Berkshire Healthcare
NHS Foundation Trust

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

TRUST BOARD MEETING HELD IN PUBLIC

10:00am on Tuesday 10 December 2019
Boardroom, Fitzwilliam House,
Skimped Hill Lane, Bracknell, RG12 1BQ

AGENDA

No	Item	Presenter	Enc.
	OPENING BUSINESS		
1.	Chairman's Welcome	Chris Fisher, Vice-Chair	Verbal
2.	Apologies	Chris Fisher, Vice-Chair	Verbal
3.	Declaration of Any Other Business	Chris Fisher, Vice-Chair	Verbal
4.	Declarations of Interest i. Amendments to the Register ii. Agenda Items	Chris Fisher, Vice-Chair	Verbal
5.1	Minutes of Meeting held on 12 November 2019	Chris Fisher, Vice-Chair	Enc.
5.2	Action Log and Matters Arising	Chris Fisher, Vice-Chair	Enc.
	QUALITY		
6.0	Patient Story – A Young Person's Self-Harm Story	Debbie Fulton, Director of Nursing and Therapies	Verbal
6.1	Freedom to Speak Up Guardian's Six Monthly Report	Mike Craissati, Freedom to Speak Up Guardian	Enc.
6.2	Quality Assurance Committee – 19 November 2019 a) Minutes of the Meeting b) Learning from Deaths Quarterly Report c) Guardians of Safe Working Quarterly Report	David Buckle, Chair of the Quality Assurance Committee Dr Minoo Irani, Medical Director	Enc.
	EXECUTIVE UPDATE		
7.0	Executive Report	Julian Emms, Chief Executive	Enc.
	PERFORMANCE		
8.1	Month 7 2019/20 Finance Report	Alex Gild, Deputy Chief Executive and Chief Financial Officer	Enc.
8.2	Month 7 2019/20 True North Scorecard Performance Report	Alex Gild, Deputy Chief Executive and Chief Financial Officer	Enc.
8.3	Board Vision Metrics Report	Alex Gild, Deputy Chief Executive and Chief Financial Officer	Enc.

No	Item	Presenter	Enc.
8.4	Finance, Investment & Performance Committee	*The next scheduled meeting of the Committee is on 29 January 2020*	
STRATEGY			
CORPORATE GOVERNANCE			
9.0	Council of Governors Update	Chris Fisher, Trust Chair	Verbal
Closing Business			
10.	Any Other Business	Chris Fisher, Vice-Chair	Verbal
11.	Date of the Next Public Trust Board Meeting –11 February 2020	Chris Fisher, Vice-Chair	Verbal
12.	**CONFIDENTIAL ISSUES:** To consider a resolution to exclude press and public from the remainder of the meeting, as publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted.	Chris Fisher, Vice-Chair	Verbal

Berkshire Healthcare
NHS Foundation Trust

AGENDA ITEM 5.1

Unconfirmed minutes

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

Minutes of a Board Meeting held in Public on Tuesday 12 November 2019

Boardroom, Fitzwilliam House

Present:	Martin Earwicker	Chair
	David Buckle	Non-Executive Director
	Naomi Coxwell	Non-Executive Director
	Mark Day	Non-Executive Director
	Mehmuda Mian	Non-Executive Director
	Julian Emms	Chief Executive
	Alex Gild	Deputy Chief Executive and Chief Financial Officer
	Debbie Fulton	Director of Nursing and Therapies
	Dr Minoo Irani	Medical Director
	Aileen Feeney	Non-Executive Director
	Bev Searle	Director of Strategy and Corporate Affairs
	David Townsend	Chief Operating Officer
In attendance:	Julie Hill	Company Secretary
	Nathalie Zacharias	Deputy Director of Allied Health Professions *(present for agenda item 6)*

19/195	**Welcome** (agenda item 1)
	Martin Earwicker, Chair welcomed everyone to the meeting including the observers: Kathryn MacDermott, Director of Strategic Planning, David Lloyd-Williams, Public Governor and Guy Dakin, Staff Governor. The Chair extended a particular welcome to Aileen Feeney, Non-Executive Director who was attending her first Board meeting in her role as Non-Executive Director.
19/196	**Apologies** (agenda item 2)
	Apologies were received from: Chris Fisher, Non-Executive Director.

19/197	**Declaration of Any Other Business** (agenda item 3)
	There was no other business declared.
19/198	**Declarations of Interest** (agenda item 4)
	i. Amendments to Register None
	ii. **Agenda Items** – none
19/199	**Minutes of the previous meeting – 10 September 2019** (agenda item 5.1)
	The Minutes of the Trust Board meeting held in public on Tuesday 10 September 2019 were approved as a correct record of the meeting after the following corrections had been made: Minute No 19/161 – the word "manufacturing" to be replaced with the word "safety". Minute No 19/165 – 9th paragraph to read: "David Buckle, Non-Executive Director referred to table 11 (page 31 of the agenda pack) which showed the volume of mental health complaints reported for the South England region and commented that without comparative data, the number of complaints did not provide useful data."
19/200	**Action Log and Matters Arising** (agenda item 5.2)
	The schedule of actions had been circulated. **The Trust Board**: noted the schedule of actions.
19/201	**Patient Story – Reducing Patient Falls with Assistive Technology** (agenda item 6.0)
	The Chair welcomed Nathalie Zacharias, Deputy Director of Allied Professions to the meeting. The Board watched a short video about the Trust's Quality Improvement Programme initiative to reduce patient falls using assistive technology. Ms Zacharias explained that falls were the number one cause of harm for in-patients and therefore reducing the number of falls was chosen as one of the Trust's Quality Improvement programme objectives. In the video, staff on Donnington Ward explained that the initial work involved gathering data from patients, family members, staff and reviewing fall incident reports in order to gain as full a picture as possible about when and in what circumstances falls were most likely to occur. From this data, staff identified that 42% of falls occurred between 3pm-6pm and that two-thirds of falls were unwitnessed falls with most falls occurring in the patients' bedroom. Ms Zacharias explained that as a Global Digital Exemplar, the Trust was keen to explore whether there was a digitally supported solution to reduce falls. It was noted that the Trust

	worked with a Technology Company who devised an assistive technology system which alerted staff if a patient left their chair. Staff were then able to help the patient to ensure that they did not fall. Ms Zacharias reported that the technology had been used for ten months and during this time only one patient had refused to use the system. During this period, the number of unwitnessed falls and significantly decreased. The Chair asked whether false alarms were a problem. Ms Zacharias said that false alarms were a problem in the first few months of operation because staff needed to learn where to put the sensors on the chairs. The Deputy Chief Executive and Chief Financial Officer asked whether the technology would be suitable to be rolled out across other in-patient wards. Ms Zacharias reported that the technology was less suited to the traditional "Nightingale" wards. It was noted that the Technology Company was developing a wireless system which would not require wires which would be safer for use on the Mental Health wards. The Chief Executive said that reducing the number of falls had a number of significant benefits for both patients and the Trust and resulted in a lower length of stay and reduced admissions to acute hospitals. Ms Zacharias presented a patient story to illustrate the benefits to patients of the new assistive technology (the story is attached at appendix 1 of the minutes). The Chair thanked Ms Zacharias and the staff in the video for sharing their impressive work to reduce falls.
19/202	**Six Monthly Safe Staffing Report** (agenda item 6.1)
	The Director of Nursing and Therapies presented the paper and highlighted the following points: • The report supported the 2016 National Quality Board and October 2018 NHS Improvement Developing Workforce Safeguard expectations in relation to Board oversight of staffing on in-patient wards and the requirement to undertake an annual review of staffing establishments using nationally available tools, benchmarking and clinical judgement. The report also included workforce and quality data. • The report included the Nursing and Medical Directors' declaration that they were satisfied with the outcome of any assessment that staffing was safe, effective and sustainable. • During the reporting period, the main challenge associated with all of the wards continued to be the recruitment and retention of registered nurses and as a consequence, the Trust's ability to achieve two registered nurses on each shift. • During the reporting period, 5.6% of total shifts had not achieved the target of two registered nurses. In the majority of these shifts, ward managers and other senior clinicians who were registered nurses and therapy staff but who were not counted into the staffing figures were available to support ward staff. • Senior staff and managers had continued to deploy the available staff resource in order to maintain safety with all areas having mitigation and processes in place for

	when there were staff shortages. • The outcome of the staffing review was that for Orchid, Rowan, Sorrel, Campion, Henry Tudor, Jubilee, Oakwood, Donnington, Highclere, Wokingham wards and Willow House, was that the current agreed staffing establishments, alongside the use of additional staffing to meet increased acuity and observations was at the right level to achieve safe staffing. • It was acknowledged that due to vacancy levels and reliance on temporary staff at times, this level was not achieved. • For the acute mental health wards (Rose, Snowdrop, Daisy and Bluebell), the planned pilot of an Activity Co-ordinator Role on Snowdrop ward to provide increased care hours per patient day for patients alongside the ability to provide therapeutic input was expected to achieve a positive impact. If this was the case, the pilot would be rolled out to the four acute wards. • In terms of Medical staffing, numbers in the Trust had remained stable with adequate medical cover available during routine working hours for inpatient mental health and community health wards. The Director of Nursing and Therapies reported that there had been one patient on patient assault incident on Sorrel Ward in the reporting period where had there been an additional member of staff on duty, the incident may not have happened. David Buckle, Non-Executive Director said that the purpose of the paper was to assure the Board that there was safe staffing on the Trust's inpatient wards and commented that although he was assured, it was important for the Board not to be complacent and to acknowledge the negative impact on both staff and patient experience when shifts were not covered by permanent staff. Dr Buckle requested that future reports include the percentage of shifts with less than two registered nurses for the previous six-month period so that the Board could more easily identify whether the staffing situation was improving or deteriorating. **Action: Director of Nursing and Therapies** Mark Day, Non-Executive Director referred to the section of the report on Prospect Park Hospital (page 27 of the agenda pack) and noted that there was a daily staffing huddle to identify staffing shortages and to make decisions about whether to deploy or move staff to support wards with staffing challenges. Mr Day said that in his visits to in-patient wards, he was aware that staff were attached to their wards and may be reluctant to be deployed on other wards. The Director of Nursing and Therapies acknowledged that staff preferred to work on their own wards but said that staff recognised the need to maintain safe staffing and were willing to support one another. It was noted that there was less flexibility to move staff around in the Community Hospitals. The Chair referred to the sickness absence data (page 39 of the agenda pack) and pointed out that the level of sickness was above average for Bluebell, Rose and Oakwood wards and asked whether the increase was due to the increased pressure because of staffing shortages. The Director of Nursing and Therapies confirmed that the sickness absence figures included a mix of short- and long-term sickness, but acknowledged that staffing shortages inevitably led to increased pressure on staff which in turn may lead to more stress related sickness.

	Mehmuda Mian, Non-Executive commented that the Community Nursing section of the report (page 44-45 of the agenda pack) made reference to the fact that the Community Nursing actual staffing against current agreed whole time equivalent establishment did not reflect the additional unpaid hours that staff worked to meet demand and asked about the impact of working longer hours on the health and wellbeing of staff. The Chief Operating Officer reported that the Trust had successfully recruited more Community Nurses and that this would help to reduce the workload pressures. **The Trust Board:** noted the paper and noted that declaration by the Director of Nursing and Therapies and Medical Director that they were satisfied with the outcome of any assessment that staffing was safe, effective and sustainable.
19/203	**Research and Development Annual Report** (agenda item 6.2)
	The Medical Director presented the paper and highlighted the following points: • The Trust has a small Research Team. The Trust was ranked in the Top Ten Mental Health Trusts in the country for its volume of research; • By recruiting over 500 research participants in 2018-19, the Trust would receive £20,000 of Research Capability Funding in 2019-20, • The Trust had collaborated with the University of Reading on two successful National Institute for Health Research Patient Benefit grant applications; • Patients in Community Health Services had been provided with increased opportunities to be involved in research. David Buckle, Non-Executive Director said that the Trust had a good track record in research and noted that the Trust had received £0.5m of research income. Dr Buckle asked about the associated costs of undertaking research. The Medical Director explained that the Trust's aim in terms of the costs of research was to break even. The Chair commented that a lot of research was long term and that it was common for there not to be any direct benefit for the organisation undertaking the research. The Medical Director said that some of the best research projects were multicentered across the country and in some cases were international studies and said that the Trust was a small cog in the wheel. The Chief Executive said that inevitably the Trust could not compete with the scale of research undertaken by the large teaching hospitals but pointed that over the last eight years, the Trust had continued to expand its research activities. The Deputy Chief Executive and Chief Financial Officer said that the Trust's research activities also included working with Technology partners to develop Apps and other IT solutions. **The Trust Board**: noted the report.
19/204	**Information Governance Annual Report** (agenda item 6.3)

	The Medical Director presented the paper and said that the Information Governance Annual Report included details of Information Governance incidents and complaints, information sharing agreements and subject access request performance. The Medical Director said that the key areas for development during 2019-20 included: • A review of the training and guidance available to staff for responding to Subject Access Requests; • A review of the Information Governance Team resource to ensure that the Trust had adequate capacity to meet its requirements and to support staff; • Continuing to be engaged with the Integrated Care System Information Governance Steering Group. It was noted that the resource review of the Information Governance Team has been completed and a business case was approved to increase the capacity of the Team and that all roles had been successfully recruited to. Mark Day, Non-Executive Director asked which Committee received the Information Governance Serious Incident reports. The Medical Director confirmed that the Information Governance Serious Incidents were reported to the Quality Assurance Committee as part of the Serious Incident quarterly report. Naomi Coxwell, Non-Executive Director asked for more information about the Information Governance Team resource review. The Medical Director explained that the internal audit review of the Trust's Information Governance work had identified the need for additional staffing resources to meet the expanding remit of the Team which included system work. The Chief Executive pointed out that Subject Access Requests required a bespoke response and were often complex and time consuming because it involved redacting any information relating to a third party. **The Trust Board:** noted the report which provided assurance that robust arrangements were in place to effectively manage all information risks within the Trust.
19/205	**Executive Report (**agenda item 7.0)
	The Executive Report had been circulated. The following issue was discussed further: **a) Staff Flu Vaccination Campaign** Mehmuda Mian, Non-Executive Director referred to page 79 of the agenda pack and commented that it was disappointing that only 26.20% of doctors and dentists had been vaccinated. The Director of Nursing and Therapies explained that the vaccine had been delivered in three tranches this year and that the Trust had only recently received the third batch of vaccine.

	The Medical Director pointed out that last year doctors and dentists were one of the highest staff groups vaccinated. The Board expressed their commitment to achieving the ambition of 100% of front line healthcare workers being vaccinated. The Director of Nursing and Therapies reported that the Trust ran out of hours clinics and had its largest number of Peer Vaccinators this year. The Chair confirmed that all Board members had received their vaccinations. It was noted that various members of the Board had been photographed having their vaccinations and this had been used as part of the Trust's internal flu vaccination campaign staff communications. It was noted that the Trust had completed NHS Improvement's Healthcare worker flu vaccination best practice management checklist (appendix 1 of the report, page 81 of the agenda pack). It was noted that the Trust had agreed the incentive of a Tetanus vaccine being donated to Unicef for every member of staff who received the flu vaccination. **b) WestCall Out of Hours GP Service Care Quality Commission Inspection** The Chief Executive congratulated the WestCall Out of Hours GP service for achieving a Care Quality Commission rating of "good" across all domains. **The Trust Board:** noted the report.
19/206	**Month 06 2019-20 Finance Report** (agenda item 8.1)
	The Deputy Chief Executive and Chief Financial Officer presented the report and highlighted the following points: • The Trust had a £0.6m, year to date deficit at the end of Quarter 2 (excluding Provider Sustainability Funding). This was in line with the agreed Control Total trajectory and therefore the Trust had met NHS Improvement's criteria for the Quarter 2 tranche of the Provider Sustainability Funding; • After accounting for Provider Sustainability Funding and donations, the Trust had a reported surplus of £0.3m (£0.1m ahead of the financial plan year to date); • The Trust was forecasting to deliver this year's financial plan and had confirmed this commitment to NHS Improvement; • Delivery of the financial plan would require maintaining the good performance in relation to reducing the number of inappropriate Out of Area Placements and that the increase in permanent salary costs would be being offset by a reduction in temporary staffing costs; • The Use of Resources rating had returned to a "1" overall, in line with the financial plan; • Despite a fall in salary costs, overall, the year to date pay costs were £0.6m above the financial plan, after absorbing recruitment assumptions; • Cash at the end of September 2019 was £2.6, better than planned mainly due to the timing of capital expenditure, receipt of the Provider Sustainability Funding bonus payment and was offset by working capital pressures; • Capital expenditure was behind the revised Capital Plan but the expectation was that the full year spend would be in line with plan.

	Mark Day, Non-Executive Director asked why the recent successful recruitment campaign had not been matched by a reduction in the cost of bank and agency staff. The Deputy Chief Executive and Chief Financial Officer explained that the Trust had successfully recruited more Community Nurses, but this service which was not a big user of bank and agency staff. In addition, there were some additional short-term double running costs in relation to the Preceptees at Prospect Park Hospital until the new recruits had completed their registration process. The Chair referred to the graph on management and administration full time equivalents hours worked (page 90 of the agenda pack) and asked why the numbers had increased. The Deputy Chief Executive and Chief Financial Officer explained that this included a number of roles such as Project Support and IT. The Chair said that it would be helpful to understand whether this growth led to greater efficiencies elsewhere in the Trust. The Deputy Chief Executive and Chief Financial Officer agreed to provide more information to the Finance, Investment and Performance Committee. **Action: Deputy Chief Executive and Chief Financial Officer** **The Trust Board noted:** the following summary of the financial performance and results for Month 6 2019-20: (The Trust reports to NHS Improvement its "Use of Resources" rating which monitors risk monthly, "1" is the highest rating possible and "4" is the lowest). Year to date (Use of Resource) metric: • The Trust's overall Use of Resources rating was "1" (the plan was "1") • Capital Service Cover rating was 2 • Liquidity days rating was 1 • Income and Expenditure Margin rating was 2 • Income and Expenditure Variance rating was 1 • Agency target rating was 1 Year to date Income Statement (including Provider Sustainability Funding) excluding donations: • Plan: £0.2m surplus • Actual: £0.3m surplus • Variance: £0.1m better than plan Year to date Cash: £24.8m versus plan of £22.2m Year to date Capital expenditure: £3.1m versus plan of £4.9m
19/207	**Month 06 2019-20 "True North" Performance Scorecard Report** (agenda item 8.2)
	The Deputy Chief Executive and Chief Financial Officer presented the paper and highlighted the following points: • The True North Performance Scorecard had been reviewed by both the Finance, Performance and Risk Executive and by the Finance, Investment and Performance

	Committee; • The Finance, Performance and Risk Executive had agreed to keep the mandatory information governance statutory fire training as tracker metrics because performance was so close to target. The Chair referred to page 109 of the agenda pack and pointed out that some of the bars on the graph for falls in in-patient wards had the heading "QMIS" and asked for more information. The Chief Executive explained that the heading related to those wards where staff had completed the Quality Improvement Quality Management Information System training and where reducing falls was a driver metric for that ward. The Deputy Chief Executive and Chief Financial Officer agreed to include an explanation to this effect in future reports. **Action: Deputy Chief Executive and Chief Financial Officer** The Chair confirmed that he liked the more visual presentation of the performance report and said that it made it easier for the Board to hone in on key issues and trends rather than focusing on the detail of monthly variations. **The Trust Board:** noted the report.
19/208	**Patient Experience Report – Quarter 2** (agenda item 8.3)
	The Chief Executive presented the paper and highlighted the following points: • There were no new complaint themes or any new trends identified this Quarter; • During Quarter 2, the Trust had received 54 formal complaints (including re-opened complaints). • The formal complaint response rate, including those within a timescale re-negotiated with complainants was 100% and this continued to be exceptional performance; • The Trust's level of formal complaints received was in the lowest 25% quartile when compared with peers; • There were two services that had experienced an increase in the number of complaints this Quarter: Common Point of Entry and the Integrated Pain and Spinal Service. This reflected the demand versus capacity pressures in both of these services. Actions were in place to support an improved position. Patient feedback would be monitored over the coming Quarter to ascertain whether the increase in complaints represented a spike or an on-going concern; • The Trust's Mental Health Wards, Community Health Wards and Community Nursing which were all services known to be under pressure had received fewer complaints in Quarter 2 compared with Quarter 1; • CAMHS services continued to receive the highest number of complaints with concerns raised about wait times and access, particularly with regard to Attention Deficit Hyperactivity Disorder and Autism Spectrum Disorder services • The Friends and Family Test response rate was 15%. The Director of Nursing and Therapies reported that following a procurement exercise, the Trust had appointed KPMG to develop a new patient experience measurement tool. David Buckle, Non-Executive Director said that the report contained a lot of really useful information and commented that there was increasing demand for NHS services, for example, for CAMHS and Community Neuro-Rehabilitation Services and commented that

	it was challenging to maintain good quality services when demand continued to go up. The Chief Executive said that he was confident that additional income would be forthcoming to address increased demand for services over and above the contracted level. Naomi Coxwell, Non-Executive Director asked whether the increase in the number of detained patients at Prospect Park Hospital had impacted on patient experience. The Director of Nursing and Therapies pointed out that there had been a decrease in the number of complaints about in-patient Mental Health Services in Quarter 2. The Chief Executive said that the increase in the number of detained patients was a national trend. Mark Day, Non-Executive Director welcomed the new section of the report (page 151 of the agenda pack) on the changes that had been made as a result of patient feedback. David Buckle, Non-Executive Director asked whether staff monitored feedback via NHS Choices. The Director of Nursing and Therapies confirmed that the Trust's Patient Advice and Liaison Service Manager responded to feedback from NHS Choices. **The Trust Board**: noted the report.
19/209	**Finance, Investment and Performance Committee meetings on 25 September 2019 and 30 October 2019** (agenda item 8.4)
	Naomi Coxwell, Chair of the Finance, Investment and Performance Committee commented that the Committee had reviewed the Trust's month 6 financial report which was a good indication about the year-end position. Ms Coxwell confirmed that she expected the next six months to be a mirror image of the first six months. The key risks related to balancing the cost of substantive staff against the costs of temporary staffing following the Trust's recent successful recruitment campaign. Ms Coxwell said that the Committee continued to oversee the delivery of the Cost Improvement Programme and highlighted the reduction in the number of inappropriate Out of Area Placements. Ms Coxwell reported that the capital programme was currently underspent and pointed out that some of the slippage, for example the Learning Disabilities service move to Jasmine Ward was outside of the Trust's control as it related to the timing of approval for capital works from the Private Financial Initiative funders for Prospect Park Hospital. The Chair thanked Ms Coxwell for her update.
19/210	**Mental Health Strategy Implementation – Update Report** (agenda item 9.0)
	The Director of Strategy and Corporate Affairs presented the paper which provided a report on progress against the key priorities as set out in the Mental Health Strategy approved by the Trust Board in December 2016. The Director of Strategy and Corporate Affairs reported that the Trust had made good progress with most national targets achieved or on course for delivery by 2020. There were significant challenges posed by demand pressures which meant that achieving and

	sustaining zero Out of Area Placements and the increased access targets for children young people was very challenging. It was noted that work had commenced on refreshing the Trust's Three Year Strategy. This would be informed by the NHS Long Term Plan and implementation guidance as well as by the Trust's work with partners as part of the two Integrated Care Systems. The Chair noted the continuing pressure on recruitment and retention. **The Trust Board:** noted the progress made against the Mental Health Strategic priorities.
19/211	**Strategy Implementation Update Rep**ort (agenda item 9.1)
	The Director of Strategy and Corporate Affairs presented the paper and highlighted the following points: • The paper set out the progress of the 2019-20 Strategy Implementation Plan for Quarter 2. • Good progress was being made in most areas of the Plan with very minor slippage on target dates • The Zero Suicide and Mental Health Pathways projects were transferring to "business as usual"; • The Trust has achieved it financial control total at Quarter 2 and was forecasting delivery of the annual target **The Trust Board:** noted the progress made against the Strategy Implementation Plan at Quarter 2.
19/212	**Freedom to Speak Up Strategy** (agenda item 9.2)
	The Director of Strategy and Corporate Affairs presented the paper and highlighted the following points: • The Freedom to Speak Up Strategy outlined the background and purpose of the national Freedom to Speak Up initiative. • The Strategy reflected the guidance from NHS England/NHS Improvement and was aligned to the Trust's own organisational values and commitment to promote an open and transparent culture where staff were positively encouraged to speak up and to raise concerns; • The Strategy outlined the four areas of focus for the Trust: - Leadership and Behaviour - Equality and Inclusion - Communication; and - Policy and Processes • The Trust would measure its progress in delivering the Strategy using the new national Freedom to Speak Up Index which was made up of responses to four questions form the annual NHS Staff Survey; • The Internal Auditors had reviewed the Trust's Freedom to Speak Up systems and processes and had given a rating of: "reasonable assurance" • The Trust Board would continue to receive reports from the Freedom to Speak

	Guardian every six months. The Director of Strategy and Corporate Affairs thanked Mark Day, Non-Executive Director for his help and support in his role as the Non-Executive Director lead for Freedom to Speak Up. Mark Day, Non-Executive Director said that Board members had a key role to play in testing the degree to which frontline staff were aware of and felt confident in raising the Freedom to Speak Up route as part of their visits to services. The Chief Operating Officer explained that there were two key elements: were staff aware of the different mechanism available to raise concerns and did they feel confident to use these mechanisms. The Chief Operating Officer said that the Trust was working closely with the Staff Networks to understand how best to encourage and support staff to raise concerns. The Chair referred to the section on demonstrating commitment to Freedom to Speak Up (page 195 of the agenda pack) which was around the Board welcoming workers to speak about their experiences in person at Board meetings and pointed out that individual members of staff had not been invited to speak about their experiences at Board meetings. The Deputy Chief Executive and Chief Financial Officer reported that at the last Finance, Investment and Performance Committee meeting, it was proposed inviting one of the Preceptees to attend a future Board meeting to talk about their experiences of the Trust. The Chief Executive said that that best indicator about the culture of the organisation was the NHS Staff Survey. The Chief Executive pointed out that the Freedom to Speak Up initiative was developed in the wake of the Mid Staffordshire NHS Foundation Trust scandal and was focused on supporting staff to raise patient safety clinical concerns. It was noted that the majority of concerns raised with the Trust's Freedom to Speak Up Guardian related to staff conduct issues, team dynamics and bullying and harassment. The Chief Executive reported that the Freedom to Speak Up Guardian attended the Corporate Induction session to ensure that newly appointed staff were aware of the process. The Chief Executive said that it was incumbent on each Board member to set the tone of the Trust by being open and approachable when meeting staff. **The Trust Board**: approved the Freedom to Speak Up Strategy.
19/213	**Audit Committee Meeting Minutes** (agenda item 10.0)
	Naomi Coxwell, member of the Audit Committee reported that the Audit Committee had held its second professional development seminar facilitated by the Trust's Internal Auditors, RSM, prior to the meeting on the Board Assurance Framework. Ms Coxwell said that the seminar provided a useful opportunity for both members of the Finance, Investment and Performance Committee and the Audit Committee to review the Trust's Board Assurance Framework and Risk Management systems and processes in the light of alternative approaches elsewhere.

	It was noted that some Trusts had 25-30 risks on their Board Assurance Framework. The Chief Operating Officer pointed out that in addition to the risks on the Trust's Board Assurance Framework and Corporate Risk Register, each service, division and project had their own local risk registers. It was also acknowledged that risks on the Trust's Board Assurance Framework were broad in their scope and could conceivably be broken down into multiple individual risks. Ms Coxwell reported that the Internal Auditors' review of the Trust's Risk Management systems and processes had recommended that there needed to be a more consistent approach across the Trust in relation to the approach taken to the divisional and local risk registers. Ms Coxwell reported that the general conclusion was that the Trust's Board Assurance Framework and Corporate Risk Register were effective and did not need to be changed. Ms Coxwell reported that the Audit Committee had received a presentation from Dr Guy Northover, Lead Clinical Director on the "Getting It Right First Time (GIRFT)" national initiative. It was noted that the Getting It Right First Time programme had started in the acute sector and the principles were now being applied to mental health services. The objective of the programme was to reduce unwarranted variation. Ms Coxwell said that she was particularly interested to note that the Lead Clinical Director was applying the GIRFT methodology as part of the Trust's focus on reducing the length of stay at Prospect Park Hospital. The Chair thanked Ms Coxwell for her update. **The Trust Board**: noted the minutes of the Audit Committee held on 30 October 2019.
19/214	**Council of Governors Update** (agenda item 10.1)
	The Chair reported that there had been a good discussion at the Joint Trust Board and Council of Governors meeting on 6 November 2019. The Chair reported that during the table discussions between Governors and Non-Executive Directors, Governors had asked whether there was any progress with the work to support carers. The Chief Operating Officer reported that the Trust had appointed a member of staff last week to develop the new Carers' Strategy. The Chair reported that following feedback from Naomi Coxwell, Non-Executive Director, the he had agreed to have a new standing item on the In Committee agenda to review whether any items which had been discussed in private could have been discussed in public. The Chair reported that he was aware that some Trusts had a programme of engagement with young people and asked whether this was an area where the Trust could do more. The Chief Executive reported that each local authority area had a Youth Parliament and that this was a useful mechanism to engage with young people. The Director of Strategy and Corporate Affairs reported that the Children and Young People division had an active patient participation group. **The Trust Board:** noted the update.
19/215	**Any Other Business** (agenda item 11)

	National Campaigns **a) Anti-Bullying Week** The Chief Operating Officer reported that the Trust was participating in the national Anti-Bullying Week Campaign. **b) "Hello My Name Is…"** The Chief Operating Officer reminded the meeting that the "Hello My Name Is…." Campaign was started by Dr Kate Granger, a doctor who had terminal cancer and died in 2016. As a patient, Dr Granger noticed that not all staff who approached her introduced themselves to her. The Chief Operating Officer said that the Trust's yellow name badges were designed to make it easy for patients to read the name of the member of staff. The Chair encouraged members of the Board to wear their name badge when making visits to clinical services.
19/216	**Date of Next Meeting** (agenda item 11)
	Tuesday, 10 December 2019 The Chair reported that Chris Fisher, Vice Chair would be chairing the next meeting because he would be in hospital.
19/217	**CONFIDENTIAL ISSUES:** (agenda item 12)
	The Board resolved to exclude press and public from the remainder of the meeting on the basis that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted.

I certify that this is a true, accurate and complete set of the Minutes of the business conducted at the Trust Board meeting held on 12 November 2019.

Signed……. Date 10 December 2019
(Martin Earwicker, Chair)

Appendix 1

Use of Guardian Sentry Falls alarm

Pen Portrait

- B. is an 84 year old gentleman who until having a stroke was independent and a keen gardener
- He suffered a stroke with significant right sided weakness and visual neglect. He had also sustained fractures to left ankle.
- He was admitted to Donnington ward for rehabilitation

On admission

- B. had a level of capacity but was unable to recognise his safety issues with mobility. He also had a need to get to the toilet quickly to urinate and as a result often tried to stand unaided even though he had poor balance and often fell to his right side

- B. was assessed through the falls risk assessment as being at high risk of falling due to his poor mobility and lack of insight into his current ability and the fact that this meant he did not call for assistance. To mitigate risk of falls and harming himself
    - High low bed
    - With consent use of Guardian Sentry falls alarm

Value / impact of falls alarm

- In the early stages of his rehabilitation he did not like to use his call bell for assistance mostly because in his opinion he did not need assistance
- Alerted staff to B.'s movements such as when he attempted to sit on the edge of the bed or chair and as he improved when he started to move himself from bed to chair. As he initiated any movement the pager would alarm and staff would attend. Prompting him to concentrate on his balance, assisting him to place the urinary bottle and undress in a safe manner.
- As his balance started to improve he became easily frustrated that he was unable to be independent and would attempt to do things without assistance.
- Because the alarm is in the bed/ chair but there is no audible sound by the patient B. was not troubled by noise of the alarm ringing loudly by him as happens with other falls alarms. This resulted in less agitation for him.
- In time he realised that when he started to move a nurse would arrive to assist him. He learnt to then call out for assistance shouting "Bed bottle" rather than trying to stand by himself and risk injury. The result of this was that B. became less frustrated, maintained his continence and dignity as well as his safety.
- The Guardian Sentry would alarm resulting in at least 15 or 20 near misses with this patient alone.

Feedback

Patient have generally accepted the value of using this as it is an initiative for their safety as the first few days can be disorientating especially in a smaller bed or the toilet being on a different side in the bay compared to the last hospital.

Berkshire Healthcare NHS Foundation Trust

AGENDA ITEM 5.2

BOARD OF DIRECTORS MEETING 10/12/2019

Board Meeting Matters Arising Log – 2019 – Public Meetings

Key:

Purple - completed
Green – In progress
Unshaded – not due yet
Red – overdue

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
10.07.18	18/136	Strategy Summary Document 2018-21	The Trust's strategy to be distilled into three or four lines of text which would be discussed at the Board's Annual Strategic Planning Away Day in October 2018.	April 2020	**BS**	To be considered when the three year strategy is refreshed in April 2020.	
10.07.18	18/138	Equality Strategy Annual Report	The Director of Strategy and Corporate Affairs to include a section on gender pay equality when the Equality Strategy was refreshed.	TBC	**BS**	To be reviewed as part of the Strategy Review in April 2020.	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
13.11.18	18/204	Physical Health of Mental Health Patients Presentation	Improving the physical health of people with severe mental health illness to be incorporated into the Trust's strategic planning cycle.	April 2020	**BS**	To be incorporated into the 3 year Strategy Document refresh in April 2020.	
12.02.19	19/016	Health and Safety Annual Report	The Campion Unit to be invited to give a presentation to a future Trust Board meeting on their Quality Improvement Programme work on reducing the number of physical assaults.	Jan 2020	**DT/JH**	A presentation will be made to the January 2020 Trust Board Discursive meeting.	
12.02.19	19/021	Annual Trust Board Planning	The Annual Trust Board Planner to include Discursive Trust Board meetings.	Feb 2020	**JH**	Future Annual Trust Board Planners will include the Discursive Trust Board meetings.	
09.07.19	19/125	Freedom to Speak Up Guardian Report	Future reports to give an indication about the seriousness of the cases and what changes had been implemented as a result of the member of staff speaking up.	08.12.19	**FTSU Guardian**	The FTSU Guardian's report is on the agenda for the meeting.	
12.11.19	19/202	Six Monthly Staffing Report	The percentage of shifts with less than two registered nurses for the previous six months to be shown in future reports.	May 2020	**DF**		

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
12.11.19	19/206	Finance Report	The Finance, Investment and Performance Committee to be provided with more information about the increase in the number of admin roles and whether this resulted in greater efficiencies elsewhere in the Trust.	Jan 2020	**AG**		
12.11.19	19/207	True North Performance Scorecard	The in-patient falls graph to include an explanation that the heading "QMIS" indicated those wards which had reducing falls as one of their driver metrics.	10.12.19	**AG**	The Trust North Performance Scorecard has been amended to explain the QMIS heading.	

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	10th December 2019
Title	**Freedom to Speak Up Report**
Purpose	To update the Trust Board on the work of the Freedom to Speak Up Guardian over the last 6 months.
Business Area	Corporate
Author	Freedom to Speak Up Guardian – Mike Craissati
Relevant Strategic Objectives	To strengthen our highly skilled and engaged workforce and provide a safe working environment
CQC Registration/Patient Care Impacts	The Care Quality Commission assesses Trust's Speaking Up Culture as part of its Well-Led Inspection
Resource Impacts	None
Legal Implications	All UK NHS Provider organisations are required to appoint a Freedom to Speak Up Guardian
Equality and Diversity Implications	Good links have been made with the Staff Networks, and the Freedom to Speak Up Guardian also attends our Diversity Roadshows and other Equality and Inclusion events – for example the Black History Month Celebration in October.
SUMMARY	The Freedom to Speak up Guardian is a relatively newly established role within the NHS and was a recommendation of the Freedom to Speak up Review by Sir Robert Francis published in 2015. The Freedom to Speak up Guardian (FTSUG) came into post in this Trust in March 2017. This is a report directly to the Trust Board for July - December 2019 The paper includes: • a summary of communication activity being undertaken by the FTSUG • data from the most recent report to the National Guardians Office • results of the FTSU Index Report • key points about improving FTSU culture • action taken to address the FTSU internal audit report

	• recommendations from the Freedom to Speak Up Guardian who will be attending the Trust Board meeting to present the report.
ACTION REQUIRED	The Trust Board is asked: a) to note the contents of this report by the Freedom To Speak Up Guardian; and b) to provide support for the Guardian's recommendations detailed in this report

Report to the Meeting of the Berkshire Healthcare NHS Foundation Trust Board of Directors

Freedom to Speak up Guardian - Report for Q1 & Q2 2019/20

Background

A Freedom to Speak up Guardian (FTSUG) within every Trust was a key recommendation made by Sir Robert Francis QC in the Freedom to Speak Up review 2015. FTSU has also become part of the CQC Well Led inspection component since October 2016.

A standard integrated FTSU policy for the NHS issued in April 2016 is the basis of the Trust's Raising Concerns policy. As part of our regular policy review process, the FTSU policy has been reviewed by the FTSUG pending consideration by Human Resources colleagues and out Joint Staff Consultative Committee.

The National Guardian's office (NGO) was established in October 2016 at the same time as it became a contractual obligation for every NHS Provider Organisation to have appointed a FTSU Guardian.

The Role of the Freedom to Speak Up Guardian

"the Freedom to Speak Up Guardian will work alongside Trust leadership teams to support the organisation in becoming a more open and transparent place to work, where all are actively encouraged and enabled to speak up safely." (NGO 2018)

The FTSUG is independent and impartial. The Guardian reports directly to the Chief Executive, and has access to anyone in the organisation. There are two main elements to the role.

- To give independent, confidential advice and support to members of staff who wish to speak up that have an impact on patient and staff safety or issues around malpractice, wrongdoing and fraud. This is not exclusive to permanent members of staff but extends to temporary or agency staff, trainees or students, volunteers and trust governors.

- To promote a culture where members of staff feel safe to raise concerns and do not fear adverse repercussions as a consequence.

Bev Searle, Director of Corporate Affairs is Executive Lead for Freedom to Speak Up and Mark Day, Non-Executive Director, has taken on the role of nominated Non-Executive Director for Freedom to Speak Up.

Communication

It is crucial that the FTSU role is visible and accessible to all staff. The communications plan outlines how this is achieved.

The plan includes the following:

- Creating an animation (final version published in September 2019)
- Presentations and attendance at management/team meetings
- FTSU month, focused promotion across the trust during October of each year
- Production and dissemination of posters, leaflets and cards
- Market stall at Corporate Induction
- Regular session as part of junior doctor induction
- Presentation at Essential Knowledge for New Managers training
- Presentation at student nurse induction
- Presentation at teams meetings
- Supporting all Equality & Diversity/Network Events
- Supporting a team of FTSU Champions recruited from a variety of services across the organisation (we currently have 11 champions).

Contribution to the Regional and National Agenda

The Guardian is a member of the Thames Valley and Wessex Regional FTSU Network and a more local network consisting of all NHS Trusts in the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System.

Quarterly submissions to the National Guardian's Office (NGO)

The NGO requests and publishes quarterly speaking up data.

Contacts are described as "enquiries from colleagues that do not require any further support from the FTSUG".

Cases are described as "those concerns raised which require action from the FTSUG".

Outlined below are the national and local number of cases raised for Q1 & Q2, 2019/20.

It's difficult to make comparisons with other similar organisations as the data does not provide a narrative regarding how many guardians or champions there are, how many days a week they work and if they have recorded both cases and contacts. All cases and contacts at Berkshire Healthcare are reported.

	2019/20	Cases Raised	Anon	%	# Cases with element of patient safety	%	# cases with element of bullying & harassment	%	# cases causing some form of harm or detriment	%
NATIONAL	Q1	3156	439	14	767	24	1213	38	116	4
	Q2	3473	455	13	884	25	1240	36	127	4
BHFT	Q1	6	6	100	0	0	4	67	4	67
	Q2	11	9	82	1	9	8	73	10	91
TOTAL	**Q1 & Q2**	**17**	**15**	**88**	**1**	**6**	**12**	**71**	**14**	**82**

Assessment of Issues

- The number and type of cases raised fit into the general pattern of cases from previous periods and could be considered the norm.
- Returns show very few cases are raised via FTSU around patient safety
- A high proportion of cases raised are done so where the person raising the concern wishes some form of anonymity.
- A significantly high proportion of cases are around the “staff experience” and specifically from staff who are stating the cause is bullying & harassment (B&H) from fellow staff members (no cases have been received where B&H has been reported as coming from patients of the public at large – this would normally be highlighted via Datix).
- Q3 is showing a higher proportion of cases of B&H that have a racial aspect to them. It is presumed that increased FTSU exposure at recent Equality & Diversity Roadshows, the B&H video & posters is having a positive effect in encouraging staff to come forward.

Freedom to Speak Up Index Report 2019

The Board will be aware of this recent publication by the National Guardian’s Office (NGO), as highlighted in the BHFT Freedom to Speak Up Strategy previously approved by the Trust Board. The index calculates the mean average responses to 4 questions from the NHS annual National Staff Survey (questions 17a&b, 18a&b which relate to reporting of incidents and raising concerns around unsafe clinical practice).

The survey questions that have been used to make up the FTSU index are:

• % of staff responded "agreeing" or "strongly agreeing" that their organisation treats staff who are involved in an error, near miss or incident fairly (question 17a)

• % of staff responded "agreeing" or "strongly agreeing" that their organisation encourages them to report errors, near misses or incidents (question 17b)

• % of staff responded "agreeing" or "strongly agreeing" that if they were concerned about unsafe clinical practice, they would know how to report it (question 18a)

• % of staff responded "agreeing" or "strongly agreeing" that they would feel secure raising concerns about unsafe clinical practice (question 18b)

FTSU Index Score for all MH/LD/CH Trusts with under 5,000 employees (rated as small) from 2018 staff survey

Outstanding	
Good	
Requires improvement	
Inadequate	

2018 National Median for all MH/LD/CH Trusts (regardless of size) = 80%

Index Score from 2018 Staff Survey %	CQC OVERALL RATING	WELL LED	NHS Trust
85			Northamptonshire Healthcare NHS Foundation Trust
82			**Berkshire Healthcare NHS Foundation Trust**
82			Cambridgeshire and Peterborough NHS Foundation Trust
82			Cumbria Partnership NHS Foundation Trust
81			Somerset Partnership NHS Foundation Trust
81			Worcestershire Health and Care NHS Trust
80			2gether NHS Foundation Trust
80			Cheshire and Wirral Partnership NHS Foundation Trust
80			Oxleas NHS Foundation Trust
79			Bradford District Care NHS Foundation Trust
79			Cornwall Partnership NHS Foundation Trust
79			Leeds and York Partnership NHS Foundation Trust
79			North West Boroughs Healthcare NHS Foundation Trust
78			Barnet Enfield and Haringey Mental Health NHS Trust
78			Coventry and Warwickshire Partnership NHS Trust
77			Derbyshire Healthcare NHS Foundation Trust
77			Humber NHS Foundation Trust
77			Rotherham Doncaster and South Humber NHS Foundation Trust
76			Black Country Partnership NHS Foundation Trust

- Even though the FTSU Index Report is produced by the NGO, the Index reflects an organisation's culture as a whole around reporting of incidents and not specifically about the FTSU agenda.
- There is a correlation (from the NGO) that organisations with a positive speaking up or reporting culture tend to have a higher CQC rating.

Improving FTSU Culture

Creating a culture where all staff feel able to speak up and feel valued for doing so is dependent on the organisation showing it is listening and taking their concerns seriously. Giving feedback is one important way the Trust can demonstrate it values staff that speak up. The importance of this stage of the process is not always recognised by managers. Staff who speak up to the FTSUG fear suffering detriment as a result and this can present a barrier.

From personal observations and feedback from those who have spoken up, the following is highlighted:

- To achieve an open culture around speaking up, all elements of good, effective communication need to be included in the process. Speaking Up is only part of this, and is relatively easy to address.
- An effective process is only achievable if the other elements are addressed, namely improving the Listening Up Culture and removing barriers to communication.
- Part of the Listening Up process should include improved feedback to those who raise concerns, including timescales, expectations around outcomes.

Internal Audit Recommendations

A review of FTSU arrangements at Berkshire Healthcare NHS Foundation Trust was completed as part of the Trust's approved Internal Audit Plan for 2019/20. This report provided "reasonable assurance" that the controls in place to manage the risk linked to Freedom to Speak Up arrangements are suitably designed and consistently applied. The audit took place when work was in progress, but had not been completed, on our FTSU Strategy, and the review of our FTSU Policy. Both of these have now been completed.

The audit also recommended that the reports provided to the Board by the FTSUG contain information recommended by the NHSI guidance published in 2019, while the audit was taking place. This guidance was included as an appendix to the FTSU Strategy approved by the Trust Board in November 2019.In addition, this report includes those areas included in the NHSI guidance that the audit identified as not being specifically included in previous FTSU reports (Assessment of Issues, Improving FTSU Culture, Learning & Improvement, and Recommendations).

Learning and Improvement

The FTSU Status Exchange between the FTSUG, Chief Executive, Director of Nursing and Therapies and Director of Strategy and Corporate Affairs continues to provide a good forum for a structured information exchange, triangulation of information, and ensuring action is completed regarding concerns raised. A regular meeting between the FTSUG and Head of Operational HR has also been added to our standard work to enable direct communication about case work in a confidential manner.

Progress has also been made since the last FTSU Report to the Trust Board in terms of the completion and approval of our FTSU Strategy and FTSU Policy Review.

The internal audit provided a helpful opportunity to reflect on the strengths of our current arrangements and improvements to be achieved. All recommendations have now been implemented.

Following an internal recruitment process, our FTSUG has now been confirmed substantively in post.

Recommendations from the Freedom to Speak Up Guardian

The Trust Board is asked to support the following:

- Seek assurance that any patient safety issues are raised and addressed by methods other than via the FTSU process.
- Support and encourage initiatives to address “Staff Experience” concerns, specifically those that include an element of bullying & harassment and those concerns that may affect Network members.
- Support and encourage initiatives to improve a Listening Up culture, so that all staff will feel more able to challenge in a positive way, to encourage positive suggestions that may improve ways of working, the patient experience or efficiencies. In turn this will make raising more traditional FTSU concerns easier and more a part of the culture.
- Assist in minimising those barriers to communication that may prevent those wishing to speak up (in any way) from doing so.
- Improved FTSUG/HR joint working to provide a more structured approach to dealing with FTSU cases to provide those raising cases with better feedback.

Author and Title:

Mike Craissati, Freedom to Speak Up Guardian

December 2019

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	10 December 2019
Title	**Quality Assurance Committee – 19 November 2019**
Purpose	To receive the unconfirmed minutes of the meeting of the Quality Assurance Committee of 19 November 2019
Business Area	Corporate
Author	Julie Hill, Company Secretary for David Buckle, Committee Chair
Relevant Strategic Objectives	To provide good outcomes from treatment and care.
CQC Registration/Patient Care Impacts	Supports ongoing registration
Resource Impacts	None
Legal Implications	Meeting requirements of terms of reference.
Equalities and Diversity Implications	N/A
SUMMARY	The unconfirmed minutes of the Quality Assurance Committee meeting held on 19 November 2019 are provided for information. Attached to the minutes are the following reports which were discussed at the Quality Assurance Committee meeting and are presented to the Trust Board for information: • Learning from Deaths Quarterly Report • Guardians of Safe Working Hours Quarterly Report
ACTION REQUIRED	The Trust Board is requested to receive the minutes and the quarterly Guardians of Safe Working Hours and Learning from Deaths Reports and to seek any clarification on issues covered.

Berkshire Healthcare
NHS Foundation Trust

Minutes of the Quality Assurance Committee Meeting held on Tuesday, 19 November 2019, Fitzwilliam House, Bracknell

Present:	David Buckle, Non-Executive Director (Chair) Mehmuda Mian, Non-Executive Director Aileen Feeney, Non-Executive Director Dr Minoo Irani, Medical Director Dr Guy Northover, Lead Clinical Director Debbie Fulton, Director of Nursing and Therapies David Townsend, Chief Operating Officer Amanda Mollett, Head of Clinical Effectiveness and Audit
In attendance:	Julie Hill, Company Secretary Rose Warne, Clinical Director for Inpatient Mental Health* Nav Sodhi, Associate Medical Director (*via Teams*)* Sara Fantham, Clinical Director, East Physical Health *(via Teams)** Vicki Matthews, Clinical Director, Mental Health East* **Present for the Clinical Audit agenda item*

1 Apologies for absence and welcome

Apologies were received from: Julian Emms, Chief Executive.

David Buckle, Chair welcomed everyone to his first meeting as the Committee's Chair. The Chair introduced and welcomed Aileen Feeney who had recently taken up her role as a Non-Executive Director.

The Chair commented that the Committee only met four times a year and invariably each meeting had a full agenda. The Chair said that he would endeavour to ensure that the Committee made the most effective use of its time and focussed on the key issues.

2. Declaration of Any Other Business

There were no items of Any Other Business.

3. Declarations of Interest

The Chair reported that he had recently been appointed as a Non-Executive Director for Salisbury Hospital NHS Foundation Trust.

4.1 Minutes of the Meeting held on 21 August 2019

The minutes of the meeting held on 21 August 2019 were confirmed as an accurate of the proceedings after a correction had been made to the Quality Concerns section on page 5 of the agenda pack as follows:

4th paragraph to read: "…..the Community Based Neuro-Rehabilitation Team and Integrated Pain and Spinal services were receiving between 25%-30% more referrals…."

4.2 Matters Arising Log

The Matters Arising Log had been circulated. The following actions were considered further:

NHS Safety Thermometer

The Director of Nursing and Therapies reported that she would be meeting with the Chair after the meeting and would brief him on how the Trust used the NHS Safety Thermometer.

The Chair explained that he was familiar with the use of the NHS Safety Thermometer in an acute setting, but did not know how it was deployed in Mental and Community Health Hospitals.

The Committee noted the schedule of actions.

5. Patient Safety and Experience

5.0 CAMHS Sustainability Report

The Chief Operating Officer presented the paper which provided an overview of the pressures and workforce concerns within the Child and Adolescent Mental Health service (CAMHs) together with the mitigating actions and initiatives that were being taken by both the service and the Quality Improvement team. The report also outlined the key elements of the system transformation work.

The Chief Operating Officer pointed out that the impact on patients of increased waiting times related largely to patient experience because there were systems in place to manage safety and clinical risk.

The Medical Director explained that this included triaging patients and screening for patients with severe mental illness. The Medical Director stressed that the increased demand for services meant that children had to wait longer for a diagnosis. It was noted that the Trust currently had around 2,000 people on the CAMHs waiting list and of these over half were waiting for an Autistic Spectrum Disorder assessment.

The Chair commented that it was a helpful report and said that he accepted that the increased waiting times was not a significant patient safety issue, but said that longer waiting times did pose a reputational risk for the Trust.

The Chief Operating Officer pointed out that the increased demand for CAMHs services reflected the fact that other services, for example, those which used to be provided by local authorities designed to support children and families had been cut as part of the national austerity drive.

The Chair asked whether there were any further actions the Trust could take to manage the continuing increased demand for CAMHs services.

The Director of Nursing and Therapies reported that the Trust was involved in a number of initiatives to manage waiting lists, but pointed out that these initiatives would take time.

Mehmuda Mian, Non-Executive Director referred to page 21 of the agenda pack and asked for more information about the Attain Consultancy Review of all age Autism and Attention Deficit Hyperactivity Disorder need in East Berkshire.

The Chief Operating Officer explained that the East Berkshire Clinical Commissioning Group had decided to commission an independent review of need in order to gain a better understanding of the level of demand for services.

The Lead Clinical Director said that the Trust's mental health e-pathways work presented opportunities to change the service model for children and young people.

The Chair asked for assurance that senior commissioners were fully aware of the pressures on the service. The Chief Operating Officer confirmed that they were.

The Committee noted the paper.

5.1 Quality Concerns Status Report

The Director of Nursing and Therapies presented the paper and reported that updates had been provided in respect of the following Quality Concerns:

- **Nursing and Therapy vacancies** – Campion Unit had been removed from the concern due to no staffing concerns being raised and only a small number of vacancies. Willow House staffing had been added to the concern.
- **Mental Health Act Compliance** – this concern had been updated following the Trust Board's request to make the description of the Quality Concern more explicit that it related to the application of the Act.
- **Bed Occupancy** – actions had been updated to reflect that there were robust processes in place for gatekeeping of beds through bed management and escalation to Executive Directors to enable Out of Area placements if required.
- **Physical Health monitoring in Mental Health Services** – the action had been updated to reflect dates for the Rapid Improvement event agreed for December 2019.
- **Record Keeping** – this concern had been updated to reflect an improvement in audit results and a focus on quality of safety planning with revised training.

The Committee noted the report.

5.2 Serious Incidents Report – Quarterly Report

The Director of Nursing and Therapies presented the paper and highlighted the following points:

- During Quarter 2 there were 16 Serious Incidents;
- Trends and learning from incidents closed within the Quarter were: assessing and managing risk of falls; gathering information from families; and managing signs of the deteriorating patient;
- Two Serious Incidents reported in Quarter 2 had indicated that a standard operating procedure introduced following a letter from the Coroner in Quarter 3, 2018-19 for covering staff sickness in Community Mental Health Teams had not as yet been fully embedded in all localities. Further work was underway to address this.

The Chair commented that it was important for the Committee to be aware of the range, trends and types of Serious Incidents, together with any learning from the investigations.

Mehmuda Mian, Non-Executive Director referred to the Standard Operating Procedure for covering staff absences in the Community Mental Health Teams and asked about the timescale for embedding the process (page 37 of the agenda pack).

Vicki Matthews, Clinical Director, Mental Health East said that the systems and processes around staff absences had been tightened. For Care Co-ordinators who had unexpected absences of seven days, the Standard Operating Procedure was triggered and this included reviewing the absence at the daily Status Exchange meetings and putting in place appropriate cover arrangements. In addition, there was a standard agenda item on the monthly Patient Safety and Quality meetings about instances when the Standard Operating Procedure was triggered and this would be subject to regular audits.

The Chair said that it would be helpful if the Committee would have a one page flow diagram setting out Serious Incident investigation process.

Action: Director of Nursing and Therapies

The Committee noted the report.

5.3 Learning from Deaths Quarterly Report

The Medical Director presented the paper and highlighted the following points:

- 790 deaths were recorded on the clinical information system (RiO) during Quarter 2 where a patient had been in contact with a Trust service in the year before they died;
- Of the deaths, 108 met the criteria to be reviewed further. All 108 deaths were reviewed by the Mortality Review Group. 43 deaths were closed with no further action; 10 deaths were classified as “Serious Incidents” requiring further investigation; and 55 deaths required ‘second stage’ review (using an initial findings review/structured judgement review methodology);
- During Quarter 2 the Mortality Review Group had reviewed the findings of 58 second line review reports of which 13 related to patients with a learning disability.
- Of the 58 case reviews received by the Mortality Review Group, 3 were escalated as potential lapses in care for root cause analysis.
- One lapse of care had been confirmed in Quarter 2. This related to a suicide in the Community which occurred in June 2019 and the independent investigation was concluded through the Serious Incident process.
- The new statutory role of Medical Examiner was likely to be shared with the acute trusts.

The Chair reported that as part of his preparation for his new role as the Committee’s Chair, he had attended a Mortality Review meeting and commented that the meeting had been very well-run and it had provided him with a high degree of assurance about the Trust’s mortality review systems and processes.

The Committee noted the report.

5.5 WestCall Out of Hours Service Care Quality Commission Inspection Outcome

The Director of Nursing and Therapies reported that following a recent inspection, the Care Quality Commission had given the WestCall Out of Hours Service a “good” rating across all domains.

The Director of Nursing and Therapies said that WestCall’s previous Care Quality Commission had been “requires improvement” and said that staff had worked hard to address the issues raised by the previous inspection. It was noted that the concerns raised in the previous inspection were mainly around record keeping.

The Director of Nursing and Therapies pointed out that WestCall was inspected by the Care Quality Commission’s Primary Care Team and was not one of the Trust’s core services. It was noted that in the previous inspection, the Inspectors had not always appreciated that WestCall was not a stand-alone service and used the Trust wide systems and processes, for example, DATIX for incident reporting etc. The Director of Nursing and Therapies said that the Trust had made sure that as part of the latest inspection, the Inspectors were fully briefed about the Trust-wide systems and processes which supported the WestCall service.

The Chair asked whether there were succession plans in place for when WestCall’s Medical Director retired. The Director of Nursing and Therapies confirmed that succession plans were in place.

The Chair thanked the Director of Nursing and Therapies for her update and congratulated WestCall on its positive Care Quality Commission inspection. The Chair said that the service had a good reputation and was well regarded by patients.

5.6 Action Plan in Response to Regulation 28 Notice

The Director of Nursing and Therapies presented the paper which set out the Trust’s response to the Coroner’s Section 28 report to prevent future deaths issued to both the Trust and NHS Professionals following the Inquest of Anne Roberts who died from choking at Prospect Park Hospital.

The Director of Nursing and Therapies reported that the Trust had completed the action plan with the exception of the recruitment of additional Speech and Language Therapist cover. It was noted that the additional post was currently being covered by an NHS Professional temporary member of staff to mitigate any quality or safety concerns, however substantive recruitment had not been successful to date.

The Clinical Director for Inpatient Mental Health said that one of the key roles of the new post would be to provide staff training and reported that the Trust was reviewing whether another team member could deliver the training.

The Director of Nursing and Therapies confirmed that the last action plan update would be presented to the February 2020 meeting and said that this would include an update on how the Trust was addressing this issue.

Action: Director of Nursing and Therapies

The Committee noted the report.

5.7 Sexual Safety on Mental Health and Learning Disability Wards Update Report

The Director of Nursing and Therapies presented the paper and reported that the Care Quality Commission’s report *Sexual Safety on Mental Health Wards* was

published in September 2018 set out recommendations on how sexual safety could be improved on mental health and learning disability inpatient wards.

The Director of Nursing and Therapies reported that in the Trust had developed a Sexual Safety Action Plan in response to the Care Quality Commission's recommendations.

It was noted that all actions within the plan were progressing with no actions identified as not being able to be achieved.

The Clinical Director for Inpatient Mental Health reported that the Trust had developed new systems and processes to improve sexual safety and commented that the key challenge was around raising awareness and to ensure that staff felt confident to implement the new processes. This included having conversations with staff to determine what behaviour was acceptable and what was not.

The Chief Operating Officer said that it would be helpful if the amber RAG rated actions could have timescales for completion.

Action: Director of Nursing and Therapies

The Director of Nursing and Therapies suggested that the Committee receive the next update on the implementation of the action plan in six months' time.

Action: Director of Nursing and Therapies

The Committee noted the report.

Clinical Effectiveness and Outcomes

6.1 Quality Accounts Report 2019-20 Quarter 2

The Medical Director presented the paper and explained that the Head of Clinical Effectiveness and Audit's role was to ensure that the Quality Accounts Report met the requirements of NHS Improvement and that it presented the Trust's Quality data in a format that was easy to read by members of the public.

The Head of Clinical Effectiveness and Audit reported that the December 2019 meeting of the Council of Governors would be invited to select the local indicator for external audit.

The Chair reported that his experience outside of the Trust was that the final Quality Accounts Report was presented for approval and commented that he welcomed the opportunity to review the development of the Quality Accounts.

The Chief Operating Officer pointed out that the data set out in the Quality Accounts had already been reported to the various Executive Committees and to the Trust Board, but commented that it was helpful to have the various quality performance information sources clearly set out in one document.

The Chair asked whether it was necessary for the Committee to receive the Quarter 1 report. The Head of Clinical Effectiveness and Audit said that the External Auditors liked our present process which was to receive the information quarterly. The Chair requested that the Head of Clinical Effectiveness and Medical Director discuss whether it was necessary to have a quarter 1 report.

Action: Head of Clinical Effectiveness and Audit/Medical Director

The Committee noted the report.

6.2 Clinical Audit Reports

The Committee reviewed the outcome of the following local and national clinical audits:

Local Clinical Re-Audits

1. Trust re-audit of prescribing for substance misuse: alcohol detoxification
2. Trust re audit of prescribing of Valproate in Females of Child Bearing Potential in inpatient mental health services
3. Trust re-audit of Venous thromboembolism risk assessment at admission- Prospect Park Hospital - August 2019

National Clinical Audits

4. POMH Topic 6d: Assessment of the side-effects of depot/Long Acting Injectable antipsychotics
5. POMH - Topic 7f - Monitoring of patients prescribed lithium
6. National Diabetes Audit – Insulin Pumps (Type 1 Diabetes) 2017/18
7. The National Clinical Audit of Psychosis – Early Intervention in Psychosis spotlight audit

The Chair welcomed Rose Warne, Clinical Director for Inpatient Mental Health, Vicki Matthews, Clinical Director, Mental Health East, Sara Fantham, Clinical Director, East Physical Health and Nav Sodhi, Associate Medical Director to the meeting.

The Chair requested that abbreviations be spelt out in full for future reports.

Action: Medical Director

The Chair reported that he had reviewed the full Clinical Audit Reports and commented that the summary report included with the meeting papers provided a good overview of the outcome of each of the Clinical Audits.

The Chair said that he was pleased that the re-audit of Sodium Valproate prescribing had provided the assurance that no female inpatients of child bearing potential had been prescribed Valproate during the audit period.

Similarly, the Chair commented that he was also pleased that the re-audits of prescribing for substance misuse (alcohol detoxification) and venous thromboembolism (VTE) risk assessments at admission to Prospect Park Hospital had both demonstrated that significant improvements in compliance had been achieved.

The Medical Director presented the paper and reported that the Clinical Audit Team ran the Clinical Audits but explained that the relevant Clinical Directors were responsible for developing and implementing the actions plans.

The Medical Director said that the three local re-audits reflected the improvements that had been made by the Trust since the results of the national clinical audits had been published.

The Medical Director said that the Psychosis audit had rated the Trust as “performing well”. This previous rating in 2017-18 was “requires improvement”. The Medical

Director reported that the Trust was exploring with the Commissioners the funding of a dedicated trained Specialist Team to support patients in using an insulin pump.

Sara Fantham, Clinical Director, East Physical Health reported that the Trust had a very small team (3.8 whole time equivalents) of Diabetic Nurse Specialists and they did not have the capacity to provide the level of support needed to help patients use their insulin pumps. It was noted that the National Institute for Health and Care Excellence (NICE) recommended that there was a specialist insulin pump team.

Ms Fantham agreed to report back to the Committee on the outcome of the discussions with the Commissioners.

Action: Clinical Director, East Physical Health/Chief Operating Officer

The Medical Director reported that the monitoring of patients prescribed lithium audit had highlighted the need to improve reporting when physical health checks were undertaken and pointed out this was particularly challenging because patient care was shared between primary and secondary care.

The Chair reflected that whilst there were significant practical difficulties, Lithium was an old drug and this was not a new problem. The chances of a patient being harmed were not high, but lithium was potentially a dangerous drug and we needed to do everything we reasonably could to reduce the risk of harm.

The Lead Clinical Director reported that the Trust's new electronic mental health pathways had just gone live and that this would help with record keeping.

Mehmuda Mian, Non-Executive Director referred to page 174 of the agenda pack and asked whether there was any patient feedback on the patient information lithium booklet.

The Lead Clinical Director said that this was developed from a national resource and said that he would find out whether there had been any patient feedback.

Action: Lead Clinical Director

The Chair thanked the Clinical Director for attending the meeting.

The Committee noted the report.

7.0 Patient Safety Systems and Processes for Assurance

The Chair explained that he had requested that the Director of Nursing and Therapies produce a short paper setting out the Trust's systems and processes for providing assurance to the Trust Board and to the Committee in relation to patient safety.

The Director of Nursing and Therapies said that she had focussed on the key internal and external assurance mechanisms and pointed out that there was a range of other "soft" intelligence, including feedback from members of the Board's visits to frontline services which also provided assurance and identified areas for improvement.

Mehmuda Mian, Non-Executive Director thanked the Director of Nursing and Therapies for producing the paper and said that it was a helpful reminder.

Aileen Feeney, Non-Executive Director echoed Ms Mian's comments and said that as a new Non-Executive Director it provided a useful overview of the Trust's patient safety systems and processes.

The Chief Operating Officer said that the Trust had effective governance and assurance processes, which took account of feedback from staff, patients and carers as well as processes around data assurance, benchmarking and the outcome of internal audits etc. The Chief Operating Officer said that members of the Board were then able to triangulate this information to see if there were any gaps or areas for improvement when they visited services and met with frontline staff.

The Chair requested that the Committee review the patient safety systems and processes for assurance on an annual basis.

Action: Director of Nursing and Therapies/Company Secretary

The Chair commented that as part of assurance, it was important that the Board had confidence in the quality of the data and data analysis.

The Chief Operating Officer reported the Health and Social Care Information Centre published an annual Data Quality Maturity Index which assessed NHS providers on the quality of the data they submitted to the centre. In addition, the Trust's undertook its own data quality audits, including Internal Audits on data quality.

The Chair requested that the Committee received a paper setting out the systems and processes for assuring the quality of data.

Action: Deputy Chief Executive and Chief Financial Officer

The Committee noted the report.

Update Items for Information

8.0 Guardians of Safe Working Hours Quarterly Report

The Medical Director presented the paper which had been written by the Trust's Guardians of Safe Working Hours.

It was noted that during the reporting period (7 August 2019 to 31 October 2019) there were four hours exception reports and a rest exception report.

It was noted that the Guardians of Safe Working Hours had provided assurance to the Trust Board that no unsafe working hours had been identified and there were no other patient safety issues requiring escalation.

The Chair asked whether the four hours exception reporting related to the total number of hours. The Medical Director confirmed that this was the case.

On behalf of the Committee, the Chair thanked the Guardians of Safe Working Hours for their report.

The Committee noted the report.

8.1 MHA Comparator Annual Report

The Director of Nursing and Therapies pointed out that the data was from 2017-18 and was therefore two year's out of date.

The Director of Nursing and Therapies reported that the Care Quality Commission undertook an annual review of the Trust's compliance with the Mental Health Act.

The Committee noted the report.

8.5 Quality Executive Committee Minutes

The minutes of the Quality Executive Committee meetings held on: 12 August 2019, 9 September 2019 and 14 October 2019 were received and noted.

Closing Business

9.0 Standing Item – Horizon Scanning

The Company Secretary reported that the following items were on the Committee's forward plan:

- Carer's Strategy Update (February 2020)
- Trust's Compliance with the new CPA Guidance
- Sexual Safety on Mental Health Wards – Update on Performance
- Single Rooms and Therapeutic Environment at Prospect Park Hospital
- Review of the True North Patient Safety Indicators

The Company Secretary reported that she would discuss with the Chair and the Director of Nursing and Therapies the scheduling of the above agenda items.

Action: Company Secretary/Director of Nursing and Therapies

Aileen Feeney, Non-Executive Director asked whether the Committee discussed patient experience.

The Director of Nursing and Therapies reported that the Trust Board and the Council of Governors received a quarterly report on Patient Experience.

9.2. Any Other Business

The Chief Executive's comments were echoed by the rest of the Committee.

9.3. Date of the Next Meeting

18 February 2020 at 10.00

These minutes are an accurate record of the Quality Assurance Committee meeting held on 19 November 2019.

Signed:-_____

Date: - 18 February 2020_____

Berkshire Healthcare
NHS Foundation Trust

Meeting date	19 November 2019
Title	**Learning from Deaths Quarter 2 Report 2019/20**
Purpose	To provide assurance to the Trust Board that the trust is appropriately reviewing and learning from deaths
Business Area	Clinical Trust Wide
Authors	Head of Clinical Effectiveness and Audit, Medical Director
Relevant Strategic Objectives	1 – To provide accessible, safe and clinically effective services that improve patient experience and outcomes of care
Resource Impacts	The trust mortality review and Learning from Deaths process has operated without any additional resource allocation since it was launched in 2016. Additional resource will be required to progress further quality improvements.
Legal Implications	None
Equality Diversity Implications	A national requirement is that deaths of patients with a learning disability are reviewed to promote accessibility to equitable care. This report provides positive assurance of learning from these deaths
SUMMARY	790 deaths were recorded on the clinical information system (RiO) during Q2 where a patient had been in contact with a trust service in the year before they died. Of these 108 met the criteria to be reviewed further. All 108 were reviewed by the executive mortality review group (first stage review) and the outcomes were as follows: • 43 were closed with no further action • 10 were classed as Serious Incident Requiring Investigation (SI) • 55 required 'second stage' review (using an initial findings review (IFR)/ Structured Judgement Review (SJR) methodology). During Q2, the trust mortality review group (TMRG) received the findings of 58 2nd stage review reports (detailed on p8), of which 13 related to patients with a learning disability (these are cases reviewed in Q2 and will include cases reported in previous quarters). **Lapse in Care** Of the 58 case reviews received by the TMRG, 3 reviews were escalated and are currently being investigated using root cause analysis. One lapse in care has been confirmed in Q2: This related to suicide in the community which occurred in June 2019 and the investigation was concluded through the SI process. 6 keys areas of learning have been identified, of these 3 are learning themes which have previously been identified as outcome of SI investigations. • Involving families more in patient care • Managing signs of the deteriorating patient • A standard operating procedure introduced in Q3 2018-19 for covering

	staff sickness in community mental health teams has not been fully embedded and further work is underway to address this. The additional 3 areas of learning identified though the SJR process include: • Development of Sepsis awareness packs including easy read information for people with learning disabilities are being distributed by team members, at meet the team events and via the LD SHaRON platform. • Development of a respiratory care pathway within the learning disabilities service to identify people at risk of respiratory illness and to support multi-disciplinary working to reduce risks. • A standard operating procedure for court liaison and diversion services.
ACTION REQUIRED	The committee is asked to receive and note the Q2 learning from deaths report in order to provide assurance to the Trust Board that the Trust is complying with CQC and NHS Improvement requirements in respect of learning from deaths.

Table of Contents

1.0 Purpose

It has become increasingly important for trusts to evidence that they are systematically and continuously reviewing patient outcomes including mortality (patients who have died).

It is acknowledged that most deaths do not occur as a result of a direct patient safety incident. None the less, it is important that opportunity for learning from deaths and learning from the review of the care provided and patient experience of our services in the period prior to the person's death are not missed and that when deaths are deemed not to require any further investigation the rationale and justification for this is clearly documented.

2.0 Scope

This report supports the Trust learning from deaths policy which was published in August 2017 and updated in March 2019.

3.0 Introduction

Berkshire Healthcare is a combined community and mental health trust, providing a wide range of services to people of all ages living in Berkshire. The trust employs over 4,200 staff who operate from our many sites as well as out in people's homes and in various community settings. This report sets out how we review deaths of patients who have been under our care at any point in the year before they died, to ensure that the most appropriate care was given.

The first part of the report identifies the total numbers of patients who have died, in most cases these are expected deaths but where a specific 'red flag' or concern is noted (as identified in our policy) we then review these deaths further. First stage review is through weekly review of Datix reported deaths by the Executive Mortality Review Group (EMRG). Second stage reviews (using IFR/SJR) are discussed at the monthly Trust Mortality Review Group (TMRG) where learning is identified and service improvement actions are followed through.

The level of review will depend on whether certain criteria are met, the report sets out the numbers which were reviewed and the type of review we conducted.

We review the care provided for all patients who had a learning disability and died. We are required to notify the National Learning Disability Mortality Review Process (LeDeR) of all patients who have died with a learning disability, LeDeR carry out an independent review which also involves contacting the person's family. The purpose of this is to learn from all aspects of care (primary, secondary, community and social care) and inform national learning.

Following second stage review, any death where there is suspected to be a lapse in care which could have potentially contributed to the death of the patient would be escalated to a full investigation using a Root Cause Analysis (RCA) approach.

The final section of this report looks at the learning we have identified from the review of deaths in the quarter.

Definitions:

2nd stage Case Review (SJR/IFR): A review is usually a proactive process, often without a 'problem', complaint or significant event. It is often undertaken to consider systems, policies and processes. A review is a broad overview of a sequence of events or processes. It can draw on the perceptions of a range of individuals and a range of sources. The resulting report does not make findings of fact, but it summarises the available information and makes general comments. A review may identify some areas of concern that require investigation e.g. if there is some evidence of poor practice, in which case the appropriate recommendation for an investigation should be made.

Investigation (RCA and SI): An Investigation generally occurs in response to a 'problem', complaint or significant event. An investigation is often initiated in relation to specific actions, activities or questions of conduct. It is a systematic analysis of what happened, how it happened and why. An investigation draws on evidence, including physical evidence, witness accounts, policies, procedures, guidance, good practice and observation - in order to identify the problems in care or service delivery that preceded the event to understand how and why it occurred and to reduce the risk of future occurrence of similar events.

4. Summary of Deaths and Reviews completed in 2019/20.

Figure 1.

	17/18 total	18/19 total	Q1 19/20	Q2 19/20	Q3 19/20	Q4 1920	YTD 19/20
Number of deaths seen by a service within 365 days of death	4381	3961	967	**790**			**1757**
Total deaths screened (Datix) 1st stage review	307	320	90	**108**			**198**
Total number of 2nd stage reviews requested (SJR/IFR/RCA)	153	134	49	**65**			**114**
Total number of deaths investigated as serious incidents	32	40	8	**10**			**18**
Total number of deaths judged > 50% likely to be due to problems with care (lapse in care)	1	3	1	**1**			**2**
Number of Community Hospital Inpatient deaths (Including patients at the end of life)	123	144	21	**22**			**43**
Total number of deaths of patients with a Learning Disability	35	28	11	**13**			**34**
Total number of deaths of patients with LD judged > 50% likely to be due to problems with care	0	0	0	**0**			**0**

Note: The date is recorded by the month we receive the form which is not always the month the patient died

4.1 Total Number of deaths in Q2

The trust electronic patient record (RiO) is directly linked to the national spine which allows information regarding deaths to be shared amongst providers of health care. Figure 1 identifies all deaths where a patient had any contact with one or more of the trust services in the preceding 365 days before their death and was on an active caseload of the service at the time of death (Figure A in Appendix 1 details the specific service). In Q2, 790 deaths were recorded, this number may increase slightly due to a time lag in spine updates.

Figure 2 below details the age of the patients, this has allowed us to also ensure we are aware of all children's deaths which are reviewed in detail by the child death overview panel (CDOP) hosted by the Local Authority. The highest number of deaths is in the over 75 age group with the majority of these in receipt of community nursing services in their homes receiving care at the end of life.

	July to September 2019				
Figure 2	**A:0-17**	**B:18-65**	**C:66-75**	**D:Over 75**	**Grand Total**
Grand Total	**5**	**106**	**129**	**550**	**790**

4.2 Total Deaths Screened (1st stage review)

The Trust learning from deaths policy identifies a number of criteria which if met require the service to submit a Datix form for review on the Trust incident management system following the notification of a death. 108 deaths were submitted for review in Q2, higher than the mean of 80 per quarter in 2018/19 (Figure B in Appendix 1 details the specific services).

These Datix notifications are all reviewed weekly by the Executive Mortality Review Group (EMRG) which consists of the Medical Director, Director of Nursing and Governance, Lead Clinical Director, Deputy Director of Nursing and Quality and the Head of Clinical Effectiveness & Audit.

There are four outcomes upon EMRG review (as identified in the learning from deaths policy):

1. Datix form advised to be closed, no 'red flags'/ concern identified.
2. Further information requested to be able to make a decision, to be reviewed at next EMRG
3. Identified as a serious incident (SI)
4. Identified as requiring a review (SJR/IFR) report

Of the 108 deaths undergoing first stage review, 43 were closed with no further action required, 55 were referred for 2nd stage review and 10 were classed as serious incidents for RCA investigation.

5. Involvement of families and carers in reviews and investigations

There are established processes to involve all families and carers where a death is reported as an SI or a death which relates to an individual with a learning disability and these are detailed with regards to the level of involvement for those deaths reported in Q2. In addition, for all expected inpatient end of life deaths or deaths where a 2nd line review (SJR) is undertaken, the family will receive a letter of condolence and the bereavement booklet, with the opportunity to raise any concerns about the care provided to the patient..

6. 2nd Stage Reviews Completed

The purpose of the 2nd stage review of deaths is to determine if any potential problem or lapse in care may have contributed to the person's death, to identify learning and to utilise the learning to guide necessary changes in services in order to improve the quality of patient care. It is expected that, over a period of time, these improvements in response to learning from deaths will nationally contribute to reduction in premature deaths of people with learning disabilities and severe mental illness.

The Trust-wide mortality review group (TMRG) meets monthly and is chaired by the Medical Director; 58 (66 inQ1 of 2018/19) reviews have been received and considered by the group in Q2. Figure 3 details the service where the review was conducted.

Figure 3: Reviews Conducted in Q2

	Total Number	**Services**
July 2019	21	Common Point of Entry: 1 CJLD: 1 Older Peoples Mental Health: 3 Community Mental Health: 4 Community Inpatient Wards: 6 Community Nursing: 1 Learning Disabilities: 5
August 2019	11	Community Inpatients: 2 Learning Disabilities: 4 Community Nursing: 2 Older adults mental health: 1 Talking Therapies: 1 Psychological Liaison Service:1
September 2019	26	Learning Disability: 4 Community Health Inpatient Ward: 5 Older peoples Mental Health: 4 Community Nursing: 5 Community Mental Health: 4 Veterans mental health: 1 Talking Therapies: 2 Psychological lisison:1

Upon review the trust mortality review group will agree one of the following:

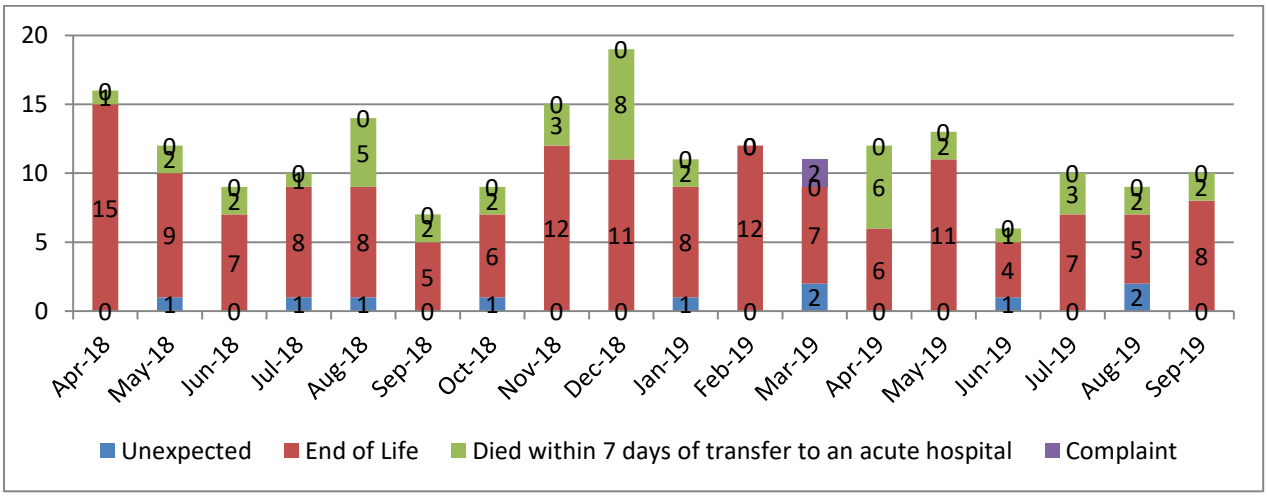
- Request further information (if required) from trust services or other providers
- Agree to close the case and note any actions on the action log
- Agree to close and make recommendation for service level learning and improvements
- Identify a potential lapse in care and recommend investigation through the SI process.

An action log is maintained and reviewed by the group to ensure that all actions are completed.

7. Deaths of patients (including palliative care) on community health inpatient wards

For community health inpatients we require all deaths to be reported on the Datix system including patients who are expected to die and receiving palliative care. Figure 4 details these.

Figure 4: Deaths occurring on the community health inpatients wards or following deterioration and transfer to an acute hospital.



In Q2 29 (compared to 31 in Q1 of 2018/19) deaths in total were reported by the Community Inpatient Wards, of these 20 were expected deaths and related to patients who were specifically receiving end of life care. These were reviewed by the EMRG and closed where sufficient information had been provided to give assurance that appropriate end of life care had been given.

9 deaths were unexpected (10 in Q1), of which 2 patients died on the community inpatient ward and 7 were transferred to an acute hospital. 9 2nd stage reviews were requested, 3 have been completed and closed at TMRG.

8. Deaths of Children and Young People

8 deaths were submitted as a Datix for 1st stage review in Q2.

5 of these were submitted by the Health Visiting teams 3 unexpected deaths and 2 where the infant died before discharge from hospital. All 5 cases were closed at EMRG 1st line review with the 3 unexpected deaths following the CDOP process.

2 deaths were submitted where the child or young person had been in contact with the children's specialist nursing service in the year before their death, both were unexpected and 2 stage review (SJR) has been requested.

1 death was reported by school nursing upon review the child was not receiving BHFT services and the case was closed at 1st line review.

9. Deaths of adults with a learning disability

In Q2 the Trust Mortality Review Group (TMRG) reviewed a total of 13 deaths of adults with learning disabilities who had received services from Berkshire Healthcare in the 12 months prior to their death. The Structured Judgement Review methodology was used for all reported deaths with these reviews appraised by the LD Clinical Review Group (CRG) prior to review and sign off by the TMRG

Of these 13 deaths there were no identified lapses in care provided by Berkshire Healthcare.

The deaths were attributed to the following causes:

5 - Diseases of the Respiratory System

3 - Heart & Circulatory Disorders

2 – Infections

1- Cancer

1 – Diseases of the Nervous System

1 - Endocrine, nutritional and metabolic diseases

Demographics:

Gender:

Female	8
Male	5

Age:

The age at time of death ranged from 30 to 88 years of age (median age: 64yrs)

Severity of Learning Disability:

Mild	1
Moderate	5
Severe	2
Profound	2
Not Known	3

Ethnicity:

White British	10
Asian Pakistani	2
Not Known	1

Engagement with family members

The Learning Disability Service makes contact with the family and/or staff team following the reported death of a person with a learning disability. Of the 13 deaths reported, 7 people's families were sent information and condolence cards. There have been no responses received to date from those contacted in this quarter.

Of those who were not contacted, the rationale is provided below:

1. 3 individuals had not been in receipt of learning disability services, therefore the information was not held by the service
2. 2 individuals had no known family
3. 1 individual had no active family involvement

In each case where a decision had been made to refrain from contacting family, it was decided that contact would be more appropriately followed up through the LeDeR process.

10. Deaths categorised as Serious Incidents (In line with Trust SI policy and Learning from deaths policy)

In Q2, 10 deaths have been reported as serious incidents; figure 5details the service where the SI occurred.

Figure 5. Service (**Source Q2 Serious Incident Report)**	**Number**
West Berkshire CMHT	1
Slough CMHT	2
Reading CMHT	5
CPE	1
Prospect Park Hospital Inpatient	1
Total	**10**

10.1 For all deaths which are categorised as an SI
The family is contacted in line with our duty of candour (DoC) policy and advised of the process of investigation.

Someone from the service (usually a senior clinician or manager) makes contact with the family as soon as it is known that an incident causing death has occurred. At this time they offer a face to face meeting which will include:

- an explanation about what is known regarding the incident,
- the offer of support
- An explanation regarding the investigation process including who the investigating officer is and that they will be in touch.
- an apology for the experience, as appropriate

Duty of Candour (DoC) applied to 13 deaths in Q2 (10 SIs, 3 reviews (RCA) following referral from TMRG). Phone contact has been attempted with all families or nominated next of kin (NoK), however phone contacts for 3 families / NoK have gone unanswered. A DoC letter and written communication providing condolences, with an explanation of the investigation and offering support has been sent to all families or NoK.

5 families have taken up the offer of a face to face meeting at this stage. Further opportunities to meet or talk, should they wish, are offered at the point of sharing any outcomes in written format from the review or investigation.

Process for Bereavement Support in the trust after Suspected Suicide

As part of the duty of candour process, families and carers are signposted to a range of support options for coping with a traumatic death or suspected suicide via the Help is at Hand resource, a copy of this is routinely provided.

4 families received support in Q2 from staff who have undertaken PABBs (Postvention- Assisting those Bereaved by Suicide) training. This course offers health professionals an opportunity to build confidence and skills in caring for those bereaved by suicide. The training is evidence-based theory-driven and has been informed by a three-year study, funded by the National Institute for Health Research (NIHR) Research for Patient Benefit Programme, which identified the vulnerability and perceived needs of parents bereaved by suicide and health professionals who were responsible for their care. It is a collaboration between the University of Manchester and Pennine Care NHS Foundation Trust. Offering support following suicide has been highlighted in the NICE Suicide Prevention Guidelines in Community and Custodial Settings (Sept, 2018); and also within the NHS Long Term Plan (Jan, 2019). 2 families are continuing to receive support.

10.2 Lapse in Care
Of the 58 case reviews received by the TMRG, 3 reviews were escalated and are currently being investigated using root cause analysis.

One lapse in care has been confirmed in Q2: This related to a suicide in the community which occurred in June 2019 and the investigation was concluded through the SI process.

11. Additional Case Review

The 2nd round of the National Audit of End of Life Care has been underway and data submission is now complete. For all EOL inpatient deaths which occurred between April 2019 and June 2019,(17 patients, 100% of the requested population) had data collection forms submitted in line with the national requirements.

16 questionnaires were sent to the nominated person. Only one questionnaire was not sent as the address of the nominated person had not been recorded. Responses from these questionnaires are returned directly to the national team, we should expect some initial feedback on this in spring 2020.

12.Learning from Deaths

The aim of the trust policy and process is to ensure that we learn from deaths and improve care even when the death may not be due to a lapse in care. The following section details areas of quality improvement identified in Q2.

12.1 Themes and learning from serious incidents (SI)

Gathering information from families – Involving families in our SI investigations allows them to share their experience of our services and provides them with the opportunity to raise any concern related to the care of their loved one . In a number of SIs, families share that they feel they have had limited involvement during their relative's care yet can provide valuable information about the patient based on their experiences and understanding of their needs. Families feel their knowledge of the patient could support staff when assessing risk whether it be in relation to risk of self-harm or risk of falling or observing deterioration. Whilst this has been identified in previous quarterly report, this continues to be a clear theme across both mental health and physical health SIs.

Managing signs of the deteriorating patient – This was identified an as an area that needed improving in a previous quarterly SI report (Q1 2018-19). Whilst there is evidence across the inpatient wards that use of NEWS2 has improved, SIs from Q2 this year identify that there is still more that can be done to increase awareness within the nursing team of managing the signs of the deteriorating patient, using all the available tools (NEWS 2, fluid balance, postural drop) to inform care and having the knowledge of when to escalate.

Actions are being undertaken to address these main themes identified from Q2. In addition, it has been recognised in this quarter that the standard operating procedure introduced in Q3 2018-19 for covering staff sickness in community mental health teams has not been fully embedded so further work is underway to address this.

12.2 Learning from deaths of patients with a learning disability (LD)

Actions and learning identified during the previous quarter have been completed / shared.

In Q2, there was ongoing evidence of good communication and information sharing across services, and externally with other organisations, with appropriate escalation and monitoring in accordance with concerns raised.

In Q2, the following pieces of work have been undertaken by the LD service in with the aim of reducing the number of premature deaths of individuals with a learning disability:

- Development of Sepsis awareness packs including easy read information for people with learning disabilities are being distributed by team members, at meet the team events and via the LD SHaRON platform.
- Development of a respiratory care pathway within the learning disabilities service to identify people at risk of respiratory illness and to support multi-disciplinary working to reduce risks.
- Promotion of Flu vaccine for people with learning disabilities, family members and carers.

12.3 Learning from deaths of patients who access the court liaison and diversion service.

A review of the deaths reported for first line review had identified the requirement to develop a specific standard operating procedure for court liaison and diversion services, this is being led by the West Mental Health Clinical Director to ensure consistency as we are contracted to provide this in a number of services outside of Berkshire. Due to the very specialist and often limited contact the service may have with the patient, a service specific 1st line tool,

which will be adapted from the current IFR, will be used to review care given in line with the standard operating procedure and can then be shared appropriately if we or another organisation are also reviewing the death as an SI.

13. Further Quality Improvements

Preparing for the introduction of the Medical Examiner(ME) System.

A process for quality check of Medical Certificates of Cause of Death (MCCD) is being piloted and cause of death is triangulated at the EMRG until we have a medical examiner in place.

The Medical Director is in discussions with the local acute trust for the extension of their current ME service to cover community deaths based on an approximation of 60-80 deaths per annum which are issued a MCCD in the trust. This will be confirmed with the regional ME and once agreed, the aim would be to pilot the extended service from April 2020.The current proposal is:

- As face to face conversations between the ME and the doctor issuing the MCCD would not always be feasible in a reasonable time frame, it is suggested that a video conferencing solution is put in place to enable good conversation between the ME and community medical staff..
- The MEs would be able to scrutinise clinical notes in RiO.
- The process for Cremation part 2 forms would remain the same due to logistics to reviewing after death.
- NoK would be contacted by the ME as in all other deaths and asked if they have any concerns. A feedback mechanism would need to be developed from the ME Office to BHFT Clinical Governance team to let them know of any concerns or positive feedback.
- MEs will triage the deaths for SJR review. Whilst BHFT will continue to review and learn from far more deaths than the MEs would flag for review, the MEs may pick up an issue that would be worthy of review that may not have been picked up otherwise.

14. Conclusion

Of the 58 case reviews received by the TMRG, 3 reviews were escalated for local Root Cause Analysis and are currently being investigated.

One lapse in care has been confirmed in Q2: This related to suicide in the community which occurred in June 2019 and the investigation was concluded through the SI process.

6 keys areas of learning have been identified, of these 3 are areas which have previously been identified and are directly linked to SI's.

- Greater involvement of families in patient care
- Managing signs of the deteriorating patient
- A standard operating procedure introduced in Q3 2018-19 for covering staff sickness in community mental health teams has not been fully embedded and further work is underway to address this.

The additional 3 areas of learning identified though the SJR process include:

- Development of Sepsis awareness packs including easy read information for people with learning disabilities are being distributed by team members, at meet the team events and via the LD SHaRON platform.
- Development of a respiratory care pathway within the learning disabilities service to identify people at risk of respiratory illness and to support multi-disciplinary working to reduce risks.
- A standard operating procedure for court liaison and diversion services.

Appendix 1

Figure A:Number of deaths of patients who were open to services and had contact in the preceding 365 days before death.

	July	**August**	**September**	**Total**
Nursing episode	**118**	**112**	**95**	**325**
Community health services medical	**41**	**25**	**27**	**93**
Palliative medicine	**24**	**20**	**15**	**59**
Old age psychiatry	**18**	**20**	**15**	**53**
Podiatry	**18**	**18**	**8**	**44**
Dietetics	**12**	**20**	**10**	**42**
Rehabilitation	**19**	**13**	**4**	**36**
Adult mental illness	**10**	**8**	**7**	**25**
General medicine	**5**	**11**	**2**	**18**
Cardiology	**7**	**6**	**4**	**17**
Physiotherapy	**7**	**4**	**5**	**16**
Speech and language therapy	**5**	**5**	**4**	**14**
Intermediate care	**4**	**7**	**3**	**14**
Respiratory medicine	**6**	**4**	**1**	**11**
Genito-urinary medicine	**2**	**2**	**3**	**7**
Geriatric medicine	**1**	**3**	**1**	**5**
Community paediatrics		**2**	**1**	**3**
Occupational therapy		**3**		**3**
Learning disability	**2**	**1**		**3**
Clinical psychology		**1**	**1**	**2**
Grand Total	**299**	**285**	**206**	**790**

Figure B

Division	**Service**	**Total**
CHS East	Assessment and Rehabilitation	1
	Community Hospital	6
	Community Nursing	5
CHS West	Community Hospital	23
	District Nursing and Intermediate Care	4
	Integrated home care service	1
	West call Out of Hours GP service	1
CYP&F	Health Visiting	5
	School Nursing	1
	Children's Community Nursing	1
	Children's Physiotherapy	1
MH East	CMHT	7
	CMHTOA	1
MH West	CJLD	7
	CMHT	8
	CMHTOA	6
	Complex Treatment for Veterans	2
	CPE	5
	CRHTT	2
	CTPLD	12
	Hard to reach homeless	1
	Psychological Liaison service	3
	neuropsychology	1
	Talking Therapies	3
Mental Health Inpatients	Adult Acute Ward	1
Total		**108**

Berkshire Healthcare NHS Foundation Trust

Quality Assurance Committee Paper

Meeting Date	November 2019
Title	Guardian of Safe Working Hours Quarterly Report (August to October 2019)
Purpose	To assure the Trust Board of safe working hours for junior doctors in BHFT
Business Area	Medical Director
Author	Dr Matthew Lowe, Dr James Jeffs, Ian Stephenson
Relevant Strategic Objectives	1 – To provide accessible, safe and clinically effective services that improve patient experience and outcomes of care
CQC Registration/Patient Care Impacts	Supports maintenance of CQC registration and safe patient care
Resource Impacts	Currently 1 PA medical time shared by the 2 Guardians
Legal Implications	Statutory role
Equalities and Diversity Implications	N/A
SUMMARY	This is the latest quarterly report for consideration by Trust Board from the Guardians of Safe Working. This report focusses on the period 1st August to the 31st October 2019. Since the last report to the Trust Board we have received four hours exception reports. We do not foresee any problems with the exception reporting policy or process; neither do we see a significant likelihood of BHFT being in frequent breach of safe working hours in the next quarter.
ACTION REQUIRED	The QAC/Trust Board is requested to: Note the assurance provided by the Guardians

Berkshire Healthcare
NHS Foundation Trust

QUARTERLY REPORT ON SAFE WORKING HOURS: DOCTORS AND DENTISTS IN TRAINING

This report covers the period 7th August to the 31st October 2019

Executive summary

This is the latest quarterly report for consideration by Trust Board from the Guardians of Safe Working.

This report focusses on the period 7th August to the 31st October 2019 and covers the first half of the August to February changeover and the introduction of the new rota pattern. Since the last report to the Trust Board we have received four hours exception reports.

We do not foresee any problems with the exception reporting policy or process; neither do we see a significant likelihood of BHFT being in frequent breach of safe working hours in the next quarter.

Introduction

The current reporting period covers the second half of a six month CT and GPVTS rotation.

High level data

Number of doctors in training (total): 43 (FY1 – ST6)

Included in the above figure are 3 MTI (Medical Training Initiative) trainees.

Number of doctors in training on 2016 TCS (total): 43

Amount of time available in job plan for guardian to do the role: 0.5 PAs Each (job share)

Admin support provided to the guardian (if any): Medical Staffing

Amount of job-planned time for educational supervisors: 0.25 PAs per trainee

a) **Exception reports (with regard to working hours)**

Exception reports by department				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Psychiatry	0	4	4	0
Sexual Health	0	0	0	0
Total	0	4	4	0

Exception reports by grade				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
FY1	0	0	0	0
CT	0	4	4	0
ST	0	0	0	0
Total	0	4	4	0

Exception reports by rota				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Psychiatry	0	4	4	0

Exception reports (response time)				
	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
FY1	0	0	0	0
CT1-3	0	0	4	0
ST4-6	0	0	0	0
Total	0	0	4	0

In this period we have received four hours & rest exception reports totaling an extra three hours 45 minutes worked over and above the trainees' work schedules. Exception reporting is a neutral action and is encouraged by the Guardians and DME. We continue to promote the use of exception reporting by trainees, and make sure that they are aware that we will support them in putting in these reports.

The four hours & rest exception reports relate to three occasions. On one occasion a trainee stayed 30 minutes for in their words a "unique learning experience". TOIL was agreed. Two exception reports were submitted by two trainees and relate to the same incident where both had to stay an extra hour and fifteen minutes to document the admission clerking and admission paper work. The consultation took longer than was expected due to the sensitive nature of the mental status of the patient. The fourth relates to an unfortunate situation where a trainee was delayed in handing over at the end of their shift as the change of mobile providers had meant the mobile signal was not adequate to be able to contact the incoming doctor. This incident has been raised appropriately to the DME and inpatient Clinical Director as well.

There have been no systemic concerns about working hours, within the definitions of the 2016 TCS.

b) Work schedule reviews

There have been no work schedule reviews in this period. The Medical Staffing department has created Generic Work Schedules. The DME, working with tutors, the School of Psychiatry and Clinical Supervisors, has developed Specific Work Schedules. These are both required by the contract.

Work schedule reviews by grade	
CT1-3	0
ST4-6	0

Work schedule reviews by department	
Psychiatry	0
Dentistry	0
Sexual Health	0

c) **Gaps**

(All data provided below for bookings (bank/agency/trainees) covers the period 7th August to the 31st October 2019

Psychiatry	Number of shifts requested	Number of shifts worked	Number of shifts worked by:			Number of hours requested	Number of hours worked	Number of hours worked by:		
			Bank	Trainee	Agency			Bank	Trainee	Agency
	41	41	16	25	0	293.5	293.5	138	155.5	0

Reason	Number of shifts requested	Number of shifts worked	Number of shifts worked by:			Number of hours requested	Number of hours worked	Number of hours worked by:		
			Bank	Trainee	Agency			Bank	Trainee	Agency
Gap	35	35	11	24	0	246.5	246.5	96.5	150	0
Sickness	6	6	5	1	0	47	47	41.5	5.5	0
Maternity	0	0	0	0	0	0	0	0	0	0
Total	41	41	16	25	0	293.5	293.5	138	155.5	0

The gaps from August changeover were anticipated as they were planned into the new rota pattern in order to allow the psychiatry CTs an increased ability to access teaching at Oxford. All of the gaps were filled before the rota went live, with a high number being filled by GPVTS trainees who are not required to attend CT psychiatry training.

d) **Fines**

Fines levied by the Guardians of Safe Working should be applied to individual departments, as is the intent of the contract. No fines have been levied in this quarter.

Fines by department		
Department	Number of fines levied	Value of fines levied
None	None	None
Total	0	0

Fines (cumulative)

Balance at end of last quarter	Fines this quarter	Disbursements this quarter	Balance at end of this quarter
£0	£0	£0	£0

Qualitative information

The increase in the number of trainees on previous rotations derives from a combination of factors. Firstly, we had a far higher than usual fill rate by HEETV, where usually we would have gaps this rotation saw all of our CT places filled. WE have also in agreement with the GP School increased the number of GPVTS we will take, two extra from August 2019, with a third new GP trainee from February 2020. This will take the number of GP trainees we have in psychiatry to eight. Finally we now have three MTI trainees, as this year we were allocated two by the Royal College. The increase in numbers is important and worthwhile in that it allows us to run a lighter rota which improves educational opportunities for the trainees, improves their work life/balance, gives them more time in their chosen sub-specialties, and does not compromise patient care in the Out of Hours (OOH) rota.

As mentioned in the last two reports, the junior doctors OOH rota pattern had been reviewed and the new pattern is now in place. Operating since the August 2019 changeover, the new pattern has been in place for three months (half its cycle).

The Junior Doctors' Forum (JDF) continues under the oversight of the junior doctor leads, and has been well attended. The new Chair of the Junior Doctor Forum is Dr Parul Jha. The issue raised in the forum regarding the availability of food on site at PPH at weekends for junior doctors working is now being addressed as part of the wider redecorating of the junior doctor's facilities project at PPH.

The Guardians are actively involved in the regional Guardian of Safe Working Hours Network (Thames Valley) and continue to stay abreast of the details of how to implement new guidelines from NHS Employers. Both Guardians attended the National Guardian of Safe Working Hours conference in Leeds in September. BHFT compared to the other trusts in HETV (Health Education Thames Valley) region continues to have a low number of exception reports.

In July 2019, an agreement was reached between NHS Employers and the British Medical Association (BMA) on amendments to the 2016 terms and conditions for doctors in training. These agreements are being progressively implemented in the remainder of 2019. I have included a summary of the changes from NHS England as appendix B. The changes should not pose any difficulties for BHFT as we believe that the rota as planned is already compliant with the published changes.

No immediate patient safety concerns have been raised to the guardians in this quarter.

Issues arising

Exception reporting remains at a level consistent with previous GOSW Board reports. None of these reports indicate problems with posts that have required the work schedules to be reviewed. The current level of exception reporting suggests that Junior Doctors are not working unsafe hours and this is confirmed by the qualitative information from the Junior Doctors Forum. However, it is possible that there is under-reporting of small excess hours worked.

Actions taken to resolve issues

Next report to be submitted February 2020.

Summary

All work schedules are currently compliant with the Contract Terms and Conditions of Service. No trainee has breached the key mandated working limits of the new contract.

The Guardians give assurance to the Trust Board that no unsafe working hours have been identified, and no other patient safety issues requiring escalation have been identified.

We remain mindful of the possibility of under-reporting by our trainees, whilst having no evidence of this. Trainees are strongly encouraged to make reports by the Guardians at induction and at every Junior Doctor Forum. They are assured that it is a neutral act, and asked to complete exceptions so that the Guardians of Safe Working can understand working patterns in the trust.

Questions for consideration

The Guardians ask the Board to note the report and the assurances given above.

The Guardians make no recommendations to the Board for escalation/further actions.

Report compiled by the Guardians of Safe Working Hours, Dr James Jeffs and Dr Matthew Lowe and Ian Stephenson, Medical Workforce Manager.

Appendix A: Glossary of frequently used terms and abbreviations

Guardian of Safe working hours: A new role created by the Junior Doctors Contract that came into effect for the majority of trainees in BHFT in February 2017. The Guardian has a duty to advocate for safe working hours for junior doctors and to hold the board to account for ensuring this.

FY – Foundation Years – Doctors who are practicing usually in the first two years after completing their medical degrees.

CT – Core Trainee – The period usually following FY where a junior doctor is specializing in a particular area of medicine (in BHFT this is primarily for Psychiatry or General Practice). Typically 3 years for psychiatry trainees.

ST- Speciality Trainee – The period following Core training where a junior doctor sub-specializes in an area of medicine, for example Older Adult Psychiatry. Typically 3 years for psychiatry trainees.

Work Schedule – A work schedule is a new concept for junior doctors that is similar to a Job Plan for Consultants. A work schedule sets out the expectations of the clinical and educational work that a Junior Doctor will be expected to do and have access to. Before entering each post the Junior Doctor will have a "Generic Work Schedule" that the Clinical Supervisor and Medical Staffing feels sums up the expectations and opportunities for the that post. At the initial meeting between Clinical Supervisor and trainee this will be personalized to a "Specific Work Schedule" giving the expectations of that trainee in that post. If exception reporting or other information indicates a need to change the work schedule this is called a work schedule review. The new policy indicates the procedures for this process and appeal if it is not considered satisfactory.

Junior doctors' forum – A formalized meeting of Junior Doctors that is mandated in the Junior Doctors Contract. The Junior Doctors under the supervision of the Guardians are amalgamating other pre-existing fora under this meeting so it will be the single forum for Junior Doctors to discuss and formally share any concerns relating to their working patterns, education or patient safety. The Junior Doctor Forum includes representation from the Guardians, Director of Medical Education and others as required to ensure these concerns can be dealt with appropriately.

Fines – If doctors work over the hours in their Specific Work Schedule they are entitled to pay or to time back in lieu for that time. In this trust we are looking for trainees to have time back as the preference. However if the doctor works so many hours as to further breach certain key mandated working limits the trust will be fined with the fine going into a separate fund managed by the Guardians to be used for educational purposes for the trainees.

Appendix B

Factsheet: Safety limits and rest

The below table highlights the changes to the safety limits and rest provisions between the 2016 terms and conditions and the 2018 contract refresh. For full details please refer to schedule 3 of the terms and conditions of service (TCS).

2016 terms and conditions	2018 contract refresh
Maximum of 72 hours work in any 7 consecutive day period.	Maximum of 72 hours work in any 168-hour consecutive period.
46-hours rest required after 3-4 consecutive night shifts.	46-hours rest required after any number of rostered nights.
Doctors paid at nodal point 2 are exempt from the requirements that no doctor shall be rostered for work at the weekends greater than 1 week in 2 for one placement during their foundation year.	No doctor shall be rostered for work at the weekend at a frequency of more than 1 week in 2.
No doctor shall be rostered for work at the weekend at a frequency of greater than 1 week in 2.	All reasonable steps should be taken to avoid rostering trainees at a frequency of greater than 1 in 3 weekends.
Where 8 shifts of any length are rostered or worked on 8 consecutive days, there must be a minimum 48-hours rest rostered immediately following the conclusion of the eighth and final shift.	Maximum of 7 shifts of any length can be rostered or worked on 7 consecutive days. Where a shift contains hours of work across more than one day, the work on each day will be counted independently toward the total number of consecutive days*.
No more than 5 long shifts shall be rostered or worked on consecutive days. Where 5 long shifts are rostered on consecutive days, there must be a minimum 48-hour rest period rostered immediately following the conclusion of the fifth long shift.	No more than 4 long shifts shall be rostered or worked on consecutive days. There must be a minimum 48-hour rest period rostered immediately following the conclusion of the final long shift*.
A doctor must receive: • at least one 30 minute paid break for a shift rostered to last more than 5 hours, and • a second 30 minute paid break for a shift rostered to last more than 9 hours.	A doctor must receive: • at least one 30 minute paid break for a shift rostered to last more than 5 hours • a second 30 minute paid break for a shift rostered to last more than 9 hours • A third 30-minute paid break for a night shift as described in paragraph 15 of Schedule 2, rostered to last 12 hours or more.

*As soon as reasonably practicable from August 2019, and in any event as soon as possible before 5 August 2020, the employer will consult with doctors and agree to alter existing rotas.

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	10 December 2019
Title	**Executive Report**
Purpose	This Executive Report updates the Board of Directors on significant events since it last met.
Business Area	Corporate
Author	Chief Executive
Relevant Strategic Objectives	N/A
CQC Registration/Patient Care Impacts	N/A
Resource Impacts	None
Legal Implications	None
Equality and Diversity Implications	N/A
SUMMARY	This Executive Report updates the Board of Directors on significant events since it last met.
ACTION REQUIRED	To note the report and seek any clarification.

Berkshire Healthcare
NHS Foundation Trust

Trust Board Meeting 10 December 2019

EXECUTIVE REPORT

1. Never Events

Directors are advised that no 'never events' have occurred since the last meeting of the Trust Board.

Executive Lead: Debbie Fulton, Director of Nursing and Therapies

2. Medical Staffing Update

About our trainee doctors:

The 2019 General Medical Council National Training Survey results placed Berkshire Healthcare at the top spot among all Local Education NHS Trust providers within Health Education England Thames Valley (HEE TV) region.

Every year the General Medical Council asks doctors in training for their views on the training they receive. They also ask trainers about the support they get in their role. These results are used to improve training programmes and posts across the United Kingdom. More information about the survey and a summary report can be found at https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/national-training-surveys-reports

The annual General Medical Council survey was completed by 56 559 doctors in training from across the United Kingdom.

Junior doctors ranked their overall satisfaction in Berkshire Healthcare at 85.21%, which is above the national average of 79.45%

The Trust ranked number one in HEE TV for the percentage of good and very good responses in quality of teaching, quality of clinical supervision, quality of experience, and describing the post to a friend who was thinking of applying for it.

Our *trainer* satisfaction was 76.32%, which is not only higher than the national average of 71.8%, but also the highest of all other Local Education Providers in Thames Valley.

About our vacancies and use of agency medical staff:

Throughout the year, we have used a range of measures to recruit to our vacancies and have successfully recruited 14 Consultants in 2019, such that our current

medical vacancies are mainly limited to Older Adults Mental Health Service (1 inpatient Consultant vacancy, 1.2 Consultant and 0.8 specialty doctor vacancy in one of our Older Adults CMHT) with a less than full time vacancy in CAMHS Eating Disorder Service.

CAMHS had the highest number of vacancies as a result of retirement and requests for less than full time working from senior staff. we recruited 4 Consultants (2 have started, 1 to start January 2020, and 1 later in 2020) in addition to 2 locum consultants on NHS contracts. Bracknell and Reading CMHT, Learning Disability service and Wokingham Older People Mental Health (OPMH) Service have all recruited to Consultant vacancies in 2019. Locum Consultants on NHS contracts were recruited to CRHTT East and Slough OPMH. A second substantive consultant was recruited in Elderly Care Medicine. In addition to Consultant vacancies we have recruited to 6 Specialty Doctor vacancies in the year.

Use of agency locum medical staff has been progressively reduced to the point where we currently have only one agency locum doctor working less than full time in the Trust (November/ December 2019).

Executive Lead: Dr Minoo Irani, Medical Director

3. Updates on System Work

The Trust is part of two Integrated Care Systems (ICS): Frimley Health and Care and Buckinghamshire, Oxfordshire and Berkshire West (BOB). The appendix contains a briefing from both systems on current issues and progress to date.

Executive Lead: Julian Emms, Chief Executive

Presented by: Julian Emms
Chief Executive
December 2019

Frimley Health and Care

Message from Andrew Lloyd, Chair of the Frimley Health and Care ICS Board

Dear all, as part of our on-going briefings to you, please see this month's update on the key discussions that were held at our Board meeting on **15 October 2019**.

This was the first meeting with Andrew Lloyd as **Independent Chair of the Frimley Health and Care Board**. Andrew was formerly the chair of NHS Surrey Heath Clinical Commissioning Group (CCG) and before that the Chief Executive of Rushmoor Borough Council.

The Board started with usual reflections from Board members, with many people noting the pace of change both locally and nationally, within and outside health and care. It was World mental health day the previous week, supported by a national campaign which we shared across the system. The importance of developing opportunities for preventing ill health and strengthening co-design with all partners, voluntary sector and local people, to collectively work together to make real changes grows. Through our plan we want to drive a change in the way we spend our time and energy listening to what people say and better understanding how their experiences can drive the re-design how we work to address broader health, care and wellbeing, and health inequalities. There is a growing sense of excitement about what we want to achieve and we are keen to move to a place of delivery.

Fiona Edwards fed back on **national ICS position,** how she can see our '**Creating healthier communities'** plan can provide a strategic opportunity to rethink the way in which we work.
A first draft of the plan has been submitted and we attended the NHSE assurance review. The purpose of the meeting was to ensure our plan has clarity of delivering it's vision, triangulation of key elements and demonstrates how we will meet the requirements of the NHS Long Term Plan. There were some challenges around the money, and how we will manage our performance and activity leading up to winter. The feedback was positive with a consensus that we are in strong position with a forward thinking plan.

The next step will be to describe the outcomes we expect the actions to deliver and how we need to organise ourselves to undertake the work. A copy of the first draft strategy is available as part of our on-going communications pack, on the Frimley Health and Care website:
https://www.frimleyhealthandcare.org.uk/about/our-plans/creating-healthier-communities/

We have a rare opportunity to work in a different way across our systems so will need to continue to review our structure and form and develop our ways of working to reflect the best way to achieve our priorities, ensuring that whatever we do, patients remain at the heart of our decision making. Next timelines for the strategy are:

- Final version of the pack by 1 November for last checks
- Formal final submission of the plan by 15 November and publication on 27 November

The Frimley Health and Care Board want to thank everyone for their contributions and hard work so far.

Andy Brooks fed back on the development of the **Frimley Commissioning Collaborative** – a collaboration of the three Clinical Commissioning Groups of East Berkshire, North East Hampshire and Farnham and Surrey Heath. The three Governing Bodies are working together to understand how they can evolve their arrangements in line with Frimley Health and Care Integrated Care System (ICS), working together with ICS partners and wider partnerships, and continuing to break down organisational barriers. The work to develop the appointments process for the Executive Team is now underway along with a series of staff events to engage with the wider teams and understand

how they could work together more effectively in the future. It is intended the appointment of the Accountable Officer will be completed as soon as possible.

Dr Peter Bibawy produced a paper on the future direction of travel for the Frimley Health and Care **Leadership Academy** which was considered. The Board were keen to hear more about the value and impact of the work of the academy and the strands of work that already exist and have been delivered. This includes the work of the 2020 programme (now recruiting for cohort 4), Wavelength (it's second cohort) and the newer network facilitator roles.

Current financial position – Individual organisations are reporting delivery of their individual control totals, including an assumption of system support funding yet to be identified. Four of the five local authority partners have shared financial positions reflecting Q1 positions. Forecasts for the year however reflect an emerging risk against the delivery of the system position.

We are currently building our financial planning for the next five years. Pressures are being experienced across Continuing Healthcare, Primary Care Prescribing and with NHS Property Services and acute over performance at Frimley Hospitals. Surrey & Borders are also experiencing higher than planned costs in our Child and Adolescent Mental Health Services (CAMHS). The Finance reference group is meeting this week to bring together the organisational positions to support our system wide collective position.

Alan Sinclair provided a Slough Local Authority financial positon. Times are more uncertain and challenging than ever. He fed back on the continuing cycle of completing transformation, identifying savings and ensuring that statutory responsibilities continue to be met. There is an opportunity to think about how our collective strategy, particularly around our 'Starting Well' ambition provides an opportunity to do things differently and change what and how we invest, disinvest safely and spend. The importance of working together to channel resources and capacity to where they will make the most impact, centred on outcomes for people and local communities, not based around organisational boundaries, is essential.

GP Transformation/PCN Update & Hearing back from PCN Alliances – Mark Pugsley fed back with good news on community mental health bidders. The areas chosen to be in the first wave of a ground-breaking community mental health service have been announced. There are eight sites within the Frimley Health and Care Integrated Care System (ICS) that will introduce the new service, thanks to £5.2 million of funding. The locations will be: Slough LOCC, Aldershot, Farnborough, Bracknell Health Triangle, Bracknell and District, Windsor, Surrey Heath, Farnham.

Frimley Health and Care has been awarded £5.20m by NHS England to transform community mental health care in twelve 'early implementer' areas. Mental health specialists Surrey and Borders Partnership NHS Foundation Trust and Berkshire Healthcare NHS Foundation Trust will lead the local implementation over the next two years, with the new Primary Care Networks (PCNs) to work with community services, social care and other health and care service providers.

Further sub-committees updates:

Estates Group – Julian Emms provided a update on the Estates element of the ICS capital programme. We now have a revised timeline for the business case submissions and the ICS Board will be receiving a more detailed presentation on this item in November.

Health and Wellbeing Alliance. – At the most recent meeting Jane Hogg presented the emerging strategy and this was well received. Andrew Lloyd reflected that we had fed back on the Board conversation about housing and how LA and health need to work together in the future for instance housing applications and implications for health and social care that

should be considered. Andrew and Councilor Dale are going to meet and develop a workshop for us to consider what we could do. Sharon Ward and Ellie Davies presented the statistics and a walk around our Frimley health and Care website which has been live for one year. With a growing interest and hits of over 5k a month, the website aims to focus on the delivery and work of the ICS and act as a central place to hear about what is happening across the ICS.

NED Assurance Group – The group made up of Non-executives and Lay members is in a place where we need to look at the opportunity to develop our governance in a way that supports integration, reports statutory functions. Focus has been on Primary Care Networks and Connected Care governance which has provided good practical conversation which needs to be broadened to the wider Board.

LWAB (Workforce) – Caroline Corrigan fed back on the work the group has been undertaking on the Workforce development tool. We are 1 of 8 ICS piloting to self-assess and plan on our workforce. Workforce Planning workshop on 23 October to share what we've done and progress so far. Following this, the group plans to bring back a report to Board on this work, our strengths, challenges and strategic way forward.

Programme Delivery Board – Good conversations around outpatients and elective care. This work is still at a formative stage and the Programme Delivery Board made some constructive suggestions to the programme leads about how progress may best be achieved on what is not only a complex change programme but a significant cultural transformation for staff and patients.
Quality Group – Number of Tier 4 children who have been experiencing long waits in Frimley Hospitals. Looking at wider system to understand what is happening and what we can do to understand the length of stay, what's happening in the wider system and what we might be able to do to unblock.

Clinical Reference Group –There was some concern of Leadership academy not trying to do too much and focussing and have we done enough focus on what we've done so far and measuring the impact of what we've done.

News: See the latest news on our website: Frimleyhealthandcare@org.uk

New funding to transform community mental health care - People in South West Surrey, North East Hants and East Berkshire who have a severe mental illness are set to benefit from a ground-breaking new community mental health service designed to improve access to a wide range of specialist support.

End of life care - Over the last year, the three CCGs within the Frimley Health and Care Integrated Care System (ICS) have been working closely together to align End of Life Care (EOLC) across the area.

Academy shortlisted for national award - The Frimley Leadership and Improvement Academy, launched to develop and support great leaders across health and social care services across the Frimley Health and Care ICS, has been shortlisted for a prestigious national award. The academy is one of nine entries in the running to be named System Leadership Initiative of the Year at the HSJ Awards 2019. It was selected for its ambition, vision and most importantly for the positive impact its work has had on patient and staff experiences in the health and social care sectors.

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

NHS

NEWS BULLETIN

Buckinghamshire Oxfordshire and Berkshire West Integrated Care System

November 2019

ICS Joins National Population Health Management Programme

BOB ICS has been selected to take part in a national NHS England Population Health Management Development Programme. The invitation follows the very successful participation from Berkshire West in the first wave of the programme, which was delivered over the past year.

The programme aims to accelerate the adoption of Population Health Management techniques at all levels from neighbourhoods and Primary Care Networks to across the ICS footprint.

Population Health Management is an emerging technique to use data to design new models of proactive care and deliver improvements in health and wellbeing, while making best use of the collective resources. It aims to improve physical and mental health outcomes, promote wellbeing and reduce health inequalities across an entire population. This includes focusing on the wider determinants of health – which have a significant impact as only 20% of a person's health outcomes are linked to the ability to access good quality health care – and the crucial role of communities and local people.

In Berkshire West, analysis pinpointed poorer outcomes in their Nepalese community with diabetes and a lack of uptake in the standard NHS offer. Primary Care Networks in the area are now offering longer consultations including group consultations in the evening, with more information about diet and nutrition, and social prescribers are connecting people into community health coaching. This is providing better personalised care to help people to stay well, active and independent.

Dr Dan Alton, GP and Berkshire West CCG Population Health Management Clinical Lead described the benefits of the approach:

"We've developed a system where at every level we have close working to really understand what's happening in our populations, identify cohorts who may need a slightly different approach and try to get under the surface of what's happening in their lives."

Population Health Management will be an important foundation to the work of the ICS to deliver its five year plan and the ambitions of the NHS Long Term Plan – by supporting work to join up care for the increasing number of people with long-term conditions and proactively helping people to stay healthy and avoid complications. By taking part in the national programme, the ICS will be able to accelerate its journey on the path to Population Health Management, it will enable a better understanding our population's needs at both a system and local level, support new ways of working in Primary Care Networks and build our system's analytical capability.

Preparing for Future Population and Economic Growth

The wide range of health and care organisations that make up the Buckinghamshire Oxfordshire and Berkshire West Integrated Care System (BOB ICS) together serve a total of 1.8 million people, with this set to increase in the coming years. At its November meeting, the BOB ICS Systems Leaders Group considered how to harness the opportunities and find solutions to the challenges that future economic and population growth could bring – a strategic priority for the ICS.

The population within the BOB ICS area is one the fastest growing in the country, predicted to increase by over 20% by 2033, particularly amongst the elderly and very elderly population. The overall population is also likely to further increase as the ambition is realised of what is known as the Oxfordshire-Cambridge ARC, which aims to stimulate economic growth, research and business opportunities https://www.gov.uk/government/publications/the-oxford-cambridge-arc-government-ambition-and-joint-declaration-between-government-and-local-partners

The ICS covers an area with a strong infrastructure - there are a number of highly regarded medical schools, universities and biomedical research centres and there is strong investment in research, development and innovation, including over 500 life sciences businesses with major strengths in medical diagnostics and digital innovation. It also faces a number of challenges. For example, many health and care employers experience difficulty in recruiting and retaining staff due to the high cost of living; there is significant house building in some areas of our system but in other locations, building is restricted; population growth will bring increased pressure on services.

Economic and population growth is a key issue for many partners across different scales and geographies and our approach will reflect that, with Local Authorities playing a particularly key role. Many of our relationships will focus on Place, and our Place leaders will continue to build relationships with Local Economic Partnerships (LEPs) and growth boards and other local partners. As BOB ICS Executive Lead, Fiona Wise is spearheading work to ensure close links are established with other ICS/STP leaders within the Oxford/Cambridge ARC area. By working in this way, System Leaders will be able to bring a health and care voice to longer term strategies, such as infrastructure and innovation, and to more immediate work to make sure health and care services, and the way they are delivered are fit for our future population and its needs.

Deadline Approaches for Views to be submitted on Proposals for NHS Commissioning Arrangements

Colleagues and ICS stakeholders have until **midnight on 1st December** to submit their feedback on proposals for future arrangements for NHS commissioning in Buckinghamshire, Oxfordshire and Berkshire West. This first stage of engagement, launched in October, will help inform CCG Governing Body decisions about next steps. To support the engagement process, an engagement document has been produced which outlines proposals for new two ways of working:

- Local working in each of the three counties through Integrated Care Partnerships
- Wider, at-scale working across the three countries through an Integrated Care System

A copy of the engagement document and details of how to respond are available on the BOB website https://bobstp.org.uk/what-is-the-ics/news/posts/2019/october/views-sought-on-the-future-of-nhs-commissioning-arrangements/

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	10 December 2019
Title	Financial Summary Report – M7 2019/20
Purpose	To provide the Month 7 2019/20 financial position to the Trust Board
Business Area	Finance
Author	Chief Financial Officer
Relevant Strategic Objectives	3. - Strategic Goal: To deliver financially sustainable services through efficient provision of clinical & non-clinical services
CQC Registration/Patient Care Impacts	N/A
Resource Impacts	None
Legal Implications	Meeting regulatory requirements
Equalities and Diversity Implications	N/A
SUMMARY	The Financial Summary Report provides the Board with summary of the M7 2019/20 financial position.

ACTION REQUIRED	The Board is invited to note the following summary of financial performance and results for Month 7 2019/20 (October 2019):
	
	The Trust reports to NHS Improvement its 'Use of Resources' rating, which monitors risk monthly, 1 is the highest rating possible and 4 is the lowest.
	
	YTD (Use of Resource) metric:
	• Overall rating 1 (plan 1)
	  ○ Capital Service Cover rating 2
	  ○ Liquidity days rating 1
	  ○ I&E Margin rating 2
	  ○ I&E Variance rating 1

	○ Agency target rating 1 **YTD Income Statement (including PSF Funding; excluding donations):** • Plan: £0.3m surplus • Actual: £0.5m surplus • Variance: £0.1m better than plan. **YTD Cash** £25.4m vs Plan £21.2m. **YTD Capital expenditure:** £5.1m vs Plan £6.6m.

Berkshire Healthcare NHS
NHS Foundation Trust

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

Finance Report

Financial Year 2019/20

Month 7 (October 2019)

Purpose

To provide the Board and Executive with a summary of the Trusts financial performance as at 31st October 2019.

Document Control

Version	*Date*	*Author*	*Comments*
1.0	12/11/19	Bharti Bhoja	1st Draft
2.0	18/11/19	Paul Gray	Final

Distribution

All Directors

All staff needing to see this report.

Contents

1.0 Key Messages

Key Metric	Actual £'m	YTD Plan £'m	Variance £'m	vs Last Mth	vs Prior Year
Surplus / (Deficit) for PSF	(0.7)	(0.7)	0.0	▼	▼
PSF - Trust	0.7	0.6	0.1	▲	▼
PSF - System	0.4	0.4	0.0		
Control Total Surplus / (Deficit)	**0.5**	**0.3**	**0.1**	▲	▼
Statutory Surplus / (Deficit)	0.4	0.3	0.1	▼	▼
CIP Delivery	0.0	0.0	0.0	▼	▼
Agency Spend	3.1	2.9	0.2	▲	▼
OAPs - Specialist Placements (incl LD)	4.7	4.7	(0.0)	▼	▼
OAPs - Out of Area Placements	1.4	1.0	0.5	▼	▼
Capital Expenditure	5.1	6.6	(1.5)	▲	▲
Cash	25.4	21.2	4.2	▲	▲

NHSI Compliance	Actual	Plan
Capital Service Cover	**2**	**2**
Liquidity	**1**	**1**
I&E Margin %	**2**	**2**
I&E Variance From Plan %	**1**	**1**
Agency vs Target	**1**	**1**
Use Of Resources Rating	***1***	***1***

Key Messages & Actions

- The Trust reported for PSF deficit of £0.1m taking the YTD deficit to £0.7m. This is in line with our NHSi plan. After accounting for PSF and donations, the Trust reported a surplus of £0.4m YTD, £0.1m ahead of plan.
- Use of Resources rating is a "1" overall, in line with plan.
- The overall pay bill rose by £0.2m and was £0.4m above plan. The YTD overspend rose to £1.0m after factoring recruitment assumptions.
- Non pay costs fell due to a substantial reduction in Out of Area placement usage in October. Costs would have been lower still, if not for the acuity of the patients placed.
- Cash at the end of period was £4.2m better than planned. Capital slippage and the receipt of PSF bonus payments driving performance.
- Capital expenditure increased, but remains £1.5m behind plan, with current projections indicating a £0.6m under-spend at YE, which continue to be reviewed.

Key Risks

- Our permanent pay costs were the highest this month with no corresponding reduction in temporary staffing; this presents the highest risk remaining within budget this year. Temporary staffing costs must reduce to fund the growth in permanent staffing numbers and to remain within budget overall.

2.0 Income & Expenditure

Income Statement	In Month			YTD			FY	Prior Year YTD		
	Act	Plan	Var	Act	Plan	Var	Plan	Act	Var	
	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	+/-	%
Operating Income	20.2	20.2	(0.0)	141.2	141.5	(0.4)	242.4	133.2	7.9	6.0%
DoH Pay Award	0.0	0.0	0.0	0.3	0.0	0.3	0.0	1.4	(1.1)	(79.2)%
Other Income	1.6	1.6	(0.0)	11.1	11.0	0.1	19.4	11.8	(0.7)	(6.2)%
Total Income	***21.8***	***21.7***	***0.0***	***152.5***	***152.5***	***(0.0)***	***261.7***	***146.4***	***6.1***	***4.2%***
Staff In Post	14.1	13.9	0.3	97.4	98.0	(0.6)	167.5	90.1	7.3	8.1%
Bank Spend	1.2	1.1	0.1	8.9	7.4	1.5	12.8	8.0	0.9	10.6%
Agency Spend	0.4	0.4	0.0	3.1	2.9	0.2	5.0	3.3	(0.2)	(6.2)%
Total Pay	***15.8***	***15.4***	***0.4***	***109.4***	***108.3***	***1.0***	***185.2***	***101.5***	***7.9***	***7.8%***
Purchase of Healthcare:										
- Placement Costs	0.7	0.8	(0.1)	6.2	5.9	0.3	9.8	7.5	(1.4)	(18.2)%
- All Other P. of Healthcare	0.4	0.4	0.0	2.7	2.6	0.2	4.4	2.2	0.5	21.1%
Drugs	0.4	0.6	(0.1)	3.2	3.9	(0.8)	6.7	3.4	(0.3)	(7.7)%
Premises	1.3	1.4	(0.1)	9.5	9.3	0.2	15.1	8.5	0.9	11.0%
Other Non Pay	1.7	1.7	(0.0)	11.5	12.2	(0.8)	21.9	12.0	(0.5)	(4.0)%
PFI Lease	0.5	0.6	(0.0)	3.8	3.9	(0.1)	6.7	3.7	0.1	2.4%
Total Non Pay	***5.1***	***5.4***	***(0.3)***	***36.8***	***37.9***	***(1.0)***	***64.7***	***37.4***	***(0.6)***	***(1.6)%***
Total Operating Costs	***20.8***	***20.8***	***0.0***	***146.2***	***146.2***	***(0.0)***	***249.9***	***138.9***	***7.3***	***5.3%***
EBITDA	***1.0***	***1.0***	***(0.0)***	***6.3***	***6.3***	***0.0***	***11.8***	***7.5***	***(1.2)***	***(15.6)%***
Interest (Net)	0.3	0.3	(0.0)	2.1	2.1	(0.0)	3.6	2.1	0.0	1.4%
Impairments	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(0.0)	(89.1)%
Disposals	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(0.0)	
Depreciation	0.6	0.6	(0.0)	3.8	3.8	0.0	6.6	2.7	1.0	38.8%
PDC	0.2	0.2	0.0	1.2	1.2	0.0	2.0	1.0	0.2	22.6%
Total Finanacing	***1.0***	***1.0***	***(0.0)***	***7.0***	***7.0***	***(0.0)***	***12.3***	***5.7***	***1.3***	***22.2%***
Surplus/ (Deficit) for PSF	***(0.1)***	***(0.1)***	***(0.0)***	***(0.7)***	***(0.7)***	***0.0***	***(0.4)***	***1.8***	***(2.4)***	***(138.6)%***
PSF - Trust	0.1	0.1	0.0	0.7	0.6	0.1	1.4	1.1	**0.1**	**5.0%**
PSF - System	0.1	0.1	0.0	0.4	0.4	0.0	0.9			
PSF - Subtotal	***0.2***	***0.2***	***0.0***	***1.1***	***1.0***	***0.1***	***2.3***	***1.1***	***0.1***	
Surplus/ (Deficit) for CT	***0.2***	***0.2***	***(0.0)***	***0.5***	***0.3***	***0.1***	***1.9***	***2.9***	***(2.4)***	***(83.6)%***
Donated Income	(0.0)	0.0	(0.0)	(0.0)	0.0	(0.0)	0.0	0.0	(0.0)	
Donated Depreciation	(0.0)	(0.0)	(0.0)	(0.0)	(0.1)	(0.0)	(0.1)	0.0	0.1	(322.8)%
Impact of Donations	***0.2***	***0.2***	***(0.0)***	***0.4***	***0.3***	***0.1***	***0.0***	***2.9***	***(2.5)***	***(85.4)%***
Impairments	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(0.0)	(0.0)%
Surplus/ (Deficit) Statutory	***0.2***	***0.2***	***(0.0)***	***0.4***	***0.3***	***0.1***	***1.8***	***2.9***	***(2.5)***	***(85.4)%***

Key Messages

The Trust reported a pre PSF deficit of £0.1m increasing the YTD deficit to £0.7m. After accounting for PSF and the impact of donations, the Trust is reporting a YTD surplus of £0.4m, £0.1m better than planned.

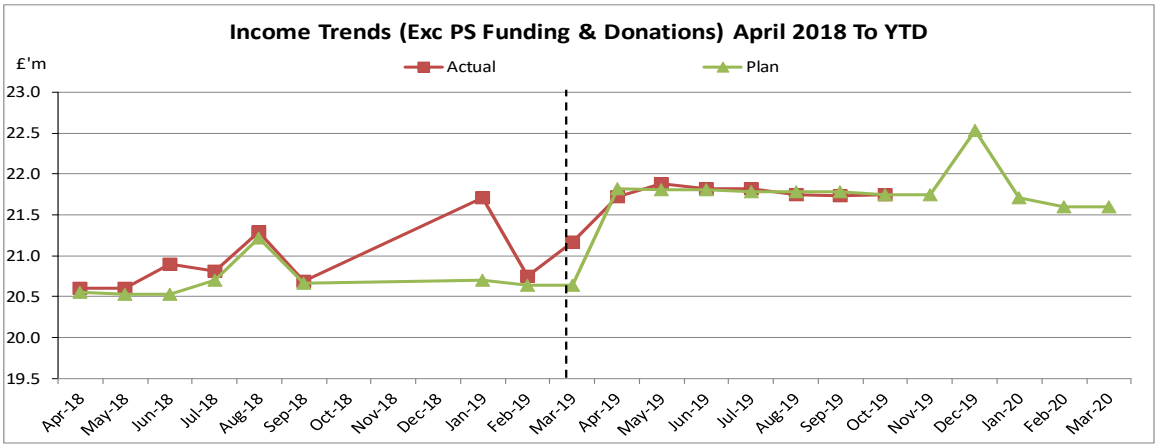
Overall income remains on plan, with shortfalls in Pass-Through income offset by non-recurrent NHSI local authority AfC funding support and small contract variations.

Staff costs increased by £0.2m in October and were £0.4m ahead of plan. The increase in costs is driven by substantive recruitment, with non permanent staffing overall on a par with last month. Whilst the successful recruitment of substantive staff is a huge positive, the overall pay bill is already ahead of our initial forecast which could impact YE delivery and increase the full year pressure moving into 20/21.

Non pay spend reduced and was £0.3m below plan; increasing the YTD underspend to £1.0m. The key reduction this month was in Placement costs, which reflected the low usage of out of area placements during the majority of the month, with average placement number over the month of 3 vs 8 over the past quarter.

Income & Contracts

Income Statement	In Month			YTD			Prior YTD		
	Act	Plan	Var	Act	Plan	Var	Act	Var	
	£'m	£'m	£'m	£'m	£'m	£'m	£'m	+/-	%
Block Income	17.9	17.7	0.1	124.8	124.5	0.3	115.9	8.9	7.7%
Tariff Income	0.2	0.2	0.0	1.2	1.1	0.1	1.6	(0.3)	(22.5)%
Pass Through Income	0.3	0.4	(0.1)	2.1	2.8	(0.7)	2.3	(0.1)	(5.0)%
DoH Pay Award	0.0	0.0	0.0	0.3	0.0	0.3	1.4	(1.1)	(79.2)%
Other Income	3.4	3.4	(0.0)	24.0	24.1	(0.1)	24.7	(0.7)	(2.7)%
Total Operating Income	***21.8***	***21.7***	***0.0***	***152.5***	***152.5***	***(0.1)***	***145.8***	***6.7***	***4.6%***
PSF - Trust	0.1	0.1	0.0	0.7	0.6	0.1	0.7	0.1	85.2%
PSF - System	0.1	0.1	0.0	0.4	0.4	0.0	0.4		
Donated Income	0.0	0.0	(0.0)	0.0	0.0	(0.0)	0.0	(0.0)	
Total Reportable Income	***22.0***	***22.0***	***0.0***	***153.6***	***153.6***	***0.0***	***146.9***	***6.7***	***4.6%***



Income

YTD	£'m
2019/20	152.5
2018/19	145.7
▲	*5%*

Prior Yr	£'m
Oct-19	21.8
Oct-18	20.8
▲	*5%*

Key Messages

Overall income was to plan in month, but is £0.1m behind plan YTD. In month under-recovery of pass through income is off-set by new CCG contract variations for Children's Community Nursing and IAPT Employment Advisors.

Commissioner Focus

Following on from the work undertaken for the recent 5 Year Plan submission, the process has begun to gain early agreement on contract values for 20/21, including where and how growth will be allocated, and expectations of funding from ring-fenced LTP allocations.

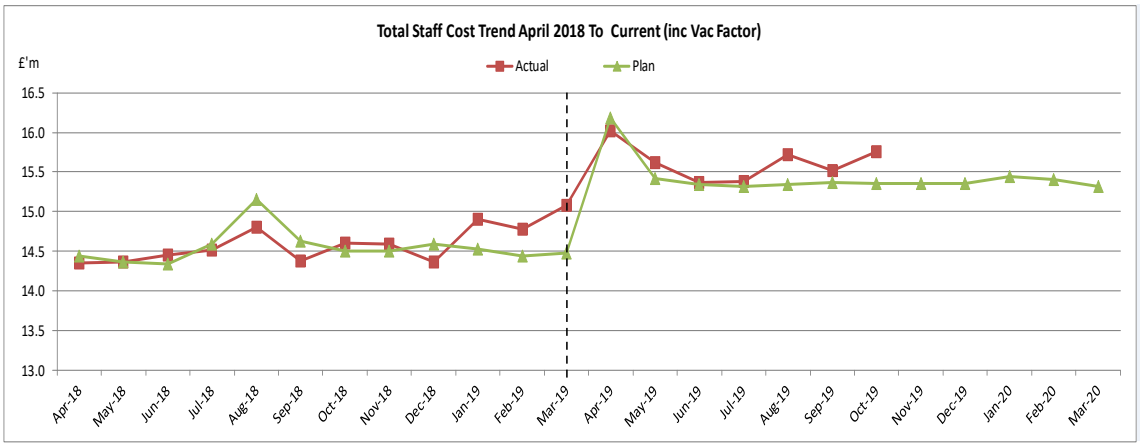
Berkshire West CCG have agreed to fund an expansion for the Community Based Neuro Rehab Team, as a first call on community growth in 20/21. Over the coming months the Trust and CCG will need to agree funding priorities for the coming year. In Frimley we continue to work to agree both in year and future year allocation of the successful joint MH Transformation bid.

System Focus

The ICS 5 Year System plans have been submitted with the Trust forecasting below trajectory deficits over the next two years, before returning to breakeven. Overall the Frimley plan assumes the system as a whole delivery its trajectory, albeit highlighting the risk of delivery of the required efficiencies.

The BOB system plan does not deliver the required trajectory and work is on-going to review opportunities which can be derived to mitigate the current planning gap.

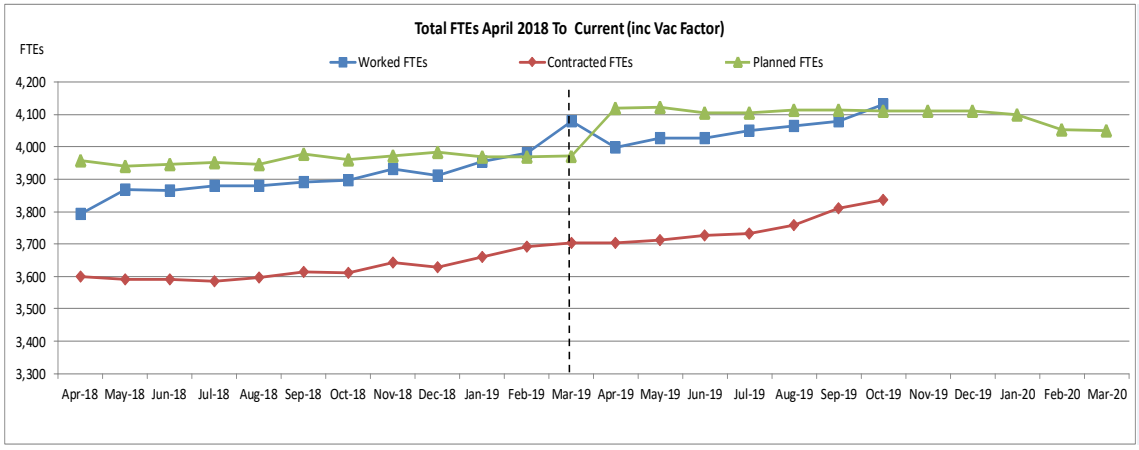
Workforce



Staff Costs

YTD	£'m
2019/20	109.4
2018/19	101.5
▲	8%

Prior Yr	£'m
Oct-19	15.8
Oct-18	14.6
▲	8%



FTEs

Prior Yr	CFTE	WFTE
Oct-19	3,836	4,130
Oct-18	3,611	3,896
	6% ▲	6% ▲

Prior Mth	CFTE	WFTE
Oct-19	3,836	4,130
Sep-19	3,809	4,078
	1% ▲	1% ▲

Key Messages

Overall monthly staff costs increased £0.2m and were £0.4m higher than planned.

The Trust has spent £1.0m more than planned YTD. Following targeted recruitment and retention activity, worked and contracted staff numbers hit a new high, reflecting a 6% increase on 18/19. When combined with non permanent staff usage, the overall level of worked hours in October exceeded planned levels.

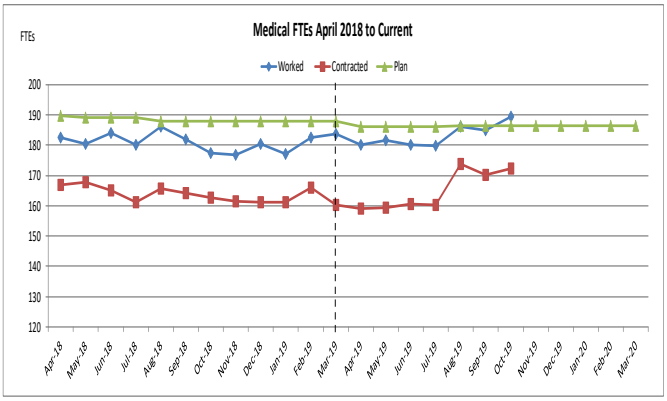
Substantive costs accounted for the £0.2m increase this month, with two thirds of services showing some level of pay increase, and a third reporting both an increase in substantive and non-permanent costs. At a divisional level, only MH IPs reported a reduction in staff costs this month.

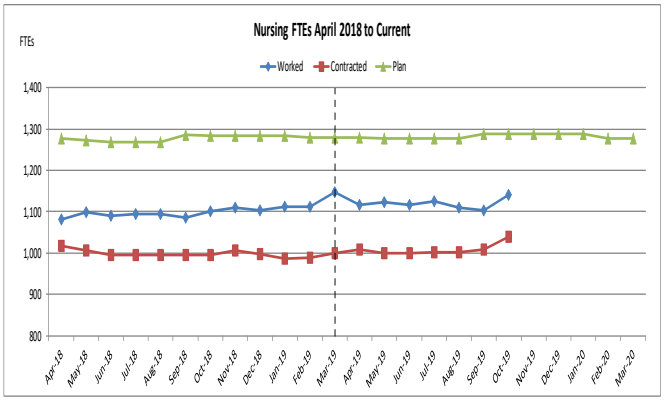
The Trust has seen the cost of Qualified Nursing and Other Clinical Staff increase, with costs £140k and £130k higher respectively. For Nursing, this reflects the impact of trainee and other appointments, with all divisions reporting higher substantive costs, £115k. Of this increase £77k relates to Band 5 Nurses. MH West was the only area reporting a notable reduction in non permanent Nursing spend. As with Nursing, Other Clinical staffing costs have increased across all divisions, with substantive increases of £106k, while at the same time incurring increasing non permanent costs of £22k.

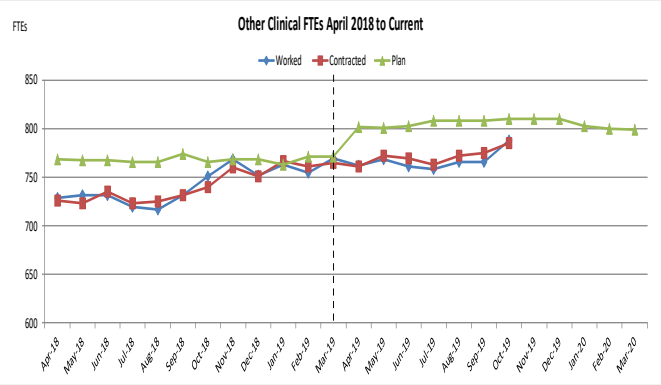
Offsetting these increases, the cost of Clinical Support staff fell by £56k, with reductions in substantive and non permanent numbers. MH IPs accounted for £30k of this reduction, linked to substantive appointments and activity in October.

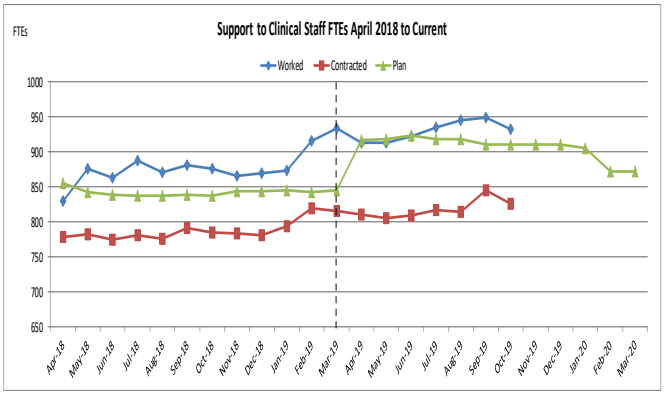
In terms of FTEs, October saw a further increase in contracted number of 27 FTE, which combined with non permanent staff usage resulted in an increase in worked hours the equivalent of 52 FTE.

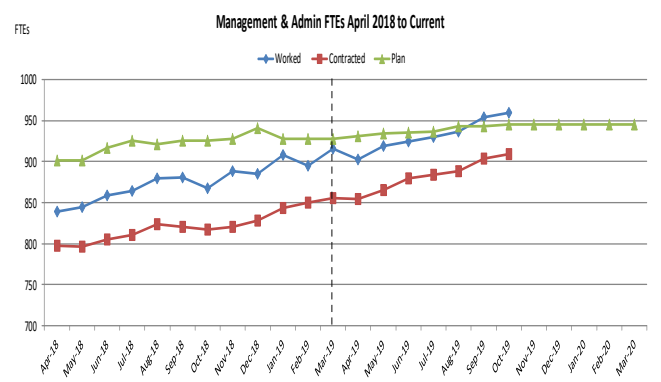
Workforce: Staff Groups

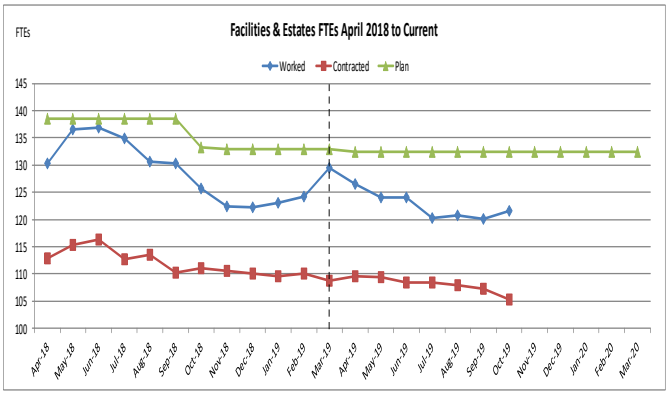












Key Messages

Please note that the above graphs do not include the assumed vacancy factor incorporated into the overall plan.

Medical Staffing saw both worked and contracted FTE increased. Increases include agency medical cover employed within Community Geriatrics and recruitment of doctors in Adult Mental Health and CPE.

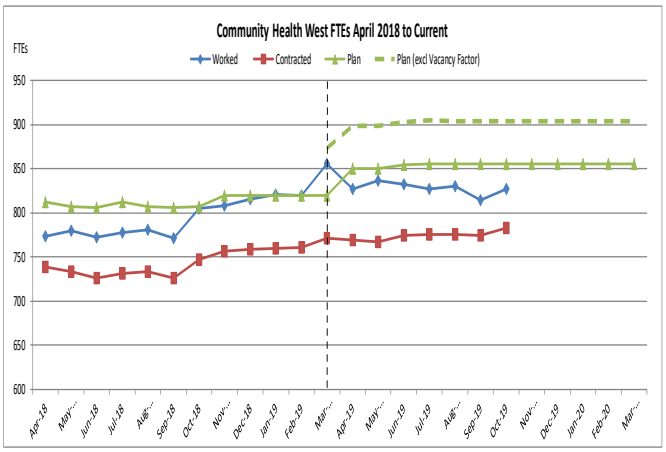
Nursing worked and contracted FTEs reflect the full impact of the trainee intake in September as well as other recruitment.

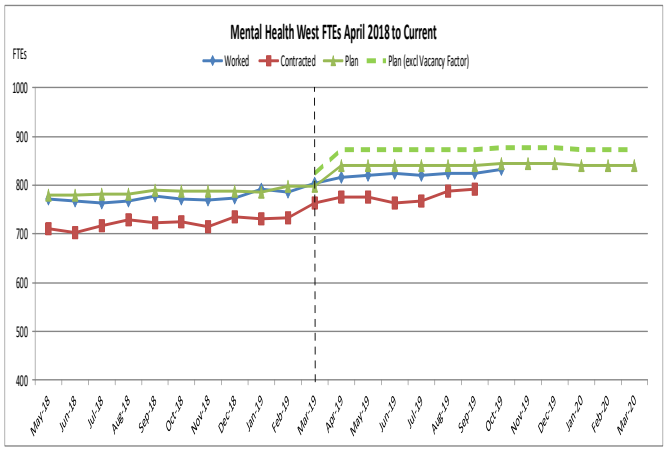
Clinical Support staff numbers and costs fell, with substantive reductions seen in CYPF and MH West and non permanent reductions in MH IPs.

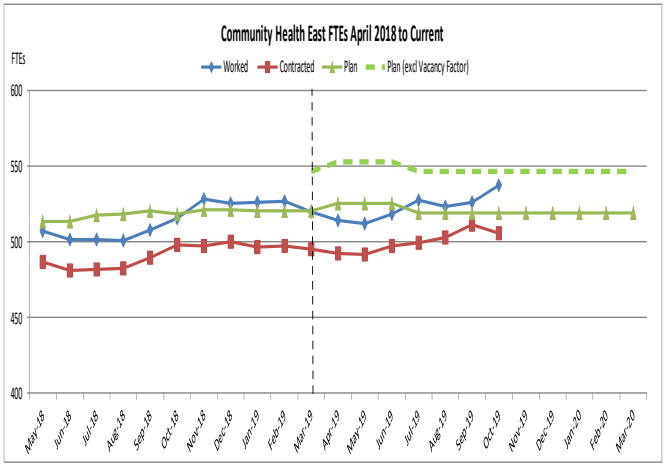
Management & Admin numbers continue to increase with worked hours breaching plan. Increases have been seen in numerous services and corporate areas and includes planned release of capitalised GDE staff back into revenue.

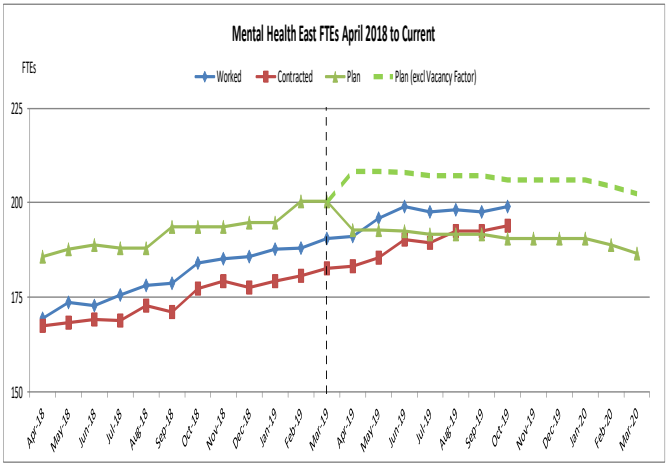
Although Facilities & Estates contracted numbers fell, worked and corresponding costs increased due to higher non-permanent usage.

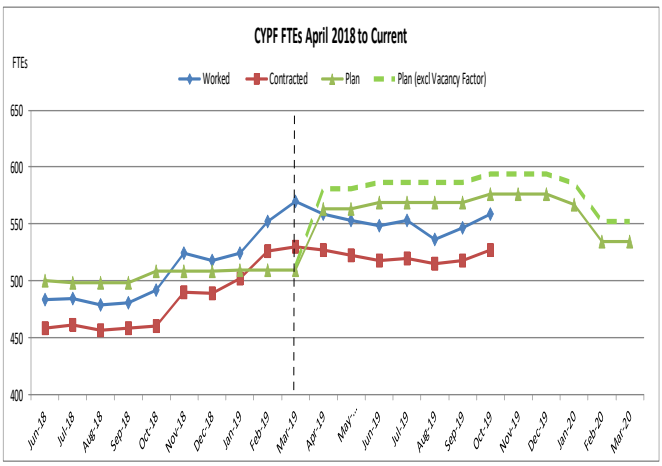
Workforce: Divisional

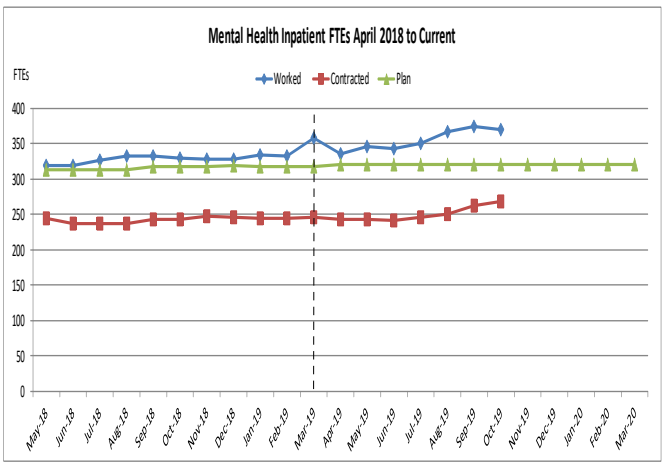


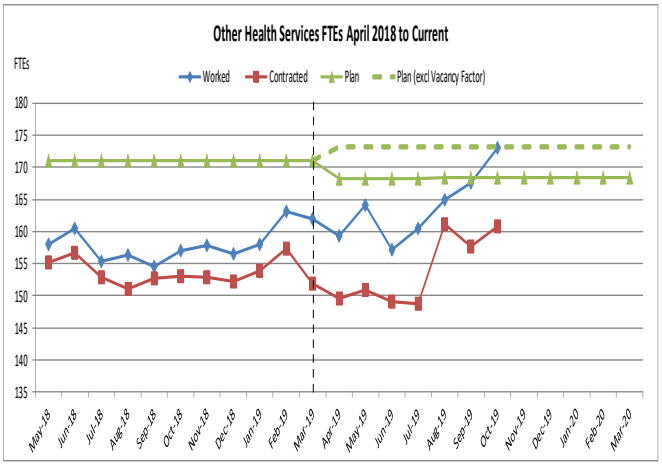


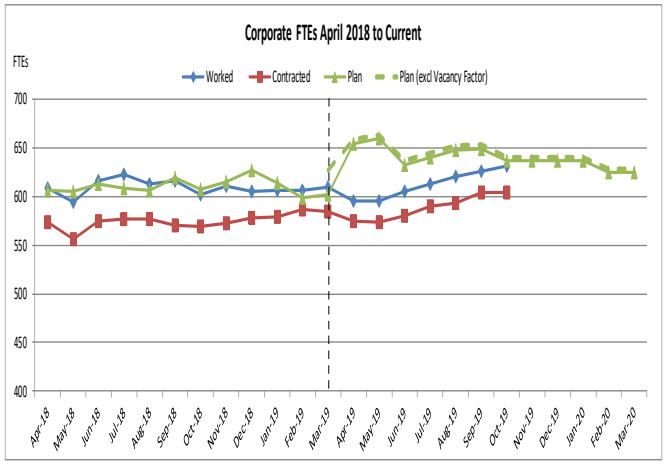




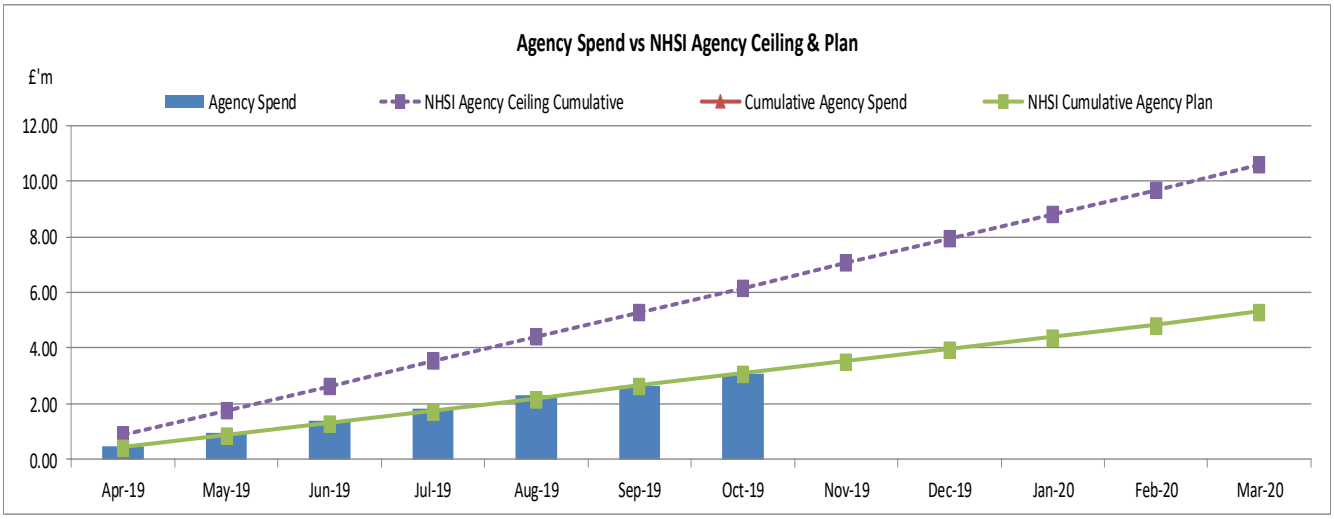


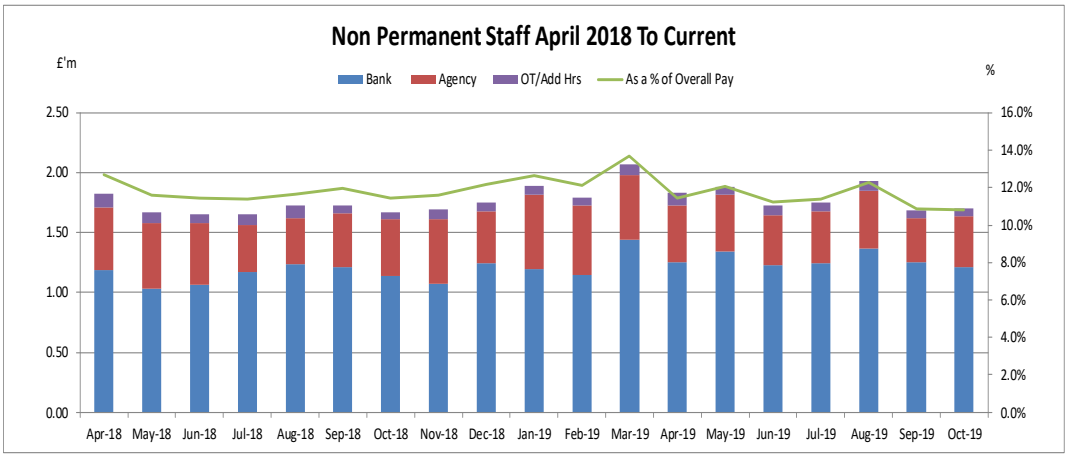






Non Permanent Pay

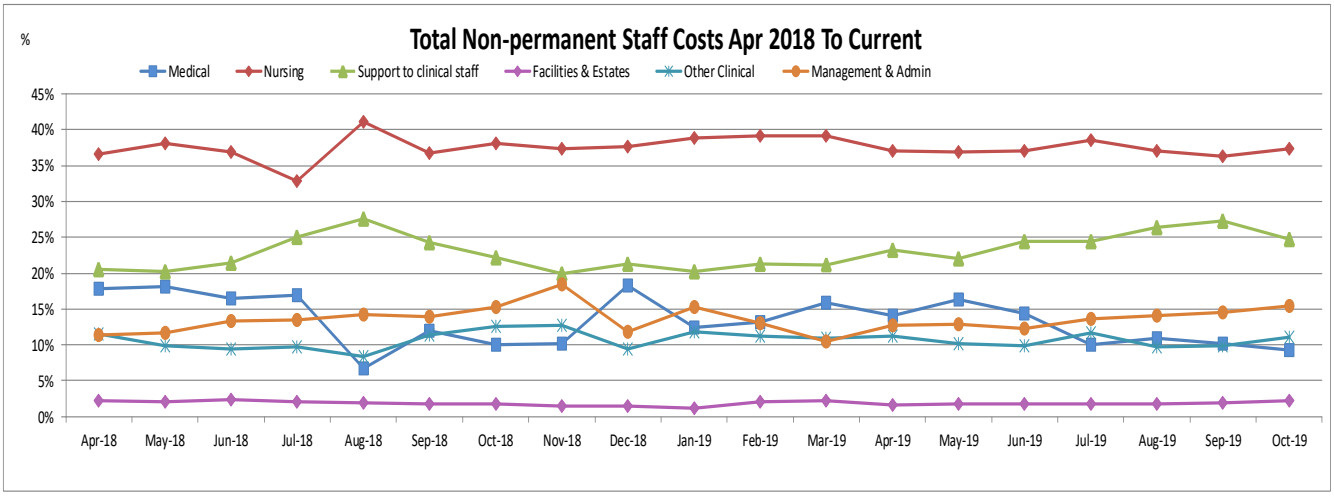




Non Permanent Pay

YTD	Bank	Agency	OT/Add Hrs
2019/20	8.9	3.1	0.5
2018/19	8.0	3.3	0.6
	10% ▲	-7% ▼	-8% ▼

Prior Yr	Bank	Agency	OT/Add Hrs
Oct-19	1.2	0.4	0.1
Oct-18	1.3	0.4	0.1
	-4% ▼	14% ▲	9% ▲



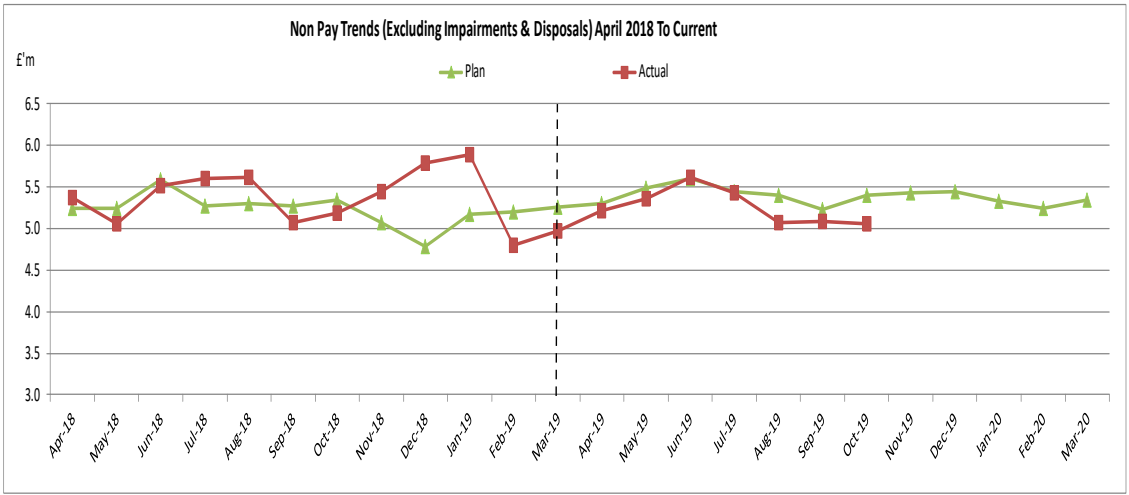
Key Messages

Overall non permanent staffing costs were £1.6m, which is in line with this years average monthly spend if bank holiday payments are excluded.

Overall agency cost increased by £59k offsetting a £44k reduction in bank costs. The reduction in bank expenditure was driven by a fall in usage in Medic grades, £29k, and reduced HCA usages at Prospect Park. Agency costs rose in total across all staffing groups, and in total across all divisions; the only notable reduction being in agency HCAs usage at Prospect Park and within CPE.

Non Pay Expenditure

Non Pay	In Month			YTD			Prior YTD		
	Act £'m	Plan £'m	Var £'m	Act £'m	Plan £'m	Var £'m	Act £'m	Var +/-	Var %
Purchase of Healthcare:									
- Placement Costs	0.7	0.8	0.1	6.2	5.9	(0.3)	7.5	(1.4)	(18.2)%
- All Other P. of Healthcare	0.4	0.4	(0.0)	2.7	2.6	(0.2)	2.2	0.5	21.1%
Drugs	0.4	0.6	(0.1)	3.2	3.9	(0.8)	3.4	(0.3)	(7.7)%
Premises	1.3	1.4	(0.1)	9.5	9.3	0.2	8.5	0.9	11.0%
Supplies and services – clinical	0.4	0.4	(0.0)	2.7	2.9	(0.2)	2.7	(0.0)	(0.5)%
Transport	0.3	0.3	(0.0)	1.9	2.0	(0.2)	1.8	0.1	5.1%
Establishment	0.3	0.3	0.0	1.9	1.8	0.1	2.2	(0.3)	(11.8)%
Other Non Pay	0.7	0.8	(0.0)	5.0	5.5	(0.5)	5.2	(0.3)	(5.6)%
PFI Lease	0.5	0.6	(0.0)	3.8	3.9	(0.1)	3.7	0.1	2.4%
Total Non Pay	**5.1**	**5.4**	**(0.3)**	**36.8**	**37.9**	**(1.0)**	**37.4**	**(0.6)**	**(1.6)%**



Non Pay

YTD	£'m
2019/20	36.8
2018/19	37.4
▼	-2%

Prior Yr	£'m
Oct-19	5.1
Oct-18	5.2
▼	-3%

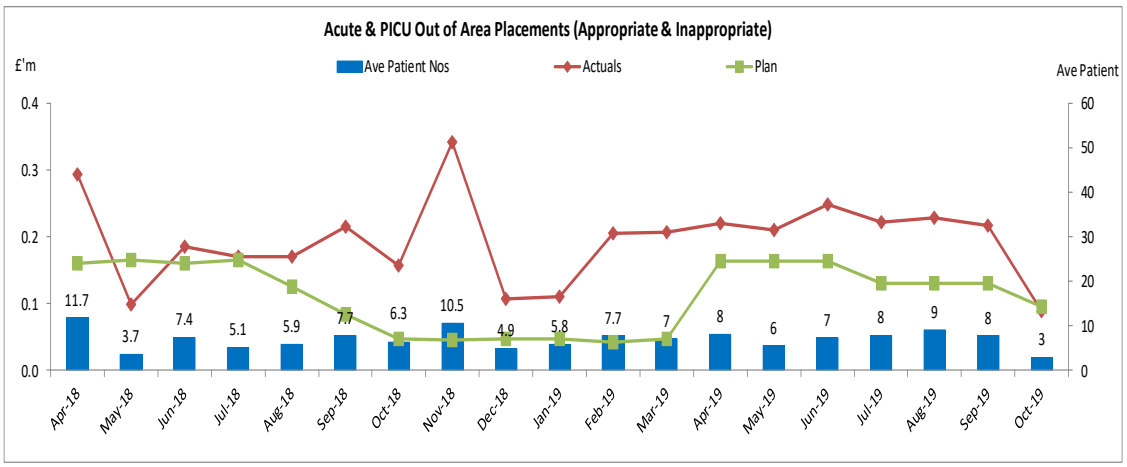
Key Messages

Non Pay costs were £0.3m below plan overall, taking the YTD underspend to £1.0m. Excluding the Drug underspend which is predominantly offset by income under recovery, our YTD costs are £0.2m below plan.

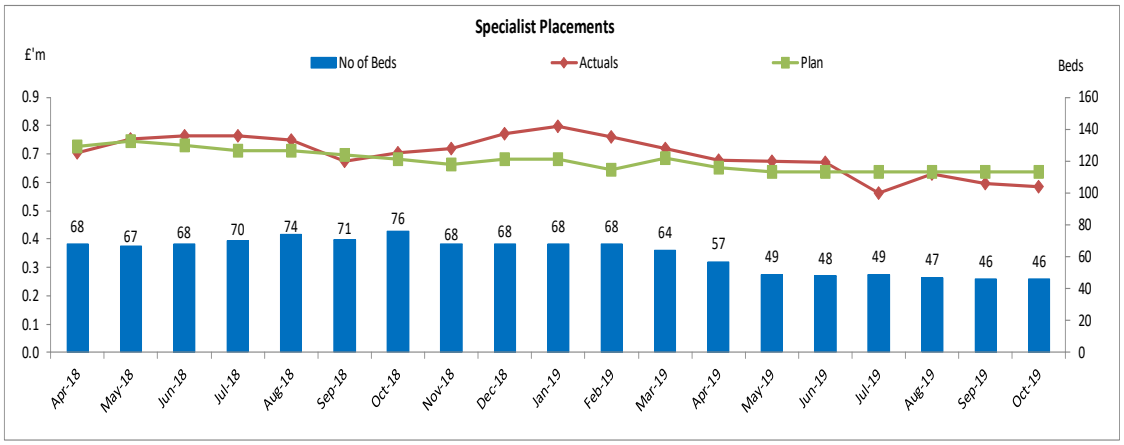
Placement Costs reduced by £0.1m, driven by lower utilisation over the majority of the month. Savings were suppressed due to high patient acuity. In the final week of October and continuing into November, usage has increased with average patient number back closer to an average of 8. This will obviously increase costs in November.

Premises costs, which were higher than planned earlier in the year were £0.1m below plan, continuing the reduced level of spend seen in September.

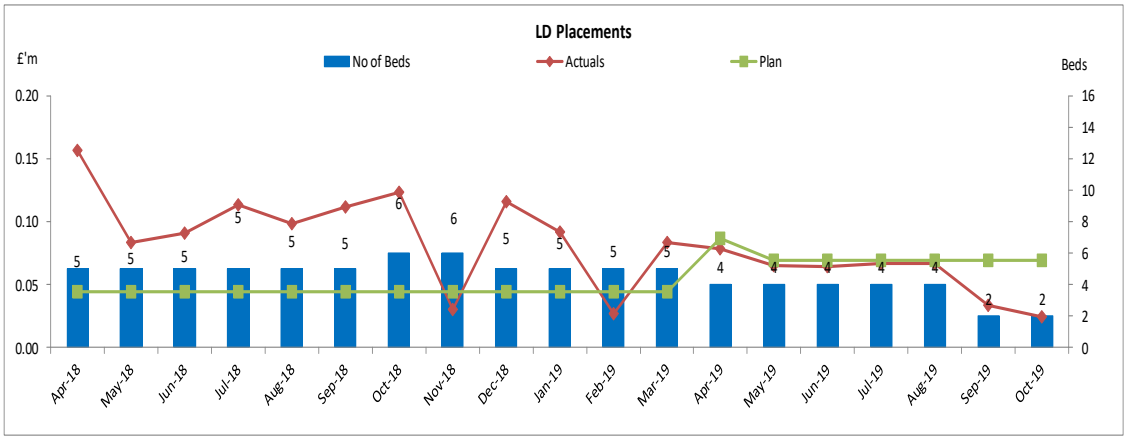
Non Pay Expenditure - Placement Costs



Non Pay	
YTD	£'m
2019/20	1.4
2018/19	1.3
▲	*11%*
Prior Yr	**£'m**
Oct-19	0.1
Oct-18	0.2
▼	*-43%*



Non Pay	
YTD	£'m
2019/20	4.4
2018/19	5.1
▼	*-14%*
Prior Yr	**£'m**
Oct-19	0.6
Oct-18	0.7
▼	*-17%*



Non Pay	
YTD	£'m
2019/20	0.4
2018/19	1.2
▼	*-67%*
Prior Yr	**£'m**
Oct-19	0.0
Oct-18	0.2
▼	*-87%*

Key Messages

Out of Area Placement. The average number of patients out on placement reduced to their lowest levels in October, at 2.9. This has resulted in a reduction in cost of £129k compared to September. Costs would have been lower still except for an appropriately placed patient who incurred a high level of observation costs. Whilst the volume of usage during the first 3 weeks of October were low, usage at the end of the month and into November has returned to previous levels, with resultant costs expected to increase next month.

Specialist Placement costs were £49k below plan as patient numbers in the Cloisters reduced to 12, in line with the number of patients assumed in the re-negotiated contract. YTD costs are £0.7m lower than 18/19.

LD Placement costs were £45k lower than plan in month, £0.1m YTD and £0.4m lower than 18/19 YTD, reflecting the reduction in the number of placements.

3.0 Divisional Summary

Income Statement	In Month			YTD			Full Year			Prior YTD		
	Act	Plan	Var	Act	Plan	Var	Forecast	Plan	Var	Act		Var
	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	+/-	%
Community Health West												
Income	0.3	0.4	(0.1)	2.7	3.0	(0.3)	4.6	5.2	(0.7)	2.9	(0.2)	(7.3)%
Pay	3.0	3.0	0.0	21.1	21.0	0.1	35.8	35.9	(0.1)	19.4	1.7	8.7%
Non Pay	0.5	0.5	(0.0)	3.3	3.5	(0.1)	5.6	5.9	(0.3)	3.2	0.1	2.7%
Net Cost	***3.1***	***3.0***	***0.1***	***21.7***	***21.4***	***0.3***	***36.9***	***36.6***	***(0.3)***	***19.7***	***2.0***	***10.2%***
Mental Health West												
Income	0.2	0.2	0.0	1.1	1.1	(0.0)	1.8	1.9	(0.1)	1.8	(0.7)	(37.5)%
Pay	3.1	3.1	(0.0)	21.7	21.9	(0.2)	37.3	37.5	(0.2)	19.5	2.2	11.1%
Non Pay	0.5	0.5	0.0	3.9	3.6	0.3	6.2	5.8	0.3	4.3	(0.3)	(7.3%)
Net Cost	***3.4***	***3.5***	***(0.1)***	***24.5***	***24.4***	***0.2***	***41.6***	***41.4***	0.2	***22.0***	***2.5***	***11.5%***
Community Health East												
Income	0.1	0.2	(0.1)	1.0	1.3	(0.3)	1.9	2.2	(0.2)	1.7	(0.7)	(41.5)%
Pay	1.9	1.8	0.1	13.3	13.1	0.2	23.0	22.3	0.7	12.3	1.0	7.9%
Non Pay	0.5	0.6	(0.1)	3.4	3.9	(0.5)	5.9	6.6	(0.7)	3.7	(0.3)	(9.1%)
Net Cost	***2.3***	***2.2***	***0.1***	***15.7***	***15.7***	***(0.1)***	***27.0***	***26.8***	0.2	***14.3***	***1.4***	***9.5%***
Mental Health East												
Income	0.1	0.1	(0.0)	0.8	0.9	(0.1)	1.5	1.6	(0.1)	1.0	(0.2)	(16.3)%
Pay	0.8	0.7	0.0	5.2	5.2	0.0	9.1	8.9	0.2	4.6	0.6	13.0%
Non Pay	0.7	0.8	(0.0)	5.2	5.3	(0.1)	8.7	9.0	(0.3)	5.8	(0.6)	(10.6%)
Net Cost	***1.4***	***1.4***	***(0.0)***	***9.6***	***9.6***	***(0.0)***	***16.3***	***16.3***	(0.0)	***9.4***	***0.2***	***1.6%***
CYPF												
Income	0.4	0.3	0.0	2.7	2.4	0.3	4.8	3.9	0.8	1.4	1.3	88.4%
Pay	2.0	2.1	(0.1)	13.7	14.4	(0.7)	23.7	24.6	(0.9)	12.1	1.6	13.5%
Non Pay	0.1	0.1	0.0	1.0	0.9	0.1	1.7	1.6	0.1	1.0	(0.0)	(2.5%)
Net Cost	***1.8***	***1.8***	***(0.1)***	***12.0***	***12.8***	***(0.8)***	***20.7***	***22.3***	(1.6)	***11.6***	***0.3***	***3.0%***
Mental Health Inpatients												
Income	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.1	0.0	0.0	1,081.4%
Pay	1.1	1.0	0.2	7.7	6.8	0.9	13.4	11.6	1.7	6.9	0.8	11.5%
Non Pay	0.1	0.1	0.0	0.6	0.6	0.0	1.0	1.0	0.0	0.5	0.1	10.1%
Net Cost	***1.2***	***1.0***	***0.2***	***8.3***	***7.4***	***0.9***	***14.3***	***12.6***	1.7	***7.5***	***0.8***	***10.9%***
Other Health Services												
Income	0.3	0.3	0.0	1.7	1.8	(0.1)	3.0	3.2	(0.2)	1.4	0.3	21.7%
Pay	1.4	1.3	0.1	9.4	9.4	0.0	16.2	16.1	0.1	8.6	0.8	9.3%
Non Pay	0.2	0.2	(0.0)	1.1	1.2	(0.2)	1.8	2.1	(0.3)	0.8	0.3	36.1%
Net Cost	***1.3***	***1.2***	***0.0***	***8.8***	***8.8***	***(0.0)***	***15.0***	***15.0***	(0.0)	***8.0***	***0.8***	***9.7%***
Corporate												
Income	1.3	1.1	0.1	8.9	8.6	0.3	16.0	15.3	0.7	10.0	(1.1)	(10.5)%
Pay	2.5	2.3	0.2	17.1	16.5	0.7	29.5	28.3	1.2	17.9	0.8	(4.3%)
Non Pay	2.5	2.7	(0.2)	18.4	19.0	(0.6)	31.4	32.6	(1.2)	18.2	(0.2)	1.4%
Net Cost	***3.7***	***3.9***	***(0.2)***	***26.6***	***26.8***	***(0.2)***	***44.9***	***45.5***	(0.6)	***26.1***	***(0.5)***	**2.0%**
Corporate Income & Financing												
Income	19.4	19.3	0.1	134.6	134.3	0.3	231.0	230.7	0.3	126.9	7.8	6.1%
Financing	1.037	1.055	(0.0)	7.1	7.1	(0.0)	12.4	12.4	0.0	5.8	1.3	22.5%
Surplus/ (Deficit) Statutory	***0.2***	***0.2***	***(0.0)***	***0.4***	***0.3***	**0.2**	***1.9***	***1.8***	***0.2***	***2.4***	***(2.0)***	***(82.8)%***

Key Messages

All localities continue to be on or below plan overall with few exceptions.

Community Health West: Pay and income variances relate to discontinuation of ED Streaming Service.

Community Health East: Income and pay variances relate predominantly to Sexual Health costs vs those assumed in the original plan for tender implementation.

Mental Health Inpatients: reflects the recruitment of new staff combined with higher than planned bank and agency cover for sickness and patient observations.

4.0 Cost Improvement Programme

Scheme	In Month			YTD			Full Year		
	Act £'m	Plan £'m	Var £'m	Act £'m	Plan £'m	Var £'m	Forecast £'m	Plan £'m	Var £'m
Placement Projects									
Inappropriate Out of Area Placements	0.06	0.10	(0.04)	0.50	0.40	0.10	0.71	1.00	(0.29)
Long Term Specialist Placement Contracts	0.07	0.09	(0.01)	0.56	0.59	(0.02)	1.01	1.02	(0.01)
Total OAPS Saving	***0.13***	***0.19***	***(0.06)***	***1.06***	***0.99***	***0.07***	***1.72***	***2.02***	***(0.30)***
Operations									
CRHTT	0.00	0.01	(0.01)	0.00	0.06	(0.06)	0.00	0.10	(0.10)
Total Service Line Savings	***0.00***	***0.01***	***(0.01)***	***0.00***	***0.06***	***(0.06)***	***0.00***	***0.10***	***(0.10)***
Procurement									
Procurement Spend	0.01	0.03	(0.03)	0.13	0.15	(0.02)	0.28	0.30	(0.02)
NHS Supply Chain	0.00	0.02	(0.02)	0.02	0.14	(0.12)	0.04	0.25	(0.21)
Medicine Optimisation	0.01	0.00	0.00	0.04	0.03	0.01	0.07	0.05	0.02
Total Procurement Savings	***0.02***	***0.06***	***(0.04)***	***0.20***	***0.32***	***(0.12)***	***0.39***	***0.60***	***(0.21)***
Contracts									
Sexual Health	0.00	0.04	(0.04)	0.00	0.25	(0.25)	0.06	0.43	(0.37)
Liaison & Diversion Hampshire	0.05	0.05	0.00	0.50	0.43	0.06	0.69	0.62	0.07
Veterans	0.01	0.02	(0.01)	0.23	0.19	0.04	0.31	0.27	0.04
Total Other Savings	***0.06***	***0.10***	***(0.04)***	***0.72***	***0.87***	***(0.15)***	***1.06***	***1.32***	***(0.26)***
Total CIP Delivery (NHSi Plan)	***0.21***	***0.35***	***(0.15)***	***1.98***	***2.24***	***(0.25)***	***3.17***	***4.04***	***(0.87)***
Internal Stretch									
Long Term Placements (LD)	0.07	0.03	0.04	0.28	0.13	0.14	0.60	0.30	0.30
Immunisations Technology	(0.02)	0.02	(0.03)	0.15	0.06	0.08	0.17	0.14	0.02
Contract - SLT	0.01	0.01	0.00	0.04	0.04	0.00	0.06	0.06	0.00
Corporate Benchmarking	0.00	0.02	(0.02)	0.00	0.05	(0.05)	0.00	0.15	(0.15)
Temporary Staffing	0.01	0.02	(0.01)	0.09	0.10	(0.01)	0.15	0.20	(0.05)
NHSPS VAT	0.00	0.06	(0.06)	0.00	0.30	(0.30)	0.35	0.62	(0.27)
PFI Benchmarking Review	0.00	0.01	(0.01)	0.00	0.06	(0.06)	0.13	0.13	0.00
Carter - eRoster	0.00	0.02	(0.02)	0.00	0.02	(0.02)	0.00	0.10	(0.10)
New Contract - Community Health West	0.01	0.00	0.01	0.11	0.00	0.11	0.16	0.00	0.16
New Contract - Community Health East	0.00	0.00	0.00	0.01	0.00	0.01	0.03	0.00	0.03
New Contract - Mental Health West	0.00	0.00	0.00	0.00	0.00	0.00	0.03	0.00	0.03
New Contract - CYPF	0.01	0.00	0.01	0.01	0.00	0.01	0.07	0.00	0.07
Unidentified	0.00	0.05	(0.05)	0.00	0.05	(0.05)	0.00	0.30	(0.30)
Total CIP Delivery (Internal Stretch)	***0.09***	***0.24***	***(0.15)***	***0.68***	***0.81***	***(0.13)***	***1.73***	***2.00***	***(0.27)***
Total CIP Delivery	***0.30***	***0.59***	***(0.29)***	***2.66***	***3.05***	***(0.38)***	***4.90***	***6.04***	***(1.14)***

Key Messages

The Trust has delivered £2.7m of savings against a year to date plan of £3.0m.

Following the wider Q2 financial forecast, full year CIP delivery is estimated to be £4.9m. This forecast takes into account the view on Out of area Placements, which is not a continuation of the low levels of usage seen in October and the continuing lower than planned levels of LD placements.

Savings delivered in October were £0.3m, lower than planned. This reflects shortfalls resulting from a Q2 immunisation income reconciliation, £40k, and slippage for Liaison and Diversion £27k. These were offset by an increase for inappropriate out of area beds of £18k.

Supply Chain savings continue to be below planned levels and this has been raised with local and national NHSI finance leads and is an issues mirrored for the majority of providers.

The decision to Opt to Tax has been deferred whilst we await HMRC response to the first tranche of reclaims. As a result the forecast has been amended to assume, at best, the FY impact of properties already opted and only Q4 benefit from the remaining portfolio. A separate paper will be considered at the Trust board in December.

5.0 Balance Sheet & Cash

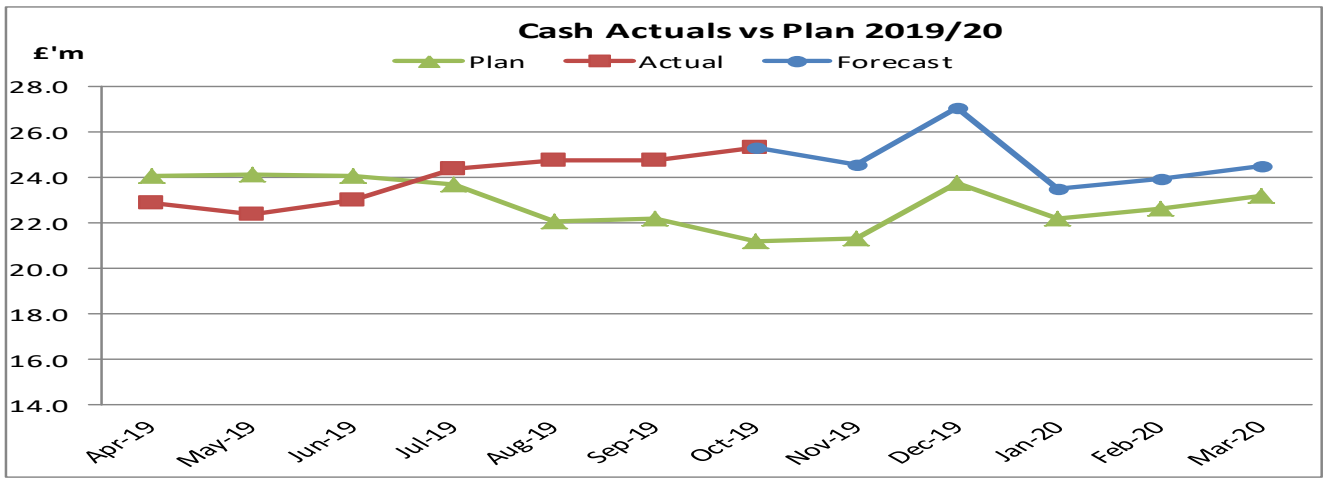
Balance Sheet	18/19 Actual £'m	Current Month Act £'m	Current Month Plan £'m	Current Month Var £'m	YTD Act £'m	YTD Plan £'m	YTD Var £'m	19/20 Plan £'m
Intangibles	5.2	5.8	6.0	(0.2)	5.8	6.0	(0.2)	6.3
Property, Plant & Equipment (non PFI)	37.7	37.8	34.6	3.2	37.8	34.6	3.2	36.4
Property, Plant & Equipment (PFI)	59.8	60.4	65.0	(4.6)	60.4	65.0	(4.6)	65.4
Total Non Current Assets	**102.7**	**103.9**	**105.6**	***(1.6)***	**103.9**	**105.6**	***(1.6)***	**108.1**
Trade Receivables & Accruals	11.8	16.6	10.8	5.8	16.6	10.8	5.8	10.8
Other Receivables	0.2	0.2	0.3	(0.1)	0.2	0.3	(0.1)	0.3
Cash	25.6	25.4	21.2	4.2	25.4	21.2	4.2	23.2
Trade Payables & Accruals	(23.9)	(27.4)	(26.3)	(1.1)	(27.4)	(26.3)	(1.1)	(28.1)
Current PFI Finance Lease	(1.2)	(1.4)	(1.4)	(0.0)	(1.4)	(1.4)	(0.0)	(1.5)
Other Current Payables	(2.7)	(5.3)	(2.3)	(3.1)	(5.3)	(2.3)	(3.1)	(2.3)
Total Net Current Assets / (Liabilities)	**9.6**	**8.0**	**2.3**	***5.7***	**8.0**	**2.3**	***5.7***	**2.4**
Non Current PFI Finance Lease	(28.5)	(27.6)	(27.6)	0.0	(27.6)	(27.6)	0.0	(27.0)
Other Non Current Payables	(1.5)	(1.5)	(1.6)	0.1	(1.5)	(1.6)	0.1	(1.6)
Total Net Assets	***82.4***	***82.8***	***78.7***	***4.2***	***82.8***	***78.7***	***4.2***	***81.9***
Income & Expenditure Reserve	28.1	28.5	25.1	3.4	28.5	25.1	3.4	26.6
Public Dividend Capital Reserve	18.0	18.0	16.5	1.5	18.0	16.5	1.5	18.3
Revaluation Reserve	36.2	36.2	37.0	(0.8)	36.2	37.0	(0.8)	37.0
Total Taxpayers Equity	***82.4***	***82.8***	***78.7***	***4.1***	***82.8***	***78.7***	***4.2***	***81.9***

Cashflow		18/19 Actual £'m	Current Month Act £'m	Current Month Plan £'m	Current Month Var £'m	YTD Act £'m	YTD Plan £'m	YTD Var £'m	19/20 Plan £'m
Operating Surplus/(Deficit)	+/-	11.8	0.6	0.6	(0.0)	3.7	3.5	0.1	7.5
Depreciation and Impairments	+	5.5	0.6	0.6	(0.0)	3.8	3.8	(0.0)	6.8
Operating Cashflow		***17.3***	***1.2***	***1.2***	***(0.0)***	***7.5***	***7.4***	***0.1***	***14.3***
Net Working Capital Movements	***+/-***	***(0.2)***	0.3	(0.2)	***0.4***	***0.0***	***(0.1)***	***0.1***	***(0.1)***
Proceeds from Disposals	+	0.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Donations to fund Capital Assets	+	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Donated Capital Assets	-	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Capital Expenditure (Net of Accruals)	-	(10.3)	(0.4)	(1.7)	1.2	(3.9)	(7.6)	3.7	(11.3)
Investments		***(9.5)***	***(0.4)***	***(1.7)***	***1.2***	***(3.9)***	***(7.6)***	***3.7***	***(11.3)***
PFI Finance Lease Repayment	-	(1.0)	(0.1)	(0.1)	0.0	(0.7)	(0.7)	(0.0)	(1.2)
Net Interest	+/-	(3.6)	(0.2)	(0.3)	0.1	(2.1)	(2.2)	0.1	(3.7)
PDC Revieved	+	2.1	0.0	0.0	0.0	0.0	0.0	0.0	1.7
PDC Dividends Paid	-	(1.7)	(1.1)	0.0	(1.1)	(1.1)	(1.0)	(0.0)	(2.0)
Financing Costs		***(4.3)***	***(1.4)***	***(0.4)***	***(0.9)***	***(3.9)***	***(3.9)***	***0.1***	***(5.2)***
Other Movements	+/-	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Net Cash In/ (Out) Flow		***3.3***	***(0.3)***	***(1.0)***	***0.7***	***(0.2)***	***(4.3)***	***4.0***	***(2.3)***
Opening Cash		22.3	25.7	22.2	3.5	25.6	25.6	0.0	25.6
Closing Cash		***25.6***	***25.4***	***21.2***	***4.2***	***25.4***	***21.2***	***4.2***	***23.2***

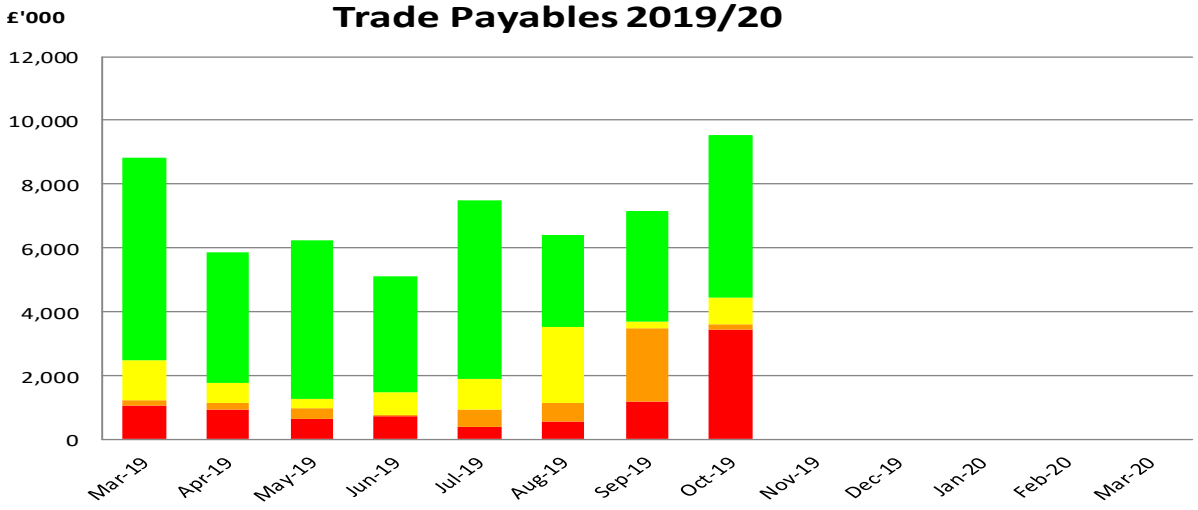
Key Messages

The cash balance at the end October was £25.4m, £4.2m above the plan.

Cash is higher than plan following the receipt of £2.1m unplanned PSF bonus from the end of 18/19. In addition, slippage and capital expenditure plan re-phasing has resulted in less cash being spent. This benefit is being partially offset by weaker working capital balances including unpaid invoices from NHSPS.



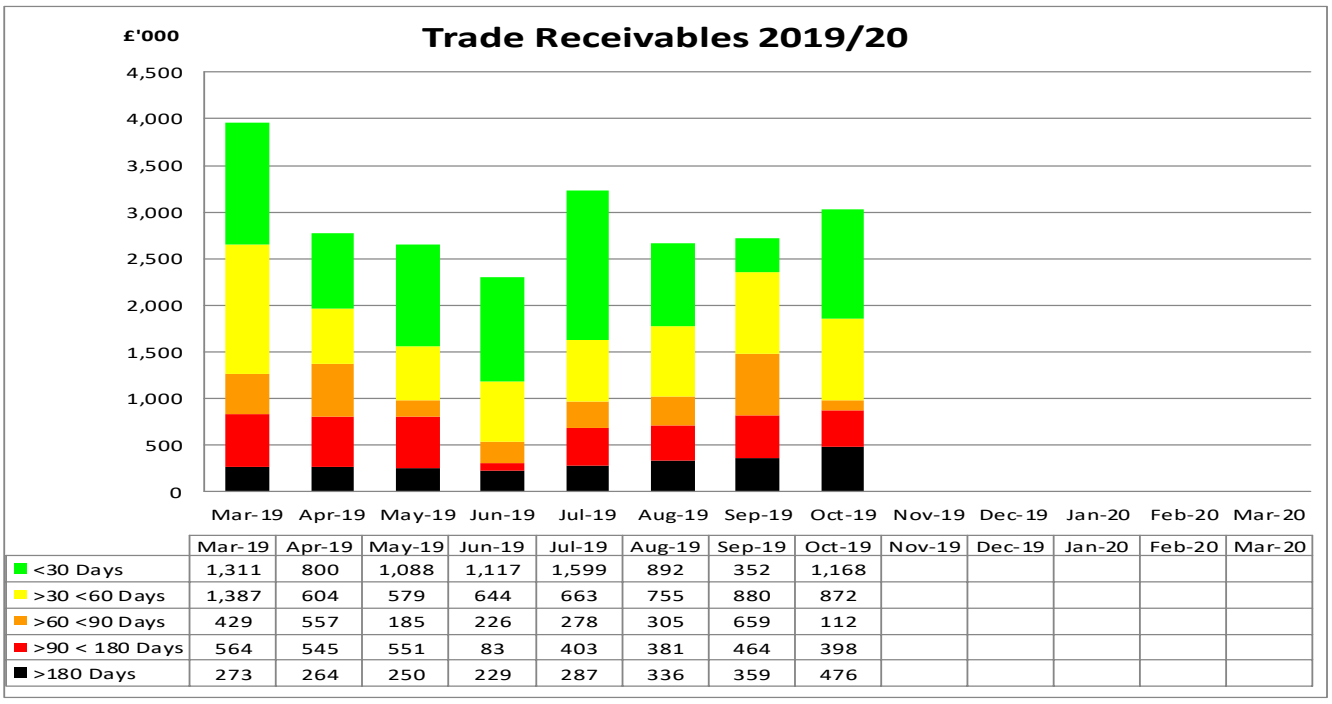
Cash Management



	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
<30 Days	6,353	4,086	4,962	3,621	5,590	2,894	3,481	5,124					
>30 <60 Days	1,242	593	299	700	952	2,372	191	804					
>60 <90 Days	177	231	305	73	530	584	2,310	183					
>90 days	1,047	933	653	706	406	562	1,173	3,443					

Key Message

Payables due >30 days increased by £0.8m. NHSPS debt of £3.1m remains unpaid and continues to age, accounting for the movements in the over 90 day debt. We have engaged once again with NHSPS in an effort to clear the outstanding balances of both parties, with the agreement reached as to the actions required to facilitate payments.



	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
<30 Days	1,311	800	1,088	1,117	1,599	892	352	1,168					
>30 <60 Days	1,387	604	579	644	663	755	880	872					
>60 <90 Days	429	557	185	226	278	305	659	112					
>90 < 180 Days	564	545	551	83	403	381	464	398					
>180 Days	273	264	250	229	287	336	359	476					

Key Message

Receivables balances increased by £0.3m. Debt >30days fell due to the settlement of £0.9m of debt from the RBH, reducing their old debt to £0.1m. The largest remaining balances remaining over 60 days are with NHS PS (£0.2m), Reading Borough Council (£0.1m), University of Reading (£0.1m) and combined remaining CCG debt of £0.3m. We are continuing to engage with these customers to clear these aged balances.

6.0 Capital Programme

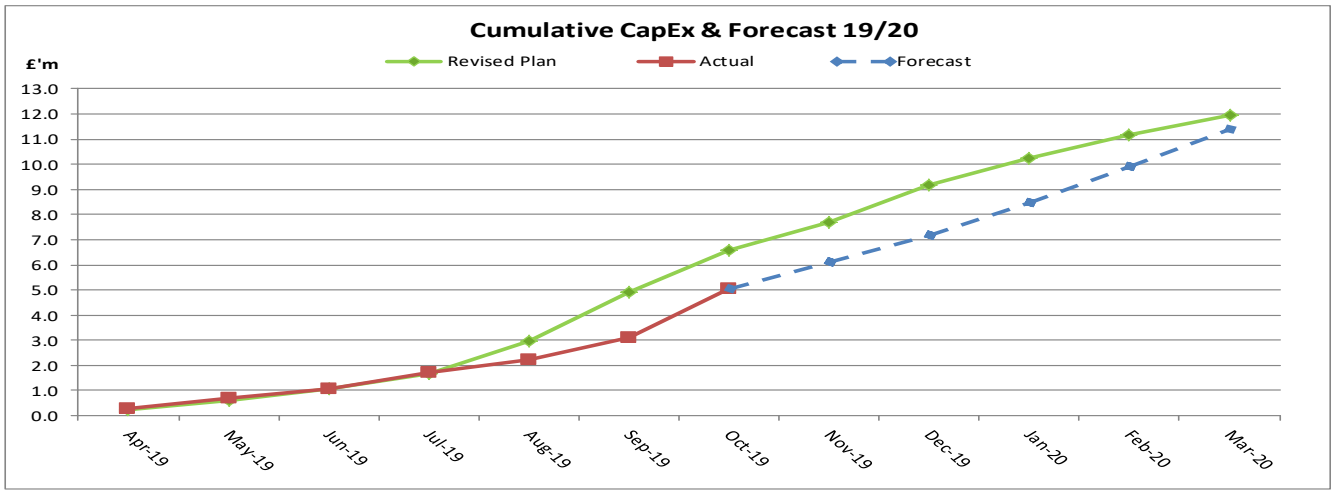
Schemes	Current Month			Year to Date			FY
	Actual £'000	Plan £'000	Variance £'000	Actual £'000	Plan £'000	Variance £'000	Plan £'000
Estates Maintenance & Replacement Expenditure							
STC Phase 3/Erlegh House	168	415	(247)	685	1,431	(746)	3,200
LD to Jasmine	1	0	1	8	5	3	1,533
Abel Gardens - Mobility Relocation	76	184	(108)	254	394	(140)	388
PPH Ligature Removal Works	13	20	(7)	254	250	4	250
PPH Willow House	(32)	0	(32)	181	0	181	0
Trust Owned Properties	(0)	0	(0)	123	135	(12)	147
Leased Non Commercial (NHSPS)	88	99	(11)	292	367	(75)	382
Leased Commercial	0	0	0	2	0	2	0
Statutory Compliance	1	2	(1)	5	37	(32)	200
PFI	0	125	(125)	2	289	(287)	580
Subtotal Estates Maintenance & Replacement	**315**	**845**	**(529)**	**1,805**	**2,908**	**(1,102)**	**6,680**
IM&T Expenditure							
IM&T Business Intelligence and Reporting	0	0	0	33	40	(7)	320
IM&T System & Network Developments	1,427	660	767	1,661	2,255	(594)	2,415
IM&T Other	0	0	0	14	0	14	30
IM&T Locality Schemes	50	0	50	232	15	217	55
HSLI Community Mobile Working	16	20	(4)	150	84	66	239
HSLI Bed Management	0	0	0	0	0	0	0
HSLI Ward Digitalisation	0	0	0	0	0	0	0
Subtotal IM&T Expenditure	**1,494**	**680**	**814**	**2,089**	**2,394**	**(305)**	**3,059**
GDE Expenditure							
GDE Trust Funded	0	0	0	795	795	0	795
GDE Trust Funded	158	166	0	255	429	(175)	1,258
Subtotal GDE Expenditure	**158**	**166**	**0**	**1,050**	**1,224**	**(175)**	**2,053**
Other Locality Schemes	0	0	0	119	65	54	150
Total Capital Expenditure	**1,967**	**1,690**	**284**	**5,064**	**6,591**	**(1,527)**	**11,942**

Key Message

The Trust has spend £5.1m on CapEx YTD, £1.5m less than anticipated.

Slippage on Estates projects represents £1.1m, the majority of which relates to Phase 3 of Erlegh House. This project is still expected to complete by end of March with spend expected to be incurred in Q3/Q4. The table above included up-front fees associated with the development of the STP Funded CAMHS Tier 4 business case which will be recouped once the case is agreed.

IM&T expenditure increased with orders placed for replacement kit. There remains £0.3m of slippage on the purchase of replacement mobile equipment , now planned for November. GDE expenditure is behind plan and it is anticipated that some project spend may run into early 20/21.



Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper - Public

Board Meeting Date	10th December 2019
Title	**True North Performance Scorecard** **Month 7 (October 2019) 2019/20**
Purpose	To provide the Board with the new True North Performance Scorecard, aligning divisional driver metric focus to corporate level (Executive and Board) improvement accountability against our True North ambitions, and QI break through objectives for 2019/20.
Business Area	Trust-wide Performance
Author	Deputy Chief Executive and Chief Financial Officer
Relevant Strategic Objectives	2 - To provide safe, clinically effective services that meet the assessed needs of patients, improve their experience and outcome of care and consistently meet or exceed the standards of CQC and other stakeholders.
CQC Registration/Patient Care Impacts	All relevant essential standards of care.
Resource Impacts	None.
Legal Implications	None.
Equality and Diversity Implications	None.
Summary	The new True North Performance Scorecard for Month 7 2019/20 (October 2019) is included. Individual metric review is subject to a set of clearly defined “business rules” covering how metrics should be considered dependent on their classification for driver improvement focus, and how performance will therefore be managed. The business rules apply to three different categories

	of metric: • **Driver metric**: the few key improvement drivers with target performance and will be the focus of meeting attention. • **Tracker Level 1 metric**: no attention required if within set threshold for the period. Threshold performance usually defined by regulator / external body and relates to "must do" national standards or areas of focus. Update required if threshold performance is missed in one month. • **Tracker metric**: no attention required unless performance is deteriorating from threshold for a defined period (over four months). Threshold set internally, where sustained underperformance will trigger a review of threshold level or need to switch to a driver metric dependent on capacity. **Month 7** **2019/20 business rule exceptions, red rated with the True North domain in brackets:** **Driver Metrics** Context and update to driver performance to be provided in discussion of counter measure action and development: • Self-harm incidents **(Harm-free care)** – revised reduced target based on review. • Patient FFT Recommend rate **(Patient Experience)** • Patient FFT Response rate **(Patient Experience)** • Mental Health Clustering **(Patient Experience) –** recently moved to driver section. Problem statement, A3 and counter measures being developed. Further detail of highest contributors shared with Operational teams. • Physical Assaults on staff – **(Supporting our Staff)** • Mental Health Acute Occupancy Rate (excluding home leave) - **(Money Matters) -** QI Project in development, linked to the Length of Stay Project. • Mental Health Acute Average Length of Stay **(Money Matters) -** QI Project in development using Get It Right First Time (GIRFT) methodology. **Tracker Level 1 Metrics** • Ensure that Cardio Metabolic assessment and treatment for people with psychosis is delivered

	routinely in inpatient wards **(Regulatory Compliance)** – it was agreed to defer the review of this metric until the output of a Rapid Improvement Event in December, where more meaningful metrics would be defined. No longer part of the Oversight Framework or Quality Schedule. • Ensure that Cardio Metabolic assessment and treatment for people with psychosis is delivered routinely in EIP **(Regulatory Compliance)** – as above • Ensure that Cardio Metabolic assessment and treatment for people with psychosis is delivered routinely in the Audit of Community Health Services (people on CPA) **(Regulatory Compliance)** – as above • Sickness Rate **(Regulatory Compliance)** – this is not a compliance focus with NHSI but is tracked. **Tracker Metrics** • Uptake of at least one patient outcome measure (ReQoL) in adult Mental Health for new referrals from April 2019 **(Harm-free care)** – it was agreed to review this indicator in January 2020, as is a new process. • Statutory Training – Fire **(Supporting Our Staff)** – the Executive have agreed to hold this as a tracker as it is so close to the target. • Statutory Training – Information Governance **(Supporting Our Staff) –** the Executive have agreed to hold this as a tracker as it is so close to the target. • Community: Delayed Transfers of Care (NHSI target) Monthly and Quarterly **(Money Matters)** – target to be reviewed at system meeting before action taken.
Action	The Board is asked to note the new True North Scorecard and provide feedback to support development.

True North Performance Scorecard – Business Rules & Definitions

The following metrics are defined as and associated business rules applied to the True North Performance Scorecard:

Driver - True North / break through objective that has been prioritised by the organisation as its area of focus	**Tracker Level 1-** metrics that have an impact due to regulatory compliance	**Tracker -** important metrics that require oversight but not focus at this stage in our performance methodology

Rule #	Metric	Business Rule	Meeting Action
1	**Driver** is **Green** in current reporting period	Share success and move on	**No action** required
2	**Driver** is **Red** in current reporting period	Share top **contributing reason**, the amount this contributor impacts the metric, and **summary of initial action(s)** being taken	Standard structured **verbal** update
3	**Driver** is **Red** for **2+** reporting periods	Produce full structured **countermeasure summary**	Present full written **countermeasure analysis and summary**
4	**Driver** is **Green** for **6** reporting periods	Retire to **Tracker** level status	Standard structured **verbal** update and retire to **Tracker**
5	**Tracker 1 (or Tracker)** is **Green** in current reporting period	**No action** required	**No action** required
6	**Tracker** is **Red** in current reporting period	Note metric performance and move on unless they are a **Tracker Level 1**	If **Tracker Level 1,** then structured **verbal** update
7	**Tracker** is **Red** for **4** reporting periods	Switch to **Driver** metric	Switch and replace to **Driver** metric (decide on how to make capacity i.e. which **Driver** can be a **Tracker**)

Performance Scorecard - True North Drivers (October 2019)

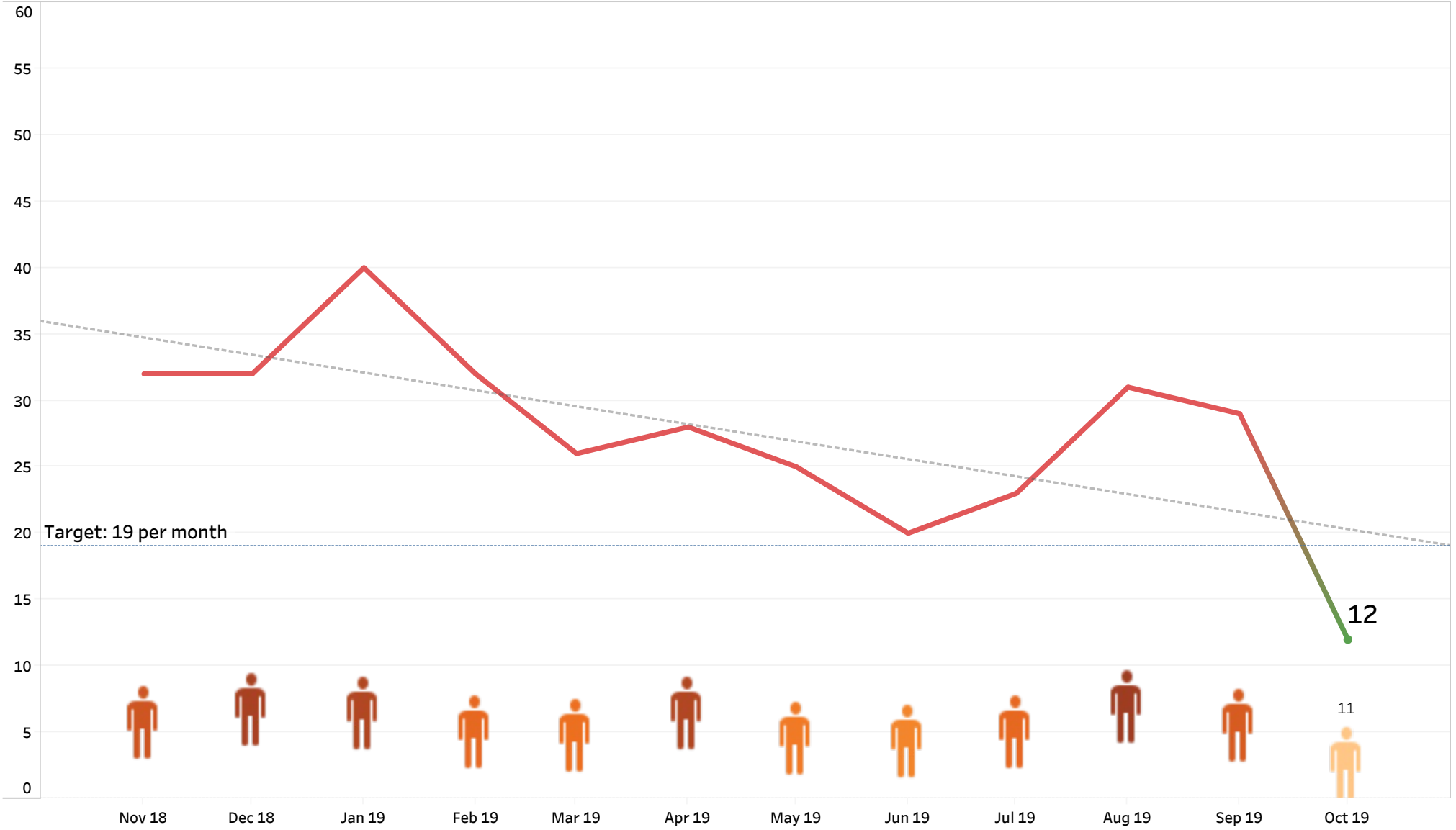
Metric	Target	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19
Harm Free Care												
Falls incidents in Community & Older Adult Mental Health Inpatient Wards	19 per month	39	47	41	36	32	26	22	28	35	33	12
Self-Harm Incidents on Mental Health Inpatient Wards (excluding LD)	42 per month	74	40	36	40	35	94	71	44	20	23	48
Pressure ulcers acquired at BHFT due to lapse in care - Grade 3 & 4 (Cumulative YTD)	<18 per year	0	3	0	0	3	4	6	6	6	6	6
Medication errors (moderate patient impact and above)	5 in a year		0	0	0	0	0	0	0	0	0	0
Number of suicides (per month)	Equal to or less than 3 per month	3	1	2	2	3	2	2	2	2	0	4
Gram Negative Bacteraemia	1 per ward per year					0	1	0	0	0	0	0
Patient Experience												
Mental Health: Prone (Face Down) Restraint	2 per month	11	7	3	3	2	2	3	6	13	5	2
Patient FFT Recommend Rate: %	95% compliance	94%	94%	92%	89.7%	93%	92.2%	90.6%	92.4%	91.7%	94.1%	93.2%
Patient FTT response rate: %	15% compliance	27.7%	21%	25.1%	20%	11%	12.5%	12.4%	12%	9.15%	10.9%	14.6%
Mental Health Clustering within target: %	90% compliance	82.8%	79.2%	78.0%	78.7%	80.2%	79.3%	78.9%	77.7%	80.5%	80%	81.3%

Performance Scorecard - True North Drivers (October 2019)

Metric	Target	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19
Supporting our Staff												
Physical Assaults on Staff	44 per month	32	38	27	18	34	38	56	36	50	56	49
Staff Engagement Score (Annual Staff Survey)	Score of 4				3.93	3.93	3.93	3.93	3.93	3.93	3.93	3.93
Money Matters												
CIP target (£k): (Cumulative YTD)	£4m (annual)					£0.25M	£0.46M	£1.17M	£1.63M	£2.02M	£2.36M	£2.66M
Financial surplus £k (excl. STF): (Cumulative YTD)	-£0.4m					£0.49M	£0.56M	£0.70M	£0.70M	£0.76M	£0.60M	£0.68M
Mental Health: Acute Occupancy rate (excluding Home Leave): %	85% Occupancy	93.5%	97.5%	98.5%	93.3%	95.9%	94.5%	97.8%	98.7%	97.0%	95.7%	94.4%
Mental Health: Acute Average Length of Stay (bed days)	30 days	47	43	39	41	37	39	36	38	41	42	45
Staff turnover: %	<16% per month	17.1%	17.1%	17.1%	17.5%	17.4%	17.1%	16.7%	16.3%	16.1%	15.8%	
Inappropriate Out of Area Placements	386 bed days (cumulative for Qtr)	152	150	323	467	136	207	288	109	266	412	29

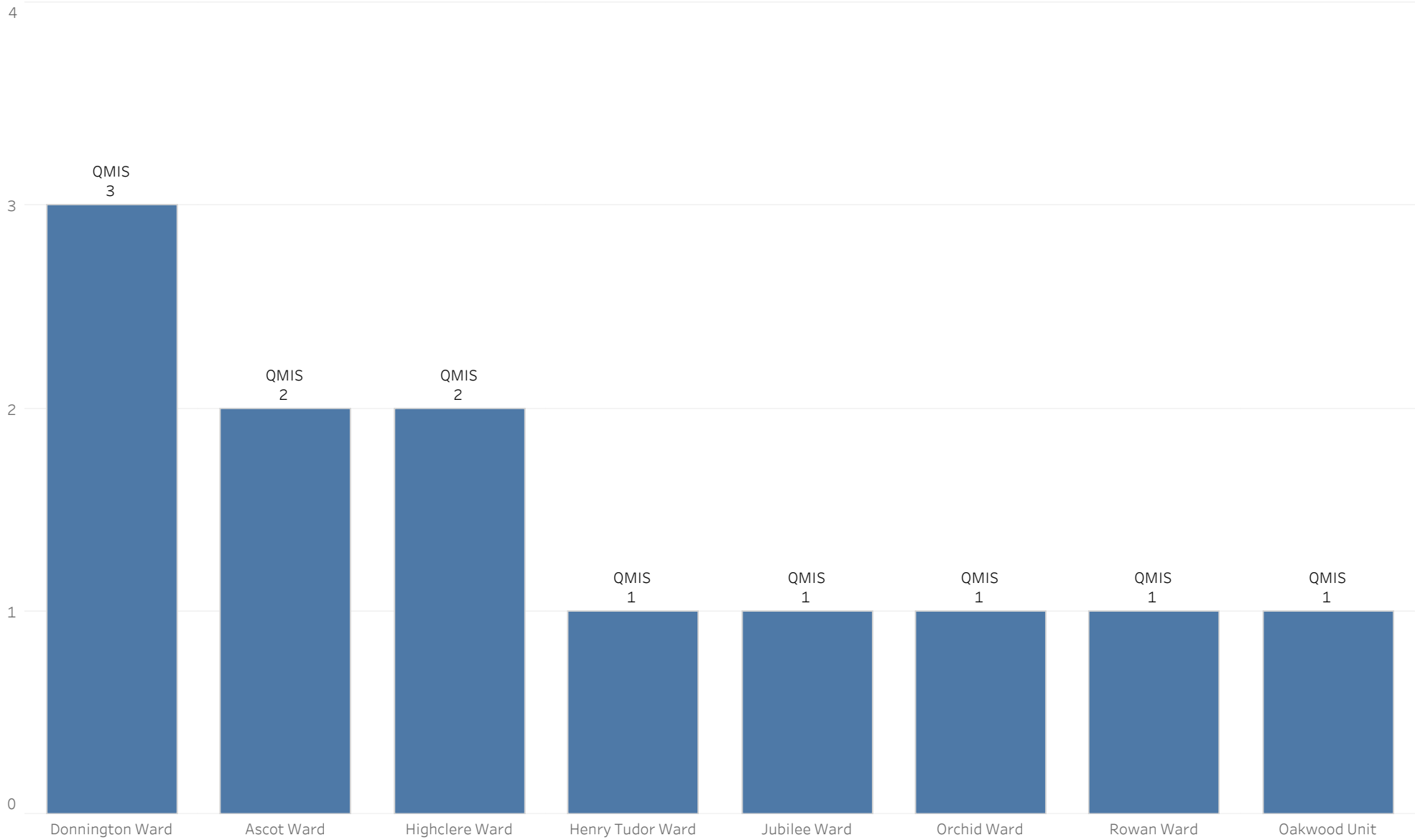
Harm Free Care Driver: Fall incidents in Community & Older Adult Mental Health Inpatient Wards (Nov 18 to Oct 19)

Any incident (all approval statuses) where sub-category = fall from chair/bed, level surface, found on floor/unwitnessed fall, Location exact excluding Patient/staff home and incident type = patient



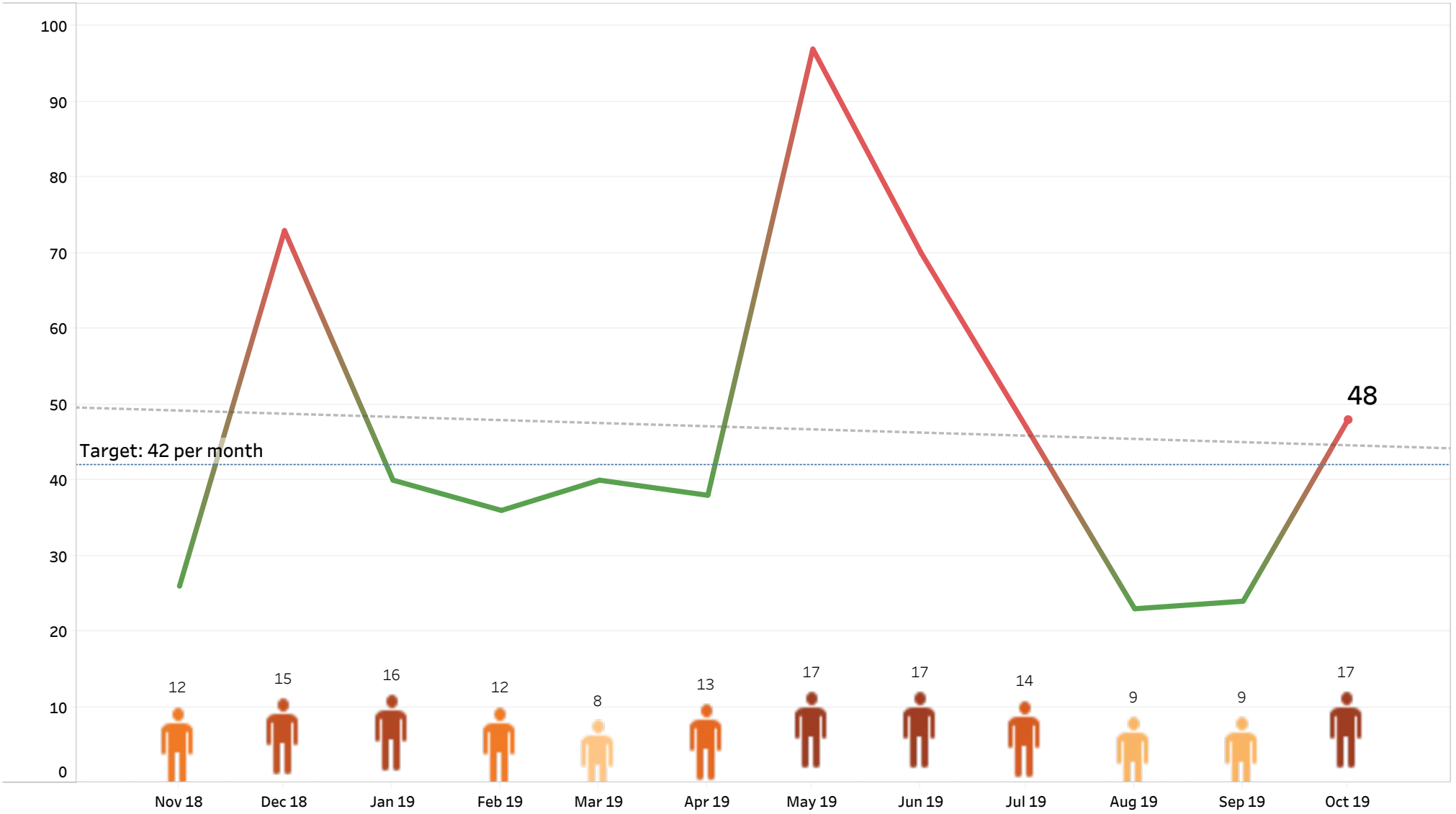
Harm Free Care Driver: Fall incidents in Community and Older Adult Mental Health Inpatient Wards (October)

* QMIS above the bar indicates that the ward / unit are focussing on this particular driver metric



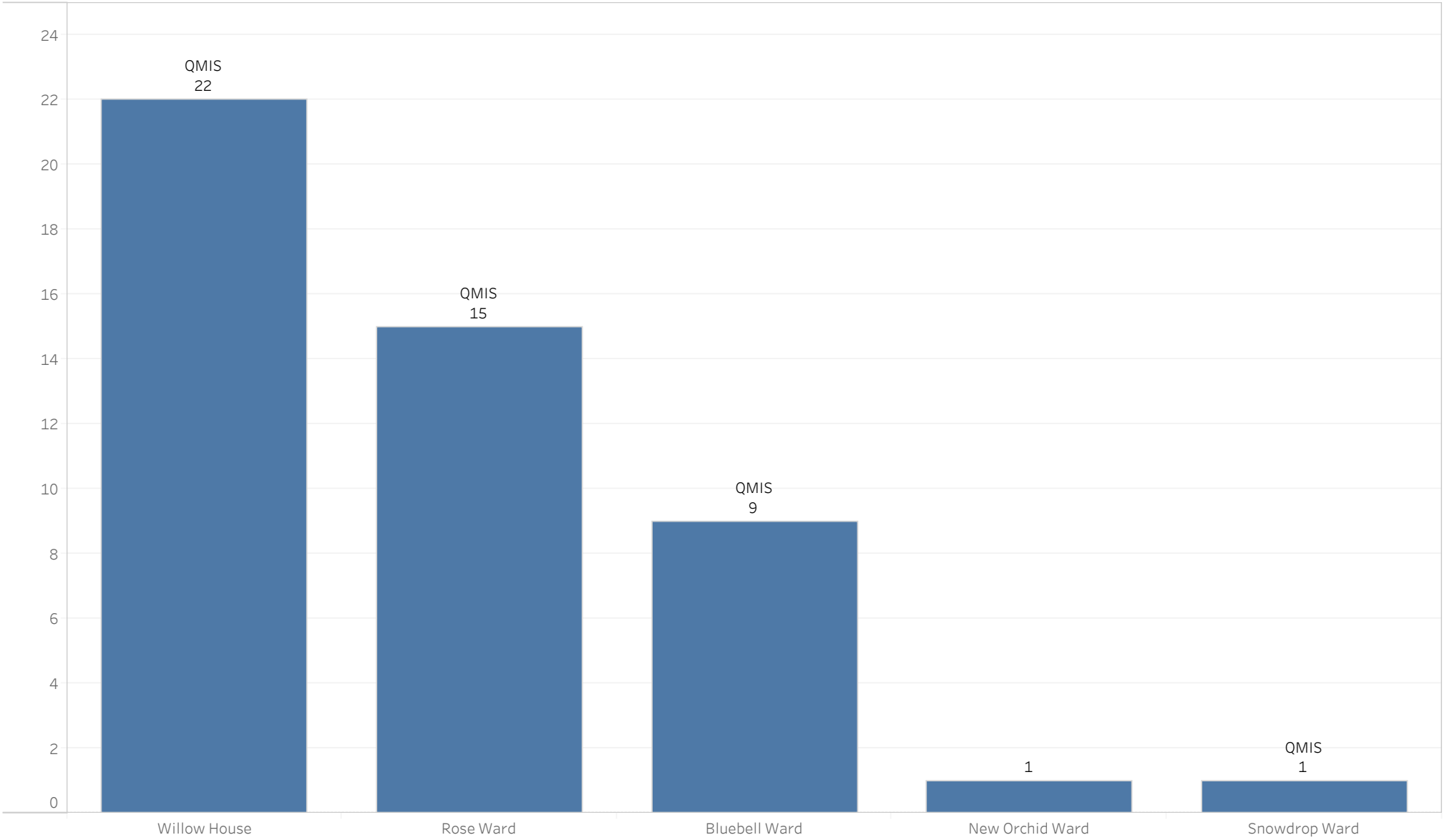
Harm Free Care Driver: Self-Harm incidents on Mental Health Inpatient Wards (excluding LD) (Nov 18 to Oct 19)

Any incident (all approval statuses) where category = self harm



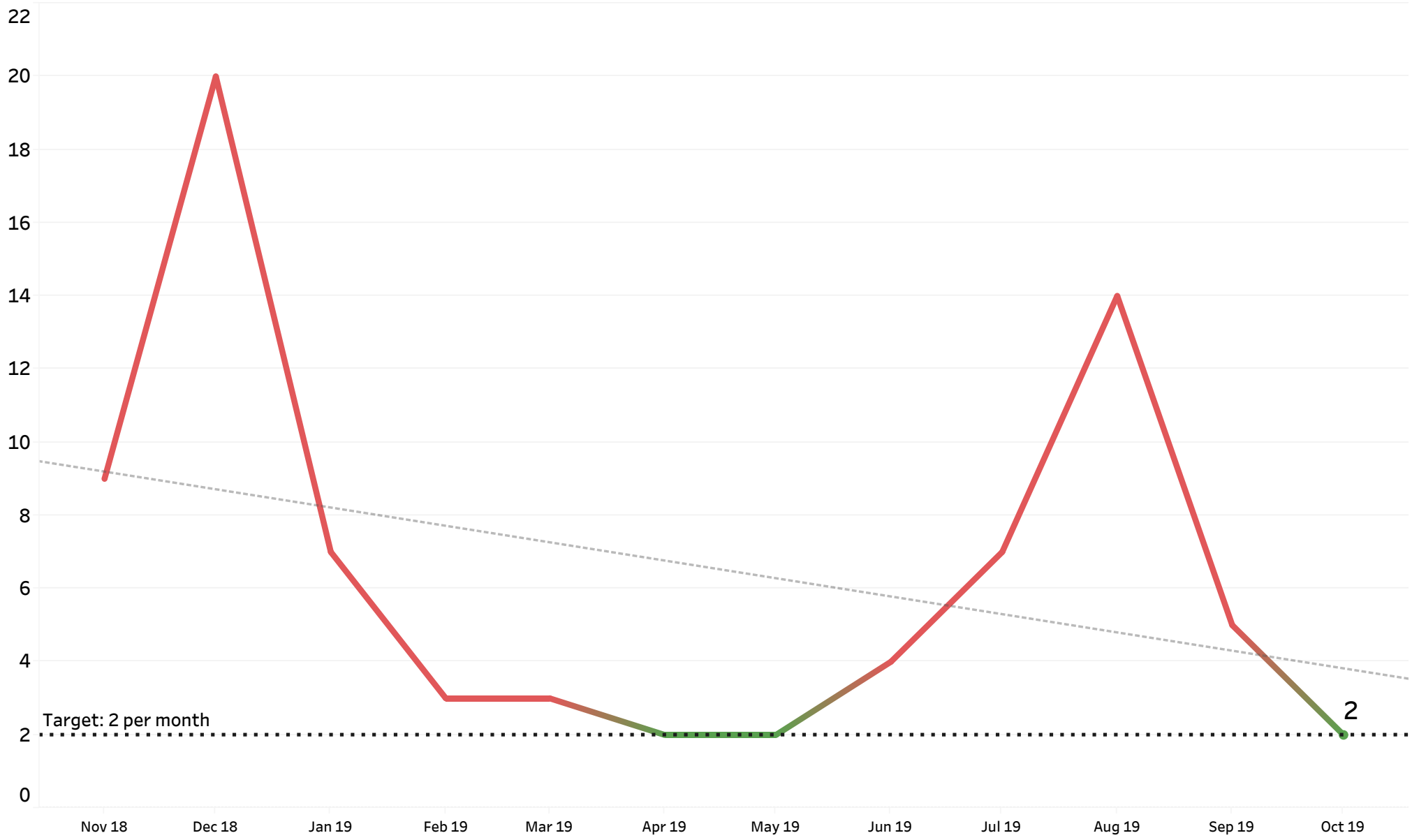
Harm Free Care Driver: Self-Harm incidents on Mental Health Inpatient Wards (excluding LD) by location (October)

* QMIS above the bar indicates that the ward / unit are focussing on this particular driver metric

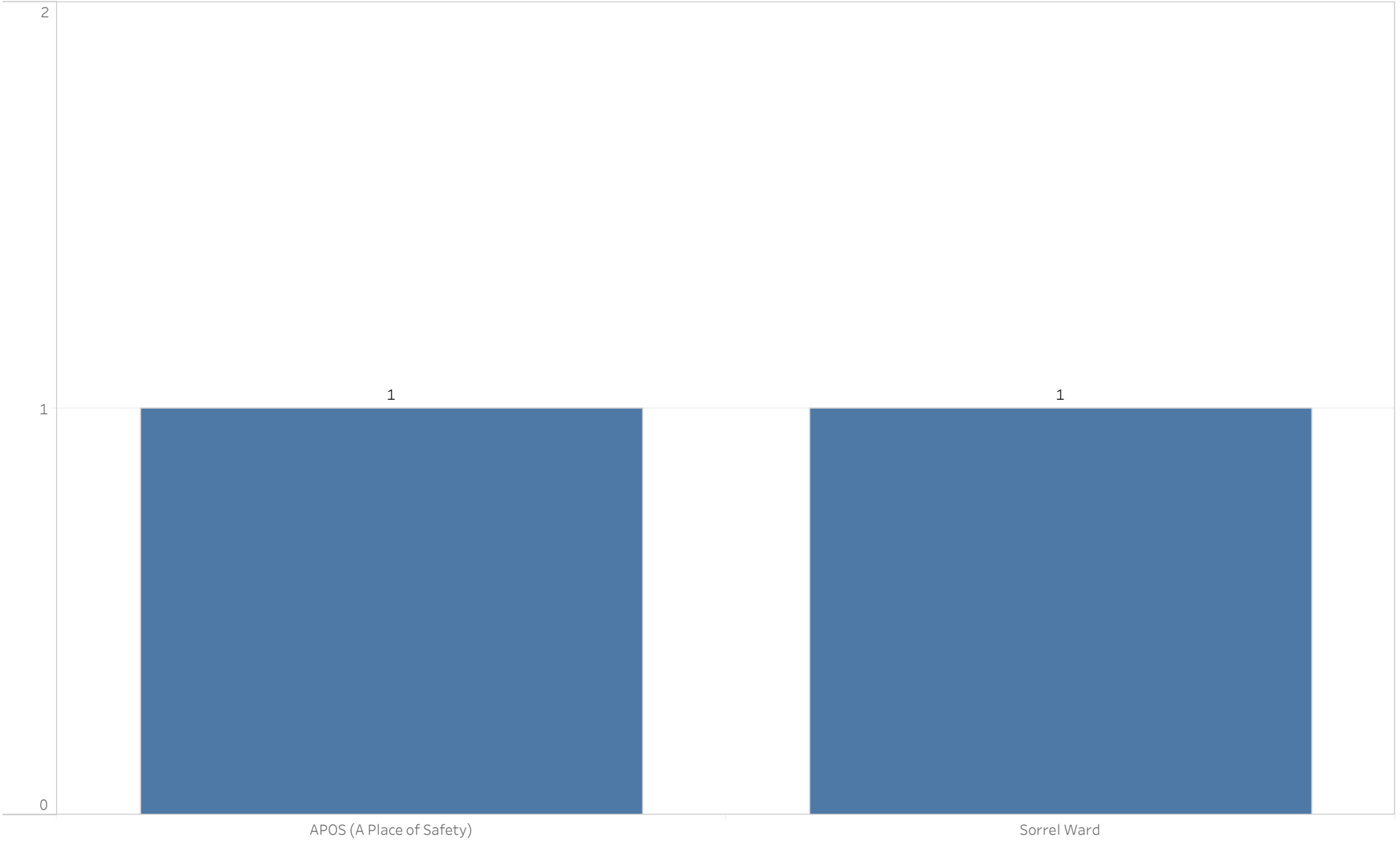


Patient Experience Driver: Mental Health: Prone (Face Down) Restraint incidents (Nov 18 to Oct 19)

(All approval statuses)

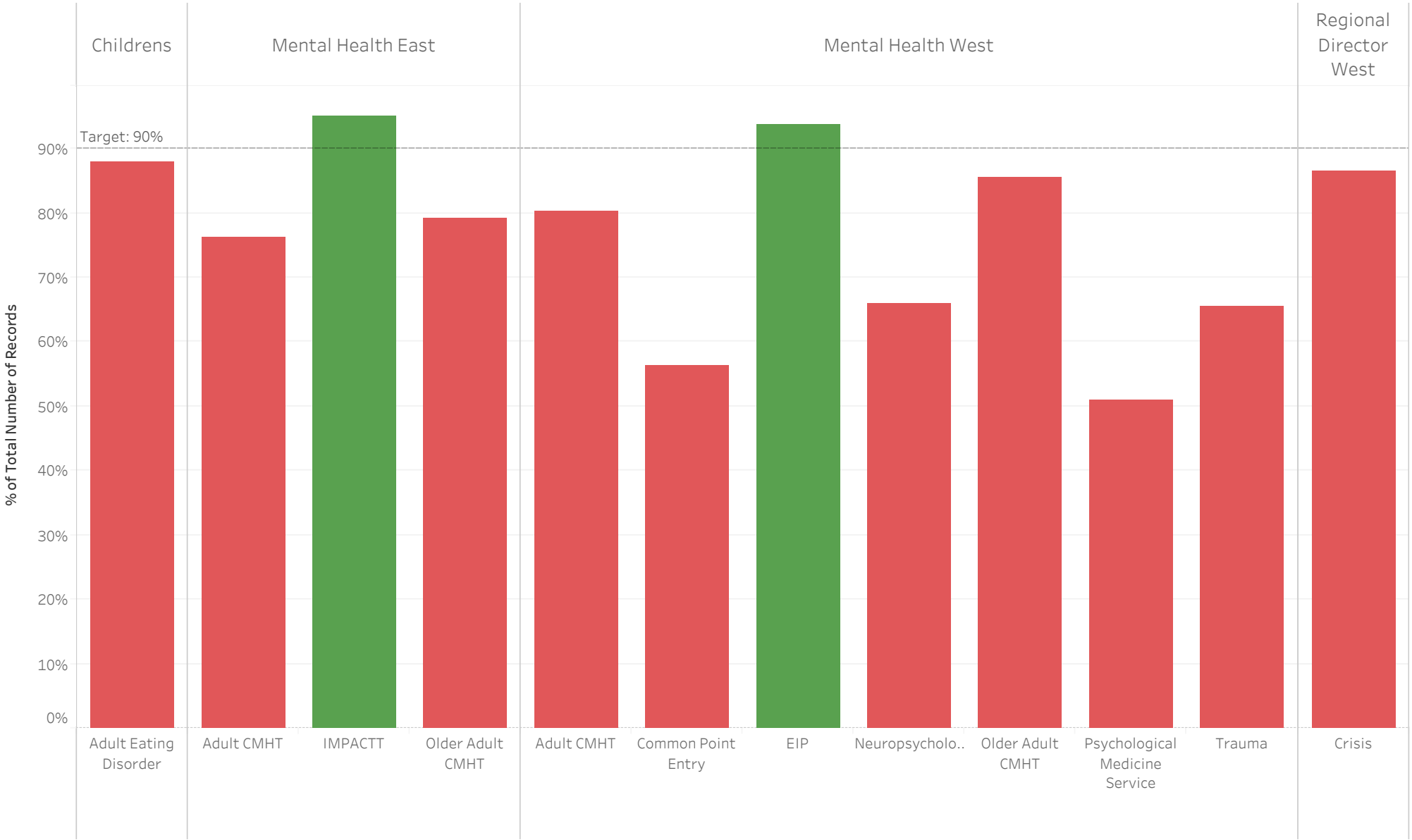


Patient Experience Driver: Mental Health: Prone (Face Down) Restraint incidents by location (October)



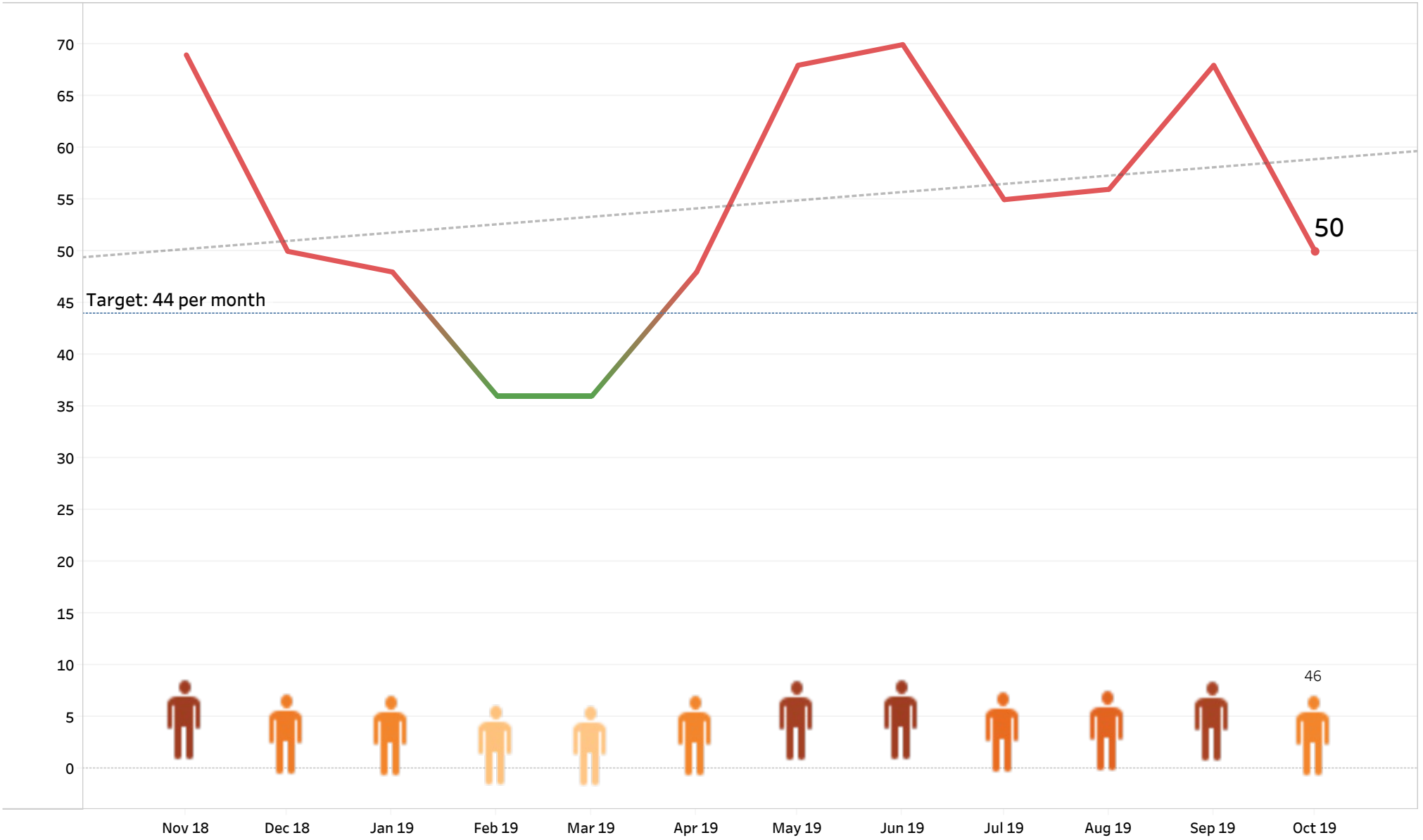
Patient Experience: Clustering breakdown (October)

Outpatient Cluster Status (by Service)



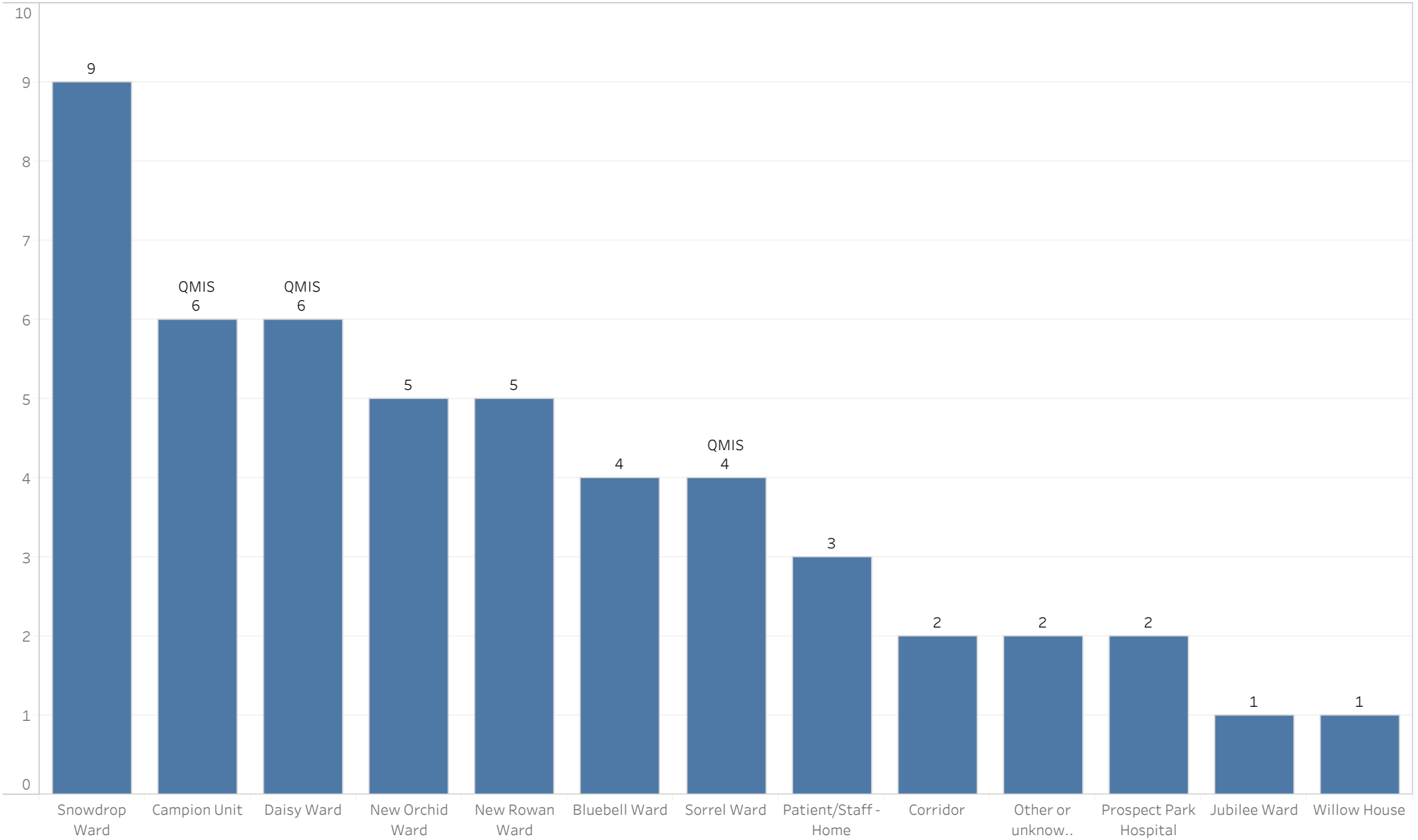
Supporting Our Staff Driver: Physical Assaults on Staff (Nov 18 to Oct 19)

Any incident where sub-category = assault by patient and incident type = staff



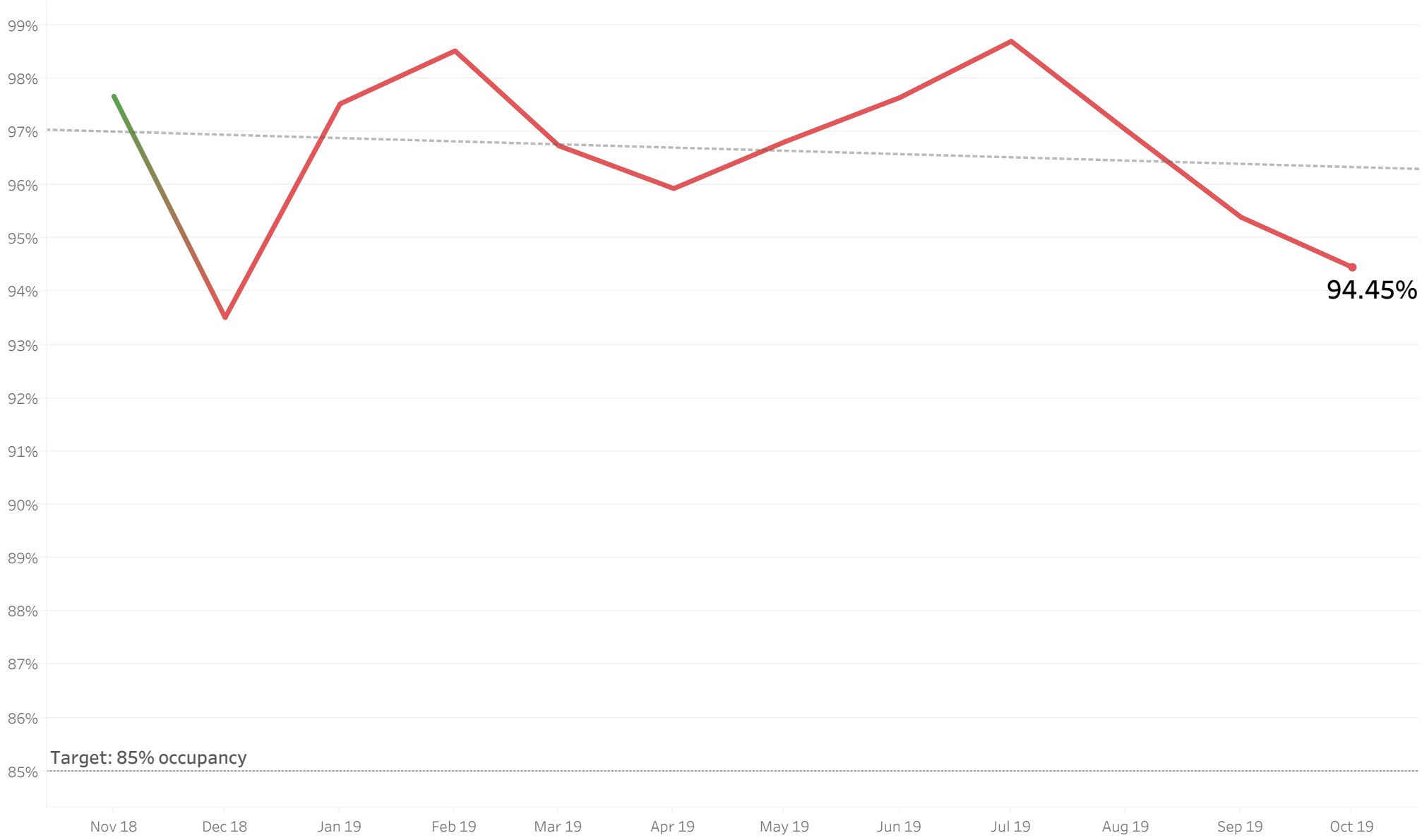
Supporting Our Staff Driver: Physical Assaults on Staff by Location (October 2019)

* QMIS above the bar indicates that the ward / unit are focussing on this particular driver metric

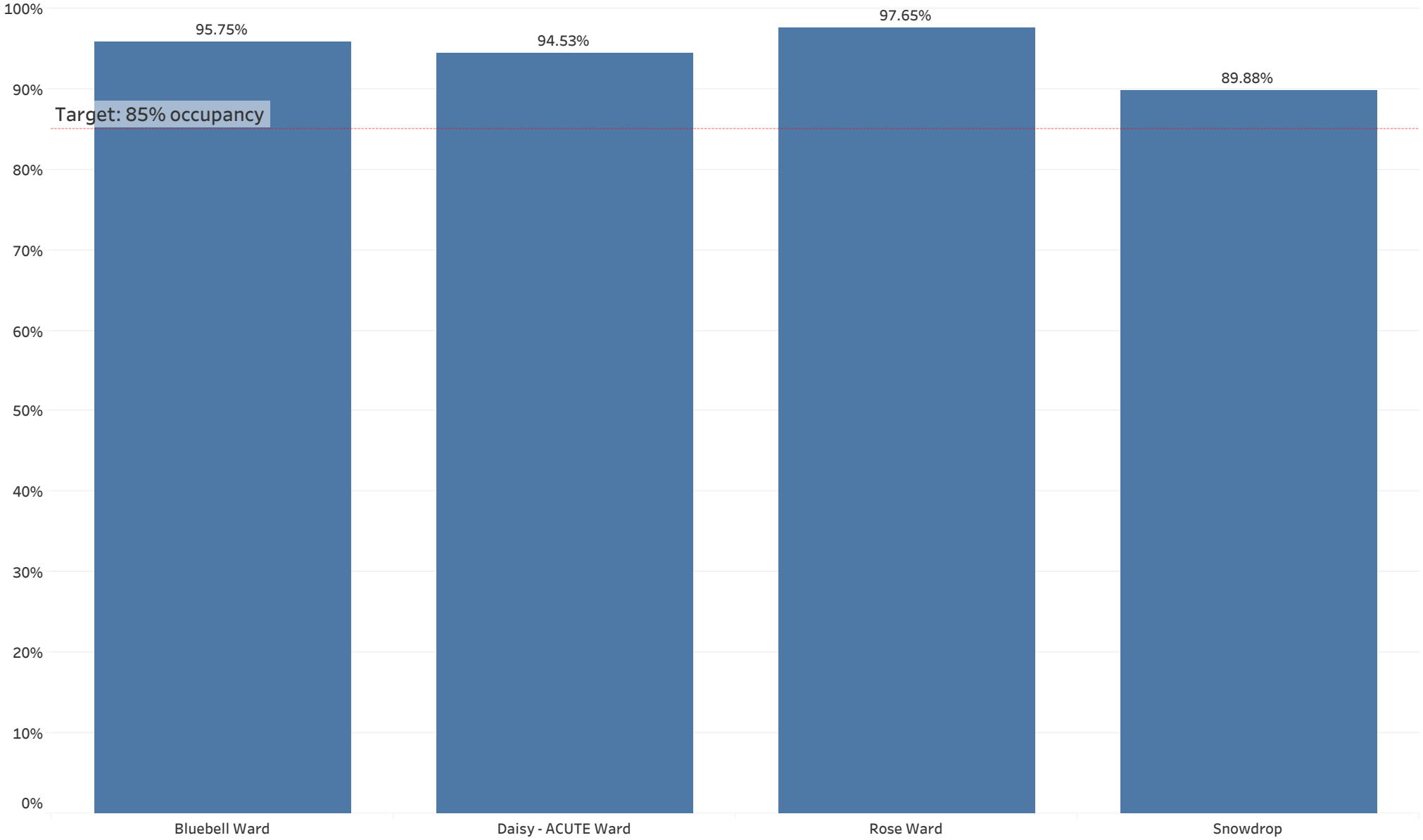


Money Matters: Mental Health Acute Bed Occupancy Rate

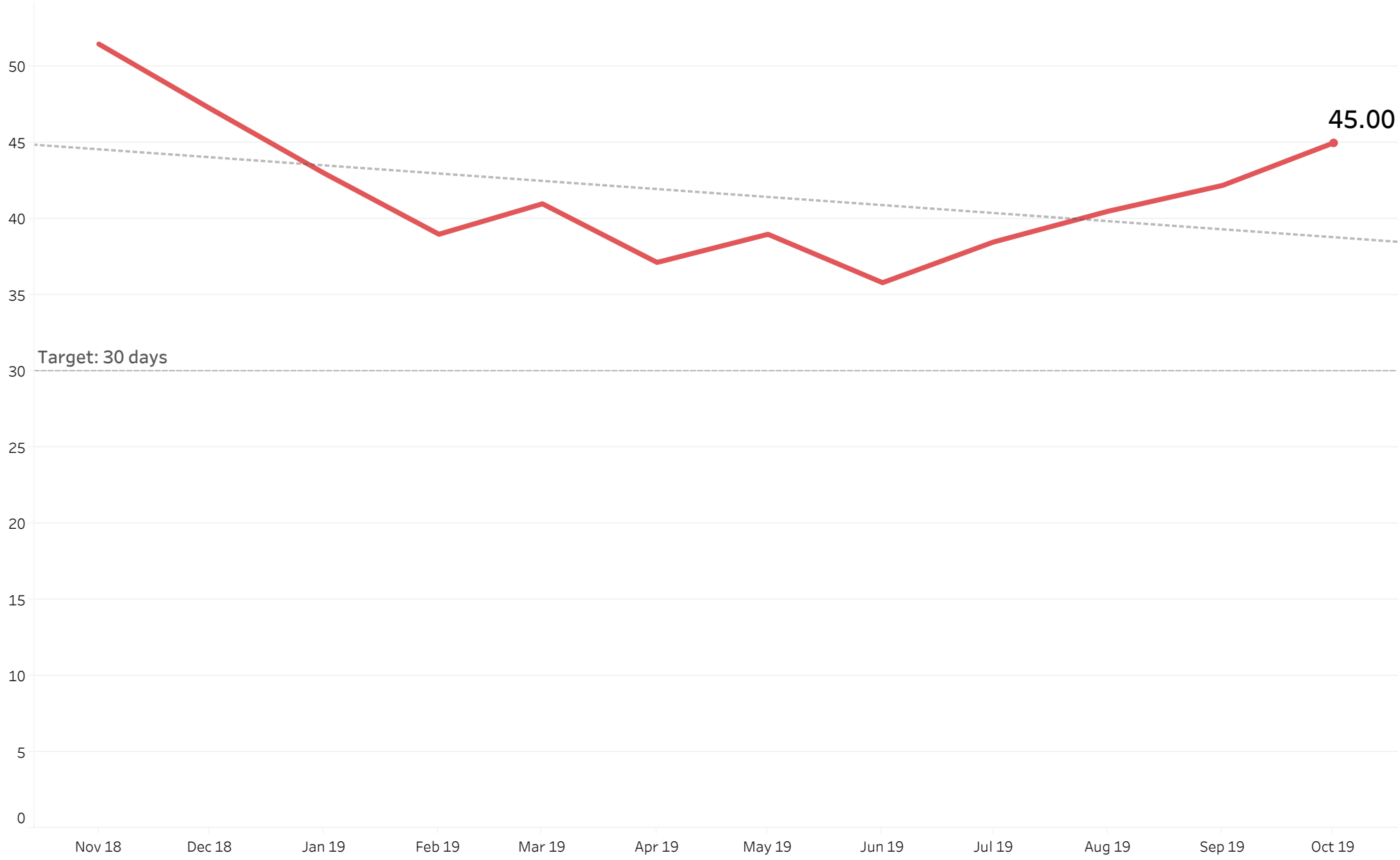
(Nov 18 to Oct 19)



Money Matters Driver: MH Acute Bed Occupancy by Unit (October)



Money Matters: Mental Health: Acute Average Length of Stay (bed days) (Nov 18 to Oct 19)



Money Matters Driver: Inappropriate Out of Area Placements (October)

True North Harm Free Care Summary

Tracker Metrics

		Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19
Pressure ulcers acquired due to lapse in (Inpatient Wards)	180 days free in the year						30	61	91	52	83	122	153
Pressure ulcers acquired due to lapse in (Community East)	180 days free in the year												214
Pressure ulcers acquired due to lapse in (Community West)	180 days free in the year												159
Mental Health: AWOLs on MHA Section	16 per month	16	20	25	24	18	14	16	17	13	11	13	18
Mental Health: Absconsions on MHA Section	8 per month	22	26	40	33	19	7	8	9	9	8	9	7
Uses of Learning Disability Strategy for Crisis Intervention & Prevention (SCIP)	10 per month	13	3	0	0	8	4	5	7	1	2	2	6
Mental Health: Readmission Rate within 28 days: %	<8% per month	4.58	6.32	6.74	7.87	7.50	7.92	6.90	6.25	7.29	6.56	6.25	6.04
Safety Plan for Patients on CPA (formerly MH Crisis Plans for Patients on CPA): %	90% compliance	95.8	95.9	96.7	96.3	96.9	97.0	97.2	97.2	96.6	96.0	95.5	95.6
Patient on Patient Assaults (LD)	6 per month	13	10	7	3	6	3	4	2	4	5	1	0
Uptake of at least one patient outcome measure (ReQoL) in adult Mental Health for new referrals from April 2019	25% by Sept 2019; 40% by March 2020						11.2%	14.4%	11.8%	15.1%	12.7%	16.5%	12.1%
Suicides per 10,000 population in Mental Health Care (annual)	8.3 per 10,000		4.3										
Self-Harm Incidents within the Community	31 per month	25	20	20	19	18	28	30	25	37	28	38	24

True North Patient Experience Summary

Tracker Metrics

		Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19
Patient on Patient Assaults (MH)	38 per month	54	53	59	49	45	24	28	21	25	33	34	19
Health Visiting: New Birth Visits Within 14 days: %	90% compliance	89.9%	90.4%	92.3%	90.6%	94.2%	92.0%	90.6%	97.1%	94.0%	93.8%	90.0%	93.9%
Mental Health: Uses of Seclusion	13 in month	15	18	12	10	8	15	11	12	11	6	12	5
Learning Disability: Seclusion	0	0	2	0	0	0	0	0	0	0	0	0	0
Community Inpatient Average Length of Stay (bed days)	<28 days	23	20.2	22.1	22	21.1	22.3	22.6	22.6	26.1	24.0	24.7	20.3

True North Supporting Our Staff Summary

Tracker Metrics

		Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19
Gross vacancies: %	<10%	8.30%	9%	7.79%	7.00%	6.80%	10.1%	10%	9.30%	9.19%	9.19%	7.5%	6.80%
Statutory Training: Fire: %	95% compliance	89.9%	87.8%	87.2%	87.9%	88.7%	88.5%	90.2%	90.7%	92.1%	94.3%	93.2%	93.0%
Statutory Training: Health & Safety: %	90% compliance	94.1%	93.5%	94.0%	94.5%	94.6%	94.8%	95.2%	95.2%	95.9%	96.0%	96.5%	96.4%
Statutory Training: Manual Handling: %	90% compliance	92.1%	88.9%	89.2%	90.2%	90.2%	90.8%	92.2%	92.6%	93.0%	93.2%	92.2%	92.9%
Mandatory Training: Information Governance: %	95% compliance	94.0%	94.5%	88.7%	92.1%	94.2%	93.6%	94.0%	93.3%	94.6%	94.8%	93.4%	94.7%
PDP (% of staff compliant) Appraisal: %	95% compliance by end of May 2019	89.6%	88.0%	86.9%	85.0%	82.6%	9%	75.9%	95%	87.7%	91.1%	87.8%	88.9%

True North Money Matters Summary

Tracker 1

		Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19
Mental Health: Delayed Transfers of Care (NHSI target) Monthly and Quarterly	7.50%	7.82	12.8	11.2	9.00	8.09	5.89	6.27	6.29	5.80	4.90	4.59	6.09

Tracker Metrics

Community Inpatient Occupancy: %	80-85% Occupancy	76%	71.6%	81.3%	86.5%	82.7%	81.6%	74.9%	81.8%	76.7%	71.1%	76%	75.4%
Mental Health: Non-Acute Occupancy rate (excluding Home Leave): %	80% Occupancy	64.35%	83.56%	93.41%	92.82%	87.01%	83.59%	92.82%	65.65%	76.59%	85.70%	88.42%	80.07%
DNA Rate: %	5% DNAs	4.75%	4.70%	4.76%	4.79%	4.85%	5.29%	4.90%	5%	4.90%	5%	5%	4.79%
Community: Delayed transfers of care Monthly and Quarterly	7.5% Delays	7.82%	12.8%	10.1%	9.67%	9.90%	4.70%	4.79%	4.79%	9.70%	10.9%	9.70%	9.90%

Regulatory Compliance - Tracker Level 1 Summary

Metric	Threshold / Target	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19
Mental Health: 7 day follow up (Quality Domain): %	95% seen	97.0	97.5	96.2	96.9	99	99	94.3	95.3	95.1	98.3	96.0	96.1
C.Diff due to lapse in care (Cumulative YTD)	0	1	1	0	0	0	0	1	0	0	0	0	0
Ensure that Cardio Metabolic assessment and treatment for people with psychosis is delivered routinely in inpatient wards: %	90% treated	97.8	97.8	97.8	97.8	97.8	97.8	97.8	42.1	42.1	42.1	42.1	42.1
Ensure that Cardio Metabolic assessment and treatment for people with psychosis is delivered routinely in EIP: %	90% treated	93	93	93	93	93	93	93	88.4	88.4	88.4	88.4	88.4
Ensure that Cardio Metabolic assessment and treatment for people with psychosis is delivered routinely in the Audit of Community Health Services (people on CPA): %	65% treated	100	100	100	100	93	93	100	21	21	21	21	21
Meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate per 100,000 bed days	2 in East; 4 in West	0	0	0	0	0	0	0	0	0	0	0	0
Meticillin-susceptible Staphylococcus aureus (MSSA) bacteraemias	No target - report number	1	0	1	0	1	0	0	0	0	0	0	0
Mixed-sex accommodation breaches	Zero tolerance	0	0	0	0	0	0	0	0	0	0	0	0
Count of Never Events in rolling six- month period (Safe Domain)	0	0	0	0	0	0	0	0	0	0	0	0	0
Number of children and young persons under 16 who are admitted to adult wards (Safe Domain)	Zero tolerance	0	0	0	0	0	0	0	0	0	0	0	0
EIP: People experiencing a first episode of psychosis treated with a NICE approved package of care within 2 weeks of referral: %	56% treated	100	60	100	90	62.5	90	100	100	75	100	100	66.7
A&E: maximum wait of four hours from arrival to admission/transfer /discharge: %	95% seen	100	100	100	99.9	99.7	99.5	99.9	100	98.8	99.7	99.7	98.4
People with common mental health conditions referred to IAPT will be treated within 6 weeks from referral: %	75% treated	99	99	97	98	99	98	97	96	95	96	96	95
People with common mental health conditions referred to IAPT will be treated within 18 weeks from referral: %	95% treated	100	100	100	100	100	100	100	100	100	100	100	100

Regulatory Compliance - Tracker Level 1 Summary

Metric	Threshold / Target	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19
People with common mental health conditions referred to IAPT completing a course of treatment moving to recovery: %	50% treated	55.0	56.9	57.9	57.9	57.5	57.5	56.0	56.0	55.0	56.2	55.1	59
% clients in Mental Health Services in Settled Accommodation	58% in Settled Accommodation	70	70	71	71	69	69	66	66	66	66	66	60
% clients in Mental Health Services in Employment	9% in Employment	12	12	12	12	12	12	12	12	12	12	12	11
Proportion of patients referred for diagnostic tests who have been waiting for less than 6 weeks (DM01 - Audiology): %	99% seen	100	100	100	100	100	100	100	100	100	100	99.5	100
Diabetes - RTT (Referral to treatment) waiting times - Community: incomplete pathways (how many within 18 weeks): %	95% seen	100	97.4	100	98.2	100	100	100	100	100	100	100	100
CPP- RTT (Referral to treatment) waiting times - Community: incomplete pathways (how many within 18 weeks): %	95% seen	100	100	100	99.1	100	100	100	98.5	100	100	100	98.9
Sickness Rate: %	<3.5%	4.65	4.10	4.39	4.59	3.89	3.81	3.59	3.75	4.58	3.99	4.10	
Staff - Count of those categorised as extremely likely or likely to recommend (Quality of Care Domain) - For IP, A&E, MH & Community	Null	84	84	84	84	84	84	84	84	84	84	84	84
Finance Score - Was Continuity of Services Risk Rating now Use of Resources	Month 1=3, months 2 to 5 =2 then month 6 onward=1	1	1	1	1	1	3	2	2	2	2	1	1
Mental Health Data Set Data Quality Maturity Index Score (DQMI)	95% achieved	99.7	99.7	99.9	99.9	99.9	96.5	96.5	91.5	94.2	94.5	97.7	96.2
Patient Safety Alerts not completed by deadline	0								0	0	0	0	0

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	10th December 2019
Title	Board Vision Metrics Update
Purpose	To provide the board with a performance update on metrics agreed in measuring progress towards achieving our vision
Business Area	Performance
Author	Chief Financial Officer
Relevant Strategic Objectives	3. - Strategic Goal: To deliver financially sustainable services through efficient provision of clinical & non-clinical services
CQC Registration/Patient Care Impacts	N/A
Resource Impacts	None
Legal Implications	Meeting regulatory requirements
Equalities and Diversity Implications	N/A
SUMMARY	Vision metric performance is provided at annex 1 of the paper. Indicators are YTD October 2019 performance unless otherwise stated within the narrative. To note: • The Trust dropped from 2nd to 3rd position in last combined trust cohort staff survey rankings. • No inpatient death from self-harm since October 2018. • FFT response rate has improved and is just below 15% target. • Most recent stakeholder survey responses reported in separate board paper, positive and broadly in line with previous survey findings. • CQC compliance actions and Good overall rating will remain until next core services inspection. Compliance actions completed / numbers reduced

	in relation to recent Westcall CQC inspection and Good ratings across all service inspection domains. • Segment 1 regulatory autonomy maintained since segmentation began. Trust financial position delivering lowest financial risk rating of 1 YTD as planned. • Benchmark positions to be refreshed in quarter 4 19/20 once detailed analysis toolkits are available. QI focus on prone restraint seeing sustained reduction in year.
ACTION REQUIRED	The Board is asked to note the update.

Board Vision Metrics: Performance Update to end October 2019

Supporting Delivery of the Trust's Vision

Trust Board – Public Meeting 10th December 2019

Alex Gild, Chief Financial Officer
30th November 2019

Purpose

Update the Finance Performance and Risk Executive and Trust Board on Vision Metrics.

Document control

Version	*Date*	*Author*	*Comments*
1.0	21/11/2019	I Hayward & C Magee	
1.1	29/11/19	I Hayward & C Magee	Format updates and additional drivers added

Distribution

Trust Board

Document references

Document title	*Date*	*Published by*
M7 – True North Performance Scorecard	25/11/2019	Performance Team

Contents

1. Introduction

Background

1.1. Our vision is:

> **"To be recognised as the leading community and mental health service provider by our staff, patients and partners."**

1.2. The Board Vision metrics monitor the Trust's progress across key indicators of vision delivery, split into the following sections:

- Quality
- Safety
- Engagement
- Regulatory Compliance

1.3. These sections cover the key indicators in order to assure the Trust on its progress towards the vision.

1.4. This is a performance update as per the quarterly interval (or as agreed with the Board). A number of the indicators are annual, so updates will occur when information is available via a dashboard, see Appendix 1.

1.5. The national benchmarking network has expanded participants in the Mental Health project to include providers from Wales, Northern Ireland, the Channel Islands and Scotland. The data here shows the rankings against the 55 English providers and the 32 Combined Mental Health and Community Trust respondents in 2017/18. Indicator performance has been updated to the latest available, the detail of our 2018/19 benchmarking position is expected for the next report.

2. Rationale for Metric Inclusion

Sections

By dashboard section in appendix 1, the following metrics were identified as having an impact on assessing our level of performance in delivering our vision.

Quality

2.1. Key quality metrics that indicate how well we treat and care for our patients, predominantly focused on care experience metrics for mental health inpatients and uses our benchmarked scores.

2.2. A long-term stretch performance measure is maintained in the dashboard to achieve top 3 ranking of all Mental Health service providers in the national benchmarking cohort, however, where data is

available, we have shown how we compare to the combined community and mental health trust cohort in the descriptions below. The 2017/18 benchmarking results have been updated to the dashboard as follows:

- **Mental Health Patient on Patient Physical Assaults** – The benchmark position target shown here is a long-term stretch target. The Trust was below the mean for 2017/18 but above the median per 100,000 occupied bed days excluding leave and is ranked 19th out of 55 English Mental Health respondents. The Trust ranks 11th out of 32 combined Mental Health & Community Health Trust respondents. This is an improvement in our performance from our 2016/17 position, where the Trust was ranked 51st out of 55 Mental Health trusts and 28th out of 32 combined Mental Health and Community Health Trusts.

- **Mental Health Patient on Staff Assaults** – The benchmark position target shown here is a long-term stretch target. The Trust was below the mean for 2017/18 and is in the upper quartile per 100,000 occupied bed days, excluding leave. The Trust is ranked 24th out of 55 English Mental Health benchmarking respondents. Trust ranks 15th out of 32 combined Mental Health & Community Trust respondents. This is an improvement in our performance from our 2016/17 position, where the Trust was ranked 44th out of 55 Mental Health trusts and 23rd out of 32 combined Mental Health and Community Health Trusts. Absolute and benchmark improvement in this area is a driver metric (seeking "breakthrough" improvement) within our Quality Improvement (QI) programme.

- **Mental Health Use of Restraint** – The benchmark position target shown here is a long-term stretch target. The Trust was below the mean for 2017/18 and the Trust is ranked 20th out of 55 English benchmarking respondents, which shows a worsening in our position from 2016/17, where the Trust was below the mean and ranked 19th out of 55 English benchmarking respondents. The Trust ranks 12th out of 32 combined Mental Health & Community respondents and this was an improvement from our 2016/17 position where the Trust was below the mean and ranked 13th out of 32 combined Mental Health & Community respondents.

    - From recently published data Prone restraint, a component of *all* restraint used in this vision metric, has shown a significant reduction and benchmark improvement in 2018/19 thanks to quality improvement focus. Other benchmark positions will be updated for the next report when data 2018/19 data is available.

Safety

2.3. Key metrics that indicate how safe our services are, performance being within our control and influence:

- **Falls –** where the fall results in significant harm due to a lapse in care. In the financial year, two such incidents occurred in 2018/19 and none so far in 2019/20. Reduction in falls is a focus for our QI programme breakthrough objective.

- **Mental Health Inpatient Deaths because of self-harm –** the metric has been updated to zero mental health inpatient deaths resulting from self-harm within a 12-month period. The last incident of an inpatient death from self-harm was in October 2018. The metric requires further consideration to confirm inclusion and definition of inpatient deaths from lapse in care, and whether this covers patients who were expected to be on a ward at the time of death. Reduction

of all self-harm is a QI programme breakthrough objective. There has been no change since reported in September 2019.

- **Mental Health Bed occupancy** – for mental health acute beds. The figure shown here were occupancy rates in October 2019 and shows 94.5% against a target of 85%. This is a decrease from 99% in July 2019.

- **Never Events –** all never events that occur in the Trust. None reported.

- **Pressure Ulcers -** Reduction in the level of developed category 3 and 4 pressure ulcers due to lapse in care in our community health services. The cumulative total was 17 incidents in the period 1st April 2018 to 31st March 2019, which was an improvement on 18 in the year 2017/18. There have been 6 Category 3 & 4 pressure ulcers identified due to lapse in care so far in 2019/20; this is a reduction from 10 in the same period (April to October 2019) last year. Pressure ulcers are an improvement focus under the QI programme's Harm Free Care domain.

- **Suicide Rate -** By 2020/21, the Five Year Forward View (FYFV) for Mental Health set the ambition that the number of people taking their own lives will be reduced by 10% nationally compared to 2015/16 levels. The Trusts suicide rate reduced to 4.3 per 10,000 under mental health care in 2017/18. This local target was based on a 10% reduction on the 2015/16 suicide level of 9.2 per 10,000 people under mental health care. The next update will be in Quarter 4 2019/20. Our zero-suicide initiative and QI programme around self-harm provide complementary improvement activity in this critical safety area.

Engagement

2.4. Key metrics on how our patients, carers, staff and stakeholders view us and our contribution to the local system and performance:

- **Commissioner Satisfaction - Net Commissioner Investment Maintained –** achieved in line with last three years for 2019/20; with commissioner investment in mental health and community physical health contract demand growth, IAPT service expansion into Long Term Conditions and NHSE investment in Individual Placement Support (employment) services for people with severe mental illness, and court liaison and diversion services.

- **Stakeholder Satisfaction - Survey of System Partners –** Results of the last survey were very positive with only 11% giving a neutral response to the Trust's leadership, quality, governance and service delivery within the two Integrated Care Systems it operates in. Survey respondents included our six local authorities, and NHS commissioner and provider system partners. Results from the latest survey for 2019/20 are being collated for the next report.

- **Patient Friends & Family Test Response Rate –** 14.7% in October 2019 against the target of 15%, which is an increase from August 2019 (12.4%). This is a QI driver metric.

- **Staff Survey Engagement Rating –** latest available performance ranking published on 26th February 2019 and is shown against our cohort of 32 combined mental health and community Trusts (3rd), which is one place lower than the 2017/18 results.

Regulatory Compliance

2.5. Key metrics on how we are measured nationally based on external assessment:

- **Care Quality Commission Rating –** Good rating

- **NHSI Segmentation -** maintained segment 1 of the Single Oversight Framework (now replaced by the Oversight Framework) in latest assessment. Highest level of autonomy, with no NHSI support required. Use of Resources rating of 1 (lowest financial risk rating on scale of 1 to 4, as per plan for this year from September 2019) in line with plan.

- **Number of CQC Compliance Actions –** there was 1 compliance action outstanding for Willow House which forms part of our core services. This is an improvement from 4 compliance actions reported in September 2019. Of which, 3 compliance actions for Westcall were removed following re-inspection and publication of the CQC's report on 31st October 2019, providing "Good" ratings across all domains. Review of residual compliance matters will be subject to the outcome of CQC core services inspections.

Appendix 1 – Board Vision Metrics