Berkshire Healthcare
NHS Foundation Trust

COUNCIL OF GOVERNORS

The next meeting will be held on Wednesday, 04 December 2019
starting at 10.30 am
At Easthampstead Baptist Church, South Hill Road, Bracknell

There will be a governor pre-meeting at 9.50am which is open to all governors

AGENDA

ITEM	DESCRIPTION	PRESENTER	TIME
1.	**Welcome & introductions**	Chair	2
2.	**Apologies for Absence**	Company Secretary	1
3.	**Declarations of Interest** 1. Amendment to the Register 2. Agenda items	 All All	1
4.1	**Minutes of Last Formal Meeting of the Council of Governors – 18 September 2019** *(this includes the minutes of the private meeting – these minutes are not confidential)*	Chair	2
4.2.	**Matters Arising**	Chair	5
5.	**Community Mental Health Team Presentation**	Gerry Crawford, Regional Director (West)	20
6.	**Annual Audit Committee Report** *(Enclosure)*	Chris Fisher, Chair of the Audit Committee	15
7.	**"Bite Size" Learning – the Role of the Audit Committee** *(a typical agenda for the Audit Committee is attached)*	Chris Fisher, Chair of the Audit Committee	5
8.	**Staff Wellbeing Initiatives Presentation**	Steph Moakes, Wellbeing and Engagement Lead	10
9.	**Diversity and Equalities – Staff Networks Presentation**	Bev Searle, Director of Strategy and Corporate Affairs	5
10.	**Quality Accounts Indicator** *(Enclosure)*	Amanda Mollett, Head of Clinical Effectiveness and Audit/Minoo Irani, Medical Director	10
11.	**Committee/Steering Groups** Reports: *a)* Living Life to the Full *(to follow)* *b)* Membership & Public Engagement (*to follow)* *c)* Quality Assurance meeting *(Enclosure)*	 Committee Group Chairs and Members	10

12.	**Executive Reports from the Trust** 1. Patient Experience Quarter 2 Report *(Enclosure)* 2. Performance Report *(Enclosure)*	Heidi Ilsley, Deputy Director of Nursing Julian Emms, Chief Executive	15
13.	**Governor Feedback Session** *This is an opportunity for governors to feedback relevant information form any external meetings/events they have attended*	Martin Earwicker, Chair	
14.	**Council of Governors Annual Work Programme** *(Enclosure)*	Martin Earwicker, Chair	2
15.	**Any Other Business**	Chair	5
16.	**Dates of Next Meetings** 5 February 2020 – Joint Non-Executive Directors and Council of Governors Meeting 18 March 2020 – Council of Governors meeting *(Meetings held at Easthampstead Baptist Church)*	Martin Earwicker, Chair	2

Berkshire Healthcare
NHS Foundation Trust

Council of Governors

Wednesday 18 September 2019

Minutes

Public Governors	John Barrett Tom Lake Paul Myerscough Nigel Oliver Andrew Horne Linda Berry Pat Rodgers Ray Fox David Lloyd-Williams Tom O'Kane Jenny Cheng Tom Wedd Suzanna Carvalho Graham Bridgman
Staff Governors	Julia Prince Guy Dakin June Carmichael
Appointed Governors	Isabel Mattick Suzanna Rose
In attendance	Martin Earwicker, Chair Julian Emms, Chief Executive Alex Gild, Deputy CEO and Chief Financial Officer Julie Hill, Company Secretary Jenni Knowles, Office Manager and Assistant Company Secretary Louise Arnold, Deputy Office Manager and Executive Assistant (Minutes)

Apologies:	Natasha Berthollier Joan Rosalind-Moles Verity Murricane Marion Child Gerry Barber Gillian Mohamed Jagiwan Lal Gopal Amrik Banse

1. Welcome and Introductions

Martin Earwicker, Chair welcomed all Governors and staff to the meeting.

2. Apologies for Absence

Apologies for absence were received and noted above.

3. Declarations of Interest

1. Amendments to the Register – None to note.

2. Agenda items – None to note.

The Declarations were noted.

4.1 Minutes of the previous meeting – 17 June 2019

The minutes of the meeting held on 17 June 2019 were approved with no amendments to be made.

4.2 Matters Arising

There were no matters arising.

5. External Auditors Report to the Council of Governors on the Quality Accounts 2018/19

The Chair formally welcomed Chris Randall, External Auditor, to the meeting.

Chris Randall introduced the report and explained that the purpose of the external audit was to check the quality and consistency of the information provided in the Quality Accounts. It was also to make sure that the Quality Accounts met the requirements of NHS Improvement. It was noted that the External Auditors had reviewed three indicators in detail selected from a list of indicators chosen by NHS Improvement. The Governors had also selected an indicator for external review.

Mr Randall assured the Council that there were no issues reported regarding the quality of the data, with only one minor recommendation made.

Paul Myerscough questioned whether there could be additional data problems not picked up by the external auditors if they were only sampling data. Chris Randall confirmed that this was a possibility; however the way the sampling was conducted was nationally agreed with NHS Improvement. There was also additional reassurance provided through the internal Trust data assurance processes on indicators on all areas of the report.

The sample size reviewed by the external auditors was currently less than 1%. Paul Myerscough asked whether this could be increased. Chris Randall explained that a bigger sample could be reviewed, however the main purpose of the external review was to ensure overall processes and procedures were being followed. With this being reviewed, it should give adequate reassurance that the Management of the Trust were monitoring all quality aspects across all services to the same standard. If

the auditors had any concerns about the above, then further investigations would take place.

Chris Randall reassured the Council that the data contained in the Quality Accounts report provided was deemed to be 'satisfactory' which was the highest level of assurance that can be awarded to a Trust for this work.

6. BHFT Annual Report and Accounts 2018/19

Julian Emms, Chief Executive, was formally welcomed to the meeting. The report was taken as read.

Julian Emms shared that the full version of the annual report and accounts was available on the Trust Website if any Governors or members of the public would like to read the report in more detail.

Mr Emms drew attention to the following areas of performance:

Harm Free Care
This focussed on reducing the incidence of self-harm, pressure ulcers, falls, infection and suicide.

There were improvements being made for each of the above areas, with agreed targets to be achieved within set time frames. The Trust was a national high performer in relation to reducing patient falls, however there was still ongoing work to improve this area further.

There was a short period of time where the number of self-harm incidents had increased. However, this was thought to be due to improved reporting of incidents rather than the number of incidents increasing. The number of self-harm incidents was now reducing and performance was on track to achieve targets agreed at the beginning of the year.

Julian Emms noted that the CQC had awarded the Trust 'Outstanding' for the Well-Led domain but with a 'Good' rating overall. It was likely that the CQC would be re-inspecting the Trust again by the end of the calendar year.

Supporting our staff

The number of assaults on staff had initially increased, like the number of self-harm incidents, however data has shown a significant increase in reporting and a better accuracy in the reported numbers. Since the baseline had now been set, there had been a significant reduction recorded.

Julian Emms specifically highlighted that the Recruitment and Retention targets had been achieved, however as this area continued to be a high risk for the Trust, improvement work would be ongoing and new targets set.

There had been significant improvements relating to staff network groups, including the creation of; LGBT, BAME and Disability staff networks. All of which were chaired by staff members, with Executive Leads associated and supporting them. There were long term plans in place to continue to grow these and the work was being monitored through the 'Making it Right' campaign. Additional support to Managers was being provided to ensure they understood the importance of the above networks and their teams felt supported.

Good patient experience
Julian Emms specifically noted that there had been significant improvements made to reducing the use of prone restraint across Trust services, which had been achieved by using Quality Improvement methodology. It was noted that some patients chose prone restraint in their safety plan but in these cases, staff would work with patients to make sure that they understood the associated risks and would try and persuade them to opt for a safer method of restraint.

Linda Berry asked how a patient was able to choose the use of prone restraint as part of their safety plan.

Linda Berry asked whether a reduction in prone restraint use resulted in an increased risk to staff. Julian Emms reassured the Committee that restraint had always been the last course of action and it was only used to de-escalate situations.

Money Matters
Julian Emms confirmed that the Trust had achieved the £5million savings target in the 2018/19 financial year. This was partly achieved via efficiencies and procurement improvements which did not directly affect the front-line staff or patients.

Andrew Horne questioned the target of zero waste going landfill. Julian Emms explained that the Trust paid for as much waste to be recycled as possible. This was separated between clinical and non-clinical waste. The clinical waste incinerated and therefore did not go to landfill.

John Barrett asked how many teams had completed the Quality Improvement training. Julian Emms shared that there were approximately 190 teams within the Trust, half of which were now trained.

Tom O'Kane asked whether all Managers received Equality and Diversity training. Julian Emms confirmed that all Managers had to undertake equality and diversity awareness training; however there was ongoing work to expand this training and ensure that an appropriate level of training was provided to all existing and new Managers.

Financial Review for 2018/19

Alex Gild, Deputy Chief Executive and Chief Financial Officer, was formally welcomed to the meeting. The report was taken as read.

Alex Gild shared that the full version of the Trust's Annual Accounts are available on the Trust Website if any Governors or members of the public would like to read the report in more detail. The reports have all been audited by external auditors prior to being published.

The Trust was currently in a strong, steady and stable position financially. In March 2019, the Trust had delivered a better position than set targets, meaning that there would be less financial pressure in the current financial year.

There had been significant temporary staffing costs reported in previous years and the Trust had been targeting this area for significant monetary savings. There had been a change from using agency staff to workforce Bank staffing to provide more flexibility and less cost.

Alex Gild shared that there are restraints on the capital funding provided by NHS Property Services, which has impacted all Trusts nationally. The main financial focus for the current year is to ensure a healthy cash income to support workforce and support the ongoing improvements across services.

Paul Myerscough referred to a recent news report on Radio Berkshire relating to long waiting times for CAMHs and eating disorder services. Paul asked whether additional monies could be allocated to services such as these to minimise waiting times. Alex Gild explained that funding for services such as the Eating Disorders team was provided by the Commissioners and the team was continually working in partnership with them to request and negotiate additional funding to support with the services. The Trust would not be able to sustain internal funding allocated to services such as this and therefore the monies must be provided by the Commissioners.

Tom O'Kane noted that there was a current staff vacancy of 10% and asked what the impact would be if the 5% target was achieved. Alex Gild confirmed that if the target was achieved then it would increase monthly outgoings of Trust PAYE, however it would simultaneously reduce costs for turnover and the cost of temporary staffing.

7. Quality Improvement Programme – Finance Department

The Chair formally welcomed Guy Dakin, Finance Manager, to the meeting in his staff capacity.

Guy Dakin explained the purpose of the discussion and noted that Governors had requested to hear some first-hand feedback on the new Quality Improvement Programme, how the metrics, weekly huddles and standard ways of working work.

The Finance Team are in a current wave of training, where improvements are being made with the quality improvement processes. Guy Dakin explained that the True North goals set by the Trust Board have been reviewed and the Finance Team have subsequently worked together to consider how their team can support those goals. An example was provided relating to filing vacancies across the Trust. This is a live example of a 'Tracker Metric' where the team are monitoring the work, but no changes are being made yet. It is likely that it may be improved in the future, but not until enough evidence is collated.

Another example was provided relating to aged debts and what external stakeholders owe the Trust. This is an example of a 'Driver Metric' where the team will actively work to make improvements to the area. This specific example has seen a significant reduction since changes have been made and is now at the lowest level it has been for a long period of time.

'Standard Work' is a terminology used to encourage the whole finance team to work in one way, using the best practice available to complete the task. These standard ways of working are designed collectively as a team to ensure the highest standard is achieved by all. To support with the standard way of working, every staff member has a monthly 1:1 with their Manager additional to the group work sessions and huddles. During the 1:1's workloads are discussed, along with the staff members' health and wellbeing, personal objects and personal development throughout the year.

There is a 'huddle' scheduled once a week for the entire finance team, 30 of which usually attend regularly. The purpose of a huddle is to discuss performance on work and improvement ideas suggested by team members. The team make informed decisions together about which ideas want to be prioritised and implemented in the

service and which ideas may be delayed for review at a later date. By using the Huddles to discuss new ways of working, it ensures that there will be no duplication, resources are being used efficiently, ideas are validated and prioritisation is being considered across all sectors of the team.

Guy Dakin shared that the Finance team had been shortlisted for an Award by the HFMA South Central Branch for system working. Recently the service found out that they had won the Award. Guy noted that this Award was partly down to the new ways of implemented working and the changes the Quality Improvement System had encouraged them to make.

8. Appointment of Lead Governor and Deputy Lead Governor

Julie Hill explained to the Council that there would be no requirement for an election in the meeting as only one Governor for each position had put themselves forward.

Lead Governor appointed – Paul Myerscough
Deputy Lead Governor appointed – David Lloyd-Williams

The above individuals were appointed.

9. Committee Steering Groups

a) Living Life to the Full

The report was taken as read.

John Barrett gave an overview of the meeting, noting that the majority of the meeting was based around the Carers Strategy and how this is implemented across the Trust. A presentation was provided by Chris Allen and his trainee, which informed the members about the improvements being made.

John Barrett highlighted that there have been some new additions to the group, including Ray Nair who is based within the Crisis Team in East Berkshire.

Ruth Lysons and Chris Fisher, Non-Executive Directors have joined the group and supported with the revised Terms of Reference. John Barrett requested that the Council of Governor review those submitted within the paper pack and approve if they feel the changes are appropriate.

It was unanimously agreed that the proposed changes to the Terms of Reference would be approved.

b) Membership & Public Engagement Group

The report was taken as read.

Tom Lake briefly updated the Council on the membership numbers, explaining that the Trust target is 12,000 members, which means the team are over achieving. It was noted that the Talking Therapies service are currently recruiting a lot of new members via their service route which is supporting the increase of members.

Tom Lake referred to the Sub-Committees Terms of Reference and shared that no changes are being suggested to be made.

It was unanimously agreed that the Terms of Reference would be approved.

C) Quality Assurance Group

The report was taken as read.

Paul Myerscough explained to the Governors that the Sub-committee meeting was held the week prior to this meeting and therefore there was a delay in circulating the formal update.

Paul Myerscough shared that after chairing the sub-group for three years, he will be passing over the responsibility over to Susana Carvalho. If any Governors would like to join this group, then it was requested they contact Susana.

The Terms of Reference for the Sub-Group were discussed virtually, and proposed changes submitted for approval by the Council.

It was unanimously agreed that the proposed changes to the Terms of Reference would be approved.

10. Executive Reports from the Trust

a) Performance Report

The report was taken as read.

Graham Bridgman highlighted that on page 5 of the report, it referred to a 'RAG rating' for the Friends and Family Test, however there was no scope for 'Amber' to be used. Graham asked for clarification regarding the coding of the report. Julian Emms agreed that it should not be referred to as a 'RAG rating' as only green and red indicators are used to represent improvements or reduction in performance. It was agreed that Alex Gild would review this offline with the performance team and update the report.

Action: Deputy Chief Executive and Chief Financial Officer

b) Patient Experience Report

The report was taken as read. Heidi Ilsley, Deputy Director of Nursing, was formally welcomed to the meeting.

Heidi Ilsley, Deputy Director of Nursing highlighted the main headlines of the report, including;

- The Friends and Family Test (FFT) achieved 12% response rate, however the national target was currently set at 15% response rate. Heidi explained that there had been an increase of responses received from patients in all services, however due to the accuracy of discharge data; it did not reflect the increase in the response percentage. Work continued to happen in this area to achieve the national target.
- There had been the same number of complaints received compared to the previous year and 100% of those were responded to within the national set time frames.

- 1004 compliments had been received by services which was an increase to 2018/19 data.

Tom Lake asked about the variety of FFT responses across services and asked for additional information about the next steps to improve these across all areas. Heidi Ilsley, Deputy Director of Nursing reassured the Governors that the work was being focussed on in the majority of services, specifically inpatient wards, with countermeasure summaries in place to support the ongoing work. It was acknowledged that receiving feedback from patients or family of patients who had been sectioned is difficult to obtain.

11. "Bite Size Learning" – Naomi Coxwell, Non-Executive Director - A Non-Executive Director's Perspective

Naomi Coxwell, Non-Executive Director, was formally welcomed to the meeting.

Naomi Coxwell is the Chair of the Finance, Investment and Performance (FIP) Committee. Naomi explained to the Governors that good reporting was key to the success and monitoring of data. All reports were received 1 week prior to the meetings to allow sufficient time for the attendees to review the information and prepare any questions or challenges they may have. The finance and performance reporting was noted to have significantly improved in the last year and the data now provided was much easier to understand and use.

The responsibilities of the Committee were to focus on finance reporting, performance of finance measures, operations delivered through the True North Goals and Safe Staffing. Naomi highlighted that without safe staffing guaranteed in services, the Trust would not be able to function. In recent years it had shown that recruitment for the Trust was not a risk, but the retention of staff which caused the safe staffing issues. The Committee continued to monitor progress with regular updates from the Human Resources directorate.

John Barrett referred to staff retention and noted that there was a high percentage of young female staff in the workforce. John asked whether there was dedicated work to ensure their return to work after maternity leave. Naomi Coxwell confirmed that there were initiatives to support with return to work. One particular staff group it was difficult to retain staff were the Band 5 nurses. This was due to promotions and the high cost living in Berkshire. The Trust continues to work with this staff group, as well as others, to engage and find sustainable fixes to support with retention.

Tom Lake asked how Investment of projects arises. Naomi Coxwell explained that proposals for capital expenditures were submitted via the finance and capital teams. Projects were only reviewed through recommendations and after consideration of costs relating to estates and I.T.

12. Governor Feedback Session

Falls Technology

Graham Bridgman referred to a recent programme that piloted a project to track falls in the community, in patient's own homes. This pilot was for a box to be installed into the patient's living room. It could detect whether the individual had fallen. The sensors used were of high quality and could also know whether there were additional people in the home or if the patient had gone to bed. Graham noted that this may be

of interest for other Governors to watch and may be something to be considered by the Trust for future falls technology.

Equality and Diversity Training

Tom O'Kane asked whether it would be helpful for Governors to complete online Equality and Diversity training. The Chair agreed to look into this offline.

Action: Chair/Company Secretary

ICS – Partnership Working

Isabel Mattick requested for an update on the ICS and partnership working in one of the coming meetings. Julie Hill agreed to review this request offline.

Action: Company Secretary

13. Governors Document Store Update

Paul Myerscough gave a brief introduction about a new Document store which will be available for Governor use soon. The purpose of this document store is to provide a secure archive of meeting papers, minutes, and other important documents of interest to Governors. This means Governors can access current and historical documents independently via the Internet without having to rely on support from Trust admin staff. Paul requested the support of a few Governors to test this new system before it was made available for all to use. If Governors would like to be involved, it was requested that they contact to Jenni Knowles or Paul outside of the meeting.

14. Council of Governors Annual Work Programme

Julie Hill referred to page 91 of the papers, which was a proposed work schedule of meetings for the coming annual year and asked for Governors' comments.

Tom Lake asked when the Governors would have an opportunity to receive the Quality Accounts. Julie Hill agreed to ask the Medical Director and Head of Clinical Effectiveness and Audit if they would be available to present the draft Quality Accounts at the March 2020 meeting.

Action: Company Secretary

15. Annual Schedule of Meetings

The Chair referred to the Annual Schedule of Meetings for 2020 and recommended that they are approved for the next calendar year.

It was agreed that the format of the meeting frequency and content would continue. The proposed dates were unanimously supported by the Council of Governors.

16. Any Other Business

Suzanna Rose noted that the Bed Occupancy rates and admissions at Prospect Park Hospital were particularly high currently and asked whether the issue was being addressed. Heidi Ilsley, Deputy Director of Nursing acknowledged this and reassured the meeting that this was continuously monitored as a high priority at Board level. It

was explained that Bluebell Ward had recently been closed due to a high acuity of patients and this had a subsequent impact on the other wards at Prospect Park Hospital.

The Chair shared with the Council that Ruth Lysons, Non-Executive Director, would be retiring at the end of October 2019. Formal thanks were recorded for her dedication to the Trust during the past 6 years and for her valued input into the Council of Governors.

Dates of next Council meetings

- 06 November 2019 – Joint NED and Council of Governor Meeting
- 04 December 2019 – Formal Council of Governor Meeting

I certify that this is a true, accurate and complete set of the Minutes of the business conducted at the meeting of the Council held on 20 March 2019.

Signed:……
(Martin Earwicker, Chair) Date: 04 December 2019

Berkshire Healthcare NHS Foundation Trust

Council of Governors – Confidential Meeting

Wednesday 18 September 2019

Minutes

Public Governors	John Barrett Tom Lake Paul Myerscough Nigel Oliver Andrew Horne Linda Berry Pat Rodgers Ray Fox David Lloyd-Williams Tom O'Kane Jenny Cheng Tom Wedd Suzanna Carvalho
Staff Governors	Julia Prince Guy Dakin June Carmichael
Appointed Governors	Isabel Mattick Suzanna Rose
In attendance	Martin Earwicker, Chair Julie Hill, Company Secretary Jenni Knowles, Office Manager and Assistant Company Secretary Louise Arnold, Deputy Office Manager and Executive Assistant (Minutes)

Apologies:	Natasha Berthollier Joan Rosalind-Moles Verity Murricane Marion Child Gerry Barber Gillian Mohamed Jagiwan Lal Gopal Amrik Banse

1. Welcome and Introductions

Martin Earwicker, Chair welcomed all Governors and staff to the confidential part of the meeting.

2. Apologies for Absence

Apologies for absence were received and noted above.

3. Declarations of Interest

1. Amendments to the Register – None to note.

2. Agenda items – None to note.

The Declarations were noted.

4. Appointment of Vice Chair and Senior Independent Director

The Chair explained that Ruth Lysons was the Vice Chair and Senior Independent Director for the Trust, as well as Non-Executive Director. Ruth also chaired the Sub-Committee Quality Assurance Committee. The Chair recommended the following:

- Chris Fisher, Non-Executive Director, is appointed to Vice Chair
- Naomi Coxwell, Non-Executive Director, is appointed to Senior Independent Director for the Trust

The Council unanimously agreed the above recommendations.

5. Council of Governors' Appointments and Remuneration Committee Report

Appointment of a new Non-Executive Director

The Chair explained to the Council that Ruth Lysons would be leaving the Trust at the end of October and shared the full recruitment process. GatenbySanderson were the independent recruiters for the position.

The recommendation for appointment is for Aileen Feeney to be appointed as Non-Executive Director.

The Council unanimously agreed the above recommendation.

Changes to Non- Executive Directors' Remuneration

The Chair explained to the Council that the renumeration of Non-Executive Directors had been unchanged since 2013, where each individual received a salary of £11k and additional responsibility allowance where applicable.

After completing a National benchmarking exercise, neighbouring Trusts are currently paying a fixed salary of £15k. The Chair recommended that all Non-Executive's pay is increased to £15k, with no additional allowances for responsibilities.

The Council unanimously agreed the above recommendation.

6. Council of Governors' Appointments and Remuneration Committee

The Chair, Martin Earwicker left the room and Paul Myerscough, Lead Governor led on the following items for discussion.

Re-Appointment of the Trust Chair

Paul Myerscough explained that Martin Earwicker was appointed as Chair 3 years ago, with a 3-year term. A recommendation has been provided to automatically renew Martin's term for an additional 3 years.

The Council unanimously agreed the above recommendation.

Chair's Remuneration

Paul Myerscough shared the recommendation to leave the Chair's remuneration the same, with no change to be made.

Graham Bridgeman noted that he was surprised to see no change proposed to the Chair's remuneration. Paul Myerscough explained that there was also a Benchmarking piece of work completed and the current salary is in line with neighbouring Trusts.

The Council unanimously agreed the above recommendation.

Berkshire Healthcare
NHS Foundation Trust

ACTION LOG
COUNCIL OF GOVERNORS – FORMAL MEETING
December 2019

Action Log - Items Requiring Decision/Discussion or For Information		
Minute No 10 a)	*Performance Report* The format of the Friends and Family Test performance information to be changed so it would no longer be a RAG rating (because the target was either achieved or not. Response The format of the Performance Report has been amended for future reports.	**Completed**
12	*Governor Feedback Session* Governors having access to an online Equalities and Diversity training module. Response The Company Secretary has arranged for the Trust's Equality, Diversity and Inclusion Manager to run a short Equalities and Diversity training session for Governors. The date is to be confirmed.	**In progress**
12	*Governor Feedback Session* The Governor to be updated about the work of the Integrated Care Systems Response The Joint Non-Executive Directors and Council of Governors meeting on 6 November 2019 focussed on the work of the Integrated Care Systems.	**Completed**
14	Council of Governors Annual Work Programme The Annual Work programme to be amended to include an opportunity for Governors to receive the draft Quality Accounts Report. Response The draft Quality Accounts Report will be submitted to the March 2020 Council of Governors meeting. The work programme has been updated.	**Completed**

Berkshire Healthcare
NHS Foundation Trust

Annual Report of the Trust's Audit Committee to the Council of Governors
04 December 2019

SUMMARY

In line with the NHS Foundation Trust Code of Governance, it is regarded as best practice for the Audit Committee to provide a report annually to the Council of Governors to:

- Highlight any relevant audit issues identified during the year in respect of which the Committee considers action or improvement is warranted and setting out the steps to be taken.
- Comment on the quality of the auditors work and on the reasonableness of the fees (if appropriate).
- The guidance states that the Audit Committee "must make a recommendation to the Council of Governors with respect to the reappointment of the auditor".

Introduction

The Audit Committee's chief function is to advise the Trust Board on the adequacy and effectiveness of the Trust's systems of internal control, risk management and governance and also its arrangements for securing economy, efficiency and effectiveness. The Committee's terms of reference are attached at appendix 1.

As requested by the Council of Governors, this annual reported has been expanded to provide more detail about the work of the Committee. It should be noted that the full minutes of the Audit Committee are presented to the next meeting of the Public Trust Board (the Trust Board's meeting papers are available from the Trust's website).

Committee Membership

The members of the Committee during 2019 (all of whom are Non-Executive Directors) were as follows:

Chris Fisher, Non-Executive Director and Audit Committee Chair
Naomi Coxwell, Non-Executive Director
Mehmuda Mian, Non-Executive Director

Mark Day, Non-Executive Director deputised for Mehmuda Mian at the October 2019 meeting.

Executive support to the Committee included regular attendance by the Deputy Chief Executive and Chief Financial Officer, Director of Finance, Director of Nursing and Therapies, Medical Director and Head of Clinical Effectiveness and Audit. The Committee is supported by the Company Secretary.

External representation included representatives of Deloitte, External Auditors, RSM Risk Assurance Services, Internal Auditors and TIAA, Counter Fraud Services.

During 2019, the Committee met on five occasions, including May 2019 when the Annual Accounts were presented. All meetings were quorate.

The minutes of each Committee meeting are received at the next available Trust Board meeting. The Audit Committee Chair presents the minutes and highlights any key areas of the Committee's discussions.

Committee Self-Assessment of Effectiveness

The Committee undertakes an annual self-assessment of effectiveness. Members and regular attendees are requested to rate the performance of the Committee and make suggestions for improvement. The results are then considered to determine what action, if any, may be necessary. The results of the latest self-assessment exercise were reported to the July 2019 Audit Committee meeting.

Overall, the results were very positive. Non-Executive Director succession planning was identified as an area for improvement, especially as the Audit Committee Chair's second term of office will end on 30 September 2020. The Council of Governors' Appointments and Remuneration Committee would start the recruitment process for the Audit Committee Chair's successor in the New Year.

Audit Committee Professional Development Session

One of the areas identified for further improvement from the 2018 Committee self-assessment was around continuing professional development for Committee members.

Starting from July 2019, the Committee now holds a professional development session an hour before each meeting (with the exception of the special meeting to approve the annual accounts on behalf of the Trust Board in May 2019).

Members of the Finance, Investment and Performance Committee (which meets in the morning on the same day as the Audit Committee) are also invited to attend.

These sessions are facilitated by the Trust's External or Internal Auditors or by the Counter Fraud Specialist.

The first session in July 2019 was on Corporate Governance and was facilitated by Deloitte, the External Auditors. The topic for October 2019 was the Board Assurance Framework.

The sessions provide an opportunity for the members of the Audit Committee and the Finance, Investment and Performance Committee to discuss topical issues and to find out from the Trust's external partners about best practice elsewhere in the sector.

Summary of Work Undertaken

During 2019 key activity included:

A) Board Assurance Framework and Corporate Risk Register

The Committee reviews the Board Assurance Framework and the Corporate Risk Register at each meeting in order to maintain scrutiny on the management of risks to strategic and corporate objectives. In addition, the Committee identifies risks for "deep dives". The deep dives provide the Committee with more information about how the risks are being mitigated and managed.

The Committee received deep dive reports on the following risks:

- **Demand Outstripping Supply** (Board Assurance Framework risk)

This risk is around managing the increased demand for community and mental health services due in a number of factors, including increased referrals and shortages and a lack of alternative services from other providers.

- **Ligature Risk** (Corporate Risk)

The Ligature Risk is a standing risk on the Corporate Risk Register. The assessment and management of ligature points is a key requirement for mental health trusts, as hanging is the most frequently used method of suicide for mental health service users. The Trust's policy is to remove all ligature points considered to pose a significant risk to service users so far as is reasonably practicable.

- **"Near Miss" Incident Reporting** (Corporate Risk)

A "Near Miss" is an event not causing harm, but has the potential to cause injury or ill health. The risk was added to the Corporate Risk Register following a serious incident on Sorrel Ward, Prospect Park Hospital where a patient managed to get out of the ward through the airlock. On this occasion, the patient was immediately found and escorted back to the ward and did not suffer any harm. Staff did report the incident but did not recognise the significance of the "near miss". A few weeks later another patient left the ward via the airlock and took their life.

- **Physical Environment of Prospect Park Hospital** (Corporate Risk)

This risk is around ensuring that that the physical environment at Prospect Park Hospital is maintained so that it meets current regulatory standards and complies with national safety alerts. For example, following a national safety alert, the taps at Prospect Park were replaced to remove a potential ligature risk.

In each of the above "deep dive" reports, the Committee was assured that the correct controls and actions were in place to mitigate the respective risks.

B) Cyber Security Annual Report

The Cyber Security Annual Report provided assurance that the Trust's cyber security systems and processes were effective. We noted that between November 2018 and December 2018, the Trust had received 2.6 million emails of which 2,452 were blocked because they contained malware.

C) Changes to the Application of Financial Limits to the Scheme of Delegation and Reservation of Powers to the Board and Delegation of Powers

Minor changes were made to the Application of Financial Limits to the Scheme of Delegation and Reservation of Powers to the Board and Delegation of Powers policies. The most significant change was around the approval of invoices. Prior to the change, Executive Directors needed to approve invoices above £75,000 and three Executive Directors were required to approve invoices above £100,000. The Committee agreed to amend the policy to allow Executive Directors' direct reports to approve invoices up to £100,000. For invoices over £100,000, the authorisation would be for one Executive Director. For invoices over £300,000, the requirement was that these would be approved by the Chief Executive.

D) Clinical Audit Programme

The Audit Committee's role is to ensure that there is an effective Clinical Audit process. This includes reviewing the annual clinical audit plan and receiving regular reports on both progress against plan and status of relevant action plans. The results of the individual clinical audits together with action plans to address any areas identified for further improvements are reviewed by the Quality Assurance Committee.

The Committee was assured that the Trust's Clinical Audit annual plan was on track. The Internal Auditors had also reviewed the Trust's Clinical Audit Action Planning process and had given a rating of "significant assurance".

E) Data Quality Assurance

The Trust recognises that all its decisions, whether clinical, managerial or financial need to be based on sound information that is of the highest quality. Information is derived from individual data items that are collected from numerous manual and digital sources. Use of information to support:

- effective patient care
- clinical governance
- management and service agreements for healthcare planning

This means that data quality is a crucial element in providing assurance that decisions made are the correct ones. The Committee received a quarterly Data Quality Assurance Report which sets out the results of the Trust's data quality audits.

F) Single Waiver Report

The Committee receives a quarterly report setting out details of any contracts which have been awarded to a provider without going through the usual procurement process. There are a number of reasons for single waiver contracts, for example, if the provider is the sole source of supply or an existing contract is extended pending a full procurement exercise.

G) Losses and Special Payments Report

The Committee receives a quarterly report on any losses or special payments made during the reporting period.

H) Clinical Claims and Litigation Report

The Committee receives a quarterly report on clinical negligence and employers' liability claims together with any learning and on-going work in relation to any themes identified as part of the claims process. Learning from the analysis of the claims (both clinical and employee detailed within this paper will be shared with the wider organisation through learning curve and patient safety and quality forums.

I) Approval of the Trust's Annual Accounts on behalf of the Trust Board

We convened a special meeting in May 2019 to approve the Trust's Annual Accounts on behalf of the Trust Board.

J) "Getting It Right First Time" Presentation

The Lead Clinical Director gave a presentation on the national "Getting It Right First Time" programme which aimed to reduce unwarranted variation in service delivery.

The Lead Clinical Director is the national lead for Crisis and Acute Children and Young People's Mental Health.

K) Other Matters

The Committee also receives:

- Reports from the Internal Auditors, External Auditors and Counter Fraud Specialist.
- The Internal and External Auditors and the Counter Fraud Service share national good practice and help the Audit Committee to be keep up to date with any new policy developments.
- Minutes of assurance related Committees, including the Finance, Investment and Performance and Quality Assurance Committees

There are no substantial issues or concerns that the Audit Committee needs to draw to the Council's attention from its work in 2019.

External Audit Matters

The Trust's External Auditors, Deloitte, attended the September 2019 Council of Governors meeting to present their audit report to the Governors.

The External Auditors audited the Trust's 2018-19 accounts and issued an unmodified audit opinion with no reference to any matter in respect of the Trust's arrangements to secure economy, efficiency and effectiveness in the use of resources or the Annual Governance Statement.

The External Auditors also issued a clean quality report opinion in respect of the Trust's Quality Accounts.

Internal Audit Reports

A copy of the Internal Auditor's 2018/19 annual report to the Audit Committee is provided at Appendix 2 *(to be attached to the report to the Governors)* for fuller information and assurance purposes.

The report concluded that based on the work undertaken in 2018/19, the Trust has an adequate and effective framework for risk management, governance and internal control. However, the Internal Auditors identified further enhancements to the framework of risk management, governance and internal controls to ensure that it remained adequate and effective. The required enhancements to the internal control framework were driven by the following "reasonable assurance" opinions:

- Fit Proper Persons Test
- Conflict of Interests
- Cost Improvement Programme Realisation
- Data Quality
- Supplier Contract Management

The Internal Auditors identified no actions rated as "high" priority in respect of the audits above. The actions rated as "medium" priority as set out below:

Medium Priority Actions

Fit and Proper Persons Test

The internal Auditors concluded that the Trust's revised Fit and Proper Person Test revised policies and procedures introduced in February 2018 reflected the Care Quality Commission's guidance published in January 2018. The Internal Auditors also commented that they had found instances where the Trust's procedures went above and beyond the Care Quality Commission Guidance and were reflective of best practice.
The Internal Auditors made one medium priority recommendation:

Enhanced Disclosure and Barring Service (DBS) certificate in place for all Board members.

- At the time of the audit one Executive Director only had a standard DBS certificate. There was a delay in the processing of the DBS checks and the Enhanced DBS certificate was issued a couple of days after the audit.

So far, the Internal Auditors issued no "partial assurance" or "no assurance" opinions during 2018-19/2019-20.

Conflicts of Interests

The Internal Auditors recommended that the Trust adopt NHS England's template for its annual members' declarations of interests and which requires each member of the Board to sign to confirm any business interests.

The Trust has adopted this template and the Company Secretary ensures that all Board members return and sign annual declarations of interest forms even if it is a "nil return".

The Internal Auditors recommended that for all items that require a tender, the Trust will perform a check on the last conflicts of interest disclosure by the employees involved in that decision. As part of the procurement paperwork, the Trust should confirm that the check has been completed and should record any actual and potential conflicts of interest and the actions that have been taken to mitigate these conflicts.

The Internal Auditors used independent Tracker software and found four instances where a directorship had appeared to match the Director's name and date of birth that had not previously been entered on the Register of Interests. The Company Secretary investigated each of the claims and in all cases, the Directorship related to historic interests.

Cost Improvement Programme Benefit Realisation

The aim of the review was to ascertain and test the process in place for the creation and approval of the Cost Improvement Programme systems, the underpinning assumptions to these schemes, the target setting takes place and the oversight arrangements of both senior management and the Board and divisional engagement with Cost Improvement Programme schemes.

The Auditors recommended that going forward, Cost Improvement Programme (CIP) schemes will be supported by pre-approval documentation that includes: the rationale of the CIP scheme; completed quality and equality assessments; assumptions made when planning the programme; action plan for achieving the planned scheme; and key performance indicators and SMART targets (both financial and non-financial).

The Internal Auditors recommended that a CIP methodology should be created and issued that detailed the Trust's approach to CIP schemes, CIP lifestyle and actions to place when developing, reviewing and reporting them.

Data Quality

The Internal Auditors concluded that there were sufficient, clear policies and procedures for data quality across the Trust.

The Internal Auditors recommended that whilst 85% of the Trust Services on the RiO (electronic patient record system), there was no overarching group that systematically looked at data quality systems for non-RiO services. The Trust agreed to ensure that there was sufficient oversight and governance of data quality for all Trust systems either through the Trust Business Group or another forum.

The Internal Auditors identified from their sample of three key performance indicators, that there was a lack of information about changes to standards being passed to localities and that this was also not easily available from the Trust's IT systems.

The Trust has completed an internal and action plan for ensuring compliance with standards, particularly around access standards.

Supplier Contact Management

The Internal Auditors reviewed three of the Trust's contacts. The Internal Auditors concluded that there was no Trust-wide contract management guidance and approaches to contract management. The Trust has developed an approach to managing contracts, whereby in most instances responsibility for contact management practice and standards rested with the department that owned the contractual relationships.

The Internal Auditors recommended that the Trust improved its management of the change control process within the Clinical Information Systems contract. This included requesting that the supplier introduced monitoring and reporting on the progress of each change control notice. It was also recommended that the Trust would include a breakdown of costs within its change control notice documentation so that there was a clear audit trail of what had been purchased through each change control notice.

Further recommended actions included: establishing and maintaining a control register; investing in supporting those contracts that the Trust considered as business critical; and introducing guidance around contract management practice so that there was an established view of good practice on how staff should manage contracts across the organisation.

The Internal Auditors issued "substantial assurance" opinions in respect of:

- Key Financial Controls
- Clinical Audit Assurance Process
- Risk Management and Board Assurance Framework

2019-20 Audit Programme *(audits completed after October will be reported as part of the Annual Audit Committee Report 2020)*

High and Medium Priority Actions

Fire Safety

The Internal Auditors concluded that there was adequate reporting and monitoring around fire safety incidents and issues and that the Trust had fire safety training courses in place for clinical and non-clinical staff.

The Internal Auditors identified areas for improvement in relation to fire safety training compliance (which was below target) and a lack of awareness around key roles and responsibilities. The Internal Auditors also recommended the appointment of an Authorising Engineer to provide technical assurance to the Authorised Persons (Fire) in line with the Fire Safety Policy.

The Internal Auditors identified a "high" priority action around making an easily accessible Fire Folder containing the up to date Fire Safety Policy to ensure that staff were aware of key roles and responsibilities in the event of a fire incident.

The Trust was also investigating ways of making the online fire safety training easier to access, including via smart phones and iPads. The recruitment of an Authorising Engineer is currently in progress.

Risk Management Culture

The Internal Auditors concluded that Senior Management had a strong understanding of their roles and responsibilities and that corporate processes were strong. To support the review, the Internal Auditors asked the Senior Leadership Team to complete a questionnaire to assess the risk management culture in the Trust. The results highlighted that additional training in risk management was required at the divisional level. This would also help to ensure that there was a more consistent approach to risk management across the Trust at the divisional level.

Medical Job Planning

The Trust has developed guidance which has been aligned to good practice to assist in the development of Consultants' job plans to ensure that a consistent approach was adopted across the Trust. The Internal Auditors identified inconsistencies in relation to the application of this guidance to ensure that appropriate plans were in place and had been appropriately reviewed and adopted.

(The remaining reviews for 2019-20 will be included in next year's Annual Audit Committee Report to the Council of Governors).

Overall Internal Audit Programme Progress

The table below sets out the ratings of the audit reviews conducted in 2018-19 which were not finalised when the Council of Governors received last year's annual audit committee report.

The table also sets out the ratings of the audit reviews conducted so far during 2019-20.

Audit Area	***Risk Rating***
2018/19	
Supplier Contract Management	Reasonable Assurance
Cost Improvement Programme Realisation	Reasonable Assurance
Clinical Audit/Effectiveness Follow Up	Significant Assurance
Board Assurance Framework and Risk Management	Significant Assurance
General Data Protection Regulation	Advisory
Key Financial Controls	Significant Assurance
Data Quality	Reasonable Assurance

Audit Area	*Risk Rating*
2019/20	
Fire Safety	Reasonable Assurance
Medical Job Planning	Reasonable Assurance
Rostering	TBC
Freedom to Speak Up – Draft	Reasonable Assurance
Risk Management Culture	Reasonable Assurance
Compliance with the Mental Health Act	TBC
Business Continuity and Disaster Recovery	TBC
Key Financial Controls	TBC

ACKNOWLEDGEMENTS

The Audit Committee also commends the sterling work carried out by the Trust's finance team on the annual accounts this year.

COUNTER FRAUD AND AUDITORS' CONTRIBUTION:

Throughout the year, the Audit Committee has been supported fully by the Trust's internal and external auditors and by the Counter Fraud Service.

The Committee is fully satisfied with the quality of the work undertaken by the Counter Fraud Service, TIAA, the Internal Auditors, RSM and the External Auditors, Deloitte.

ACTION:

The Council of Governors is invited to note the report and to seek any clarification.

Prepared by: Julie Hill
Company Secretary

Presented by: Chris Fisher
Chair of Audit Committee

Berkshire Healthcare
NHS Foundation Trust

Terms of Reference

Audit Committee

Purpose

This document contains the terms of reference for the Trust Audit Committee.

Document Control

Version	Date	Author	Comments
1.0	12 Mar 08	Garry Nixon	Initial Draft for Committee Chair
2.0	14 Mar 08	Garry Nixon	Updated following Committee Chair comments
3.0	1 May 08	Garry Nixon	Updated following Audit Committee consideration
4.0	22 May 09	John Tonkin	Revised per Internal Audit Report Recommendations on Integrated Governance – Ref: 080902
5.0	28 May 09	Clive Field	Minor amendments
6.0	12 August 2010	John Tonkin	Revision following Audit Committee review July 2010
7.0	14 Sept 2010	John Tonkin	Revision following Board consideration 14 Sept 2010
8.0	8 May 2012	John Tonkin	Revision following Board consideration 8 May 2012
9.0	12 April 2013	John Tonkin	General revision to reflect changes in past year
10.0	23 May 2013	John Tonkin	Revision following Board discussion on 14 May 2013
11.0	11 June 2013	John Tonkin	Board approved – 11 June 2013
12.0	13 May 2014	John Tonkin	Board approved - 13 May 2014
13.0	27 July 2016	Julie Hill	Revision following Audit Committee review – October 2016
14.0	08 November 2016	Julie Hill	Board approved – 08 November 2016
15.0	July 2018	Julie Hill	Revision following Audit Committee review – July 2018 – Board approved September 2018
16.0	July 2019	Julie hill	Revision following Audit Committee review – July 2019 – Board approved September 2019

Document References

Document Title	Date	Published By
NHS Audit Committee Handbook	2005	Department of Health & Healthcare
The NHS Foundation Trust Code of Governance	2006	NHS Improvement, Independent

		Regulator of NHS Foundation Trusts

Authority

1.1 The Audit Committee is constituted as a Standing Committee of the Trust Board of Directors. Its constitution and terms of reference shall be set out as below, subject to amendment at future Board of Directors' meetings.

1.2 The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee.

1.3 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary.

Purpose

2.1 To conclude upon the adequacy and effective operation of the Trust's overall internal control system and independently review the framework of risks, controls and related assurances that underpin the delivery of the Trust's objectives.

2.2 To review the disclosure statements that flow from the Trust's assurance processes ahead of its presentation to the Trust Board, including:

a. Annual Governance Statement, included in the Annual Report and Accounts and the Annual Plan together with the external and internal auditors' opinions.

b. Annual Plan declarations relating to the Assurance Framework.

Membership

3.1 The membership of the Committee shall comprise three Non-Executive Directors, at least one of whom shall have recent and relevant financial experience, plus, ex officio, the Chair of the Finance, Investment & Performance Committee. The Chair of the Quality Assurance Committee will attend as and when there are appropriate matters to discuss with the Audit Committee.

3.2 The Chair of the Trust and the Chief Executive shall **not** be members.

3.3 The Chair of the Committee will be a Non-Executive Director and will not be a member of any other standing Committee of the Board.

3.4 A quorum shall be two members.

In attendance at meetings

4.1 The Committee will be supported by the following in attendance:

- Chief Financial Officer
- Director of Finance
- Medical Director
- Head of Clinical Effectiveness and Audit
- Director of Nursing and Governance

- The Company Secretary

4.2 The Committee can invite the Chairman and Chief Executive as well as other Trust Directors or Officers to attend to discuss specific issues as appropriate.

4.3 The Committee will be attended by representatives of the following:

- External Audit
- Internal Audit
- Counter Fraud
- Clinical Audit

4.4 The Committee will consider the need to meet privately, at least once a year, with both the internal and external auditors. The internal and external auditors may request a private meeting with the Committee at any time.

Frequency and Administration of Meetings

5.1 The Committee will meet at least 4 times a year. It may meet more frequently at any time should circumstances require.

5.2 It will be supported by the Company Secretary who will agree the agenda for the meetings and the papers required, directly with the Chair.

5.3 Minutes of all meetings shall be formally recorded and submitted, together with recommendations where appropriate, to the Board of Directors.

Duties

Governance Risk Management and Internal Control

6.1 The Committee shall review the establishment and maintenance of an effective system of integrated Governance, risk management and internal control, across the Trust's clinical and non-clinical activities that support the achievement of its objectives.

6.2 The Committee shall ensure that the Board Assurance Framework is effective in enabling the monitoring, controlling and mitigation of risks to the Trust's strategic objectives.

6.3 In particular, the Committee will review the adequacy of the following:

a. All risk and control related disclosure statements, together with any accompanying Head of Internal Audit statement, external audit opinion or other independent assurances, prior to endorsement by the Board;

b. The underlying assurance processes that indicate the following:

- The degree of the achievement of corporate objectives
- The effectiveness of the management of principal risks
- The appropriateness of the disclosure statements

c. The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements.

6.4 The Committee shall request and review reports and positive assurances from Directors and managers on the overall arrangements for governance (including clinical audit and data quality), risk management and internal control.

Audit & Counter Fraud

6.5 The Committee shall ensure that there is an effective internal audit function and clinical audit function that provide appropriate independent assurance to the Audit Committee and includes the following:

a. Review the Internal Audit Plan, operational plan and programme of work and recommend this for acceptance by the Trust Board of Directors.

b. The review of the findings of internal audits and the management response.

c. Discussion and agreement with the External Audit of the nature and scope of the External Audit annual plan.

d. The review of all external audit reports, including the agreement of the annual audit letter before submission to the Board and any work completed outside the External Audit annual plan.

e. Review and approval of the Counter Fraud Plan and operational plans.

f. The review of the findings of the Counter Fraud plan and the management response.

6.6 Clinical Audit

The Committee shall ensure that there is an effective Clinical Audit process. This includes reviewing the annual clinical audit plan and receiving regular reports on both progress against plan and status of relevant action plans.

6.7 The Committee shall ensure that Internal Audit, External Audit and Clinical Audit recommendations are implemented promptly by management.

Financial Reporting

6.8 The Committee shall review the Annual Accounts and Financial Statements before submission to the Board.

6.9 It will ensure that the financial systems for financial reporting to the Board are subject to review as to completeness and accuracy of the information provided to the Board.

6.10 It will review the annual accounts of the Charitable Trustees prior to submission.

Reporting

6.11 The Committee will routinely review the minutes of:

- Finance, Investment & Performance Committee
- Quality Assurance Committee
- Quality Executive Committee

and will review the work of other committees within the organisation whose work can provide relevant assurance to the Committee.

6.12 The Minutes of the Audit Committee will be formally submitted to the Trust Board.

6.13 The Chair of the Committee shall report to the Board any concerns and assurances relating to the Trust and the Committee's work.

6.14 The Audit Committee Chair will produce an Annual Audit Report setting out the work of the Committee and highlighting any issues raised during the course of year by the Trust's Internal and External Auditors and the Counter Fraud Specialist. It will report annually to the Council of Governors Trust Board through an 'Audit and Governance Report' which will include the following:

a. The fitness for purpose of the assurance framework.

b. The completeness and embeddedness of risk management.

c. The integration of Governance arrangements.

d. The Committee's self-assessment and any action required.

Other functions

6.15 The Committee will review and monitor compliance with Standing Orders and Standing Financial instructions.

6.16 It will review the following:

a. Schedules of losses & compensations and making recommendations to the Board

b. Any decision to suspend Standing Orders

c. Decision to waive the competitive tendering rules when requested by the Board

d. New and existing claims

6.17 It will approve changes in accounting policies.

6.18 It will review the performance of the Audit Committee through self-assessment and independent review to be completed at least annually. It will also review the output from the annual self-assessment exercises conducted by other Board Committees.

6.19 It will provide oversight of the Trust's processes for ensuring robust data quality and will review periodic reports on data quality performance.

6.20 The Committee shall provide assurance on the quality checks of data used in the preparation of the Performance Assurance Framework.

6.21 The Committee will provide assurance on the system for identifying cost improvement plans, including the process for ensuring that there are no adverse impacts on quality.

Amended: July 2019
Board approved: September 2019

Next review: July 2020

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

Annual internal audit report 2018/2019

April 2019

RSM

CONTENTS

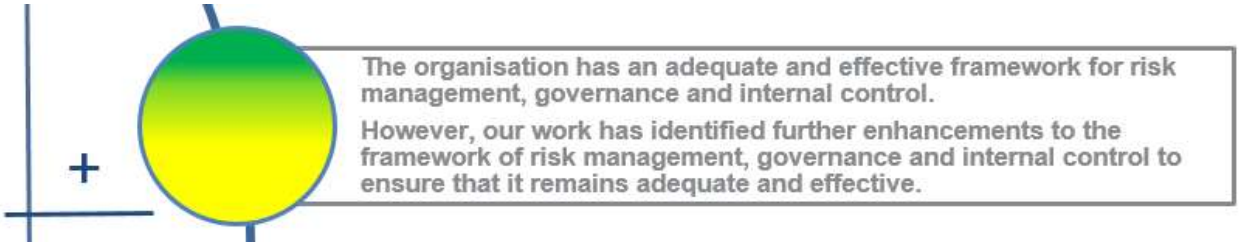
1 THE HEAD OF INTERNAL AUDIT OPINION

In accordance with Public Sector Internal Audit Standards, the head of internal audit is required to provide an annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes. The opinion should contribute to the organisation's annual governance statement.

1.1 The opinion

For the 12 months ended 31 March 2019, the head of internal audit opinion for Berkshire Healthcare NHS Foundation Trust is as follows:

Head of internal audit opinion 2018/19



The required enhancements to the internal control framework are driven by the following reasonable assurance opinions:

- Fit and Proper 1. 18/19
- Conflict of Interest 2. 18/19
- CIP Benefits Realisation 5. 18/19
- Data Quality 6. 18/19
- Supplier Contract Management 7. 18/19

Please see appendix A for the full range of annual opinions available to us in preparing this report and opinion.

1.2 Scope and limitations of our work

The formation of our opinion is achieved through a risk-based plan of work, agreed with management and approved by the audit committee, our opinion is subject to inherent limitations, as detailed below:

- the opinion does not imply that internal audit has reviewed all risks and assurances relating to the organisation;
- the opinion is substantially derived from the conduct of risk-based plans generated from a robust and organisation-led assurance framework. As such, the assurance framework is one component that the board takes into account in making its annual governance statement (AGS);
- the opinion is based on the findings and conclusions from the work undertaken, the scope of which has been agreed with management and lead individual;
- the opinion is based on the testing we have undertaken, which was limited to the area being audited, as detailed in the agreed audit scope;

- where strong levels of control have been identified, there are still instances where these may not always be effective. This may be due to human error, incorrect management judgement, management override, controls being by-passed or a reduction in compliance;
- due to the limited scope of our audits, there may be weaknesses in the control system which we are not aware of, or which were not brought to attention; and
- it remains management's responsibility to develop and maintain a sound system of risk management, internal control and governance, and for the prevention and detection of material errors, loss or fraud. The work of internal audit should not be seen as a substitute for management responsibility around the design and effective operation of these systems.

1.3 Factors and findings which have informed our opinion

Risk Management

In 2018/19, RSM undertook a review of the Trust's Risk Management and Board Assurance Framework (3. 18/19) and concluded that the Trust could take '*Substantial Assurance' on the controls in place*.

Internal Controls:

We provided a further eight assurance reviews and one advisory review (GDPR) resulting in the Trust being able to take the following levels of assurance:

Substantial assurance:

- Key Financial Controls 4. 18/19
- Clinical Audit Assurance Process 8. 18/19

Reasonable assurance:

- Fit and Proper 1. 18/19
- Conflict of Interest 2. 18/19
- CIP Benefits Realisation 5. 18/19
- Data Quality 6. 18/19
- Supplier Contract Management 7. 18/19

Advisory:

- General Data Protection 9. 18/19

Follow up:

A total of 63 management actions were due for implementation by 31 March 2019. 55 actions had been implemented, one Medium and two low priority actions were in progress / awaiting responses, and with five actions (2 medium and 3 low) not yet due for implementation.

A summary of internal audit work undertaken, and the resulting conclusions, is provided at appendix B.

1.4 Topics judged relevant for consideration as part of the annual governance statement

Based on the work we have undertaken on the Trust's system of internal control, we do not consider that within these areas there are any issues that need to be flagged as significant control issues within the Annual Governance Statement (AGS) as all reports have resulted in positive assurance opinions. The Trust may wish to consider whether any other issues have arisen, including the results of any external reviews which it might want to consider for inclusion in the AGS.

2 THE BASIS OF OUR INTERNAL AUDIT OPINION

As well as those headlines discussed at paragraph 1.3, the following areas have helped to inform our opinion. A summary of internal audit work undertaken, and the resulting conclusions, is provided at appendix B.

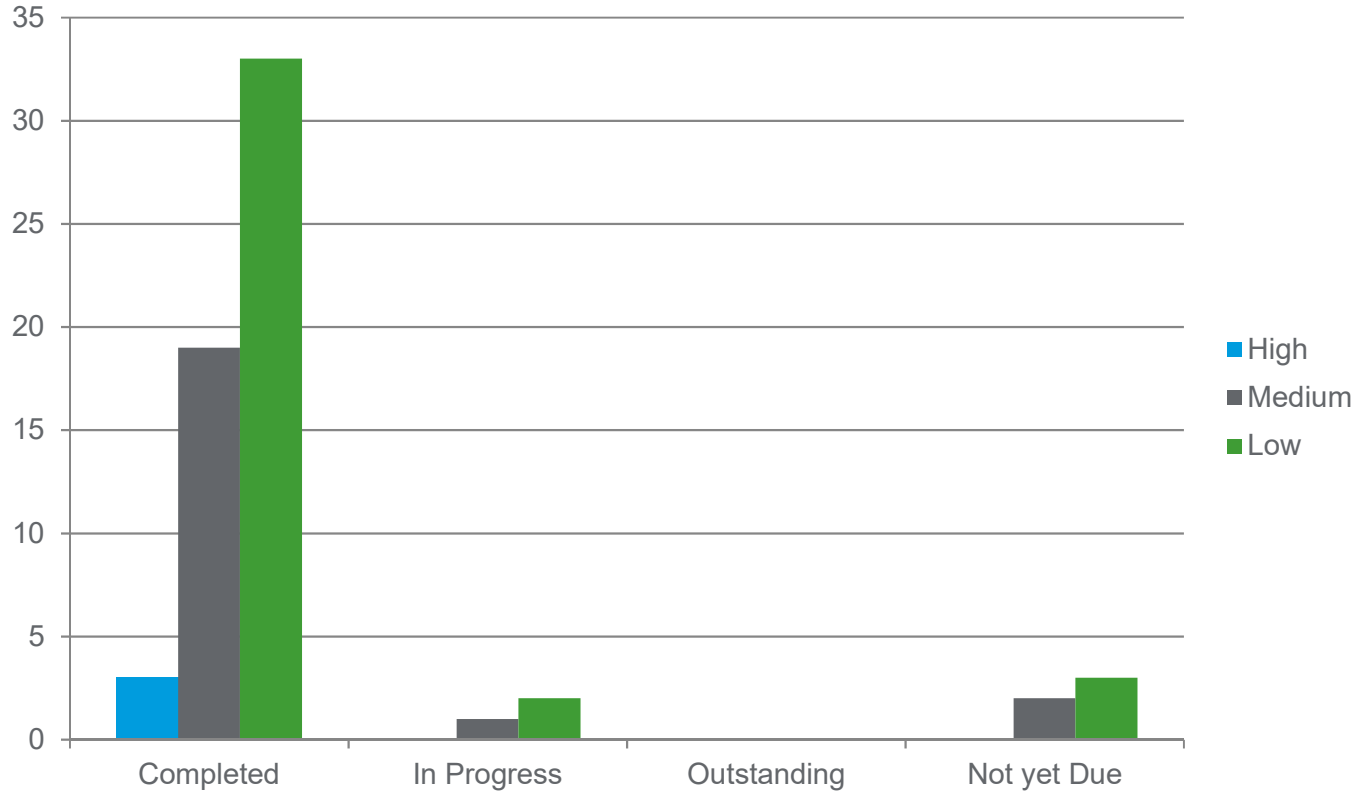
2.1 Acceptance of internal audit management actions

Management have agreed actions to address all of the findings reported by the internal audit service during 2018/2019.

2.2 Implementation of internal audit management actions

Where actions have been agreed by management, these have been monitored by management through the action tracking process in place. During the year progress has been reported to the audit committee, with the validation of the action status confirmed by internal audit and reported as part of our progress reports.

Our follow up of the actions agreed to address previous years' internal audit findings shows that the organisation had made good progress in implementing the agreed actions.



2.3 Working with other assurance providers

In forming our opinion, we have not placed any direct reliance on other assurance providers.

3 OUR PERFORMANCE

3.1 Wider value adding delivery

As part of our progress reports, we regularly provide sector updates to management and the audit committee.

Area of work	How this has added value
Use of clinical consultants	We have utilised our clinical consultants within internal audit work to add value to the overall findings and provide assurance with regards to clinical aspects of our work, and actions that are achievable given the confines of the current health economy.
Health Matters publications	We published our Health Matters reports. These included articles on: • Post-implementation of GDPR in the healthcare sector; • Managing today's challenges of modern workforce planning in the healthcare sector; • Guide to making tax digital; • How to evaluate a preventative health programme; and • Insourcing, Outsourcing and Assurance
GDPR Benchmarking Analysis	We provided a paper on GDPR benchmarking, which detailed the implementation and preparedness of our clients in relation to GDPR. Although many clients were prepared for the implementation of the GDPR legislation, some weaknesses were seen in procedures in place to detect, report and investigate a personal data breach and the consideration of the latest guidance from the Article 29 Working Party.
Benchmarking Report	We published a benchmarking report compromising of the number of actions arising at the Trust in comparison to other internal audit NHS clients.
Client Briefings	As part of our client service commitment, during 2018/19 we issued news briefings to each Audit Committee meeting.
Audit Committee	We contributed to the discussions at the audit committee on various items on the agenda in order to ensure that the Trust benefits from wider input in further developing its governance arrangements.

3.2 Conflicts of interest

RSM has not undertaken any work or activity during 2018/2019 that would lead us to declare any conflict of interest.

3.3 Conformance with internal auditing standards

RSM affirms that our internal audit services are designed to conform to the Public Sector Internal Audit Standards (PSIAS).

Under PSIAS, internal audit services are required to have an external quality assessment every five years. Our risk assurance service line commissioned an external independent review of our internal audit services in 2016 to provide assurance whether our approach meets the requirements of the International Professional Practices Framework (IPPF) published by the Global Institute of Internal Auditors (IIA) on which PSIAS is based.

The external review concluded that ""there is a robust approach to the annual and assignment planning processes and the documentation reviewed was thorough in both terms of reports provided to audit committee and the supporting working papers." RSM was found to have an excellent level of conformance with the IIA's professional standards.

The risk assurance service line has in place a quality assurance and improvement programme to ensure continuous improvement of our internal audit services. Resulting from the programme, there are no areas which we believe warrant flagging to your attention as impacting on the quality of the service we provide to you.

3.4 Quality assurance and continual improvement

To ensure that RSM remains compliant with the PSIAS framework we have a dedicated internal Quality Assurance Team who undertake a programme of reviews to ensure the quality of our audit assignments. This is applicable to all Heads of Internal Audit, where a sample of their clients will be reviewed. Any findings from these reviews are used to inform the training needs of our audit teams.

This is in addition to any feedback we receive from our post assignment surveys, client feedback, appraisal processes and training needs assessments.

3.5 Performance indicators

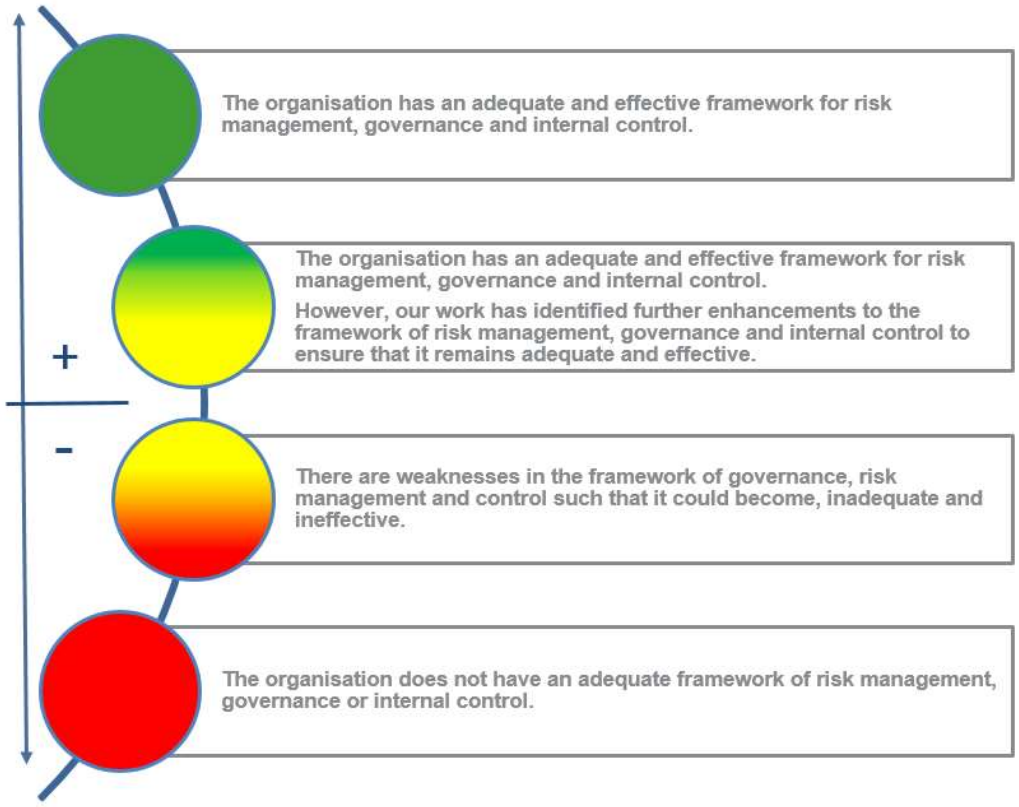
A number of performance indicators were agreed with the audit committee. Our performance against those indicators is as follows:

Delivery	Target	Actual	Notes (ref)
Discussions with senior staff at the client take place to confirm the scope six weeks before the agreed audit start date.	100%	100%	
Key information such as: the draft assignment planning sheet are issued by RSM to the key auditee four weeks before the agreed start date.	100%	100%	
The lead auditor to contact the client to confirm logistical arrangements two weeks before the agreed start date.	100%	100%	
Fieldwork takes place on agreed dates with key issues flagged up immediately.	100%	100%	
A debrief meeting will be held with the audit sponsor at the end of fieldwork or within a reasonable time frame.	100%	100%	
Draft reports issued within 10 days of debrief meeting	100%	89%	
Management responses received within 10 days or draft report	100%	67%	1
Final report issued within 3 days of management response	100%	100%	
Management responses to the draft report should be submitted to RSM.	Yes	Yes	

Notes
1. Three reports were not responded to within 10 days (Conflict of Interest, GDPR and CIP Benefit Realisation). All three reports still made their intended Audit Committee.

APPENDIX A: ANNUAL OPINIONS

The following shows the full range of opinions available to us within our internal audit methodology to provide you with context regarding your annual internal audit opinion.

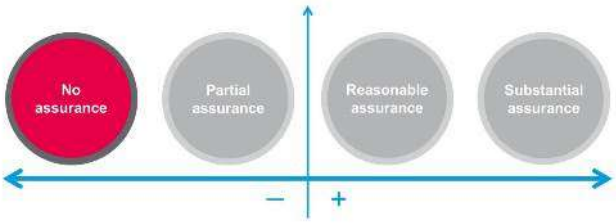
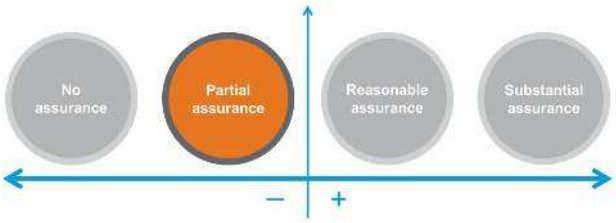
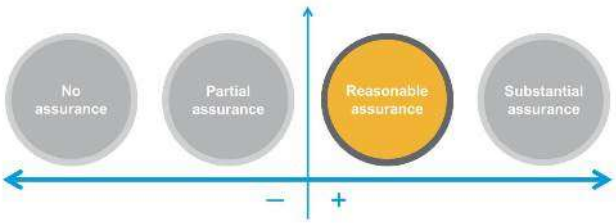
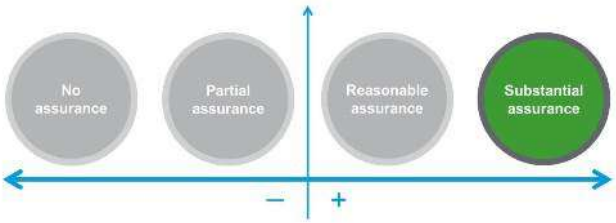
Annual opinions	Factors influencing our opinion
	The factors which are considered when influencing our opinion are: • inherent risk in the area being audited; • limitations in the individual audit assignments; • the adequacy and effectiveness of the risk management and / or governance control framework; • the impact of weakness identified; • the level of risk exposure; and • the response to management actions raised and timeliness of actions taken.

APPENDIX B: SUMMARY OF INTERNAL AUDIT WORK COMPLETED 2018/2019

Assignment	Executive lead	Assurance level	Actions agreed			
			H	M	L	A
1. Fit and Proper 1. 18/19	Company Secretary		0	1	0	0
2. Conflict of Interest 2. 18/19	Company Secretary		0	4	1	0
3. Risk Management & Board Assurance Framework 3. 18/19	Chief Financial Officer		0	0	2	0
4. Key Financial Controls 4.17/18	Director of Finance		0	0	1	0
5. CIP Benefits Realisation 5. 18/19	Director of Finance		0	2	2	0
6. Data Quality 6. 18/19	Chief Financial Officer Assistant Director of Performance & Information		0	2	3	0
7. Supplier Contract Management 7. 18/19	Chief Operating Officer Chief Financial Officer Head of Procurement		0	4	1	0
8. Clinical Audit / Effectiveness Follow up review 8. 18/19	Medical Director Head of Clinical Effectiveness and Audit		0	0	2	0
9. General Data Protection Regulation 9. 18/19	Director of Finance Clinical Information Governance Manager	Advisory	0	0	0	6

All of the assurance levels and outcomes provided above should be considered in the context of the scope, and the limitation of scope, set out in the individual Assignment Report.

We use the following levels of opinion classification within our internal audit reports. Reflecting the level of assurance the board can take:

	Taking account of the issues identified, the board cannot take assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied or effective. Urgent action is needed to strengthen the control framework to manage the identified risk(s).
	Taking account of the issues identified, the board can take partial assurance that the controls to manage this risk are suitably designed and consistently applied. Action is needed to strengthen the control framework to manage the identified risk(s).
	Taking account of the issues identified, the board can take reasonable assurance that the controls in place to manage this risk are suitably designed and consistently applied. However, we have identified issues that need to be addressed in order to ensure that the control framework is effective in managing the identified risk(s).
	Taking account of the issues identified, the board can take substantial assurance that the controls upon which the organisation relies to manage the identified risk(s) are suitably designed, consistently applied and operating effectively.

FOR FURTHER INFORMATION CONTACT

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Berkshire Healthcare
NHS Foundation Trust

AUDIT COMMITTEE

"Bite Size" – the Role of the Audit Committee – Typical Agenda

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AGENDA

No	Item	Lead
1	Apologies for absence	Chair
2	Declarations of interest	Chair
Committee Process		
3	Minutes of previous meeting	Chair
4	Matters Arising	Chair
Committee Output – on behalf of the Trust Board		
5	Corporate Risk Register Risk "Deep Dive" – Physical Environment of Prospect Park Hospital	David Townsend, Chief Operating Officer
6	a) Board Assurance Framework (BAF) b) Corporate Risk Register	Chief Financial Officer/Company Secretary
8	Single Waiver Tenders Report	Chief Financial Officer
9	Information Assurance Framework Update Report	Chief Financial Officer
10	Losses and Special Payments Report –	Chief Financial Officer
11	Clinical Audit: Progress Report	Medical Director
12	Clinical Claims and Litigation Report	Acting Director of Nursing and Governance
Work Plan – Internal Audit and Counter Fraud		
13	Internal Audit Progress Report	RSM
14	Counter Fraud Report	TIAA
Work Plan – External Audit		
15	External Audit Report	Deloitte
Work Plan – Reporting Committees		
16	Minutes of the Finance, Investment and Performance Committee	Chief Financial Officer
17	Minutes of the Quality Assurance Committee	Director of Nursing and Therapies
18	Minutes of the Quality Executive Group	Director of Nursing and Therapies
Committee Governance		
19	Annual Review of Effectiveness and Review of the Committee's Terms of Reference	Company Secretary
20	Committee Work Plan	Chair
21	Any Other Business	Chair

22	Date of Next Meeting	Chair

To: Chris Fisher, Non-Executive Director (Chair)
Naomi Coxwell, Non-Executive Director
Mehmuda Mian, Non-Executive Director

In attendance: Alex Gild, Chief Financial Officer
Paul Gray, Director of Finance
Debbie Fulton, Acting Director of Nursing and Governance
Minoo Irani, Medical Director
Amanda Mollett, Head of Clinical Effectiveness and Audit
Debbie Kinch, Counter Fraud, TIAA
Ben Sheriff, External Auditors, Deloittes
Chris Randall, External Auditors, Deloittes
Tim Merritt, Internal Audit, RSM
Clive Makombera, Internal Audit, RSM
Julie Hill, Company Secretary

PLEASE ADVISE ANY APOLOGIES TO JULIE HILL AS SOON AS POSSIBLE

Council of Governors

Meeting Date	4th December 2019
Title	Quality Account Indicators for External Audit in 2019/20
Purpose	The Council of Governors are asked to review and approve the local indicator proposal as mandated by NHS Improvement (The foundation trust regulator).
Business Area	Corporate
Author	Head of Clinical Effectiveness and Quality Account and NICE Lead
Relevant Strategic Objectives	True North Goal 1- Harm Free Care True North Goal 2- Supporting our Staff True North Goal 3- Good Patient Experience
CQC Registration/ Patient Care Impacts	Quality Account priorities and quality indicators support maintenance of CQC registration
Resource Impacts	None
Legal Implications	Statutory requirement of the Health Act 2012
Equality and Diversity Implications	None
SUMMARY	The Quality Account reports on a number of quality indicators and metrics. Each year the Council of Governors are required to approve an indicator to be externally validated by our external auditors. The auditors are required to perform an independent assurance report in respect of Berkshire Healthcare NHS Foundation Trust's quality account for the year ended 31 March 2020 and certain performance indicators contained therein. In order to present the council with an indicator for consideration we have reviewed those that are reported on within the quality account and have been reviewed in previous audits. The report considers three indicators which could be tested and recommends the following indicator for review as part of the 2019/20 Quality Account: Option 1: Community referral-to-treatment (RTT) waiting times for consultant-led treatment (specifically Diabetes and Community Paediatrics) This indicator has not previously been audited by our external auditors. This measure ensures that patients are being treated within mandated target times and relates pecifically to 2 of the trust community health services, whilst both of the mandated indicators will relate to mental health activity.
ACTION	The Council of Governors are asked to consider this recommendation and approve the indicator to be tested indicator for review by our external auditors Deloitte LLP as part of the external assurance audit.

Options and Recommendation for the Local Indicator to be reviewed as part of the Trust Quality Account External Assurance Process

1. Introduction

All NHS Foundation Trusts are required to produce an annual Quality Account that describes the quality of care they are providing in relation to a number of mandated performance metrics and other national and local quality priorities and indicators. This Quality Account aims to improve transparency and hence public accountability.

As part the assurance process, the Trust is required by NHS Improvement (NHSi) to gain external assurance on this Quality Account to ensure that the data contained within it is robust. These audits are undertaken to test the robustness of the system for collecting and reporting on data and, consequently, they support the validity of the data being reported.

Our external auditors are required to undertake substantive sample testing on three performance indicators contained within the quality report. Two of these performance indicators are mandated by NHSi, with the third being selected locally by the Trust Council of Governors. At the time of writing this paper, NHSi has yet to publish its 2019/20 guidance for external assurance on quality accounts. However, it is likely that the mandated performance indicators will remain the same as those in 2018/19.

2. Mandated Performance Indicators (contained within parts 2 and 3 of the Quality Account)

As in previous years our external auditors will be required to provide governors with a limited assurance report on whether two mandated indicators included within the quality account have been reasonably stated in all material respects. External auditors will undertake substantive sample testing of the mandated indicators included in the quality report, which will be undertaken in the first quarter of 2020.

The Trust is asked to select two relevant indicators from the following list in order (i.e. if (1) and (2) below are both reportable then those should be selected):

1. Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a National Institute for Health and Care Excellence (NICE)-approved care package within two weeks of referral
2. Inappropriate out-of-area placements for adult mental health services
3. Improving access to psychological therapies (IAPT): waiting time to begin treatment (from IAPT minimum dataset): within six weeks of referral
4. 100% enhanced Care Programme Approach (CPA) patients receiving follow-up contact within seven days of discharge from hospital.

As in 2018/19 all four of the above indicators are relevant to the Trust and therefore it is anticipated that indicators 1 and 2 will be automatically audited as the two mandated indicators.

3. Locally Determined Indicator for Agreement by Trust Council of Governors

Below are the indicators which have been reviewed in previous years:

- 2013 Incidents resulting in severe harm or death (mandated)
- 2014 Medication Errors
- 2015 Minimising delayed transfers of care
- 2016 Clostridium difficile (C Diff)- Infection Control
- 2017 Minimising delayed transfers of care
- 2018 Improving Access to Psychological Therapies (IAPT)- Waiting time to begin treatment within 6 weeks of referral
- 2019 Enhanced Care Programme Approach (CPA) patients receiving follow-up contact within seven days of discharge from hospital.

The following indicators have been chosen for consideration by the Council of Governors for the 2019/20 Quality Account. They have been chosen based on their potential impact to quality of care and also indicators which can be substantially tested.

Option 1

To review the NHS Oversight Framework indicator relating to community referral-to-treatment (RTT) waiting times for consultant-led treatment. This wait should be no longer than 18 weeks. This indicator is on the NHSi list of indicators for community trusts, and relates to patients waiting to start treatment at the end of the reporting period (known as incomplete pathways). For the Trust, this particular indicator is relevant to the Diabetes service and Community Paediatrics service and is important as it ensures that patients are being treated within mandated target times. Trust performance against this measure is detailed below.

	Target	2018/19	2019/20 Q1	2019/20 Q2
RTT waiting times Community: Incomplete pathways	92% in <18 weeks	99.4%	99.5%	100%

Option 2

To review the NHS Oversight Framework indicators relating to waiting time for treatment with Improving Access to Psychological Therapies (IAPT). The 6-week target is on the NHSi list of mandated indicators (see section 2 above), but would not be automatically chosen by the trust as two other indicators rank higher. This indicator was chosen by the Governors for external audit in 2017/18 and resulted in a low priority recommendation being made relating to time stamping of referrals. The indicator is important in demonstrating parity of esteem between physical and mental health. The trust reports on two specific IAPT waiting time indicators, details of which are detailed in the table below.

Improving access to psychological therapies (IAPT) Targets	Target	2018/19	2019/20 Q1	2019/20 Q2
People with common mental health conditions referred to the IAPT programme will be treated within 6 weeks of referral	75%	98%	97%	96%
People with common mental health conditions referred to the IAPT programme will be treated within 18 weeks of referral	95%	100%	100%	100%

Option 3

To review the NHS Oversight Framework indicator relating to 100% Care Programme Approach (CPA) patients receiving follow-up contact within seven days of discharge. This indicator is on the NHSI list of mandated indicators (see section 2 above), but would not be automatically chosen by the trust as three other indicators rank higher. This indicator was chosen by the Governors for external audit in 2018/19. This indicator is important to the trust as it ensures that patients on a CPA are appropriately reviewed following discharge from inpatient mental health care. Trust performance against this measure is detailed below.

	Target	2018/19	2019/20 - Q1	2019/20 - Q2
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	95%	98.7%	96.2%	96.5%

Recommendation:

Option 1 is the recommended indicator to be tested in 2019/20 which has not previously been audited by our external auditors. This measure ensures that patients are being treated within mandated target times and relates specifically to 2 of the trust community health services, whilst both of the mandated indicators will relate to mental health activity. The Council of Governors are asked to consider this recommendation and approve the indicator to be tested.

Report of Living Life to the Full Group

Council of Governors meeting - Wednesday 04th December 2019

Report on last meeting – 2nd October 2019

1. **Community Engagement officer Role in West Berks: Cecily Mwaniki.**

Cecily has been in post 3 years. An integral part of her role to achieve the best service and outcomes for both staff and patients.
Community Engagement uses the DEEC model, discovering where the communities are, engaging, empowering and collaborating with them.

Cecily made the point it is not necessarily about giving communities what they need but enabling them to provide current things better. The purpose is to bring together ethnic minorities in particular the hard to reach groups, to talk to them about their wellbeing, trauma and mental health issues, whilst trying to provide preventative information and support to avoid admission to mental health services or as inpatients.

Ruth Lysons asked what resources Cecily has available and enquired about capacity of workload to enable time to be spread across the range of community groups.
Cecily confirmed it is just her in West Berks. Marcella Browne was appointed in East Berks from July. The community groups work with no financial support she confirmed there is not enough time to fully engage with them.
John Barrett noted this is not the first time the Trust has been involved in initiatives such as this and referred to previous experience when he joined the Trust in 2012 where they were talking about community mapping. John added it is good to see the Trust taking a different approach across east and west communities.

Ruth Lysons questioned thinking about a strategic approach: What is problem we are trying to address and where is it most useful spending our limited resources?
The community groups contribution will only stretch to far and having reached a good level of success it would be helpful to reform the community engagement strategy and put numbers behind it to get more resources.
Ruth acknowledged this is a difficult piece of work, but all the group agreed that in the current HNS system funding comes from figures.

Andrew Horne asked if consideration has been given to recruiting a volunteer to support Cecily's work. The group suggested it would be worth speaking to Julie Addison, Volunteer Services Manager for the Trust, about this. Andrew suggested there may be retired mental health workers that might be interested in helping with this work.
Ruth Lysons asked for this to be taken forward as an action.

2. **Review of 2019 meetings and discussion of topics for 2020.**

John Barrett commented on LLTTF meetings that had taken place since October 2018 and reminded those present of the talk topics and presentations received by the group to date:

October 2018: Chaplaincy and Health & Wellbeing of Staff at Prospect Park – Rev Paul White

General Health & Wellbeing Measures across BHFT – Julia Prince

February 2019: OPMH Services – Sophie Shilton-Brown
Psychology Interventions in Nursing and Community Services – Chris Allen

April 2019: Short introduction & update on Social Prescribing – Marianne Hiley - Better Care Fund Programme Manager – East Berks CCG

July 2019: CBT for Carers – Chris Allen.

October 2019: Community Engagement in West Berks – Cecily Mwaniki

.

Ruth Lysons reminded the group agreed to keep Carers high on the agenda for meetings moving forward and for the group to look at future speakers to include someone working on the Carers Strategy.

Ruth noted an update on the Trust Carers Strategy is given to full Council meetings but this group can agree how it can work together and support and use its contacts with the voluntary network and events to dovetail with what the Carers Strategy Lead will do once in post.

3. **LLTTF Meetings for 2020: All on** Wednesday's from 10.00 - 12.00 – Boardroom, FWH

   12th February

   8th April

   8th July

   7th October

Report on Membership and Public Engagement Group to Council of Governors - 4th December 2019

I am pleased to say that this is the most radical report I have presented in my time as chair.

Trust membership numbers are close to the trust's target of 12,000, with 7,726 public members at last count. However, we still have disparities across the localities and between different communities which we can only gradually correct through public engagement.

The Marcomms department is cutting back on taking the trust out to public events, especially where clinical staff attendance means that staff take time in lieu from their normal duties.. Nevertheless, there will still be some public presence. The Reading Pride festival presence is very successful and popular with the staff who support it. I have suggested that attendance at the Reading Carnival, an event with a strong Afro-Caribbean flavour, could be reach similar success. I hope we will be able to test it out. I hope that the trust's BAME network will consider this.

The governors' document repository is now up and running and has been successfully trialled. We now invite governors and indeed non-executive directors to contact Jennifer Knowles in the office to get access.

We are looking to have a couple of articles relating to governors in the next members' magazine: one on the PLACES assessment and one on governors role with the Eight Bells charity.

We have been looking at the possibility of the Trust's Annual General Meeting being held in Reading, which has a central position in road, rail and bus transport in the county. We are currently considering Friends Meeting House which has a sizeable meeting room and an auxiliary hall which could accommodate additional stalls. Ideally we would be able to arrange for some car parking at neighbouring sites. Your comments are invited on this possibility.

Finally, we are looking into the possibility of trialling a "Meet Your Governors" event – initially in Reading – but if successful possibly in all of the localities. Invitations would go through targetted mailings – which are available with our current membership system.

Please join us at our next meeting after the joint Council/NEDs meeting on 5th February.

QUALITY ASSURANCE GROUP REPORT TO COUNCIL OF GOVERNORS DEC 2019

Meetings

All governors are welcome to attend the QAG meetings without committing to join the group.

Our last meeting took place on 14th November 2019 in Meeting Room 2, Fitzwilliam House, chaired by Susana Carvalho and was quorate. We've welcomed Heidi Ilsley, Deputy Director of Nursing to the meeting.

The next meeting will take place on Wednesday 26th February 2019, 10 am–12 pm in Meeting Room 2, Fitzwilliam House.

Feedback from our last meeting

We reviewed and commented the Quarter 2 Complaints & Patient Experience Report which we are grateful for, and provides an insight view of how the Trust is, trends in the different services and we all agree that pertaining to complaints and patient experience, the Trust maintains a fair levelled positive direction, having improved - albeit slightly, in some areas. Given the information of how the Trust stands in a national plateau, we were pleased to see the BHFT in a good position, when presented with numbers for formal complaints, as we all know, are of a small number in comparison to other similar Trusts.

Waiting lists were presented, and some members raised the need for some clarification regarding the Psychology services, which will be addressed further and commented in the next group's meeting. The Chair has invited Bridget G to come along to the next meeting, to give a talk about the different forms of psychological services and to answer any queries.

The 15 Steps report and the Complaints List were also reviewed, and Heidi kindly explained some of the processes further, for clarification.

An anonymised complaint regarding a co-operation between different Trusts where the BHFT' West Call service had a small part was discussed, and we were pleased to read the patient's family addressing a thank you to the BHFT's Executive for the handling and response to her complaint, for the part where Trust was involved.

Service Visits

Governors gave feedback to service visits to:

- Place Assessment at Wokingham Community Hospital
- Place Assessment at Prospect Park Hospital
- CRHTT Carers Group

A polite reminder that even if you are not a member of the group but are interested in visiting a particular service on the list (please refer to the Document Store to access the complete list), it may be possible for the group to arrange a visit including you on it. Let us know if that is the case.

Berkshire Healthcare
NHS Foundation Trust

Patient Experience

Quarter Two 2019-20 Report

Presented by: Heidi Ilsley, Deputy Director of Nursing

Quarter Two– Patient Experience Report (July – September 2019)

Overview

The Board is required to consider patient feedback because it provides insight into how patients, families and carers experience our services. This overview of the quarter two data is provided as a way of achieving a summary and insight of the available data alongside other relevant information from my perspective.

Data collated around characteristics demonstrates that there is no difference between the split by gender of complaints raised versus the census population data and for ethnicity given that 33% have chosen not to state, therefore it is not possible to draw any conclusions. It is, however, interesting to note that 48.7% of complaints received are from people in the 18-44 year old age groups; this is a higher percentage of complaints for this age group than is representative of the local population (30%) or the percentage of patients on our caseload (16.64%) . Some further investigation is required to understand if there are any specific cross cutting themes to complaints received from this group of patients. For all other age ranges, the proportion of complaints is lower than representation within the local population.

There is no material difference in the total number of formal complaints received this quarter compared with previous quarters; it is however, of note when considering the total complaints (formal, informal and local resolution) that whilst over 60% are resolved informally rather than taking a formal route in physical health services (adult and children), for mental health services the figure is nearer 30%. Some further work will be undertaken around this to understand the reasons behind this and whether there is learning to be shared across services.

When comparing our formal complaint rate to that of peers in quarter 1 (latest data available in model hospital) we are in the lowest 25% in terms of number of complaints received against the indicators used per 1000 WTE staff and also per £100million Trust income. We have continued to maintain our 100% response rate against negotiated timescales; it is very important to us that we continue to provide responses to all complainants when they are expecting us to.

This quarter, there has been an increase in complaints relating to common Point of Entry (CPE) with the highest number received this quarter compared to any quarter in the last two years. Whilst this still accounts for a very small percentage compared to the number of contacts (0.24% of contacts resulting in a complaint), no particular themes have emerged from the complaints received; this will be monitored over the coming quarter. There is currently work being undertaken to support improved pathways as well as processes within CPE that release capacity to ensure patients perceived to be a higher risk are seen within expected timescales.

The other service to note in terms of increased complaints is the Integrated Pain and Spinal Service which is currently experiencing significant demand pressures over and above service capacity, whilst a small number, this is not a service that generally receives complaints and all three complaints were in relation to wait times. Actions are currently in train to review the capacity versus demand gap.

CAMH services continue to generate the highest number of contacts from MP’s, these are related to access and waiting times. The number of formal complaints received are comparable with previous quarters remaining at 0.12% of total contacts, although CAMHS is under pressure as a service with increases in caseload, activity and wait times. A quality

improvement project is in progress to improve productivity and waiting list management. A significant amount of time is invested in supporting families whilst waiting for appointments.

Despite continued pressures on the Mental Health Wards, due to high occupancy and staffing challenges the wards have seen a reduction compared with the number of complaints seen in Quarter 1, receiving only three complaints this quarter. Community Wards and Community Nursing, which were also under pressure in quarter two in terms of vacancy and also demand in community nursing services, also received fewer formal complaints this quarter compared with Q1. This would indicate that despite challenges patients continue to receive a service that they are satisfied with. The mental health wards, West Berkshire Community Hospital and Community Nursing have all had successful recruitment campaigns with a positive increase in staffing anticipated during Q3.

In terms of Ombudsman investigations there are two ongoing (PMS and CMHT), we have had no Ombudsman complaints upheld to date this financial year.

Complaints are considered within each division with staff / teams reflecting on individual complaints and learning being shared through the Divisions patient safety and quality meeting.

The Friends and Family Test (FFT) has continued to be challenging in terms of reaching the 15% response rate despite the increasing number of responses achieved and the success of introducing SMS as a way for patients to provide the FFT. Our response rate does however, compare favourably against our local peer organisations in terms of both community and mental health. Our Trust overall recommendation rate to a friend for Quarter two is 91%; for community services the recommendation rate was 94% whilst for mental health services was 78%.

The Trust has continued to achieve an increased response to the Friends and Family Test from carers, with 408 responses received in Q2 this year compared to 201 last year and 32 in 2017/18. The recommend rate has remained high at 95%.

3,830 patients/carers responded to our internal patient survey in Q2, this asks patients how they rate their experience, by asking five questions; 81% reported the service they received as good or better. Work undertaken as part of our True North has shown that the use of this survey is very inconsistent across the Trust. Work is commencing over 2019/20 to develop an improved survey that all services will use. Services also registered 1,389 compliments during this quarter.

Patient experience is an important indicator of quality and it is important that services take steps to prevent similar concerns highlighted occurring and learn from all feedback received. Whilst each service takes complaints seriously we also need to be able to more easily demonstrate how we have used patient and service user feedback to change service delivery as well as how learning is shared across the organisation. Services are encouraged to use the feedback available to them to inform decisions about care and treatment and also to display information in relation to learning and changes made as a result of feedback that they receive. The 2018 staff survey results demonstrate that 61% of our staff believe that feedback from patients/ service users is used to inform decisions within their directorates and departments; whilst this is better than the average within our peer group (mental health, learning disability and community combined trusts) which is 54%, it is below the best at 71% and therefore continues to be a work in progress.

Debbie Fulton, Director of Nursing and Therapies

Main Report

1. Introduction

This report is written for the board and contains the quarterly patient experience information for Berkshire Healthcare (The Trust) incorporating; complaints, compliments, the Friends and Family Test, PALS and our internal patient survey programme (which is collected using paper, online, text, kiosks and tablets).
This report looks in detail at information gathered from 1 July 2019 to 30 September 2019 and uses data captured from the Datix reporting system, CRT (our internal survey) and the results of the Friends and Family Test captured via SMS, online and hard copy feedback.

2. Complaints received

2.1 All formal complaints received

Table 1 below shows the number of formal complaints received into Berkshire Healthcare for years 2018-19 and 2019-20 by service, enabling a comparison with Quarter two. During Quarter two 2019-20 there were 54 complaints received (including re-opened complaints), this is a decrease compared to 2018-19 where there were 63 for the same period.

Table 1: Formal complaints received

	2018-19					2019-20				
Service	**Q2**	**Q3**	**Q4**	**Total**	**% of Total**	**Q1**	**Change to Q1**	**Q2**	**Total for year**	**% of Total**
CMHT/Care Pathways	11	10	9	**46**	20	8	↑	10	**18**	17.31
CAMHS - Child and Adolescent Mental Health Services	6	8	6	**25**	10.87	10	↓	8	**18**	17.31
Crisis Resolution & Home Treatment Team (CRHTT)	5	3	4	**14**	6.09	2	-	2	**4**	3.85
Acute Inpatient Admissions – Prospect Park Hospital	12	8	3	**32**	13.91	5	↓	3	**8**	7.69
Community Nursing	1	3	3	**8**	3.48	4	↓	3	**7**	6.73
Community Hospital Inpatient	7	1	3	**17**	7.39	6	↓	1	**7**	6.73
Common Point of Entry	3	2	4	**12**	5.22	2	↑	6	**8**	7.69
Out of Hours GP Services	5	7	1	**17**	6.96	0	↑	1	**1**	0.96
PICU - Psychiatric Intensive Care Unit	0	0	0	**0**	0	0	-	0	**0**	0.00
Minor Injuries Unit (MIU)	1	2	0	**4**	1.74	1	-	1	**2**	1.92
Older Adults Community Mental Health Team	1	0	1	**3**	1.3	1	↓	0	**1**	0.96
13 other services in Q4	11	13	16	**52**	22.6	11	↑	19	**30**	28.85
Grand Total	**63**	**57**	**50**	**230**		**50**		**54**	**104**	

Previously, complaints were reported against the locality that the services reported into. As this often varies from the geographical location that the patient received the service, complaints are now reported against the geographical locality where the care was received which is considered to be more meaningful. The following tables show a breakdown of the formal complaints that have been received during Quarter two and where the service is based. Complaints relating to end of life care are considered as part of the Trust mortality review processes.

Appendix one contains a listing of the formal complaints received during Quarter two. Since 2018-19 the severity of the complaint has been extracted from the completed Investigating Officers Report; complaints under investigation at the end of Quarter two will not have this information.

2.2 Adult mental health service complaints received in Quarter two

28 of the 54 (52%) complaints received during Quarter two were related to adult mental health service provision.

Table 2: Adult mental health service complaints

	Locality						
Service	**Bracknell**	**Reading**	**Slough**	**West Berks**	**Windsor, Ascot and Maidenhead**	**Wokingham**	**Grand Total**
Adult Acute Admissions		3					3
CMHT/Care Pathways	1	2		2	3	2	10
Common Point of Entry	2			1		3	6
Crisis Resolution and Home Treatment Team (CRHTT)		1		1			2
Early Intervention in Psychosis		1	1				2
Learning Disability Service Inpatients		1					1
Perinatal				1			1
Psychological Medicine Service			2				2
Talking Therapies		1					1
Grand Total	**3**	**9**	**3**	**5**	**3**	**5**	**28**

2.2.1 Number and type of complaints made about a CMHT

10 of the 54 complaints (19%) received during Quarter two related to the CMHT service provision. Over the last year there were between 8 and 16 complaints for CMHT in each quarter. There were 13,827 reported attendances for CMHT and the ASSiST service during Quarter two giving a complaint rate of 0.07%.

The 2018-19 complaint rate for CMHT was 0.05%; therefore the 0.07% this quarter indicates a very small but not significant increase in percentage of complaints received.

Table 3: CMHT complaints

	Locality					
Main subject of complaints	**Bracknell**	**Reading**	**West Berks**	**Windsor, Ascot and Maidenhead**	**Wokingham**	**Grand Total**
Attitude of Staff					1	1
Care and Treatment		1	2	2		5
Clinical Care Received	1	1		1		3
Communication					1	1
Grand Total	**1**	**2**	**2**	**3**	**2**	**10**

Care and treatment (5) remains the main subject for formal complaints received about CMHT, although the reasons for the concerns varied: including communication and contact with the team and awareness of care plans.

The Bracknell CMHT has seen a reduction in the number of complaints (1) compared to previous quarters. Bespoke training has been offered to the services based out of Churchill House, including the older adults CMHT to include complaint management and local resolution of complaints. The CMHT based in Slough did not receive any complaints.

2.2.2 Number and type of complaints made about CPE

Main subject of complaint	Number of complaints
Attitude of Staff	2
Care and Treatment	1
Communication: in writing	1
Communication: Verbal to Patients	1
Failure/Delay in specialist Referral	1
Grand Total	6

The table above shows the number and reason for complaints received during Quarter two for the Common Point of Entry Service (CPE). This is the highest number of complaints received in any quarter in the last year and whilst there are no particular themes emerging at present this will be monitored.

There were 2,483 contacts with CPE during Quarter two, giving a complaint rate of 0.24%.

2.2.3 Number and type of complaints made about Mental Health Inpatient Services

During Quarter two, 3 of the 54 complaints (5.55%) related to mental health inpatient wards (all of these were about acute wards) this is a reduction compared on any quarter in the last year.

There were 233 reported discharges from mental health inpatient wards during Quarter two giving a complaint rate of 1.28%.

Overall for 2018-19 the complaint rate for acute inpatient ward admissions was 3.8%; therefore a significant decrease is demonstrated for this quarter by comparison.

Table 4: Mental Health Inpatient Complaints

	Ward			
Main subject of complaints	**Daisy Ward**	**Bluebell Ward**	**Rose Ward**	**Grand Total**
Care and Treatment	1		1	2
Communication		1		1
Grand Total	**1**	**1**	**1**	**3**

2.2.4 Number and type of complaints made about Crisis Resolution/ Home Treatment Team (CRHTT)

In Quarter two, 2 of the 54 complaints (3.70%) were attributed to CRHTT, the same as in Q1 and a reduction on previous quarters. There are no particular themes identified in the

complaints received for CRHTT. There were 16,148 reported contacts for CRHTT during Quarter two giving a complaint rate of 0.01%.

Table 5: CRHTT complaints

	Locality		
Main subject of complaints	**Reading**	**West Berks**	**Grand Total**
Attitude of staff	1	1	2
Grand Total	**1**	**1**	**2**

2.3 Community Health Service Complaints received in Q1

During Quarter two, 12 of the 54 complaints (22.22%) related to community health service provision.

Table 6: Community Health service complaints

	Locality					
Service	**Bracknell**	**Reading**	**Slough**	**West Berks**	**Wokingham**	**Grand Total**
Community Hospital Inpatient			1			1
District Nursing	2		1			3
GP General Practice			1			1
Integrated Pain and Spinal Service - IPASS		1		1	1	3
Minor Injuries Unit				1		1
Out of Hours GP Services					1	1
Podiatry	1					1
Sexual Health			1			1
Grand Total	**3**	**1**	**4**	**2**	**2**	**12**

During Quarter one the services receiving the most complaints were community nursing (3) and IPASS (3).

The IPASS service is under significant pressure with demand outstripping capacity and all three of the complaints received were about waiting times.

2.3.1 Community Health Inpatient wards Complaints

During Quarter two, 1 of the 54 complaints (1.85%) received related to inpatient wards. There were 486 reported discharges from community health inpatient wards during Quarter two giving a complaint rate of 0.20%.

For 2018-19 the complaint rate was 0.9%, discharges indicating that there has been a reduction in the number of complaints per discharge during this quarter.

Table 7: Community Health Inpatient complaints

	Ward	
Main subject of complaint	**Jubilee Ward**	**Grand Total**
Care and Treatment	1	1
Grand Total	**1**	**1**

2.3.2 Community Nursing Service Complaints

In Quarter two, 3 of the 54 complaints (5.55%) were related to community nursing service provision (including continence). This is a decrease from 4 in Q1. There were 71,631 reported attendances for the Community Nursing Service during Quarter two 3 giving a complaint rate of 0.004%. This is a very small complaint rate well below the Trust overall rate of complaints per contact.

Table 8: Community Nursing Service complaints

	Locality		
Service	**Bracknell**	**Slough**	**Grand Total**
Attitude of Staff	1		1
Care and Treatment	1	1	2
Grand Total	**2**	**1**	**3**

2.3.3 GP Out of Hours Service, WestCall Complaints

	Service		
Main subject of complaint	**GP***	**Westcall - Wokingham**	**Grand Total**
Care and Treatment	1	1	2
Grand Total	**1**	**1**	**2**

- A historical complaint about BHFT led GP in Slough

There was one complaint about Westcall, an increase from no complaints about out of hours provision during Quarter one. There were 15,690 contacts with Westcall giving a complaint response rate of 0.006%.

For 2018-19 the service had a complaint rate of 0.024%, therefore 0.006% is showing a rate that is lower this quarter than the overall rate for last year.

2.4 Children, Young People and Family service Complaints

2.4.1 Physical Health services for children complaints

During Quarter two, 2 of a total 54 complaints (3.70%) related to children's physical health services.

Table 9: Children and Young People service complaints

	Locality		
Service	**Reading**	**Slough**	**Grand Total**
Children's Speech & Language Therapy - CYPIT	1		1
Occupational therapy		1	1
Grand Total	**1**	**1**	**2**

2.4.2 CAMHS complaints

During Quarter two, 8 of the 54 complaints (14.81%) were about CAMHS services; since Quarter one 2018-19, the number of complaints received has ranged from between 5 and 10 per quarter. Access to treatment was the main theme in Q2. There were 6,656 reported attendances for CAMHS during Quarter two giving a complaint rate of 0.12%.

For 2018-19 the number of complaints per contact was 0.8% therefore for quarter 2 there is an increased % of complaints per contact although complaints are spread across localities there is a continued theme around access and wait times.

Table10: CAMHS Complaints

	Locality				
Main subject of complaint	**Reading**	**West Berks**	**Windsor, Ascot and Maidenhead**	**Wokingham**	**Grand Total**
Access to Services	3				3
Care and Treatment				1	1
Clinical Care Received		1			1
Communication			2		2
Waiting Times for Treatment		1			1
Grand Total	**3**	**2**	**2**	**1**	**8**

2.5 Learning Disabilities

	Service	
Main subject of complaint	**Campion Unit**	**Grand Total**
Attitude of staff	1	1
Grand Total	**1**	**1**

There were no complaints about the community based team for people with a Learning Disability during Quarter two. There was one complaint about the Learning Disability Inpatient Ward, Campion Unit.

3. KO41A return

Each quarter the complaints office submit a quarterly return, called the KO41A. This looks at the number of new formal complaints that have been received by profession, category, age and outcome. The information is published a quarter behind (Q1 data). The table below shows the number of formal complaints that were reported for mental health services, nationally and for local Trusts providing mental health services in the South England region (the same Trusts that we benchmark against in the Annual CMHT Patient Survey.

Table 11 – Mental Health complaints reported in the national KO41A return

	2017-18			2018-19				2019-20
	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1
Mental Health complaints - nationally reported	**3,790**	**3,451**	**3,653**	**3,598**	**3,651**	**3,391**	**3,450**	**3,507**
2Gether NHS Foundation Trust	19	15	15	17	14	21	20	24
Avon and Wiltshire Mental Health Partnership NHS Trust	75	63	67	78	72	77	51	56
Berkshire Healthcare NHS Foundation Trust	**58**	**56**	**59**	**49**	**45**	**38**	**51**	**47**
Cornwall Partnership NHS Foundation Trust	28	32	34	31	28	20	30	24
Devon Partnership NHS Trust	47	43	49	44	56	33	45	52
Dorset Healthcare University NHS Foundation Trust	84	74	79	91	90	92	54	61
Kent and Medway NHS and Social Care Partnership Trust	72	88	86	87	115	121	118	121
Oxford Health NHS Foundation Trust	56	49	70	50	56	58	56	52
Somerset Partnership NHS Foundation Trust	20	15	14	17	14	24	18	24
Southern Health NHS Foundation Trust	114	79	96	91	95	82	68	73
Surrey and Borders Partnership NHS Foundation Trust	28	21	26	26	36	16	26	22
Sussex Partnership NHS Foundation Trust	166	169	221	209	192	181	173	178

This table demonstrates a fluctuation in the number of complaints across mental health services both nationally and locally over time, with the Trust not identifying as an outlier for complaint activity.

4. Complaints closed

As part of the process of closing a formal complaint, a decision is made around whether the complaint is found to have been upheld, or well-founded (referred to as an outcome). During Quarter two there were 57 complaints closed, an increase on Quarter one and Quarter four (47).

4.1 Outcome of closed formal complaints

Table 12: Outcome of formal complaints closed

	2018-19						2019-20				
Outcome	**Q1**	**Q2**	**Q3**	**Q4**	**Total**	**% 18/19**	**Q1**	**Q2**	**Total**	**% of 19/20**	**Comparison to Q1**
Case not pursued by complainant	0	0	2	2	4	1.67	0	0	0	0.00	=
Consent not granted	2	2	3	2	9	3.75	1	0	1	0.96	↓
Local Resolution	0	5	10	3	18	7.5	1	1	2	1.92	=
Managed through SI process	0	2	0	1	3	1.25	0	0	0	0.00	=
Referred to other organisation	0	0	0	0	0	0	1	0	1	0.96	↓
No further action	1	0	0	0	1	0.42	0	0	0	0.00	=
Not Upheld	13	11	16	15	55	22.92	16	20	36	34.62	↑
Partially Upheld	25	26	36	19	106	44.17	17	22	39	37.50	↑
Upheld	12	15	12	5	44	18.33	11	13	24	23.08	↑
Disciplinary Action required	0	0	0	0	0	0	0	1	1	0.96	=
Grand Total	**53**	**61**	**79**	**47**	**240**		**47**	**57**	**104**		

The 35 complaints closed and either partly or fully upheld in the quarter were spread across a number of differing services and there were no particular themes from any service; however, 8 were related to attitude of staff and 16 to care and treatment.

The table below shows the services where complaints were found to be upheld or partially upheld during Quarter two. Of the 35 complaints found to be upheld or partially upheld Quarter two, 68.57% (24) related to attitude and staff and care and treatment. In comparison, 19 of the 28 formal complaints (67.87%) closed in Quarter one relating to these two areas.

Table 13: Complaints upheld and partially upheld relating to attitude of staff and care and treatment

	Main subject of complaint		
Service	Attitude of Staff	Care and Treatment	Grand Total
Adult Acute Admissions		1	1
CAMHS - Child and Adolescent Mental Health Services		3	3
CMHT/Care Pathways	1	4	5
Common Point of Entry	2	1	3
Community Hospital Inpatient	1		1
Crisis Resolution & Home Treatment Team (CRHTT)	2		2
District Nursing	1	1	2
Integrated Pain and Spinal Service - IPASS		1	1

Occupational therapy		1	1
Older Peoples Mental Health (Ward Based)		1	1
Out of Hours GP Services		2	2
Psychological Medicine Service	1	1	2
Grand Total	8	16	24

4.2 Response Rate

Table 13 shows the response rate within a negotiated timescale, as a percentage total. The sustained 100% response rate achieved since 2016-17 demonstrates the commitment of the complaints office, Clinical Directors and clinical staff to work alongside complainants.

There are weekly open complaints situation reports (SITREP) sent to Clinical Directors, as well as on-going communication with the complaints office throughout the span of open complaints to keep them on track as much as possible.

Table 14 – Response rate within timescale negotiated with complainant

2019-20		2018-19				2017-18				2016-17			
Q2	Q1	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

5. Characteristic data

5.1 Ethnicity

One of the ways that the Trust can monitor the quality of its services is by seeking assurance through the complaints process, that people are not treated negatively as a result of their ethnicity or other protected characteristic.

The tables below show the characteristics of patients who have had complaints raised about their care between July and September 2019. This does not include where a different organisation was leading the investigation.

Table 15: Ethnicity

Ethnicity	Number of patients	%	Census data %
Asian-Other	2	3.7	15.1
Black-Caribbean	1	1.85	3.5
Mixed-Other	2	3.7	-
Not stated	18	33.33	-
Other Ethnic Group	1	1.85	1
White-British	26	48.15	80
White-Other	3	5.56	-
Black British	1	1.85	-
Grand Total	**54**	**100**	

5.2 Gender

There were no patients who identified as anything other than male or female during quarter two.

Table 16: Gender

Gender	Number of patients	%	Census data %
Female	27	50	50.9
Male	27	50	49.1
Grand Total	**54**	**100**	

5.3 Age

Table 17: Age

Age Group	Number of patients	%	Census data %
Under 12 years old	5	9.26	31.6
12 - 17 years old	6	11.11	
18 - 24 years old	3	5.56	14.9
25 - 34 years old	11	20.37	
35 - 44 years old	12	22.22	15.4
45 - 54 years old	5	9.26	19.3
55 - 64 years old	3	5.56	
65 - 74 years old	5	9.26	18.7
75 years old or older	3	5.56	
Not known	1	1.85	
Grand Total	**54**	**100**	

6. Parliamentary and Health Service Ombudsman

6.1 The Parliamentary and Health Service Ombudsman (PHSO) activity related to the Trust

The Parliamentary and Health Service Ombudsman (PHSO) are independent of the NHS and facilitate the second stage of the complaints process. The table below shows the Trust activity with the PHSO since April 2018

During Quarter two there were no new complaints and a previous request for information has been closed.

Table 18: PHSO activity

Month open	Service	Month closed	Current Stage
Jun-18	District Nursing	Aug-18	Not a BHFT complaint – statement provided by our staff to inform the investigation
Jul-18	CPE	Aug-18	PHSO not proceeding
Aug-18	Out of Hours GP Service	Oct-18	PHSO not proceeding
Sep-18	Psychological Medicines Service	n/a	Not Upheld
Nov-18	Psychological Medicines Service	Nov-18	PHSO not proceeding
Dec-18	Psychological Medicines Service	n/a	Investigation Underway
Dec-18	Community Hospital inpatient	n/a	Not Upheld
Jun-19	CMHT/Care Pathways	n/a	PHSO have requested information to aid their decision on whether they will investigate

7. Multi-agency working

In addition to the complaints detailed in the report, the Trust monitors the number of multi-agency complaints they are involved in, but are not the lead organisation (main area of complaint is about another organisation and therefore that organisation takes the lead). There were 10 complaints led by other organisations during Quarter two.

Table 19: Formal complaints led by other organisations

Lead Organisation	Description
Berkshire East CCG	Complaint about the attitude of CMHT staff
CCG East Berkshire	Patient is unhappy with the way that the Hearing Aid service to another provider
East Berkshire CCG	Joint complaint with CCG MH Commissioning team regarding the patient's request for funding
Frimley Park Hospital	Complainant wishes to know if staff are trained to deal with hypoxic brain jury on a community inpatient ward
NHS England	Following an injury in 2017, patient is unhappy with care provided by MSK physio in Church Hill House
NHSE	NHSE complaint with an element relating to effectiveness of Talking Therapies and CPE declining referrals on multiple occasions
RBH	Complaint made to RBH re care and treatment received. However, complainant wishes to know why a referral was not made for domiciliary physio before discharge from Wokingham Inpatients
RBH	Family of patient complaining of poor discharge from ICU of patient involving PMS
SCAS	Family feel OOH GP took too long to call back
SCAS	Patient states they did not get a call from Westcall after speaking to 111

8. MP enquiries, locally resolved complaints and PALS

8.1 MP enquiries

In addition to raising formal complaints on behalf of their constituents, Members of Parliament (MPs) can also raise service and case specific queries with the Trust.

Table 20: Enquiries from MP Offices

Service	Number of enquiries
CAMHS - Child and Adolescent Mental Health Services	7
CMHT/Care Pathways	3
Community Dental Services	1
Physiotherapy Musculoskeletal	1
Grand Total	**12**

There were 12 MP enquiries raised in Quarter two. The number of MP complaints has varied each quarter over the last year from 3-10 meaning that this is the highest number received in any quarter over the last year.

The 7 CAMHS enquiries related to access to treatment (2), waiting times for treatment (2) and care and treatment (3). 3 of these complaints related to access and waiting time to the ASD pathway, the remaining complaints were about access to and care from the secondary CAMHS service. There was one complaint about safeguarding concerns, and the responsiveness to a patient's risk.

8.2 Local resolution complaints

The complaints office will discuss the options for complaint management when people contact the service, to give them the opportunity to make an informed decision as to whether they are looking to make a formal complaint or would prefer to work with the service to resolve the complaint locally. Some concerns are received and managed by the services directly and the complaints office is not involved. These are called Local Resolutions and services log these so that we can see how services are doing at a local level.

Table 21: Concerns managed by services – Local Resolution complaints

Service	Number of concerns managed by services
Podiatry	7
District Nursing	5
CMHTOA/COAMHS - Older Adults Community Mental Health Team	3
CAMHS - Child and Adolescent Mental Health Services	3
CMHT/Care Pathways	2
Children's Speech and Language Therapy - CYPIT	2
Health Visiting	2
Neuropsychology	1
Minor Injuries Unit	1
Physiotherapy Musculoskeletal	1
Residential Care	1
Mobility Service	1
Admin teams and office based staff	1
Out of Hours GP Services	1
Clinical Health Psychology Service	1
Crisis Resolution & Home Treatment Team (CRHTT)	1
Learning Disability Service Inpatients	1
Talking Therapies	1
Admin teams & office based staff	1
District Nursing Out of Hours Service	1
Grand Total	**37**

The Podiatry service logged the highest number of locally resolved concerns during Quarter two. The concerns varied, with no themes, and included experiences such as patients unhappy about the service not cutting their nails, delays in being seen and in communication with other organisations for further tests. None of the concerns were escalated to formal complaints.

8.3 Informal complaints received

An informal complaint is managed locally by the service through discussion (written or verbal) and when discussing the complaints process, this option is explained to help the complainant to make an informed choice.

Table 22: Informal complaints received

Service	Number of informal complaints
CMHT/Care Pathways	1
Diabetes	1
Out of Hours GP Services	1
PICU - Psychiatric Intensive Care	1
Grand Total	**4**

8.4 NHS Choices

There were 22 postings during Quarter two; 13 were positive and 9 were negative.

Service	Number of postings	Positive	Negative
Athena Centre	1	I found the atmosphere calm and positive. The staff were respectful and professional and my experience was a good one.	
CAMHS	1		Failed to keep promises. Was promised an ASD assessment before my child turned 18 then after several months received a phone call to say they couldn't see her before she was 18 but PROMISED it will be done well before her exams. Exams are finished and no help. What a waste of 3 years.
CMHT WAM	1		Appalling 'care' given by the duty worker last month. When a friend also called to express concern about my mental state they were told confidential information about me, as well as being told I shouldn't 'expect everything her (my) own way'.
Community Dental Service	1	Great dental surgery & lovely friendly nurses. Will definitely recommend this place to anyone! I have been terrified all my adult years, but no more, the nurses were all so respectful and caring.	
Highclere Ward	1	All staff and doctors went over and above their duties.	
Inpatients PPH	1		A patient that may be unstable cannot expect to wait from 6pm till 10pm without being shown the room (which was ready for them) and then the bags searched which I know is necessary. Please just think what the patients and family are going through just sat around. This has been sent to the PPH leadership team. The anonymous enquirer was asked to make contact with PALS to further discuss their experience; however they have not been in touch.
King Edward V11	1	Great service, shame about parking. Need more Disabled parking because there was none when we arrived. Staff at the main entrance were very helpful to my mum and especially the porter who went out of his way to push her to the car.	
Memory Clinic	1	I was referred to a clinical psychologist who has been so caring and empathetic that I felt safe and listened to. I was also seen by a trainee Psychologist who was helpful in allowing me to confront my fears about my declining mental faculties.	
MIU	2	I have never received any other than first class treatment from a very courteous and caring staff whenever I have needed their help and expertise. Thank you one and all.	
		The staff at the Minor Injuries unit could not have been more welcoming and helpful. The nurse I saw was very efficient, helpful and knowledgeable. Her advice put me at ease and set out a path she expected the problem to follow. Her sound advice has paid dividends and I am now walking normally.	
Oakwood Unit	1		Communications were VERY poor, in fact non-existent. We were not told what his treatment plan included, or even if there was such a plan. Finding someone to talk to was difficult and the phone was almost never answered. Even getting

Service	Number of postings	Positive	Negative
			into or out of the unit was hard ... standing outside 5 minutes sometimes to be admitted. This has been sent to Unit Manager. The anonymous enquirer was asked to make contact with PALS to further discuss their experience, however they have not been in touch.
Phlebotomy WBCH	2	An excellent service. I have been having blood tests, often on a weekly basis, for twelve years at WBH and have nothing but praise for the service and staff.	
			Blood test delays staff couldn't care less. Arrive 25 minutes early for a routine blood test, was not informed of any delays. At my appointed time I explained that I needed to take my disabled wife for another NHS appointment. I explained that the delay of over half an hour gave me problems. After pleading 3 times a cold "nothing can be done" left me frustrated and disappointed.
Physiotherapy	2	The therapist was excellent. He did a thorough assessment and started me off with some exercises. He referred me on to the yoga class which is proving to be of great benefit.	
		Last year I had excellent treatment in the physiotherapy department for Achilles tendonitis.	
Podiatry	1	The staff are brilliant and very professional and very caring. No complaints.	
Prospect Park Hospital	1		I have noticed that on every occasion that I have attended, I have seen staff parking their cars in the disabled spaces, whilst I can appreciate that they need somewhere to park, this really should not be allowed and more thought given to others.
Psychology -PPH	1		The worst care. Treatment was decided before I had even met the clinicians, when I said I felt this wasn't appropriate for me this was completely dismissed and I was still pushed into group therapy.
Rose Ward PPH	1	Rose Ward - exemplary care. Throughout our son's time on Rose ward the team of doctors, nurses and health care workers exhibited compassion, understanding and care. They are very special people. Thanks to their dedication and patience, we have our son back.	
School Nursing	1	Saw a member of the school nursing team at the immunisation clinic, and was so very pleased and grateful for her kindness, calmness, patience, and positivity.	
Upton Hospital Duty Nurse	1		The duty nurse was extremely rude and unpleasant. No proper courtesy. Was very bossy and ordered to sit down. Highly unfriendly facial expressions.
Westcall	1		We were put in a side room. I had my other child of 5 with me too, very hot and trying to keep 2 little ones from running riot is a job. No one came and told us there was a huge wait and that that huge wait had an extra 3 hours added on top of the 3 hours we had already been there. I understand they are busy people but there's no communication between staff and patients. This has been sent to the Urgent Care services leadership team. The anonymous enquirer was asked to make contact with PALS to further discuss their experience; however they have not been in touch.

8.5 PALS Activity

There were 361 queries during this period. There were 198 non BHFT queries reported by PALS. This is a decrease in activity compared to Quarter one.

The main reasons for contacting PALS were:

- Access to services – Choice and flexibility
- Communication with other organisations
- General information requests
- Communication. Written to patients

Contact around access to services included:

- Patients wanting to self-refer
- Intervention needing to be brought forward due to deteriorating condition and pressure on family
- Preference for 1:1 intervention
- Request for reasonable adjustments to be made
- Requesting a service closer to home
- Needs more input to increase mobility
- Wants on line access.
- Neighbour requesting access for vulnerable person
- Recognition of assessments from a private provider.
- Needs interim care in lead up to therapy.
- Wants to return to NHS provider.

9. The Friends and Family Test

The NHS Friends and Family Test (FFT) gives an opportunity for patients and their carers to share their views in a consistent way across the Health Service. Berkshire Healthcare has aligned its Strategic Objectives to support a 15% response rate for the FFT in both physical and mental health services. The results of the NHS England national review of the FFT have been published and the FFT question will be changing from April 2020 to Overall, how was your experience of our service. There is an implementation plan underway, being led by the Head of Service Engagement and Experience.

The monthly FFT results, for each service and reporting locality, are shared on our intranet to make them accessible to all staff. The comments are also available online and the patient experience team are currently exploring how to share these more visually. A summary of the comments from the FFT is sent to the Clinical Directors on a monthly basis which is discussed in the locality Patient Safety and Quality Meetings.

The introduction of SMS and dedicated PPI Champions within the Children, Young People and Families locality are contributing to an increase in the number of responses to the FFT. The inclusion of FFT as one the Trusts' True North objectives has increased the focus on it within services. The Patient Experience Team is also formally monitoring this as part of ongoing Quality Improvement.

9.1 Friends and Family test responses

9.1.1 Overall responses

Our Trust overall recommendation rate to a friend for Quarter two is 91%; for community services the recommendation rate was 94% whilst for mental health services was 78%.

In Quarter one, the Trust overall recommendation rate to a friend was 92%; for community services the recommendation rate was 93% whilst for mental health services was 87%.

Our Trust overall recommendation rates to a friend was 93% for 2018/19, for community Hospital inpatients recommendation rate was 96% whilst for Mental health Inpatients this was 70%.

Data shows that introducing SMS as a way of providing FFT has proved very popular with 42% of responses being received via this method. There is on-going work to support services that do not use RiO to utilise the SMS system.

Based on the number of discharges from our services, there were 102,187 patients eligible to complete the FFT during Quarter two. Our response rate has been impacted by the increase in the discharge data provided to the Patient Experience Team; this continues to be monitored on a monthly basis.

July: 12%
August: 9%
September: 11%

Table 2: Quarterly number of Friends and Family Test responses

		Number of responses	Response Rate
2019-20	Q2	11,095	10.86%
	Q1	11,721	12.20%
2018-19	Q4	11,919	22%
	Q3	7631	12.82%
	Q2	5443	14.82%
	Q1	6625	11.64%
2017-18	Q4	5463	11.24%
	Q3	4105	6.81%
	Q2	4987	9.63%
	Q1	4238	7.04%
2016-17	Q4	3696	5.10%
	Q3	4024	5.10%
	Q2	5357	2.20%
	Q1	6697	2.70%
2015-16	Q4	4793	2.10%
	Q3	5844	4.20%
	Q2	6130	4.50%
	Q1	7441	6.60%

9.1.2 Inpatient ward responses

Table 24: FFT results for Inpatient Wards showing percentage that would recommend to Friends and Family

		2019/20		2018/19				2017/18			
Ward	**Ward type**	**Q2%**	**Q1%**	**Q4%**	**Q3%**	**Q2%**	**Q1%**	**Q4%**	**Q3%**	**Q2%**	**Q1 %**
Oakwood Ward	Community Inpatient Ward	100%	95.83%	95.83	100	100	95.83	100	72.97	93.75	100
Highclere Ward		100%	100%	97.5		97.37	93.98	94.64	96.7	100	100
Donnington Ward					94.12						
Henry Tudor Ward		90.48%	97.44%	90.91	93.48	89.8	97.78	97.59	42.86	98.86	93.5
Windsor Ward		91.89	-	100	100	96.67	88	95.24	94.44	100	100
Ascot Ward		100%	-	100	94.12	93.75	100	100	100	100	100
Jubilee Ward		96.34%	95.45%	92.86	100	94.92	97.5	97.83	100	100	100
Bluebell Ward	Mental Health Inpatient Ward	65.22%	60%	80	72.73	50	-	-	-	100	40
Daisy Ward		62.50%	75%	62.79	78.95	50	100	33.33	-	66.67	50
Snowdrop Ward		74.49%	71.11%	76.74	70.59	70.73	70.59	100	85.71	76.19	60
Orchid Ward		77.78%	84.48%	75	69.44	50	100	-	-	100	-
Rose Ward		76.92%	62.50%	45.95	62.5	0	100	33.33	100	50	100
Rowan Ward		86.67%	93.33%	100	83.33	-	-	-	-	-	100
Sorrel Ward		-	-	100	100	-	-	-	-	-	-

- = no responses received

9.1.3 Learning Disabilities

There were 12 surveys received for the Learning Disability Inpatient Ward, Campion Unit. The recommendation rate for Quarter two is 58.33%. There was no qualitative feedback on the surveys that were completed, and these results have been shared with the leadership team within the Learning Disability service for further exploration.
The Head of Service Engagement and Experience is leading a project to create a Trust standard for accessible surveys formats across the survey programme including the FFT.
There were 94 responses received from patients seen by the community teams for people with a learning disability, compared to 96 in Quarter one and 26 in Quarter four.

The recommendation rate for Quarter two is 85%, compared with 83% in Quarter one, 86% in Quarter four and with 71% in Quarter three.

9.1.4 Carer FFT

There has been a continued increase in carer responses. In Quarter two, 95% of carers would recommend the Trust to friends or family compared to 96% in Quarter one and 95% in Quarter four.

Table 25: Carer FFT Responses

Number of responses					
2019/20		**2018/19**		**2017/18**	
Q1	335	Q1	67	Q1	111
Q2	**408**	Q2	201	Q2	32
		Q3	314	Q3	39
		Q4	258	Q4	86

9.1.5 Friends and Family Test comparison information available from NHS England

Each month health services (both NHS and independent providing NHS services) submit a report to the Department of Health and Social Care on their FFT results and activity. As each organisation differs in the services that they provide, and the guidance for calculating the response rate differs substantially. The table below shows the most up to date comparison information available from NHS England, which is August 2019.

Table 26: Community Health services FFT data; August 2019

	Aug-19		Apr-19		Feb-19		Nov-18		Jul-18	
Trust Name	**Response R**	**% RR**	**Response R**	**% RR**	**Response R**	**% RR**	**Response R**	**% RR**	**Response R**	**% RR**
Berkshire Healthcare	**9%**	**95%**	**11%**	**94%**	**17%**	**94%**	**9%**	**96%**	**11%**	**98%**
Solent NHS Trust	5%	97%	3%	97%	7%	98%	5%	97%	4%	97%
Southern Health NHS FT	5%	98%	6%	96%	5%	95%	5%	97%	5%	98%
Oxford Health NHS FT	4%	95%	4%	95%	4%	93%	4%	97%	3%	96%

%RR – Recommendation rate

Berkshire Healthcare has maintained a significantly higher response rate compared to other local Trusts, this is positive and means that the results achieved are more valid; for August 2019 the Trust recommendation rate has increased to 95% for community services; this continues to be monitored.

Table 27: Mental Health services FFT data; August 2019

	Aug-19		Apr-19		Feb-19		Nov-18		Jul-18	
Trust Name	**Response R**	**% RR**	**Response R**	**% RR**	**Response R**	**% RR**	**Response R**	**% RR**	**Response R**	**% RR**
Berkshire Healthcare	**12%**	**86%**	**19%**	**87%**	**21%**	**86%**	**37%**	**83%**	**5%**	**87%**
Solent NHS Trust	9%	89%	9%	92%	13%	92%	11%	94%	9%	87%
Southern Health NHS FT	3%	91%	3%	92%	2%	93%	2%	92%	3%	92%
Avon and Wiltshire MH Partnership	11%	87%	17%	89%	14%	90%	16%	89%	13%	91%
Oxford Health NHS FT	9%	92%	9%	92%	9%	93%	9%	93%	9%	91%

%RR – Recommendation rate

There has been a decrease in the number of responses received over Quarter two. This is in part due to annual leave within services, where staff proactively promote and offer the survey to patients.

As the Family and Friends Test response rate is receiving less than the 15% target an action plan for improvement has been put in place and is being monitored through the Trust Finance Performance and Risk Committee, as well as being a Driver metric for the Patient Experience Team.

10. Our internal patient survey

At the end of the quarter we have received feedback from 3,830 patients or carers compared to 5,236 in the last quarter.

This quarter there has been a significant drop in responses but we have noticed a drop in numbers across all of the summer months. Mental Health Services are still showing an increased level of responses with responses showing from Campion Unit and Willow Ward

which is positive. Community Health services have seen a significant drop in responses mainly impacted by Immunisation and School Nursing being term time only.

The highlights are:

- 81% reported the service they received as good or better – a reduction from 86% in Quarter one and Quarter four
- Community Health Services had responses from 2,487 patients and carers with 88% of them reporting the service they received as excellent or good
- Mental Health Services responses increased to 1,343, with 68% of patients and carers rating the service provided as excellent or good
- 12 services carrying out the internal patient survey were rated 100% for excellent or good care with a further 18 services rating 85% or above

11. Learning Disabilities survey

There were 50 survey responses by people seen by our Community Team for people with a Learning Disability during Quarter two; a decrease from 96 in Quarter one and increase from 26 in Quarter four. A selection of the results is in the table below (there were 49 responses to the questions);

Table 28: Patient survey responses – Community based Learning Disability Services

My meeting with you was helpful. (49)	**Response Breakdown**	**Response Breakdown**	**I got answers to my questions. (49)**	**Response Breakdown**	**Response Breakdown**
Not at all	0	0	Not at all	2.04	1
Not much	0	0	Not much	0	0
A little	6.12	3	A little	6.12	3
Quite a bit	2.04	1	Quite a bit	4.08	2
A lot	73.47	36	A lot	71.43	35
Question not answered	18.37	9	Question not answered	16.33	8
You were polite and friendly to me (49)	**Response Breakdown**	**Response Breakdown**	**You listened to me. (49)**	**Response Breakdown**	**Response Breakdown**
Not at all	0	0	Not at all	0	0
Not much	0	0	Not much	0	0
A little	2.04	1	A little	2.04	1
Quite a bit	0	0	Quite a bit	0	0
A lot	81.63	40	A lot	81.63	40
Question not answered	16.33	8	Question not answered	16.33	8

The inpatient survey has been revised and below is a selection of the results from Quarter two.

Table 29: Patient survey responses – Campion Unit

How do you feel about food and drink on Campion? (36)	Response Breakdown	Response Breakdown	How do you feel about talking with staff on Campion? (35)	Response Breakdown	Response Breakdown
Positive	58.33	21	Positive	57.14	20
Not sure	25	9	Not sure	14.29	5
Negative	16.67	6	Negative	28.57	10
How do you feel about safety on Campion? (36)	**Response Breakdown**	**Response Breakdown**	**How do you feel about the help from staff on Campion? (34)**	**Response Breakdown**	**Response Breakdown**
Positive	55.56	20	Positive	61.76	21
Not sure	25	9	Not sure	23.53	8
Negative	19.44	7	Negative	14.71	5

12. Updates: Always Events and Patient Participation and Involvement Champions

The Always Events programme has been embedded within the WestCall service. The operational team are being supported by the Patient Experience Team with this project, a review of the feedback from the service led observations has taken place and the analysis from this is being drawn up to create the Always statement for the service. Further work on this project is taking place in Quarter three, as this has been on hold due to absence in the service.

PPI Champions are fully established and embedded within the Children, Young People and Families locality. Participation representatives from the services act as champions for service user feedback and participation. The champion role provides opportunities for passionate and enthusiastic staff, at all levels, to play an active role in generating a positive focus towards the progression of service user feedback and participation, with direct support from both their peers and corporate services. Services with a Champion are seeing an increase in the response rates for the FFT and wider participation. PPI Champions have been established across the community health west and mental health west localities, and are in the process of developing their local plans and vision.

Appendix Two contains the 15 Steps report for quarter two. There were 4 visits during this period; one to an inpatient ward and three two were in community based services.

13. Compliments

There were 1,389 compliments reported during Quarter two. The services with the highest number of recorded compliments are in the table below.

Table 30: Compliments

Service	Number of compliments
Talking Therapies	483
ASSiST	229
Cardiac Rehab	108
Community Hospital Inpatient	68
Community Respiratory Service	61
Integrated Care Home Service	38
District Nursing	36
Adult Acute Admissions	31
CMHTOA/COAMHS - Older Adults Community Mental Health Team	29
Heart Failure Team	28

Table 31: Compliments, comparison by quarter

	2018-19					2019-20	
	Q1	Q2	Q3	Q4	18/19	Q1	Q2
Total Compliments	1,008	1878	1,670	1,409	5,965	1,404	1,389

14. Changes made as a result of feedback

Examples of changes made as a result of feedback are detailed below

PPH:
'Hello my name is' badges were introduced as a result of feedback from a carers group The Clinical Director attended. They wondered why we weren't using the hello my name is… as a way of encouraging that immediate welcome when carers are coming on to the wards. We have fed back to the carers group what we have done and sent them some photos of our staff wearing them and they are really pleased.
This feedback was also shared with our Community Health wards who have now also implemented the badges.

Perinatal:
Service users said they wanted group work and to meet others in the same position. The service is looking to introduce monthly groups (to provide social interaction as many mothers are isolated). In addition many ex-service users would like the opportunity to 'give something back' so there is potential for peer volunteers within the service; therefore a quarterly peer support experience group is currently being scoped.

CRHTT:
Feedback was that telephone manner was abrupt and information requested was repetitive. Telephone approach has improved considerably through feedback and monitoring behaviour and assessment form has been made smarter. There has been significant reduction of negative feedback in these areas as result.

Community Nursing West Berkshire:
As a result of a delay in adequate pain control to a palliative patient who had experienced pain overnight and was not due to be visited until late afternoon a team member from each team now contacts all palliative patients/families first thing in the morning to check they are ok and intervene/arrange a visit sooner if there are any issues with symptom control.

Continence service:
A patient evaluation of the prescription service was undertaken and it highlighted patients wanted an alternative method of ordering (other than telephone) and they were wanting more information on new product developments. The service are as a result just in the process of contacting all patients with a flier regarding email ordering and a focus group which will happen in the new year, where patients will be invited to attend an exhibition and educational event.

Hi-Tech care team:
We set up our PICC clinics with the starting time for 8.am but we have patients that are still working and they have suggested earlier appointments we have adapted the service to accommodate patients earlier in the morning

Intensive Community Rehab:
You said: that you were not always fully informed about the service and what it entails.
What we did: On accepting a referral, we advise the client/family whilst still in hospital about the service offer. Then on the initial visit to client home, again the service is explained to client and family.

You said: Unsure of what time staff will visit.
What we did: All Clients are called before visiting

Immunisation Team:
Children have fed back through the patient experience tools that they would like more privacy. As a result a pop up privacy screen as been ordered for trial.

Elizabeth Chapman

Head of Service Engagement and Experience

Formal Complaints received during Quarter two 2019/20

Berkshire Healthcare NHS Foundation Trust

Geo Locality	Service	Complaint Severity	Description	Outcome code	Outcome
Windsor, Ascot and Maidenhead	CMHT/Care Pathways	Low	Complainant unhappy that they only received a cc letter into the patients care and not all their personal areas of concern were addressed.	Consent Not Granted	
Slough	Psychological Medicine Service	Minor	Pt seen by EBMH team at Wexham Park on 2 occasions. Pt extremely unhappy that she was visited and disagrees with the report that was written following the meeting. Pt wishes for the report to be removed from her records and other organisations it was sent to.	Upheld	Patients wishes not respected.
Wokingham	CAMHS - Child and Adolescent Mental Health Services	Low	Complainant feels elements still have not been addressed and wishes to have a LRM. ORIGINAL COMPLAINT BELOW Family unhappy with the lack of care and support for their child with ASD, they are also waiting for a report from the psychiatrist dating back to April.		
Reading	Adult Acute Admissions	Moderate	Family unhappy with care and treatment the patient has received from PPH.	Not Upheld	Consent not received, internal investigation to be undertaken by Patient Safety team.
Reading	CAMHS - Child and Adolescent Mental Health Services		Parent complaining that child's referral for ADHD assessment has been closed.	Not Upheld	Local Resolution.

Geo Locality	Service	Complaint Severity	Description	Outcome code	Outcome
Bracknell	Podiatry	Low	Patient unhappy with Podiatry booking system over the course of a month.	Local Resolution	Team Leader Bracknell Podiatry spoken to patient today regarding her complaint. She advice on what caused her frustration: 1. That she did not know how long she needed to wait for this appointment 2. the fact that that she contacted Podiatry to book an appointment and was told she is on the waiting list, and contacted the GP to say she can not book an appointment and still the choose and book system has generated letters (2) to tell her she need to book an appointment with in a certain time.
West Berks	Minor Injuries Unit	Low	Parent complaining about care and treatment of child's burn over the course of a week which they allege was incorrectly dealt with when the child required antibiotics.	Not Upheld	Following a review by the clinical team, care and treatment was appropriate. There was no sign of an infection when seen by the MIU staff.
Slough	Early Intervention in Psychosis	Low	Following a meeting with SCMHT, pt still believes lies and untruths exist in a report written about them and they wish this removed.	Partially Upheld	Amended letter not sent to patient and GP as promised - so partly upheld.
Reading	Early Intervention in Psychosis	Low	Email from parents of child who is under CAMHS Early Intervention in Psychosis stating that he wishes to dis-engage from services and all his healthcare will be met by his new GP. The parents forwarded an email to JE that they had sent to the two healthcare professionals who attended his son and advised them to not contact the child again.	Not Upheld	Not upheld as not consented to and no clinical failings.
Windsor, Ascot and Maidenhead	CAMHS - Child and Adolescent Mental Health Services	Minor	Parent unhappy they are being left out of care and meetings. Previously complained about the same thing in March.	Partially Upheld	Actions promised before had not happened.
Slough	GP General Practice		Relation complaining on behalf of patients family stating patient was wrongly diagnosed at Chapel Practice at Slough Walk-in Health Centre between 2010 and 2014 and that this resulted in his death in 2016.		

Geo Locality	Service	Complaint Severity	Description	Outcome code	Outcome
West Berks	Common Point of Entry	Low	Parent complaining about care and treatment of adult child, stating the patient had turned up for an appointment but staff member did not attend and then was arrogant. Claims child has had no MH support despite being released from Section in Chertsey a week ago.	Upheld	CPE need to display greater understanding and empathy towards family members who are supporting people with substance misuse problems and sign post them appropriately to family focused support groups. This will be raised at the next Team Meeting with plan to invite family to a future meeting to give overview of service to CPE clinicians.
Reading	Adult Acute Admissions		Pt fell out of his bed whilst in PPH Aug / Sept 2018, sent to RBH where they were told they and broken S1 and S2 vertebrae.		
Reading	Children's Speech & Language Therapy - CYPIT		Complainant believes the Pts SALT report was changed between 4th to 9th May 2018. Previously looked into locally now a formal complaint seeking several apologies and a financial remuneration of £900.		
Reading	CAMHS - Child and Adolescent Mental Health Services		Pt seen by GP in August 2017 and referred to CAMHS (Autism pathway) no referral apt offered to date and family need help.		
Slough	Occupational therapy		Family received a letter stating 18 weeks for OT assessment for the child, called to chase to be told it would now be summer 2020 - a further year. No strategies or advice given.		
Slough	District Nursing		Ex-GP complaining re standard of nursing care and lack of aseptic technique which allegedly caused an infection.		
Reading	CAMHS - Child and Adolescent Mental Health Services		Parent concerned about waiting times for ADHD assessment.		
Bracknell	Other		Pt waiting for out of area placement wishes to understand why it is taking so long and why she needs a further assessment.		

Geo Locality	Service	Complaint Severity	Description	Outcome code	Outcome
West Berks	CMHT/Care Pathways		Pt under services since 2018. Care worker appointed who kept cancelling apt on the day of the visit. Recent email from service states Care worker is on leave and will not return and a further person will be appointed but the pt has heard nothing.		
Windsor, Ascot and Maidenhead	CMHT/Care Pathways		Patient unhappy with support received from Maidenhead CMHT, several changes of support worker and unhelpful reception staff.		
Wokingham	CMHT/Care Pathways	Moderate	Pt wishes to change care co-ordinator as they feel they do not understand or relate to the pt's diagnosis.	Not Upheld	Complainant has had significant level of support and no longer needs a care co-ordinator.
Bracknell	Corporate/Policy		Family unhappy with the lack of report following the SIRI investigation into the suicide of the pt.		
Slough	Community Hospital Inpatient		Complainant found the patient in their home in a state of confusion and wants to know why a care package had not been put in place following discharge from a community inpatient stay.		
Reading	Integrated Pain and Spinal Service - IPASS		Long delays in pain management and the organisation of scans.		
Wokingham	Out of Hours GP Services	Low	Delay in a call from the Dr.	Partially Upheld	111 said she would be spoken to within an hour and it took longer than that - however, the prescription was a repeat so not an emergency.
Bracknell	District Nursing		Pt with Cerebral Palsy requiring a weekly bladder wash out is very unhappy with the district nurse who attended resulting her needing to go the A&E, very frightened that she will end up in A&E again if they reattend.		
Wokingham	Common Point of Entry		Communication with the patient's GP was not in writing but by telephone, pt unhappy as there is no audit trail. Pt feels this 'subterfuge' is completely unacceptable. Pt wishes to know why psychiatrist is unable to diagnose the pt's clinical depression and therefore why they have not responded.		

Geo Locality	Service	Complaint Severity	Description	Outcome code	Outcome
Bracknell	District Nursing		Family feels at war with services from DN's, Wheelchairs service and Tissue Viability. Unhappy that safeguarding measures were raised against the family.		
Bracknell	Common Point of Entry	Minor	Complainant has raised concerns that were not covered by a recent PHSO investigation. Concerns are about the impact of delays in being referred to secondary mental health services.	Not Upheld	Patient has already had these matters dealt with by PHSO and apology given - nil new to investigate.
Bracknell	Other		Pt unhappy with the person allocated as the main point of contact from the corporate office.		
Wokingham	Integrated Pain and Spinal Service - IPASS		Delay in appointment following GP referral which the pt feels has had a negative affect on the pts potential recovery.		
Reading	CMHT/Care Pathways	Low	Friend of patient rang to complain about no-one getting back to him several times recently and feels that patients admission was due to neglect by services over the last year.	Not Upheld	patient refused consent.
West Berks	Integrated Pain and Spinal Service - IPASS	Low	Complaining about GP and IPASS.	Partially Upheld	Communication issues.
Wokingham	CMHT/Care Pathways		Patient unhappy with assessment. Nurse did not listen to patient and allegedly formulated her own opinions. Patient referred back to GP but urgently needs professional help. Would like another assessment.		
West Berks	Perinatal		Patient unhappy with phone call with named clinician and social services being involved.		
Slough	Psychological Medicine Service		Patient attempted suicide on two occasions. Feels that he needed inpatient care. CRHTT visited late and left a compliments slip and a message. Complainant feels that this was not good enough and we did not exercise our Duty of Care.		
West Berks	CAMHS - Child and Adolescent Mental Health Services		Parent complaining about delay in ADHD assessment.		

Geo Locality	Service	Complaint Severity	Description	Outcome code	Outcome
West Berks	CMHT/Care Pathways		Pt feels unsupported from services. Pt unaware of their care plan and whether they will be seeing a psychiatrist as they did when under Reading CMHT on a regular basis.		
Windsor, Ascot and Maidenhead	CAMHS - Child and Adolescent Mental Health Services		Mother unhappy that CAMHS will not assess her child based on what the school say and not her. She says the child is violent to her and she feels this is medical negligence not assessing him.		
Reading	Crisis Resolution and Home Treatment Team (CRHTT)	Low	Pt unhappy with the attitude from one of the staff members who attended their house and the delay in being assigned a care co-ordinator.	Partially Upheld	Partly upheld for staff attitude.
Wokingham	Common Point of Entry	Low	Delay in receiving report from April virtual consultation. Complainant want the referral expedited to a fully qualified MH Professional as they feel the pt needs support.		Lack of communication and delays for appointment.
West Berks	CAMHS - Child and Adolescent Mental Health Services		Complaint about communication and support from CAMHS. The patient is also raising a number of concerns about how he feels he has been treated by the Trust - these have previously been responded to.		
Bracknell	CMHT/Care Pathways	Low	Pt feels there have been systemic failings regarding their care and treatment, particularly relating to their safety. Pt feels their suicidal thoughts have not been addressed by the Trust.		Apology for misunderstanding about PIP. Complaint about CRHTT unfounded as call recording states that the patient was happy with the care. Therapy not indicated due to drug use.
Reading	Learning Disability Service Inpatients	Moderate	Complaint about the attitude of staff involved in an altercation with the mother of a patient.		Incident will be subject to HR investigation.
Reading	Pharmacy - Mental Health only	Minor	Carer complaining about the defective / unreliable PPH Clozapine Clinic Point of Care Instrument.		Service need improvements so wait is shorter and proper waiting room. Machine was broken and has now been repaired.
Slough	Sexual Health	Minor	Pt presented at Garden clinic to be told lots of services no longer exist despite the website saying they do. Pt feels they can not discuss issues with their GP.	Upheld	Service website gave incorrect info and patient was turned away due to very busy day.

Geo Locality	Service	Complaint Severity	Description	Outcome code	Outcome
West Berks	Crisis Resolution and Home Treatment Team (CRHTT)	Minor	Pt unhappy with the attitude of the member of staff from Crisis in March 2016 for which they are still having flash backs.	Upheld	The IO acknowledged that there were issues with staff attitude and communication at the time of the contact with the service. Improvements have been made to the admission process for Yew Tree Lodge since the time of their care.
Bracknell	Common Point of Entry	Low	Pt unhappy with the attitude of the staff member who called.	Upheld	The call recording affirmed that the member of staff did not act appropriately. An apology has been given and this is being managed with the staff member as a performance issue.
Wokingham	Common Point of Entry	Low	Called CPE in order to chase care and treatment. Was told that they would call back on the same day but didn't hear anything.	Upheld	Apology for the delay in a call back from CPE
Reading	Adult Acute Admissions		Complainant wishing information regarding the pt for whom they hold LPOA but is finding no one will communicate with them and they need to inform family members abroad of the pt's progress and care plan.		
Reading	CMHT/Care Pathways		Family feel there has been a lack of care for the patient and no consistency with care co-rdinators.		
Windsor, Ascot and Maidenhead	CMHT/Care Pathways	Minor	Re-opened as promised documents still have not been said - Pt feels they have not had a consistent approach to care from services, patient feels there has have been continuous delays.		Withdrawn by complainant.
Reading	Talking Therapies	Low	Pt feels the therapist did not respect confidential information and feels extremely vulnerable now as a result.	Upheld	Service manager has dealt with it to complainants satisfaction.

Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

15 Steps Challenge

Quarter 2 2019/20

The success of this programme relies on the support of volunteers as part of the team during visits. This can be challenging at times when the circumstances of volunteers change or they risk becoming 'experts' due to the number of visits they have completed. Currently volunteers are very limited which has had an impact on the programme. A volunteer recruitment campaign is planned for November.

Overview of visits this quarter

ARC

- The unit was spacious, bright and clean with a calming atmosphere.
- The staff were all very welcoming and keen to chat with the team. Interaction seen with patients was professional whilst being friendly and considerate.
- The team felt that should a friend or family member be referred they would be confident in the professional assessment and care provided.

Dental Clinic

- The clinic is small with no receptionist; there is only a small waiting area immediately outside the surgery room. Once admitted to the clinic room staff were friendly and helpful.
- Parking was found to be difficult on the St Marks site at the time of the visit.
- The team were impressed by the staff and their enthusiasm on this visit and would be confident to bring a family member to the clinic.

Donnington Ward

- Positive visit with staff very engaged throughout the process and keen to receive feedback. Well organised ward with staff working purposely with each other and their patients in a relaxed and caring environment.
- A lot of information around the ward which at times was not clear who this was directed at, patients, visitors or staff. Suggested colour coded background/outline for each group may assist all visitors to the ward.

Podiatry

- Professional service observed with all staff engaged with their patients and working well together.
- Good range of leaflets although on top of cabinets outside clinic rooms which made it difficult to read, particularly for wheelchair users. (Staff reported that they do give out leaflet during and after treatment when they discuss this more with their patients).

- No staff board observed to identify who was working within the clinic. Discussed at feedback, informed this is being reviewed.

Pam Mohomed-Hossen & Kate Mellor
Professional Development Nurses
October 2019

Berkshire Healthcare NHS Foundation Trust

Berkshire Healthcare NHS Foundation Trust

Performance Report to Council

December 2019

Chief Executive Highlights Report

Local

• The Care Quality Commission has rated the WestCall Out of Hours GP service as "good" following their recent inspection. WestCall's previous rating was "requires improvement"

• The Care Quality Commission will be on-site on 12-13 December 2019 to conduct their Well Led Inspection

• The Trust is launching a new "Talking Therapies" website which will make it easier for people to find support if they are coping with depression, stress, anxiety or phobias. Our website now uses Browsealoud. This tool can translate and read out pages, including leaflets, in over 20 different languages.

• The Trust's Mental Health Services in Slough have been presented with two prestigious awards at the National Positive Practice Mental Health Awards 2019 ceremony. In partnership with Slough Borough Council and other partners from across Slough, the Slough Team were winners in the "Addressing Inequalities in Mental Health" category and were highly commended in the "Primary and Secondary Mental Health Services" category

• From 24 October 2019, the East Berkshire Specialist Mobility Service has re-located from St Mark's Hospital to 2-3 Abell, Gardens, Maidenhead. The service has also changed its name to: East Berkshire Specialist Wheelchair Service

• At the Annual South Central Healthcare Financial Management Association Conference, the Trust's Finance Team were awarded the coveted title of "South Central Regional Finance Team of the Year". The HFMA brings together healthcare financial professionals from across the region.

• Bev Searle, Director of Strategy and Corporate Affairs is retiring at the end of the month. Following an unsuccessful recruitment round, the Chief Executive will be putting interim arrangements in place to cover Ms Searle's role pending the appointment of a permanent Director.

National

• Research from the London School of Economics and Political Science, commissioned by the Alzheimer's Society has concluded that while the number of people with dementia in the United Kingdom is expected to nearly double to 1.6 million people by 2040, the cost of dementia care will almost triple to £45.4bn from today's cost of £15.7bn.

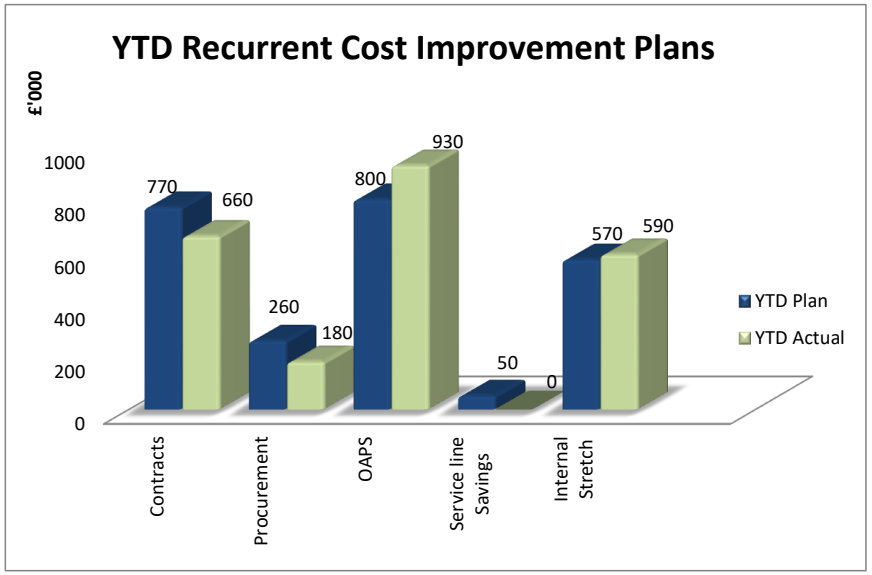
• NHS England has recorded the worst Accident and Emergency waiting times in 15 years when records began. The latest figures show that 83.6% (the national waiting time target is for 95% of patients to be seen within four hours) of patients were seen within four hours in October.

• NHS England and NHS Improvement have launched their NHS 111 campaign. The campaign encourages people to go straight to NHS 111, instead of worrying, self-diagnosing or second-guessing what they should do when they have an urgent health problem. The primary audience is all members of the public over the age of 16, with a focus on groups that NHS data show to be more frequent users of A&E departments, such as young adults aged 20-29 years.

• Figures from the Office for Students has found that the proportion of students declaring mental health issues has doubled in the past five years. Last year 3.5% of undergraduates in England told their university that they suffer from mental health conditions, up from 1.4% in 2012-13.

Performance Report to Council of Governors – Finance July to September 2019

CIP Achievement YTD (£K's)



As a public body, it is the Trusts duty to look to be efficient in every £ that it spends. An efficiency factor is applied to the Trusts contract prices each year. In 2019/20 the efficiency requirement was 1.1%. As part of this, ways of reducing costs are reviewed every year as part of Cost Improvement Plans. During 19/20 the trust has been set a cost improvement target of £4m by NHSI and it has set itself a target of a further £2m to ensure it delivers its control totals. This £2m cost improvement target is termed the internal stretch. At the end of Q1 the Trust was ahead of its cost improvement plans by £0.2m. This was due to over-achievement of OAPs and internal cost improvements plans.

Performance Report to Council of Governors – Finance July to September 2019

The Regulator View (NHSi)
Use of Resources Risk Rating

Metric	*Explanation*	*Metric Score*	*Score*
Capital Service Cover	Degree to which income covers financial obligations	1.8 times	2
Liquidity (Days)	Days of operating costs held in cash or cash-equivalent	13.4 days	1
I&E Margin	Surplus or Deficit / Total Revenue	0.1 %	2
Distance from Financial Plan	YTD Actual I&E margin vs YTD plan for Control Total	0.0 %	1
Agency Spend	Distance from Provider Agency Cap	-0.5 %	1
Overall Rating			**1**

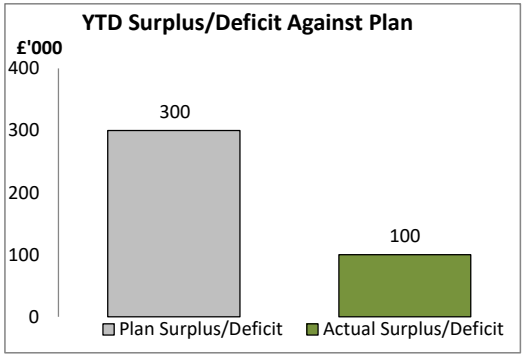
Please Note:
Marked on a scale of 1 to 4 with 1 being the highest.
The five metrics are equally weighted to give an overall score, rounded to the nearest whole number.

The thresholds (minimums) for each of the measures are as follows:-

Thresholds	*1*	*2*	*3*	*4*
Capital Service Capacity (times)	*>2.5*	*1.75-2.5*	*1.25-1.75*	*<1.25*
Liquidity (days)	*>0*	*(7)-0*	*(14)-(7)*	*<(14)*
I&E Margin (%)	*<=-1%*	*-1%*	*0%*	*1%*
I&E Margin Variance from plan (%)	*>=0%*	*(1%)-0%*	*(2%) - (1%)*	*<=(2%)*
Agency Spend (%)	*<=0%*	*0% -25%*	*25%-50%*	*>50%*

Marked on a scale of 1 to 4 with 1 being the lowest financial risk and 4 being the highest financial risk. NHSi use of resources score of 1 required to maintain low risk performance view.

YTD Surplus/Deficit Against Plan (£k's)



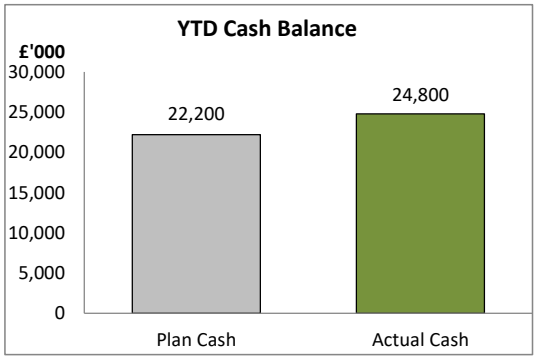
This surplus or deficit reflects the difference between the Trust spending and the income it receives.

The Trust had a £0.6m YTD deficit at the end of Q2, excluding PSF. This is in line with our agreed Control Total trajectory and therefore qualifies for the Q2 tranche of PSF. After accounting for PSF and donations, the Trust has a reported surplus of £0.3m, £0.1m ahead of plan YTD.

Of our total available £2.3m PSF for the year, £0.9m has been allocated to Frimley system. Frimley ICS is continuing to forecast delivery of the system control total for 19/20, and the Finance Group is monitoring
any emerging system risk. There is no allocation of system PSF in relation to the BOB system and as such no direct financial risk to the trust.

The Trust continues to perform well against its target to reduce 'inappropriate ' OAPs however our overall out of area placement numbers remain higher than planned with an YTD over spend of £0.4m.

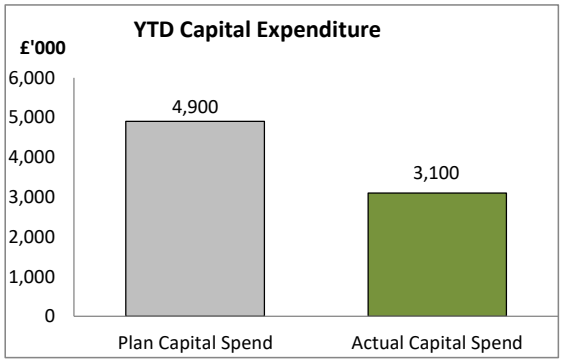
Latest Cash Position (£k's)



The cash surplus shown in the graph supports liquidity and capital expenditure.

The Trust ended Q2 with £2.6m more cash than planned due to the timing of capital spend, receipt of PSF bonus payment, offset by working capital pressures.

YTD Capital (£k's)



Capital Spend is cash spent on items that last longer than 1 year and have a value of over £5,000. Examples of this are buildings and networked IT. It is important that the trust re-invests in capital items to provide good facilities and equipment for patient care.

Capital spend was behind the revised plan , but with expectation that FY spend will be to plan.

Performance Report to Council of Governors – Performance July to September 2019

Friends and Family Test

Indicator		Target
Recommendation Rate	93%	**85%**

The above number shows the proportion of patients who when surveyed would recommend the Trust services to their friends and family. In Quarter 1 this was 92%.

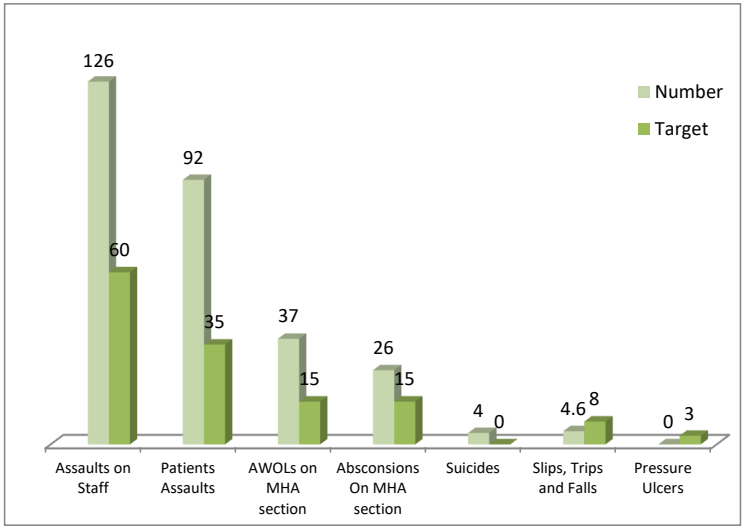
The response rate was 11% in Quarter 1 against a target of 15%.

Safer Staffing

Indicator	RAG Rating
Safe Staffing	

There is a shortage of registered nursing staff available in the Thames Valley area and therefore registered nursing vacancies are hard to fill and good registered temporary nursing staff are equally hard to find. While we continue to actively advertise and take steps to recruit into the registered nursing vacancies on the wards we are using good temporary care staff who are available and know the wards to fill shift gaps because it is safer for patients. Whilst filling shifts with care staff maintains patient safety, having more registered nursing staff once recruited will improve staff morale as there will be greater peer support, more supervision of care staff and ultimately improved patient care.

User Safety



The above chart is showing the September 2019 rolling quarter Actual Vs target. Please note that lower than the stated target means KPI has achieved its target. There has been a decrease on assaults on staff and pressure ulcers due to lapse in care. There has been an increase in absent without leave (AWOL) by patients detained under the mental health act, and apparent suicides in comparison to the rolling quarter to June 2019. Falls has remained the same as Quarter 2 Assaults on staff, Falls and Pressure Ulcers are breakthrough objectives for the Trust's Quality Improvement programme.

Performance Report to Council of Governors – People July to September 2019

Staff Turnover

Target	Actual
15.20%	16.14%

Agency Position

Target	Actual
< 6%	3.0%

Sickness

Target	Actual
< 3.5%	4.23%

Note: lower than the stated target means KPI has achieved its target

Appraisals

Target	Completed %
> 95%	88.92%

The target was achieved in June 2019.

Days Taken For Recruitment

Target	55
Days Taken	72.4

Note: Equal or lower than the stated target means KPI has achieved its target

The Board Assurance Framework sets out the key risks to the Trust achieving its strategy.

Each risk has an action plan, key control and sources of assurance.

The risk summary sets out the risk description and key mitigations.

Risk Description	Mitigations
Risk 1 Failure to recruit, retain and develop the right people in the right roles at the right time and at the right cost could impact on our ability to meet our commitment to providing safe, compassionate, high quality care and a good patient experience for our service users.	• Prospect Park Hospital and Children and Young People's Services both have dedicated Human Resources support to support work to reduce vacancy levels. In addition, a fixed term role has created additional capacity to address staff wellbeing. • Recruitment and Resourcing Group has been established across Human Resources, Finance, Nursing and Governance functions to oversee workforce planning • Monthly recruitment and retention whole day workshops are in place to oversee the range of activities in place as part of the workforce strategy implementation • Diversification of apprenticeships has been achieved to include non-clinical staff, for example, estates and facilities, electrical, carpentry etc. and leadership and management opportunities for all staff
Risk 2 Failure to achieve national efficiency benchmarks could impact on the Trust's future sustainability and lead to increased regulatory scrutiny	• The Trust will incorporate specific opportunities for efficiencies into 2019/20 planning and NHS Improvement strategy submission financial projections in summer 2019. • The Trust is developing patient level costing.
Risk 3 Failure of the Sustainability and Transformation Plans to deliver transformational change and required investment in mandated national priorities, including in the mental health five year forward view, could result in the local health economy not being able to safely keep pace with the rising costs and demand for services.	• Frimley Health are hosting an governor engagement event in 5 February for governors and lay members of the provider and clinical commissioning groups • The Trust has contributed to the Integrated System's Five Year Plans
Risk 4 There is a risk that other providers may acquire the Trust's adult and children's community services which would impact organisational sustainability and reduce the Trust's scope to develop new models of out of hospital care	• The Trust has robust business and development and horizon scanning processes in place. • The Trust has regular meetings with the Commissioners and plays an active role in the East and West Integrated Care Systems. • Review of Mental Health Implementation Plan and Primary Care Network requirements has been undertaken to inform development of our strategy. The Trust Board Away day in October 2019 and subsequent engagement with services, stakeholders and governors will facilitate the development of our overarching organisational strategy supported by divisional implementation plans as well as those for key enablers e.g. workforce, estates and IM&T.
Risk 5 Failure to develop collaborative working relationships with key strategic partners could result in the Trust losing influence in key decisions leading to less effective services for local people	• Development of working relationships with CCG Mental Health leads. • Effective contribution to partnership forums for mental health, ensuring clarity of objectives, and actions required for their delivery and robust performance monitoring to regulators and within Berkshire Healthcare • The Executive Team are represented on key forums in Berkshire West and Frimley Health Integrated Care Systems as well as the Berkshire West Integration Delivery Group • Locality and Clinical Directors are engaged in specific Integrated Care System initiatives at local level. • The Stakeholder Satisfaction Survey is being repeated and will provide feedback on how others regard the Trust as a partner organisation.

Risk 6 There is a risk of a rise in demand for community and mental health services and a lack of available capacity due to – • failure of other health, social care and third sector providers to deliver their services leading to increase in referrals and higher acuity patients • demographic changes leading to increased patient numbers and greater need • financial constraints of commissioners limiting options for investment to meet growth • system developments and changes to patient pathways increase expectations and demands on Trust services • increase in vacancies due to high turnover and lack of available workforce reducing capacity in Trust services. This is a particular risk for Mental Health Inpatient, Community Nursing, Child and Adolescent Mental Health Services and Common Point of Entry currently.	• The Trust is fully involved in the development Integrated Care Systems. • The Trust is also represented at a number of system wide meetings, for example, the Emergency Care Board and the Learning Disability Transformation Steering Group. • The Trust has good engagement with the developing Primary Care Networks. • Community Mental Health transformation for Frimley Health Integrated Care System project is being managed with Trust Directors

Performance Report to Council of Governors – NHS Improvement Requirements July to Sept 2019

KPI	Target	Actual	Definition
7 day follow up	95%	96.56%	This is the percentage of Mental Health Patients discharged from our wards who were within 7 days.
DM01 Diagnostics Audiology - 6 weeks	99%	99.87%	This is the % of patients waiting 6 weeks or less for Audiology diagnostic tests.
A&E 4 Hour Waits	95%	99.47%	This is the percentage of patients waiting in the Trust's Minor Injury Unit to treat/discharge or transfer within 4 hours.
RTT Community: incomplete pathways	92%	100.00%	This is the percentage of patients waiting within 18 weeks for their first outpatient appointment in the Trust's Diabetes and Children's Community Paediatric teams.
Data Quality Maturity Index	95%	95.57%	This measures the Trust's completeness of Mental Health Services Data Set data in relation to the 29 fields including: - Ethnic Category, GMC Practice Code, NHS Number, Organisation Code, NHS Number, Organisation Code, Gender, and Postcode. This is the latest score.

Early Intervention in Psychosis New Cases - 2 week wait	56%	91.67%	This is the percentage of patients who present with first episode psychosis, who are assessed and accepted onto a caseload and receive a NICE Concordant package of care.
Out of Area Placements occupied bed days - East CCGs	266	294	The number of occupied bed days for acute, older adult or PICU patients, from East CCGs who were sent out of area as there was no bed available within the Trust.
Out of Area Placements occupied bed days - West	276	118	The number of occupied bed days for acute, older adult or PICU patients, from West CCGs who were sent out of area as there was no bed available within the Trust.
Improving Access to Psychological Therapies - waiting times for:- Assessment Treatment and Recovery	75% 95% 50%	96% 100% 55.47%	This measures the percentage of IAPT patients who were assessed within 6 weeks, started treatment within 18 weeks, and the percentage of those who have recovered.
Clostridium Difficile due to Lapse In Care - Year to Date	6	4	This measures the number of cases of Clostridium Difficile which were caused by a lapse in care in our inpatient services.

Cardio Metabolic CQUIN assessment and treatment for people with psychosis in the following settings:-			This CQUIN looks to improve health outcomes for those patients with psychosis by sampling a number of cases and calculating the percentage of clients who have received an assessment, and where risks are identified, intervention covering the following:
Inpatient settings	90%	42%	. smoking status
Early Intervention in Psychosis Services	90%	88%	. lifestyle (including exercise, diet, alcohol and drug use)
Community Mental Health Patients on CPA	65%	21%	. body mass index
			. blood pressure . glucose regulation (HbA1c or fasting glucose or random glucose, as appropriate) . blood lipids. This must be clearly recorded in the patients' records.
MRSA	0	0	This is the number of cases of the infection meticillin-resistant Staphylococcus aureus identified on our wards as occurring due to lapse in care.
Gram Negative Bacteraemia	0	0	This is the number of cases of infection Gram Negative Bacteraemia cases including, E coli, Pseudomonas and Klebsiella identified on our wards as occurring due to lapse in care. One case occurred on Ascot Ward.
MSSA	0	0	This is the number of cases of the infection Methicillin-sensitive Staphylococcus aureus identified on our wards as occurring due to lapse in care.

Berkshire Healthcare NHS Foundation Trust

Council of Governors Annual Work Programme 2019-20

May 2019 Joint Board and CoG informal meeting	June 2019 Formal Council meeting	July Joint NEDs and CoGs 2019 informal meeting	September 2019 Formal Council meeting	November 2019 Joint Board and CoGs informal meeting	December 2019 Formal Council meeting	Feb 2020 Joint NEDs and CoG informal meeting	March 2020 Formal Council meeting
Strategic Update	Patient Experience Report	Strategic Update	Patient Experience Report	Strategic Update	Patient Experience Report	Strategic Update	Patient Experience Report
Last Board meeting	Performance Report	Last Board meeting	Performance Report	Last Board meeting	Performance Report	Last Board meeting	Performance Report
Service Presentation	Working Group Reports	Service Presentation	Working Group Reports	Service Presentation	Working Group Reports	Service Presentation	Working Group Reports
Governor Questions	NHS Staff Survey Results	Governor Questions	Lead and Deputy Lead Governor Appointment	Governor Questions	Chair of Audit Committee's Report to the Governors	Governor Questions	Annual Plan on a Page
Round table discussions with NEDs	Election Report	Round table discussions with NEDs	Annual Report and Accounts Presentation	Round table discussions with NEDs	CMHT Update	Round table discussions with NEDs	Annual Governor Declarations of Interests
		Carers Strategy Presentation	External Auditors Report to the Governors	Annual Strategic Planning session with the Board	Quality Accounts Indicator		Draft Quality Accounts
		Volunteers Presentation	CoGs A&R Committee Report				
			Dates of Future Meetings				