

Berkshire Healthcare NHS Foundation Trust

Quality Account 2015

Draft

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 252 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 2015

To be finalised at Q4

96% of community mental health and physical health patients would recommend the service for a friend of family member who needed it. This is improved from 86% last year

85% of mental health inpatients rate their care as good or very good. This has improved from 75% last year

71% of staff would agree or strongly agree that they would be happy with the standard of care for a friend or family member. This compares with 60% for similar trusts nationally.

62% of staff agree or strongly agree they would recommend the organisation as a place to work (54% nationally)

By the end of March 2015, 66 extra health visitors will have been recruited over the last 2 years, exceeding the Trusts target.

5 of 7 community wards achieved the target of over 120 days without a developed grade 3 or 4 pressure ulcer.

The Trust is implementing its plan to be smoke free by the end of 2015/16

1. Statement on Quality

The Trust continues to deliver high quality care for the vast majority of patients and their families. Standards are continuing to rise despite significant financial pressures across the health and social care system.

Where lapses in best care occur there is an increasingly robust governance and incident reporting system to highlight areas for improvement and foster learning across the organisation. We continue to strive to improve these processes further.

Evidence continues to build of high levels of staff engagement. We recognize that our staff are working extremely hard, often over and above the requirements of their job plans, to deliver high quality care for patients with ever increasing demands. We do not take this dedication for granted and are very grateful to all our employees who strive every day to provide the best possible care.

This year we have particularly focussed on patient engagement and involvement in improving services. The Listening into Action methodology, which has been helping us to involve staff in removing obstacles to high quality care has been applied successfully to patients and carers. This has included involvement of people with learning disabilities. One of the key messages concerns the value of friendly and courteous interactions and thoughtfulness when working with patients in addition to good clinical skills. This has led to our SHINE campaign – Stop, Hear, Interested, Notice, Engage – to help all employees remember that the most important person at any time is the person in front of them.

There has been an emphasis in children's mental health services during the year, working with health commissioners and local authorities across the health and social care system to provide better joined up care from the community, home and school to specialist inpatient care. There is much work still to be done in this area, but a great deal of progress has been made in identifying what needs to change and securing additional investment to address this.

We have taken an opportunity to expand our involvement in primary care by taking over the running of a GP practice in Circuit Lane, Reading. This builds on our existing expertise in out of hours GP services and walk in centre provision. We are

interested in taking on more GP services where we are best placed to improve services for patients and provide sound financial and quality governance management. This model is very much in line with the type of organisational structure being developed through the NHS Forward View.

The Trust is implementing its plan to go smoke free across all sites in 2015. This will have a major impact in promoting a positive message on illness prevention and, in particular, will help to tackle the major discrepancy in physical health outcomes for people with long term mental health problems.


The Trust's values - *caring, committed and working together* - remain key underlying principles which drive the pursuit of high quality care. These are embedded within the Trust appraisal system for all staff. The principle of *working together* extends beyond the organisation with respect to work with others to find innovative solutions to the wider health and social care challenges in Berkshire and beyond.

There has been very promising collaboration in Berkshire across providers and local authorities to improve care pathways for older people and with respect to urgent care. We very much welcome the involvement of Frimley Health Foundation Trust in driving improvements in the acute hospital services in East Berkshire. We are active participants in the Oxford Academic Health Science Network and the Thames Valley Strategic Clinical Networks with a view to learning from each other, contributing to research and service development and resolving unwarranted variation in care quality.

There is much more that can be done to ensure 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



2.1 Priorities for Improvement 2014/15

This section of the Quality Account details Trust achievements against the 2014/15 priorities and information on the quality of services provided during 2014/15. The priorities support the trust quality strategy 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 aim was to continue to ensure patients and carers have a positive experience of care and are treated with dignity and respect. This has been measured in a number of ways, through the ‘Friends and Family Test’ where patients and staff are asked whether they would recommend the service they have received to a friend or family member if required and through learning from compliments and complaints

Improving patient participation and involvement has been a key theme for the Trust during 2014/15 and there have been a number of initiatives in this area.

1. ‘Listening into action’ events with staff to identify the best ways to remove barriers to better patient and carer involvement in their clinical areas.

2. ‘Listening into action’ events with patient and carer groups to improve care.

There has been a particular focus on enhancing patient, family and referrer experience in key areas and services. For example, in child and adolescent mental health services an independent review has been undertaken to understand better how to improve care pathways and reduce waiting lists.

Figure 1. Percentage of Patients Extremely likely or likely to recommend the service to a friend or family member (Q3)

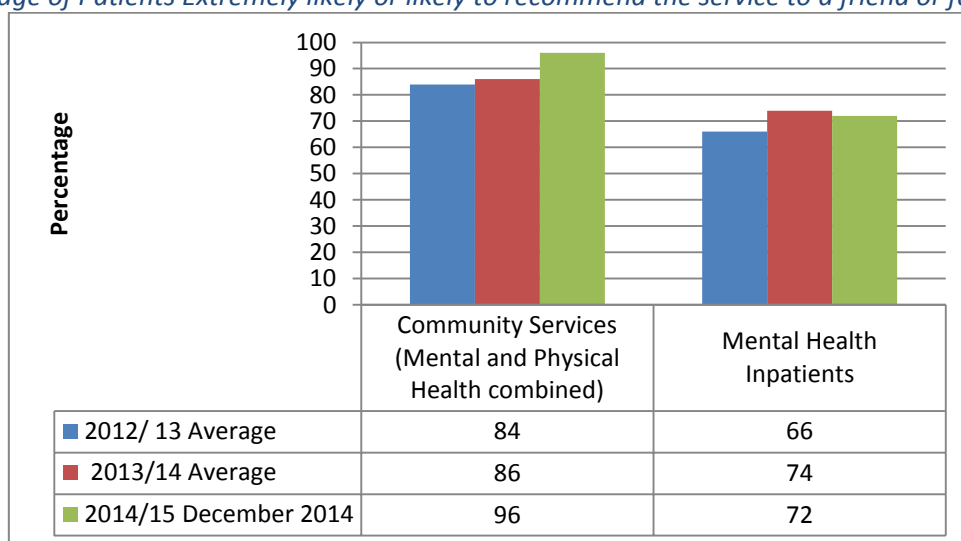
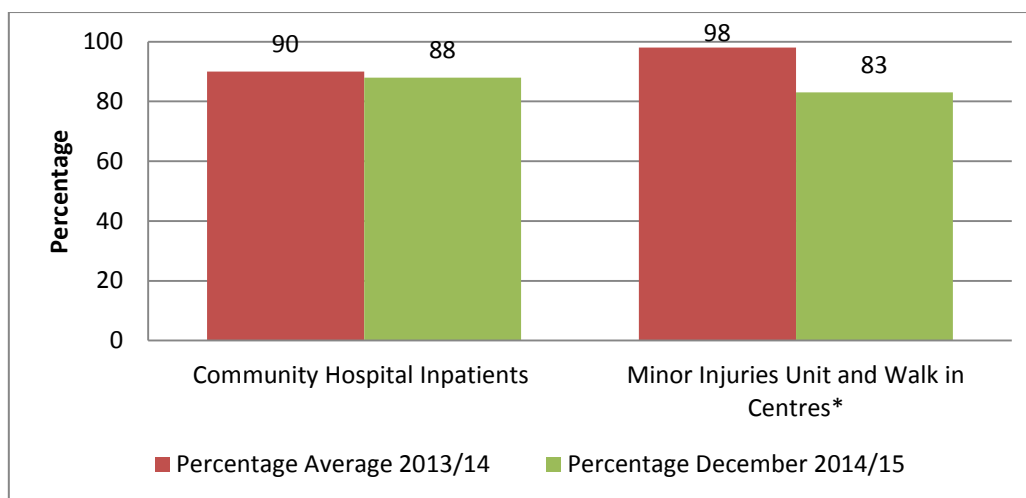


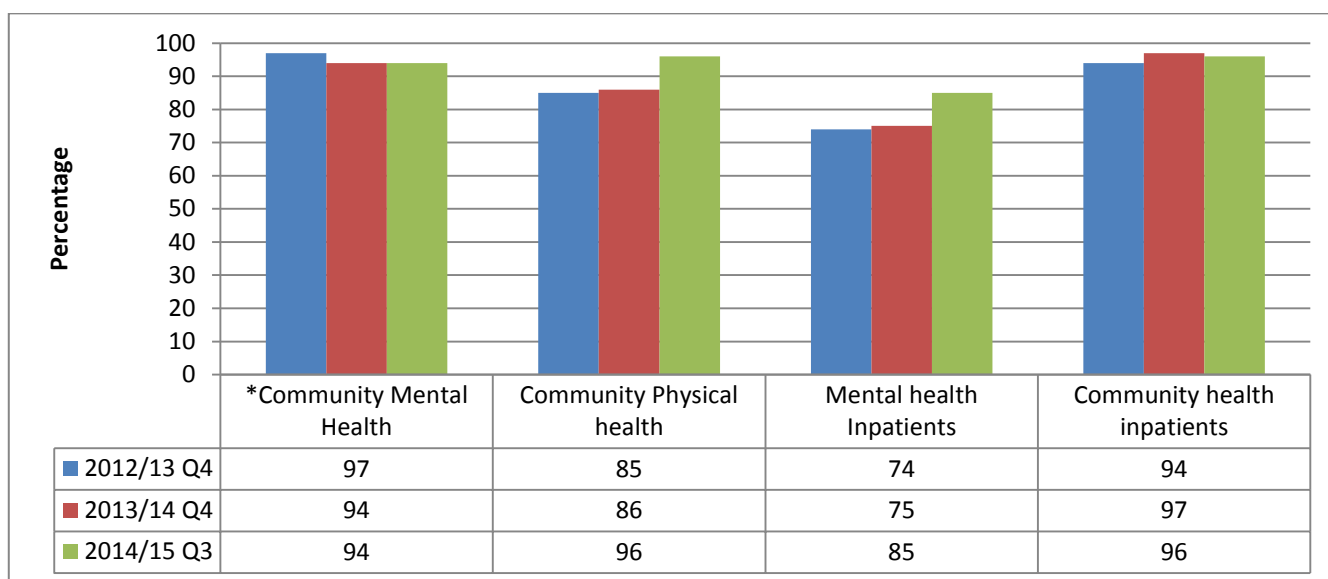
Figure 1 shows that our community services in both physical and mental health are highly valued with 96% of people surveyed likely to recommend the services. For our mental health inpatients the percentage who would recommend the services remains high considering the circumstances and challenges this patient group faces.

Figure 2 Percentage who would recommend to a friend or family member (no figures are available for 2012/13)(Q3).



* 2013/14 figures are for Minor Injuries Centre only 2014/15 figures include Slough Walk in Health Clinic. There has also been some change in the methodology to ensure visitors report in higher numbers and anonymously.

Figure 3 Percentage of patients who rated the service they received as very good or good (Q3).



(Year-end average rounded to nearest whole number. 2012/13 Community mental health results only include learning disability and older people’s services as data for adult and children services are unavailable. Community Mental Health Teams and Electroconvulsive therapy included for 2013/14).Source: Figure 1-3 Trust Patient Experience Reports.

3,818 service users and carers have provided feedback through the internal patient survey programme, with 95% saying their experience was good or better. In addition 99% of patients with a Learning Disability who gave feedback said that they found their meeting

with the service helpful. The vast majority of services have increased their satisfaction ratings in quarter three; all of the community hospital wards have increased their satisfaction ratings or maintained a 100% good or better satisfaction rating. This is also

reflected in all but one of the Mental Health inpatient wards (Rowan ward has decreased from 98.3% rating good or better to 90%). The low number of good or better ratings continues to be an issue in the Slough Walk in Health Centre. The impact of the implementation of the Friends and Family Test in this service is going to be monitored specifically.

In terms of volume the level of positive feedback received by services far outweighs the negative feedback found in complaints and on NHS Choices.

Learning from Complaints

In Quarter three, the Trust received 58 formal complaints in comparison with 67 in quarter two and 61 in quarter one. In addition, eight complaints were received which were being led by a different organisation (in comparison with nine in quarter two and five in quarter one).

The Services that received the highest number of formal complaints during quarter three were Adult Acute Mental Health Inpatients (five), Community Mental Health Teams (eleven), Crisis Resolution/Home Treatment Team (six) and Child and Adolescent Mental Health Services (CAMHS) (nine).

The main themes from the complaints were care and treatment (23), attitude of staff (11) and waiting times for treatment (9).

The formal complaint response rate, including those within a timescale re-negotiated with complainants is 88% for quarter three. It took an average of 29 days to investigate and respond to a formal complaint during the quarter.

Waiting times for Child and Adolescent Mental Health services (CAMHS) continue to increase accounting for 55% of complaints about waiting lists. This is partly due to a very large increase in demand for these services. The trust recognises that some families wait too long for assessment and has asked commissioners for investment into the service to address these waits using the 'parity of esteem' funding stream. All these complaints are rightly upheld because children and young people are waiting too long to access an appropriate service.

Patient 'big conversations' including an event for people with learning disabilities have been very successful. Increased patient and public representation on key groups and projects has occurred. Examples include the medical revalidation group and a collaborative project group developing Physician Associate courses at Reading University. The Trust is prominently involved with the Thames Valley Patient and Public Involvement, Experience and Engagement (PPIEE) Strategy Group.

Timely access is very important for these children in terms of their wellbeing and longer term development, including in many cases educational achievement levels.

75% of complaints received about care and treatment provided were attributed to mental health services. These complaints are often complex with patients unhappy about diagnosis, medication and the level of provision available i.e. related to patient expectation not being fully met. The deep dive survey into Community Mental Health Team patients will help the Trust to understand the service changes needed to improve patient experience.

Attitude of staff continues to be a theme with many complaints and the Listening into Action campaign 'Smile' and 'SHINE' were launched on 2nd February encouraging staff to think about the person in front of them and how they might come across. The 'Listening into Action' public sessions also showed that the public wanted staff to smile and be more welcoming in their approach, as well as providing effective care.

National Community Mental Health Survey

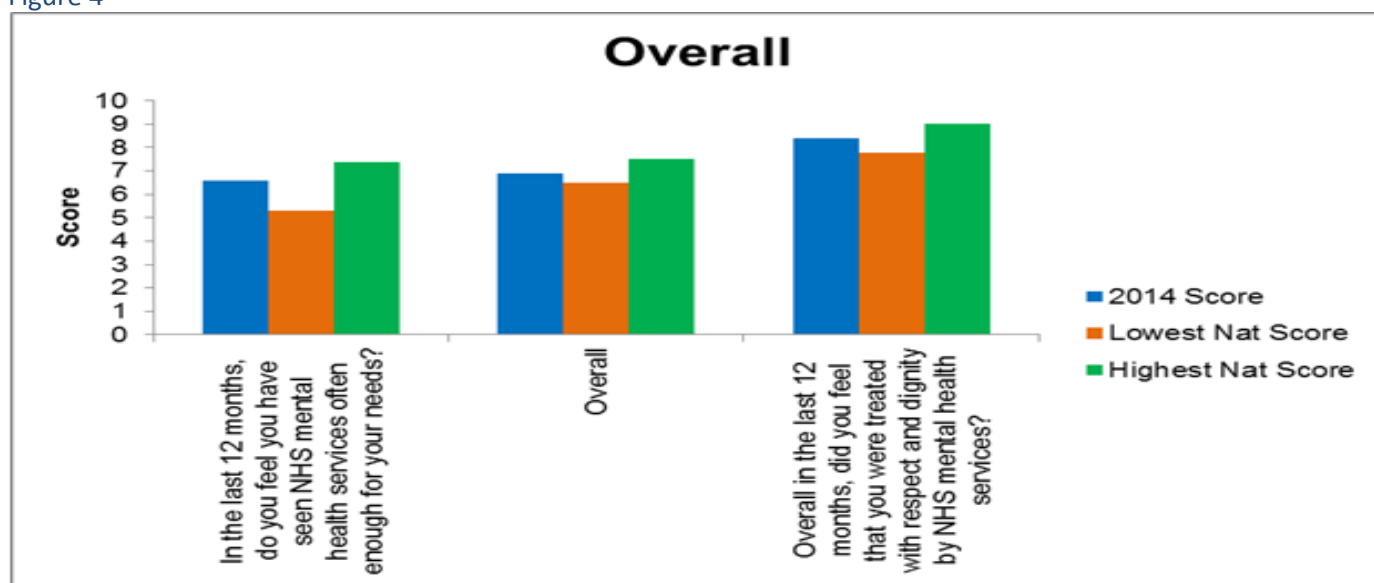
The Trust uses national surveys to find out about the experiences of people who receive care and treatment. The annual Community Mental Health Patient survey was published in September 2014. This year's survey asks different questions to previous years and therefore the results are not directly comparable overall.

The survey this year had 33 questions (compared with 38 last year), categorized within nine Sections. A score for each question is calculated out of 10.

A questionnaire was sent to 850 people who received community mental health services. Responses were received from 238 people (28%).

This year the Trust has not received any ratings where performance has been judged to be lower than the majority of other Trusts, last year there were 12 questions rated in this category

Figure 4



(Source: DoN CMHS overview report)

There is one question which is identical to previous years where patients were asked whether services involved a member of your family or someone else close to you, as much as you would like. Previously the Trust was rated as performing lower than the majority of other Trusts in this area and this year is rated as performing at the same level as the majority of other Trusts. It is not unusual for families to report that they do not feel sufficiently involved or listened to, so this is an area where further improvement is sought.

The Trust would like to see improvement next year in how patients rate performance in supporting them to manage in a crisis in their illness. An initiative, in conjunction with the Centre for Mental Health, to get service users back into employment is a key patient outcome which should be reflected in the national survey results for future years.

2014 National Staff Survey

Figure 5 details the key results of the 2014 National staff survey, which was conducted between October and December 2014. As a result of the Trust decision to complete the survey electronically the response rate increased with over 1,800 staff participating.

The results are very positive and the Trust is again in the top 20% of similar Trusts for staff engagement. The Staff engagement measure is an overall rating that includes staff motivation at work, staff recommending the trust as a place to work and receive treatment and the ability to contribute towards improvements at work. This result is particularly important as research conclusively demonstrates the most powerful indicator from the survey in predicting the quality of care and performance of Trusts is the level of staff engagement.

The most significant improvement was in how appraisals are carried out. This year the Trust scored highest in comparison with similar trusts – 96% of staff responding said they had had an appraisal in the last 12 months and a higher percentage than last year (48% compared with 40%) said it was a well-structured appraisal. This is because of the improvements the Trust made to the appraisal process, guidance and paperwork. Also, the Excellent Manager Programme which was run for Trust managers has contributed to better quality appraisals. These scores are reinforced by the responses to questions which asked staff if they noticed a positive difference in their managers. The aim for the year ahead is to further increase the scores for ‘well structured’ appraisals.

Of the 1700 who replied to the question:

- 49% agreed or strongly agreed “Over the last 12 months I have noticed a positive difference in how my line manager listens to me and involves me in decisions that affect work.”
- 50% agreed or strongly agreed “Over the last 12 months I have noticed a positive difference in the way my line manager role models the behaviours required by the Trust.”

Also at a time when the media is reporting that only two thirds of staff feel secure in whistleblowing on poor care; the Trust had the best score (78%) amongst

similar trusts for staff agreeing that they would feel secure raising concerns about unsafe clinical practice. This was 9 percentage points better than last year.

There has been significant work in this area over the year with increased awareness of the policy and practice on raising concerns, together with the improved response rate this demonstrates that progress has been made.

However, the Trust recognises that there is still more to do in creating a culture where everyone feels safe to speak up and this will continue to be an area of focus over the next few years.

One concerning result was staff perceptions about equal opportunities in respect of career progression and promotion. Although the score was in line with the national average it was less positive than last year. It is vital staff have the confidence in the integrity of the recruitment and selection processes. The Trust has clear policies and processes in this area. In line with the Trust values, poor practices that inadvertently or otherwise damage some colleagues’ confidence in their managers’ judgments will be identified and addressed.

The results overall for 2014 were the most positive to date for the Trust. Next year’s staff survey will provide evidence as to whether planned further improvements make a difference for staff.

Figure 5

Question reference	Question	Trust 2012 %	Trust 2013 %	Trust 2014 %	National average for all mental health trusts 2014 %
Q12a	<i>Care of patients / service users is my organisations top priority (agree or strongly agree)</i>	62	71	73	65
Q12b	<i>My organisation acts on concerns raised by patients and service users (agree or strongly agree)</i>	69	75	78	71
Q12c	<i>I would recommend my organisation as a place to work (agree or strongly agree)</i>	58	62	62	54
Q12d	<i>If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation (agree or strongly agree)</i>	64	69	71	60
Q5a	<i>I look forward to going to work (often or always)</i>	62	58	59	54
Q5b	<i>I am enthusiastic about my job (often or always)</i>	74	71	74	68
Q8g	<i>How satisfied am I that the organisation values my work (Satisfied or very satisfied)</i>	47	44	47	42
Q11c	<i>Senior managers try to involve staff in important decisions (agree or strongly agree)</i>	35	41	41	32
Q11d	<i>Senior managers act on staff feedback (agree or strongly agree)</i>	26	38	41	29
Q18a	<i>My organisation treats staff who are involved in an error, near miss or incident fairly (agree or strongly agree)</i>	54	54	51	44
Q18b	<i>My organisation encourages us to report errors, near misses or incidents</i>	88	90	88	86
Q18d	<i>My organisation blames or punishes people who are involved in errors, near misses or incidents (agree or strongly agree)the</i>	10	9	10	15
Q18e	<i>When errors, near misses or incidents are reported my organisation takes action to ensure that they do not happen again (agree or strongly agree)</i>	63	67	67	62
Q18f	<i>We are informed about errors, near misses or incidents that happen in the organisation (agree or strongly agree)</i>	51	48	51	46
Q18g	<i>We are given feedback about changes made in response to reported errors, near misses and incidents (agree or strongly agree)</i>	49	48	51	48
Q19b	<i>I would feel secure raising concerns about unsafe clinical practice (agree or strongly agree)</i>	74	71	78	69
Q19c	<i>I am confident that my organisation would address my concern (agree or strongly agree)</i>	58	55	65	57

(Source: 2014 National Staff Survey Table A3.2: Survey questions benchmarked against other mental health/learning disability trusts).

2.1.2 Patient Safety

Patient safety is fundamental to care and the Trust wants to continue to protect patients from avoidable harms. This can be achieved by encouraging a positive patient safety culture within the trust and ensuring a safe and reliable delivery of health care. This has been measured through an increased positive staff survey response to questions regarding incidents and learning. The staff survey (Fig.5) indicates that the

Trust has maintained a positive culture with respect to incident reporting in comparison with similar Trusts. In particular, staff feel increasingly secure in raising concerns (Q19b) and confident that the organisation will address these (Q19c).

Figure 6 Overview of Pressure Ulcer Events during the last 12 months.

2014 - 2015										
Developed Pressure Ulcers	Q1			Q2			Q3			Total
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
Category 2 PU	2	1	4	4	3	3	5	4	2	28
Cat 3 & 4 PU Avoidable	1	1						1	2	5
Cat 3 & 4 PU Unavoidable					1	2	2			5
Grand Total	3	2	4	4	4	5	7	5	4	38

The Trust also aimed to achieve no developed pressure ulcers on community and mental health wards and reports on the number of days without a developed grade 3 or 4 pressure ulcer on each of the wards. The aim during 2014/15 was to exceed 120 days on all wards

Figure 6 gives an overview of Pressure Ulcer Events during the past 9 months showing the number of pressure sores which patients have developed whilst an inpatient on one on our inpatient units. Five community wards have exceeded 120 days without a developed category 3 & 4 pressure ulcer during the year. Two wards have not achieved this yet. It was disappointing that in November and December three pressures ulcers were identified which could have been prevented. Full investigations are under taken to ensure we learn why they were not prevented and to ensure that these lessons are shared with staff

Patient Safety Thermometer

The NHS Safety Thermometer is the measurement tool for a programme of work to support patient safety improvement. It is used to record patient harms at the frontline, and to provide immediate information and analyses for frontline teams to monitor their performance in delivering harm free care.

The Trust has completed a pilot of a similar mental health tool which will be reported separately.

The NHS Safety Thermometer records the presence or absence of four harms:

- Pressure ulcers
- Falls
- Urinary tract infections (UTIs) in patients with a catheter
- New venous thromboembolisms (VTEs)

These four harms were selected as the focus by the Department of Health's QIPP Safe Care programme because they are common, and because there is a clinical consensus that they are largely preventable through appropriate patient care. The concept of Harm Free Care was designed to bring focus to the patient's overall experience. Patients are assessed in their care settings. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

All eligible patients are surveyed on one day of the month. This is typically around 4000 patients for the Trust

The national average for harm free care is 93.7% for the past 12 months to December 2014. The average monthly percentage for the Trust over the 12 months to December 2014 is 91.5%. The Trust has a lower number of harm free patients due to the significant number of 'acquired' pressure ulcers. This means that patients have acquired the pressure ulcers in another setting before coming in to the care of the Trust.

When compared nationally the data shows that compared to all organisations BHFT has a higher % of pressure ulcers reported. The number of community pressure ulcers has reduced in quarter 3, however (Fig 7). The percentage of falls with harm has usually been

lower than the national percentage (Fig 8). The Trust has a lower percentage of harms due to catheters and UTI but a higher percentage due to Venous Thrombo Embolism (VTE). (Further details available in Appendix C)

Figure 7 Community Pressure Ulcers

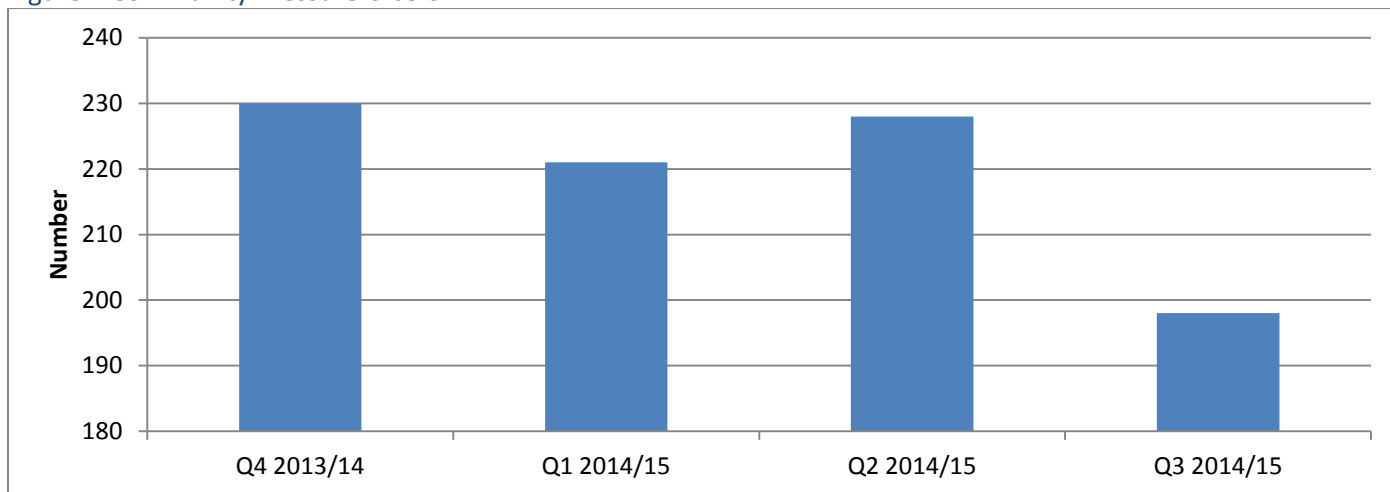
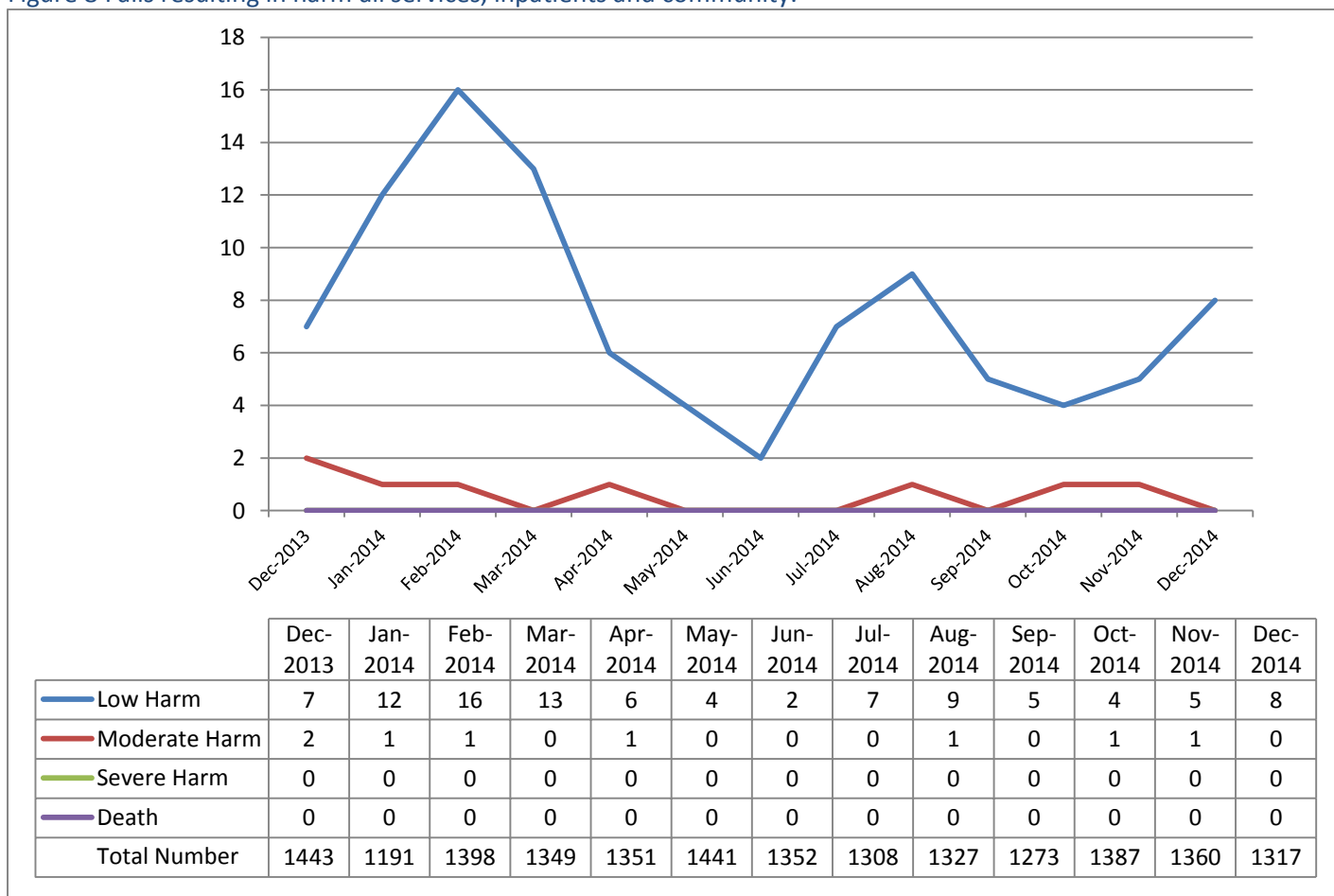


Figure 8 Falls resulting in harm all services, inpatients and community.



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.

The current Trust quality concerns relate to four broad theme areas and the Board monitor the actions being taken to mitigate these.

- Staffing shortages in key areas
- Increasing demand against block contract funding
- Internal cultures
- Sharing of learning.

Additional information on the progress in tackling key quality concern priorities is also contained within Part two of this report both within the priorities for 2014/15 and the priorities for 2015/16. Some specific examples are included below.

Nursing Vacancies

Nursing and increasingly therapy staff vacancies mean that more agency staff are covering shifts. Research shows that often agency staff do not offer the same level of care as a permanent member of staff and therefore the quality of care has potential to be impacted. Equally, if there is insufficient nursing staff to offer a service the quality of care may be impacted. The level of vacancies across the trust means that there is increased risk of poor staff morale, serious incidents, complaints and poor patient satisfaction scores. The services particularly affected are Mental Health, Learning Disabilities and Community Inpatient Units, Crisis resolution and home treatment teams (CRHTT), Community Nursing Services particularly Bracknell and Slough, Musculoskeletal physiotherapy and Community Mental Health Teams. Inpatient safe staffing levels are monitored on a monthly basis and correlated across to incidents. Managers are monitoring staff morale and caseload levels.

There is an increasing national shortage of registered nursing staff and additional student placements have been commissioned, however these will not qualify for 3 years. Human Resources (HR) is working with services to develop recruitment campaigns to attract nursing staff. The trust is developing a workforce plan

as there is a need to redesign the workforce to meet the increasing demand and staffing shortages. Where appropriate, changes in skill mix are being considered.

Child and Adolescent Mental Health (CAMHS)

The Trust Board is aware of the concerns associated with increased demand on CAMHS services within tier 3 and 4 having received regular reports. Waiting lists are of concern in several areas within the service.

Minors continue to be admitted to the Prospect Park Place of Safety (POS) and acute adult wards because insufficient specialist tier 4 CAMHS beds are available. Children and young people are safe in the POS or ward but the environment is not optimal for them and therefore quality of care is compromised.

Additional investment has been provided to reduce waiting lists and prior to Christmas the lists were reducing however since the New Year they have been slowly rising again. A triage process is in place to monitor children on the waiting and high risk patients are seen immediately.

The CAMHS service is using the funding received from winter pressures to manage risk by seeing those clients identified as high risk and seeing children more quickly when they present at A&E. This short term funding is also being used to extend the common point of entry opening hours until 8pm with sessions are being offered at weekends. In addition, an extended hours' pilot is taking place in the Windsor and Maidenhead specialist CAMHS service.

A tier 3 business case has been presented to commissioners for additional resourcing. A tier 4 business case has been presented to NHS England for the creation of a 24/7 unit at Berkshire Adolescent Unit - this is agreed in principle.

The University of Reading has been approached to assess those waiting on the Autistic Spectrum Disorder pathway to reduce waits in that service. Meetings have also been set up with colleagues in the Unitary Authorities to understand their current provision regarding the emotional health and well-being of children (including tier 1 and 2 services)

Ward environments

Some mental health wards, inherently, present a greater risk for the organisation in terms of the nature or vulnerability of the patients accommodated. The

Board has particularly focussed on the learning disability, Psychiatric intensive care unit and older peoples wards to seek reassurance that the environments and culture on these are conducive with optimal patient care.

Intervention has been put in place where necessary to improve leadership, staff supervision, performance management and culture on these wards.

Safe staffing levels are monitored on a monthly basis and have been maintained. Steps have been taken to avoid agency use or, where this is absolutely necessary, to use regular agency staff who know the ward well. Staff have worked hard with commissioners and local authorities to return patients to appropriate community placements in a timely fashion when inpatient care is no longer required.

Common Point of Entry, Crisis Resolution Home Treatment Team (CRHTT) and Community Mental Health (CMHT)

The interface between these three teams has been of some concern. It is important that it is clear which team is taking ownership of vulnerable and at risk patients at any time and that there is effective communication between services and with referrers, partners, patients and families at all stages of the care pathway. Patients often present with complex problems which could fall between agencies and services so excellent collaboration is required. One common example would be the combination of mental health, substance misuse and social problems. CRHTT caseloads are often much higher than the service was originally designed to cover.

A review of CPE has been commissioned and a business case for additional investment into CRHTT has been presented to commissioners under mental health 'parity of esteem' proposals because their caseloads continue to be over and above the level originally commissioned.

Waiting Times for Services

Where a patient is waiting for over 18 weeks or above the target commissioned their experience will be affected. Services currently under performing in December 2014 include:

1. Musculoskeletal physiotherapy (MSK) - waiting 7 weeks against a target of 4-6 weeks

2. Hearing and balance paediatrics (East Berkshire) - waiting 7 weeks against a target of 4 weeks
3. Speech and Language Therapy Ear Nose and Throat (West) - waiting times up to 26 weeks
4. Children's Occupational therapy (West) - waiting 26 weeks against a target of 18 weeks. There is high demand for this service in this area. ,
5. Children's physiotherapy (East) - waiting 26 weeks against an 18 week target.
6. Children's Integrated Assessment (East) - waiting 26 weeks against a target of 18 weeks

Actions have been taken in each service to resolve these waiting times. In MSK physiotherapy additional locum staff have been brought in to help address demand. A demand and capacity action plan has been created to address children's waiting list pressures on service delivery in the immediate future. This action plan is intended to mitigate the risk of increased waiting times and to ensure time is protected to complete a scoping exercise into practise across the service. Where relevant services are trying to recruit additional staff; in the mean time staff are being moved to provide cover. Agencies are being contacted should recruitment be unsuccessful. Caseloads are being reviewed to improve throughput. Waiting times are monitored on a monthly basis.

Falls

Some wards have been noted to have a higher number of falls than expected in comparison with others. This is partly related to the nature of the patients on the wards. However, staffing levels, ward leadership, learning culture and other factors play a part. Falls action plans have been developed and low rise beds procured which are particularly good for managing older adults at a high risk of falls. Falls are monitored on a monthly basis by the Executive. Additional investment into staffing for wards where required has been agreed.

Record Keeping

The quality of record keeping across the trust remains inconsistent and can be improved further. A record keeping strategy is in place for implementation across the Trust. For mental health inpatients there is a peer review process in place to improve the quality of risk assessment recording and patient and carers' views.

Demand Pressure on Services and Staff Morale

For some staff groups there is a perception that management do not recognise the pressure additional

demand is placing on their service in particular community nursing services. This means that when questioned some staff might say their morale is low and that the Trust does not listen to their concerns.

Managers are monitoring staff morale. The results of the national staff survey and staff pulse checks indicate that BHFT is in the top 25% of trusts. The CEO is building a culture of patient safety based on Trust vision and values and members of the Board regularly visit services. Listening into Action is a key staff engagement process. A workforce review is underway for community nursing led by the Deputy Director of Nursing.

Safe Staffing

During 2014/15 the trust has publicly declared that ward staffing levels have been safe.

The Trust monitors on a daily basis the levels of registered nurse and healthcare assistant staff on a shift. The staffing numbers for each shift on each ward have been agreed with the Trust Board. The number of staff required on each ward have been agreed using nationally recognised workforce tools that take in to account the number of beds on a ward and the amount of care that the patients on the ward need. The workforce analysis showed that three wards required additional investment for more staff. This additional investment was provided to the wards from April 2014.

The Trust agreed that staffing is safe on a ward when it has at least 90% of shifts filled because wards can cope with one fewer member on a shift providing this does not happen too often.

In assessing whether the wards were staffed safely the Director of Nursing considered the following information and whether there was any correlation to reduced staffing levels:

Mental Health and Learning Disability Inpatient Wards

- Actual versus planned staffing levels
- Numbers and types of incidents on each ward every 24 hours
- Number of times prone restraint used on each ward every 24 hours
- Number of patients who abscond or fail to return from leave at the agreed time

- Number of patients found on the floor on each ward every 24 hours
- Number of patient on patient assaults on each ward every 24 hours

Community Health Inpatient Rehabilitation Wards

- Actual versus planned staffing levels
- Pressure ulcers developed whilst in the care of trust staff declared
- Number of patients found on floor on each ward every 24 hours
- Numbers and types of incidents on each ward every 24 hours

All wards have other professionals working with patients during the day including doctors and allied health professionals such as occupational therapists and physiotherapists. All of these staff, along with the nurses, provide care to patients on Trust wards.

2.1.3 Clinical Effectiveness

The Trust aimed to provide services based on best practice through the implementation of the National Institute for Health and Care Excellence (NICE) Quality Standards and increasing access to psychological therapies in secondary care this will include mapping of skills within the workforce, training and supervision of staff.

Implementation of the National Institute for Health and Care Excellence (NICE)

In November 2013 NICE published guidance PH48 - Smoking cessation in secondary care; acute, maternity and mental health was issued. This builds on previous NICE guidance issued around smoking cessation and is based on the duty of health care providers to protect the health of, and promote healthy behaviour among, people who use, or work in, their services; including providing them with effective support to stop smoking or to abstain from smoking while using or working in secondary care services.

Within the trust the aim is to support tobacco reduction amongst our staff and patients. We will do this by becoming a smoke free organisation during 2015/16 through encouraging temporary abstinence of tobacco during contact with us or by quitting.

Recommendations within NICE guidance relevant to the Trust:

- Provision of information to patients for planned or anticipated use of secondary care
- Identification of people who smoke and offer help to stop
- Provision of intensive support for people using mental health services
- Provision of information and advice for carers, family, other household members and hospital visitors
- Advise on and provide stop smoking pharmacotherapies
- Adjustment of drug dosages for people who have stopped smoking
- Making stop smoking pharmacotherapies available in hospital
- Putting referral systems in place for people who smoke
- Provision of leadership on stop smoking support
- Development and communication of smoke free policies
- Supporting staff to stop smoking

- Provision of stop smoking training for frontline staff

The approach is to implement becoming smoke-free organisation using a staged approach to maximise the chance of long term success with implementation of the full range of recommendations within the guidance, we will stagger the implementation of key milestones to ensure that we are not implementing all of the recommendations simultaneously with the goal being totally smoke free by October 2015.

The proposed Key Milestones around the staged implementation are:

- Implementation of recommendations to support staff reduction of tobacco reduction during March 2015 to include not smelling of smoke, professional image, not being seen smoking in or out of uniform during working hours
- Implementation of recommendations/abstinence of patients in own homes during treatment and care delivery, OPD, hospital grounds during July 2015.
- Implementation of full recommendations / abstinence for patients within inpatient wards commencing October 2015.

Child & Adolescent Mental Health (CAMHS)

There has been a continued increase in the demand for specialist CAMHS and the Trust has been working closely with both the local commissioners, NHS England and local authorities to agree plans to ensure that effective care is provided for children and young people with mental health problems. Additional resource this year has enabled plans to be put in place to keep children safe, but waiting times still remain unacceptably high for those requiring the service.

Over the winter months the hours for specialist CAMHS support through the common point of entry (CPE) service has been extended from 8am-8pm (previously 9am-5pm). The trial has been successful and has given the ability to respond to young people in crisis later in the afternoon when they are home from school. A report showed that CPE had an additional 150 contacts in January calling during the extended period and prevented 20 young people presenting in A&E.

Staff in the service are working hard to ensure good communication with people who are waiting, and

providing information on what to do if something changes. This was as a specific action following a complaint.

Work with health commissioners for support in delivering more timely services. An exciting development is the agreement to create a 24 hour 7 day a week inpatient unit for children in Berkshire which will allow care to be provided close to family and home.

The service have been working to increase service user participation and as part of this a series of summer building inspections was carried out by service users who walked round buildings and identified the changes they thought would benefit the environment for others. As a result of their feedback, art workshops for service users have been held, the outputs of which will be put on display. The literature and information in the public waiting areas has been reviewed. In particular more positive information has been provided where possible and locations have been adjusted so that service users feel more comfortable to pick it up. Work is being carried out with the estates teams to develop separate areas in waiting rooms for younger children and teenagers and ensure that all waiting rooms have a staff photo board in them.

Increasing access to psychological therapies in secondary care.

We aimed to achieve the following:

1. Minimum of 70% of trust Care Pathways staff with clinical contact and not employed as a qualified psychologist or psychotherapist to have completed training in three psychological techniques.
2. Minimum of 40% of Care Pathways clients, who have been open to the teams for more than 4 months at the end of the year, to have been offered a psychological package.
3. Minimum of 75% of those clients who accept and complete a psychological intervention, to have completed outcome and satisfaction measures

This priority has been delivered through a number of steps. At the beginning of the Trust produced a training package established the required training and supervision for staff. Workshops were held and locality leads and champions were identified.

Three techniques were chosen based on their suitability as brief, stand-alone intervention to address specific difficulties commonly presenting as part of the complex problems experienced by clients in the Pathways teams (Problem Solving; Behavioural Activation; and Graded Desensitisation). Psychologists from within each Pathway team volunteered to develop and teach the training packages.

The content of the three training programmes (including e-learning, podcasts and manuals) were developed to enable staff to understand and utilise the psychological techniques with suitable clients. These will provide the essential learning but the teaching methods in each locality will be according to local requirements.

The trainers are working with Learning & Education and Informatics to create three e-learning/podcast teaching packages and accompanying manuals.

Supervisors have been identified to facilitate group supervision in teams to support and consolidate learning and ensure/monitor quality standards for delivery of the interventions.

The Trust committed funding to engaging a production company to create three training modules when it was identified that no training packages currently on the market were suitable for the audience. In addition, psychologists from all localities and L&D have been released to develop the content of the training packages and facilitate their production.

The training packages consist of the following modules for each of the three interventions:

- Internet based teaching, including slides and video that provide the rationale and aims for each intervention, as well as clear guidance on how to work through the techniques with clients and examples via role plays.
- Manuals for clinicians to guide them through the intervention; how to engage clients, working safely, the required steps, how to overcome obstacles, and endings.
- Manuals for clients that outline the purpose and steps of the interventions, as well as providing work sheets and self-help hints.

These modules have been developed for all three interventions and are available to staff.

The three training modules (including e-learning and manuals) provide the essential information to enable staff to understand and utilise the psychological techniques with suitable clients. In order to ensure that staff understand the materials and to support skilled application, the teaching will be supported by additional psychology input in each locality.

The delivery of this is according to local requirements. Three teams have had between 1 and 3 teaching or workshop days based around the internet training packages and facilitated by locality psychologists, one locality have an external psychologist contracted to provide teaching and supervision, 2 localities have dates for teaching days scheduled. For the 4 localities where training has been completed, approximately 79% of staff have been trained.

2.1.4 Health Inequalities

The Trust aimed to ensure that services responded better to population need. In 2013 the Trust recognised that it needed to increase the number of employed health visitors.

The Trust had a growth target of 52 new health visitor posts to achieve between April 2013 and April 2015. This was in addition to filling all vacant existing health visitor posts which totalled approximately 9 staff in April 2013. Therefore, a total of at least 62 more health visitors was required to be recruited by 2015, to meet our target of having 185 health visitors across Berkshire. Supporting the training of health visitors was part of the implementation plan.

There are currently 165 health visitors across BHFT. Another 23 completing their training in January 2015 have been appointed which brings the total to 189. This exceeds the Trust target. This represents an important success at a time when other Trusts are also trying to increase health visitor numbers.

Health visitors have been allocated across Berkshire as they have been recruited based on a model agreed with public health and the 6 local authority directors across Berkshire. This ensures that the areas of greatest need have the greatest part of the resource.

To improve accessibility of the age 2 reviews especially for working parents and hence improve uptake, the evening clinic trialled at Bracknell has proved very successful and will become a permanent

Psychologists in the localities are providing group supervision for community mental health staff to facilitate appropriate selection of clients to work through the interventions, discuss application of the materials and any obstacles so as to support safe and effective care.

Informatics arrangements (Rio care plans) for the recording, collation and reporting of psychological interventions offered have been established. The collation of outcome data will be by manual trawl at Q4.

The offer and delivery of Psychological interventions, evidenced via the relevant CQUIN care plan on Rio, is the focus for Q4.

feature. In Slough the team have used the new community room in the large Tesco store in the centre of town which has also had excellent attendance and will be now be used on a regular basis as well as the Saturday review slots in a Slough children's centre .

The next steps for the 2 year reviews are to link up with those children in childcare settings to ensure the results of their health reviews contribute to the early years development assessment undertaken. This work is being carried out with local authority colleagues.

Within Windsor, Ascot and Maidenhead the health visiting teams are in the process of reviewing how they run the drop in clinics and they have undertaken additional surveys of families to contribute to this work. They will be sharing what works best with all teams at the end of the project and this will be used together with the client survey results to help improve the clinic experience for all. In the meantime they have produced a health visitor newsletter for parents in response to feedback which is already proving popular.

In response to feedback from parents, the visit will be a combination of family focused conversations which include an holistic assessment to identify those families needing additional support.

The antenatal, new birth and post natal assessments have now been combined into one document to help ensure that clients are not asked the same questions

repeatedly as the information from the first assessment follows through into the others.

Diabetes Education Project

An agreement was reached in July 2014 that the Equality & Inclusion Strategic objective to “reduce inequalities in service usage by people with protected characteristics which correspond with inequity in life expectancy and health outcomes” would be met by developing and delivering a Diabetes Education programme across the Trust for staff. The Trust will progress work on improving access to people with long term conditions such as diabetes, who live in socio-economically deprived areas’.

Key objectives

1. To raise awareness amongst staff of Type 2 diabetes
2. To develop education materials relating to Diabetes Type 2
3. To increase recognition and identifying people who may have undiagnosed diabetes (as set out below).
4. To ensure that staff with protected characteristics access education materials
5. To ensure the diabetes education is rolled out to target staff working in in areas of greater prevalence. To develop this to enable a focus on (population) wards where there is deprivation and/or people with protected characteristics who make them more vulnerable to the disease, namely Reading and Slough.
6. To run the proposed education programme across all Trust services in Berkshire
7. To develop a tool to measure results.

A group was established in August 2014 with the aim to take early action with the large numbers of people expected to be diagnosed with Diabetes over the next 5 years and for the large number who remain undiagnosed. The trust is developing an education programme to raise diabetes awareness both internally with staff and externally with patients.

The aim is to reduce health inequality with respect to diabetes in the Berkshire area.

Key outcomes to date

1. The information for staff was updated with respect to diabetes and the associated risk factors

2. The Trust devised and launched a Diabetes Type 2 quiz as a survey monkey to be completed by staff to establish a baseline on knowledge and numbers of staff motivated to complete this. It was sent out in November and 129 staff completed the survey.
3. The Trust launched the Diabetes Education project with three roadshows –one at Upton Hospital, Bracknell and at Prospect Park Hospital for staff to make them aware of the risk factors for diabetes and how this may affect them or their families personally. This was to launch the project ‘Together we can defeat Diabetes’ which started on World Diabetes Day-November 14th 2014.
4. Trust communications were used to publicise information, quizzes on team brief and on Newline in December 2014. This encouraged staff in all disciplines to be alert to the risk factors and to signpost themselves and their patients who may exhibit these risk factors to undertake a recognised diabetes risk assessment.

Future activity in progress

- To continue the project until World Diabetes day November 2015
- To re-advertise the Diabetes survey monkey and measure changes in uptake and knowledge
- To develop a factsheet to be attached to all payslips in April/May 2015
- To design information posters with Diabetes recognition information for display in Slough and Reading to all waiting areas and staff areas
- To request staff demographics from HR and work closely with Healthy Hearts and other Trust programmes to create a Trust health and well-being page for our staff.
- To work with Diabetes UK from April 2015 onwards to create a risk assessment tool that can be anonymised for BHFT staff so that data on success of the project can be collected specifically for BHFT and outcomes measured.

2.2 Priorities for Improvement 2015/16

2.2.1 Patient Safety

The Trust aim is 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.

Further initiatives to achieve this will be implemented during 2015/16 and described in the Quality Account. The Trust will continue to engage with and contribute to cross organisational initiatives such as the patient safety collaborative. We will report specifically on the following:

Staff survey results will demonstrate continued improvement (Questions 18 and 19) with the aim of being amongst the best 20% of similar Trusts for these measures.

Staff Staffing, having the right capacity of registered nurse and care staff on each ward allows for staff to have the best chance of achieving safe care, however to ensure that patients receive a safe and quality service capability of the workforce is also important. To monitor safety of care delivered on the wards the Director of Nursing and Governance reviews a range of quality indicators on a monthly basis alongside the daily staffing levels. These indicators are and will be reported on:

1. Community wards
2. Falls where the patient is found on the floor (an unobserved fall)
3. Developed pressure sores
4. Medication related incidents
5. Mental health wards
6. AWOL (Absent without leave) and absconsion
7. Falls where the patient is found on the floor (an unobserved fall)
8. Patient on patient physical assaults
9. Seclusion of patients
10. Use of prone restraint on patients

2.2.2 Clinical Effectiveness

NICE guidelines, technology appraisals and quality standards provide valuable evidenced-based information on clinically effective and cost-effective services. The Trust has continued demonstrate 100% compliance with technology appraisals but levels of assurance around other

NICE guidelines compliance assurance has reduced to below 75%. NICE guidance will be prioritised and assurance will be sought through expert opinion and clinical audit that all high priority guidance is adhered to. Assurance on all NICE guidance above 80% will be achieved.

2.2.3 Patient Experience

We will continue to report on the friends and family recommendations with an aim of further increasing this. A Friends and Family Test for Carers has been created which will be distributed to services from February 2015. This will give our 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 that their feedback has. The Trust aims to demonstrate continuing improvement during the year and recommendation levels which are among the best of similar Trusts where this comparison is possible. Learning from complaints will remain a priority together alongside improving our results in national surveys.

2.2.4 Health Promotion

The Trust will deliver its priority to become smoke free across all sites in 2015/16. Delivery of the implementation plan will be reported on quarterly throughout the year and fully documented in the 2016 Quality Account. This will have a major positive impact on the physical and mental health of patients across all services and will also promote healthy lives among staff. The plans include a programme of activities for staff and patients to support them in stopping smoking.

Work to tackle diabetes and increase awareness among staff and patients will continue. This will focus on targeting high risk groups. Initiatives to support weight loss and exercise will be promoted.

Several clinical audits have indicated less than optimal monitoring of physical health risk factors, including weight monitoring, blood pressure and smoking among young people and adults with mental health problems. Associated action plans will be implemented to improve the physical health of these patients and further clinical audits carried out in this area.

Monitoring of Priorities for Improvement.

They will be monitored on a quarterly basis by the Quality Assurance Committee as part of the Quality report and the Board of Directors will be informed of performance against agreed targets. We will report on our progress against these priorities in our Quality Account for 2016.

2.3 Statements of Assurance from the Board

During 2014/15 the Trust provided 72 NHS services. The Trust Board has reviewed all the data available to it on the quality of care in all 72 of these NHS services. The income generated by the NHS services reviewed in 2014/15 represents 100%* of clinical services and 89%* of the total income generated from the provision of NHS services by the Trust. **Figures to be confirmed*

The data reviewed aims to cover the three dimensions of quality – patient safety, clinical effectiveness and patient experience. Further improvements in the metrics used and processes in place to gather good quality data in these areas were implemented early in 2014/15. The key quality performance indicators presented to the Board have been further reviewed. Details of a selection of the measures monitored monthly by the Board which are considered to be most important for quality accounting purposes are included in Part 3. These incorporate more than three indicators in each to the key areas of quality.

2.4 Clinical Audit

During 2014/15, 10 national clinical audits and 1 national confidential enquiries covered relevant healthcare services which Berkshire Healthcare Trust provided.

During 2014/15 Berkshire Healthcare NHS Foundation Trust participated (or is due to participate) in 100% (n=10) national clinical audits and 100% (n=1) national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

National Clinical Audit and Patient Outcome Programme (NCAPOP)

1. NCAPOP - Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)
 2. NCAPOP - National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme
 3. NCAPOP - Sentinel Stroke National Audit Programme (SSNAP)
 4. NCAPOP - Falls and Fragility Fractures Audit Programme (FFFAP) - Incl. Hip fracture database, and National audit of falls and bone health (*TBC – query may only be relevant to acute services this time*)
 5. NCAPOP - Chronic kidney disease in primary care
 6. NCAPOP – Ophthalmology (*TBC – still not confirmed details*)
 7. NCAPOP - Epilepsy 12 audit (Childhood Epilepsy)
 - a. No relevant patients
 8. Non-NCAPOP - Prescribing Observatory for Mental Health (POMH) National Audit - Prescribing Observatory for Mental Health (POMH): Topic 14: Prescribing for substance misuse: alcohol detoxification
 9. Non-NCAPOP - Prescribing Observatory for Mental Health (POMH): Topic 12: Prescribing for people with personality disorder
 10. Non-NCAPOP - National Audit of Intermediate Care
-
1. Mental health clinical outcome review programme: National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH)

Four National audits were removed from the quality account list in-year.

1. Non-NCAPOP - National Audit of Seizures in Hospitals (NASH)
 - Removed 9/7/14
2. Non-NCAPOP - Parkinson's disease (National Parkinson's Audit)
 - Removed 2/6/14
3. Non-NCAPOP - Prescribing Observatory for Mental Health (POMH): Topic 6: Assessment of side effects of depot antipsychotic medication
 - Postponed in light of national CQUIN – September 2014
4. Non-NCAPOP - Prescribing Observatory for Mental Health (POMH): Topic 15: Use of Sodium Valproate (provisional)
 - Postponed to September 2015

The reports of 4 (100%) national clinical audits were reviewed in 2014/15. This included 3 national audits that collected data in 2013/14 that the report was issued for in 2014/15.

- Prescribing Observatory for Mental health (POMH) - Topic 4: Prescribing antedementia drugs
- POMH - Topic 10: use of antipsychotic medication in CAMHS
- National audit of Schizophrenia 2013
- POMH - Topic 14: Prescribing for substance misuse: alcohol detoxification

The national clinical audits and national confidential enquiries that Berkshire Healthcare Foundation Trust participated in, and for which data collection was completed during 2014/15, are listed in figure 10 alongside the number of cases submitted to each audit or enquiry as a percentage of the number registered cases required by the terms of the audit or enquiry.

Figure 10

NCAPOP Audits	
Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)	Registered to participate.
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	Registered to participate.
Sentinel Stroke National Audit Programme (SSNAP)	Registered to participate.
Chronic kidney disease in primary care	<i>Project noted as relevant to primary care – to be confirmed for SWIC.</i>
Ophthalmology	<i>(TBC – still not confirmed details)</i>
Epilepsy 12 audit (Childhood Epilepsy)	No relevant patients
Non-NCAPOP audits	
Prescribing Observatory for Mental Health (POMH) National Audit - Prescribing Observatory for Mental Health (POMH): Topic 14: Prescribing for substance misuse: alcohol detoxification	Data collected March – April 2014 54 patients submitted, across 6 teams. Report received September 2014
Prescribing Observatory for Mental Health (POMH): Topic 12: Prescribing for people with personality disorder	Data collected June-July 2014 31 patients submitted, across 4 teams Report received January 2015
National Audit of Intermediate Care	Data collected June-July 2014 14 service elements included. Initial Report received.
Other audits reported on in-year (data collected in previous year(s))	
POMH - Topic 4: Prescribing antidementia drugs	Data collected October 2013 88 patients submitted, across adult and CAMHS services
POMH - Topic 10: use of antipsychotic medication in CAMHS	Data collected March 2014. 48 patients submitted, across CAMHS services.
National audit of Schizophrenia 2013	Report received October 2014 111 patients submitted, across adult and CAMHS services.

The reports of all the national clinical audits were reviewed in 2014/15 and Berkshire Healthcare Foundation Trust intends to take actions to improve the quality of healthcare which are detailed in Appendix A.

Local Audits

- Registered – (157 last year) 80
- Completed- (56 last year) 66 (may have started in previous year)
- Active – (159 last year) 184(may have started in previous year)
- Awaiting action plan – (19 last year) 18

The reports of 25 local clinical audits were reviewed by the Trust in 2014/15 and Berkshire Healthcare Foundation Trust intends to take actions to improve the quality of healthcare which are detailed in Appendix B. (NB: Projects are only noted as ‘completed’ after completion of the action plan implementation, which is why there may be more local projects ‘reviewed’ than total ‘completed’).

The national clinical audits and national confidential enquiries that Berkshire Healthcare Foundation Trust participated in, and for which data collection was completed during 2014/15, are listed in Figure 9 alongside the number of cases submitted to each audit or enquiry as a percentage of the number registered cases required by the terms of the audit or enquiry.

Figure 9

NCAPOP Audits	
Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)	Registered to participate.
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	Registered to participate.
Sentinel Stroke National Audit Programme (SSNAP)	Registered to participate.
Falls and Fragility Fractures Audit Programme (FFFAP) - Incl. Hip fracture database, and National audit of falls and bone health	<i>(TBC – query may only be relevant to acute services this time)</i>
Specialist rehabilitation for patients with complex needs	<i>(TBC – query may only be relevant to acute services this time)</i>
Chronic kidney disease in primary care	<i>Project noted as relevant to primary care – to be confirmed for SWIC.</i>
Ophthalmology	<i>(TBC – still not confirmed details)</i>
Epilepsy 12 audit (Childhood Epilepsy)	No relevant patients
Non-NCAPOP audits	
Severe trauma (Trauma Audit & Research Network, TARN)	<i>Project noted as relevant to primary care – to be confirmed for SWIC.</i>
National Comparative Audit of Blood Transfusion programme	Registered to participate.
Prescribing Observatory for Mental Health (POMH) National Audit - Prescribing Observatory for Mental Health (POMH): Topic 14: Prescribing for substance misuse: alcohol detoxification	Data collected March – April 2014 54 patients submitted, across 6 teams.
Prescribing Observatory for Mental Health (POMH): Topic 12: Prescribing for people with personality disorder	Data collected June-July 2014 Report yet to be received.
National Audit of Intermediate Care	Data collected June-July 2014 14 service elements included. Report yet to be received.
Other audits reported on in-year (data collected in previous year(s))	
POMH - Topic 4: Prescribing antedementia drugs	Data collected October 2013 88 patients submitted, across adult and CAMHS services
POMH - Topic 10: use of antipsychotic medication in CAMHS	Data collected March 2014. 48 patients submitted, across CAMHS services.

The reports of all the national clinical audits were reviewed in 2014/15 and Berkshire Healthcare Foundation Trust intends to take actions to improve the quality of healthcare which are detailed in Appendix A.

Local Audits

- Registered – (157 last year) 60
- Completed- (56 last year) 48 (may have started in previous year)
- Active – (159 last year) 183(may have started in previous year)
- Awaiting action plan – (19 last year) 22

The reports of 21 local clinical audits were reviewed by the Trust in 2014/15 and Berkshire Healthcare Foundation Trust intends to take actions to improve the quality of healthcare which are detailed in Appendix B. (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’)

2.5 Research

The number of patients receiving NHS services provided or sub-contracted by the Trust that were recruited to end of January 2015 to participate in research approved by a research ethics committee was as follows:

665 patients were recruited from 90 active studies, of which 218 were recruited from studies included in the National Institute of Health Research (NIHR) Portfolio and 447 were from non-Portfolio studies.

Figure 10 R&D recruitment figures 2014/15

Type of Study	No of Participants Recruited	No of Studies
NIHR Portfolio	218	55
Student	355	24
Other Funded (not eligible for NIHR Portfolio & Own Account (Unfunded))	92	11

Source: R&D department.

2.6 CQUIN

A proportion of the Trust’s income in 2014/15 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 2014/15 and for the following 12 month period can be found in Appendix D.

The income in 2014/15 conditional upon achieving quality improvement and innovation goals is £1,440,148.18. The associated payment received for 2013/14 was £ (to be confirmed).

2.7 Care Quality Commission

The Trust is required to register with the Care Quality Commission and its current registration status is registered without conditions. The Care Quality Commission has not taken enforcement action against Berkshire Healthcare Foundation Trust during 2014/15. The Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

In 2013/14 the CQC inspected Sorrel ward where they raised two concerns and an improvement notice was given in respect of Outcome 1 (Respecting and involving people who use services), and Outcome 2 (Consent to care and treatment). For Outcome 1, the CQC said, “It

was not clear if people’s views and experiences were taken into account in the way the service was provided and delivered in relation to their care”. For Outcome 2, the CQC said, “It was not clear that care and treatment was planned and delivered in a way that ensured people’s safety and welfare”. On this latter point, the CQC wanted to see improvement in the quality and triangulation of risk assessments, care planning and progress notes recorded on the Trust’s clinical record keeping system.

In August 2014 the CQC re visited Sorrel ward and lifted the two concerns which had previously been raised.

The Trust received a CQC Mental Health Act (1983) thematic review during the reporting period. The Trust was asked by the CQC to coordinate the inspection on behalf of the local authority, Thames valley police, South Central Ambulance Service and other stakeholders. The inspection focused on patients within the Windsor and Maidenhead area and included people who had experienced a mental health crisis and who are detained under Section 136 of the Mental Health Act (MHA). The CQC are yet to publish their findings on this review.

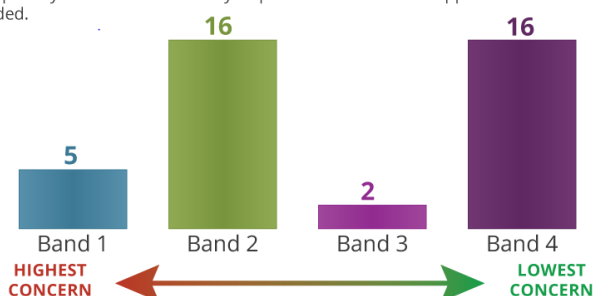
The current quality intelligence draft report which has replaced the CQC Quality & Risk Profile can be found at:

<http://www.cqc.org.uk/Provider/RWX>

Figure 11 details the priority bandings on a scale of 1 to 4 with 4 being the slowest concern. The Trust is currently banded as a priority level 3 and this is due to a higher than expected number of parliamentary health service ombudsman (PHSO) inquiries into our complaints, it has been established that this number is in fact increased due to a backlog of complaints being cleared by the PHSO in the time frame reported on rather than an increase in the number reported to the PHSO.

Figure 11
THE FOUR PRIORITY BANDINGS

We have placed 40 NHS trusts providing mental health services in England into one of four priority bands. Those recently inspected under our new approach have not been banded.



2.8 Data Quality and Information Governance

The Trust submitted records during 2014/15 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:

98.6% 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 Information Governance Assessment Report overall score for 2013/14 was (68%) and was graded satisfactory (Green).

The Information Governance Group is responsible for maintaining and improving the information governance Toolkit scores, with the aim of being satisfactory across all aspects of the IG toolkit for Version 11. An action plan was agreed to achieve this. This has led to an improved score from 2012/13 66% (Amber) to be confirmed at Q4 when submission for 2015 is due.

Data Quality

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 (Full descriptions Appendix X to be added):

- 100% enhanced Care Programme Approach (CPA) patients receiving follow-up contact within 7 days of discharge from hospital
- Admission to inpatients services having access to crisis resolution home treatment teams
- Admissions to inpatient services had access to Crisis resolution home treatment teams (gatekeeping).

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

3.1 Review of Quality Performance 2014/15

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 assurance performance 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 in 2014/15.

Incidents and Serious incidents requiring investigation (SIRI)

Reporting levels remain consistent over recent quarters, with over 2,400 incidents reported in Q3.

The severity model is as expected, with near miss / no harm incidents accounting for the largest proportion of reports, followed by minor, then moderate incidents. Major and severe incidents are relatively rare, and are reported as SIRIs when they involve our services

The top 5 incident categories for Q3 Trust-Wide:

1. Pressure ulcers
2. Assaults
3. Behavioural
4. Nonphysical assaults
5. Falls

Key Learning points from SIRIs in 2014/15:

1. **Standards of clinical record-keeping** including triangulation of information from all sources into effective clinical assessments and care planning.
2. **Historical information** including summaries of in current records.
3. **Multi-Disciplinary / Multi-Agency Planning and Co-ordination** for patients presenting with complex mental, physical and social needs.

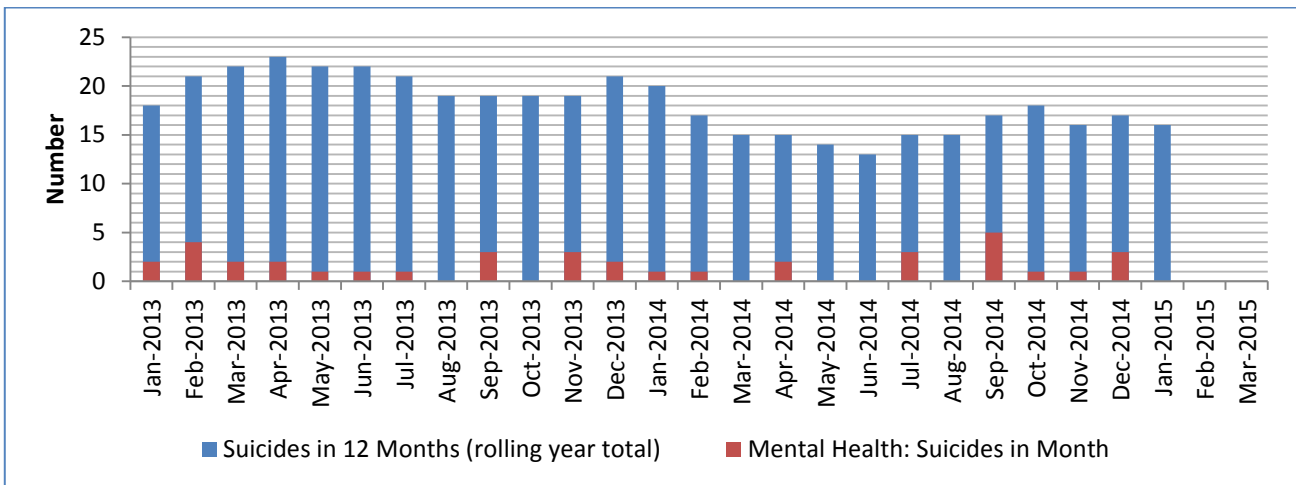
4. **Interface with substance misuse agencies** and access to dual diagnosis specialists in each locality.
5. **Changes in Risk Post-Discharge from Mental Health Inpatient Units.** Careful consideration needs to be given to changes in levels of assessed risk when mental health inpatients are discharged. Patients whose risk is contained on inpatient units may suddenly be re-exposed to outside stressors and risks in the community.
6. **Carer / Family Involvement** in care planning and treatment.

Trust-Wide Initiatives Informed by SIRI Learning

1. One of the key recurrent findings in mental health SIRIs is around the quality of risk assessments and clinical record-keeping. The Trust is launched a new record-keeping strategy in 2014/15, and has revised the Risk Assessment Policy and training. Auditing and one-to-one peer supervision have been extended from mental health inpatient units out into the community teams to support improvement.
2. Work is in progress to provide further support for mental health professionals in assessing and treating suicide risk; lead professionals are involved in promoting best practice with reference to the Interpersonal Theory of Suicidality (Joiner, 2005); this is also being piloted as an evaluation framework in SIRI investigations.
3. The Trust is reviewing its operational model in relation to Crisis Resolution and Home Treatment. SIRI cases have exemplified the systemic challenges faced in delivering this service, and have informed the decision to undertake an operational review.

There have been no inpatient suicides during 2014/15. 17 suicides occurred in the community (Figure 13) in the last 12 months. Clinicians have worked hard to improve processes for assessing and managing risks for patients in relation to suicide and self-harm.

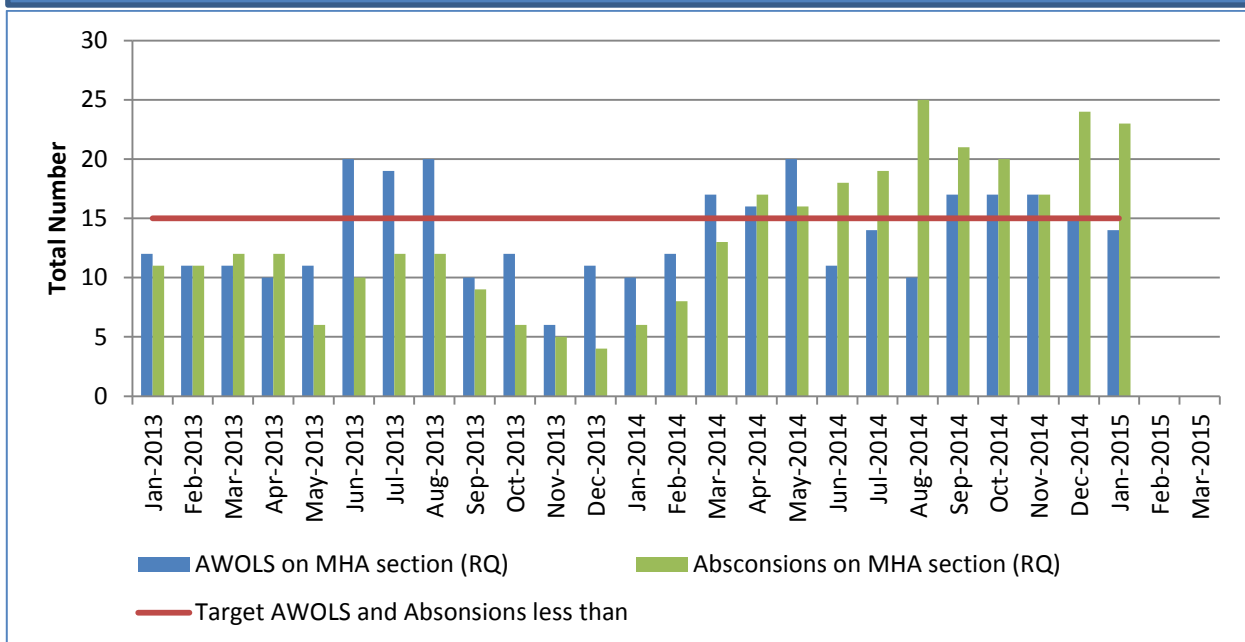
Figure 12 Suicides



Absence Without Leave (AWOL)

There have been fluctuations in patients AWOL from the ward and in episodes of absconding. There has not, however been any clear trend in these areas. There has been an increase in the number of absconsions on a MHA section.

Figure 13 Absent Without Leave (AWOL) and Absconsions on a Mental Health Act (MHA) Section



Slips Trips and Falls

The number of slips, trips and falls is now being recorded since April 2014 per 1000 bed days, and therefore comparative data is not presented.

Figure 14

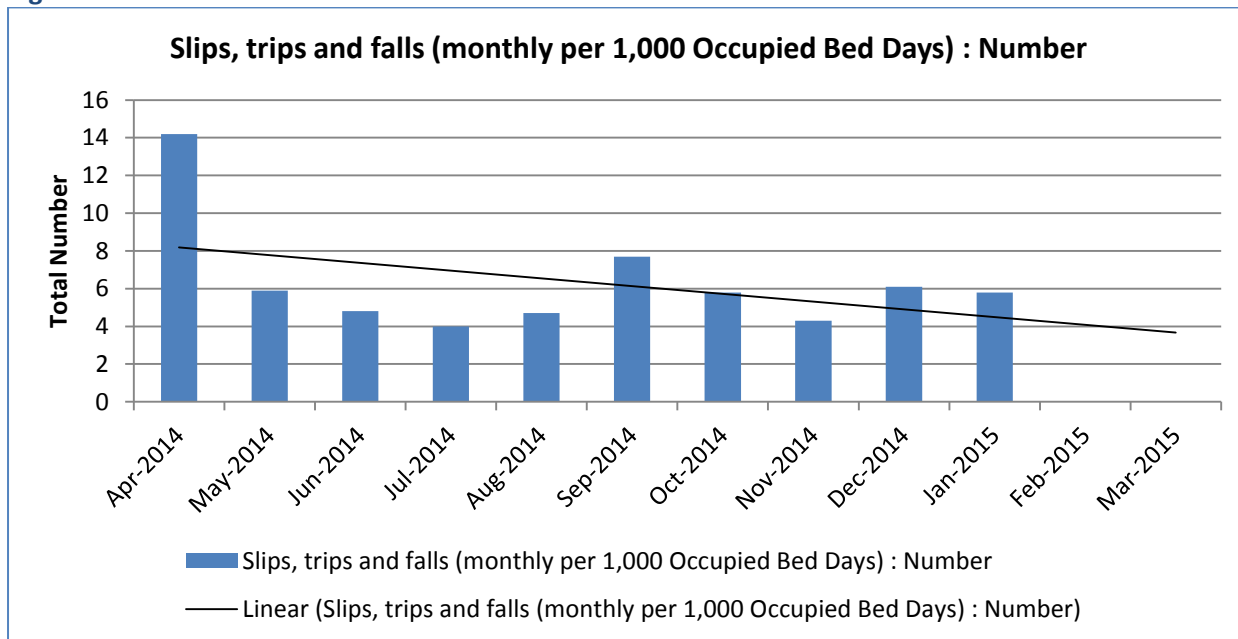
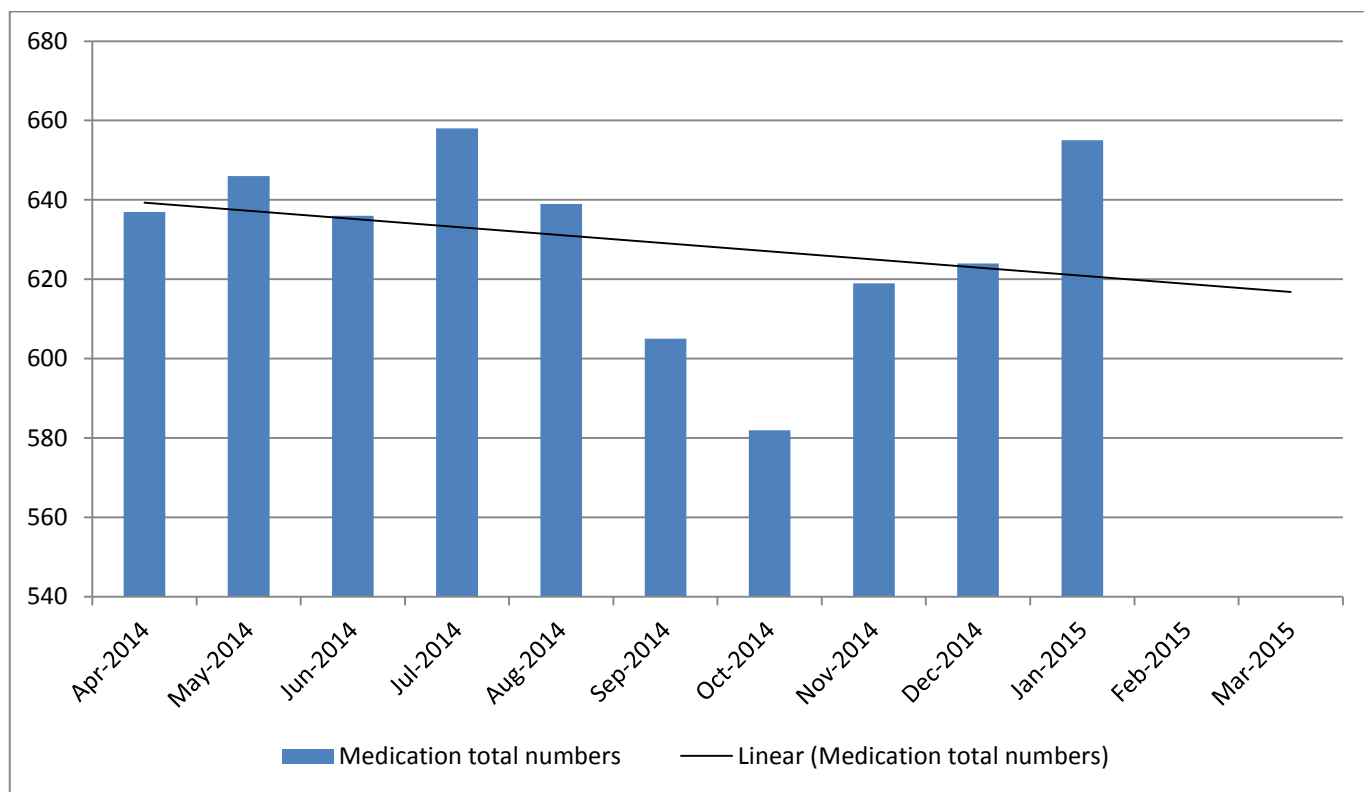


Figure 15 Medications Errors



Medication errors

Reporting levels with respect to medication errors have been maintained in the region of 600 each month. There has been 1 error rated as severe and 2 rated as moderate during the year with respect to patient harm. All others were of low severity. Audits have been carried out and action plans implemented with respect to ‘blank boxes’ on medication charts where it is not clear whether prescribed medication has been given or not. The Trust is looking at the options for electronic prescribing which will reduce medication errors and recording errors.

Physical Assaults

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. Fluctuations in the level of patient on patient assaults appear to show a slight decrease in the last 8 months.

Figure 16 Patients to Patient and Patient to Staff Physical Assaults

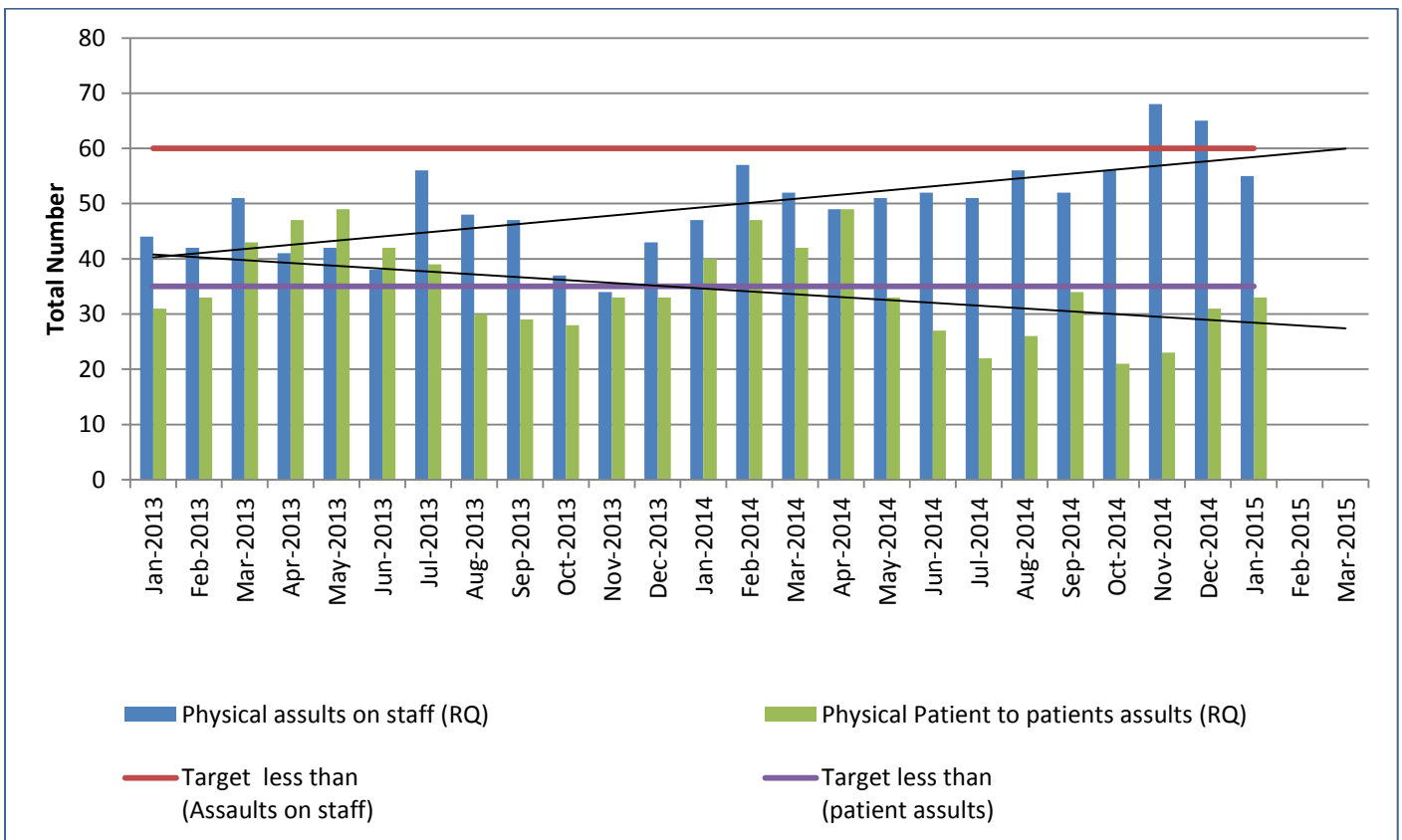


Figure 17 Compliments

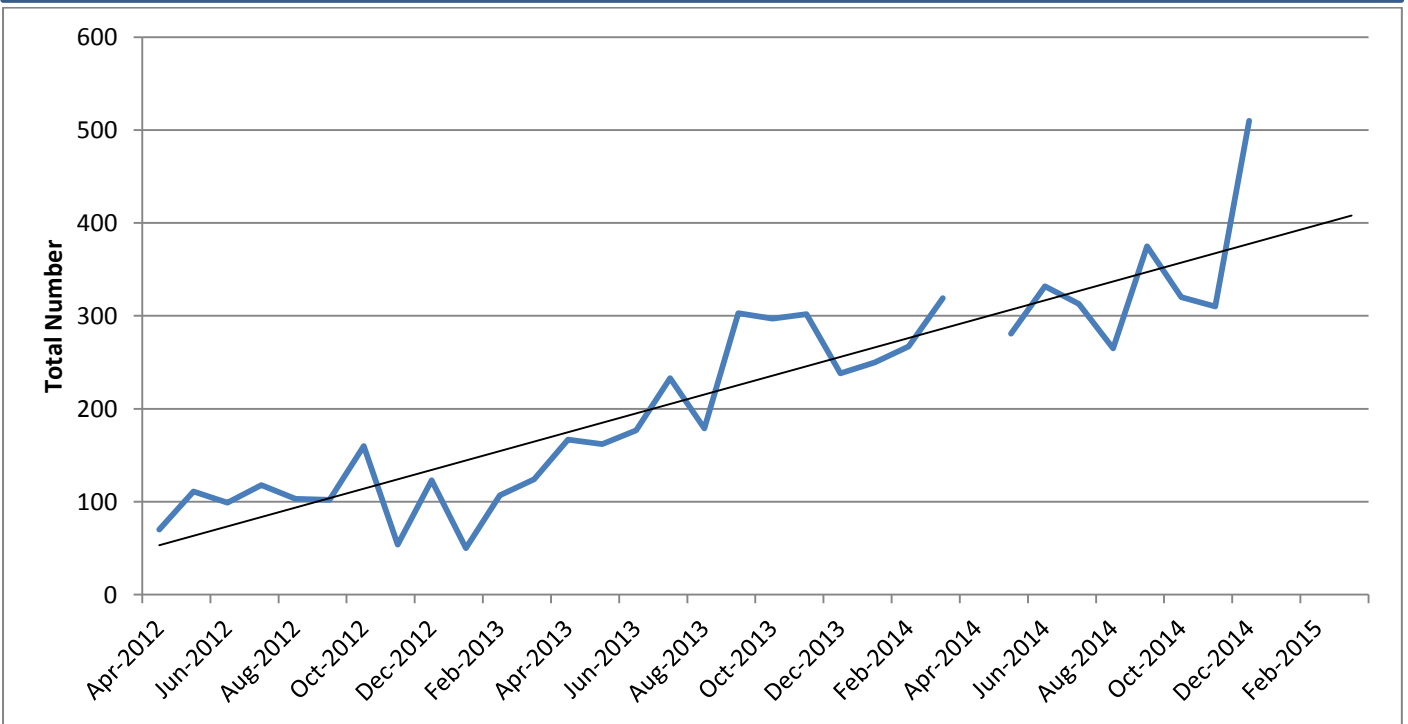
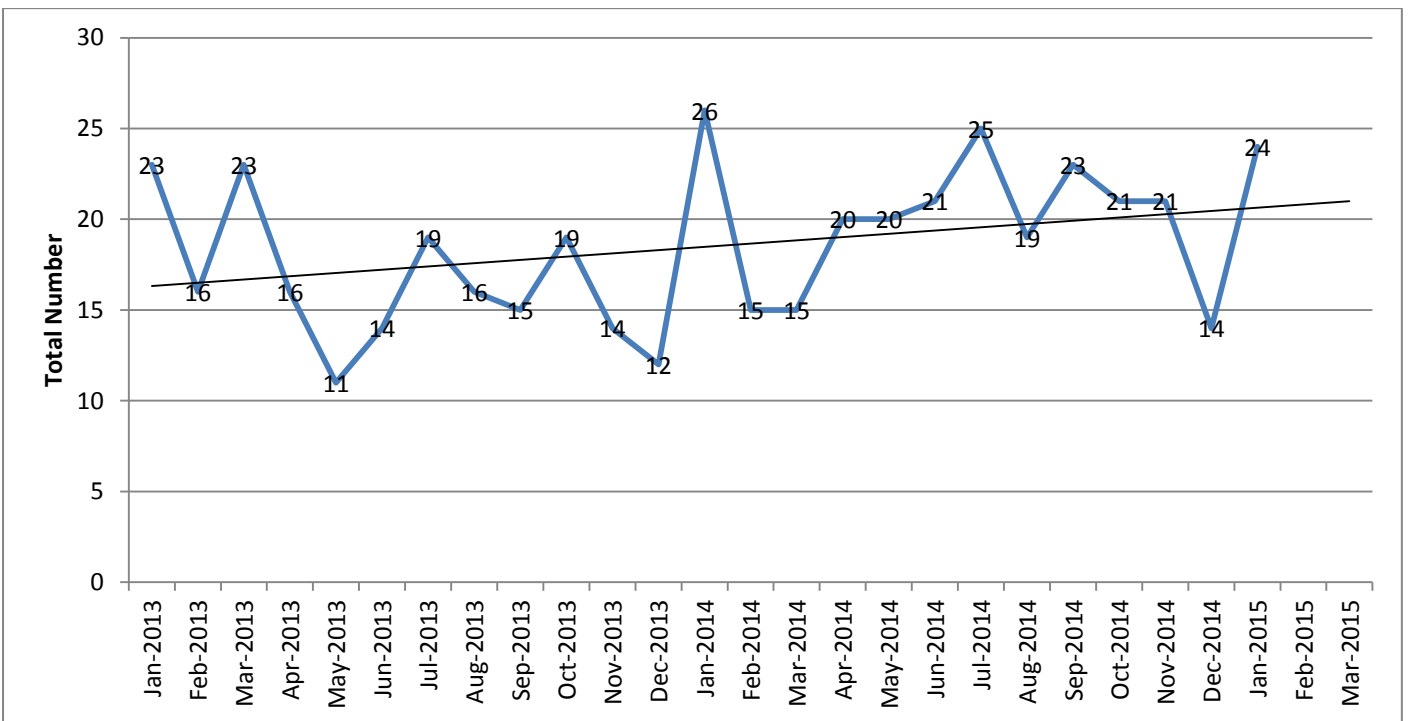


Figure 18 Complaints



Source complaints annual report 2013/14

Monitor Authorisation to be completed at Q4

Performance in relation to metrics required by Monitor, the Foundation Trust regulator, has achieved the required targets. This relates to mental health 7 day follow up (96.02%), delayed transfer of care (1.8%), community referral to treatment compliance (98.1%), Care Programme Approach review within 12 months (96.4%) and new early intervention in psychosis cases 136 (154 12/13).

Figure 19 Q3 figures based on PAF	2010/11	2011/12	2012/13	2013/14	National Average	Highest and Lowest
The percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care during the reporting period	98%	96%	95.8%	97.8%	(TBC)	-

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

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

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

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

Figure 20	2010/11	2011/12	2012/13	2013/14	National Average	Highest and Lowest
The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period	100%	94%	97.6%	98.2%	(TBC)	-

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 21	2011/12	2012/13	2013/14	2014/15	National Average	Highest and Lowest
The percentage of 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%	12.7%	(TBC)	

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 a 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.

Figure 22	2011/12	2012/13	2013/14	2014/15	National Average	Highest and Lowest
The indicator score of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends	3.55 65%	3.61 64%	3.76 69%	3.79	3.57	4.15

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.

Figure 23(New section score for 2012/13)	2011/12	2012/13	2013/14	2014/15	National Average	Highest and Lowest
Patient experience of community mental health services indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period	-	8.5	8.7	7.8	About the same as similar Trusts	7.3-8.4

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.

Figure 24	2011/12	2012/13	2013/14	2014/15 (to end Q3)	National Average	Highest and Lowest
The number of patient safety incidents reported	3995	3661	3754	2759	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**	30.5**	26.71*	
The number and percentage of such patient safety incidents that resulted in severe harm or death	29 (0.7%)	42 (1%)	33 (0.9%)**	37 (1.3%)**	1.1%*	
*NRLS report 1st October 2013 – 31 st March 2014 **Trust figure						

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 September 2014, the median reporting rate for the cluster nationally was 26.71 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 1.1% shown in the most recent NRLS report, published in September 2014.

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.

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.

Figure 25 Annual Comparators Q3	Target	2011/12	2012/13	2013/14	2014/15	Commentary
Patient Safety						
CPA review within 12 months	95%	97.6%	97.9%	96.4%	96.5%	For patients discharged on CPA in year last 12 month average
Never Events	0	1	0	0	0	Full year
Infection Control (MRSA bacteraemia)	< 2 per annum	1	0	0	0	Full year
Infection Control (<i>C.difficile</i>)	<10 per annum (reduced from <19)	15	5	5	0	Year to date C. Diff due to lapses in care
Medication errors	Increased reporting	574*	562	614	655	Cumulative total year end
Clinical Effectiveness						
Minimising delayed transfers of care	<7.5%**	3%	1.1%	2.6%	1.8%	average % in year Range 0-5.6%
Mental Health: New Early Intervention cases	99	155	154	136	98	Year to date
A&E: maximum waiting time of four hours from arrival to admission/ transfer/ discharge***	95%	99.6%	99.9%	99.9%	99.4%	Year average
Completeness of Mental Health Minimum Data Set	1) 97%	1) 99.6%	1)99.8	1)99.8	99.8%	New Monitor target for Identifiers 97% for 2012/13, target for 2011/12 was 99%.
	2) 50%	2) 97.9%	2)98.62	2)97.8	99.3%	
Completeness of Community service data	Referral to treatment information	-	-	70%	72%	Year end average (new 2013/14)
	Referral information	50%		67%	62.5%	
	Treatment activity information	50%		99%	98.3%	
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%	99.3%	Waits here are for consultant led services in what was East CHS, Diabetes, and Consultant Led Paediatric services from referral to treatment (stop clock). Notification has been received from NHS England to exclude Sexual Health services from RTT returns last 12 month average
RTT (Referral to treatment) waiting times - Community: Incomplete pathways	92% <18 weeks	-	-	99%	100%	Year end average (new 2013/14)

Figure 25 Annual Comparators	Target	2011/12	2012/13	2013/14	2014/15	Commentary
Access to healthcare for people with a learning disability	Score out of 24	22	22	Green 22	Green 21	
Complaints received	<25 per month	232	250	193	208	Cumulative in year (note PAF figure discrepancy of 2 (184) Q3 Patient Ex Board report with Nancy and Catherine Magee to resolve)
Complaints	100% Acknowledged within 3 working days	100%	91.3%	93.3%	86%	Final quarter
	90% Complaints resolved within agreed timescale of complainant			64% (82%)	96%	2014/15 note change to indicator previously 80% Responded within 25 working days (% within an agreed time)

*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

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

The directors are required under the Health Act 2009 and the National Health Service Quality Accounts Regulations to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2013/14; The content of the Quality Report is not inconsistent with internal and external sources of information including:

1. Board minutes and papers for the period April 2014 to May 2015
2. Papers relating to Quality reported to the Board over the period April 2014 to May 2015
3. Feedback from the commissioners dated XX 2015
4. Feedback from governors dated XX/XX/2015
5. Feedback from Local Health watch organisations dated XX/XX/2015
6. The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated XX/XX/2015
7. The national patient survey 18th September 2014
8. The national staff survey 24/02/2015
9. The Head of Internal Audit's annual opinion over the trust's control environment dated XX/2015
10. CQC Intelligent Monitoring Report XX/04/2015

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

XX/XX/XXXX Date



John Hedger Chairman

XX/XX/XXXX Date



Julian Emms Chief Executive

Appendix A National Clinical Audits Reported in 2014/15 and results received that were applicable to Berkshire Healthcare NHS Foundation Trust

National Clinical Audits Reported in 2014/15 and results received that were applicable to Berkshire Healthcare NHS Foundation Trust		
National Audits Reported in 2014/15	Recommendation (taken from national report)	Actions to be Taken
Non-NCAPOP audits		
POMH - Topic 4: Prescribing antidementia drugs	Data were submitted on over 9,000 patients with dementia, nearly 70% of who were prescribed an anti-dementia drug. Donepezil was by far the most commonly prescribed AChE inhibitor. There was marked variation in the prevalence of anti-dementia drug prescribing across the 54 participating mental health Trusts, from 35% to 98% in the samples submitted. The proportion of patients prescribed an antipsychotic drug also varied markedly across Trusts, from 0% to almost 70%. Multivariable analysis revealed that the variables significantly associated with being prescribed an anti-dementia drug included living at home (with or without a carer), being in the 66-75 age group, female gender and White ethnicity. Both severity and sub-type of dementia were also significantly associated with prescription of anti-dementia medication: these drugs were most commonly prescribed for patients with Alzheimer's, followed by mixed dementia and Parkinson's disease/Lewy body dementia, and for patients with dementia of moderate severity rather than mild or severe illness	Produce Trust Guidelines for prescribing of anti-dementia drugs (to include the standards set by the POMHUK audit.) Improve monitoring as part of memory clinic processes. Intermediate –time re-audit.
POMH - Topic 10: use of antipsychotic medication in CAMHS	The audit shows an improvement in the number of young people having undertaken appropriate investigations prior to initiating antipsychotic medication and an improvement in the monitoring of side effects since the baseline audit. However in comparison to other trusts BHFT performed worse than average with clear room for improvement. BHFT fared well in regards to recording the reasons for medication to be started and in following up young people in appropriate time scales however fared very poorly in recording of baseline measures and follow up measures.	Creation and adoption of antipsychotic initiation monitoring pack. Training for staff on above. Exploration of adoption of RiO based e-system to record above information.

<p>POMH - Topic 14: Prescribing for substance misuse: alcohol detoxification</p>	<p>The National level results highlight that 16% of admissions were planned for those patients admitted under the care of a general adult psychiatrist for alcohol detoxification. The respective figure for those under the care of a specialist in alcohol detoxification was 93%. The Trust's performance for the NICE guideline on the proportion of patients prescribed medication for alcohol withdrawal is in line with the national standard of 95%. BHFT was successful in completing 85% cases as planned of alcohol detoxification.</p>	<p>The largest effect size could be achieved through addition of the AUDIT-C questionnaire to the 'admission pack' (a group of documents and checklists circulated at admission). This would allow swift and immediate assessment of newly admitted patients' alcohol histories, while not adding substantively to workload of clerking doctors and admitting nurses. A full action plan is being circulated for review and comment to clinical staff</p>
<p>Other audits reported on in-year (data collected in previous year(s))</p>		
<p>National audit of Schizophrenia (2013)</p>	<p>Availability and uptake of Psychological Therapies was average for our Trust though was still below what should ideally be provided Performance in monitoring of Physical Health risk factors was average for our Trust. Even then, it is below the ideal target and was poor for provision of intervention for service users with elevated blood pressure Many aspects of Prescribing Practice were approx. average for our Trust. However, a higher than average proportion of service users whose illness was not in remission did not appear to have an acceptable reason for not having had a trial of clozapine</p>	<p>Results have been disseminated to the clinical staff involved in the project. An action plan to improve compliance will be developed by the Clinical Audit Department in collaboration with the audit team and clinicians via the medicines audit action plan group initially.</p>

Appendix B Local Clinical Audits Reported in 2013/14:

	Audit Title	Conclusion/Actions
1	Audit of anti-infective prescribing on BHFT inpatient wards (Antibiotics) (2014)	<p>There have been routine audits in this area as part of the infection control team's programme of work. The aim of the audit was to ensure that local policy (ICC014) on antibiotic prescribing was followed. There is an increased risk of patients developing Clostridium difficile infections (which are linked to poor antibiotic prescribing). The audit identified several areas for improvement.</p> <p>Action: An agreed Action Plan has been implemented.</p>
2	Re-Audit: Consent to Treatment (2013)	<p>This is a CQC related re-audit. The first cycle of the audit was carried out by a CQC inspection. It was identified that documentation of consent fell below the standard. As a result much work has been done following the last audit. The purpose of the re-audit was to further review documentation of patients consent to treatment.</p> <p>Action: An action plan has yet to be developed.</p>
3	Re-Audit: Clinical Supervision (2014)	<p>The aim of the reaudit was to establish the level of compliance with Clinical and Management Supervision for all BHFT staff, including clinical and non-clinical staff. Some criteria have shown an improvement since the previous audit last year, however, some have also declined. Action plans are currently in development to ascertain how improvements (where relevant) can be made.</p> <p>Action: Local action plans have been developed. The following areas of actions have been noted and will be followed up as part of the normal process.</p> <p>Inform staff re: content, frequency, and training availability</p> <p>Records of supervision and work/reflective diaries to be maintained accurately</p> <p>Staff to attend supervision and training.</p>
4	Child protection clinical supervision - quantitative study	<p>The aim of the audit was to ascertain if practitioners are receiving Child Protection Supervision in line with recommended time frames following new policy in 2012. The findings identified that 76% of practitioners working with the 0-19 children's community health teams across Berkshire were compliant with receiving individual child protection supervision between September 2012 and April 2013. Supervision is part of the Trust's quality schedule and there is a risk that the Trust will fail in this if it does not report and manage supervision effectively.</p> <p>Action: On-going monitoring of compliance. Maintain database tool on shared drive (health visiting & school nursing)</p> <p>To identify why compliance is currently 76% for the health visiting and school nursing teams.</p> <p>To identify the reasons for non-compliance by either practitioner to be documented more accurately.</p>

	Audit Title	Conclusion/Actions
5	Dental Decontamination (2014)	<p>The aim of the audit was to assess the salaried dental services' ability to comply with the essential quality requirements as set out in National guidance, and also their environment and their use of personal protective equipment.</p> <p>There were 17 standards that were non-compliant within all clinics, seven of these related to the issues requiring support from the Estates Department.</p> <p>Action: The audit report will be disseminated to the Joint Heads of Service for Dental in accordance with the requirements of the BHFT IPC annual audit programme. Managers will be responsible for ensuring identified deficiencies are addressed.</p> <p>Action: The action plan will be presented and reported within the Infection Prevention & Control Working Groups and Infection Prevention and Control Strategic Group.</p>
6	Quality and timing of GP letters (2014)	<p>The audit was carried out in March 2013 covering all new patient referrals to Reading South Community Mental Health Team for Older People from June 2012 to November 2012. The audit was chosen due to anecdotal concerns about the length of time taken to complete documentation following the change in 2010 from paper patient records to an electronic recording system (RIO) of patient records. The audit identified that a high percentage of risk assessments were not completed in a timely basis.</p> <p>Action: The action plan is to be developed.</p>
7	Management of Depression in Older Adults (2013)	<p>The audit looked at how staff from the Reading Older People's Mental Health Services assessed people with depression and whether information was provided to patients on their condition and treatment</p> <p>Action: Present findings at the Reading OPMHS team meeting and the West Berkshire Clinical Effectiveness Meeting for the OPMHS.</p>
8	Audit of Pathway of Inpatient Services (2013)	<p>The aim of the audit is to confirm whether appropriate processes are in place around admission, treatment and discharge to and from BHFT's inpatient services for people with learning disabilities. The audit concluded that appropriate processes are in place for admission, treatment and discharge to and from inpatient services. The action plan relates to completion of fields on RiO.</p> <p>Action: Agreed actions are to complete the Formulation field on RIO for every patient admitted to inpatient services and the use of one standard CPA form across both units documenting whether patients have been invited to their CPAs. In addition, progress notes are to be documented in RiO or in agreed templates including the questions staff/professionals ask patients about their care and their responses.</p> <p>The 'MCA & Information Sharing & Consent' field in RIO is to be used to document & share with other professionals whether a patient has given consent for specific treatment or if consent's been reached.</p>
9	Audit Of Urinary Catheter Care Bundle	<p>The aim of the audit was to assess compliance with the requirements set out in the urinary catheter care bundle through review of completion/documentation on the care bundle. The audit found that community nursing demonstrated a high level of compliance with the requirements set out in the urinary catheter care bundle in comparison to inpatient wards.</p> <p>Action: An agreed action plan is to be developed.</p>

	Audit Title	Conclusion/Actions
10	Client, Patient or Service User? The views of healthcare workers and the people they care for (2014)	The aim of the audit was to review consistency across documentation in the Trust, in light of awareness that different terms maybe preferred by different professionals. The term 'patient' was also termed as a 'client or 'service user' Action: The report is to be shared with Patient Experience, for information.
11	Re-Audit to ensure quality of accompanying documentation for patients admitted to community inpatient wards	The community hospitals have criteria and principles that support appropriate use of the community beds, providing clear guidance for the referrer around documentation and processes required to support a safe transfer. These criteria were shared with PCT, GP's, secondary care and unitary authorities' partners prior to approval within BHFT. Anecdotal evidence from ward staff across all wards is that referrers are not adhering to the criteria and principles for admission and this has potential to impact on patient safety. The aim of the audit was to gain objective evidence around the adherence to the admission criteria and principles that can support communication for improvement with relevant referrers. Action: The action plan is to be shared with the Hospital development group as sub-group of Adult SIG.'
12	Reaudit: Consent to ECT	The audit objective was to monitor current standard of obtaining consent to ECT and whether BHFT ECT department were compliant with national guidelines, if patients had a capacity assessment and relevant documentation was in place prior to ECT. Action: The audit findings resulted in the following action points: Monitor Capacity Assessments completion at each ECT Maintain updates of current & training of new ECT ward based leads ECT treating staff to check pathway at each treatment and ECT Pathway documentation sent to ECT on Completion
13	Audit of assessment letters sent to GP's by Clinical, Counselling Psychologists and Psychological Therapists	The aim of the audit was to establish if good practice is being followed in communicating through letters written by clinical and counselling psychologists to GPs. 100% compliance was met in all four service standards. Action: The observations within the report will be disseminated via locality patient safety and effectiveness groups for discussion It was advised that clinical/counselling psychologists and psychological therapists in older people services should complete a similar audit within three months and to share and discuss the findings of the report with locality teams and organise a retrospective audit for the period September 2014 – December 2014.

	Audit Title	Conclusion/Actions
14	Audit of antipsychotic medication monitoring for older adults with dementia	<p>The decision to start anti-psychotics drugs for older adults is made in the context of a careful risk-benefit assessment. Although anti-psychotic medication has an important role in treatment of serious mental illness, it needs to be used with careful monitoring of physical health. Early detection is important to allow medication to be altered and adverse effects on physical health to be treated.</p> <p>The aim of the audit was to ensure that older adult services in Berkshire comply with Trust guidelines on anti-psychotic monitoring, to raise awareness of current guidelines and provide further education and reaudit following interventions to assess whether improvements have taken place, or whether further intervention is necessary. The audit identified low levels of compliance with monitoring.</p> <p>Action: An action plan is in development.</p>
15	Prolactin monitoring in general adult inpatients receiving antipsychotics	<p>The aim of the audit was to improve current clinical practice by establishing clear guidance on the use of antipsychotic drug treatment. A raised level of prolactin is a common consequence of the treatment, with clinically short and long term effects. Compliance was tested against three audit standards.</p> <p>Action: An action plan is in development.</p>
16	GP Referrals to Memory Clinic	<p>The aim of the audit was to ensure that the GP referral forms had vital information about the patients which helps in their assessment of memory issues including documented information on the required tests</p> <p>Action: The agreed action is to educate GPs to emphasise the importance of a standard referral.</p>
17	Clinical audit of the copying of Windsor, Ascot & Maidenhead Memory Clinic letters to patients, their families and carers	<p>In Berkshire Healthcare NHS Foundation Trust, a policy (Copying Letter to Patients; CCR107) was drawn up advising that letters should be copied to patients. Given the wealth of guidance, it seemed appropriate to seek to audit this element of practice within the Windsor, Ascot & Memory Clinic service.</p> <p>The audit identified that 58.8% patients had received a copy of their initial assessment letter but only 12% of cases where the letter was sent to the patient's carers.</p> <p>Action: An action plan is in development.</p>
18	Survey of provision of Psychological services to Bluebell Ward	<p>The project was to review the psychological therapies available to the ward and stakeholder opinions of these, plus what stakeholders would like to see offered. 33 responses were received in total.</p> <p>Action: An agreed action plan is in place.</p>

	Audit Title	Conclusion/Actions
19	School Nursing Assessment Audit	<p>This audit has been undertaken as part of the Berkshire Healthcare Foundation Trusts (BHFT) Universal Children's Services Improvement School Nursing Sub Group requirements, to assist with the quality assurance and development of the School Nursing assessment process and recording.</p> <p>The audit did identify areas of high compliance, but there were 33% of cases where all sections with demographic information had not been completed.</p> <p>Action: Record keeping task group to update assessment paperwork Written guidance for practitioners Training on the use/content of progress notes Audit tool to be amended to reflect change from Notable events to Event Timeline.</p>
20	Early Detection of Deterioration in Health Score on In Patients Units	<p>Older adult psychiatric inpatients often have multiple physical health co-morbidities and their physical health is as much a priority as their mental health. This quality improvement project was conceived after noticing multiple incidents of patients having abnormal physical observations recorded which should have warranted urgent review by a doctor, but were not raised as a concern.</p> <p>The audit identified that physical observations are poorly understood and under-utilised by mental health nursing staff. The project received raised some significant concerns over (lack of) use of NEWS, and also the lack of knowledge of observations and the interpretation/escalation procedure. As such it was taken to CEG as a special paper, and directly reported to the medical and nursing directors</p> <p>Action: Redoing the training in NEWS for staff on Daisy Ward and Bluebell Ward to ensure staff understand importance of scoring and escalating concerns. Relaunch of NEWS on Daisy & Bluebell Wards Audit of NEWS on Daisy & Bluebell to ensure compliance with standards Start NEWS on Snowdrop, Rose, Campion & Sorrel Wards.</p>
21	CMHT Risk Assessment Triangulation Audit Initial Results from Audit Pilot	<p>The aim of the audit is to help review how effective the work by the Risk Management and Crisis Contingency Sub Group implemented across the Trust is, and to ensure on going high quality of record keeping.</p> <p>Action: To set up a workshop for the auditors to ensure consistency in undertaking of the audit across the trust To undertake Peer review audit across the localities To undertake the next round of audits once the workshop has been undertaken. Provisionally October's Audit</p>

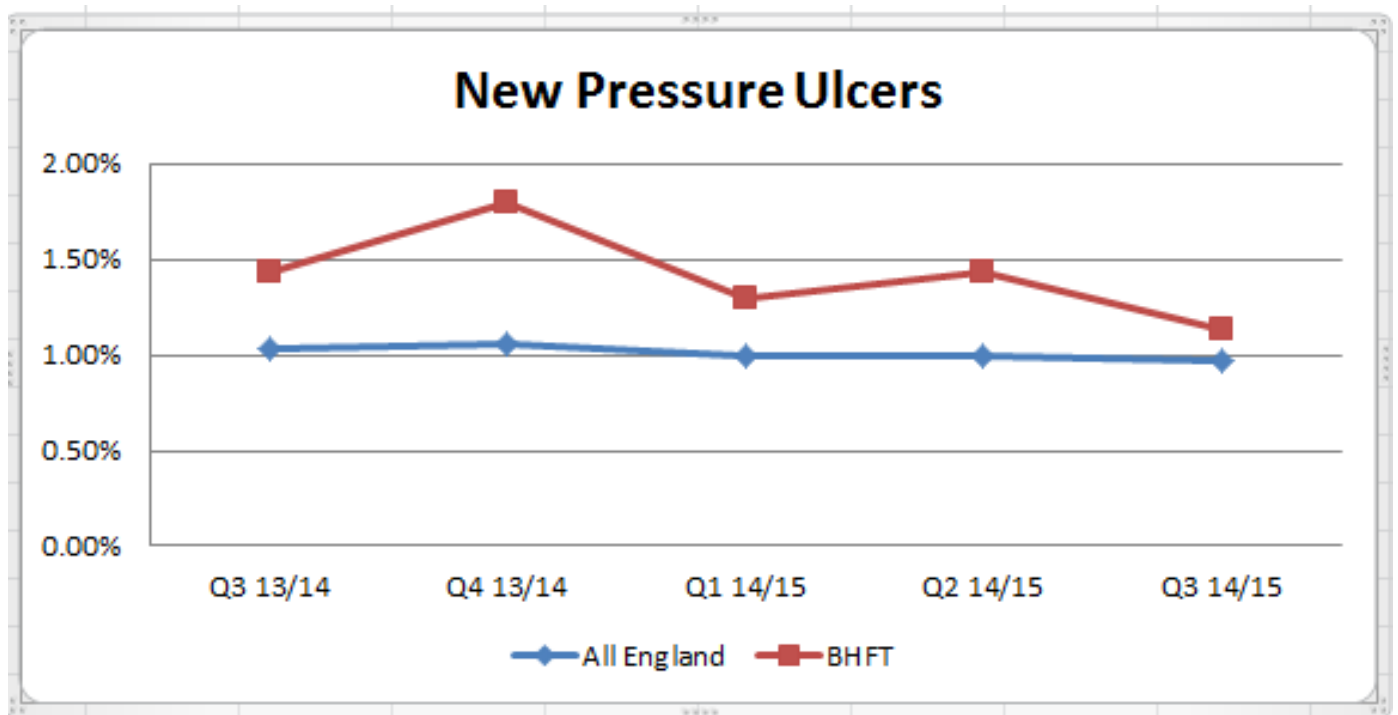
	Audit Title	Conclusion/Actions
22	Annual Audit of PGD's for Diptheria Tetanus Polio PGD	<p>The aim of the audit was to ensure documentation required during administration of the DTP immunisation under Patient Group Direction (PGD) is of the highest standard. The audit set out to demonstrate that the PGD system of staff training, signing of the PGD and the correct documentation on each child's PGD consent form was correct.</p> <p>Action: The consent forms for DTP and Meningitis C need to have "Site of immunisation" and "Route of immunisations – intramuscular (IM) or sub-cutaneous (SC) added to them to improve the recording of these areas.</p> <p>The parent information sheet given to the child after the session stating what vaccine they received that day should be changed to include which arm each vaccine was given in.</p> <p>Staff training record sheet needs to be fully completed for each PGD that is being used. These are currently under review by the Patient Group Direction (PGD) working group.</p>
23	Child Sexual Exploitation: An Audit of Staff Knowledge and Training Needs	<p>The audit commissioned by Health Education Thames Valley was conducted to explore the child sexual exploitation (CSE) knowledge and training needs for staff required to undertake Level 2 and above safeguarding training across Thames Valley. This included staff from across the nine health care Trusts (including South Central Ambulance Service), and health care staff working in the community, including GPs, dentists and pharmacists.</p> <p>Action: The audit report will be shared with lead for safeguarding children, and deputy director of nursing.</p>
24	Clostridium Difficile Infection (CDI) (East Berkshire CCG's) - Commissioning	<p>The Clinical Audit Department at Berkshire Healthcare NHS Foundation Trust was commissioned by the three Clinical Commissioning Groups in the East of Berkshire (Slough, Bracknell & Ascot and Windsor & Maidenhead) to undertake an audit on Clostridium Difficile Infection and how it is managed and reported within the respective surgeries.</p> <p>The audit was designed to identify appropriate monitoring and reporting of patients who have been selected in the specific surgeries as having a Clostridium Difficile Infection episode recorded within their patient notes."</p> <p>Action: The completed audit report has been sent to the Commissioning CCG Lead.</p>
25	Clostridium Difficile Infection (CDI) (West Berkshire CCG's) - Commissioning	<p>The Clinical Audit Department at Berkshire Healthcare NHS Foundation Trust was commissioned by the four Clinical Commissioning Groups in the West of Berkshire (Newbury & District, North & West Reading, South Reading and Wokingham) to undertake an audit on Clostridium Difficile Infection and how it is managed and reported within the respective surgeries.</p> <p>The audit was designed to identify appropriate monitoring and reporting of patients who have been selected in the specific surgeries as having a Clostridium Difficile Infection episode recorded within their patient notes.</p> <p>Action: The completed audit report has been sent to the Commissioning CCG Lead.</p>

Appendix C Safety Thermometer Charts

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

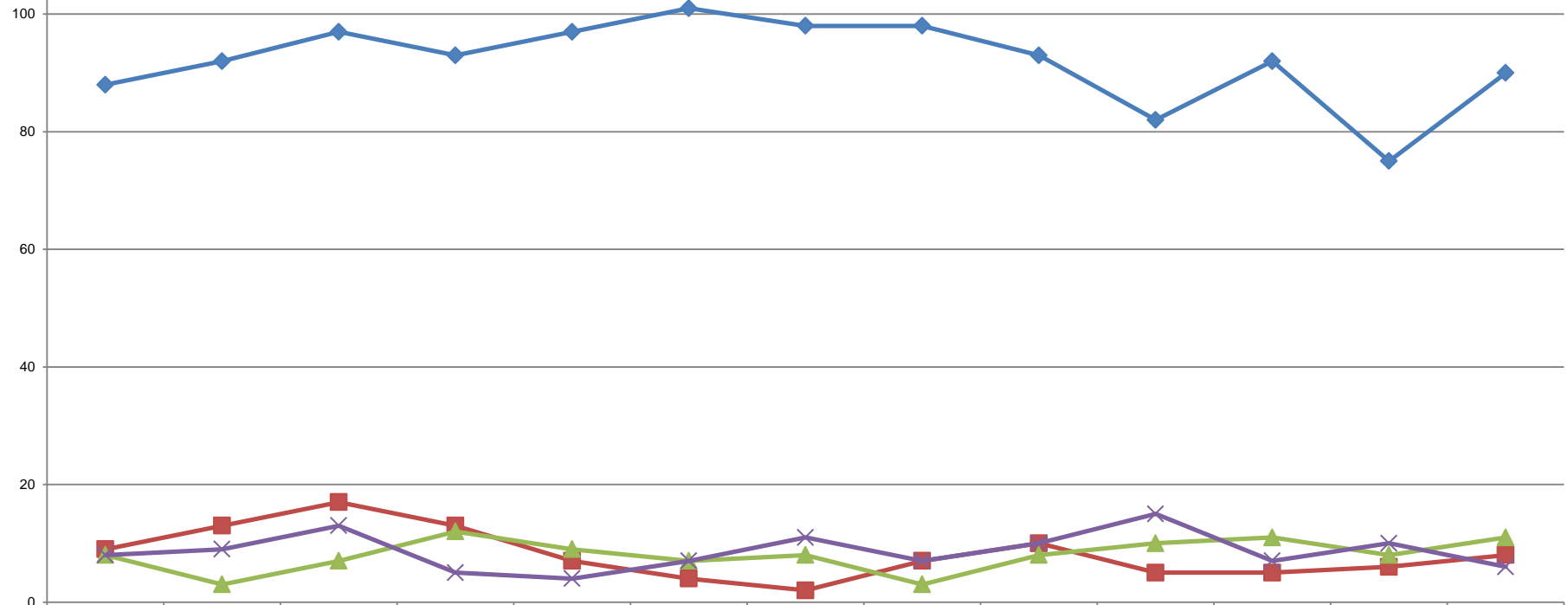
Data capture period	Number of patients surveyed	Percentage of Harm free care
Q3 2014/15	4064	92.2%
Q2 2014/15	3908	91.3%
Q1 2014/15	4144	91.7%
Q4 2013/14	3938	90.9%
Q3 2013/14	4241	92.0%

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



Types of Harm: patients with each type of Harm

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST
All Wards, All Settings, All Services, All Ages, All Sexes



	Dec13	Jan14	Feb14	Mar14	Apr14	May14	Jun14	Jul14	Aug14	Sep14	Oct14	Nov14	Dec14
Pressure Ulcers	88	92	97	93	97	101	98	98	93	82	92	75	90
Falls	9	13	17	13	7	4	2	7	10	5	5	6	8
Catheter & UTI	8	3	7	12	9	7	8	3	8	10	11	8	11
New VTE	8	9	13	5	4	7	11	7	10	15	7	10	6
Patients	1443	1191	1398	1349	1351	1441	1352	1308	1327	1273	1387	1360	1317

Appendix D CQUIN 2014/15 and 2015/16 (to be confirmed)

Goal Number	Description of Goal	Expected Financial Value of Goal (subject to agreement of weighting)
1a	Friends and Family Test – Implementation of staff FFT	£43,204.45
1b	Friends and Family Test - Early Implementation – Outpatient and Day Case Departments	£14,401.48
1c	Friends and Family Test - Phased Expansion	£43,204.45
2	Safety Thermometer - Reduction in pressure ulcers	£100,810.37
4a	Cardio Metabolic Assessment for Patients with Schizophrenia	£57,605.93
4b	Patients on CPA: Communication with GPs	£28,802.96
Local 5a	Frail Elderly – HWPFT	£180,018.52
Local 5b	Frail Elderly – FPFT	£144,014.82
Local 5c	Participation in integrated working with the Frimley System	£108,011.11
Local 6	Care Planning – EAST	£144,014.82
Local 7	7 day working	£100,810.37
Local 8	Psychological Interventions in Secondary Care	£86,408.89
Local 9	Employment Support	£86,408.89
Local 10	Smoking	£100,810.37
Local 11	CRHTT/Urgent Care	£100,810.37
Local 12	CAMHS	£100,810.37
		£1,440,148.18

