
Hosting Serious Incident learning events and online resources for clinical staff.

Figure 31 Annual Comparators	Target	2011/12	2012/13	2013/14	2014/15	2015/16 Q1	2015/16 Q2	2015/16 Q3	Commentary
Patient Safety									
CPA review within 12 months	95%	97.6%	97.9%	96.4%	96%	95.1%	98.0%	**96.3%**	For patients discharged on CPA in year last 12 month average
Never Events	0	1	0	0	0	0	0	**0**	Full year- *Source Trust patient Safety Report*
Infection Control (MRSA bacteraemia)	0	1	0	0	0	0	0	**0**	Full year
Infection Control (C.difficile due to lapses in care)	<6 per annum (reduced from <10)	15	5	5	0	0	1	**0**	Year to date C. Diff due to lapses in care
Medication errors	Increased reporting	574*	562	614	606	658	656	**699**	Cumulative total year end (15/16 Quarterly data is rolling year)
Clinical Effectiveness									
Mental Health minimising delayed transfers of care	<7.5%**	3%	1.1%	2.6%	1.5%	1.27%	1.22%	**1.4%**	Average percentage in year (15/16 Quarterly data is quarter to date total)
Mental Health: New Early Intervention cases	99	155	154	136	124	33	71	**99**	Year to date (15/16 Quarterly data is cumulative year to date for 15/16).
A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge	95%	99.6%	99.9%	99.9%	99.5%	99.4%	99.0%	**99.4%**	Year average
Completeness of Mental Health Minimum Data Set	1) 97% 2) 50%	1) 99.6 2) 97.9	1) 99.8 2) 98.6	1) 99.8 2) 97.8	1) 99.6 2) 99.2	1) 99.7% 2) 99.6%	1) 99.7% 2) 99.8%	**1) 99.7%** **2) 99.2%**	New Monitor target for Identifiers 97% for 2012/13, target for 2011/12 was 99%. (Figure is last 12m average)
Completeness of Community service data Referral to treatment information Referral information Treatment activity information	50% 50% 50%	-	-	70% 67% 99%	72.3% 62.4% 98.0%	71.9% 62.0% 96.9%	72% 62% 97%	**72.1%** **61.8%** **96.9%**	Year-end average (new 2013/14) (Figure is last 12m average)

Bolstering the internal governance and scrutiny of serious incident reports, their recommendations and action plans.
Implementation of strategies to address common findings in serious incident reports, including clinical record keeping and triangulation of patient risk information.

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

Figure 31 Annual Comparators	Target	2011/ 12	2012/ 13	2013/ 14	2014/ 15	2015/16 Q1	2015/16 Q2	2015/16 Q3	Commentary
Patient Experience									
Referral to treatment waiting times – non admitted -community***May 2013 - Updated figure to include Slough WIC	95% <18 weeks	99.9%	99.9%	98.1%	99.8%	100%	99.6%	99.6%	Waits here are for consultant led services in East CHS, Diabetes, and Paediatric services from referral to treatment (stop clock). Notification has been received from NHS England to exclude Sexual Health services from RTT returns last 12 month average
RTT (Referral to treatment) waiting times - Community: Incomplete pathways	92% <18 weeks	-	-	99%	100%	99.2%	99.2%	100%	Year-end average (new 2013/14)
Access to healthcare for people with a learning disability	Score out of 24	22	22	Green 22	Green 21	Green 21	Green 20	Green 21	
Complaints received	<25 per month	232	250	193	244	56	51	47	
Complaints	100% Acknowledged within 3 working days	100%	91.3%	93.3%	100%	100%	92%	98%	
	90% Complaints resolved within agreed timescale of complainant			64% (82%)	92 %	95%	87%	85%	2014/15 note change to indicator previously 80% Responded within 25 working days (% within an agreed time)

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

*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

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

The directors are required under the Health Act 2009 and the National Health Service Quality Accounts Regulations to prepare Quality Accounts for each financial year.
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 2015/16 and supporting guidance; 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 2015 to May 2016
2. Papers relating to Quality reported to the Board over the period April 2015 to May 2016
3. Feedback from the commissioners dated May 2016
4. Feedback from governors dated April 2016
5. Feedback from Local Health watch organisations dated April 2016
6. Feedback from Overview and Scrutiny Committees dated April 2016
7. The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2016
8. The national patient survey dated October 2015
9. The national staff survey dated February 2016
10. The Head of Internal Audit's annual opinion over the trust's control environment dated April 2016
11. CQC Intelligent Monitoring Report April 2016

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

Date ………………………………………… **John Hedger Chairman**

Date ………………………………………… **Julian Emms Chief Executive**

Quality Strategy 2014 - 16

Aims: **To provide accessible, safe and clinically effective community and mental health services** that improve patient experience and outcomes of care.

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 six elements of our Quality Strategy

1. Clinical Effectiveness

Aim: Provide services based on best practice.

Agree: To follow relevant NICE guidance and implement our policies and procedures as set out by the Trust.

We will also use quality improvement tools for example clinical audit and participate in research and development.

2. Safety

Aim: To avoid harm from care that is intended to help.

Agree: To build a culture of patient safety by being open , honest and transparent with incidents and complaints, ensuring lessons are learnt and shared.

3. Efficient

Aim: To provide care at the right time, way and place.

Agree: To review our services to ensure they're well organized and cost effective.

4. Organisation Culture

Aim: Satisfied patients & motivated staff.

Agree: listen and respond to our staff, and provide opportunities for training and development.

5. Patient Experience and Involvement

Aim: For patients to have a positive experience of our service and receive respectful, responsive personal care.

Agree: To ask and act on both positive and negative patient feedback.

Engaging people in their care, supporting them to take control and get the most out of life.

6. Equitable

Aim: To provide equal care regardless of personal characteristics, gender, ethnicity, location and socio-economic status.

Agree: To provide services based on need.

Healthcare from the heart of your community

Performance and outcomes: Outcome measures and performance against the six objectives identified will be identified through the Quality Account Priorities, CQUIN and Quality Schedule, and monitored by the Quality Executive Group and Quality Assurance Committee.

Appendix B National Clinical Audits Reported in 2015/16 and results received that were applicable to Berkshire Healthcare NHS Foundation Trust

National Audits Reported in 2015/16	Recommendation (taken from national report)	Actions to be Taken
NCAPOP Audits		
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2736)	Approximately 5,800 people die by suicide in the UK each year. Of these 1,638 (28%) are in contact with mental health services in the 12 months prior to death. 153 (9%) of the 1,638 mental health patients die by suicide on in-patient wards. There were on average 18 suicides by in-patients under observation per year in the UK over a 7 year study period. Ninety-one per cent of deaths under observation occurred under level 2 (intermittent) observation. Compared to in-patient suicides generally, patient suicides under observation were associated with personality disorder, alcohol and drug misuse, detention under mental health legislation and death in the first 7 days following admission. A third of suicides under observation occurred off the ward. The commonest location for a death by suicide on the ward was the patient's bedroom and the most frequently used method was hanging.	The report has been circulated for information to PSQ meetings. This work is also feeding into the Trust processes on safe staffing.
National Confidential Inquiry into Suicide & Homicide for people with Mental Illness (2780)	As part of its core work the Inquiry examines suicide, and homicide committed by people who had been in contact with secondary and specialist mental health services in the previous 12 months. It also examines the deaths of psychiatric inpatients which were sudden and unexplained. Previous findings of the Inquiry have informed national mental health strategies, and continue to provide definitive figures for suicide and homicide related to mental health services in the UK. The report sets out national information on suicide, and this summary is supported by local information. The current suicide rate (2011-13) in the UK is 10.1 per 100,000; for Thames Valley 9.0 and for Berkshire localities between 7.0 (WAM) and 9.0 (W Berks). Suicides in contact with mental health services have increased nationally, reaching a 10 year high, but even more so in Berkshire. Changing risk patterns across England for suicide, which are likely to be present in Berkshire also, particularly relate to middle aged males, CRHTT services, the importance of family involvement and attention to the physical health needs of mental health patients.	A full Summary Report was shared via QAC. This is in turn reported to the board where full discussions took place. Further work is being undertaken to raise the profile of this with community mental health teams and the crisis response and home treatment team.
Non-NCAPOP audits		
None		

National Audits Reported in 2015/16	Recommendation (taken from national report)	Actions to be Taken
Other audits reported on in-year (data collected in previous year(s)		
POMH - Topic 12: Prescribing for people with personality disorder (June 2014) (1340)	This re-audit aimed to present data on prescribing practice for people with a personality disorder in acute psychiatric inpatient settings, and compare this with 2012 results. The Trust showed good practice for the prescribing of Z-Hypnotics with 0% cases of the medication being prescribed for more the 4 weeks. The Trust had a high compliance rate of 100% for evidence of documented medication review. Therapeutic response and a patient's view of treatment were considered at review more often than side effect and adherence to treatment. Areas for improvement centred upon documentation for reasons for prescribing the antipsychotic medicine, crisis plans, and patient's involvement in their crisis plan. NICE guidelines state all medication is to be documented and the reasons stated if medication is continued for more than 4 weeks, the Trust identified 22% cases where the duration had not been documented. This finding was also reflected in those patients who had been prescribed Benzodiazepines	For in-patients, WRAP will address the standard that there is a written crisis plan and there is evidence that the patient's views have been sought in its development. The prescribing of medication if longer than 4 weeks and how it is to be documented and recorded will be promoted via presentation at Academic Meetings and Medical Staffing Committee. Pharmacy is to monitor prescription of Z-Hypnotics and ensure stopped after 7 days on TTA.
POMH - Topic 9c: Antipsychotic prescribing for people with a learning disability (2629)	This audit was a supplementary audit for a quality improvement programme, addressing the use of antipsychotic medication in people with a learning disability. BHFT provided data from 4 participating teams, which involved reviewing 56 patient records. The audit was measured against 3 standards:- 1: The indication for antipsychotic medication should be documented in the clinical records. 2: The continuing need for antipsychotic medication should be reviewed at least once a year. 3: Side effects of antipsychotic medication should be reviewed at least once a year. BHFT was found to have excellent compliance, and in some cases the Trust was above the national average. However, Trust compliance has decreased from the previous audit in documenting evidence of assessment of EPS and blood pressure.	A lot of work is currently being done in the Trust to improve physical health monitoring and intervention, involving training of staff and purchasing equipment. There is a potential to that this could be rolled out to the LD service. The audit results have been presented to the LD governance group and a follow up meeting has been arranged with the relevant staff to formulate actions to increase compliance in monitoring EPS and blood pressure.

Appendix C Local Clinical Audits Reported in 2015/16:

	Audit Title	Conclusion/Actions
1	Audit on the completion of multi- disciplinary team meeting forms used in the Crisis Response and Home Treatment Team (1962)	The multidisciplinary team meetings are held weekly in the Crisis Team and Home Treatment Team. MDT meetings are a key part of care planning, if these do not happen effectively, then the patient may come to harm. This project was undertaken after a SIRI investigation following the death of a patient. As an outcome of this investigation it was found that that the MDT meetings were not recorded and hence, an audit was conducted across the six sectors (localities) of the Trust to identify the current practice of completing these forms. The audit identified that MDT forms were not completed in full and localities across BHFT were not following the same process in documenting the MDT meetings. It was further identified that medical records contained notes deemed as unnecessary and no benefit to patient care. A lack of accurate and timely clinical documentation for a patient under the care of a Crisis Resolution Home Treatment Team exposes both the patient and BHFT to unnecessary risk. Actions: The Trust's CHRTT MDT form is to be redesigned. Existing and new staff are to be updates on risks surrounding poor quality documentation. Progress is to be monitored with a re-audit to be undertaken in February 2015.
2	MH CQUIN(prt1) National Audit (2094)	The national CQUIN included a new national indicator on improving physical healthcare to reduce premature mortality in people with severe mental illness. Basic data analysis on the six screening measures and interventions shows a wide variability in which screening and intervention measures patients received. There was no consistency, and a low overall percentage score reflects this. For example all patients were screened for their smoking status but 14% did not have an intervention documented (for those recorded as smoking). Action: A significant action plan was implemented, which linked with many actions from the NAS audit, which will lead to significant improvements in this area.
3	Audit of anti-infective prescribing on BHFT inpatient wards (Antibiotics) (2015) (2648)	This audit was a re-audit and part of the Quality Schedule for 2014/15. The last Trust wide antimicrobial audit was performed across all inpatient settings in November 2013 as part of the annual audit programme. It highlighted which audit standards of good antimicrobial prescribing and stewardship required significant improvements. The re-audit looked at whether relevant cultures were being taken, if drug charts recorded drug allergies, the route of administration, the dose and frequency of the drug, the stated course length and the indication and if treatment prescribed was in line with Trust guidelines. The re-audit confirmed that some improvements had been made since the previous audit. Action: The report findings are to be disseminated to the next IPCSG and DTG, and an action plan is to be developed.
4	Audit of clinical practice standards in the Psychological Service for People with Learning Disabilities 2014. (2060)	This audit looked at the Psychology Service performance against its record keeping standards. Good record keeping and attainment with standards of clinical practice is important to maintain, to ensure safe and effective provision of services. The results were compared to the previous audit. The Trust failed to achieve 100% in 4/5 standards with a decrease in performance in the standard to maintain a continuous record of risk issues and actions in RiO progress notes. Action: Findings and recommendations were discussed by the by the team and an action plan has been put into place. Those areas deemed necessary to re-audit will be carried out in 2016.
5	JD/QIP Re audit-bone density scans for female eating disorder patients referred to BAU Eating Disorder Service (2064)	Amenorrhea for over 6 months is correlated with an increased risk of osteopenia and osteoporosis which must be monitored and recorded, so appropriate treatment can be started. The objective of this re-audit was to reassess how closely the BAU eating disorder service was adhering to the NICE guidelines and whether there had been any improvement since the recommendations put forward in the last audit. For 4/7 standards the Trust achieved 100% compliance. Action: The Trust will continue to review compliance with standards via re-audit once measures have been implemented.

	Audit Title	Conclusion/Actions
6	Clinical characteristics of adolescents referred for anxiety (1630)	Adolescents with anxiety are under-researched and little is known about their clinical characteristics compared to children/adults. The finding that children and adolescents with anxiety disorders have distinct clinical characteristics has clear implications for treatment. The risk is that if best practice/latest evidence is not followed, we may persevere with treatment that is not as effective as it could be. The Trust has been carrying out diagnostic assessments since July 2012 on referred adolescents. The findings were published in a peer-reviewed journal. Action: The Report has been published in the Journal of Affective Disorders 167 (2014) 326-332.
7	JD/QIP - Audit of quality and timeliness of full discharge summaries for patients on adult wards (1924)	The objective of the audit was to evaluate the quality of discharge summaries according to a set of criteria informed by published audits on similar topics, as well as research into GP preferences concerning discharge summary information content. It was highlighted that different wards were using different templates for discharge summaries and discharge summaries were not being uploaded to RiO in a timely manner. There is potential risk as the period following discharge is a time of high risk for patients, with increased rates of suicide reported, with disruption of continuity of care associated with dramatically increased risk. Action: Audit results have been presented and will be circulated to medical staff and ward managers.
8	Audit of assessment letters sent to GP's by Clinical and Counselling Psychologists in Community OPMH Services (2724)	This audit supports other BHFT initiatives aimed at improving documentation as well as providing evidence to be shared with commissioning organisations who have previously wanted to ensure good communication between services and GPs. This audit addresses this through an audit of assessment letters to GPs written by clinical and counselling psychologists in BHFT Older Peoples Mental Health Services in each of the Trusts localities. The Trust was fully compliant across the four service standards. Action: No further action required.
9	Physical health monitoring post rapid tranquilisation (2244)	Rapid tranquillisation (RT) is when medicines are given to a person who is very agitated or displaying aggressive behaviour to help quickly calm them. The risk with RT is that it may cause loss of consciousness, loss of airway, respiratory and cardiovascular collapse. BHFT has a protocol in place which specifies the necessary physical health monitoring that should take place post RT. The aim of the audit was to document compliance to BHFT RT protocol. For each of the seven standards, the Trust was not 100% compliant. It was identified that there is a substantial shortfall between the standards set in the audit and the practice within the Trust. Action: To be raised in the DTC, to consider whether the physical health monitoring post RT needs to be added to the Trust "risk register." To raise awareness of the findings of this audit and to ensure guidance on RT is up to date and reflect practice as per the updated NICE guidelines.
10	Audit of Records on RiO for Patients Conditionally Discharged under S.37/41 of the MHA (2728)	Following an enquiry in 2014 by the Ministry of Justice to Berkshire Healthcare NHS Foundation Trust it became clear that, although Local Authorities are responsible for the provision of Social Supervision of patients conditionally discharged under Sections 37 and 41 of the Mental Health Act, BHFT is seen by the Ministry of Justice as the lead agency in Berkshire for such supervision. The audit was to ensure that effective governance arrangements for this group of patients are in place. If patient's records do not actively reflect the information around risk and other areas effectively, then patients may be at risk. The initial audit found evidence of good practice and high compliance rates in the management of conditionally discharge patients. However, the re-audit showed deterioration in the timeliness, completeness and quality of the clinical records. Action: An action plan has been agreed to improve case management processes, with a review to be undertaken six monthly.
11	Retrospective Audit on Neuro-imaging in Charles Ward inpatients (1576)	The audit aimed to measure the current practice of assessment and management of people with suspected dementia against the NICE Clinical Guidelines 42 in an Old Age Psychiatry inpatient setting. Guidelines advocate the use of radiology in combination with history to aid diagnosis and management of patients with dementia. The audit highlighted the fact that patients with possible dementia /cognitive impairment may remain undiagnosed or not accurately diagnosed if they do not have a full examination that includes a brain scan. Action: Relevant recommendations have been made and all actions completed.

	Audit Title	Conclusion/Actions
12	Audit of Urinary Catheter Care Bundle - Community Services (March 2015) (2842)	The aim of this clinical audit was to assess compliance of documentation with the standards set out in the Trust policy through review of documentation on the catheter care bundle. The audit included all patients with a catheter who received care from BHFT healthcare workers in the community setting. The audit found 5 criteria where 100% compliance was achieved; there were 6 areas where compliance had improved since the initial audit and 4 criteria where compliance was lower in comparison to the 2013/14 audit. Action: An agreed action plan to improve documentation and understanding of the care bundle.
13	School Nursing RK Assessment Audit (2588)	Good record keeping is an integral part of clinical practice and is essential to the provision of safe and effective care. This audit has been undertaken as part of BHFT School Nursing Sub Group following the implementation of new assessment templates across all six localities. The aim of the audit was to assist with the quality assurance and development of the School Nursing assessment process and recording. The audit identified training needs across staff with regards to fully completing assessments and updating all required fields on RiO and general record keeping training. Action: Staff training has been agreed in the relevant areas, the assessment form has been modified to ensure all data is captured. There is to be continuous evaluation of the School Nurse assessments.
14	An evaluation of psychiatric admissions from the RBH (2722)	The aim of the audit was to evaluate whether the increase in funding for Psychological Medicine could produce savings by decreasing the number of unhelpful admissions to Prospect Park Hospital. The audit confirmed that Psychological Medicine continues to be an important factor in decreasing unhelpful or damaging admissions from RBH to Prospect Park and thus ensuring appropriate care is given to 'high risk' patients only and potentially impacting on saving of costs.
15	JD-QIP - Psychiatric In-patient Patient Physical Health Assessment Audit (1791)	There is increased morbidity and mortality among patients suffering from mental illness. Physical healthcare is a key issue to be reviewed amongst this patient population. The Royal College of Psychiatrists recommends that all patients admitted to a psychiatric hospital should receive a full physical examination on admission, or within twenty-four hours of admission. A snapshot audit was carried out at Prospect Park Hospital in Reading, which highlighted that The Royal College of Psychiatrist's recommendation, along with Trust guidelines regarding physical examination were not being met, with only 78 out of 111 patients (70.3%) undergoing an examination during their admission. A psychiatric inpatient physical health assessment sheet (PIPHAS) was designed and introduced, providing a quick and standardised approach to the documentation of a physical examination. Following introduction of the PIPHAS form there was an increase in the number of patients undergoing physical examination on admission to hospital (75 out of 100 patients, 75% - an increase from 70%). Action: The project highlighted the requirement to implement the PIPHAS form, and its impact then evaluated.
16	JD/QIP Service evaluation of Memory clinic's telephone activities in WAM (2052)	The purpose of this service evaluation was to check if the memory clinic's service demand is beyond the memory service's remit. The main reasons for telephone contacts were clarified and action required following those calls was noted. This was to help identify the most common problems arising between appointments and the resources required. It was highlighted that follow up actions and the length of telephone calls place an impact on the work load of memory services which is likely to increase over time. Action: Action is to be agreed.
17	JD/QIP Provision of information (written and verbal) to patients at PPH when commenced on drug treatment (2101)	The Royal College of Psychiatrists stipulates in their guidance that patients should be provided written and verbal information on the treatment they are receiving. The purpose of the audit was to explore medical records over a wider range of time to see if when changes to medication are being made that this is accompanied by provision of information both in verbal and written forms. The main finding was that when new psychotropic medication was prescribed it was not documented whether the patient had received any written information although in some cases verbal information was provided. Those patients that lacked capacity were not provided with any information about the drug. There is a risk to patients who are not provided with information, that they be less likely to be compliant with their medication. Action: Action is to be agreed.

	Audit Title	Conclusion/Actions
18	Can known use of data logging increase hearing aid use (1833)	It is presented in literature that patient knowledge of data logging improves accuracy of self-reported Hearing Aid use. The aims of this study were to investigate whether patient knowledge of data logging increases daily amount of Hearing Aid use, and leads to more accurate estimates of self-reported Hearing Aid use. The study concluded that patient knowledge of data logging does not influence Hearing Aid use; and new Hearing Aid users are relatively accurate with their estimates of self-reported Hearing Aid use; irrespective of whether they are aware or unaware of data logging verification. Action: The audit report has been shared to CEG.
19	Annual Service Activity Report for The Psychological Service for People with Learning Disabilities (2013-2014) (2059)	The Psychological Service for People with Learning Disabilities in Berkshire completed a report of its activities annually since 2008. The aim of this report was to summarise the activities of the Service for People with Learning Disabilities (the Service) over the course of the period starting on 1 April 2013 and finishing on 31 March 2014. This identified projects undertaken, referral patterns and client related activities and Service evaluation (i.e. HoNOS-LD, PES). It is noted that no risks were identified to the Trust from this report, by the authors Action: A number of agreed recommendations to manage the referral process more effectively have been put in place.
20	LD Services; Re-Audit: People who Present Severe Challenging Behaviour: Positive Behaviour Support ICP - April 2015 (2188)	The aim of this re-audit was to demonstrate that good practice recommendations are used with people whose behaviour challenges. The audit included the process of assessment and intervention. Overall, the audit demonstrated areas of excellent practice with findings in the 90 - 100% compliance range. However, the audit highlighted that there are still areas where achieving consistent practice has proved difficult. Action: These areas will be followed up within the Clinical Audit Action Plan 2015/16.
21	MSNAP Audit of communication,& assessment of consent and capacity of patients attending Wokingham Memory Clinic (2696)	Wokingham Memory Clinic achieved an excellent rating by the Memory Services national accreditation Programme (MSNAP). This audit was to monitor that the service is maintaining excellent standards in terms of verbal and written communication and assessment of capacity and consent. Only new patients were assessed. 100% compliance in all of the standards was met. Action: No further action is required.
22	Quality schedule audit of referrals to Memory Clinic and compliance with NICE and MSNAP standards (2697)	The Prime Minister's Challenge on Dementia issued in 2012 set out an ambitious programme of improvements to be made to dementia care over a three-year period, including improved diagnosis rates. The aim of the audit was to look at the percentage referred with mild and moderate dementia and MCI as a reflection of timely diagnosis. All of the standards were met in the audit. Action: Findings of the audit report were to be disseminated to the OPMHS Clinical effectiveness Group.
23	JD/QIP - Rapid Tranquilisation in older adults - re-audit (March 2015) (2691)	The use of rapid tranquilisation in older adults at Prospect Park was audited in 2013. Our compliance with the standards set out by the Trust were reviewed, and we only reached 100% compliance in 3 out of 11 of the standards. This is a re- audit, to identify whether there have been any changed to our practice since instating the following action plan one year later. The audit identified slight improvement in the results of the re-audit in comparison with the previous audit, despite an action plan having been implemented that involved numerous clinical staff. Action: An action plan has been put in place with the setting up of a steering group in order to develop actions to bring about improvements.

	Audit Title	Conclusion/Actions
24	JD/QIP - Referrals and outcome audit (April 2013) (1438)	NHS England became responsible for commissioning CAMHS inpatient beds nationally from April 2013. Prior to April 2013 this was done on a population basis (Primary Care Trust/ Specialised Commissioning Group). The Berkshire Adolescent Unit was not included in the national bed stock. The audit sought to identify the number of patients referred to all services at BAU, what services were offered and to identify whether the implementation of the NHS England inpatient network would have any short term impact on the Trusts referral pattern. The audit found a percentage of missed appointments and unnecessary appointments being made. In addition, the need to educate staff about pathways was highlighted. It was suggested that pathways may need amending to ensure that non-applicable patients are prevented from continuing to receive appointment and that the existing pathway is appropriate. Action: An action plan has been agreed to improve appropriateness of referrals, and DNAs, and a re-audit is scheduled once all actions have been implemented.
25	An audit of model fidelity in Crisis Resolution Teams (1559)	This fidelity measure was developed from research evidence, government and expert guidelines, a survey of CRTs in England and interviews with all key CRT stakeholder groups. The risk of non-compliance may mean services are not cost effective. BHFT's overall score was 101, with the maximum score possible being 195. Actions: A number of agreed action plans –around staffing and assessment - for CRT have been developed.
26	Quality Schedule Audit into failed patient self-taken tests on the East Berkshire Chlamydia Screening programme (2227)	The CSP is responsible for developing effective self-taken test kits for Chlamydia & Gonorrhoea aimed at the under 25 population of East Berkshire. The audit identified that the instructions on the test kits need to be clearer, the need to review the method of testing requests via primary care and other clinical areas and to review clinical and non-clinical training standards to make sure IR is included. Action: The highlighted findings have resulted in a number of agreed actions. These include pictorial representation, and electronic ordering systems.
27	Evaluation of 'One chance to get it right' (scoping of end of life care). (2289)	The philosophy underlying "one chance to get it right" (OCTGIR) is that providing end of life care is everyone's business. Structured around 5 priorities all focussing on supporting the dying person and their families and carers, the five priorities of care are– dying recognised, excellent communication, with involvement and support of patients and families, and that patients have an individual and holistic plan of care. Following the audit of 34 Recommendations from One Chance To Get It Right (OCTGIR) an action plan was developed highlighting the main areas of development. The BHFT EOLC group will continue to develop a BHFT EOLC policy and BHFT Individualised EOLC plan. A review of training needs and EOLC training that is available needs to be undertaken. Action: Action is to be confirmed.
28	JD/QIP - Audit of driving safety advice given to patients at Prospect Park Hospital (2450)	National Driver and Vehicle Licensing Agency (DVLA) guidelines recommend that patients fulfilling certain criteria are legally obligated to report themselves if they believe they are unfit to drive. Driving when medically unfit is against the law and continuing to drive may pose a significant risk of danger to self and to others. It is good practice that staff are meant to advise patients on their driving fitness, and are encouraged to report patients if they continue to drive when they should not be. This should then be documented in notes for accurate record keeping. The purpose of the audit was to assess staff awareness of DVLA guidelines and to review documentation for evidence of driving advice given to patients. The audit found that 100% of staff surveyed did not give advice to patients within the last six months. Action: An agreed action plan is to be confirmed.

	Audit Title	Conclusion/Actions
29	Infection Control: Hand Hygiene Facilities (2784)	Following a gap analysis of NICE Quality Standard 61- Infection Prevention & Control the need for a review of hand hygiene facilities through an audit was identified. A total of 1841 hand wash bins were assessed and were fully complaint against the audit tool. The main area of non-compliance associated with cleanliness of the hand wash areas. Action: Agreed action is to be confirmed.
30	Monitoring allocation of complex & routine ADHD cases in ADHD pathway in CAMHS since NGC (Aug 2013) (1553)	The aim of the project was to study workload allocation on ADHD pathway and to establish if guidelines for ADHD pathway, NGC (next generation care) are followed. The project findings led to the below advisory recommendation. Action: Clinicians in ADHD pathway are to check their cases and allocate to appropriate clinicians in the ADHD pathway. If needed, they will discuss this with their supervisors.
31	Resident Experience Audit (Papist Way) (August 2013) (1556)	The decision has been made to close this project despite not receiving an update on whether actions were achieved due to this now being old data, the audit lead having left the Trust, and Papist Way since having been outsourced. (Old project following update)
32	Re-audit of compliance with Trust guidelines on monitoring patients receiving Antipsychotics (1573)	The was a re-audit and the aim was to optimise the physical health of inpatients prescribed on-going antipsychotics; and to ensure that relevant investigations are offered to inpatients receiving on-going treatment with antipsychotics. The Trust was fully compliant with all the audit standards.
33	Audit to Ensure the Quality of Preliminary Discharge Letters from MH Inpatients to GPs (1575)	This audit aimed to assess the effectiveness of the use of electronic preliminary discharge letter, to improve communication and reduce errors when discharging patients for psychiatric inpatient units to the community. The audit found that despite implementation of a new form to resolve issues of poor communication and errors, the form was not being fully completed, thereby continuing to lead to potential risks on discharge due to lack of information regarding safeguarding, named care coordinator and psychiatrist, and long term and depot medication details. Action: Action is to be agreed.
34	Re-Audit: People who Present Severe Challenging Behaviour. Formulation Planning Process (April 2014) (1715)	This is the fourth cycle of this audit and its aim was to demonstrate that good practice recommendations were used in the assessment and intervention for people who present challenges to services. The audit resulted in the Winterbourne Interim Report which advocates as best practice the use of Positive Behaviour Support. Recommendations from the report were presented to the Learning Disability governance meeting and a completion of an audit action plan. Action: The action plan included implementation of the outcome measures in the team, and improvement to DOLs processes. The audit was repeated in April 2015.
35	JD/QIP - Audit of quality and timeliness of full discharge summaries for patients on adult wards (1924)	The objective of this audit was to evaluate the quality of discharge summaries according to a set of criteria informed by published audits on similar topics, as well as research into GP preferences concerning discharge summary information content. There were some areas of significant improvement compared with the previous audit. The audit found that different wards were using different templates for discharge summaries. Action: An action plan is in place, which includes sharing of findings, and work on the discharge summary template.

	Audit Title	Conclusion/Actions
36	Blood transfusion bed side audit (2506)	The aim of the audit was to ensure that BHFT's blood transfusion practice is in line with the required National Standards. The initial audit was carried out in October 2012 and January 2013. Re-audits were undertaken during November and December 2013, January 2014 and March 2014. The 2014-15 audit was carried out in February and March 2015. The Trust was fully compliant with twenty-two of the twenty-eight standards the service was measured against. Action: A number of agreed actions have been discussed and implemented, around the transfusion care pathway.
37	JD/QIP - Audit of Clinic Letter to Patients/Relatives in the Slough Joint Memory Clinic (2685)	It is important for patients or their carers to be well aware of what has been discussed in clinics and what the plans are and has been a standard that all patients should have access to the letters sent to the GPs. The aim of this audit was to assess the current standard of writing clinical letters to patients or carers in the Slough Joint Memory Clinic and whether it met the local Berkshire Healthcare Trust Guidelines and national guidelines. The Trust was fully compliant. Action: No action is required.
38	Delirium NICE Quality Improvement Project (2726)	Delirium, also known as 'acute confusional state', is a common clinical syndrome characterised by disturbed consciousness, cognitive function or perception which has an acute onset and fluctuating course. Its prevalence tends to rise with increasing age. It is a serious condition that may be associated with poor outcomes if not effectively identified and managed. BHFT hosts a number of wards that manage patients that are at risk of or have been diagnosed with delirium. The aim of the project is to improve the outcome and experience of patients at risk of or diagnosed with delirium by ensuring that best practice is followed in line with NICE Quality Standard 63- Delirium (July 2014). 100% compliance was achieved for prescribing appropriate medication for patients with delirium and the diagnosis of delirium was communicated to their GP on discharge. Areas for improvement were based upon assessment of delirium on admission, assessment of all clinical factors within 24hs of admission and ensuring that tailored interventions were given to patients to prevent delirium. Recommendations to address the findings have been made and include the delivery of delirium awareness training for all relevant inpatient wards/ units and the development of a patient information leaflet that can be given to all patients diagnosed with delirium, as well as their family members. These recommendations have been written into an action plan attached to the main report.
39	Evaluation of Falls Risk Assessment Tool at Oakwood (2870)	Oakwood has a high instance of patient falls in comparison to other wards within BHFT. The ward has felt this links directly with the environment and there has been continual work on reviewing instances and evaluating what measures can be put in place to reduce falls. This is also now reflected trust wide on the quality schedule where there is an expected reduction required in number of falls across community hospitals as a whole. The consequences of falls are high for patients and staff and therefore it is a priority to continue to look at ways to reduce further instances. A wristband trial as a falls prevention tool was put forward as an opportunity to reduce incidence of falls on Oakwood inpatient ward. However, this did not provide any additional benefits for patient or staff – therefore this will not be continued. The review found that there was poor compliance with the falls prevention care plan. The main areas are lying/standing, blood pressure (BP) and urinalysis not being completed. Action: An agreed action plan has been put in place.

	Audit Title	Conclusion/Actions
40	High Dose Antipsychotic Audit 2015 (2661)	In 2010, Berkshire Healthcare NHS Foundation Trust (BHFT) introduced high dose antipsychotic guidelines and a monitoring form, following less favourable local results in a national POMH-UK re-audit on the prescribing of high dose antipsychotics. Soon after introducing the guidance, the Trust POMH-UK high dose antipsychotic audit results showed marked improvements and BHFT were considered a high performing organisation. This audit looked at the rate of compliance to the high dose antipsychotic monitoring guidelines in BHFT by reviewing all inpatients at Prospect Park Hospital. Data was collected in February 2015. The findings from the audit highlighted that there is significant room for improvement across all the set standards. Areas of concern included, poor documentation, lack of documentation surrounding the prescribing of high dose antipsychotics for a patient and what monitoring is required and lack of appropriate monitoring (and documentation of monitoring) i.e. whether the nurses are made aware of the patient being prescribed high dose antipsychotics and what monitoring they are required to undertake. Better communication (verbal and written) is needed to ensure that nursing staff are aware when increased monitoring is necessary for particular patients. Action: Non-compliance needs to be swiftly addressed as significant levels of risk exist for patients prescribed these medications if not properly monitored. As a result of the audit a number of agreed action plans have been put into place to increase compliance in this area.
41	Audit of Cardio-metabolic Risk Screening for Patients on Anti-psychotics in the Slough Pathways Outreach Team (2871)	The aim of the audit was to ensure cardio-metabolic risk parameters are being monitored at least annually and interventions provided if positive risks are identified for patients with psychosis on antipsychotic drugs in an assertive outreach team. The National audit of Schizophrenia 2014 (NAS2) was used as a comparison tool. The results show that apart from smoking and blood pressure, a higher percentage of patients in SPOT were screened for BMI (body mass index), glucose and lipids than the NAS2. Similarly, apart from BMI, interventions were offered to a higher percentage of SPOT patients compared to the NAS2 sample for smokers, abnormal glucose, lipids and blood pressure with a 100% standard being met for glucose and blood pressure. The audit found that barriers to screening and conducting the audit cantered upon problems accessing the data easily, lack of an integrated form in RiO to document information and problems accessing information via primary care. It was highlighted that in terms of training of staff it is ensured any change in guidance for diabetes, cardiovascular health and lipid modification is updated and communicated. It was found that it would be helpful if a systemised approach within the team to provide the necessary screening at the right time. Organisational change is essential to facilitate improvements in monitoring by reviewing RiO documents, training and working towards shared care protocols for physical health monitoring of patients with psychosis between primary and secondary care. Action: As a result a number of agreed action plans have been discussed implemented.
42	Audit of Crisis Resolution Home Treatment Team for Unlicensed Use of Antipsychotics (2144)	The Crisis Resolution and Home Treatment Teams (CRHTTs) often manage complex patients in the community who require intensive pharmacological treatment and often have changing and complex psychotropic medication needs. The audit followed the auditable process of ensuring that upon referral to the CRHTT, patients' GP Summaries or Summary of Care Records (SCRs) are obtained and uploaded to the patients notes in a timely manner to assist with the safe and effective treatment of the patient; medicines reconciliation on admission to mental health acute wards is a routine part of care co-ordination and admission to CRHTT and other mental healthcare teams; all prescribing should be recorded appropriately. The audit found some areas for improvement with regards to GP summaries or SCRs not being available, no documented evidence of health checks and monitoring requests and issues regarding patient safety and the extent of the patient notes for clarity and communication to other healthcare professionals. Action: An action plan is in the process of development.

	Audit Title	Conclusion/Actions
43	Audit of Intravenous therapy practice in community hospital wards with BHFT (2078)	This audit was carried out to look at clinical practice relating to IV therapy delivered within the community hospitals. As well as providing assurance of the compliance to external and internal standards of the IV therapy that is being delivered. The data collection was for 3 months beginning of November 2014 until the end of January 2015. The audit results showed that work is required in most areas to ensure 100% compliance with all standards is achieved. Areas identified were to establish why some wards were not giving IV therapy, to Improve prescribing of all aspects of the treatment plan and improve correct usage of VIP score. Action: A re-audit of the IV practice is to be arranged.
44	JD/QIP - Assessment and Management of Pain in patients with Dementia on a psychiatric inpatient ward at Prospect Park Hospital (2727)	The aim of the audit was to improve care that patients with dementia receive when they are admitted to a psychiatric ward, by ensuring their pain is effectively managed. The audit measured: 1. Percentage of patient days where there has been a documented pain assessment from patient's notes, drug cards and observation charts over a time course of the previous 2 weeks. 2. Percentage of drug charts that have appropriate step up analgesia prescribed for nurses to administer in case of moderate to severe pain. 3. In cases where moderate to severe pain documented, percentage that have follow up documentation to say pain has resolved or further investigation of cause is required. Key Findings from the Report were that pain is not assessed regularly as recommended by guidelines in the findings of this audit; if a pain assessment is documented, it is often only when the patient verbally volunteers the information; when patients do complain of pain, they are not routinely re-assessed and patients are not all prescribed appropriate step up analgesia. Action: An agreed action plan has been agreed and implemented for pain to be assessed via a pain assessment tool when observations are being recorded, intervention of analgesia if there is severe pain and doctors to prescribe PRN analgesia for all patients.
45	Re-audit of Records on RiO for Patients Conditionally Discharged under S.37/41 of the MHA Report Audit (February 2015) (2955)	This is a second re-audit looking at the progress made since the first re-audit which suggested deterioration in the timeliness, completeness, and quality of the clinical records. Recommendations and oversight of implementation of this was put in place at the time. 10 records per locality were audited. Overall, the findings were positive and a significant improvement on those of the previous audit. The overall findings were reported through Quality Executive Group, and were fed back to individual localities directly. The audit will be done on a yearly basis and provide a governance trail. Action: An action plan is in development.
46	UN Nations International Children's Emergency Fund (UNICEF) BFI Standards - Slough Locality (2837)	This audit has been undertaken as part of BHFT Health Visiting service, East localities working towards gaining full accreditation Baby Friendly Status. The audit aimed to give a baseline for all the health visiting areas that clients attend where they may receive breastfeeding assistance or have the need to breastfeed their baby within these areas as well as key areas that the service refers them to such as audiology. The baseline audit demonstrated excellent standards of practice across all BHFT sites and Children Centres with only minor additions needed to meet the full requirements for the environment. Action: An action plan is in development.
47	Annual Service Activity Report for the Psychology Service for People with Learning Disabilities 2014-2015 (2718)	The aim of this service evaluation was to review the activities of the Psychological Service for People with Learning Disabilities in Berkshire over the course of the period starting on 1 April 2014 and finishing on 31 March 2015. Following the previous Annual Service Activity Report, the Service actioned the recommendations agreed, the review established that the service has implemented these actions effectively. However, the completion of HoNOS to measure the outcome in all cases involving an intervention at assessment and closure is low at 39.3%. Action: The service will continue to update the referral spreadsheet, complete the HoNOS-LD measure and will continue to monitor and review referrals.

	Audit Title	Conclusion/Actions
48	Consent to ECT Re-audit (2290)	This was a re-audit to monitor the current standard of obtaining ECT, to ensure BHFT adheres to the national guidelines for compliance and to ensure all patients have a capacity assessment and relevant documentation prior to ECT to ensure consent is valid. The re-audit showed that the Trust has 100% compliance against all the standards. Action: No action required.
49	ECT clinical Global impression scale survey (2288)	ECT Department at Prospect Park Hospital is responsible for the provision of ECT treatment to all BHFT patients. This department has been assessed and awarded excellence status by RCP ECTAS (Royal College of Psychiatrist- ECT Accreditation Service) and has maintained this status for seven years, last awarded in March 2014. The review was to evaluate the ECT treatment response and efficacy of treatments in treatment studies of patients with mental disorders. The results showed that 95% of patients showed clinical improvement according to this survey. The Trust will continue to evaluate ECT treatment using CGI survey and will repeat the survey annually. Action: No action required
50	JD/QIP - Audit of driving safety advice given to patients at Prospect Park Hospital (2450)	This audit aimed to assess the level of information given to patients by staff at Prospect Park Hospital and to assess the level of staff awareness of DVLA guidelines. DVLA guidelines recommend that patients fulfilling certain criteria are legally obligated to report themselves if they believe they are unfit to drive. Driving when medically unfit is against the law and continuing to drive may pose a significant risk of danger to self and to others. The audit established that 73.3% of doctors and 36% of nurses were aware of DVLA guideline. 47.5% of the total 40 surveyed gave driving advice to patients at least once before discharge. No one had given advice to 100% of their patients within the last 6 months. As a result a teaching session for medical staff, nursing and support staff is to be implemented. Action: An agreed action plan has been put in place, via a teaching session, to place posters in clinical areas, distribute leaflets and re-analyse the data within 3 months after the changes have been implemented.
51	JD/QIP - Audit of recording of capacity and monitoring of time taken to complete clinic letters (2596)	This audit looked at clinic letters of patients seen by CMHT clinicians, assessing which patients attended the clinic and how quickly the letter was sent to their GP. When clients are seen at the CMHT by clinicians, the letter written to the GP details important information on their progress, mental state examination, risk assessment and future management plan, including any medication changes. The standard for all clinic letters to be communicated within 3 working days was set at 100%. The audit found that 68.3% of clinic letters were communicated to the GP with 3 days, 31.7% of clinic letters were sent later between 4 and 24 days. Action: An agreed action plan is in place, with the use of DOCMAN for those GP surgeries that have access to this, for all letters that contain medication changes or other changes in the client's risk or management plan are to be faxed to the GP. A re-audit is planned for the following year.
52	JD/QIP A clinical audit on Driving and Dementia (2080)	The aim of this project was to evaluate the documentation of the proportion of patients who are taking memory enhancing medication and documented as driving, who have not been advised to inform the DVLA when they should have been. The audit showed that 29% of patients were found to have no documented evidence of their driving status or any information on driving given. Action: The results of the audit have been presented and a re-audit was due in six months' time.
53	Management of Young People in the sexual health service (2694)	The audit aimed to review the management of those aged 18 and under within the sexual health service and to ensure that BHFT performance is within the recommended guidelines. Data was collected over a two month period July-August 2014. The review established that a larger proportion of young females attend the clinic than males, STI screening was completed for only 48% of people and a CSE risk assessment pro-forma was completed in only 35% of cases. In addition a fully electronic system needs to be implemented as the current system is outdated and is producing inaccurate data. Action: An agreed action plan has been put into place.

	Audit Title	Conclusion/Actions
54	Re - audit of use of Dementia Assessment Integrated Care Pathway in Learning Disability Services (2692)	This re audit was to look at the use of the Dementia Assessment Integrated Care Pathway on referrals received by the service in 2014. People with learning disabilities are at greater risk of developing dementia than the general population. The Trust did not meet 100% compliance for completion of the 12 areas included in the Dementia Assessment ICP. Action: An agreed action plan has been put in place covering feedback of the results to key clinicians, training for relevant teams on using the ICP, and uploading of the ICP paperwork onto RiO.
55	Compliance with faculty audit standards for emergency contraception provision (2104)	The aim of the audit was to assess if women are offered emergency contraception for the prevention of unplanned pregnancy. Clinically the FSRH guidelines should be followed and standards adhered to. Only 50% of women presenting for emergency contraception were offered an IUD. In addition, better use of the pro-forma is required to document cycle length. Action: An action plan is currently under review.
56	Management of Gonorrhoea in the sexual health service. (2625)	National service standards for sexual health services in UK have defined a set of quality outcome Indicators that have been adopted by Berkshire commissioners as benchmarks for East Berkshire Sexual Health Service. Standard 14 relates to Percentage of people who are NAAT (nucleic acid amplification test) positive for Neisseria gonorrhoea who have a culture performed. This audit is required on a quarterly basis. The compliance rate is 90%. The audit achieved a 93% compliance rate. Action: No further action is required.
57	The impact of the 2011 BASHH PEPSE guidelines - local re-audit (1881)	The re-audit aim was to review documentation of partners HIV treatment status following the institution of an updated PEPSE prescription proforma, and secondly, to compare PEPSE outcomes to BHIVA/BASHH auditable standards. The re-audit results showed an increase in compliance rates across the standards. Action: No further action is required.

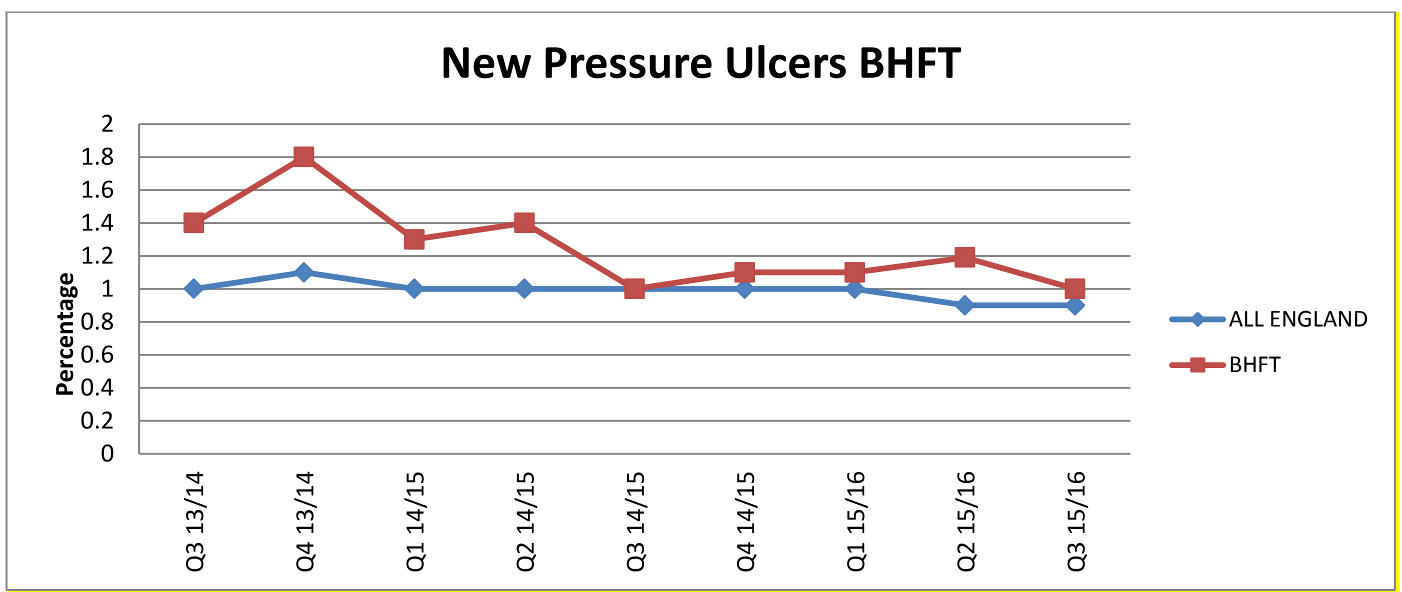
Appendix D Safety Thermometer Charts

Below are the figures for the year on the number of patients surveyed

Data capture period	Number of patients surveyed	Harm free care in Berkshire Healthcare	Harm free care nationally
Q3 2015/16	3819	94.4%	94.2%
Q2 2015/16	3960	93.2%	94.2%
Q1 2015/16	4093	93.4%	94%
Q4 2014/15	4089	93.2%	93.9%

Source: Trust Safety Thermometer Reports

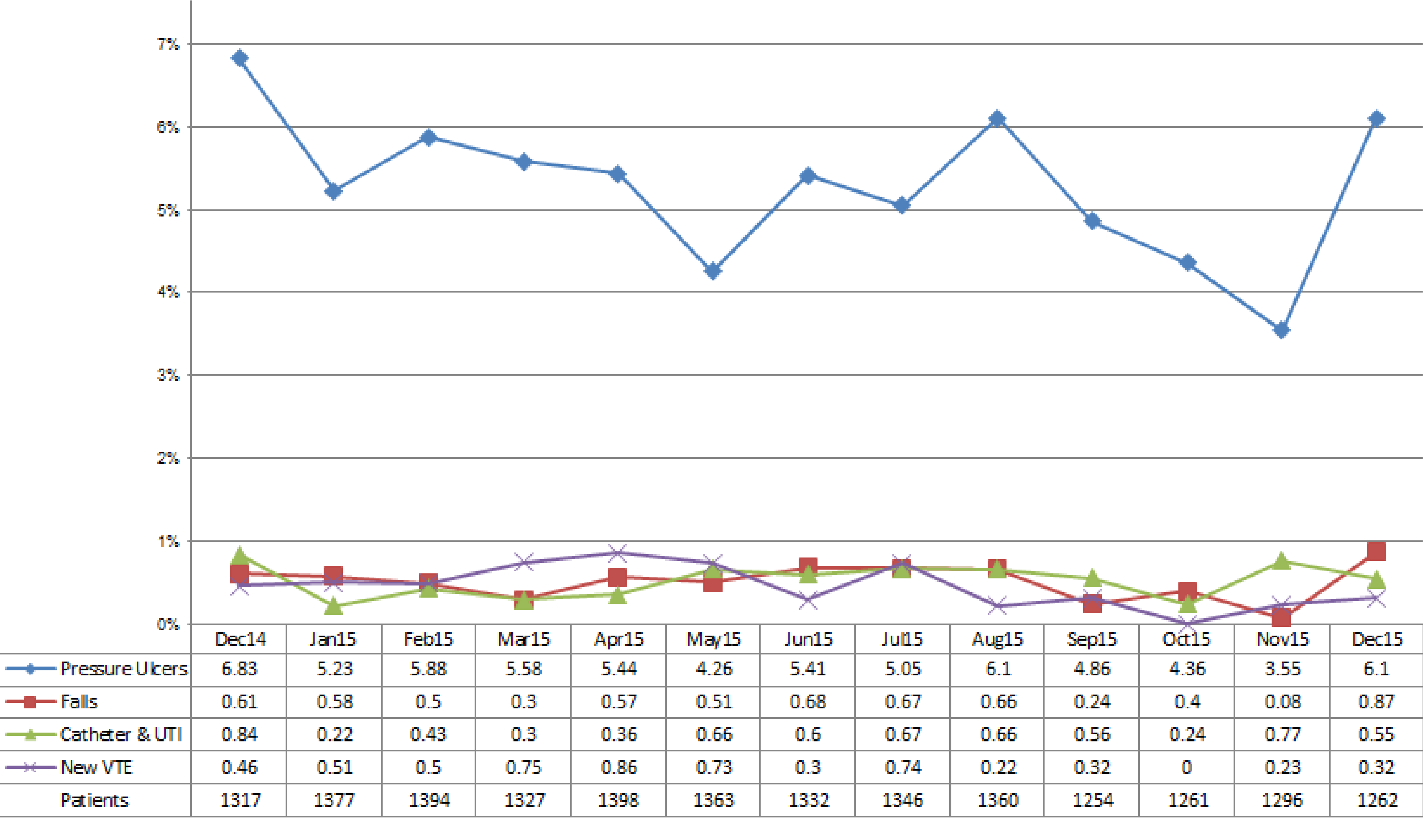
When compared nationally the data shows that the Trust has a higher percentage of *new* pressure ulcers, but the gap is closing as can be seen below.



Source: Trust Figure- Safety thermometer, All England Figure- HSCIC Pressure Ulcer Reports

Types of harm

The chart below splits the types of harms across the whole organisation. Pressure ulcers remain the highest harm



	Dec14	Jan15	Feb15	Mar15	Apr15	May15	Jun15	Jul15	Aug15	Sep15	Oct15	Nov15	Dec15
Pressure Ulcers	6.83	5.23	5.88	5.58	5.44	4.26	5.41	5.05	6.1	4.86	4.36	3.55	6.1
Falls	0.61	0.58	0.5	0.3	0.57	0.51	0.68	0.67	0.66	0.24	0.4	0.08	0.87
Catheter & UTI	0.84	0.22	0.43	0.3	0.36	0.66	0.6	0.67	0.66	0.56	0.24	0.77	0.55
New VTE	0.46	0.51	0.5	0.75	0.86	0.73	0.3	0.74	0.22	0.32	0	0.23	0.32
Patients	1317	1377	1394	1327	1398	1363	1332	1346	1360	1254	1261	1296	1262

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Source- Safety Thermometer

Appendix E CQUIN 2015/16

Indicator Number	Indicator Name	Description of indicator
Local 1	Children's transition (physical and mental health)	BHFT children's services will, where relevant to the needs and wishes of young people, work jointly with internal and external services in supporting global transition to Adult services in accordance with national guidance described in 'Moving on Well', through multi agency participation in Person Centred Health Care Plans. This would include all BHFT professionals involved in the care of young people taking responsibility for referral of identified physical and mental health conditions to appropriate services linked to their specialities. The role of Health Plan Coordinator will be agreed according to the criteria within 'Moving on Well' and based on the identified 'most significant area of need'. The end outcome of this programme, and that which will be measured, will be an increase in the percentage of young people who report the transition process as having been a positive experience.
Local 2	Hydrate	To ensure that patients hydration is given a high priority and its importance is understood by staff as well as patients and carers. Information regarding importance of hydration will be readily available on the ward and discussions will be had with patients/carers on admission, throughout their stay and prior to discharge. All patients will have a risk/ needs assessment and care plan if risk identified. Where this identifies a need for supervision and support to achieve sufficient hydration, a user friendly chart to monitor intake will be implemented. It is important that patients and their carers understand the reasons for adequate hydration. Therefore the purpose of the hydration chart is to provide some patient ownership where possible with the aim that they will understand the importance of hydration and maintain their fluid intake following discharge. A staff education programme will be undertaken by the Trust in order to support the launch of Hydrate. This CQUIN will include patients on all community health and older adult wards. In quarter 4 the Trust will communicate any learning from the project with staff working in the community.
Local 4	Smoking Cessation	To improve the physical health of Mental Health inpatients (Prospect Park) by offering Nicotine Replacement Therapy (NRT) to those patients who have been identified as being smokers, and to provide NRT to those who agree to commence this treatment within 2 hours of admission to an

Indicator Number	Indicator Name	Description of indicator
		inpatient area. This is an option to assist in abstinence of tobacco whilst on the ward. This will exclude Learning Disabilities and those who lack mental capacity to make the decision.
Local 5	7 Day working	1.The treatment plan of all new admissions under a section will be reviewed, on the phone, by the on-call Consultant between 5pm and 12 midnight, 7 days a week (this includes adult and Older Adult patients and also those admitted under section MHA) 2. Weekend medical cover will be enhanced with Consultant/ Specialty Doctor presence on site at PPH between 9 am and 5pm to 1. review all new admissions under a section (patients admitted after midnight) 2. ·provide medical input to CRHTT for decisions about appropriateness of admissions to PPH 3. ·prescribing for CRHTT patients where clinically required 4. ·medical input, as required, for APOS and seclusions

Appendix F BHFT draft CQUINs 2016/17

Please note that these are only the agreed Local CQUINs, mandated CQUINS and the associated value of all CQUINs are still to be finalised. **To be added at end of Q4**

Appendix G Statements from Stakeholders

To be added at end of Q4

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

To be added at end of Q4

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Health Scrutiny Panel – 21st March 2016
Report of Slough CCG

Slough Walk in Centre Options For A Future Service

Introduction
Slough CCG presented a paper to the 14 January Slough Health Scrutiny Panel providing information on the Slough walk in centre and setting out the next steps for deciding the future of the service once the contract expires in June 2017.

This paper provides an update on progress and sets out a number of options which have been considered with stakeholders for the walk in element of the current service.

Engagement with stakeholders
Since 14 January two further workshops have been held. The first on 19 January was attended by GP members of the Slough CCG. The Chair and Head of Operations for Windsor, Ascot and Maidenhead (WAM) CCG also attended and Chiltern CCG representatives were invited but unfortunately could not attend.

The second workshop was held on 26 January and was attended by patient and public representatives, councillors (including the chair of the Slough Health Scrutiny Panel) from Slough, WAM and Chiltern CCGs and NHS England.

Both these events set out options for the future of the Slough Walk in Centre as presented below.

Options
There are five options open for the **walk in element** of the service. Options 1-4 were presented at the December Slough Walk in Centre steering group. A further Option 5, emerged during the meeting which had evolved from the thinking around the 'Steps to the Future' strategy for primary care in Slough and the review of the Walk in Centre. This option brought together elements of the first 18 months of learning from the Slough Prime Minister's Challenge Fund (PMCF) together with the knowledge and experience of existing commissioning plans in Slough such as complex case management.

Each of the options together with their pros and cons are described below.

Option 1 Do not reprocure. Current walk in attendances are for primary care services mainly from Slough GP practices. It might be possible to accommodate these 42,000 attendances within the current GP practice capacity. This option might release £1m expenditure.

Pros	**Cons**
Possibility of releasing savings	Additional workload for Slough GPs Could increase A&E attendances
This option was rejected as unsustainable due to lack of capacity in the current GP systems	

Option 2 Do not reprocure like for like. Enhance other primary care services eg provide a dressings service or phlebotomy service in the community. The option could potentially release savings depending upon which services are enhanced.

Pros	Cons
New service provision eg dressings, phlebotomy	No walk in service Demand for on the day appointments would continue but no service provision would be available
This option was rejected as unsustainable due to lack of service for on the day appointments and was seen as poor value for money	

Option 3 Do nothing. The walk in centre would continue in much the same way as it is currently. However as attendances have increased from the original contract (30,000) to 42,000 there will be a cost pressure.

Pros	Cons
Leaves service unchanged and minimises need for change	Current service needs modernising and would require investment to meet the current activity demand.
This option was rejected as the current issue of limited on the day booked appointments remains.	

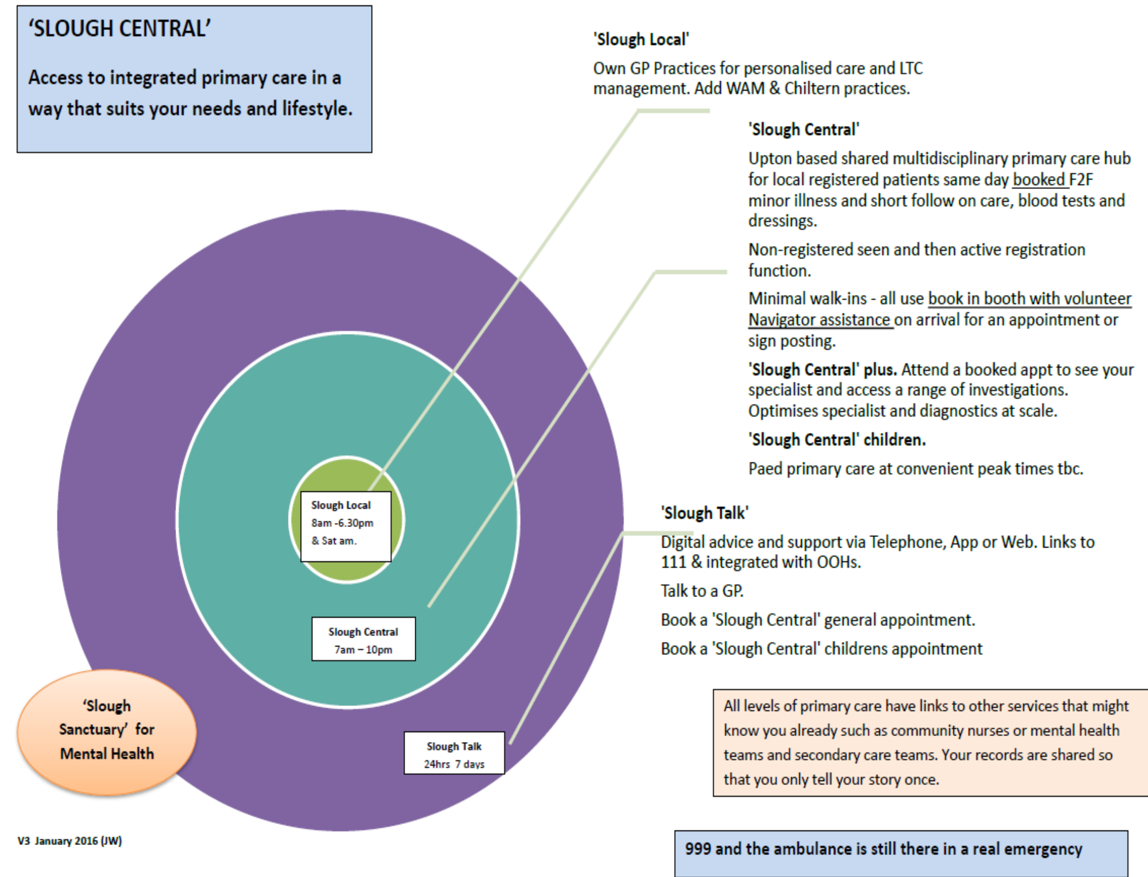
Option 4 An enhanced walk in service is developed. This service would include the current service elements but would be enhanced to cover other primary and community services such as

- Dressings service
- Phlebotomy
- Mental Health safe haven
- Minor injuries
- Potential for open access Physio
- Potential for expanding pharmacy for repeat meds
- Extend to One stop shop for LA – Local navigators

These additional services might require other services eg Minor injuries would require diagnostics on site. The model has not been worked up in detail but expectation is that this option would be a substantial cost pressure.

Pros	Cons
New service provision for local population	Unaffordability of this enhanced service Does not address same day booked appointment element Does not fit with Slough primary care strategy Does not fit with new digitalised communications used by modern society
This option was supported by some of the 19 January GP workshop participants and 26 January patient/public workshop participants. However the view was that this option could be implemented in a stepped approach toward option 5 by integrating some existing service plans or possibly a hybrid between option 4 and option 5 could be developed.	

Option 5 This is a new model of integrated out of hospital care and represented in the diagram below.



The model uses existing primary care GP practices as its foundation. This core layer of service would be termed *Slough Local* and practices would remain as they are in terms of providing continuity of care to those that require and seek this. For example, patients of all ages with long term conditions, complex needs and others with issues that need consistency for a period of time such as problems through the maternity period or with mental health issues. It will optimise access to the right support, be that a GP, Specialist, Nurse or Allied professional.

This is important to patients who have told us they want;
• Time for important conversations; to talk
• Regular follow ups
• A close relationship with a GP whom they know (Family carers, people with LTCs and families)

Longer opening hours might extend to Saturday mornings for this *Slough Local* element.

Working outwards on the model, we know there are significant numbers of appointments required of GP practices on the same day. This is the element that would be provided collectively by all local practices at a *Slough Central* location. It would in effect lift a significant amount of activity from all practices to a central point and be recognised as providing same day primary care.

People have told us;
• They want to be more in control; especially people who are generally well.
• Everyone wants the GP appointment booking system to change.
• Everyone wants it to be easier to access their GP. They default to other services only when their GP is not available.

• They want shorter waiting times for appointments, particularly for children in urgent situations.

Slough Central would be an extension of all local general practices and staffed or funded by local GPs in core hours. Patients would book by phoning their practice and choosing an option which would enable them to talk to someone with a view of all available appointments and staff. Some patients would like to access their appointments on line or by App on their mobile device. The service would be available to those needing short term care or maximum of one or two follow ups to complete an episode. Healthwatch Slough in a series of audits during late 2015 highlighted the benefits of having easier access to GP surgeries and how uniformity in some aspects would be beneficial. Things such as telephone access, messages, both notices and websites and one clear message about extended hours. The *Slough Central* model is a step towards a collective way of operating and offering services to patients.

Any patients that still chose to walk in would be greeted by a navigator to source their most appropriate access to care, be that at the *Slough Central* or elsewhere and be educated in how to access care in the future. The *Slough Central* service should be operational from 7am to 10pm each day and would have integral relations with the GP Out of Hours service.

The physical *Slough Central* location would also house 3 other distinct elements.
Slough Central Plus - other professionals and diagnostics that would be accessed by referral. Such as joint consultant clinics.
Slough Central Children - paediatric element that would be available at peak times for children*;*
Slough Sanctuary/Haven - close contact with something akin to a 'crisis café' for those with mental health needs.

Finally the outer ring of the model *'Slough Talk'* represents the technological and digital framework that will join the model as a seamless experience for patients and professionals.
A virtual entity, it will be the coordinator of manpower and appointments, the link for patients to advice, be that navigator or clinical. It will be the access point for GP web consultation or advice and the link to GP OOH's, 111, A&E and other 7 day services.

Clinical records will be shared as in PMCF and 'Share Your Care' existing programmes.

999 and the Ambulance is still there in a real emergency.

The funding for this model is yet to be worked through but could be provided from the following budgets:

- Element from primary care budget in terms of manpower to staff clinical elements of model in core hours.
- SWIC
- OOHs

Pros	**Cons**
Access to on the day booked appointments Digitalisation of information for patients New flexible easier to use appointments booking system Focus on educating people and self help Pathway for walk in element developed Longer access hours for primary care booked appointments	Concern that GP practices would be destabilised

This option was supported by some of the 19 January GP workshop participants and 26 January patient/public workshop participants. However the view was that this option could contain some of the elements of option 4. Also that there was a possibility of phasing the model in starting with variations to the current contract.

Criteria

Having listened to the views of Slough patients the CCG and NHS England have proposed to use the following criteria to formally assess the options.

Improved access to services – provide same day booked appointments (for GPs, Health care professional) over a longer number of hours in the day
Fit with local primary care strategy–

- Cluster and federated working to create efficiencies and sustainability.
- Develop primary care access for a model of 7 day working
- Implement new & improved clinical pathways from prevention through, primary, community and acute where necessary.
- Motivate self care for all patients when appropriate.
- Innovate & support patients with long term conditions in primary care and motivate self-management.
- Primary care clinicians will develop further areas of specialist expertise and refer patients to each other.
- New arrangements will be introduced to manage demand, including initial telephone consultations to assess whether an appointment is necessary and non-face-to- face appointments.

Sustainable services - which deliver value for money, are affordable, fully staffed and will be sustainable in the long term. Reducing demand at A&E and for acute services is a key element of sustainability
Flexibility to adapt to changes - both in healthcare and lifestyle (eg digital services, apps, mobile phones)
High quality services – safe, efficient and effective services delivered by the most appropriate health professional for the service required
Reflective of clinical evidence base – adopting the 'right care' approach to primary care services. Local evidence points to integrated services, digitalisation, hubs and availability of 8.00am-10pm services.

Next Steps

Two further focus groups with patient and public representatives have been arranged for 18 March (Slough) and 24 March (WAM) to test out a number of patient scenarios and how the model in option 5 would address these scenarios. Chiltern representatives have been invited to attend either focus group.

Formal scoring of the options against the criteria set out above should be completed by the end of March.

The preferred option will be costed and tested for affordability.

Reprocurement for the service is expected to begin in June 2016.
Prior to implementation of the new service a communications plan will be developed to inform the public of any service changes and how these would be accessed.

March 2016

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SLOUGH BOROUGH COUNCIL

REPORT TO: Health Scrutiny Panel

DATE: Monday 21st March 2016

CONTACT OFFICER: Ricky Chana, Project Manager Slough CCG
01753 63 6480

WARD(S): All

FOR COMMENT & CONSIDERATION

EAST BERKSHIRE CCGs' STROKE SERVICE RECONFIGURATION PROJECT

1. Purpose of Report

The purpose of this report is to inform and engage with the Committee about proposed plans to reconfigure the way acute stroke services are delivered in East Berkshire and particularly in Windsor, Maidenhead and Slough.

2. Recommendation/Proposed Action

The Panel is requested to scrutinise and comment on the proposed service reconfiguration plans.

The proposed plans are to reconfigure stroke services in East Berkshire to deliver a modified version of the 'London Model', which ensures that all suspected stroke patients are conveyed to a Hyper Acute Stroke Unit (HASU) for their care. The Thames Valley Clinical Senate has endorsed this reconfiguration in East Berkshire.

3. The Slough Joint Wellbeing Strategy, the JSNA and the Five Year Plan

3(a) Slough Joint Wellbeing Strategy Priorities – (Compulsory Section)

The proposed action relates to the Slough Joint Wellbeing Strategy priority of Health, as patients who receive the optimal level of stroke care in a Hyper Acute Stroke Unit will have improved health outcomes and better chance of recovery and better quality of life following a stroke.

The proposed action will impact positively on patients' health by reducing mortality rates resulting from stroke and increase the life expectancy of patients who suffer a stroke; these are indicators in the JSNA.

3(b) **Five Year Plan Outcomes (Compulsory Section)**

The proposed action will help to deliver the NHS Five Year Plan Outcome that more people will take responsibility and manage their own health, care and support needs. Patients that are conveyed directly to a Hyper Acute Stroke Unit for their care if they are suspected of having suffered a stroke are more likely to make a better recovery following a stroke, which will result in them being more independent and they will need to rely less on health and social care services.

4. Other Implications

4(a) Financial

There are no financial implications of the proposed action, as a National Tariff is payable for acute stroke services.

4(b) Risk Management

Risk	Mitigation
Patients and relatives may object to the reconfiguration plans due to the additional distance they would have to travel to Wycombe Hospital.	To mitigate the risk, comprehensive patient engagement is planned and ongoing.
Wexham Park Hospital may not offer in-patient rehabilitation services as a stand-alone stroke service for local patients,	The East Berkshire Stroke Steering Group is exploring options with other providers.
HASU providers may not have sufficient capacity to meet the additional activity demands	We are carrying out detailed modelling and having meetings with our proposed HASU providers to ensure capacity is in place.

4(c) Human Rights and Other Legal Implications

There are no Human Rights or legal implications.

4(d) Workforce

There is potentially an impact on the Frimley North (Wexham Park Hospital) workforce, due to the services delivered by the Trust changing. The implications of this will be managed by Frimley Health.

5. Supporting Information

The National Stroke Strategy, published in 2007 by the Department of Health, collated the key evidence and outlined what was needed to be achieved to create effective stroke services in England. It identified major stages in the stroke patient's pathway and established quality markers that need to be delivered for stroke patients. The strategy recognised the potential benefits for all patients if effective early treatment and fast rapid access to acute stroke specialist services were provided.

"Time is brain" and the first 72 hours care is vital to ensure the optimum clinical outcome. This needs to be underpinned by an effective whole system pathway for assessment, discharge and repatriation to local stroke services, subsequent rehabilitation and longer term support.

It has been recommended by the British Association of Stroke Physicians (BASP) and Royal College of Physicians (RCP) that all suspected acute stroke patients should be admitted directly to a Hyper Acute Stroke Unit (HASU) to ensure the best possible health outcomes for stroke patients. HASUs bring experts and equipment under one roof to provide world-class treatment 24 hours a day, reducing mortality rates and long-term disability.

5.1. Current Provision of Stroke Care in East Berkshire

Currently, patients who live in Ascot, Maidenhead or Bracknell are most likely to go to Frimley Park Hospital in Camberley or the Royal Berkshire Hospital in Reading. Both hospitals offer excellent stroke services and the decision on which hospital patients go to will be based on a number of factors, including the speed at which patients can be transported there. Both the Royal Berkshire Hospital and Frimley Park Hospital are Hyper-Acute Stroke Units (HASU), so when patients are being seen at either hospital site, this is in line with clinical recommendations.

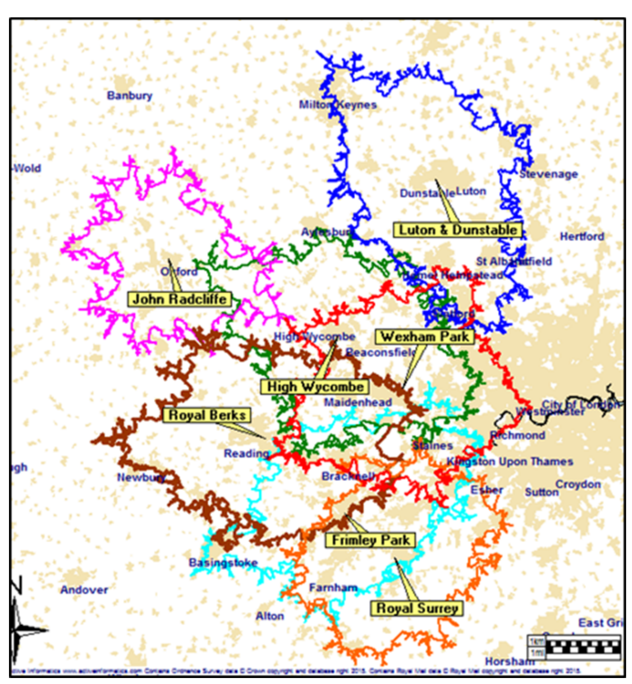
However, the vast majority of stroke patients from Windsor, Slough and also some areas of Maidenhead are likely to be treated at Wexham Park Hospital which is part of the NHS Frimley Health Foundation Trust; this site is which is not a HASU. Since Frimley Health NHS Foundation Trust has acquired the Wexham Park Hospital site, there have been significant improvements to quality across many services but concerns remain about the quality of the stroke services. Quality indicators are monitored by the CCG as well as nationally through the Royal College of Physicians' Sentinel Stroke National Audit Programme (SSNAP) indicators.

Following on from Wexham Park Hospital's performance against these indicators, the CCGs' discussions with the provider and agreed that they would not be able to provide a HASU level of service and as such, patient

outcomes would not be provided at the standard we require. Treatment of stroke patients does not, therefore, currently follow best practice, as all stroke patients should first be admitted to a Hyper-Acute Stroke Unit (HASU) for assessment and initial treatment following a stroke.

In order to ensure that Windsor, Maidenhead and Slough patients also receive the optimal standard of care should they suffer a stroke, it is proposed that they should be treated at the nearest HASU, which for the majority of Windsor, Maidenhead and Slough patients is Wycombe Hospital. For patients resident in the Windsor area who are closer to Frimley Park Hospital, which is also a HASU, they would continue to be transported there.

21 min isochrones - Wexham Park and Surrounding HASUs



HASU	21min isochrone border colour
Wexham Park	Red
Luton & Dunstable	Dark Blue
Royal Surrey	Orange
Frimley Park	Light Blue
Royal Berks	Brown
High Wycombe	Green
John Radcliffe	Pink

As illustrated by the isochrone map above, the patients of Slough and East Berkshire are all within 21 minutes of a HASU. For Slough patients, the closest HASU will be Wycombe Hospital.

5.2. Proposed Plan

The proposed plan is therefore to reconfigure stroke services in East Berkshire to deliver a modified version of the ‘London Model’, which ensures that all suspected stroke patients are conveyed to a Hyper Acute Stroke Unit (HASU) for their care.

For Windsor, Maidenhead and Slough patients, the proposed plans would mean the following-

- Patients who would have previously been conveyed to Wexham Park Hospital would in future be conveyed to the nearest HASU, which for the majority of these patients will be at Wycombe Hospital;
- Patients would remain at the HASU for the duration of the acute stage of their care – 7-10 days;
- Patients would then be transferred to an in-patient stroke rehabilitation or neuro rehabilitation unit closer to where they live;
- Wexham Park Hospital would no longer provide an acute stroke unit. Once Windsor, Maidenhead and Slough patients have completed the acute stage of their care, they will complete in-patient rehabilitation at a local centre.

On 26th May 2015, the Thames Valley Clinical Senate undertook a Stage 1 Clinical Review of the principle of the proposed move to the London model. They found that the evidence to support the move was robust and the proposal was therefore supported.

5.3. How many patients will be affected?

In 2014/15, 176 patients from the Slough CCG area were admitted to Wexham Park Hospital for stroke. In future, the assumption will be that approximately 80% of these stroke patients will be transported to Wycombe Hospital, and the remainder will be transported to the other neighbouring HASUs either Frimley Park Hospital or Royal Berkshire Hospital.

5.4. Engagement to date

We have discussed this project at various public forums, including Windsor, Ascot and Maidenhead CCG Governing Body meeting, the WAM and BA CCG Operational Leadership Teams, the Windsor & Maidenhead Adult Services and Health Overview & Scrutiny Panel and the East Berkshire Community Partnership Forum.

There is also information on the Slough CCG website. Engagement has been received positively to date and we will continue to present the clinical evidence and listen as much as we talk, to all groups including patients, carers and the public.

5.5. Benefits for Slough Patients

We believe that there will be significant benefits for the patients of Slough, as they will receive the optimal level of care enabling the best possible health outcomes. There will also be continuity of care, as all of the acute phase of their stroke care will be delivered at one site, without the need to be transferred after the initial 72 hours.

The objectives below address in more detail the benefits we want to achieve for our patients.

5.6. Objectives of the Service Reconfiguration

The objectives are to:

- Improve the outcomes of stroke patients, by reducing the levels of mortality and disability following a stroke;
- Improve patients' experience and to enhance their recovery following a stroke;
- Have a service based on an accepted international and national evidence base;
- Have equity of access to the service across the region;
- Have equity of quality of care;
- Provide a fully integrated acute stroke service;
- Implement the recommendations of the National Stroke Strategy in relation to acute care;
- Ensure specifications are in line with Royal College of Physicians and NICE guidelines;
- Have 24/7 screening, consultant and other specialist support available on HASU sites;
- Have rehabilitation services that include high-quality Physiotherapy; Speech and Language Therapy; Psychological support and Occupational Therapy;
- Give all patients access to appropriate multi-disciplinary team skills and have a comprehensive health and social care plan upon discharge, with a named person to contact;
- Have all eligible patients be supported post-discharge from hospital with high-quality Early Supported Discharge (ESD) services, including psychological support and other further rehabilitation if needed;
- Have a seamless service from an acute hospital to a rehabilitation unit with the appropriate level of support at each stage.

5.7. Implications Arising from the Proposal

The implications of Windsor, Maidenhead and Slough patients being treated at Wycombe Hospital is that friends and relatives may have further to travel to Wycombe Hospital to visit them whilst they receive their care, however the clinical benefits justify this, as receiving care in a Hyper-Acute Stroke Unit has been proven to result in better clinic outcomes for patients.

6. Comments of Other Committees

We presented the proposed service reconfiguration plans to the Windsor & Maidenhead Adult Services and Health Overview & Scrutiny Panel on the 2nd February 2016. The committee noted and commented on the reconfiguration and asked for assurance that we would manage the risks associated with the plans, such as ensuring sufficient hospital capacity, but otherwise supported the proposal.

The proposed plans have also been presented to the 3 East Berkshire CCG Operational Leadership Teams (Slough, Windsor, Ascot & Maidenhead and Bracknell & Ascot CCGs). All 3 committees supported the proposed plans.

7. Conclusion

This project has been developed through the East Berkshire Stroke Steering group that includes GP representation from Windsor, Ascot and Maidenhead, Slough and Bracknell and Ascot CCGs. We also have a representative from the Stroke Association and a stroke consultant from the Thames Valley Clinical Senate and Wycombe Hospital. This group recommends that the London Model be implemented in East Berkshire for the reasons outlined above.

The evidence is very clear that patients have a better chance of surviving and recovering from a stroke if they are treated with the optimal quality of care at a specialist stroke unit as soon as possible after the stroke has taken place.

The type of care and treatment received at this crucial time can affect the extent and speed of recovery of each stroke survivor.

The next steps are for the East Berkshire CCGs to continue to carry out extensive patient and stakeholder engagement, including consulting with local patient groups and partnership boards and holding a patient engagement event, where patients will be invited to share their thoughts on the proposed service redesign. The next patient engagement event will be held on 17th March at the Centre in Slough, where the Community Partnership Forum will be used to fully engage with stroke survivors and carers on the proposed service reconfiguration.

The Stroke Steering Group is currently in discussions with providers to agree the details of the reconfiguration.

Subject to this, patient and stakeholder engagement, we are aiming to implement the new model by Autumn 2016.

8. Background Papers

1 – The National Stroke Strategy 2007
http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081062

SLOUGH BOROUGH COUNCIL

REPORT TO: Health Scrutiny Panel **DATE:** 21st March 2016

CONTACT OFFICER: Dave Gordon – Scrutiny Officer
(For all Enquiries) (01753) 875411

WARDS: All

PART I
TO NOTE

HEALTH SCRUTINY PANEL – 2015/16 WORK PROGRAMME

1. **Purpose of Report**

1.1 For the Health Scrutiny Panel (HSP) to discuss its current work programme.

2. **Recommendations/Proposed Action**

2.1 That the Panel note the current work programme for the 2015/16 municipal year.

3. **The Slough Joint Wellbeing Strategy, the JSNA and the Five Year Plan**

3.1 The Council's decision-making and the effective scrutiny of it underpins the delivery of all the Joint Slough Wellbeing Strategy priorities. The HSP, along with the Overview & Scrutiny Committee and other Scrutiny Panels combine to meet the local authority's statutory requirement to provide public transparency and accountability, ensuring the best outcomes for the residents of Slough.

3.2 The work of the HSP also reflects the priorities of the Five Year Plan, in particular the following:

- More people will take responsibility and manage their own health, care and support needs
- Children and young people in Slough will be healthy, resilient and have positive life chances

4. **Supporting Information**

4.1 The current work programme is based on the discussions of the HSP at previous meetings, looking at requests for consideration of issues from officers and issues that have been brought to the attention of Members outside of the Panel's meetings.

4.2 The work programme is a flexible document which will be continually open to review throughout the municipal year.

5. Conclusion

5.1 This report is intended to provide the HSP with the opportunity to review its upcoming work programme and make any amendments it feels are required.

6. Appendices Attached

A - Work Programme for 2015/16 Municipal Year

7. Background Papers

None.

HEALTH SCRUTINY PANEL
WORK PROGRAMME 2015 – 2016

Meeting Date
21 March 2016
• CQC inspection of Wexham Park Hospital • Berkshire Healthcare NHS Foundation Trust Quality Account 2015/16 • Stroke project • Slough Walk In Centre Update and Options
4 April 2016 (Extraordinary)
• Measurable outcomes from formal co-operation between Slough Borough Council and CCGs • Transfer of health visitor services • Five Year Plan outcome: More people will take responsibility and manage their own health, care and support • Slough Wellbeing Board Annual Report

Currently Un-programmed:

Issue	Directorate	Date
Slough Caring for Our Carers: Joint Commissioning Strategy 2015-20 update	C&WB	Post Cabinet discussion
Thames Valley Cancer Strategic Clinical Network review of the provision of specialist surgery		2016 – 17

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MEMBERS' ATTENDANCE RECORD 2015/16

HEALTH SCRUTINY PANEL

COUNCILLOR	02/07	28/07	01/10	18/11	14/01	21/03	04/04 Ext*
Ajaib	P	P	P	P	P		
Chahal	P	P	Ap	P	P		
Chaudhry	P	P	P	Ap	P		
Cheema	P	P	P	P	P		
Chohan	P	P	P	P	P		
M Holledge	P	P	P	P	P		
Pantelic	P	P* (from 6.40pm)	P* (from 6.36pm)	P* (from 6.41pm)	P* (from 6.35pm)		
Shah	Ab	P* (from 6.35pm)	P	P	P		
Strutton	P	P	P	P	P		

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

(Ext*- Extraordinary)

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