Berkshire Healthcare
NHS Foundation Trust

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

TRUST BOARD MEETING

(conducted electronically via Microsoft Team because of the COVID-19 pandemic)

10:00am on Tuesday 08 December 2020

AGENDA

No	Item	Presenter	Enc.
	OPENING BUSINESS		
1.	Chairman's Welcome and Public Questions	Martin Earwicker, Chair	Verbal
2.	Apologies	Martin Earwicker, Chair	Verbal
3.	Declaration of Any Other Business	Martin Earwicker, Chair	Verbal
4.	Declarations of Interest i. Amendments to the Register ii. Agenda Items	Martin Earwicker, Chair	Verbal
5.1	Minutes of Meeting held on 10 November 2020	Martin Earwicker, Chair	Enc.
5.2	Action Log and Matters Arising	Martin Earwicker, Chair	Enc.
	QUALITY		
6.0	An Integrated Care Pathway Patient Story	Director of Nursing and Therapies/Caroline Edwards, Integrated Care Pathways Manager	Verbal
6.1	Freedom to Speak Up Guardian's Six Monthly Update Report	Mike Craissati, Freedom to Speak Up Guardian	Enc.
6.2	Quality Assurance Committee – 17 November 2020 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		
8.0	Month 07 2020/21 Finance Report	Alex Gild, Deputy Chief Executive and Chief Financial Officer	Enc.
8.1	Month 07 2020/21 Performance Report	Alex Gild, Deputy Chief Executive and Chief Financial Officer	Enc.
8.2	Board Vision Metrics	Alex Gild, Deputy Chief Executive and Chief Financial Officer	
	STRATEGY		

No	Item	Presenter	Enc.
9.0	COVID-19 Recovery Plan Report	Kathryn MacDermott, Acting Executive Director of Strategy	Enc.
9.1	Trust's Three-Year Strategic Plan	Kathryn MacDermott, Acting Executive Director of Strategy	Enc.
CORPORATE GOVERNANCE			
10.0	Appointments and Remuneration Committee – Terms of Reference	Mark Day, Chair of the Appointments and Remuneration Committee	Enc
10.1	Council of Governors Update	Martin Earwicker, Trust Chair	Verbal
Closing Business			
11.	Any Other Business	Martin Earwicker, Chair	Verbal
12.	Date of the Next Public Trust Board Meeting – 9 February 2021	Martin Earwicker, Chair	Verbal
13.	**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.	Martin Earwicker, Chair	Verbal

Berkshire Healthcare NHS Foundation Trust

Unconfirmed minutes

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

Minutes of a Board Meeting held in Public on Tuesday 10 November 2020

(conducted via Microsoft Teams because of COVID-19 social distancing requirements)

Present:	Martin Earwicker	Chair
	Chris Fisher	Non-Executive Director
	David Buckle	Non-Executive Director
	Naomi Coxwell	Non-Executive Director
	Mark Day	Non-Executive Director
	Aileen Feeney	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
	Kathryn MacDermott	Acting Executive Director of Strategy
	David Townsend	Chief Operating Officer
In attendance:	Julie Hill	Company Secretary
	Jane Nicholson	Director of People
	Nathalie Zacharias	Director of Equality, Diversity and Inclusion
	Joseph Kamga	Staff Nurse (*present for item 6.0)*
	Chloe Langan	Staff Nurse *(present for item 6.0)*
	Andrew Duncan	Staff Nurse (*present for item 6.0)*

20/173	**Welcome and Public Questions** (agenda item 1)
	The Chair welcomed everyone to the meeting. There were no public questions.
20/174	**Apologies** (agenda item 2)
	There were no apologies.

20/175	**Declaration of Any Other Business** (agenda item 3)
	There was no other business.
20/176	**Declarations of Interest** (agenda item 4)
	i. **Amendments to Register** – none
	ii. **Agenda Items** – none
20/177	**Minutes of the previous meeting – 08 September 2020** (agenda item 5.1)
	The Minutes of the Trust Board meeting held in public on Tuesday 08 September 2020 were approved as a correct record.
20/178	**Action Log and Matters Arising** (agenda item 5.2)
	The schedule of actions had been circulated. **The Trust Board:** noted the action log.
20/179	**Staff Story – Prospect Park Hospital Preceptees (**agenda item 6.0)
	The Chair welcomed Prospect Park Hospital Staff Nurses: Chloe Langan, Andrew Duncan and Joseph Kamga to the meeting. The Director of Nursing and Therapies reported that the three Staff Nurses had been part of the Trust's Preceptorship Programme for newly qualified staff. The three Staff Nurses shared their experiences of the Preceptorship Programme. **Chloe Langan** Chloe Langan said that she had had joined the Trust in 2014 as a Support Worker at Prospect Park Hospital and her experience had inspired her to train as a Nurse. The Trust had supported her nursing training and had been very supportive. Ms Langan reported that she found the Prospect Park Preceptorship Programme very helpful and especially valued the support she received from both the Prospect Park Hospital Senior Leadership Team and from the other preceptees on the programme. Ms Langham also valued getting involved in the Trust's Quality Improvement Programme work at Prospect Park Hospital. **Andrew Duncan** Andrew Duncan said that he had started his nurse training in Worcester and he had joined the Trust working at Prospect Park Hospital but after five months, he left the Trust. He explained that he had found it difficult to balance working on a very busy ward and keeping on top of his preceptorship work.

	Mr Duncan said that he re-joined the Trust and started the Preceptorship Programme. Mr Duncan said that his experience working at Prospect Park Hospital the second time round was much more positive and said that he felt very well supported by the Prospect Park Hospital Leadership Team. **Joseph Kamga** Joseph Kamga said that he started working at Prospect Park Hospital as an agency member of staff before securing a permanent role. Mr Kamga said that he was fortunate that the Trust financially supported his nurse training. When he qualified, he returned to Prospect Park Hospital. Mr Kamga reported that the Trust ran two Preceptorship Programmes: a Trust-wide programme and a Prospect Park specific programme. Mr Kamga commented that in his opinion, the Prospect Park Hospital Preceptorship programme was outstanding and was tailored to meet the needs of newly qualified staff. Mr Kamga said that he particularly valued the opportunities for good practice in one area to be shared across all the preceptees. The Chief Executive thanked the preceptees for sharing their positive experiences and asked whether there were any underlying themes from any of their colleagues who were less positive about the preceptorship programme and working at Prospect Park Hospital. Ms Langan said that most of the more negative experiences of her colleagues related to team dynamics but pointed out that preceptees were encouraged to share and raise their concerns with the Prospect Park Hospital Leadership and that was helpful in resolving issues. Mr Kamga commented that some of his colleagues did not attend all the Preceptorship sessions and therefore were not able to share their concerns and to access the support that was available. Mr Duncan said that his experience second time round was that the Prospect Park Hospital Leadership were very supportive and did everything they could to resolve issues and concerns. The Director of Nursing and Therapies thanked the preceptees for finding the time to attend the Board meeting and to share their experiences. The Chair added his thanks to Joseph Kamga, Chloe Langan and Andrew Duncan and wished them well for their future careers.
20/180	**Patient Experience Report – Quarter 2** (agenda item 6.1)
	The Director of Nursing and Therapies presented the paper and highlighted the following points: • During the Quarter 2, the Trust had received 62 complaints; • There were no areas that saw a significant increase in the number of complaints compared to last year; • The services with the highest number formal complaints during the quarter were: Inpatient wards (both Physical and Mental Health) and the Community Mental Health Teams.

	• Whilst a very small number of complaints could be attributed to the COVID-19 pandemic, most of the complaints were around communication and dissatisfaction with clinical care and were not related to COVID-19 or to the pandemic response; • The response rate for complaints within agreed timescale was 99%; • During the quarter, the Trust received 975 compliments; • The Trust was now conducting follow up telephone calls in order to gain more patient feedback. David Buckle, Non-Executive Director said that the report was very informative and commented that he was pleased that the report included examples of learning from patient feedback. Aileen Feeney, Non-Executive Director said that the report covered the period when the Trust had re-deployed staff from other areas of the Trust to support clinical services during the COVID-19 pandemic and asked whether there was any correlation with the nature of the complaints received during this period. The Director of Nursing and Therapies pointed out that during the reporting period re-deployed staff had returned to their substantive roles. It was noted that during quarter 1 (the period when staff were re-deployed), the Trust had received fewer complaints than normal, but the proportion of complaints which were partially or fully upheld was higher than normal. Mark Day, Non-Executive Director asked whether patients had complained about the Trust's new ways of working, for example, more telephone and virtual consultations. The Director of Nursing and Therapies reported that the Trust had received a small number of complaints relating to the new ways of working and acknowledged that some patients had found moving away from face to face meetings to telephone and virtual consultations challenging. The Deputy Chief Executive and Chief Financial Officer said that post COVID-19, the Trust would provide a mixed offer to patients and was reviewing how to best support patients who did not have access to IT facilities and/or who were not confident using new technology and preferred face to face consultations. Mehmuda Mian, Non-Executive Director said that she found the comments made by patients in the Compliment section of the report very heartening. The Chair welcomed that Trust's ongoing commitment to improve the reporting of patients' ethnicity. **The Trust Board:** noted the report
20/181	**Six Monthly Safe Staffing Report** (agenda item 6.2)
	The Director of Nursing and Therapies presented the paper and pointed out that the monthly Safe Staffing Reports were considered by the Finance, Investment and Performance Committee, but the Six-Monthly Safe Staffing Reports were presented to the Board for consideration. The Director of Nursing and Therapies reported that during this reporting period some of the data had been affected by the COVID-19 pandemic, with staff deployed from other

	areas within the Trust and lower patient numbers especially during the first part of the reporting period when a number of services were paused or reduced. The Director of Nursing and Therapies reported that the Trust had successfully recruited third year students and said that the Trust's community wards now had a minimal level of vacancies. David Buckle, Non-Executive Director said that as a clinician he found the safe staffing reports very informative. Dr Buckle said that whilst acknowledging the challenges posed by responding to the COVID-19 pandemic, he was concerned that Bluebell ward had the highest number of shifts (19% of shifts) with only one registered nurse on duty. The Director of Nursing and Therapies reported that there were staff vacancies on Bluebell ward but explained that ward managers, matrons and other senior staff were not counted as part of the safe staffing data, but in practice they would cover shifts where there was only one registered nurse on duty. Staff would also be deployed from other wards. **The Trust Board:** a) Noted the report; b) Noted the declaration by the Director of Nursing and Therapies and Medical Director that they were satisfied that staffing was safe; although high numbers of temporary staffing continued to have the potential to impact on quality and patient experience particularly across our mental health wards. In terms of medical staffing, numbers in the Trust remained stable with adequate medical cover available during routine working hours for inpatient mental health and community health wards.
20/182	**Staff Flu Vaccination Update Report** (agenda item 6.3)
	The Director of Nursing and Therapies presented the paper and reported that as at 28 October 2020, 36% of total staff (1,550 staff) have had their flu jab. This included 34% of clinical staff (1,128 staff). The Director of Nursing and Therapies reported that the Staff Flu Vaccination Campaign usually ran from September until the end of December, but this year, NHS England had reduced the timeframe to the end of November to enable the NHS to be ready to start the COVID-19 vaccination programme from December if a vaccine was approved. The Director of Nursing and Therapies reported that due to the COVID-19 pandemic a high proportion of staff were home-based and it was therefore more challenging to ensure staff were vaccinated. The Trust was providing staff with flu vouchers so they could obtain their flu jab from local Pharmacies, but many Pharmacies were experiencing delays in obtaining supplies of the flu vaccine. The Director of Nursing and Therapies reported that the Trust was continuing its efforts to encourage more staff to take up the flu jab. The Director of Nursing and Therapies referred to page 78 of the agenda pack which included the National Flu Immunisation Programme 2020-21 Healthcare Worker Flu Vaccination Best Practice Management Checklist. It was noted that the Trust had undertaken a self-assessment exercise against the Checklist and had confirmed that all the actions had been completed.

	Mark Day, Non-Executive Director reported that he had joined the virtual Executive All Staff Briefing last week which had included two members of staff describing their experiences of contracting flu. Mr Day said that he was pleased that the Chief Executive had answered a question from an anonymous member of staff who was very critical of the Trust's robust campaign to encourage staff to be vaccinated. David Buckle, Non-Executive Director expressed his disappointment about the level of take-up so far of the flu jab. Dr Buckle said that as a GP he had firsthand experience of how dangerous flu could be and recounted that one of his patients, a previously healthy young man in his 20s had contracted and died from flu. The Chief Executive said that post-COVID-19, many staff would continue to be largely home-based and therefore the Trust would need to re-think its approach to future Staff Flu Campaigns. **Action: Director of Nursing and Therapies** **The Trust Board:** noted the report and the Trust's compliance with the National Flu Immunisation Programme 2020-21 Healthcare Worker Flu Vaccination Best Practice Management Checklist.
20/183	**Infection Prevention and Control Board Assurance Framework** (agenda item 6.4)
	The Director of Nursing and Therapies presented the paper and reminded the Board that the Infection Prevention Infection and Control Board Assurance Framework was first published in May 2020 with the aim of supporting all healthcare providers to effectively self-assess their compliance with Public Health England and other COVID-19-related infection prevention The Director of Nursing the Therapies reported that Public Health England had updated the Infection Prevention and Control guidance on 15 October 2020. The Trust has made minor changes to the Infection Prevention and Control Board Assurance Framework to reflect the new guidance. Naomi Coxwell, Non-Executive Director asked whether the national supply chain of personal protective equipment had now improved. The Director of Nursing and Therapies said that the supply of personal protective equipment was more robust and confirmed that the Trust had a good supply. It was noted that the Government's aim was for 70% of personal protective equipment to be made in the United Kingdom by the end of December 2020. **The Trust Board:** noted the report.
20/184	**Executive Report** (agenda item 7.0)
	The Executive Report had been circulated. **The Trust Board**: noted the paper.

20/185	**Month 06 2020-21 Finance Report** (agenda item 8.0)
	The Deputy Chief Executive and Chief Financial Officer presented the paper and highlighted the following points: • September 2020 was the last month of the interim-COIVD-19 finance regime with central funding being accrued to cover COVID-19 response costs, ensuring the Trust was able to report breakeven year to date; • The financial forecast for the remainder of the year under the new finance regime would be considered at the In-Committee Meeting later today; • The Trust was reporting a £0.7m deficit excluding COVID-19 costs which moved the Trust to a year to date deficit of £0.4m; • The deficit reported this month reflected a £0.1m increase in Pay costs, incorporating the backdated Consultant pay award and an increase in Non-Pay of £0.5m. The increased Non-Pay costs were a combination of one-off items and the continuation of COVID-19 recovery costs increases; • After the inclusion of £0.5m of COVID-19 costs, a £1.2m Top Up payment had been assumed to enable the Trust to breakeven year to date; • COVID-19 response costs were estimated at £5.2m and the breakeven position was inclusive of £4.6m of COVID Funding and £1.0m of Retrospective Top Up support. Marginal COVID-19 costs have continued to reduce, with costs falling a further £50k in September 2020 to £0.5m. In month COVID-19 costs were at c2.2%, which was at the lower end of costs across the region; The Deputy Chief Executive and Chief Financial Officer commented that it was very unusual to have two separate financial regimes operating in one financial year. **The Trust Board noted:** the following summary of the financial performance and results for Month 06 2020-21: The Trust continued to operate under the interim COVID-19 finance regime, with central funding being provided to cover COVID-19 response costs, ensuring that the Trust was able to report a breakeven year to date position. Year to date cash was £50.2m versus the financial plan of £46.5m Year to date capital expenditure was £1.9m versus the financial plan of £2.1m.
20/186	**Month 06 2020-21 "True North" Performance Scorecard Report** (agenda item 8.1)
	The Month 06 "Trust North" Performance Scorecard had been circulated. The Deputy Chief Executive and Chief Financial Officer highlighted bed pressures within the Trust's inpatient units which had led to an increase in the number of inappropriate Out of Area Placements. The Chair commented that he liked the format of the performance report which made it easier for the Board to identify trends. **The Trust Board:** noted the report.

20/187	**Finance, Investment and Performance Committee Meeting –29 October 2020 and Terms of Reference – minor amendments** (agenda item 8.2)
	Naomi Coxwell, Chair of the Finance, Investment and Performance Committee reported that in addition to the standing items, the Committee had discussed the Trust's work to reduce the number of inappropriate Out of Area Placements and the draft People's Strategy. Ms Coxwell reported that the Committee had also reviewed the results of the annual review of the Committee's effectiveness and the Committee's Terms of Reference. The Committee had made minor amendments to the Terms of Reference which were presented for ratification by the Board. Chris Fisher, Non-Executive Director referred to the Committee's Terms of Reference and asked what was meant by "employee casework". The Deputy Chief Executive and Chief Financial Officer explained that this referred to staff disciplinaries and grievances. **The Trust Board:** ratified the changes to the Finance, Investment and Performance Committee's Terms of Reference.
20/188	**Draft People Strategy and Priorities** (agenda item 9.0)
	The Chair welcomed the Director of People. The Deputy Chief Executive and Chief Financial Officer said that the strategic vision was that "Berkshire Healthcare is Outstanding for Everyone". The Director of People presented the report and paid tribute to the Staff Networks, Staff Side and other groups who had helped to shape the new People Strategy. The Director of People said that any comments from the Board would be incorporated into the final version of the People Strategy. **Action: Director of People** The Director of People explained that the Trust had adopted a Quality Improvement approach to developing the Strategy which was underpinned by a variety of data and staff feedback. It was noted that the People Strategy was aligned with the new Equalities, Diversity and Inclusion Strategy, the refreshed Trust Strategy, the two Systems' People Strategies and with the national NHS People Strategy. The Director of People explained that the Strategy had been developed using the Quality Improvement Programme methodology and for each of the individual strands there was a clear view of the background and problem, the Trust's response, milestones and deliverables, links to True North and key risks and mitigations. Aileen Feeney, Non-Executive Director referred to the key performance indicators (page 189 of the agenda pack) and asked whether it would be better to include absolute numbers rather than percentages. Ms Feeney also suggested re-drafting the section on culture.

	Aileen Feeney, Non-Executive Director suggested including a “quick wins” pathway which would allow progress to be reported every month. Naomi Coxwell, Chair of the Finance, Investment and Performance Committee reported that the Finance, Investment and Performance Committee had reviewed an earlier version and the Committee had given its full support to the new People Strategy. The Chair said that the new People Strategy was focused on the key staff-related issues facing issues facing the Trust. The Chair also welcomed the inclusion of a set of metrics to measure performance and suggested that the wording of the metrics be tightened up. The Director of People agreed to sharpen up the Key Performance Indicators, to include a “quick win” pathway and re-draft the section on culture. **Action: Director of People** **The Trust Board:** noted the report.
20/189	**Draft Equalities, Diversity and Inclusion Strategy** (agenda item 9.1)
	The Chair welcomed the Director of Equality, Diversity and Inclusion to the meeting. The Deputy Chief Executive and Chief Financial Officer said that the draft Equalities, Diversity and Inclusion Strategy was a key component of the People Strategy. The draft Equalities, Diversity and Inclusion Strategy included both staff and patients. The Director of Equality, Diversity and Inclusion presented the report and highlighted the following points: • The Diversity and Inclusion Strategy had been co-produced with key stakeholders and aligned with the People Strategy and with the Trust’s Talent Management work; • Feedback from the staff workshops was that the Trust’s previous Equalities Strategy was too broad to address pockets of inequalities; • The Strategy also recognised that people were individuals and could have more than one protected characteristic; • Key metrics across patients and the workforce would be included in the final Equalities, Diversity and Inclusion Strategy **Action: Equalities and Diversity Director** The Chair said that he particularly welcomed the recognition that staff and patients could have more than one protected characteristic. The Chair referred to table on page 202 of the agenda pack which set out the Workforce Race Equality Standard data from 2016 to 2019 and asked why three out of the four rows for 2019 were RAG rated “green” when the data highlighted the differential experience of Black, Asian and Minority Ethic Staff when compared with White staff. Director of Equality, Diversity and Inclusion explained that the RAG rated related to progress year on year. The Chair said that he welcomed the commitment to develop key metrics for the Board could monitor the implementation of the Strategy. Aileen Feeney, Non-Executive Director suggested replacing RAG rating with arrows to indicate progress.

	The Director of Equality, Diversity and Inclusion said that the Diversity Steering Group would track the implementation of the Strategy. It was noted that the Chair and Mehmuda Mian, Non-Executive Director were also members of the Diversity Steering Group. **The Trust Board:** noted the draft Equalities, Diversity and Inclusion Strategy.
20/190	**Strategy Implementation Plan Report** (agenda item 9.2)
	The Acting Executive Director of Strategy presented the paper and said that during the first wave of COVID-19, a number of projects had been paused and confirmed that all the mission critical projects were now back up and running. **The Trust Board:** noted the report.
20/191	**COVID-19 Pandemic Recovery Plan Update Report** (agenda item 9.3)
	The Acting Executive Director of Strategy presented the paper and highlighted the following points: • Planning for the second COVID-19 pandemic wave was in progress; • Any potential impact of the first COVID-19 wave on the Recovery process would be reported via the Recovery Programme Board. At this point in time, the Trust was not reporting a negative impact; • All Community Physical Health Services that were paused or partially closed during the first COVID-19 wave had completed the formal prioritisation process and were now fully operational with a "blended" model of face to face and digital/telephone appointments for many services. • All of the staff that had been re-deployed during the first COVID-19 wave had now returned to their substantive posts. • The Trust had conducted a review of the re-deployment process and the learning had informed the COVID-19 second wave planning process; • The Recovery Programme Board had established a time-limited Capacity and Demand Task and Finish Group to consider the tools and methodologies available to support capacity and demand planning; • NHS England/Improvement had issued a number of Covid-19 related guidance, for example, the impact of COVID-19 on health inequalities, Black and Asian Minority Ethnic Communities; and on people with Cardio-respiratory conditions. The Trust had developed action plans to implement relevant recommendations. Aileen Feeney, Non-Executive Director drew attention to the Executive Report (agenda item 7.0) and noted that £10m was being made available to regions to set up and run Long COVID clinics. The Acting Executive Director of Strategy confirmed that the share of the £10m would be awarded at system level. Naomi Coxwell, Non-Executive Director asked whether the Trust had adopted a Quality Improvement approach to the COVID-19 recovery programme.

	The Acting Executive Director of Strategy explained that the Trust had taken a Project Management approach to COVID-19 recovery due to time constraints but said that going forward, the Trust would adopt a Quality Improvement approach to its transformation work. **The Trust Board**: noted the report.
20/192	**Audit Committee Meeting – 28 October 2020 and Terms of Reference – Minor Amendments (**agenda item 10.0)
	a) Audit Committee Meeting held on 28 October 2020 The minutes of the Audit Committee meeting held on 28 October 2020 had been circulated. Chris Fisher, Chair of the Audit Committee highlighted the following items which had been discussed by the Audit Committee: • **Board Assurance Framework** – the Committee had requested that the Medical Director updates the Committee on the progress of the Emotionally Unstable Personality Disorder Pathway. • **Board Assurance Framework** – the Committee had suggested that the Trust commissions an independent review of the benefits (both qualitative and qualitative) of the Quality Improvement Programme. The timing of any review would need to be considered in the light of the operational challenges of responding to the COVID-19 pandemic; • **Internal Audit Review of the Board Assurance Framework** – the Internal Auditors had recommended that the Board should consider determining its risk appetite. The October 2020 Trust Board Discursive meeting had reviewed the Good Governance Institute's Risk Appetite Matrix and had decided that this approach did not add value to the Board's discussions about risks. Both the Internal Auditors and the External Auditors agreed that the Trust had robust risk management systems and processes in place and therefore it was not necessary to determine the Board's risk appetite and that this would be done on a case by case basis; • **Annual Review of the Committee's Effectiveness** – the results of the Committee's annual review of effectiveness were very positive. **b) Audit Committee's Terms of Reference** Chris Fisher reported that the Committee had made some minor amendments to its Terms of Reference. Mr Fisher reported that after the Committee had reviewed the Terms of Reference he had agreed Medical Director that the Annual Caldicott Guardian and Information Governance Report would be presented to the Audit Committee rather than to the Trust Board. **The Trust Board**: a) Noted the minutes of the Audit Committee meeting held on 28 October 2020 b) Ratified the changes to the Committee's Terms of Reference and agreed that the Terms of Reference be further amended to reflect that future Annual Caldicott Guardian and Information Governance Reports would be submitted to the Audit Committee rather than to the Trust Board.

20/193	**Council of Governors Update** (agenda item 10.1)
	The Chair reported that twice the usual number of people had attended the Trust's Annual General Meeting which was held virtually because of the COVID-19 pandemic social distancing requirements. The Chair reported that at the request of Governors he was holding monthly informal "Coffee Morning" meetings which were open to all Governors to attend. The Chair reported that he had attended the Council of Governors' Membership and Engagement Group to discuss with the Governors how to encourage younger people and people from Black, Asian and Minority Ethnic communities to put themselves forward for election to the Council of Governors. It was noted that the composition of the current Council of Governors did not reflect the diversity of Berkshire.
20/194	**Any Other Business** (agenda item 11)
	There was no other business.
20/195	**Date of Next Public Meeting** (agenda item 12)
	The next Public Trust Board meeting would take place on 08 December 2020.
20/196	**CONFIDENTIAL ISSUES:** (agenda item 13)
	The Board resolved to meet In Committee for the remainder of the business 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 10 November 2020.

Signed……. Date 08 December 2020
(Martin Earwicker, Chair)

Berkshire Healthcare NHS Foundation Trust

BOARD OF DIRECTORS MEETING 08/12/20

Board Meeting Matters Arising Log – 2020 – 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
10.12.19	19/248	Vision Metrics	The Deputy Chief Executive and Chief Financial Officer to present options for linking True North and the Vision Metrics to the Finance, Investment and Performance Committee.	February 2021	**AG**	The Executive Team will review the True North and Vision Metrics prior to Christmas with view to agreeing the position with the Board in the new year, alongside the launch of the new strategy.	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
11.02.20	20/014	Strategy Implementation Plan 2019-20	A post project review of the Trust's new Intranet to be undertaken in order to learn any lessons for future initiatives.	December 2020	**KM**	A post project review of the Trust's new Intranet was submitted to the Business and Finance Executive meeting on 23 November 2020.	
12.05.20	20/067	Patient Experience Report	The Director of Nursing and Therapies to consider including more detail of the 15 Step Visit Reports as part of the Patient Experience Report.	Paused due to Covid-19	**DF**	15 Step Visits are currently paused because of COVID-19. The action will be completed when 15 Step Visits resume.	
10.11.20	20/182	Staff Flu Campaign Report	The Trust to consider how best to ensure that staff that working from home receive their flu vaccination in subsequent years.	December 2020	**DF**	To be reviewed as part of the preparations for next year's Staff Flu Vaccination Campaign.	
10.11.20	20/188	Draft People Strategy	The People Strategy to be submitted to the February 2020 Trust Board meeting for approval.	February 2021	**AG/JN**		

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
10.11.20	20/188	Draft People Strategy	The Director of People agreed to sharpen up the Key Performance Indicators, to include a “quick win” pathway and re-draft the section on culture.	February 2020	**AG/JN**		
10.11.20	20/189	Draft Equalities, Diversity and Inclusion Strategy	Key metrics to be included in the updated Equalities, Diversity and Inclusion Strategy.	February 2020	**AG/NZ**		

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	Tuesday 8th December 2020
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 maintained during the period with the 3 Staff Networks, the Freedom to Speak Up Guardian has promoted the concept of Freedom to Speak Up and has supported network members for any concerns they may have had around EDI issues. The Guardian has forged close ties with EDI Leads and is a member of various EDI Groups or Committees. Of the total number of "staff experience" concerns raised, it's estimated that: • 60% come from staff of a BAME background. • Approx. 50% of those concerns contain an element of BAME issues such as exclusion or perceived racial prejudice or bullying.
SUMMARY	The post of Freedom to Speak up Guardian 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 to December 2020 and contains data for Q1 & Q2 FY 2020-21 The paper includes: • a summary of communication activity being undertaken by the FTSUG • data from the most recent reports to the National Guardians Office • Feedback received from those who have raised concerns during the period • 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.
Impact of Covid-19	Throughout the period, July 2020 to date, all FTSU activity has continued as much as possible including • Promotion of Freedom to Speak Up and a "Speak Up" culture • Responding to concerns raised • Feeding back to the Organisation on lessons learnt/trends etc.
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 July - December 2020

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 or detriment as a consequence of doing so.

Debbie Fulton, Director Nursing and Therapies is Executive Lead for Freedom to Speak Up and Mark Day, Non-Executive Director, is 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 (Showing progress on plans and relevant target dates):

- Raising Concerns presence on Nexus
- Presentations and attendance at management/team meetings (ongoing)
- FTSU month, focused promotion across the trust during October of each year (This year the theme was the Alphabet, “The ABC of Speaking Up, A = Action through to Z = Zero Tolerance”)
- Production and dissemination of posters, leaflets and cards etc (ongoing)
- Virtual F2F presence at Corporate Induction, Junior Doctor’s Induction & Student’s Induction via MS Teams
- Presentation at Essential Knowledge for New Managers training (content to be reviewed Q 1 2021-22)
- Supporting all EDI/Staff Network Events as an Ally.
- “Speak up/Listen up” interview slot at the recent “Connecting across Boundaries” event
- Supporting a team of FTSU Champions recruited from a variety of services across the organisation (ongoing, Champion activity has abated during C-19 but will be reviewed Q4 2020-21).
- Membership of the Safety Culture Steering Group, OD Steering Group, Diversity Steering Group amongst others
- Lead for Microaggressions and Bullying & Harassment workstreams for the BAME Transformation Group
- Membership of the Ethical Considerations Committee

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”.

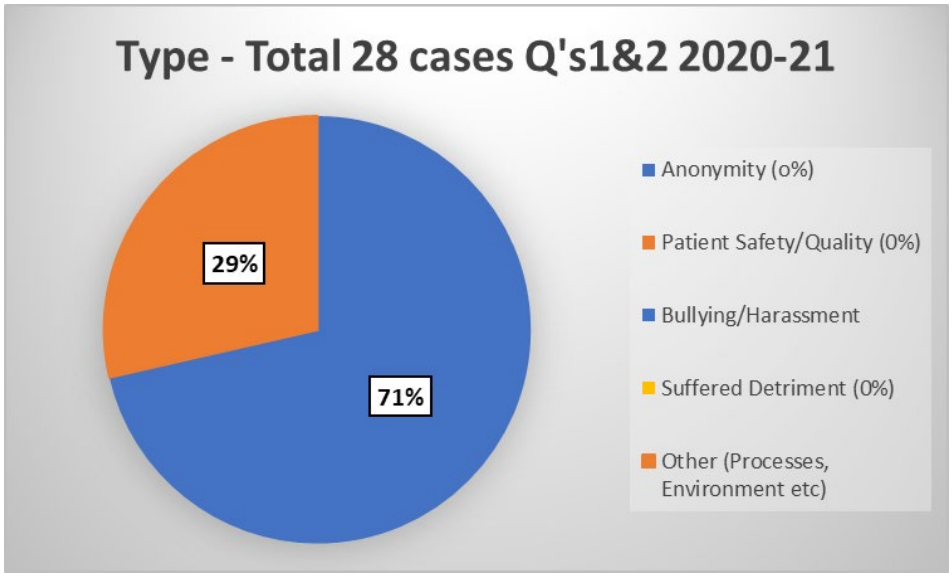
Cases are described as “those concerns raised which require action from the FTSUG”.

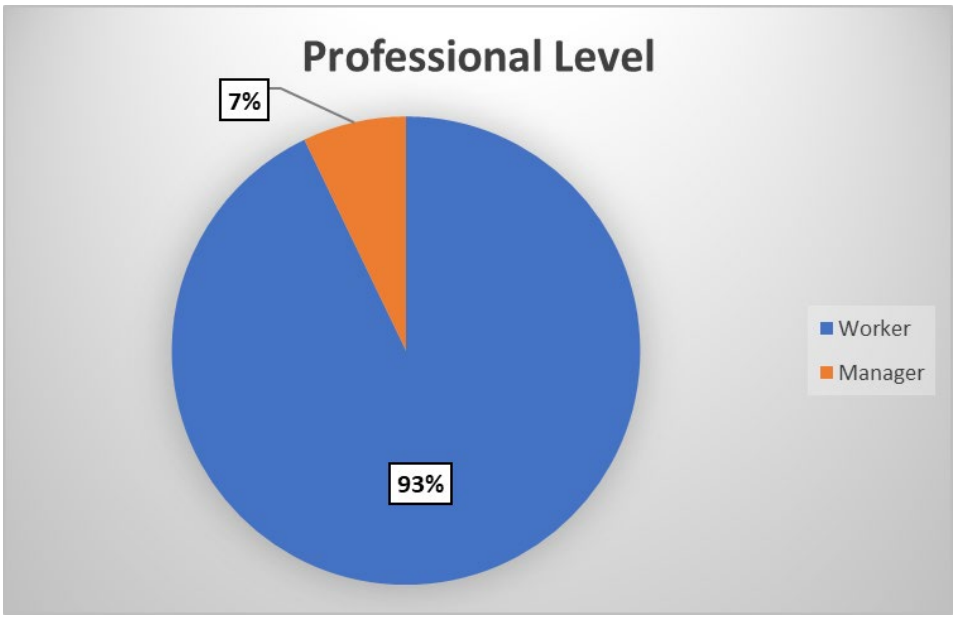
Outlined below are BHFT submissions for Q1 & Q2 FY 2019/20.

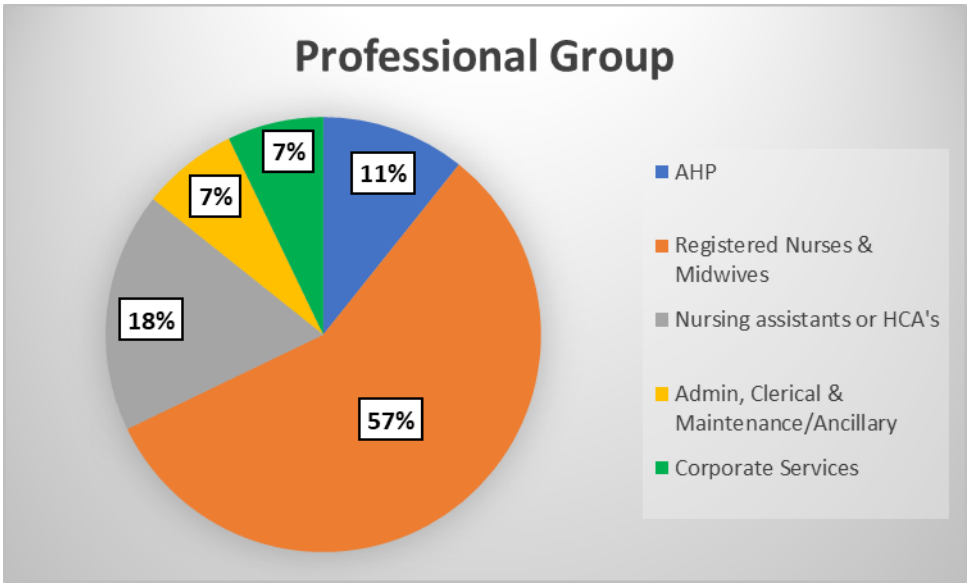
It's difficult to make comparisons with other similar organisations as the data does not provide a narrative regarding how many guardians or champions there are, how many days a week they work and if they have recorded both cases and contacts. All cases and contacts at Berkshire Healthcare are reported.

The total number of cases raised for FY 2019/20 = 31

FY 2020/21	Q1	Q2	TOTAL
Number of cases returned to the National Guardian's Office	**17**	**11**	**28**







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.
- The significant increase in the number of cases raised for Q 1&2 vs Q1-4 FY 2019/20 can partly be attributed to an increased awareness of the Guardian and associated process, an increase in cases raised can be considered a good thing (a better Speak Up culture)
- Returns show zero 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 or confidentiality having spoken to the Guardian.
- During the period the Guardian received no anonymous concerns.
- 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).
- Of the total number of “staff experience” concerns raised, it’s estimated that, during the period, 60% come from staff of a BAME background and approx. 50% of those concerns relate to BAME issues such as exclusion or perceived racial prejudice or bullying.
- There is no data on concerns raised by members of other staff networks that may relate to membership of that network.

Impact of Covid-19

From July 2020 to date, FTSU activities have continued as before (wherever possible) to ensure “business as usual”.

- **Promotional work** – Awareness has continued via Social Media, Corporate Induction, Intranet, Covid-19 weekly emails, direct meetings with services, use of MS Teams etc
- **Response to concerns –** As per usual, it has been easier for staff to communicate with the Guardian in confidence as many staff are working from home and there is no requirement to meet off site.
- **Cases –** Q1 & Q2 saw a significant increase in the number of cases raised compared to the previous 2 quarters, a few of those related to PPE issues or redeployment
- During this time the Guardian supported the wellbeing hub and HR function to ensure staff were aware of FTSU support available.
- Feedback to the Organisation on cases, lessons learnt and any trends continued as normal.

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.

Learning and Improvement

The FTSU Status Exchange between the FTSUG, Chief Executive, Director of Nursing and Therapies and Head of Operational HR 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.

The Guardian ensures that any learning from cases raised is communicated to the Organisation through this status exchange, through regular 1:1's with the Executive lead for Freedom to Speak Up.

Those who raise concerns are offered continual feedback on any investigation work undertaken as a result of speaking up and are supported throughout the whole process, the

Guardian also obtains feedback from those who raise concerns on their views of the process and this learning is reviewed and considered by the Guardian.

On occasions where reports of case reviews undertaken by the National Guardian's Office are published, the Guardian will review these reports and communicate recommendations to the Organisation.

The National Guardian's Office are planning to release a series of E-Learning packages, there will be 3 packages aimed at various levels within the Organisation.

The first module, Speak Up, has recently been released

- **Speak Up** – Core training for all workers, volunteers, students and trainees, aimed at giving all staff an understanding what speaking up is, how to do so and what to expect when they do so.
- **Listen Up** – Aimed at all line managers, raising awareness of the barriers that can exist when staff wish to speak up and how to minimise them.
- **Follow Up** – For Senior Management groups and Trust Executives, ensuring the Organisation acts on concerns raised, learns from them and uses feedback to help create an open & just culture where all workers are actively encouraged to use their voices to suggest improvements or raise concerns.

Feedback

Appendix 1 attached to this report shows a breakdown of feedback received from workers who have raised concerns to the Guardian during the period.

A detailed breakdown of responses to the free text questions are highlighted below:

Q11. Should you wish to, please expand or comment on any of your answers above (Q's 1-10)

"I was at a very low point in my working life and felt sick to my stomach at the thought of coming into work. I felt demoralised and felt my job had no real value. I felt I was not utilising my skills and knowledge and did not feel part of the team. When I heard of the freedom to speak up I was really nervous taking the first step in case I got into trouble but my close colleagues were very encouraging and supportive and spoke positively about their experience and the importance of more people speaking up."

"I would have liked to know specifically what the actions were that were taken after I spoke with the Guardian as I was only informed that my concerns were being taken seriously but nothing else?!
How does the trust make sure this situation does not happen to anyone else? Thank you :-)"

"I have stated that my concern is being addressed partially because my concerns involve my direct line manager I don't feel brave enough to raise a direct complaint against her and as such she continues to stop me from progressing in retaliation for me raising concerns about her behaviour towards me informally to her. She has taken away the work I was doing that had raised my profile in the trust and practically demoted me by taking away work that is even in my job description. I am looking for another job and will leave as soon as I find a suitable role."

"I didn't follow my concerns through, so it is hard to comment on how these were handled but I was pleased with the support I received. I regret in some ways not continuing to pursue with my concerns as I feel it will probably happen to someone else but also was not in the right headspace to at the time and was also worried about staying in the Trust if I had pursued. I am considering getting back in touch." – This staff member has made contact since they made this comment

"Mike was great to speak to and actioned my concerns immediately."

Q21. Should you wish to, please expand or comment on any of your answers above around Equality, Diversity or Inclusion.

"English as a second language network staff members" – A recommendation for a new staff network

"I wish managers understood, had more awareness around supporting staff with learning disabilities and dealing with these types of situations. Not to penalise them especially as this is protected factor and working for the NHS."

Q22. If you have any further comments around the Freedom to Speak Up process, please add them here.

"The process from FTSU is perfect and I am highly happy with the way it was dealt with/processed.
Improvement suggestion: For managers to complete training/awareness of how to support colleagues through complaints, having a process to follow and taking physical threats more seriously. It is sad to know my department lacks awareness and couldn't guarantee my safety without the support of Mike. Thankfully I am happy that Mike was there to support me through the process and eased my anxieties. May I ask do you follow up with the managers that this has been resolved? As there hasn't been a follow up/documentation, only word of mouth.
Thank you."

"Can I just mention that this is an ever-evolving service like any other, but it is sooooo important that it continues. This platform gives all staff the opportunity to speak confidentially about any workplace concerns or negative behaviours they may be experiencing. Ultimately with a view to ending and resolving the issues in a timely manner with suitable support in place. Thank you for your support."

"Mike has been fantastic and very supportive, but the trust needs to take more action from the very top to make those who are prejudiced accountable for their actions and to promote equality and diversity."

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.
- Note, learn and consider appropriate changes from feedback given.

Author and Title:

Mike Craissati - Freedom to Speak Up Guardian

December 2020

Freedom to Speak Up Feedback form

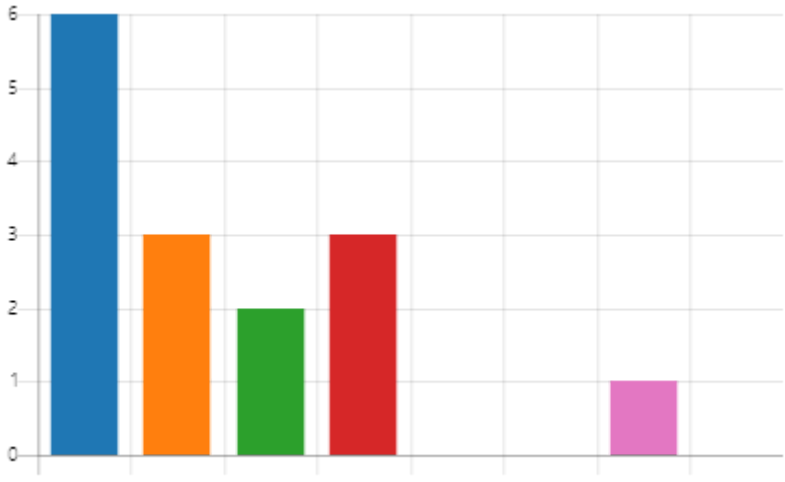
9	18:37	Active
Responses	Average time to complete	Status

1. Given your experience of raising a concern with the Freedom to Speak Up Guardian, would you speak up again?

Yes	8
No	0
Maybe	0
Don't know	1

2. How did you find out about the Freedom the Speak Up Guardian role?

Word of mouth/colleague	6
Staff Intranet	3
Weekly staff email	2
Posters/leaflets	3
Raising concerns (whistle blow...	0
Line Manager	0
FTSU Champion	1
Presentation by the Guardian	0



3. How easy was it to make initial contact?

9	★★★★★★★★★★
Responses	9.78 Average Rating

4. How did you find the initial response from the Freedom to Speak Up Guardian?

9

Responses

★★★★★★★★★★

10.00 Average Rating

5. Did you feel that your concern(s) were taken seriously?

Yes	9
No	0

6. Did you receive regular feedback from the Guardian about your concern?

Yes	9
No	0

7. Has your concern been addressed?

Yes	5
No	1
Partially	3

8. Did you feel that your contact and concerns were treated confidentially?

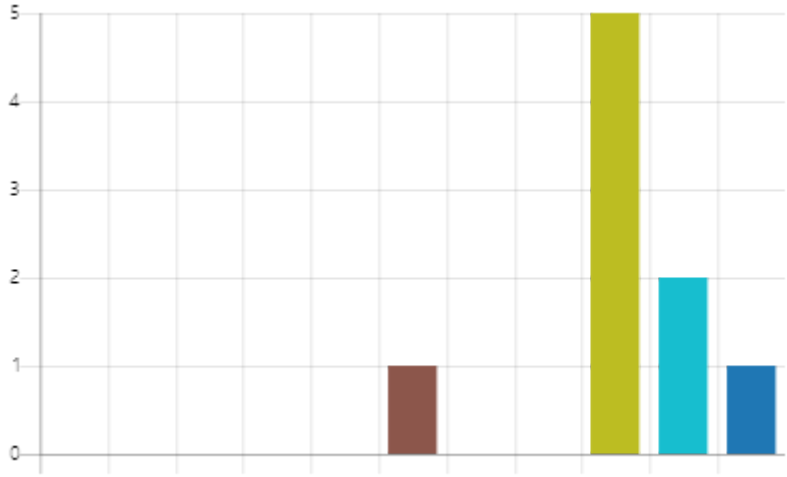
Yes	8
No	0

9. Have you suffered any detriment as a result of raising your concern?

Yes	2
No	7

10. Please indicate your staff group

Allied Health Professional	0
Medical and Dental	0
Ambulance	0
Public Health	0
Commissioning	0
Registered Nurses and Midwiv...	1
Nursing Assistants or Healthc...	0
Social Care	0
Administration, Clerical & Mai...	5
Corporate Services	2
Other	1



11. Should you wish to, please expand or comment on any of your answers above.

7

Responses

Latest Responses

"*Mike was great to speak to and actioned my concerns immediately.*"

"*I didn't follow my concerns through so it is hard to comment on how t...*

12. These next Equality, Diversity & Inclusion questions are about you and will help the Guardian (and Organisation) to know more about how the staff that contact the Guardian reflect the staff that make up the Trust

0

Responses

Latest Responses

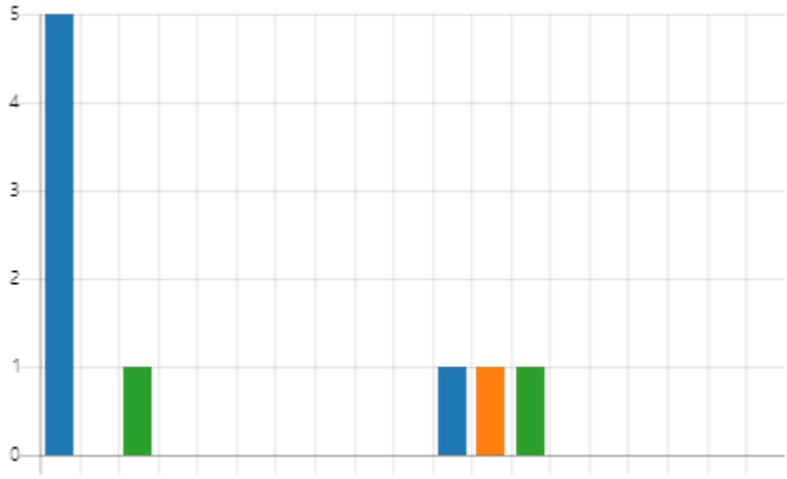
""

13. What age group are you?

Under 30 years	3
30-50 years	4
50-65 years	2
Over 65 years	0

14. Please indicate you race/ethnic origin.

White British	5
White Irish	0
White other	1
White and Black African	0
White and Black Caribbean	0
White and Black Asian	0
White and Asian	0
Black Caribbean	0
Black African	0
Black Other	0
Asian British	1
Asian Indian	1
Asian Pakistani	1
Asian Bangladeshi	0
Asian Chinese	0
Asian Other	0
Arab	0
Any other ethnic group	0
Prefer not to say	0

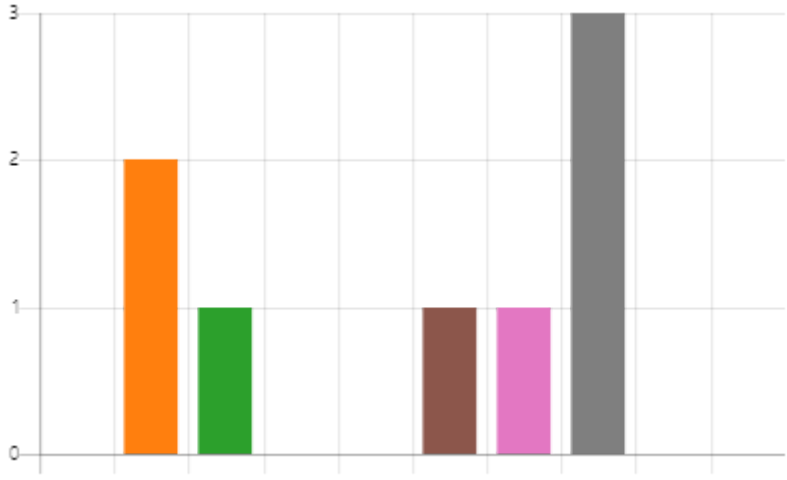


15. Please indicate your sex

Male	1
Female	8
Trans	0
Other	0
Prefer not to say	0

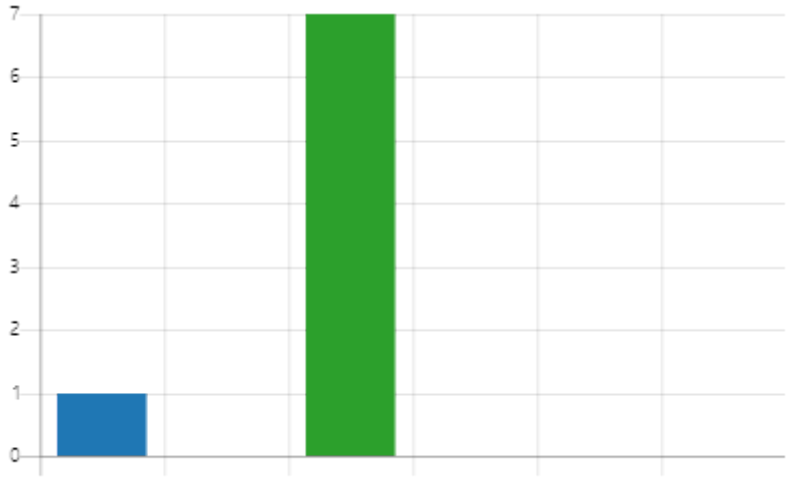
16. Please indicate your religion or belief

Buddhist	0
Christian	2
Hindu	1
Jewish	0
Muslim	0
Sikh	1
Atheist	1
None	3
Prefer not to say	0
Other (please specify below)	0



17. Please select the option that describes your sexual orientation

Bisexual	1
Gay	0
Heterosexual	7
Lesbian	0
Other	0
Prefer not to say	0

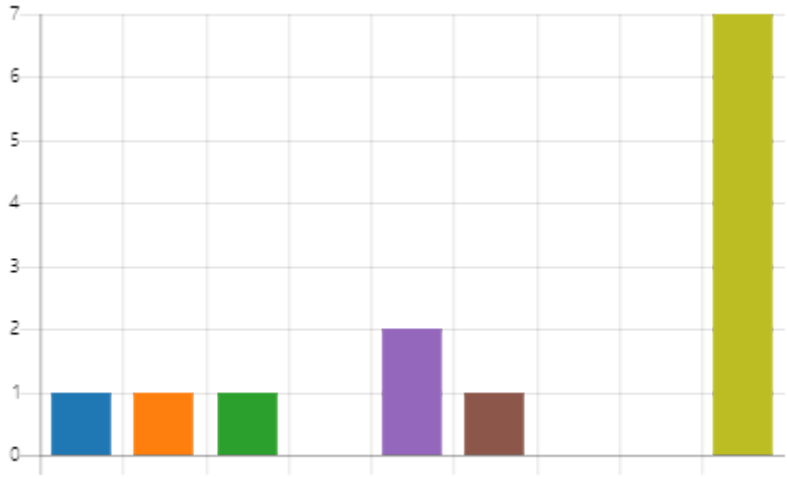


18. Do you consider yourself to have a disability?

Yes	2
No	7
Prefer not to say	0

19. If YES, please state the type of impairment(s) which applies to you.

Physical Impairment	1
Sensory Impairment	1
Mental Ill-Health	1
Neurodiversity	0
Learning Disability	2
Learning Difficulty	1
Long-term illness	0
Other	0
Other	7



20. Are you a member of any of the following BHFT staff networks?

BAME	2
Pride	0
Purple	2
Not a member of any staff net...	4
Other	2

21. Should you wish to, please expand or comment on any of your answers above around Equality, Diversity or Inclusion.

3
Responses

Latest Responses
""
""
""

22. If you have any further comments around the Freedom to Speak Up process, please add them here. Many thanks for your time in giving me important feedback.

3
Responses

Latest Responses
""
""
""

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	08 December 2020
Title	**Quality Assurance Committee –17 November 2020**
Purpose	To receive the unconfirmed minutes of the meeting of the Quality Assurance Committee of 17 November 2020
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 17 November 2020 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: a) 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, 18 November 2020

(the meeting was conducted via MS Teams because of COVID-19 social distancing requirements)

Present:	David Buckle, Non-Executive Director (Chair) Aileen Feeney, Non-Executive Director Mehmuda Mian, Non-Executive Director Julian Emms, Chief Executive David Townsend, Chief Operating Officer Dr Minoo Irani, Medical Director Debbie Fulton, Director of Nursing and Therapies Guy Northover, Lead Clinical Director Amanda Mollett, Head of Clinical Effectiveness and Audit
In attendance:	Julie Hill, Company Secretary Sara Fantham, Interim Clinical Director & Lead Nurse East Adults Physical Health *(present for agenda item 5.1)* Jan Durrant, Head of Community Diabetes Service *(present for agenda item 5.1)* Alison Jones, Senior Diabetes Service Project Manager *(present for agenda item 5.1)* Camilla Sowerby, Early Intervention Psychosis Team Pharmacist *(present for agenda item 6.2)* Bridget Gemal, Head of Psychological Therapies *(present for agenda item 6.2)* Colin Archer, Head of Learning Disability Services *(present for agenda item 6.2)* Rebecca Chester, Consultant Nurse, Learning Disabilities *(present for agenda item 6.2)* Joanna May, Early Intervention in Psychosis Service Lead *(present for agenda item 6.2)*

1 Apologies for absence and welcome

There were no apologies.

Julian Emms, Chief Executive explained that the meeting clashed with the Frimley Health and Care Integrated Care System Board and therefore he would be dipping in and out of the meeting.

The Chair welcomed everyone to the meeting.

2. Declaration of Any Other Business

There was no other business declared.

3. Declarations of Interest

There were no declarations of interest.

4.1 Minutes of the Meeting held on 18 August 2020

The minutes of the meeting held on 18 August 2020 were confirmed as an accurate of the proceedings.

4.2 Matters Arising from the Minutes and Matters Arising Log

The Matters Arising Log had been circulated.

The Chair referred to the section on “Horizon Scanning” and noted that there were outstanding items on the list.

The Company Secretary explained that there were a number of items on the agenda for today’s meeting and therefore the remaining items on the Committee’s forward plan would be timetabled for future meetings.

The Chair referred to the appendix to the Action Log which set out the priorities and objectives of the Trust’s Physical Health in Serious Mental Illness Strategy 2020-22. The Chair commented that this issue had been highlighted as an area for improvement in two out of the three Clinical Audits under discussion at today’s meeting and suggested that the issue would be discussed as part of the Clinical Audit section of the meeting.

The Committee noted the schedule of actions.

5. Patient Safety and Experience

5.1 National Diabetes Audit Assurance Report – Care Processes

The Chair welcomed Sara Fantham, Interim Clinical Director and Lead Nurse East Adults Physical Health, Jan Durrant, Head of Community Diabetes Services and Alison Jones, Senior Diabetes Service Project Manager and commented that it was clear from the paper that a lot of work had been undertaken.

The Interim Clinical Director presented the paper and highlighted the following points:

- The audit results for 2018-19 National Diabetic Audit had highlighted that the service was unable to demonstrate that HbA1c blood tests were being carried out for all people with Diabetes under their service (HbA1c measures how well a person’s diabetes was being controlled over the previous 2-3 months);This was in part due to poor historical data capture;
- The paper presented to the Committee set out the work undertaken by the service since 2019 to improve data capture so that when the National Diabetic Audit was resumed, improvements to the Trust’s HbA1c data would be evidenced;
- The service was waiting for further changes to be made to the RiO electronic patient record system by the Transformation Team, RiO and Audit teams to enable ongoing monitoring of this data without reliance on manual processes;

- Due to the COVID-19 pandemic there was potentially missing data in respect of other audit measures, for example, blood pressure and weight, in addition to HbA1c where patients were not taking up the request to obtain blood tests;
- The service did have concerns in respect of data being extracted by the Clinical Audit department from the National Diabetic Audit digital platform as a report extracted on 23 October 2020 showed very little data in respect of the insulin pump data entries. This necessitated the manual checking of data entry which was time consuming. The service was later advised that the extract taken was not correct and that data was showing but that there was a fault with the digital platform and data extraction. The Trust had raised the issue with NHS Digital and was awaiting a response.

The Chair recognised that one of the consequences of the COVID-19 pandemic was that many patients did not want to take the risk and have blood tests and other health checks, and this was likely to have a negative impact on health outcomes in the future.

The Chair said that the paper provided reassurance about improvements to data collection but had highlighted that further work was needed to ensure that the Trust met the HbA1c target in future National Diabetic Audits. The Interim Clinical Director agreed that this was work in progress

The Medical Director pointed out that that the last two National Diabetic Audits had identified data collection issues and the Trust had undertaken a significant amount of work to address this issue. The Medical Director commented that if the next National Diabetic Audit placed the Trust's performance below the national average, the Trust would need to investigate whether there were other underlying issues about the way the Trust managed patients with Diabetes.

The Chief Operating Officer supported the Medical Director's view and pointed out that the Diabetes Service had staffing challenges even before the COVID-19 pandemic. The Chief Operating Officer said that the Trust may need to review the commissioning arrangements for Diabetes Services.

The Chair said that as with the outcome of all clinical audits which highlighted performance issues, it was important to determine whether this was due to issues with data collection and accuracy or whether there were issues around clinical practice which needed to be addressed.

The Chair invited the Chief Operating Officer, Medical Director and Director of Nursing and Therapies to decide the timing of the next update report to the Committee.

Action: Chief Operating Officer/Medical Director/Director of Nursing and Therapies

5.2 Quality Concerns Report

The Director of Nursing and Therapies presented the paper and reported that where relevant, the individual Quality Concerns had been updated and pointed out that due to a technical issue, the new Quality Concern relating to Willow House had not been included when the agenda papers were combined. The risk description and actions are set out below:

Quality Concern No 12 - Willow House Adolescent Unit

Risk Description

Significant staff vacancy and challenges filling shifts with temporary staffing alongside planned absence of key roles (Psychology and Consultant) and recent patient safety incidents causing safety concerns for both young people and staff on the unit Environment has limited space and design not ideal for service type. Building is old and has limited life with replacement due by 2022. There have been delays on the replacement programme.

Action Plan Summary

Senior Oversight Group including Clinical/ Divisional Director and Deputy Director Nursing with action plan in place. weekly status exchange with Chief Operating Officer/ Director Nursing/ Clinical and Divisional Director. Maximum 50% occupancy agreed at present; dedicated input from recruitment to support reduction in vacancy factor. Service manager basing themselves on the unit. Proactive engagement with NHSE and Oxford collaborative around replacement programme. Process in place for escalation of environmental works required.

Mehmuda Mian, Non-Executive Director referred to Quality Concern No 1 (Nursing and Staffing Vacancies) which mentioned international recruitment and expressed concerns about the ethics of recruiting overseas nurses.

The Director of Nursing and Therapies explained that the Trust's work was focused on supporting those staff who had qualified overseas and who were working as Health Care Assistants to gain registration with the Nursing and Midwifery Council.

The Chair referred to Quality Concern No 8 (Physical Health Monitoring in Mental Health Services) and as mentioned earlier this issue had been identified as an area requiring improvement in two out of the three clinical audits to be discussed later in the meeting.

The Director of Nursing and Therapies agreed that further work was required to improve the physical health monitoring of mental health patients and reported that Kerry Harrison, Clinical Director (Adult Mental Health Services East) had been appointed as the Clinical Physical Health Lead in both East and West Berkshire.

The Director of Nursing and Therapies reported that the Quality and Performance Executive meeting held on 16 November 2020 had suggested adding physical health monitoring in respect of mental health patients as one of the Trust's Quality Improvement Programme's breakthrough objectives to give the issue more focus and challenge.

The Medical Director pointed out that until relatively recently the Royal College of Psychiatry had not included physical health monitoring as part of their training programmes. The Medical Director reported that he had had a meeting with Kerry Harrison who was leading the physical health monitoring for people with mental health conditions and he had been assured that the Trust was making progress but it would take time to turn the dial.

The Director of Nursing and Therapies proposed inviting Kerry Harrison to a future meeting to provide an update on progress.

Action: Kerry Harrison/Company Secretary

The Committee noted the report.

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

The Director of Nursing and Therapies presented the paper and reminded the meeting that the Care Quality Commission's Report, Sexual Safety on Mental Health Wards, published in September 2018 had set out recommendations on how sexual safety could be improved.

The Director of Nursing and Therapies reported that the Trust had developed an action plan to address the Care Quality Commission's recommendations and had made good progress against the original action plan.

The Director of Nursing and Therapies reported that further work had commenced with the Safeguarding Team, Preceptees, key Ward staff and with the Patient Safety Officer focusing on recent data that has had found that most sexual safety incidents happened in communal areas during the daytime. Daisy ward was the pilot ward for the current countermeasures as Daisy ward had seen a higher number of incidents in comparison to other wards.

Aileen Feeney, Non-Executive Director asked why Daisy ward had a higher number of incidents compared with other wards.

The Director of Nursing and Therapies explained that there were no particular reasons why Daisy ward had a higher number of incidents but said that Daisy ward had been selected to pilot the countermeasures to give more focus to the issue.

The Committee noted the report.

5.4 Serious Incidents Report – Quarterly Report

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

- There were 22 Serious Incidents reported during the quarter with 1 Serious Incident downgraded:
    - 4 suspected suicides
    - 5 unexpected deaths
    - 1 attempted suicide
    - 1 homicide
    - 1 self-harm
    - 1 assault
    - 4 pressure ulcers
    - 2 falls
    - 2 categorised as "other"
- Work had taken place to prepare for the Royal College of Psychiatrists' accreditation of the Trust's Serious Incident systems and processes which took place at the end of October 2020. The outcome of the accreditation was expected to be announced in January 2021.

Mehmuda Mian, Non-Executive Director asked whether the accreditation was mandatory.

The Director of Nursing and Therapies said that the accreditation was voluntary but explained that the Trust was keen to participate in the accreditation process in order to gain assurance about the Trust's serious incident systems and processes.

Aileen Feeney, Non-Executive Director noted that the number of serious incidents had increased compared with the previous quarter.

The Director of Nursing and Therapies said that there were a lower than normal number of serious incidents reported in quarter 1 but pointed out that it was important to look at any trends over a longer time frame.

The Committee noted the report.

5.5 Learning from Deaths Quarterly Report

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

- In Quarter 2 of 2020/21, 780 deaths were recorded on the clinical information system (RiO) where a patient had been in contact with a Trust service in the year before they died;
- Of the deaths, 101 met the criteria to be reviewed further. All 101 deaths were reviewed by the Executive Mortality Review Group. 58 deaths were closed with no further action; 48 deaths required “second stage” review (using an initial findings review/structured judgement review methodology);
- Of the 48 deaths, 9 were classed as “Serious Incidents” requiring investigation
- During Quarter 2 the Mortality Review Group had reviewed the findings of 58 second line review reports of which 11 related to patients with a learning disability.
- Of the 58 case reviews received by the Mortality Review Group none identified a lapse in care.

The Committee noted the report.

5.6 Well-Led Care Quality Commission Inspection Must Do and Should Do Action Plans

The Director of Nursing and Therapies presented the paper and reported that following the November-December 2019 inspection, the Care Quality Commission had rated the Trust as “Outstanding”. As part of the inspection, the Care Quality Commission had assessed two core services (Specialist Community Mental Health Services for Children and Young People and Acute Wards for Adults of Working Age and Psychiatric Intensive Care Wards) where the Trust must take action.

The Director of Nursing and Therapies reported that the Care Quality Commission had also identified some “should do” actions. It was noted that action plans had been developed to implement both “Must Do” and “Should Do” actions. The Director of Nursing and Therapies reported that there was good progress in relation to the “Must Do” actions, for example, the new doors at Prospect Park Hospital with anti-ligature mechanisms were on order, but pointed out that some of the “Should Do” actions would be more challenging to address, for example reducing waiting times for some CAMHS services.

Mehmuda Mian, Non-Executive Director noted that the Trust conducted an annual anti-ligature audit and had undertaken a lot of work to reduce ligature risks at Prospect Park Hospital and asked whether the Care Quality Commission’s “Must Do” actions in relation to the doors had come as a surprise.

The Director of Nursing and Therapies commented that the doors with the anti-ligature mechanisms had only recently come on the market but said that the Trust would probably have mitigated the risks in a slightly different way.

The Committee noted the report.

5.7 CQC Out of Sight – "Who Cares? A Review of Restraint, Seclusion and Segregation for Autistic People and People with a Learning Disability and/or Health Condition"

The Director of Nursing and Therapies presented the paper and reported that the Care Quality Commission's "Out of Sight – Who Cares? A Review of Restraint, Seclusion and Segregation for Autistic People and People with a Learning Disability and/or Health Condition" was published in October 2020.

The Director of Nursing and Therapies reported that the key findings in the report were that:

- People with autism, a learning disability and/or mental health condition should be supported to live in their communities where they lived;
- People who were being cared for in hospital should get good care that was right for them in small units;
- Staff must be trained to support people's needs so they can leave hospital as soon as it was possible;
- Restraint, seclusion and segregation should only be used in emergencies. It should not be seen as a way to care for someone.

The Director of Nursing and Therapies reported that the recommendations were being reviewed and steps were being taken to address each of the issues. The Prospect Park Hospital Restrictive Practice Group would be refreshed, and an Oversight Group developed to enable reporting to the Mental Health Act quarterly group for assurance and monitoring of progress in all Trust areas. The Trust's Action Plan to implement the recommendations would be presented to the next meeting of the Committee.

Action: Director of Nursing and Therapies

The Committee noted the report.

5.8 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.

The Director of Nursing and Therapies reminded the meeting that on 2 March 2020, following the inquest of Sophie Booth, the Coroner had issued a Section 28 report in relation to four areas of concern:

- Ensuring salient information was best captured by referrers when completing and sending referral forms to the Trust's Common Point of Entry service;
- The importance of effective due diligence when triaging referrals where the potential client had experienced an episode of mental health crisis abroad;
- Assurance that downgrading referrals from red to amber was consistently conducted in a rational and proportionate manner, including seeking further information from the referrer or potential client as required; and
- Ensuring that mental health services communicate effectively – particularly in relation to information sharing where someone was referred into more than one service.

The Director of Nursing and Therapies reported that the action plan set out the progress made to address the areas highlighted for improvement by the Coroner.

The Committee noted the report.

5.9 Health and Safety Investigation into a COVID-19 related death of an NHS Professional Healthcare Staff Member Who Worked on the COVID-19 Isolation Ward during April 2020

The Director of Nursing and Therapies presented the paper and reported that the Health and Safety Executive had investigated the death of the staff member who was employed by NHS Professionals and had identified two non-material breaches in Health and Safety Legislation relating to staff risk assessments.

It was noted that the Health and Safety Executive had acknowledged that the context of the response the Trust was making in the face of rapidly changing guidance during the developing COVID-19 pandemic.

The Director of Nursing and Therapies reported that the Trust had addressed the issues raised by the Health and Safety Executive.

The Committee noted the report.

5.10 COVID-19 Outbreak

The Director of Nursing and Therapies gave a verbal update to the latest COVID-19 situation in respect of the Trust's inpatient wards and reported that at Prospect Park Hospital there had been two COVID-19 outbreaks on Rowan and Orchid wards. It was noted that Rowan ward had been designated as the COVID-19 positive ward. The Director of Nursing and Therapies reported that the Trust was also treating COVID-19 patients on the Trust's physical health wards.

The Director of Nursing and Therapies reported that around 60 staff were off work because they were either tested positive for COVID-19 or were self-isolating.

The Director of Nursing and Therapies reported that NHS England/Improvement had asked NHS provider organisations to put plans in place to be ready to start the COVID-19 staff vaccination programme from 1 December 2020.

The Chair said that the initial findings from the Pfizer and Moderna vaccinations was that these vaccines were between 90-95% effective which was extremely good news. The Chair said that the logistics of conducting a vaccination programme on this scale would be very challenging and that if GPs were involved in administering the vaccine that this would mean that they would have to scale back on their other work.

The Medical Director reported that the Trust would shortly begin a programme of lateral flow COVID-19 testing for staff in order to reduce asymptomatic COVID-19 staff to patient transmission.

The Chair thanked the Director of Nursing and Therapies and Medical Director for updating the Committee.

5.11 COVID-19 Board Assurance Framework Risk

The COVID-19 Board Assurance Framework Risk had been circulated. The Company Secretary pointed out that the COIVD-19 risk had been sub-divided into two separate risks: Risk 8A – COVID-19 and Second Wave/Winter Planning and Risk 8B – COVID-19 Recovery.

Aileen Feeney, Non-Executive Director referred to page 128 of the agenda pack and pointed out that reference to the "weekly all staff Executive Briefings" should amended to read: "fortnightly".

Action: Company Secretary

The Committee noted the report.

5.12 Waiting Times Presentation

A copy of the Chief Operating Officer's presentation given at the Joint Trust Board and Council of Governors' meeting on 4 November 2020 had been circulated.

The Chair commented that nationally NHS Waiting Lists were high pre-COVID-19 and said that the pandemic had significantly increased waiting lists and in particular the number of patients waiting more than a year for treatment.

The Chair said that for the Trust, demand for CAMHS Autism and ADHD assessments continued to increase by around 18-20% year on year leading to long wait times. The Chair said that long waiting times for Autism and ADHD assessments posed a reputational rather than a patient safety issue for the Trust.

The Chief Operating Officer said that the Trust was meeting the nationally mandatory waiting times targets and pointed out that in respect of non-mandatory waiting times there were significant variations across all services.

The Chief Operating Officer reported that the Trust had developed a new Waiting Times Report which (page 137 of the agenda pack) which visually set out waiting times across the different Trust services. The new report also set out how many people were waiting for a particular service and displayed this information using different colours to indicate the wait time bands.

Aileen Feeney, Non-Executive Director said that she found the format of the new Waiting Time – Services Report very helpful but commented that some patients were waiting a year or more to be seen.

The Chair thanked the Chief Operating Officer for sharing the presentation and said that it provided the Committee with a useful summary of the Trust's waiting times.

Clinical Effectiveness and Outcomes

6.1 Quality Accounts 2020-21

The second quarter Quality Accounts 2020-21 had been circulated. The Chair thanked the Quality Accounts Team for all their work and reported that the Committee would have a more in-depth review of the Quality Accounts at the next meeting.

The Committee noted the report.

6.2 Clinical Audit Report

The Chair welcomed Bridget Gemal, Head of Psychological Therapies, Camilla Sowerby, Early Intervention Psychosis Team Pharmacist, Colin Archer, Head of Learning Disability Services, Rebecca Chester, Consultant Nurse, Learning Disabilities and Joanna May, Early Intervention in Psychosis Service Lead to the meeting.

The Medical Director presented the paper and reported that three national clinical audit reports were received by the Clinical Effectiveness Group in September 2020:

- National Clinical Audit of Psychosis: EIP (Early Intervention in Psychosis) service re-audit 2019
- National Clinical Audit of Anxiety and Depression: Additional report published following the main report received by QAC in August 2020, detailing the qualitative aspects of the patient survey results
- POMH – 9d Antipsychotic prescribing in people with a learning disability

a) National Clinical Audit of Psychosis: EIP (Early Intervention in Psychosis) service re-audit 2019

The Medical Director said that the Trust's Early Intervention in Psychosis was a re-audit and reported that the Trust's overall score had reduced since the 2018-19 audit and had achieved an overall score of "needs improvement" from "performing well" in the previous audit.

The Medical Director explained for eight of the ten standards, the Trust's performance was rated as top performing or performing well. It was noted that standards were weighted in the overall score and the relatively low compliance with standard 2.5 (undertaking physical health checks and intervention) had a significant negative impact on the Trust's overall score.

It was noted that following the audit publication, the Royal College had identified 3 patients where interventions were not recorded. All 3 cases were reviewed, and it was confirmed that 2 cases were already under the care of the GP for their pre-diabetes and the third case where there may be a sample error was being rechecked by the clinical team.

Joanna May, Early Intervention in Psychosis Service Lead reported that the service was taking a Quality Improvement approach and had reviewed the areas of concern and had identified that the main reasons were related to the complexity of the cardio-metabolic form and the difficulty staff had in accessing the test results. New physical health assessment forms in RiO were already in development to simplify data entry for staff and from December 2020, the three current physical health forms would be replaced by a single form on RiO providing a central point of information to multiple users.

Camilla Sowerby, Early Intervention in Psychosis Team Pharmacist reported that to improve the recording of physical health interventions, the Trust's Business Analysts had designed a bespoke dashboard on Tableau that would use colour coding to detect any missing or abnormal readings from RiO making it immediately visible to staff.

The Lead Clinical Director confirmed that under the leadership of Kerry Harrison in her role as Clinical Physical Health Lead, the Trust has making a number of improvements to the physical health monitoring of mental health patients and welcomed the proposal that it become one of the Trust's driver metrics.

b) National Clinical Audit of Anxiety and Depression: Additional report published following the main report received by QAC in August 2020, detailing the qualitative aspects of the patient survey results

The Medical Director reported that this was an additional report published after the main report of the National Clinical Audit of Anxiety and Depression which was reviewed at the August 2020 Committee meeting.

The Medical Director explained that in addition to the main national report all patients were sent a service user survey to identify experiences and perspectives of adults who are accessing secondary care psychological therapy for anxiety or depression. Responses were sent directly back to the national team.

It was noted that the Trust had a 19% response rate to the service user survey. The supplementary report presented the overall national patient experience which identified 4 key recommendations nationally. The Head of Psychological Therapies had reviewed the recommendations against the current action plan which was presented to the last meeting. The Head of Psychological Therapies had implemented the required actions and no additional actions were required.

c) POMH – 9d Antipsychotic prescribing in people with a learning disability

The Medical Director reported that overall, the Trust had scored higher than the Total National Sample in 12 of the 17 domains of the audit but there had been a reduction in performance in several domains compared with the 2015 audit.

The Medical Director reported that Improvements were required in relation to the monitoring and recording of side effects and physical health observations and the assessment/monitoring/and recording of the presence/absence of side effects following clinical assessment/reviews. An action plan had been developed to address the improvements required.

Rebecca Chester, Consultant Nurse reported that random sample of 150 cases were chosen for the audit which was around 10% of the Psychiatry caseload. Ms Chester reported that the action plan included: the development of a standard letter for correspondence with the GP which included the recording of the presence/absence of side effects; the introduction of an evidence based tool for assessing side effects and the introduction of the new Physical Health Form for RiO due to be launched in December 2020.

Colin Archer, Head of Learning Disability Services said that the audit had highlighted good practice and had enabled the service to identify where gaps around data recording.

The Committee noted the report and thanked the Clinicians for attending the meeting.

7.1 Quality Assurance Committee – Annual Review of Effectiveness and Review of the Terms of Reference

The Company Secretary presented the Committee's Annual Review of Effectiveness and thanked everyone for completing the questionnaire. The Company Secretary said that the results were very positive and included complimentary comment about the chairing of the meetings.

The Chair referred to one of the comments which related to reports already being discussed at the Quality and Performance Executive Group meetings but said that whilst he could appreciate the Executive's frustration over the duplication of reporting, it was important for assurance purposes that the Non-Executive Directors also had sight of the reports. The Chair commented that the reports to the Committee were high quality and informative and this meant that the Trust only needed four meetings a year.

The Chair said that he really appreciated Clinicians attending the meetings to present their reports.

The Chair said that he was also happy to have discussions outside of the meeting if members of the Committee wished to raise any issues.

The Company Secretary reported that minor changes had been made to the Committee's Terms of Reference (the proposed changes were shown in tracked changes).

The Committee:

a) Noted the results of the Committee's Annual Review of Effectiveness and;
b) Approved the changes to the Committee's Terms of Reference which would be presented to the December 2020 meeting of the Trust Board for ratification

Action: Company Secretary

Corporate Governance

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 (5 August 2020 to 30 October 2020) there were six "hours and rest" exception reports totally an extra 11,75 hours worked over and above the Trainees' work schedules and no "education" reports.

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 Committee noted the report.

8.1 Quality Executive Committee Minutes

The minutes of the Quality Executive Committee meetings held in August 2002, September 2020 and October were received and noted.

Closing Business

8.0 Standing Item – Horizon Scanning

The items on the Committee's forward plan are:

- Trust's compliance with the new CPA Guidance
- Single room and therapeutic environment at Prospect Park Hospital
- Review of the Quality Improvement Programme True North Patient Safety Indicators
- Eating Disorder Service and the Wider System
- Review of the MSK Pathway
- Post COVID-19 Lock Down and its impact on the Trust's demand for services (particularly mental health services)
- Managing the interface between physical health and mental health
- Duty of Candour process.
- Update on the Trust's Physical Health Monitoring of Mental Health patients (added at today's meeting)

- Update on HbA1c blood tests for people with Diabetes (the timing of the update to be agreed with the Chief Operating Officer/Medical Director and Director of Nursing and Therapies) (added at today's meeting)

9.1. Any Other Business

Staff Flu Vaccination Programme Update

The Director of Nursing and Therapies updated the Committee on the Trust's Staff Flu Vaccination Programme and reported that 54% of staff had had the flu vaccination. The Director of Nursing and Therapies reported that the Trust had put on additional clinics and was continuing to encourage staff to have their flu vaccination and to inform the Trust if they had had the vaccination elsewhere.

The Director of Nursing and Therapies reported that the take up rate was disappointing but pointed out that many staff were working at home and had opted not to have the flu vaccination because they did not consider themselves to be at risk of contracting flu.

The Chair thanked the Director of Nursing and Therapies for her update.

9.2. Date of the Next Meeting

2 March 2021

These minutes are an accurate record of the Quality Assurance Committee meeting held on 17 November 2020.

Signed:-

Date: - 2 March 2021

Berkshire Healthcare
NHS Foundation Trust

Quality Assurance Committee Paper

QAC	17 November 2020
Title	**Learning from Deaths Quarter 2 Report 2020/21**
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	780 deaths were recorded on the clinical information system (RiO) during Q2 (Q1 1478) where a patient had been in contact with a trust service in the year before they died. Of these 101 (Q1 170) met the criteria to be reviewed further. All 101 were reviewed by the executive mortality review group (EMRG) and the outcomes were as follows: • 53 were closed with no further action • 48 required 'second stage' review (using an initial finding review (IFR)/ Structured Judgement Review (SJR) methodology). • Of the 48, 9 were classed as Serious Incident Requiring Investigation (SI) During Q2, the trust mortality review group (TMRG) received the findings of 58 2nd stage review reports, of which 11 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 reviews received by the TMRG in Q2, none identified a lapse in care **Learning from Serious Incidents (Source: Q2 SI Report)** Themes which have been identified as learning from outcome of SI investigations. • Learning on differential diagnosis and recognition when the patient has a very opposing view of what interventions might help them.

	• A continued focus on training materials including MS Teams based bite sized learning; utilising videos and audio of call. Case studies have also been provided. **Learning from the mortality review process (first and second stage review of deaths).** There has been some significant learning across a number of services which is detailed within the report, the following key areas and points should be noted: • Additional learning to support the deteriorating patient both in physical and mental health inpatient wards. • Ensuring that documentation is accurate and available electronically • Timely and robust assessments • Lack of Ownership of this case/ Care Coordination/ Lack of ongoing care • Disagreement between services with regards to the required interventions for patient's mental health. This could be an indication of complex needs therefore consideration of CPA was required. **Conclusion** Activity levels for Q2 1st stage reviews have reduced since Q1 and are in line with other previous quarters. 2nd stage reviews were higher due to the impact of higher levels of 1st stage reviews in Q1. No lapse in care were identified Of the 58 second stage reviews a number of significant learning points were identified by the services and have been taken forwards as action plans and using the trust QI methodology.
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 2020/21

Figure 1	17/18 total	18/19 total	19/20 total	Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21	YTD 20/21
Number of deaths seen by a service within 365 days of death	4381	3961	3884	1478	**780**			**2258**
Total deaths screened (Datix) 1st stage review	307	320	406	170	**101**			**271**
Total number of 2nd stage reviews requested (SJR/IFR/RCA)	153	134	198	72	**48**			**120**
Total number of deaths investigated as serious incidents	32	40	43	7	**9**			**16**
Total number of deaths judged > 50% likely to be due to problems with care (lapse in care)	1	3	3	1	**0**			**1**
Number of Community Hospital Inpatient deaths reviewed (Including patients at the end of life)	123	144	124	56	**42**			**98**
Total number of deaths of patients with a Learning Disability	35	28	47	18	**8**			**26**
Total number of deaths of patients with LD judged > 50% likely to be due to problems with care	0	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 2 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 2:

	July 2020	August 2020	September 2020	Grand Total
Nursing episode	126	104	140	370
Community health services medical	35	16	29	80
Dietetics	19	11	29	59
Palliative medicine	17	9	24	50
Old age psychiatry	18	10	10	38
Rehabilitation	11	13	13	37
Podiatry	17	8	8	33
Adult mental illness	7	6	10	23
Respiratory medicine	4	4	12	20
Physiotherapy	8	3	7	18
Speech and language therapy	3	3	6	12
General medicine	6	1	5	12
Intermediate care	1	2	6	9
Cardiology	5		3	8
Learning disability	1	2	2	5
Geriatric medicine	2		1	3
Genito-urinary medicine	2		1	3
Grand Total	**282**	**192**	**306**	**780**

Figure 3 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/ care homes/ receiving care at the end of life.

	July to September 2020				
Figure 3	**A:0-17**	**B:18-65**	**C:66-75**	**D: Over 75**	**Grand Total**
Grand Total	**4**	**108**	**124**	**544**	**780**

4.2 Total Deaths Screened (1st stage review)

The Trust learning from deaths policy identifies several 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.

First stage reviews occur 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 second stage review (SJR/IFR) report

101(Q1 170) deaths were submitted for 1st stage (Datix)review in Q2, the average per quarter last year was 102 with a range of 90 to 108. Of the 101 deaths undergoing first stage review, the EMRG closed 53 cases with no further action required, 48 were referred for 2nd stage review and of these 9 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 stage 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, 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 (32 in Q1 of 2020/21) reviews have been received and considered by the group in Q2. Figure 5 details the service where the review was conducted.

Figure 5: Reviews Conducted in Q2

	Total Number	**Divisions**
July 2020	27	Learning Disabilities: 6 East Physical Health: 5 West Physical Health: 10 West Mental Health:2 East Mental Health:2 Mental Health Inpatients: 2
August 2020	19	Learning Disabilities: 3

		West Physical Health: 4 East Physical Health:1 East Mental Health:3 West Mental Health:4 MH Inpatients: 4
September 2020	12	Learning Disabilities: 2 West Mental Health:1 East physical health: 4 Mental Health Inpatients:1 Children's and Young Persons: 4

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 and trust level learning and improvements
- Identify a potential lapse in care and recommend investigation using RCA approach.

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

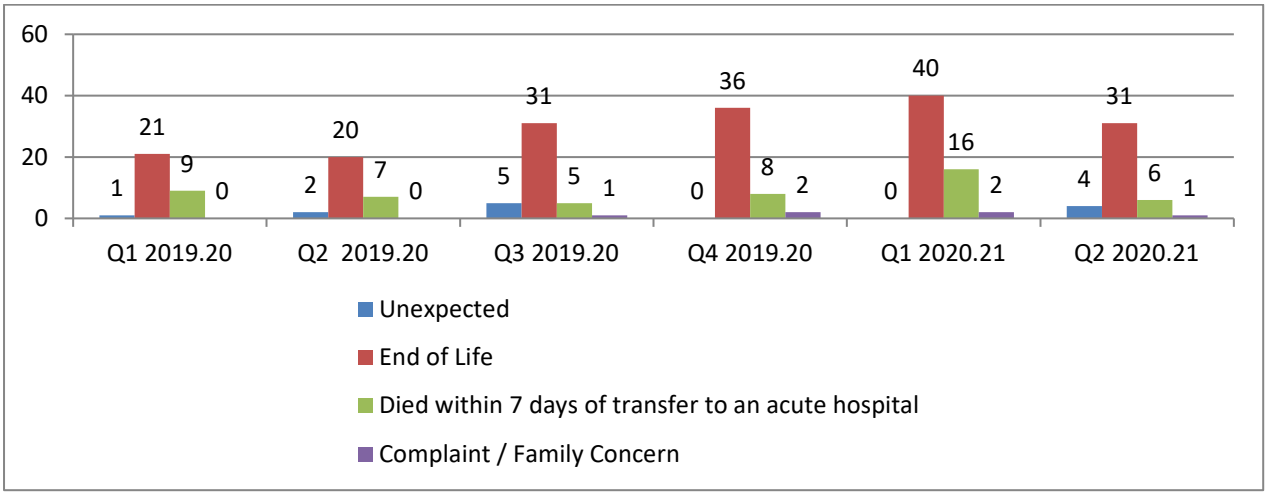
7. Concerns or Complaints

In Q2 5 complaints in total were received from families following the death of a relative, 2nd stage reviews were requested for all 5.

8. 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 6 details these.
In addition, we are required to complete a national submission to the Covid Patient Notification System (CPNS) on inpatient deaths where the patient had a positive Covid result within 28 days of death or had Covid 19 stated on the medical certificate of cause of death (MCCD).

Figure 6: Deaths occurring on the community health inpatients wards or following deterioration and transfer to an acute hospital.



In Q2 42 (Compared to 56 in Q1 of 2020/21) deaths in total were reported, 35 inpatient deaths of which 34 occurred on our Community Inpatient Wards and one death occurred on our Older Adult Mental Health Ward.7 deaths were reported where the patient was transferred to an acute hospital and died within 7 days (this includes the one patient complaint received).

Of the 42 reported deaths, 31 were expected deaths and related to patients who were specifically receiving end of life care. These were reviewed by the EMRG, 28 were closed where enough information had been provided to give assurance that appropriate end of life care had been given. 3 cases were reviewed as 2nd stage reviews.

10 deaths were unexpected (16 in Q1), 4 of these occurred on our inpatient wards and 6 following transfer to an acute provider, 2nd Stage reviews were requested for all 10 cases.

One complaint was received relating to a death which occurred on a community health inpatient ward in December 2019, this was not reviewed previously and the EMRG have requested the reason for this and assurance as part of the structured judgement review.

8.1 Covid-19 related deaths on inpatient wards between July and September 2020

No inpatient deaths were reported in Q2 where the patient died with or from Covid 19

9. Deaths of Children and Young People

In Q2 7 (Q2= 11) deaths were submitted as a Datix for 1st stage review. 5 cases were closed at EMRG following 1st stage review, 1 case is being taken forwards for a 2nd stage review to feed into the national learning disability review (LeDer) and 1 case is part of a serious case review.

10. Deaths of adults with a learning disability

In Q2 the Trust Mortality Review Group (TMRG) reviewed a total of 11 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 11 deaths there were no identified lapses in care provided by Berkshire Healthcare.

The deaths were attributed to the following causes:

Immediate cause of death	Number of deaths
Respiratory System	6*
Infections	2
Heart & Circulatory System	1
Nervous System	1
Cancer	1

**Number of COVID related deaths: 3 community patients had deaths which were related to Covid 19*

Demographics:

Gender:

Female	5
Male	6

Age:

The age at time of death ranged from 42 to 80 years of age (median age: 61yrs)

Severity of Learning Disability:

Mild	4
Moderate	0
Severe	3
Profound	0
Not Known	4

Ethnicity:

White British	11

Engagement and feedback 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 - there has been no specific feedback or concerns raised through this contact.

Work undertaken to mitigate risks/impact of Covid-19:
There were 3 deaths reported where the person had been identified as having Covid-19. All had either comorbid physical health or mental health conditions and for some they had both comorbid physical health and mental health conditions. It is difficult to identify themes relating to comorbidity at this point in time due to the different health needs of the 3 people, but the learning disability service will continue to review this alongside the wider national work involving the rapid review of a sample 50 people who death was Covid-19 related.

The learning disability service continues to promote the use of the Covid-19 Symptom Checker Tool developed by the service. There has also been further progress made in the roll out of the service's new Respiratory Health Care Pathway with presentations to the learning disability governance meeting and Best Practice Forum – with training for staff now scheduled.

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

In Q1, 9 deaths (7 in Q1) have been reported as serious incidents; figure 5 details the service where the SI occurred.

Figure 5. Service (**Source Q2 Serious Incident Report)**	**Number**
Reading Community Mental Health Team (CMHT)	1
Wokingham CMHT	1
West Berkshire CMHT	1
Crisis Resolution and Home Treatment Team (CRHTT)West	1
Bracknell CMHT/IMPACTT	2
Slough CMHT	1
Talking Therapies	1
Mental Health Inpatients	1
Total	**9**

11.1 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 10 deaths in Q2 (9 are currently under SI investigation – 4 reported as suspected suicides and 5 reported as unexpected deaths. 1 suspected suicide is being investigated as an Internal Learning Review (ILR).

Phone contact has been attempted with all families or nominated next of kin (NoK) and all phone contacts were successful in speaking with the family.

9 families / NoK have received a DoC letter and written communication providing condolences, with an explanation of the investigation and provision of offers of support. 1 letter has not been sent as the Service is awaiting confirmation of the NoK address.

2 families took up the offer of a further meeting with the service after the initial phone call. Some families may not take up the offer of an initial meeting with the service but have met later or spoken with a member of the review team as part of the investigation process. In addition, 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.

11.2 Lapse in Care
Of the 58 reviews received by the TMRG in Q2 none identified a lapse in care.

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 Q1.

12.1 Learning from Serious Incidents (Source: Q2 SI Report)
Themes which have been identified as learning from outcome of SI investigations.

- A session on differential diagnosis and recognition, empathetic skills for helping especially when the patient has a very opposing view of what interventions might help. Health related anxieties can be the most challenging for our staff and from patient notes we have been able to see they felt unheard because physical intervention was not provided.
- CRHTT Nurse Consultant is working with Senior Cognitive Behavioural Psychotherapist and our team of actors to do a video based on a recent SI case where health anxiety had progressed to an OCD type presentation. A workshop using Menti interactive elements will be included to enhance learning. We are also trying to gain feedback from people who have recovered from severe health related anxiety about what had been useful when in crisis and unable to accept other potential explanations.
- Training materials continue to be developed based on learning from serious incidents. A learning resource ideas and progress log has commenced which identifies the learning and the related training activity. It currently includes a safety planning package using interactive videos and slides; interactive menti session; MS Teams based bite sized learning; utilising different videos and audio of call. Case studies have been provided to enable actors to role play clinician and patient, participants are invited to note down their thoughts then compare and discuss assumptions based on what is heard/seen.

12.2 Learning from deaths of patients with a learning disability (LD)
Actions and learning identified during the previous quarter have been completed / shared. Learning and best practice identified in Q2:

- lack of some documents on Rio relating to the LD nursing input, learning has been implemented to support this.
- Points of good practice were identified in all 3 of the COVID related cases. These showed two instances where the allocation, assessment and interventions undertaken by BHFT professionals appeared to be in line with best practice, in addition to further instances of good communication and partnership working between professionals and the individual's family and / or carers.
- A number of points were identified by the TMRG for LeDeR to review as potential areas of learning for other providers.

12.3 Mental Health Inpatients

- There was significant learning with regards to physical deterioration and ensuring oxygen should have been given. A lot of work on deteriorating patients has been completed and within the action plan it was further identified that consideration was required on how to share with medical staff – there is clear guidance around this and this action has been implemented.

- Monitoring of hydration was identified as an area of learning. An action plan will include processes and monitoring of fluid intake and potential dehydration

12.4 Community Physical Health

- DNACPR was not on connected care, it was noted on a previous discharge summary but not carried through to services and an alert could have been put on RiO. Team have taken back for learning to put an alert on Rio
- There was an underlying issue where a GP did not visit the patient and suggested a patient at end of life was transferred to hospital, however with an immediate transfer back home. This learning has been shared with the Clinical Commissioning Groups.

The Deteriorating patient remains a theme and the following additional actions have been identified in Q2 and are being implemented:

- Ward has number of staff who require Ward Combine Training and Management of Deteriorating patient is part of the training.
- Ward Manager and Deputy Ward Manager have started weekly Internal Gemba to look at Quality and management of deteriorating patient and will be part of the Clinical Directors Gemba.
- Daily SE (Status Exchange) between Band 7 and Nursing Team Lead and we will look in to for band 7 to focus on managing of deteriorating patient.
- We will look at root cause of delay of escalation between 7 am to 9am.

12.5 Common Point of Entry (CPE) Learning

- Timely Medical Assessments by CPE
- Robust assessments by mental health practitioners (MHP's) to contain clear care plans to allow timely instigation of treatment interventions
- Consideration for timely community mental health (CMHT) referrals for ongoing support vs patients waiting on a waiting list for a psychiatry appointment
- Timely reallocation of assessment appointments should a patient miss an appointment due to reasons beyond their control eg hospital admission
- Need for responsiveness in relation to requests made to expedite patient's appointments due to deterioration in mental state
- Need to embed the Pan Berkshire model for allocation of appointments

12.6 Psychological Medical Services

- Need for holistic assessments in acute settings with consideration given to a patient's long history of mental illness and an established mental health diagnosis to inform recommendations for mental health follow up required in the community on patient's discharge
- Need for use of interpreters when assessing patients whose first language is not English
- Need for detailed assessments to evidence full exploration of mental health needs
- Need for robust evidence and consideration at assessment of poor living conditions being linked to possible poor mental health leading to poor physical health

12.7 All Community Mental Health Services

- Lack of Ownership of this case/ Care Coordination/ Lack of ongoing care
- Disagreement between services with regards to the required interventions for patient's mental health. This could be an indication of complex needs therefore consideration of CPA was required.

13 Conclusion

Activity levels for Q2 1st stage reviews have reduced since Q1 and are in line with other previous quarters. 2nd stage reviews were higher due to the impact of higher levels of 1st stage reviews in Q1.

No lapse in care were identified

Of the 58 2nd stage reviews a number of significant learning points were identified by the services and have been taken forwards as action plans and using the trust QI methodology.

QAC Meeting Date	November 2020
Title	Guardian of Safe Working Hours Quarterly Report (August to October 2020)
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
SUMMARY	This is the latest quarterly report for consideration by Trust Board from the Guardians of Safe Working. This report focusses on the period 5th August 2020 to the 30th October 2020. Since the last report to the Trust Board we have received six *'hours & rest'* exception reports and no '*education*' 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

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

This report covers the period 5th August 2020 to the 30th October 2020

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 5th August 2020 to the 30th October 2020. Since the last report to the Trust Board we have received six *'hours & rest'* exception reports and no '*education*' 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 first half of a six-month CT and GPVTS rotation.

High level data

Number of doctors in training (total): 40 (FY2 – ST6)

Included in the above figure are 2 MTI (Medical Training Initiative) trainees.

Number of doctors in training on 2016 TCS (total): 40

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 '*hours & rest*')**

Exception reports by department				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Psychiatry	0	6	3	3
Sexual Health	0	0	0	0
Total	0	6	3	3

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	6	3	3
ST	0	0	0	0
Total	0	6	3	3

Exception reports by rota				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Psychiatry	0	6	3	3

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	3	3
ST4-6	0	0	0	0
Total	0	0	3	3

In this period, we have received six '*hours and rest'* exception reports where the trainees worked hours in excess of their work schedule, totaling an extra 11.75 hours worked over and above the trainees' work schedules. Exception reporting is a neutral action and is encouraged by the Guardians and Director of Medical Education (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.

Of the six reports, 2 related to work on the out of hours rota and 4 to work from day duties that had to be completed out of hours. Both reports relating to the out of hours rota related to staying after the end of shift to ensure the safety of physically ill patients. This totaled 3 hours. Of the 4 exception reports that related to daytime work, 3 related to completing work centering around complex patients that could not easily be handed over to out of hours staff, this totaled 4.25 hours. One exception report related to workload needing to be completed outside of normal working hours due to disruption of normal working pattern by a bank holiday and study leave to prepare for exams. All of these are good examples of appropriate use of the exception reporting process.

It has been the opinion of Medical Staffing and the Guardians of Safe Working that in most cases "time off in lieu" (TOIL) is the most appropriate action following an exception report to minimize the effects of excessive work, however during the COVID crisis we agreed to change the emphasis such that payment for the extra hours worked was an equally valid outcome. At the beginning of August, we reverted to TOIL as the default option.

There have been several difficulties with trainee's and Consultant supervisors not completing the online exception reporting form in the way it was intended. This has led to some difficulty in clarifying data and understanding what elements of the process have been completed with whether TOIL has been taken by the trainees. One trainee found that they were unable to cancel a report or modify it when they realized they put in the incorrect date. 3 trainees entered the incorrect Consultant as their supervisor meaning that the appropriate individuals were not notified of the report and were not able to close the report on the system. This has meant that despite chasing by the Guardians we

do not yet know the outcome of 3 of the exception reports. We will raise the online reporting system with the trainees at the next JDF to assess whether there are any new difficulties or appropriate remedies to the reporting system.

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

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. The JDF Chair, with the encouragement of the Guardians, has been actively involved in setting up an online "Exception Reporting Survey" of trainees across the Thames Valley region looking at barriers for junior doctors in exception reporting across all trusts in the area due to the impact of COVID we are still awaiting the results of this survey.

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 5th August to 30th October 2020)

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
	51	51	21	30	0	484.5	484.5	217.5	267	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	17	17	11	6	0	163.5	163.5	116.5	47	0
Sickness	10	10	2	8	0	83	83	25	58	0
Covid-19	24	24	8	16	0	238	238	76	162	0
Maternity	0	0	0	0	0	0	0	0	0	0
Total	51	51	21	30	0	484.5	484.5	217.5	267	0

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

Currently the OOH rota is still operating at 1:12 and our system for cover continues to work as normal, with gaps being quickly filled.

Covid-19 remains the main cause of gaps for this period although the numbers are down from the last report, 24 gaps as opposed to the 59 we saw from May to August. However, as we saw with the first wave, we are prepared to see these numbers increase from November and are planning to cover accordingly.

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 2021.

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	08 December 2020
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 08 December 2020

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. Proposals for Integrated Care Legislation

Integrated Care Systems will be put on a statutory footing by April 2022 if legislation can be passed early next year. At the end of November 2020, NHS England and NHS Improvement set out guiding principles for the future of Integrated Care Systems in England and outlined two proposals for how Integrated Care Systems could be embedded in legislation by April 2022, subject to Parliamentary decision.

NHS England and NHS Improvement's proposals are set out in *Integrating Care: Next steps to Building Strong and Effective Integrated Care Systems across England*. A copy of the document is included in the appendix for those who wish to read about the proposals in more detail.

NHS England and Improvement's paper is structured in three sections.

1. Purpose

NHS England and Improvement state that its proposals on the future of Integrated Care Systems are designed to serve four fundamental purposes:

- improving population health and healthcare;
- tackling unequal outcomes and access;
- enhancing productivity and value for money; and
- helping the NHS to support broader social and economic development

2. Putting this into practice

In this section, NHS England and Improvement set out a series of practical policy changes that will need to be in place by April 2022 in order to make a consistent transition to system working. These include:

- **Provider collaboratives -** Providers will play an active and strong leadership role, joining up the provision of services within and between places. All NHS provider trusts will be expected to be part of a provider collaborative. For provider organisations operating across a large footprint or for those working with smaller systems, they are likely to create provider collaboratives that span multiple systems. Clearly this is relevant to us given our footprint. Further guidance on provider collaborative models will be published in early 2021.
- **Place-based partnerships** - The place leader will work with partners such as the local authority and voluntary sector. Their four main roles will be to: support and develop primary care networks (PCNs); simplify, modernise and join up health and care; use population health management and other methods to identify at-risk communities; and coordinate the local contribution to health, social and economic development. The exact division of responsibilities between system and place I would suggest is key to making this work.
- **Clinical and professional leadership** - Integrated Care Systems should embed system-wide clinical and professional leadership through their partnership board and other governance arrangements, including primary care network representation.
- **Financial framework -** NHS England and Improvement will increasingly organise the finances of the NHS at Integrated Care System level and put allocative decisions in the hands of local leaders. A ‘single pot’ will be created, bringing together different funding streams, including current Clinical Commissioning Group (CCG) commissioning budgets, primary care budgets, the majority of specialised commissioning spend, central support or sustainability funding and nationally-held transformation funding allocated to systems.
- **Regulation and oversight** - NHS England and Improvement recognises that regulation needs to adapt, with more support from national regulators for systems and the individual organisations within them, and a shift in emphasis to reflect the importance of partnership working. Practical steps it can take to support systems include issuing guidance under the NHS provider licence that good governance for providers includes a duty to collaborate; and ensuring foundation trust directors’ and governors’ duties to the public support system working.
- **How commissioning will change** - The activities, capacity and resources for commissioning will change in three significant ways in the future. First, there will be a single, system-wide approach to undertaking strategic commissioning. Second, provider organisations will take on some of the previous responsibilities of CCG’s and become responsible for driving transformation. And third, there will be a greater focus on population health and outcomes in contracts and the collective system ownership of the financial envelope.

3. Legislative proposals

- **Option 1: a statutory Integrated Care Systems Board/Joint Committee with an Accountable Officer (AO).** This would establish a mandatory, rather than voluntary, statutory Integrated Care System Board through the mechanism of a joint committee and enable NHS commissioners, providers and local authorities to take decisions collectively. An AO would not replace individual organisation AOs/chief executives but would be recognised in legislation and would have duties in relation to delivery of the Board's functions. One aligned CCG per Integrated Care System footprint and new powers would allow that CCGs are able to delegate many of their population health functions to providers.

- **Option 2: a statutory ICS body.** Integrated Care Systems established as NHS bodies partly by "re-purposing" CCGs, taking on the commissioning functions of CCGs. CCG governing body and GP membership model would be replaced by a Board consisting of representatives from system partners. As a minimum, this would include representatives of NHS providers, primary care and local government alongside a chair, a chief executive and a chief financial officer. The power of individual organisational veto would be removed and the Integrated Care System chief executive would be a full-time AO role.

Of the two options, NHS England and Improvement clearly states its preference for the second as it believes it offers greater long-term clarity on system leadership and accountability.

Questions for consultation

NHS England and Improvement is inviting stakeholders to share their views on four questions by Friday 8 January 2021:

1. Do you agree that giving Integrated Care Systems a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the NHS over the next decade?
2. Do you agree that option two offers a model that provides greater incentive for collaboration alongside clarity of accountability across systems, to parliament and most importantly, to patients?
3. Do you agree that, other than mandatory participation of NHS bodies and local authorities, membership should be sufficiently permissive to allow systems to shape their own governance arrangements to best suit their population's needs?
4. Do you agree, subject to appropriate safeguards and where appropriate, that services currently commissioned by NHS England/Improvement should be either transferred or delegated to Integrated Care System bodies?

Executive Lead: Julian Emms, Chief Executive

4. Staff Flu Campaign 2020

On 24 July 2020, the Department of Health and Social Care announced the expansion of the Annual Flu Vaccination Programme to support plans to ‘’ready the NHS – both for the risk of a second peak of coronavirus cases, and to relieve winter pressures’’.

Importantly for our staff, the announcement also included the ask for all frontline workers to take up the offer of a free flu vaccination. Over the last few years within Berkshire Healthcare we have achieved an uptake of around 70% frontline staff by end December.

In addition, this year consideration has also had to be given to the potential introduction of the COVID-19 vaccination and how this could potentially impact on the current Staff Flu Campaign and therefore there has been a national expectation that all staff are offered their vaccination by the end November 2020 rather than the campaign running until the end of December 2020.

Delivery of the campaign

Consideration to COVID-19 regarding social distancing when delivering the flu vaccination has been key. With the booked clinic appointments and drive thru’s at both Ascot Racecourse and West Berkshire Community Hospital, social distancing has been maintained. In addition, planned and ad hoc clinics have been run by peer vaccinators out of sites where staff are present. Peer vaccinators have also visited some of our more remote sites for example making a trip to Portsmouth to ensure that our Court Divert Team based there are also offered the vaccination.

The ward and District Nursing peer vaccinators have offered the vaccination to their teams locally, allowing for flexibility on timings for individuals shifts.

Vouchers were also available for those who would find receiving their vaccine at a local pharmacy a better option and as in previous years staff have been encouraged to let us know if they have received their vaccine elsewhere.

Social media, Trust communication platforms, newsletters and Teams’ live events have been used to promote and encourage uptake with staff sharing their experiences of having flu and all Directorates receiving their percentage uptake on a weekly basis throughout the campaign.

Like last year we have offered the incentive of ‘have a jab, give a jab’ with a Tetanus vaccine being donated to UNICEF for every member of staff that receives the flu vaccination.

As in previous years all Board members were expected to have the vaccination, the Board checklist was included as part of the Board papers in November 2020.

Progress as of 26 November 2020

As of 26 November 2020, total clinical staff uptake is at 72%.

	CYPF	Corporate	MH East	MH West	MH inpatients	CHS East	CHS West	Other health services
Total staff number	621	612	220	897	294	583	912	160
Total staff uptake (number)	466	415	154	675	195	396	632	160
Total staff uptake (Percentage)	**75.0%**	**67.8%**	**70.0%**	**75.3%**	**66.3%**	**67.9%**	**69.3%**	**100%**

	CYPF	Corporate	MH East	MH West	MH inpatients	CHS East	CHS West	Other health services
Total clinical staff number	507	121	156	734	271	492	716	159
Clinical staff uptake (number)	382	96	105	539	174	326	496	159
Uptake clinical staff (Percentage)	**75.3%**	**79.3%**	**67.3%**	**73.4%**	**64.2%**	**66.3%**	**69.3%**	**100.0%**

Final uptake figures and percentage uptake amongst clinical staff will be provided to the next public Trust Board.

Executive Lead: Debbie Fulton, Director of Nursing and Therapies

Presented by Julian Emms
Chief Executive
December 2020

Integrating care

Next steps to building strong and effective integrated care systems across England

Contents

Introduction

This document builds on previous publications that set out proposals for legislative reform and is primarily focused on the operational direction of travel. It opens up a discussion with the NHS and its partners about how ICSs could be embedded in legislation or guidance. Decisions on legislation will of course then be for Government and Parliament to make.

This builds on the route map set out in the *NHS Long Term Plan*, for health and care joined up locally around people's needs. It signals a renewed ambition for how we can support **greater collaboration** between partners in health and care systems to help accelerate progress in meeting our most critical health and care challenges.

It details how systems and their constituent organisations will accelerate **collaborative ways of working** in future, considering the key components of an effective integrated care system (ICS) and reflecting what a range of local leaders have told us about their experiences during the past two years, including the immediate and long-term challenges presented by the COVID-19 pandemic.

These are significant new steps towards the ambition set out in the *NHS Long Term Plan*, building on the experience of the earliest ICSs and other areas. Our challenge now is to spread their experience to every part of England. From April 2021 this will require all parts of our health and care system to work together as Integrated Care Systems, involving:

- Stronger **partnerships in local places** between the NHS, local government and others with a more central role for primary care in providing joined-up care;
- **Provider organisations** being asked to step forward in formal collaborative arrangements that allow them to operate at scale; and
- Developing strategic **commissioning** through systems with a focus on population health outcomes;
- The use of **digital and data** to drive system working, connect health and care providers, improve outcomes and put the citizen at the heart of their own care.

This document also describes options for giving ICSs a firmer footing in **legislation** likely to take affect from April 2022 (subject to Parliamentary decision). These proposals sit alongside other recommendations aimed at removing legislative barriers to integration across health bodies and with social care, to help deliver better care and outcomes for patients through collaboration, and to join up national leadership more formally. NHS England and NHS Improvement are inviting views

on these proposed options from all interested individuals and organisations by Friday 8 January.

It builds on, and should be read alongside, the commitments and ambitions set out in the *NHS Long Term Plan* (2019), *Breaking Down Barriers to Better Health and Care (2019)* and *Designing ICSs in England* (2019), and our *recommendations to Government and Parliament for legislative change (2019)*.

1. Purpose

1.1. The NHS belongs to us all[1] and any changes to it must bring clear improvements for our health and care. Since 2018, integrated care systems (ICSs) have begun doing just this, enabling NHS organisations, local councils, frontline professionals and others to join forces to plan and provide around residents' needs as locally as possible.

1.2. By doing this, they have driven a 'bottom-up' response to the big health and care challenges that we and other countries across the world face and have made a real difference to people's lives. They have improved health, developed better and more seamless services and ensured public resources are used where they can have the greatest impact.

1.3. These achievements have happened despite persistent complexity and fragmentation. This document describes how we will simplify support to local leaders in systems, making it easier for them to achieve their ambitions. Our proposals are designed to serve four fundamental purposes:

- improving population health and healthcare;
- tackling unequal outcomes and access;
- enhancing productivity and value for money; and
- helping the NHS to support broader social and economic development.

1.4. The *NHS Long Term Plan* set out a widely supported route map to tackle our greatest health challenges, from improving cancer care to transforming mental health, from giving young people a healthy start in life to closing the gaps in health inequalities in communities, and enabling people to look after their own health and wellbeing.

1.5. The COVID-19 pandemic has given the NHS and its partners their biggest challenge of the past 70 years, shining a light on the most successful approaches to protecting health and treating disease. Vulnerable people need support that is joined up across councils, NHS, care and voluntary organisations; all based on a common understanding of the risks different people face. Similarly, no hospital could rise to the challenge alone, and new pathways have rapidly developed across multiple providers that enable and protect capacity for urgent non-COVID care.

1.6. This has all been backed up by mutual aid agreements, including with local councils, and shared learning to better understand effective response. It has

[1] https://www.gov.uk/government/publications/the-nhs-constitution-for-england

required openness in data sharing, commitment to collaboration in the interests of patients and communities, and agile collective decision-making.

1.7. The significant challenges that face health and care as we recover from the pandemic make it even more important to have strong and thriving systems for the medium term. Important changes were driven by emergency response but must be hard-wired into our future working so that the gains of 2020 can endure. DHSC's 'Busting Bureaucracy: Empowering frontline staff by reducing excess bureaucracy in the health and care system in England' report, published on the 24th November 2020, describes in detail some of these important areas of change. The report found that there are many sources of excess bureaucracy and that these are often exacerbated by duplicative or disproportionate assurance systems and poorly integrated systems at a national, regional and local level. The report also acknowledges that the more levels of hierarchy in a system, the more likely it is that bureaucracy will exist and grow. ICS' therefore have the potential to reduce bureaucracy through increased collaboration, leaner oversight through streamlined assurance structures and smarter data-sharing agreements.

1.8. To deliver the core aims and purposes set out above, we will need to devolve more functions and resources from national and regional levels to local systems, to develop effective models for joined-up working at "place", ensure we are taking advantage of the transformative potential of digital and data, and to embed a central role for providers collaborating across bigger footprints for better and more efficient outcomes. The aim is a progressively deepening relationship between the NHS and local authorities, including on health improvement and wellbeing.

1.9. This reflects three important observations, building on the *NHS Long Term Plan*'s vision of health and care joined up locally around people's needs:

- **decisions taken closer to the communities** they affect are likely to lead to better outcomes;
- **collaboration between partners in a place** across health, care services, public health, and voluntary sector can overcome competing objectives and separate funding flows to help address health inequalities, improve outcomes, and deliver joined-up, efficient services for people; and
- **collaboration between providers** (ambulance, hospital and mental health) across larger geographic footprints is likely to be more effective than competition in sustaining high quality care, tackling unequal access to services, and enhancing productivity.

1.10. This takes forward what leaders from a range of systems have told us about their experiences during the past two years.

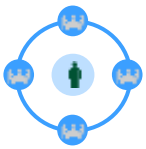
Devolution of functions and resources

1.11. Joining up delivery is not enough on its own. In many areas, we can shift national or regional resources and decision-making so that these are closer to the people they serve. For example, it will make sense to plan, commission and organise certain specialised services at ICS level, and to devolve a greater share of primary care funding and improvement resource to this more local level.

1.12. ICSs also need to be able to ensure collectively that they are addressing the right priorities for their residents and using their collective resources wisely. They will need to work together across partners to determine:

- **distribution of financial resources** to places and sectors that is targeted at areas of greatest need and tackling inequalities;
- **improvement and transformation resource** that can be used flexibly to address system priorities;
- **operational delivery** arrangements that are based on collective accountability between partners;
- **workforce planning, commissioning and development** to ensure that our people and teams are supported and able to lead fulfilling and balanced lives;
- **emergency planning and response** to join up action at times of greatest need; and
- the use of **digital and data** to drive system working and improved outcomes.

"Place": an important building block for health and care integration



1.13. For most people their day-to-day care and support needs will be expressed and met locally in the place where they live. An important building block for the future health and care system is therefore at '**place**.'

1.14. For most areas, this will mean long-established local authority boundaries (at which joint strategic needs assessments and health and wellbeing strategies are made). But the right size may vary for different areas, for example reflecting where meaningful local communities exist and what makes sense to all partners. Within each place, services are joined up through primary care networks (PCNs) integrating care in neighbourhoods.

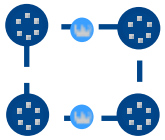
1.15. Our ambition is to create an **offer to the local population of each place**, to ensure that in that place everyone is able to:

- access clear advice on **staying well**;
- access a range of **preventative services**;
- access **simple, joined-up care and treatment** when they need it;
- access digital services (with non-digital alternatives) that put the citizen at the heart of their own care;
- access proactive support to keep as well as possible, where they are **vulnerable or at high risk**; and to
- expect the NHS, through its employment, training, procurement and volunteering activities, and as a major estate owner to play a full part in **social and economic development** and **environmental sustainability**.

1.16. This offer will be met through providers of primary care, community health and mental health services, social care and support, community diagnostics and urgent and emergency care working together with meaningful delegated budgets to join up services. It will also allow important links to be made to other public or voluntary services that have a big impact on residents' day-to-day health, such as by improving local skills and employment or by ensuring high-quality housing.

1.17. Delivery will be through NHS providers, local government, primary care and the voluntary sector working together in each place in ICSs, built around primary care networks (PCNs) in neighbourhoods.

Developing provider collaboration at scale



1.18. At some times, many people will have more complex or acute needs, requiring specialist expertise which can only be planned and organised effectively over a larger area than 'place'. This may be because concentrating skills and resources in bigger sites improves quality or reduces waiting times; because it is harder to predict what smaller populations will need; or because scale working can make better use of public resources.

1.19. Because of this, some services such as hospital, specialist mental health and ambulance needs to be organised through **provider collaboration** that operates at a whole-ICS footprint – or more widely where required.

1.20. We want to create an **offer that all people served by an ICS** are able to:

- access a full range of high-quality acute hospital, mental health and ambulance services; and
- experience fair access to these services, based on need and not factors such as geography, race or socio-economic background.

1.21. We also need to harness the involvement, ownership and innovation of clinicians, working together to design more integrated patient pathways horizontally across providers and vertically within local place-based partnerships.

2. Putting this into practice

2.1. There are many good examples of recent system working that have improved outcomes and productivity, and helped to address inequalities. But COVID has made the case for a step up in scope and ambition. NHS and local government are increasingly pressing for a more driven and comprehensive roll out of system working.

2.2. So, in this section we set out a series of practical changes which will need to be in place by April 2022 at the latest, to make a consistent transition to system working focused on further devolution to systems, greater partnership working at place and closer collaboration between providers on a larger footprint. The main themes are:

1. Provider collaboratives
2. Place-based partnerships
3. Clinical and professional leadership
4. Governance and accountability
5. Financial framework
6. Data and digital
7. Regulation and oversight
8. How commissioning will change

2.3. We will support preparatory work during 2021/22 with further guidance for systems and in the NHS Operational Planning Guidance for 2021/22.

Provider collaboratives

2.4. Provider organisations will play an **active and strong leadership role** in systems. Through their mandated representation in ICS leadership and decision-making, they will help to set system priorities and allocate resources.

2.5. **Providers will join up services across systems.** Many of the challenges that systems face cannot be solved by any one organisation, or by any one provider. Joining up the provision of services will happen in two main ways:

- **within places** (for example, between primary, community, local acute, and social care, or within and between primary care networks) through place-based partnerships as described above (‘vertical integration’); and

- **between places** at scale where similar types of provider organisation share common goals such as reducing unwarranted variation, transforming services, providing mutual aid through a formal provider collaborative arrangement ('horizontal integration' – for example, through an alliance or a mental health provider collaborative).

2.6. **All NHS provider trusts will be expected to be part of a provider collaborative**. These will vary in scale and scope, but all providers must be able to take on responsibility for acting in the interests of the population served by their respective system(s) by entering into one or more formal collaboratives to work with their partners on specific functions.

2.7. This greater co-ordination between providers at scale can support:

- higher quality and more sustainable services;
- reduction of unwarranted variation in clinical practice and outcomes;
- reduction of health inequalities, with fair and equal access across sites;
- better workforce planning; and
- more effective use of resources, including clinical support and corporate services.

2.8. For provider organisations operating across a large footprint or for those working with smaller systems, they are likely to create **provider collaboratives that span multiple systems** to provide an effective scale to carry out their role.

2.9. For ambulance trusts specifically we would expect collaboration and integration at the right scale to take place. This should operate at scale to plan resources and join up with specialist providers, and at a more local level in places where focused on the delivery and redesign with other partners of urgent and emergency care pathways.

2.10. We want to spread and build on good work of this type already under way. The partnerships that support this collaboration (such as provider alliances) often take place on a different footprint to ICS boundaries. This should continue where clinically appropriate, with NHS England and NHS Improvement helping to ensure consistent and coherent approaches across systems, especially for smaller partnerships.

2.11. Local flexibility will be important but providers in every system, through partnership or any new collaborative arrangements, must be able to:

- deliver relevant programmes on behalf of all partners in the system;
- agree proposals developed by clinical and operational networks, and implement resulting changes (such as implementing standard

operating procedures to support agreed practice; designating services to ensure their sustainability; or wider service reconfiguration);

- challenge and hold each other to account through agreed systems, processes and ways of working, e.g. an open-book approach to finances/planning;
- enact mutual aid arrangements to enhance resilience, for example by collectively managing waiting lists across the system.

2.12. In some systems, larger providers may also choose to use their scale to host functions on behalf of other system partners.

2.13. NHS England and NHS Improvement will set out further guidance in early 2021, describing a number of potential models for provider collaboratives, based on those that have been established in some parts of the country, including looser federations and more consolidated forms.

2.14. We know that providers are already making progress towards effective, collaborative working arrangements despite the constraints of relevant legislation and frameworks. Indeed, many crucial features of strong system working – such as trust between partners, good leadership and effective ways of working – cannot be legislated for.

But we recognise that these could be supported by changes to legislation, including the introduction of a 'triple aim' duty for all NHS providers to help align priorities, and the establishment of ICSs as statutory bodies with the capacity to support population-based decision-making and to direct resources to improve service provision. Our recommendations for this are set out in part 3.

2.15. Systems will continue to play an increasingly important role in developing multidisciplinary leadership and talent, coordinating approaches to recruiting, retaining and looking after staff, developing an agile workforce and making best use of individual staff skills, experience and contribution.

2.16. From April 2022, this will include:

- developing and supporting a 'one workforce' strategy in line with the NHS People Plan and the People Promise, to improve the experience of working in the NHS for everyone;
- contributing to a vibrant local labour market, with support from partner organisations and other major local employers, including the care home sector and education and skills providers.
- enabling employees to have rewarding career pathways that span the entire system, by creating employment models, workforce sharing arrangements and passporting or accreditation systems that enable

their workforce to be deployed at different sites and organisations across (and beyond) the system, and sharing practical tools to support agile and flexible working;

- valuing diversity and developing a workforce and leadership which is representative of the population it serves; and
- supporting organisational and leadership development at all levels, including talent management. This should encompass investment in, and the development of improvement expertise.

Place-based partnerships

2.17. In many places, there are already **strong and effective place-based partnerships** between sectors. Every area is different, but common characteristics of the most successful are the full involvement of all partners who contribute to the place's health and care; an important role for local councils (often through joint appointments or shared budgets); a leading role for clinical primary care leaders through primary care networks; and a clear, strategic relationship with health and wellbeing boards.

2.18. The place leader on behalf of the NHS, as set out above, will work with partners such as the local authority and voluntary sector in an inclusive, transparent and collaborative way. They will have four main roles:

- to support and develop primary care networks (PCNs) which join up primary and community services across local neighbourhoods;
- to simplify, modernise and join up health and care (including through technology and by joining up primary and secondary care where appropriate);
- to understand and identify – using population health management techniques and other intelligence – people and families at risk of being left behind and to organise proactive support for them; and
- to coordinate the local contribution to health, social and economic development to prevent future risks to ill-health within different population groups.

2.19. Systems should ensure that each place has **appropriate resources, autonomy and decision-making capabilities** to discharge these roles effectively, within a clear but flexible accountability framework that enables collaboration around funding and financial accountability, commissioning and risk management. This could include places taking on delegated budgets.

2.20. Partnerships within local places are important. Primary care networks in neighbourhoods and thriving community networks are also provider collaboratives, and for integration to be successful we will need primary care

working with community, mental health, the voluntary sector and social care as close to where people live as possible.

2.21. The exact division of responsibilities between system and place should be based on the principle of subsidiarity – with the system taking responsibility only for things where there is a clear need to work on a larger footprint, as agreed with local places.

The NHS's offer to local government

2.22. We will work much more closely with local government and the voluntary sector at place, to ensure local priorities for improved health and care outcomes are met by the NHS becoming a more effective partner in the planning, design and delivery of care. This will ensure residents feel well supported, with their needs clearly understood; and with services designed and delivered in the most effective and efficient way for each place.

2.23. As ICSs are established and evolve, this will create opportunities to further strengthen partnership working between local government, the NHS, public health and social care. Where partnership working is truly embedded and matured, the ability to accelerate place-based arrangements for local decision-making and use of available resources, such as delegated functions and funding, maximises the collective impact that can be achieved for the benefit of residents and communities.

Clinical and professional leadership

2.24. Clinical and other frontline staff have led the way in working across professional and institutional boundaries, and they need to be supported to continue to play a significant leadership role through systems. ICSs should embed **system-wide clinical and professional leadership** through their partnership board and other governance arrangements, including **primary care network** representation.

2.25. **Primary care clinical leadership** takes place through critical leadership roles including:

- Clinical directors, general practitioners and other clinicians and professionals in primary care networks (PCNs), who build partnerships in **neighbourhoods** spanning general practice, community and mental health care, social care, pharmacy, dentistry, optometry and the voluntary sector.
- Clinical leaders representing primary care in **place-based partnerships** that bring together the primary care provider leadership role in federations and group models

- A primary care perspective at system level.

2.26. **Specialist clinical leadership** across secondary and tertiary services must also be embedded in systems. Existing **clinical networks** at system, regional and national level have important roles advising on the most appropriate models and standards of care, in particular making decisions about clinical pathways and clinically-led service change. System-wide clinical leadership at an ICS and provider collaborative footprint through clinical networks should:

- be able to carry out clinical service strategy reviews on behalf of the ICS;
- develop proposals and recommendations that can be discussed and agreed at wider decision-making forums; and
- include colleagues from different professional backgrounds and from different settings across primary care, acute, community and mental health care.

2.27. **Wider clinical and professional leadership** should also ensure a strong voice for the wide range of skills and experience across systems. From nursing to social care, from allied health professionals to high street dentists, optometrists and pharmacists, and the full range of specialisms and care settings, people should receive services designed and organised to reflect the expertise of those who provide their care.

Governance and public accountability

2.28. Systems have told us from recent experience that good partnership working must be underpinned by mutually-agreed governance arrangements, clear collective decision-making processes and transparent information-sharing.

2.29. In the *NHS Long Term Plan* and *NHS planning and contracting guidance for 2020/21*, we described a set of consistent operating arrangements that all systems should put in place by 2021/22. These included:

- system-wide governance arrangements (including a system partnership board with NHS, local councils and other partners represented) to enable a collective model of responsibility and decision-making;
- quality governance arrangements, notably a quality lead and quality group in systems, focused on assurance, planning and improvement;
- a leadership model for the system, including an ICS leader with sufficient capacity and a chair appointed in line with NHSEI guidance; and
- agreed ways of working with respect to financial governance and collaboration.

2.30. ICSs now need to put in place firmer governance and decision-making arrangements for 2021/22, to reflect their growing roles and responsibilities. With the below consistent framework, these should be flexible to match local needs.

2.31. As part of this, each system should define:

- **'place' leadership** arrangements. These should consistently involve:
    i. every locally determined 'place' in the system operating a partnership with joined-up decision-making arrangements for defined functions;
    ii. the partnership involving, at a minimum, primary care provider leadership, local authorities, including Director of Public Health and providers of community and mental health services and Healthwatch;
    iii. agreed joint decision-making arrangements with local government; and
    iv. representation on the ICS board.

  They may flexibly define:

    i. the configuration, size and boundaries of places which should reflect meaningful communities and scale for the responsibilities of the place partnership;
    ii. additional membership of each place partnership that is likely to include acute providers, ambulance trusts, the voluntary sector and other partners;
    iii. the precise governance and decision-making arrangements that exist within each place; and
    iv. their voting arrangements on the ICS board.

- **provider collaborative leadership** arrangements for providers of more specialist services in acute and mental health care. These should consistently involve:
    i. every such provider in a system operating as part of one or more agreed provider collaboratives with joined up decision-making arrangements for defined functions;
    ii. provider collaboratives represented on the appropriate ICS board(s).

  They may flexibly define:

    i. the scale and scope of provider collaboratives. For smaller systems, provider collaboratives are likely to span multiple systems and to be represented on the board of each. These arrangements should reflect a meaningful scale for their responsibilities;

ii. the precise membership of each collaborative (acute providers, specialist providers, ambulance trusts at an appropriate footprint, mental health providers);

iii. the precise governance and decision-making arrangements that exist within each collaborative; and

iv. their voting arrangements on the ICS board.

- **individual organisation** accountability within the system governance framework. This will consistently involve:

  i. the responsibility and accountability of the individual provider organisations for their current range of formal and statutory responsibilities (which are unchanged); and

  ii. the accountability relationship between the provider organisation and all place-based partnerships and provider collaboratives of which it is a member.

  It may flexibly define:

  iii. Any lead provider responsibility that the organisation holds on behalf of a place partnership or a provider collaborative.

2.32. Integrated care systems draw their strength from the effectiveness of their constituent parts. Their governance should seek to minimise levels of decision-making and should set out defined responsibilities of organisations, partnerships at place, provider collaboratives and the core ICS role. Each ICS should seek to ensure that all the relevant bodies feel ownership and involvement in the ICS.

2.33. The local test for these governance arrangements is whether they enable joined-up work around a shared purpose. Provider collaboratives and place-based partnerships should enable peer support and constructive challenge between partners delivering services and accelerate partners' collective ability to improve services in line with agreed priorities.

2.34. The greater development of working at place will in many areas provide an opportunity to align decision-making with local government, including integrated commissioning arrangements for health and social care, and local responsiveness through health and wellbeing boards. There is no one way to do this, but all systems should consider how the devolution of functions and capabilities to systems and places can be supported by robust governance arrangements.

2.35. ICS governance is currently based on voluntary arrangements and is therefore dependent on goodwill and mutual co-operation. There are also legal constraints on the ability of organisations in an ICS to make decisions jointly. We have previously made a number of recommendations for legislative change to Government and Parliament to increase flexibility in decision making by enabling decision making joint committees of both

commissioners and providers and also committees of Providers. Section 3 of this document captures these options and also describes our thinking on clarifying arrangements for an ICS.

2.36. Many systems have shown great ways to involve and take account of the views and priorities of local residents and those who use services, as a 'golden thread' running through everything they do. During 21/22, every ICS should work to develop systematic arrangements to involve lay and resident voices and the voluntary sector in its governance structures, building on the collective expertise of partners and making use of pre-existing assets and forums such as Healthwatch and citizen's panels.

2.37. In particular, governance in ICSs should involve all system partners in the development of service change proposals, and in consulting and engaging with local people and relevant parts of local government (such as with overview and scrutiny committees and wider elected members) on these. It should appropriately involve elected councillors, and other local politicians such as metro mayors where relevant, and reflect transparency in wider decision-making.

2.38. Each system should also be able to show how it uses public involvement and insight to inform decision-making, using tools such as citizens' panels, local health champions, and co-production with people with lived experience. Systems should make particular efforts to understand and talk to people who have historically been excluded.

Financial framework

2.39. In order that the collective leadership of each ICS has the best possible opportunity to invest in and deliver joined-up, more preventative care, tailored to local people's needs, we will increasingly **organise the finances of the NHS at ICS level** and put **allocative decisions in the hands of local leaders**. We are clear that we want ICSs to be key bodies for financial accountability and financial governance arrangements will need to reflect that. NHSEI will update guidance to reflect these changes.

2.40. That means that we will **create a 'single pot**,' which brings together current CCG commissioning budgets, primary care budgets, the majority of specialised commissioning spend, the budgets for certain other directly commissioned services, central support or sustainability funding and nationally-held transformation funding that is allocated to systems.

2.41. ICS leaders, working with provider collaboratives, must have the freedom – and indeed the duty – to distribute those resources in line with national rules such as the mental health, and the primary and community services investment guarantees and locally-agreed strategies for health and care, for example targeting investment in line with locally-agreed health inequalities

priorities, or responding flexibly as new, more preventative services are developed and patient journeys change.

2.42. ICS leaders will also have a duty to ensure that they deploy the resources available to them in order to protect the future sustainability of local services, and to ensure that their health and care system consumes their fair share of resources allocated to it.

2.43. It also means that ICS leaders will be expected to use new freedoms to delegate significant budgets to 'place' level, which might include resources for general practice, other primary care, community services, and continuing healthcare. Similarly, through active involvement at place level, providers will have a greater say in how transformation funding is deployed. Decisions about the use of all of these budgets will usually be made at the lowest possible level, closest to those communities they serve and in partnership with their local authority. New powers will make it easier to form joint budgets with the local authority, including for public health functions.

2.44. Providers will through their role in ICS leadership have the opportunity to shape the strategic health and care priorities for the populations they serve, and new opportunities – whether through lead provider models at place level or through fully-fledged integrated care provider contractual models – to determine how services are funded and delivered, and how different bodies involved in providing joined-up care work together.

2.45. We will deliver on the commitment set out in the Long Term Plan to mostly move away from episodic or activity-based payment, rolling out the blended payment model for secondary care services. This will ensure that provider collaboratives have greater certainty about the resources available to them to run certain groups of services and meet the needs of particular patient groups. Any variable payments will be funded within the ICS financial envelope, targeted to support the delivery of locally-identified priorities and increasingly linked to quality and outcomes metrics. Each ICS will be expected to agree and codify how financial risk will be managed across places and between provider collaboratives.

2.46. These changes will reduce the administrative, transactional costs of the current approach to commissioning and paying for care, and release resources for the front line - including preventative measures - that can be invested in services that are planned, designed and delivered in a more strategic way at ICS level. This is just one way in which we will ensure that each ICS has to capacity and capability to take advantage of the opportunities that these new approaches offer.

2.47. Finally, we will further embed reforms to the capital regime introduced in 2019/20 and 2020/21, bringing together at ICS level responsibility for allocating capital envelopes with responsibility for allocating the revenue

budgets which fund day-to-day services. This will ensure that capital investment strategies:

- are not only coordinated between different NHS providers, but also aligned with local authorities' management of their estates and wider assets;
- reflect local judgments about the balance between competing priorities for capital expenditure; and
- give priority to those investments which support the future sustainability of local services for future generations.

2.48. We will set out in the 2021/22 planning guidance how we will support ICSs to begin operating more collective financial governance in 2021/22 and to prepare for the powers and duties set out above.

Data and Digital

2.49. Data and digital technology have played a vital role helping the NHS and care respond to the pandemic. They will be at the heart of creating effective local systems, helping local partners in health and social care work together. They can help improve productivity and patient outcomes, reduce bureaucracy, drive service transformation and stimulate improvement and research.

2.50. But digital maturity and data quality is variable across the health and care. Data has too often been held in siloes, meaning that clinicians and care professionals do not have easy access to all of the information that could be useful in caring for their patients and service users.

2.51. To fulfil the potential of digital and data to improve patient outcomes and drive collaborative working, systems will need to:

(1) build smart digital and data foundations
(2) connect health and care services
(3) use digital and data to transform care
(4) put the citizen at the centre of their care

Build smart digital and data foundations

- Have clear **board accountability** for data and digital, including a member of the ICS Partnership Board being a named SRO.
- Have a system-wide **digital transformation plan.** This should outline the three year journey to digitally-driven, citizen-centred care, and the benefits that digital and data will realise for the system and its citizens.

- Build the **digital and data literacy** of the whole workforce as well as specific digital skills such as user research and service design.

- Invest in the **infrastructure** needed to deliver on the transformation plan. This will include **shared contracts and platforms** to increase resiliency, digitise operational services and create efficiencies, from shared data centres to common EPRs.

Connect health and care services

- Develop or join a **shared care record** joining data safely across all health and social care settings, both to improve direct care for individual patients and service users, and to underpin population health and effective system management.
- Build the tools to allow **collaborative working** and frictionless movement of staff across organisational boundaries, including shared booking and referral management, task sharing, radiology reporting and pathology networks.
- Follow **nationally defined standards** for digital and data to enable integration and interoperability, including in the data architecture and design.

Use digital and data to transform care

- Use digital technology to **reimagine care pathways**, joining up care across boundaries and improving outcomes.

- Develop shared **cross-system intelligence and analytical functions** that use information to improve decision-making at every level, including:

    - actionable insight for frontline teams;
    - near-real time actionable intelligence and robust data (financial, performance, quality, outcomes);
    - system-wide workforce, finance, quality and performance planning;
    - the capacity and skills needed for population health management.
- Ensure **transparency of information** about interventions and the outcomes they produce, to drive more responsive coordination of services, better decision-making and improved research.

Put the citizen at the centre of their care

- Develop a road map for **citizen-centred digital channels** and services, including access to personalised advice on staying well, access to their own data, and triage to appropriate health and care services.

- Roll out **remote monitoring** to allow citizens to stay safe at home for longer, using digital tools to help them manage long-term conditions.

- We want to build on the experience of data sharing during COVID so that data is shared, wherever it can and should be. This will inform the upcoming Department of Health and Social Care Data Strategy. While this will be mainly about embedding a culture of sharing data with appropriate safeguards, we would support legislative change that clarifies that sharing data for the benefit of the whole health and care system is a key duty and responsibility of all health and adult social care organisations. This will require a more flexible legislative framework than currently exists to support further evolution and empower local systems to lead and drive that agenda.

Regulation and oversight

2.52. We have consistently heard that regulation needs to adapt, with more support from national regulators for systems as well as the individual organisations within them, and a shift in emphasis to reflect the importance of partnership working to improve population health.

2.53. Regulation best supports our ambitions where it enables systems and the organisations within them to make change happen. This means a focus on how effective local arrangements are at implementing better pathways, maximising use of collective capacity and resources, and acting in partnership to achieve joint financial and performance standards.

2.54. We have already taken steps to bring together NHS England and NHS Improvement to provide a single, clear voice to the system and our legislative proposals haven't changed – this merger should be formalised in future legislation.

2.55. As a formally merged body, NHS England will of course remain answerable to Parliament and to the Secretary of State for Health and Social Care for NHS performance, finance and healthcare transformation. There will need to be appropriate mechanisms in law to ensure that the newly merged body is responsive and accountable. We envisage Parliament using the legislation to specify the Secretary of State's legal powers of direction in respect of NHS England in a transparent way that nevertheless protects clinical and operational independence.

2.56. There are a further practical steps that we can take to support systems:

- working with the CQC to seek to embed a requirement for strong participation in ICS and provider collaborative arrangements in the "Well Led" assessment;
- issuing guidance under the NHS provider licence that good governance for NHS providers includes a duty to collaborate; and
- ensuring foundation trust directors' and governors' duties to the public support system working.

2.57. We expect to see greater adoption of system- and place- level measurements, which might include reporting some performance data such as patient treatment lists at system level. Next year, we will introduce new measures and metrics to support this, including an 'integration index' for use by all systems.

2.58. The future **System Oversight Framework** will set consistent expectations of systems and their constituent organisations and match accountability for results with improvement support, as appropriate.

2.59. This approach will recognise the enhanced role of systems. It will identify where ICSs and organisations may benefit from, or require, support to help them meet standards in a sustainable way and will provide an objective basis for decisions about when and how NHSEI will intervene in cases where there are serious problems or risks.

The proposed future Intensive Recovery Support Programme will give support to the most challenged systems (in terms of quality and/or finance) to tackle their key challenges. This will enable intervention in response to CQC findings or where other regulatory action is required. This approach enables improvement action and targeted support either at organisation/provider level (with system support) or across a whole system where required and may extend across health and social care, accessing shared learning and good practice between systems to drive improvement.

2.60. Greater collaboration will help us to be more effective at designing and distributing services across a local system, in line with agreed health and care priorities and within the resources available. However there remains an important role for patient choice, including choice between qualified providers, providers outside the geographic bounds of the system and choice of the way in which services need to be joined up around the individual person as a resident or patient including through personal health budgets.

2.61. Our previous recommendations to government for legislation include rebalancing the focus on competition between NHS organisations by reducing the Competition and Market Authority's role in the NHS and

abolishing Monitor's role and functions in relation to enforcing competition. We also recommended regulations made under section 75 of the *Health and Social Care Act 2012* should be revoked and that the powers in primary legislation under which they are made should be repealed, and that NHS services be removed from the scope of the *Public Contracts Regulations 2015*. We have committed to engage openly on how the future procurement regime will operate subject to legislation being brought before Parliament.

How commissioning will change

2.62. Local leaders have repeatedly told us that the commissioning functions currently carried out by CCGs need to become more strategic, with a clearer focus on **population-level health outcomes** and a marked reduction in transactional and contractual exchanges within a system. This significant change of emphasis for commissioning functions means that the organisational form of CCGs will need to evolve.

2.63. The activities, capacity and resources for commissioning will change in three significant ways in the future, building on the experience of the most mature systems:

- Ensuring a single, system-wide approach to undertake **strategic commissioning**. This will discharge core ICS functions, which include:
    - assessing population health needs and planning and modelling demographic, service use and workforce changes over time;
    - planning and prioritising how to address those needs, improving all residents' health and tackling inequalities; and
    - ensuring that these priorities are funded to provide good value and health outcomes.
- Service transformation and pathway redesign need to be done differently. Provider organisations and others, through partnerships at place and in provider collaboratives, become a principal engine of transformation and should agree the future service model and structure of provision jointly through ICS governance (involving transparency and public accountability). Clinical leadership will remain a crucial part of this at all footprints.
- The greater focus on population health and outcomes in contracts and the collective system ownership of the financial envelope is a chance to apply capacity and skills in transactional commissioning and contracting with a new focus. Analytical skills within systems should be applied to better understanding how best to use resources to

improving outcomes, rather than managing contract performance between organisations.

2.64. Many commissioning functions are now **coterminous with ICS boundaries**, and this will need to be consistent across the country before April 2022. Under the legislative provisions recommended in section 3 current CCG functions would subsequently be absorbed to become core ICS business.

2.65. However, with the spread of place-based partnerships backed by devolved funding, simplified accountability, and an approach to governance appropriate to local circumstances along with further devolution of specialised commissioning activity, there will be flexibility for local areas to make full use of the local relationships and expertise currently residing in CCGs.

2.66. Systems should also agree whether individual functions are best delivered at system or at place, balancing subsidiarity with the benefits of scale working. Commissioners may, for example, work at place to complete service and outcomes reviews, allocate resources and undertake needs assessments alongside local authorities. But larger ICSs may prefer to carry out a wider range of functions in their larger places, and smaller ones to do more across the whole system.

2.67. Commissioning support units (CSUs) operate within the NHS family across England, providing services that have been independently evaluated for quality and value for money. We expect that CSUs will continue to develop as trusted delivery partners to ICSs, providing economies of scale which may include joining up with provider back office functions where appropriate and helping to shape services through a customer board arrangement.

Specialised commissioning

2.68. Specialised services are particularly important for the public and patients, with the NHS often working at the limits of science to bring the highest levels of human knowledge and skill to save lives and improve health.

2.69. The national commissioning arrangements that have been in place for these services since 2013 have played a vital role in supporting **consistent, equitable, and fast access for patients** to an ever-expanding catalogue of cutting edge technologies - genomic testing, CAR-T therapy, mechanical thrombectomy, Proton Beam Therapy and CFTR modulator therapies for patients with cystic fibrosis to name just a few.

2.70. But these national commissioning arrangements can sometime mean fragmented care pathways, misaligned incentives and missed opportunities for **upstream investment and preventative intervention**. For example, the split in commissioning responsibilities for mental health services has

potentially slowed the ambition to reduce the number of children admitted for inpatient treatment and, where they are admitted, making sure they are as close to home as possible. Bringing together the commissioning of mental health services has aligned incentives and enabled resources to be moved into upstream services, reducing over-reliance on geographically distant inpatient care.

2.71. Integrated care systems provide an opportunity to further **align the design, development and provision of specialised services with linked care** pathways, where it supports patient care, while maintaining consistent national standards and access policies across the board.

2.72. The following principles will underpin the detailed development of the proposed arrangements:

- ***Principle One: All specialised services, as prescribed in regulations, will continue to be subject to consistent national service specifications and evidence-based policies determining treatment eligibility.*** NHS England will continue to have responsibility for developing and setting these standards nationally and whoever is designated as the strategic commissioner will be expected to follow them. Over time, service specifications will need to become more outcomes focused to ensure that innovative and flexible solutions to unique system circumstances and/or opportunities can be easily adopted. But policies determining eligibility criteria for specific treatments across all specialised services will remain precise and consistently applied across the country.

- ***Principle Two: Strategic commissioning, decision making and accountability for specialised services will be led and integrated at the appropriate population level: ICS, multi-ICS or national.*** For certain specialised services, it will make sense to plan, organise and commission these at ICS level. For others, ICSs will need to come together across a larger geographic footprint to jointly plan and take joint commissioning decisions. And many services, such as those in the highly specialised services portfolio, will continue to be planned and commissioned on a national footprint. Importantly, whichever level strategic commissioning occurs the national standards will apply.

- ***Principle Three: Clinical networks and provider collaborations will drive quality improvement, service change and transformation across specialised services and non-specialised services.*** Clinical networks have long been a feature of the NHS. But, during the COVID pandemic they have become critical in supporting innovation and system wide collaboration. Looking ahead they will be supported to drive clinically-led change and service improvement with even greater

accountability for tackling inequalities and for improving population health.

- ***Principle Four: Funding of specialised services will shift from provider-based allocations to population-based budgets, supporting the connection of services back to 'place'.*** We are considering from April 2021 allocating budgets on a population basis at regional level and are considering the best basis for allocating funding and will provide further information in due course. In this first year, adjustments will then be made to neutralise any changes in financial flows and ensure stability. We intend to publish a needs-based allocation formula, before using it to inform allocations against an agreed pace of change in future years. A needs-based allocations formula will further strengthen the focus on tackling inequalities and unwarranted variation.

3. Legislative proposals

3.1. The detailed policy work described above will be necessary to deliver our vision but will not by itself be sufficient. While legislation is only part of the answer, the existing legislation (*the National Health Service Act 2006 and the Health and Social Care Act 2012* does not present a sufficiently firm foundation for system working.

3.2. In September 2019, NHSEI made a number of recommendations for an NHS Bill[2]. These aimed to remove current legislative barriers to integration across health and social care bodies, foster collaboration, and more formally join up national leadership in support of the ambitions outlined above.

3.3. Recommendations included:

- rebalancing the focus on **competition** between NHS organisations by reducing the Competition and Markets Authority's role in the NHS and abolishing Monitor's role and functions in relation to enforcing competition;
- simplifying **procurement** rules by scrapping section 75 of the 2012 Act and remove the commissioning of NHS healthcare services from the jurisdiction of the Public Contracts Regulations 2015;
- providing increased flexibilities on **tariff**;
- reintroducing the ability to establish **new NHS trusts** to support the creation of integrated care providers;
- ensuring a more coordinated approach to planning **capital investment**, through the possibility of introducing FT capital spend limits;
- the ability to establish decision-making **joint committees** of commissioners and NHS providers and between NHS providers;
- enabling **collaborative commissioning** between NHS bodies – it is currently easier in legislative terms for NHS bodies and local authorities to work together than NHS bodies;
- a new "**triple aim**" duty for all NHS organisations of 'better health for the whole population, better quality care for all patients and financially sustainable services for the taxpayer; and

2 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/875711/The_government_s_2020-2021_mandate_to_NHS_England_and_NHS_Improvement.pdf

- **merging NHS England and NHS Improvement** – formalising the work already done to bring the organisations together.

3.4. These recommendations were strongly supported and backed across the health and social care sector[3]. We believe these proposals still stand.

3.5. One of the key considerations in our recommendations was how, and to what extent, ICSs should be put on a statutory footing. Responses to our engagement were ultimately mixed – balancing the relatively early stage of development of some ICSs against a desire to enable further progress and to put ICSs on a firmer footing.

3.6. At the time, we proposed a new statutory underpinning to establish ICS boards through voluntary joint committees, an entity through which members could delegate their organisational functions to its members to take a collective decision. This approach ensured support to those systems working collectively already and a future approach to those systems at an earlier stage of development.

3.7. Many respondents to our engagement and specifically Parliament's Health and Social Care Select Committee raised a number of questions as to whether a voluntary approach would be effective in driving system working. There was particular focus on those areas at an earlier stage of their development and whether a voluntary model offered sufficient clarity of accountability for health outcomes and financial balance both to parliament and more directly to the public.

3.8. The response of the NHS and its partners to COVID-19 and a further year of ICS development has increased the appetite for statutory "clarity" for ICSs and the organisations within them. With an NHS Bill included in the last Queen's Speech, we believe the opportunity is now to achieve clarity and establish a "future-proofed" legislative basis for ICSs that accelerates their ability to deliver our vision for integrated care.

3.9. We believe there are two possible options for enshrining ICSs in legislation, without triggering a distracting top-down re-organisation:

Option 1: a statutory committee model with an Accountable Officer that binds together current statutory organisations.

Option 2: a statutory corporate NHS body model that additionally brings CCG statutory functions into the ICS.

[3] https://www.aomrc.org.uk/wp-content/uploads/2019/09/190926_Support_letter_NHS_legislation_-proposals.pdf

3.10. Both models share a number of features – broad membership and joint decision-making (including, as a minimum, representatives from commissioners; acute, community and primary care providers; and local authorities); responsibility for owning and driving forward the system plan; operating within and in accordance with the triple aim duty; and a lead role in relating to the centre.

Option 1 – a statutory ICS Board/ Joint Committee with an Accountable Officer

3.11. This option is closer to our original proposal. It would establish a mandatory, rather than voluntary, statutory ICS Board through the mechanism of a joint committee and enable NHS commissioners, providers and local authorities to take decisions collectively.

3.12. Unlike previously proposed versions of this model it would have a system Accountable Officer, chosen from the CEOs/AOs of the Board's mandatory members. This Accountable Officer would not replace individual organisation AOs/CEOs but would be recognised in legislation and would have duties in relation to delivery of the Board's functions. There would be a duty for the Board to agree and deliver a system plan and all members would have an explicit duty to comply with it.

3.13. In accordance with our stated ambition, there would be one aligned CCG only per ICS footprint under this model, and new powers would allow that CCGs are able to delegate many of its population health functions to providers.

3.14. This option retains individual organisational duties and autonomy and relies upon collective responsibility. Intervention against individual NHS organisations (not working in the best interests of the system) would continue to be enhanced through the new triple aim duty and a new duty to comply with the ICS plan.

3.15. The new Accountable Officer role would have duties to seek to agree the system plan and seek to ensure it is delivered and to some extent offer clarity of leadership. However, current accountability structures for CCG and providers would remain.

3.16. There remain potential downsides to this model. In effect, many of the questions raised through our engagement in 2019 about accountability and clarity of leadership would remain. While the addition of an Accountable Officer strengthens this model, there remains less obvious responsibility for patient outcomes or financial matters. Having an ICS Accountable Officer alongside a CCG Accountable Officer may in some cases confuse rather than clarify accountability. The CCG governing body and GP membership is

also retained, and it is questionable whether these are sufficiently diverse arrangements to fulfil the different role required of CCGs in ICSs.

3.17. Furthermore, many may not consider this model to be the “end state” for ICSs and opportunities for primary legislative change are relatively rare. There are therefore strong arguments to go further when considering how the health and care system might evolve over the next ten years and more.

Option 2 – a statutory ICS body

3.18. In this option, ICSs would be established as NHS bodies partly by “re-purposing” CCGs and would – among other duties – take on the commissioning functions of CCGs. Additional functions would be conferred and existing functions modified to produce a new framework of duties and powers.

3.19. The CCG governing body and GP membership model would be replaced by a board consisting of representatives from the system partners. As a minimum it would include representatives of NHS providers, primary care and local government alongside a Chair, a Chief Executive and a Chief Financial Officer. The ICS body should be able to appoint such other members as it deems appropriate allowing for maximum flexibility for systems to shape their membership to suit the needs of their populations. The power of individual organisational veto would be removed. The ICS Chief Executive would be a full-time Accounting Officer role, which would help strengthen lines of accountability and be a key leadership role in ensuring the system delivers.

3.20. The ICS’s primary duty would be to secure the effective provision of health services to meet the needs of the system population, working in collaboration with partner organisations. It would have the flexibility to make arrangements with providers through contracts or by delegating responsibility for arranging specified services to one or more providers.

3.21. This model would deliver a clearer structure for an ICS and avoids the risk of complicated workarounds to deliver our vision for ICSs. Although there would be a representative for primary care on the Board, there would no longer be a conflict of interests with the current GP-led CCG model (created by the 2012 Act) and it could be possible to allocate combined population-level primary care, community health services and specialised services population budgets to ICS.

3.22. Many commissioning functions for which NHSE is currently responsible could, for the most part, be transferred or delegated to the ICS body, but with the ability to form joint committees as proposed through our original recommendations, with NHSE, if and where appropriate.

3.23. Through greater provider involvement, it could also reduce some of the transactional burdens of the current contracting processes. There would be powers for the ICS to delegate responsibility for arranging some services to providers, to create much greater scope for provider collaboration to use whole-population budgets to drive care pathway transformation.

Our approach

3.24. Either model would be sufficiently permissive in legislation to allow different systems to shape how they operate and how best and most appropriately deliver patient care and outcomes support at place.

3.25. Under either model we would want local government to be an integral, key player in the ICS. Both models offer a basis for planning and shaping services across healthcare, social care, prevention and the wider determinants of health. Both would allow for the delegation of functions and money to place-based statutory committees involving NHS bodies and local government. Both would enable NHS and local government to exploit existing flexibilities to pool functions and funds.

3.26. While both models would drive increased system collaboration and achieve our vision and our aims for ICSs in the immediate term, we believe Option 2 is a model that offers greater long term clarity in terms of system leadership and accountability. It also provides a clearer statutory vehicle for deepening integration across health and local government over time. It also provides enhanced flexibility for systems to decide who and how best to deliver services by both taking on additional commissioning functions from NHS England but also deciding with system colleagues (providers and local councils) where and how best service provision should take place.

3.27. Should these proposals be developed further and proposed by Government as future legislation, we would expect a full assessment of the impact of these proposals on equalities and public and parliamentary engagement and scrutiny as is appropriate.

Questions

Q. Do you agree that giving ICSs a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the NHS over the next decade?

Q. Do you agree that option 2 offers a model that provides greater incentive for collaboration alongside clarity of accountability across systems, to Parliament and most importantly, to patients?

Q. Do you agree that, other than mandatory participation of NHS bodies and Local Authorities, membership should be sufficiently permissive to allow systems to shape their own governance arrangements to best suit their populations needs?

Q. Do you agree, subject to appropriate safeguards and where appropriate, that services currently commissioned by NHSE should be either transferred or delegated to ICS bodies?

4. Implications and next steps

4.1. The ambitious changes set out here are founded on the conviction that collaboration will be a more effective mechanism for transformation against long term population health priorities and also for driving sustainable operational performance against the immediate challenges on quality, access, finance and delivery of outcomes that make difference to people's experience of services today.

4.2. International evidence points to this being the case as across the world health systems change to pursue integration as the means of meeting health needs and improving health outcomes. We have seen this reinforced through our experiences in tackling COVID-19.

4.3. The rapid changes in digital technology adoption, mutual cooperation and capacity management, provision of joined up support to the most vulnerable that have been essential in the immediate response to the pandemic have only been possible through partners working together to implement rapid change as they focus on a shared purpose.

4.4. As we embed the ways of working set out above, partners in every system will be able to take more effective, immediate operational action on:

- managing acute healthcare performance challenges and marshalling collective resource around clear priorities, through provider collaboratives;
- tackling unwarranted variation in service quality, access and performance through transparent data with peer review and support arrangements organised by provider collaboratives;
- using data to understand capacity utilisation across provider collaboratives, equalising access (tackling inequality across the system footprint) and equalising pressures on individual organisations.

The NHS England and NHS Improvement's operating model

4.5. NHSEI will support systems to adopt improvement and learning methodologies and approaches which will enable them to improve services for patients, tackle unwarranted variation and develop cultures of continuous improvement.

4.6. This will be underpinned by a comprehensive support offer which includes:

- access to our national transformation programmes for outpatients and diagnostics;
- support to tackle unwarranted variation and increase productivity (in partnership with the Getting it Right First Time programme);
- the data they need to drive improvement, accessed through the 'model health system';
- the resources and guidance that they need to build improvement capability; and
- assistance from our emergency and electivity intensive support teams (dependent on need).

4.7. Much of this support offer will be made available to systems through regional improvement hubs, which will ensure that improvement resource supports local capacity- and capability-building. Systems will then able to flexibly and rapidly deploy the support into place partnerships and provider collaboratives.

4.8. NHSEI developed a joint operating model during 2019, with input from senior NHS leaders including those in systems and regions, as well as frontline staff and other stakeholders. This resulted in a description of the different ways NHSEI will operate in future, underpinned by a set of principles including subsidiarity, and a set of 'levers of value' that NHSEI can use at national and regional level to support systems.

4.9. NHSEI will continue to develop this operating model to support the vision set out above, and any legislative changes. This will include further evolving how we interact with systems nationally and regionally; and ensuring that its functions are arranged in a way that support and embed system working to deliver our priorities.

4.10. The new operating environment will mean:

- increased freedoms and responsibilities for ICSs, including greater responsibility for system development and performance, as well as greater autonomy regarding assurance.
- the primary interaction between NHSEI and systems will be between regions and the collective ICS leadership, with limited cause for national functions to directly intervene with individual providers within systems.
- as systems take on whole population budgets they will increasingly determine how resource is to be used to 'move the dial' on outcomes, inequalities, productivity and wider social and economic development

against their specific health challenges and population health priorities.

- NHSEI regional teams will become ‘thinner’ as we move direct commissioning responsibility out to systems (individually and collectively). They will increasingly continue to enable systems to take on greater autonomy, working with them to identify their individual development priorities and support needs.

Transition

4.11. The experience of the earliest ICSs shows that great leadership is critical to success and can come from any part of the health and care system. But, to be effective, it must be felt right across, and draw on the talents of leaders from every part of, a system.

4.12. These systems have developed a new style of behaviour, which makes the most of the leadership teams of all constituent organisations and empowers frontline leaders. System leaders have impact through a collaborative and distributive leadership style that operates across boundaries, leading for communities.

4.13. This shared approach to leadership is based on qualities such as openness and transparency, honesty and integrity, a genuine belief in common goals and an ability to build consensus.

4.14. ICSs need to be of sufficient size to carry out their ‘at scale’ activities effectively, while having sufficiently strong links into local communities at a much more local level in places and neighbourhoods.

4.15. Pragmatically we are supporting ICSs through to April 2022 at their current size and scale, but we recognise that smaller systems will need to join up functions, particularly for provider collaboration. We will support the ability for ICSs to more formally combine as they take on new roles where this is supported locally.

4.16. We will work with systems to ensure that they have arrangements in place to take on enhanced roles from April 2022. We will set out a roadmap for this transition that gives assurance over system readiness for new functions as these become statutory.

4.17. We know that under either legislative proposal we need to ensure that we support our staff during organisational change by minimising uncertainty and limiting employment changes. We are therefore seeking to provide stability of employment while enabling a rapid development of role functions and purpose for all our teams, particularly in CCGs directly impacted by legislative Option 2.

4.18. We want to take a different approach to this transition; one that is characterised by care for our people and no distraction from the 'day job': the critical challenges of recovery and tackling population health.

4.19. **Stable employment:** As CCG functions move into new bodies we will make a 'continued employment promise' for staff carrying out commissioning functions. We will preserve terms and conditions to the new organisations (even if not required by law) to help provide stability and to remove uncertainty.

4.20. **New roles and functions:** For many commissioning functions the work will move to a new organisation and will then evolve over time to focus on system priorities and ways of working. The priority will be the continuation of the good work being carried out by the current group of staff and we will promote best practice in engaging, consulting and supporting the workforce during a carefully planned transition, minimising disruption to staff.

4.21. Other functions will be more directly impacted, principally the most senior leaders in CCGs (chief officers and other governing body / board members). ICSs need to have the right talent in roles leading in systems.

4.22. Our commitment is:

- not to make significant changes to roles below the most senior leadership roles;
- to minimise impact of organisational change on current staff during both phases (in paragraphs 4.19 and 4.20 above) by focusing on continuation of existing good work through the transition and not amending terms and conditions; and
- offer opportunities for continued employment up to March 2022 for all those who wish to play a part in the future.

Next steps

4.23. We expect that every system will be ready to operate as an ICS from April 2021, in line with the timetable set out in the *NHS Long Term Plan*. To prepare for this, we expect that each system will, by this time, agree with its region the functions or activities it must prioritise (such as in service transformation or population health management) to effectively discharge its core roles in 2021/22 as set out in this paper.

4.24. All ICSs should also agree a sustainable model for resourcing these collective functions or activities in the long term across their constituent organisations.

4.25. To support all of the above, all systems should agree development plans with their NHSEI regional director that clearly set out:

- **By April 2021:** how they continue to meet the current consistent operating arrangements for ICSs and further planning requirements for the next phase of the COVID-19 response
- **By September 2021:** implementation plans for their future roles as outlined above, that will need to adapt to take into account legislative developments.

4.26. Throughout the rest of 2020, the Department of Health and Social Care and NHSEI will continue to lead conversations with different types of health and care organisations, local councils, people who use and work in services, and those who represent them, to understand their priorities for further policy and legislative change.

4.27. The legislative proposals set out in this document takes us beyond our original legislative recommendations to the government. We are therefore **keen to seek views on these proposed options from all interested individuals and organisations**. These views will help inform our future system design work and that of government should they take forward our recommendations in a future Bill.

4.28. Please submit your response to this address: www.engage.england.nhs.uk/survey/building-a-strong-integrated-care-system

4.29. Alternatively you can also contact england.legislation@nhs.net or write with any feedback to NHS England, PO Box 16738, Redditch, B97 9PT by Friday 8 January.

4.30. For more information about how health and care is changing, please visit: www.england.nhs.uk/integratedcare and sign up to our regular e-bulletin at: www.england.nhs.uk/email-bulletins/integrated-care-bulletin

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	8 December 2020
Title	Financial Summary Report – M7 2020/21
Purpose	To provide the Month 7 2020/21 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 2020/21 financial position.
ACTION REQUIRED	The Board is invited to note the following summary of financial performance and results for Month 7 2020/21 (September 2020): This month is the first under the revised COVID funding regime, with performance being measured against the forecast submitted to NHSI in October, and costs being offset by fixed levels of COVID funding and deficit support. **YTD Surplus** £0.2m vs Planned Deficit £0.1m **YTD Cash** £50.2m vs Plan £46.5m. **YTD Capital expenditure:** £1.9m vs Plan £2.1m.

Berkshire Healthcare NHS
NHS Foundation Trust

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

Finance Report

Financial Year 2020/21

October 2020

Purpose

To provide the Board & Executive with a summary of the Trusts financial performance for the period ending 31st October 2020.

Version	*Date*	*Author*	*Comments*
1.0	17/11/2020	Paul Gray	Final

Distribution

All Directors

All staff needing to see this report.

Contents

1.0 Income & Expenditure

	In Month			M7 - M12 YTD			PY
	Act £'m	Plan £'m	Var £'m	Act £'m	Plan £'m	Var £'m	Plan £'m
Operating Income	21.6	21.3	0.3	21.6	21.3	0.3	127.8
Other Income	1.2	1.4	(0.2)	1.2	1.4	(0.2)	8.3
Donated Income	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Income	***22.9***	***22.7***	***0.2***	***22.9***	***22.7***	***0.2***	***136.1***
Staff In Post	15.0	15.5	(0.5)	15.0	15.5	(0.5)	93.3
Annual Leave Provision	0.0	0.0	0.0	0.0	0.0	0.0	1.4
Bank Spend	1.4	1.2	0.1	1.4	1.2	0.1	7.6
Agency Spend	0.4	0.3	0.1	0.4	0.3	0.1	1.7
Total Pay	***16.8***	***17.0***	***(0.2)***	***16.8***	***17.0***	***(0.2)***	***104.0***
Purchase of Healthcare	1.4	1.2	0.2	1.4	1.2	0.2	7.1
Drugs	0.4	0.5	(0.1)	0.4	0.5	(0.1)	2.9
Premises	1.3	1.4	(0.1)	1.3	1.4	(0.1)	8.7
Other Non Pay	1.6	1.5	0.1	1.6	1.5	0.1	9.2
PFI Lease	0.5	0.6	(0.0)	0.5	0.6	(0.0)	3.4
Total Non Pay	***5.2***	***5.2***	***0.1***	***5.2***	***5.2***	***0.1***	***31.3***
Total Operating Costs	***22.0***	***22.1***	***(0.1)***	***22.0***	***22.1***	***(0.1)***	***135.3***
EBITDA	***0.9***	***0.5***	***0.3***	***0.9***	***0.5***	***0.3***	***0.7***
Interest (Net)	0.3	0.3	(0.0)	0.3	0.3	(0.0)	1.9
Depreciation	0.7	0.7	(0.0)	0.7	0.7	(0.0)	4.1
Disposals	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Impairments	0.1	0.0	0.1	0.1	0.0	0.1	0.0
PDC	0.1	0.1	0.0	0.1	0.1	0.0	0.7
Total Finanacing	***1.2***	***1.1***	***0.1***	***1.2***	***1.1***	***0.1***	***6.7***
(Deficit) Pre COVID & Support	***(0.3)***	***(0.6)***	***0.3***	***(0.3)***	***(0.6)***	***0.3***	***(6.0)***
COVID Income	0.0	0.0	0.0	0.0	0.0	0.0	0.0
COVID Pay Costs	0.2	0.3	(0.1)	0.2	0.3	(0.1)	2.0
COVID Non Pay Costs	0.2	0.1	0.1	0.2	0.1	0.1	0.8
Total COVID Costs	***0.4***	***0.4***	***(0.1)***	***0.4***	***0.4***	***(0.1)***	***2.8***
System COVID Funding	0.4	0.4	0.0	0.4	0.4	0.0	2.8
System Top Up Funding	0.5	0.5	0.0	0.5	0.5	0.0	2.8
Total Revenue Support	***0.9***	***0.9***	***0.0***	***0.9***	***0.9***	***0.0***	***5.6***
Reported Surplus/ (Deficit)	***0.2***	***(0.1)***	***0.3***	***0.2***	***(0.1)***	***0.3***	***(3.2)***

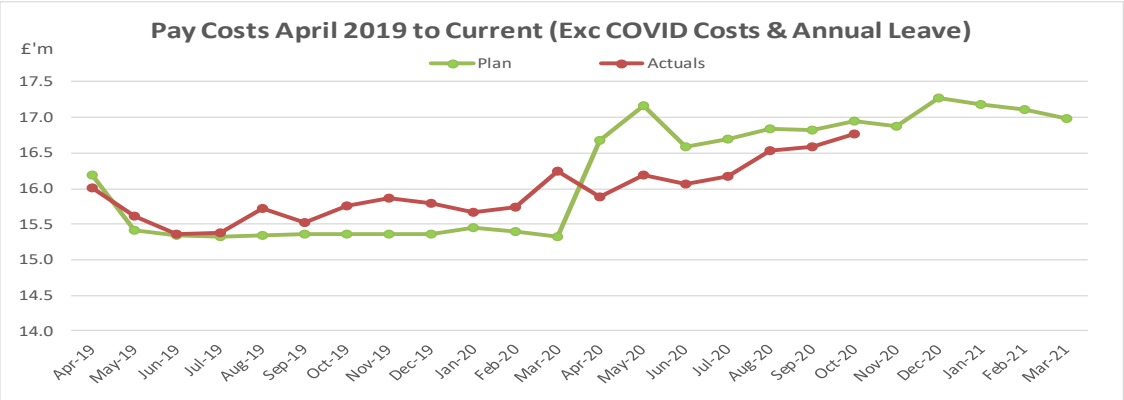
Key Messages

The table above illustrates financial performance against the forecast submitted to NHSI for Q3 and Q4. The table provides our underlying financial performance, and separately highlights our marginal COVID costs, agreed system COVID funding and underlying deficit support. A consolidated YTD Income Statement can be found on Page 6.

The Trust is reporting a £0.2m surplus in October and YTD, this is £0.3m better than forecast. Income is ahead of forecast by £0.2m, with expenditure higher than forecast by an equal amounts. This combines with lower than forecast COVID costs of £0.1m.

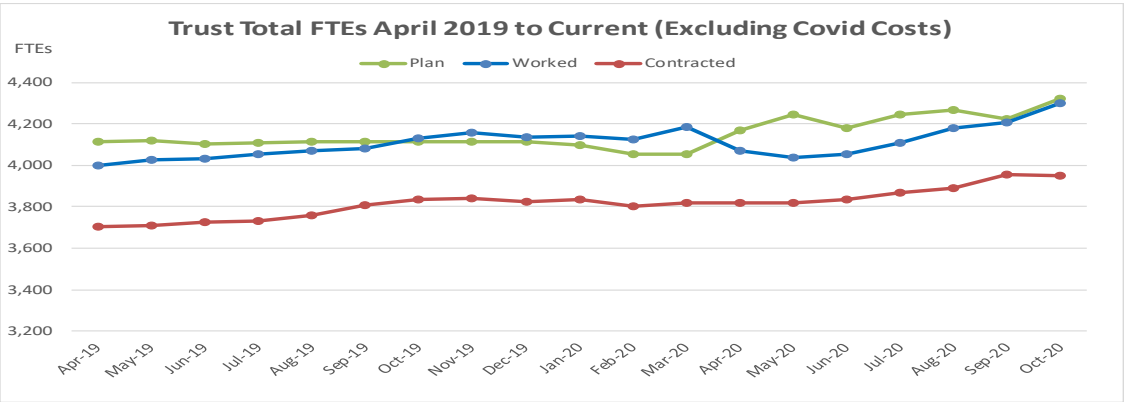
Existing forecast COVID costs as well as any new costs arising from the current wave, will need to be managed in the context of our £2.8m system allocation for the remainder of the year.

Workforce



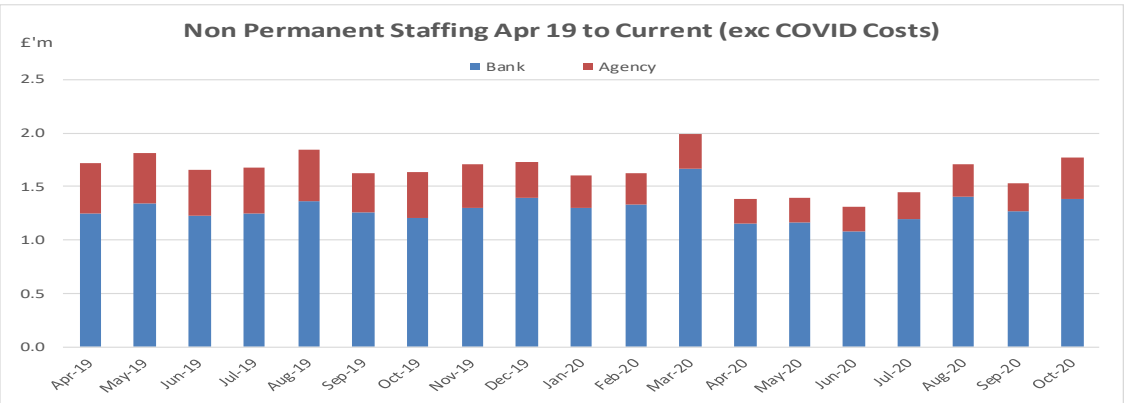
Staff Costs

YTD	£'m
2020/21	114.2
2019/20	109.4
▲	4%
Prior Yr	**£'m**
Oct-20	16.9
Oct-19	15.4
▲	10%



FTEs

Prior Mth	CFTE	WFTE
Oct-20	3,949	4,301
Sep-20	3,957	4,204
	0% ▲	2% ▼
Prior Yr	**CFTE**	**WFTE**
Oct-20	3,949	4,301
Oct-19	3,837	4,133
	3% ▲	4% ▲



Staff Costs

YTD	Bank £'m	Agency £'m
2020/21	8.7	1.9
2019/20	8.9	3.1
	-3% ▼	-39% ▼
Prior Yr	**Bank £'m**	**Agency £'m**
Oct-20	1.4	0.4
Oct-19	1.2	0.4
	15% ▲	-10% ▼

Key Messages

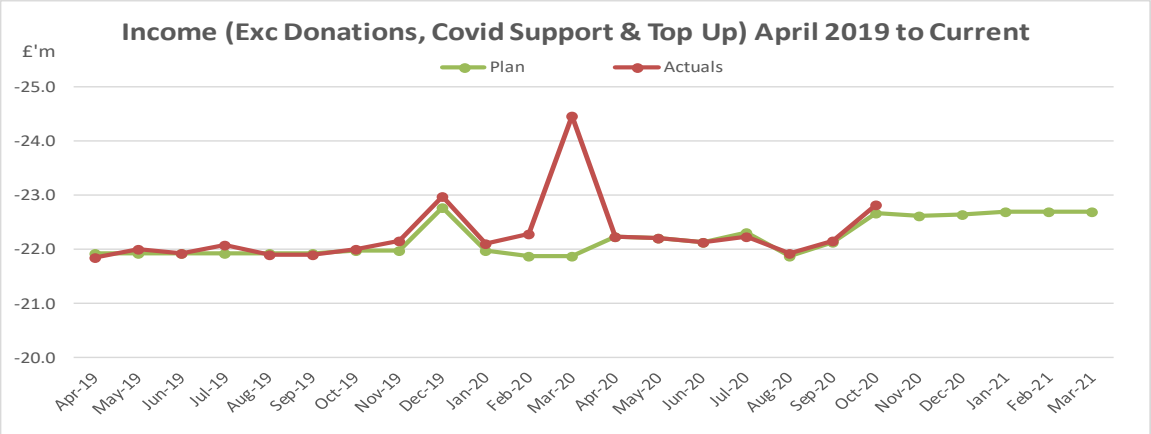
Overall Pay costs increased by a further £0.1m in October with increases in Non Permanent staffing costs being in excess of reductions in substantive and COVID costs. Pay costs were £17.0m inclusive of £0.2m of COVID related expenditure. Although increasing, costs are £0.2m less than forecast.

Substantive costs increased by £0.1m, after accounting for the backdated Medical pay award in September. This reflects increases, notably in CYPF and Corporate, in addition to the appointment of IAPT trainees.

The Trust saw £0.2m increases with both Bank and Agency expenditure increasing by £0.1m. Spend increased across a number of services, and overall monthly spend was in excess of last year. Elevated spend was seen within CAMHS, notably Willow House to support staff shortages and the Rapid Response service, WestCall utilised additional Medical cover increasing costs by £40k, in part to support set up of additional support to 111 and bank HCA usage at PPH increased spend by £29k, focused around Daisy & Bluebell Wards.

Marginal COVID costs fell by £50k to £0.2m. The majority of COVID pay costs are additional shifts and sickness cover, both of which are likely to increase in the short term given current operational pressures.

Income & Non Pay



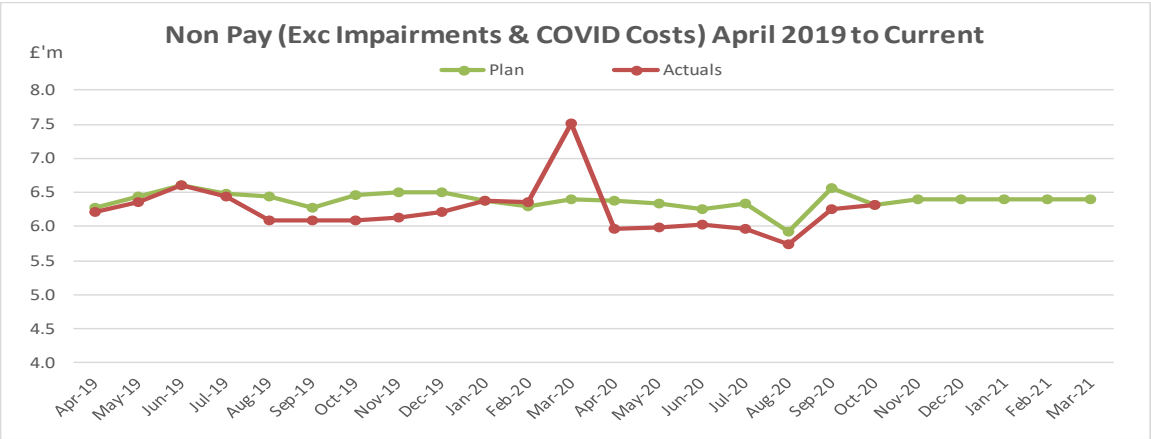
Income

YTD	£'m
2020/21	155.8
2019/20	153.7
▲	1%
Prior Yr	**£'m**
Oct-20	22.7
Oct-19	22.0
▲	3%

Key Messages

Income in October was £22.7m, reflecting a £0.7m increase on the prior month, excluding system COVID & Top Up funding. This is £0.2m ahead of forecast due secondment income and non contract activity, as well as funding for the Community Discharge service in the West.

This months increase, and the higher plan for the remainder of the year, reflects agreed adjustments in our calculated block values for Berkshire West CCG and Berkshire East CCG, including adjustments for previous inaccuracies, non recurrent sums, funding for full year impacts from 19/20 and agreed investments for the remainder of the year.



Non Pay

YTD	£'m
2020/21	42.4
2019/20	43.9
▼	-3%
Prior Yr	**£'m**
Oct-20	6.3
Oct-19	6.1
▲	4%

Key Messages

Non Pay costs were £6.3m, reflecting a small increase from September and are £0.1m higher than forecast.

The £0.1m benefit from one-off assessment costs in September were offset with a YTD adjustment following quarterly reconciliation of our main inter provider contracts.

Long Term Placement costs have risen over the year, with +5 placements, +20% increase since April, and with a cost in October of £0.7m. This is combines with the average cost of independent placement increasing, mainly due to observational requirements in small number of placements.

Out of Area Placements costs remained in line with previous months at just of £0.1m with bed requirement in Octover being entirely driven by PICU demand.

Consolidated YTD Financial Performance

	M01 - M06 YTD			M7 - M12 YTD			Consolidated YTD			FY
	Act £'m	Plan £'m	Var £'m	Act £'m	Plan £'m	Var £'m	Act £'m	Plan £'m	Var £'m	Plan £'m
Operating Income	126.4	124.5	1.8	21.6	21.3	0.3	148.0	145.8	2.2	252.3
Other Income	6.5	8.4	(1.9)	1.2	1.4	(0.2)	7.8	9.8	(2.0)	16.7
Donated Income	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Income	**132.9**	**132.9**	***(0.0)***	**22.9**	**22.7**	***0.2***	**155.8**	**155.6**	***0.2***	**269.0**
Staff In Post	88.7	90.1	(1.4)	15.0	15.5	(0.5)	103.7	105.5	(1.9)	183.4
Annual Leave Provision	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.4
Bank Spend	7.3	5.5	1.7	1.4	1.2	0.1	8.7	6.8	1.9	13.1
Agency Spend	1.5	1.8	(0.3)	0.4	0.3	0.1	1.9	2.0	(0.2)	3.5
Total Pay	***97.4***	***97.4***	***0.1***	***16.8***	***17.0***	***(0.2)***	***114.2***	***114.3***	***(0.1)***	***201.4***
Purchase of Healthcare	6.9	7.1	(0.2)	1.4	1.2	0.2	8.3	8.3	(0.0)	14.3
Drugs	2.5	2.5	0.0	0.4	0.5	(0.1)	2.9	3.0	(0.1)	5.4
Premises	8.0	8.5	(0.6)	1.3	1.4	(0.1)	9.3	10.0	(0.7)	17.2
Other Non Pay	8.5	7.7	0.7	1.6	1.5	0.1	10.0	9.2	0.8	16.9
PFI Lease	3.3	3.3	0.0	0.5	0.6	(0.0)	3.8	3.9	(0.0)	6.7
Total Non Pay	***29.2***	***29.2***	***(0.0)***	***5.2***	***5.2***	***0.1***	***34.4***	***34.4***	***0.0***	***60.6***
Total Operating Costs	***126.6***	***126.6***	***0.0***	***22.0***	***22.1***	***(0.1)***	***148.6***	***148.7***	***(0.1)***	***262.0***
EBITDA	***6.3***	***6.3***	***(0.0)***	***0.9***	***0.5***	***0.3***	***7.1***	***6.9***	***0.3***	***7.0***
Interest (Net)	1.9	1.9	0.0	0.3	0.3	(0.0)	2.3	2.2	0.0	3.9
Depreciation	3.9	3.9	(0.0)	0.7	0.7	(0.0)	4.6	4.6	(0.1)	8.1
Disposals	(0.0)	0.0	(0.0)	0.0	0.0	0.0	(0.0)	0.0	(0.0)	0.0
Impairments	0.0	0.0	0.0	0.1	0.0	0.1	0.1	0.0	0.1	0.0
PDC	0.9	0.9	0.0	0.1	0.1	0.0	1.0	1.0	0.0	1.6
Total Finanacing	***6.7***	***6.8***	***(0.0)***	***1.2***	***1.1***	***0.1***	***7.9***	***7.9***	***0.0***	***13.5***
(Deficit) Pre COVID & Support	***(0.5)***	***(0.4)***	***(0.0)***	***(0.3)***	***(0.6)***	***0.3***	***(0.8)***	***(1.0)***	***0.2***	***(6.5)***
COVID Income	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
COVID Pay Costs	3.4	3.4	0.0	0.2	0.3	(0.1)	3.6	3.7	(0.1)	5.4
COVID Non Pay Costs	1.8	1.8	0.0	0.2	0.1	0.1	1.9	1.9	0.1	2.6
Total COVID Costs	***5.2***	***5.2***	***0.0***	***0.4***	***0.4***	***(0.1)***	***5.6***	***5.6***	***(0.1)***	***8.0***
NHSE/I Top Up Funding	5.6	5.6	0.0				5.6	5.6	0.0	5.6
System COVID Funding				0.4	0.4	0.0	0.4	0.4	0.0	2.8
System Top Up Funding				0.5	0.5	0.0	0.5	0.5	0.0	2.8
Total Revenue Support	***5.6***	***5.6***	***0.0***	***0.9***	***0.9***	***0.0***	***6.5***	***6.5***	***0.0***	***11.2***
Reported Surplus/ (Deficit)	***(0.0)***	***(0.0)***	***0.0***	***0.2***	***(0.1)***	***0.3***	***0.2***	***(0.1)***	***0.3***	***(3.2)***

Key Messages

The table above represents financial performance against the revised forecast submitted to NHSE/I.

The table separately illustrates performance under the separate financial regimes that have operated this year. Q1 and Q2 being the original interim financial regime under which support was provided to ensure financial breakeven. Q3 and Q4 which reflects the current regime, where the plan is based upon our recent forecast submission.

To note the plan present in the table for Q1 and Q2, reflects a revised plan from NHSI with the plan aligning breakeven and not the original £1.1m surplus assumed in the first iteration in April. This allows greater transparency over the £6.5m planned underlying deficit, excluding the impact of COVID.

2.0 Balance Sheet & Cash

Balance Sheet	19/20 Actual £'m	Current Month Act £'m	Current Month Plan £'m	Current Month Var £'m	YTD Act £'m	YTD Plan £'m	YTD Var £'m	20/21 Plan £'m
Intangibles	7.0	5.6	5.7	(0.1)	5.6	5.7	(0.1)	5.7
Property, Plant & Equipment (non PFI)	37.5	36.8	38.0	(1.2)	36.8	38.0	(1.2)	38.2
Property, Plant & Equipment (PFI)	57.3	57.3	56.8	0.5	57.3	56.8	0.5	57.7
Total Non Current Assets	**102.7**	**99.7**	**100.5**	**(0.8)**	**99.7**	**100.5**	**(0.8)**	**101.7**
Trade Receivables & Accruals	11.3	16.5	13.4	3.1	16.5	13.4	3.1	13.4
Other Receivables	0.1	0.2	0.2	(0.0)	0.2	0.2	(0.0)	0.2
Cash	26.4	48.8	50.0	(1.3)	48.8	50.0	(1.3)	22.7
Trade Payables & Accruals	(24.8)	(29.0)	(28.2)	(0.9)	(29.0)	(28.2)	(0.9)	(27.6)
Current PFI Finance Lease	(1.5)	(1.5)	(1.5)	0.0	(1.5)	(1.5)	0.0	(1.6)
Other Current Payables	(2.5)	(24.7)	(24.9)	0.2	(24.7)	(24.9)	0.2	(2.8)
Total Net Current Assets / (Liabilities)	**9.6**	**10.2**	**9.1**	**1.1**	**10.2**	**9.1**	**1.1**	**4.3**
Non Current PFI Finance Lease	(27.0)	(26.1)	(26.1)	(0.0)	(26.1)	(26.1)	(0.0)	(25.5)
Other Non Current Payables	(1.9)	(1.9)	(1.9)	(0.0)	(1.9)	(1.9)	(0.0)	(1.9)
Total Net Assets	***82.4***	***81.9***	***81.6***	***0.3***	***81.9***	***81.6***	***0.3***	***78.5***
Income & Expenditure Reserve	29.1	29.2	28.9	0.3	29.2	28.9	0.3	25.8
Public Dividend Capital Reserve	19.2	19.2	19.2	(0.0)	19.2	19.2	(0.0)	19.3
Revaluation Reserve	33.4	33.4	33.4	(0.0)	33.4	33.4	(0.0)	33.4
Total Taxpayers Equity	***82.4***	***81.9***	***81.6***	***0.3***	***81.9***	***81.6***	***0.3***	***78.5***

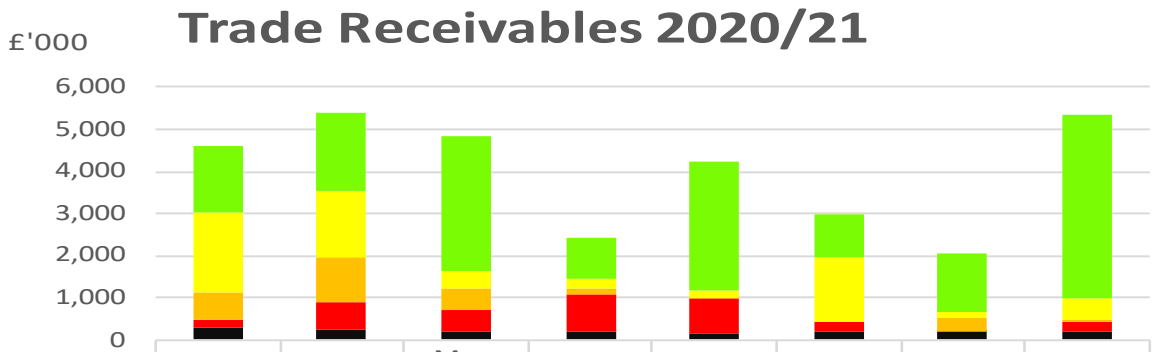
Cashflow		19/20 Actual £'m	Current Month Act £'m	Current Month Plan £'m	Current Month Var £'m	YTD Act £'m	YTD Plan £'m	YTD Var £'m	20/21 Plan £'m
Operating Surplus/(Deficit)	+/-	6.4	0.6	0.3	0.3	3.4	3.1	0.3	5.3
Depreciation and Impairments	+	8.5	0.6	0.7	(0.1)	4.6	4.6	(0.1)	8.1
Operating Cashflow		***14.9***	***1.2***	***1.0***	***0.2***	***8.0***	***7.7***	***0.2***	***13.4***
Net Working Capital Movements	+/-	***1.4***	***(1.5)***	***(0.2)***	***(1.4)***	***21.2***	***22.4***	***(1.3)***	***(1.7)***
Proceeds from Disposals	+	0.0	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)	-	(9.8)	(0.8)	(0.6)	(0.2)	(3.7)	(3.4)	(0.2)	(8.6)
Investments		***(9.8)***	***(0.8)***	***(0.6)***	***(0.2)***	***(3.7)***	***(3.4)***	***(0.2)***	***(8.6)***
PFI Finance Lease Repayment	-	(1.2)	(0.1)	(0.1)	(0.0)	(0.9)	(0.9)	(0.0)	(1.5)
Net Interest	+/-	(3.6)	(0.3)	(0.3)	(0.0)	(2.3)	(2.3)	(0.0)	(3.9)
PDC Received	+	1.2	0.0	0.0	(0.0)	0.0	0.0	0.0	0.2
PDC Dividends Paid	-	(2.1)	0.0	0.0	0.0	0.0	0.0	0.0	(1.7)
Financing Costs		***(5.7)***	***(0.5)***	***(0.4)***	***(0.0)***	***(3.1)***	***(3.1)***	***(0.0)***	***(6.8)***
Other Movements	+/-	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Net Cash In/(Out)Flow		***0.8***	***(1.4)***	***(0.3)***	***(1.2)***	***22.4***	***23.6***	***(1.2)***	***(3.6)***
Opening Cash		25.6	50.2	50.2	0.0	26.4	26.4	0.0	26.4
Closing Cash		***26.4***	***48.8***	***50.0***	***(1.2)***	***48.8***	***50.0***	***(1.2)***	***22.7***

Key Messages

We continue to hold an extra months CCG block payments, with expectation this will be recouped by the end of the year. The interim financial regime has helped to maintain our cash balances as will the deficit support built into our plans for the remainder of the year. Closing cash for 20/21 is forecast to be £22.7m.

The recent planning round restated and adjusted our block payments from commissioners and these are now feeding into our forecast.

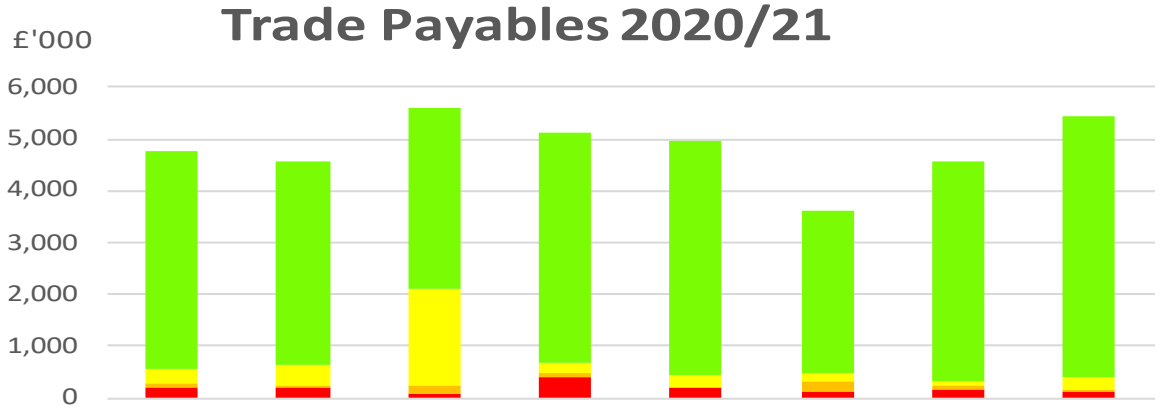
Cash Management



	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
<30 Days	1,562	1,870	3,230	973	3,032	1,000	1,377	4,337
>30 <60 Days	1,904	1,573	388	225	180	1,535	136	518
>60 <90 Days	662	1,063	500	154	34	0	327	59
>90 < 180 Days	177	673	538	864	802	251	25	204
>180 Days	295	241	197	220	182	186	200	219

Key Messages

Overall debtor balances increased by £3.3m, with overdue balances increasing by £0.3m. Overdue balances remain at a relatively low value given the current financial regime and limitation on billing. The largest balances over 60 days remain with our Local Authorities, East Berkshire CCG and Frimley FT and we are engaged with them to clear these.



	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
<30 Days	4,209	3,924	3,486	4,438	4,531	3,117	4,245	5,030
>30 <60 Days	273	391	1,858	207	227	159	99	236
>60 <90 Days	88	51	182	63	27	205	74	42
>90 days	209	196	77	403	194	126	153	124

Key Messages

Overall Creditors increased by £0.9m, due to an increase in current payables of £0.8m. Overdue balances increased by £0.1m, the majority in the 30-60 day bracket. The largest remaining balances over 60 days relate to only a small number of invoice which are all being reviewed in order to resolve the outstanding queries preventing their settlement.

3.0 Capital Expenditure

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	140	261	(121)	789	483	307	1,021
Erleigh Road (LD etc works)	0	18	(18)	0	18	(18)	153
Wokingham Willow House Projects	2	0	2	64	197	(133)	197
Trust Owned Properties Other	2	20	(18)	4	71	(67)	111
Leased Non Commercial (NHSPS)	(5)	74	(78)	150	202	(51)	335
Leased Commercial	0	7	(7)	0	18	(18)	50
Various All Sites	8	47	(38)	63	217	(154)	510
Statutory Compliance	2	39	(37)	18	204	(186)	347
Subtotal Estates Maintenance & Replacement	**150**	**465**	**(315)**	**1,089**	**1,408**	**(319)**	**2,724**
IM&T Expenditure							
IM&T Business Intelligence and Reporting	0	61	(61)	31	61	(31)	368
IM&T System & Network Developments	105	487	(383)	108	956	(848)	1,541
IM&T Other	32	0	32	321	195	126	445
GDE & Community Trust Funded	17	95	(78)	62	488	(426)	958
Subtotal IM&T Expenditure	**153**	**643**	**(490)**	**521**	**1,700**	**(1,179)**	**3,312**
Subtotal CapEx Within Control Total	**303**	**1,108**	**(805)**	**1,611**	**3,108**	**(1,497)**	**6,036**
CapEx Expenditure Outside of Control Total							
PPH - LD to Jasmine	207	238	(31)	718	238	480	1,647
Other PFI Projects	45	45	(0)	49	166	(116)	295
HSLI Projects	27	17	10	140	90	50	174
Subtotal Capex Outside of Control Totals	**279**	**300**	**(22)**	**908**	**493**	**415**	**2,116**
Total Capital Expenditure	**582**	**1,409**	**(827)**	**2,519**	**3,602**	**(1,083)**	**8,153**

New COVID Pressures	Current Month			Year to Date			FY
	Actual £'000	Plan £'000	Variance £'000	Actual £'000	Plan £'000	Variance £'000	Plan £'000
Central Funding Agreeed							
Pandemic Storage Facility	(1)	0	(1)	43	0	43	0
Point of Care Testing Bids (NHSPS sites)	1	0	1	38	0	38	0
Funding not yet agreed							
Laptops COVID-19	0	0	0	64	0	64	0
Point of Care Testing Bids (PFI - £57K)	0	0	0	0	0	0	0
Total CapEx excluded from Annual Plan	**(0)**	**0**	**(0)**	**145**	**0**	**145**	**0**

Key Messages

The overall capital spend was £0.8m lower than planned, which increased the YTD underspend to £1.1m.

Estates spend was £0.3m lower than planned on schemes that count toward the ICS control total. Estates are currently reviewing existing and new schemes which may come on line before the end of the financial year to establish if there will be slippage against this years allocation. LD to Jasmine, which sits outside of control total, remains on schedule to complete before the end of the financial year, pulling forward from next year.

IM&T Refresh & Replacement Programme spend is now expected in Q3, giving rise to the YTD underspend. Equally there will be slippage on specific GDE and Community schemes, with COVID impacting on supplier delivery, pushing schemes into the 21/22 programme.

We are still awaiting a decision regarding the central funding for the balance of the POCT bids and Laptops.

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper - Public

Board Meeting Date	8th December 2020
Title	**True North Performance Scorecard** **Month 7 (October 2020) 2020/21**
Purpose	To provide the Board with the True North Performance Scorecard
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 True North Performance Scorecard for Month 7, 2020/21 (October 2020) 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. **Note** - several indicators have been temporarily suspended either nationally of locally due to the COVID-19 pandemic. These are highlighted in grey to indicate this status. **Month 7** **Performance business rule exceptions, red rated with the True North domain in brackets:** **Driver Metrics** • Self-harm Incidents on Mental Health Inpatients Wards (excluding LD) **(Harm Free Care)** – red at 67 incidents against a target of 42. Two patients contributed to 30 out of the 46 incidents in the two highest contributing wards (Bluebell and Snowdrop). Countermeasures include safety planning and restrictive interventions. • Mental Health: Acute Average Length of Stay (bed days) **(Money Matters) –** at 43 days against a target of 30 days. Pressures continue on length of stay but remains a focus for teams. • Staff turnover (including fixed-term posts) **(Money Matters)** – this indicator is at 17.1% against a target of 16%. The indicator excluding fixed-term posts was green at 13.9%. Issue with national reporting from ESR, so no October figures. • Inappropriate Out of Area Placements **(Money Matters)** – at 160 days for the quarter against 74 bed day target. Pressures within our inpatient units have resulted in more out of area placements. **Tracker Level 1 Metrics** • None noted **Tracker Metrics (where red for 4 months or more)**

	• Statutory Training: Fire **(Supporting our Staff)** At 92.4% – focusing assurance on ward environments. All but four wards are compliant. Performance improving but slowly.
Action	The Board is asked to note the new True North Scorecard.

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 2020)

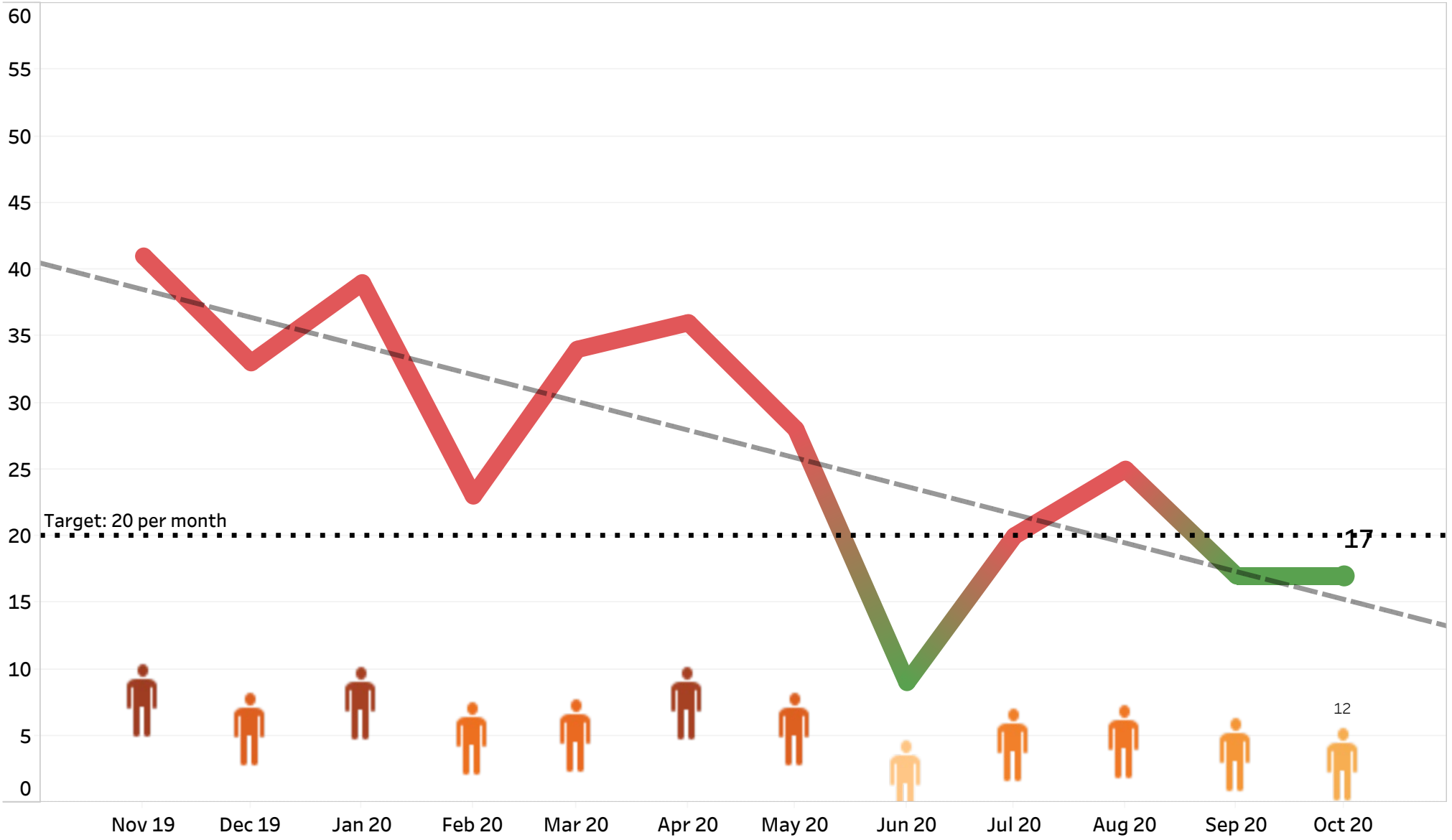
Metric	Target	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20
Harm Free Care													
Falls incidents in Community & Older Adult Mental Health Inpatient Wards	20 per month	39	32	34	21	29	27	20	8	16	25	17	17
Self-Harm Incidents on Mental Health Inpatient Wards (excluding LD)	42 per month	65	66	38	42	25	15	58	37	41	40	57	67
Pressure ulcers acquired at BHFT due to lapse in care - Grade 3 & 4 (Cumulative YTD)	<18 per year	13	16	19	21	22	0	0	0	0	0	0	0
Number of suicides (per month)	Equal to or less than 3 per month	1	3	2	1	2	2	3	1	1	1	1	3
Gram Negative Bacteraemia	1 per ward per year	0	0	0	0	0	3	0	0	0	0	0	0
Patient Experience													
Mental Health: Prone (Face Down) Restraint	2 per month	1	2	2	7	3	3	8	3	6	2	3	1
Patient FFT Recommend Rate: % [Suspended centrally due to COVID]	95% compliance	93.4%	92.4%	88.9%	87.4%	91.9%							
Patient FTT response rate: % [Suspended centrally due to COVID]	15% compliance	12.1%	8.5%	10.6%	11.7%	5.51%							
Mental Health Clustering within target: %	80% compliance	81%	79.7%	81.2%	81.5%	80.6%	81.2%	78.7%	83.8%	83.7%	82.7%	81.5%	81.7%

Performance Scorecard - True North Drivers (October 2020)

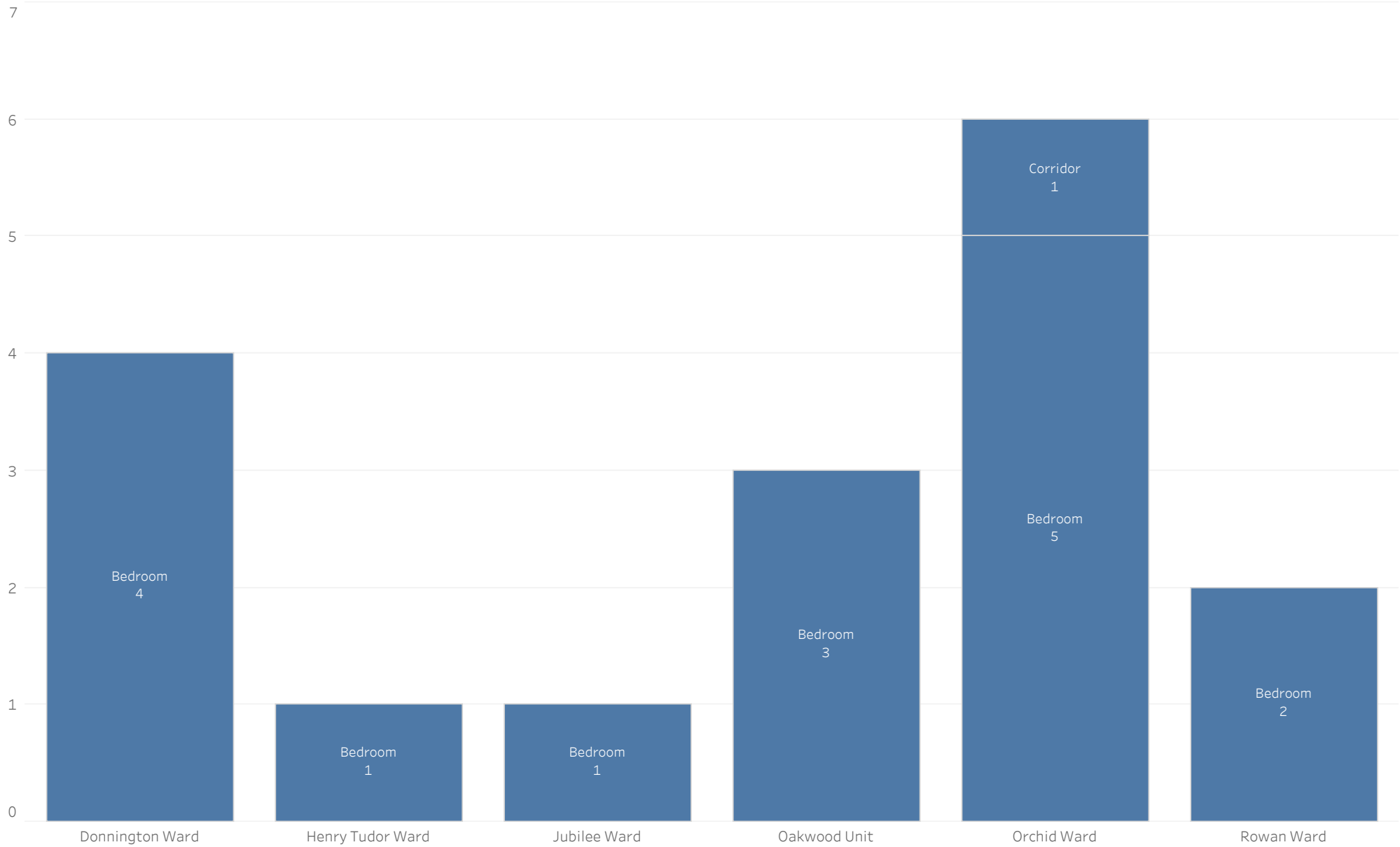
Metric	Target	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20
Supporting our Staff													
Physical Assaults on Staff	44 per month	39	30	35	41	57	36	27	34	53	51	26	34
Staff Engagement Score (Annual Staff Survey) [Suspended centrally in April due to COVID]	Score of 10	7.29	7.29	7.40	7.29	7.29	7.40	7.40	7.40	7.40	7.40	7.40	7.40
Money Matters													
CIP target (£k): (Cumulative YTD) [Suspended centrally due to COVID]	£4m (annual)	£3.19M	£3.51M	£3.90M	£4.24M	£4.60M							
Financial surplus £k (excl. STF): (Cumulative YTD to plan) [Suspended centrally due to COVID]	-£0.4m	-£0.81M	-£0.01M	-£0.20M	-£0.28M	£0.26M							
Mental Health: Acute Occupancy rate (excluding Home Leave): % [Suspended centrally due to COVID]	85% Occupancy	94.3%	91.9%	87.7%	92.6%	89.9%		81.9%	92.1%	92.2%	97.2%	92.6%	90.6%
Mental Health: Acute Average Length of Stay (bed days)	30 days	35	39	43	37	42	37	34	37	36	47	40	43
Staff turnover (excluding fixed term posts)	<16% per month	14.2%	14.6%	14.6%	14.7%	14.7%	14.6%	14.3%	13.9%	13.4%	13.3%	13.9%	
Staff turnover (including fixed-term posts)	<16% per month	15.1%	15.6%	16.2%	16.6%	16.5%	16.5%	16.2%	15.6%	15.3%	15.9%	17.1%	
Inappropriate Out of Area Placements	74 bed days (cumul. Qtr)	134	148	49	101	140	58	93	170	148	312	418	160

Harm Free Care Driver: Fall incidents in Community & Older Adult Mental Health Inpatient Wards (Nov 19 to Oct 20)

Any incident (all approval statuses) where sub-category excluding Sat or lowered to floor & near miss, Location exact excluding Patient/staff home and incident type = patient

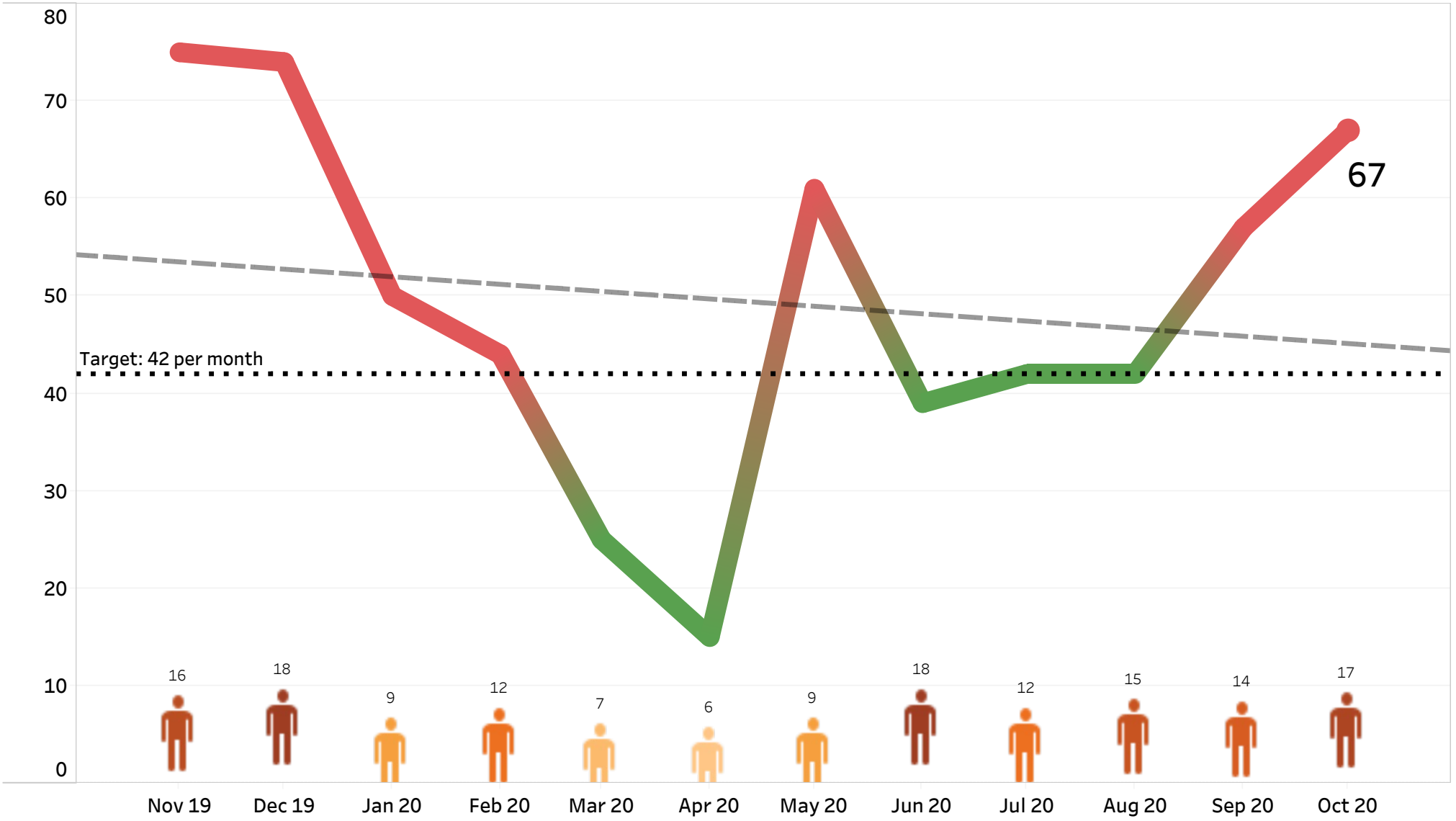


Harm Free Care Driver: Fall incidents in Community and Older Adult Mental Health Inpatient Wards (October)

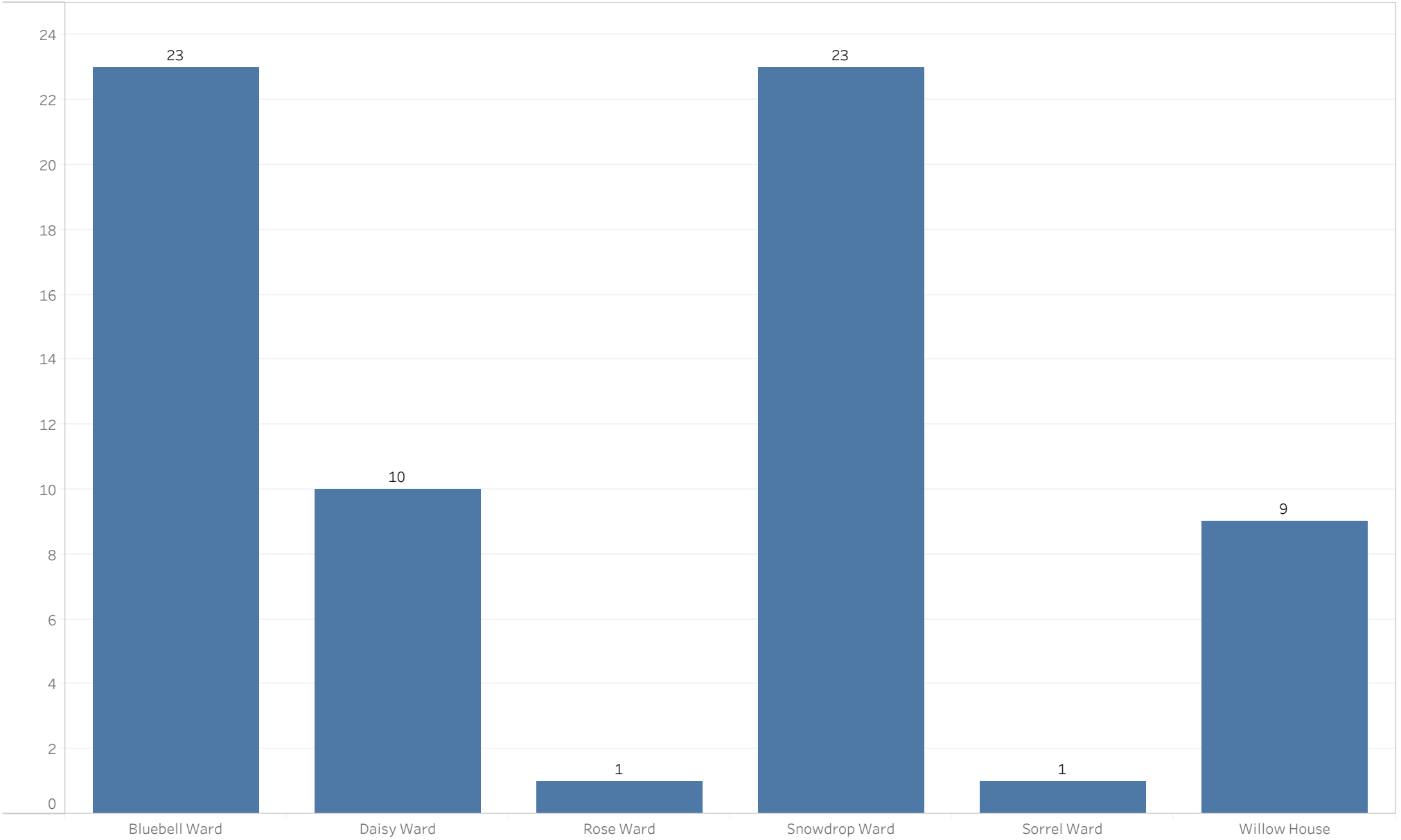


Harm Free Care Driver: Self-Harm incidents on Mental Health Inpatient Wards Inc Willow House (excluding LD) (Nov 19 to Oct 20)

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

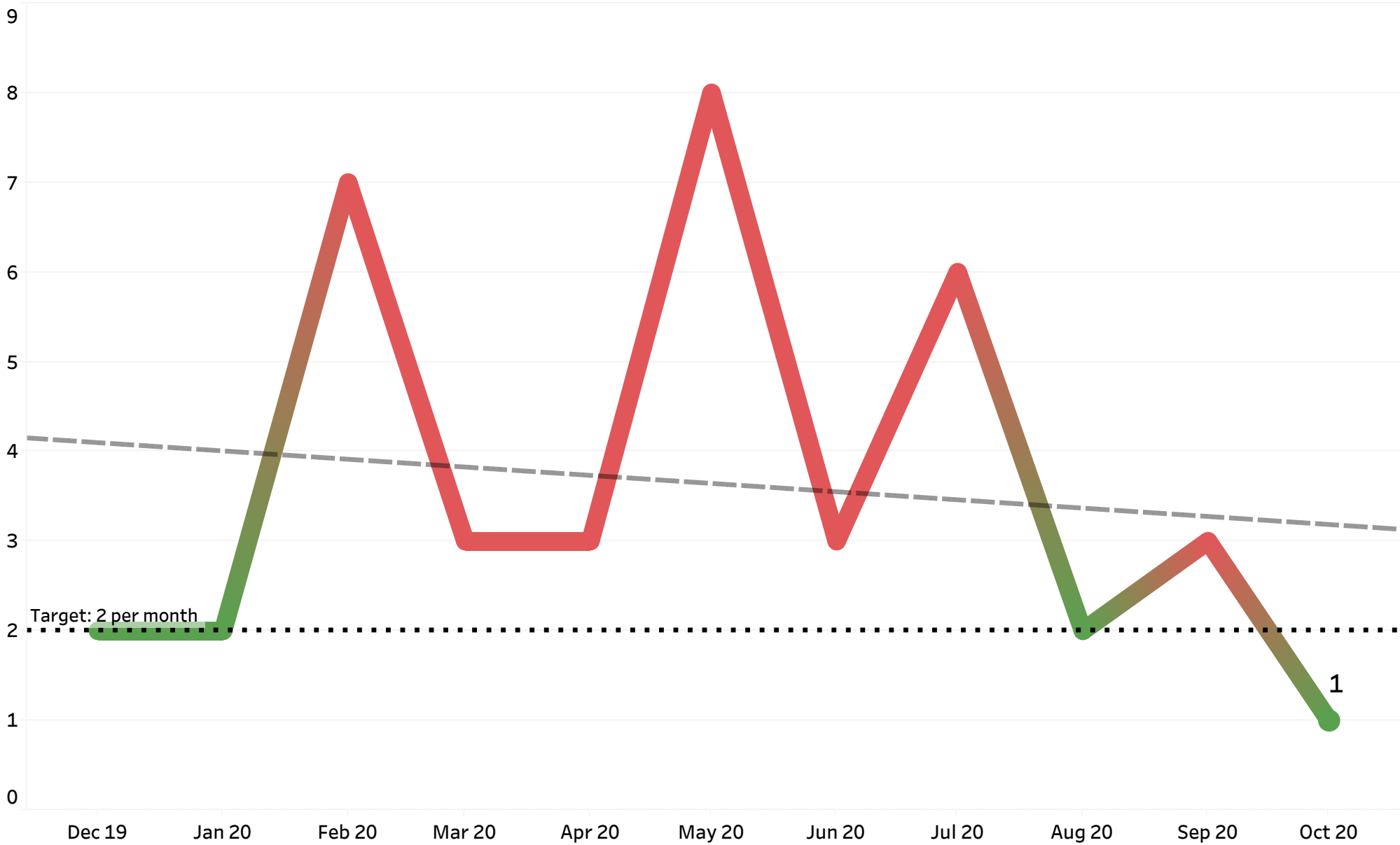


Harm Free Care Driver: Self-Harm incidents on Mental Health Inpatient Wards (excluding LD) by location (October)

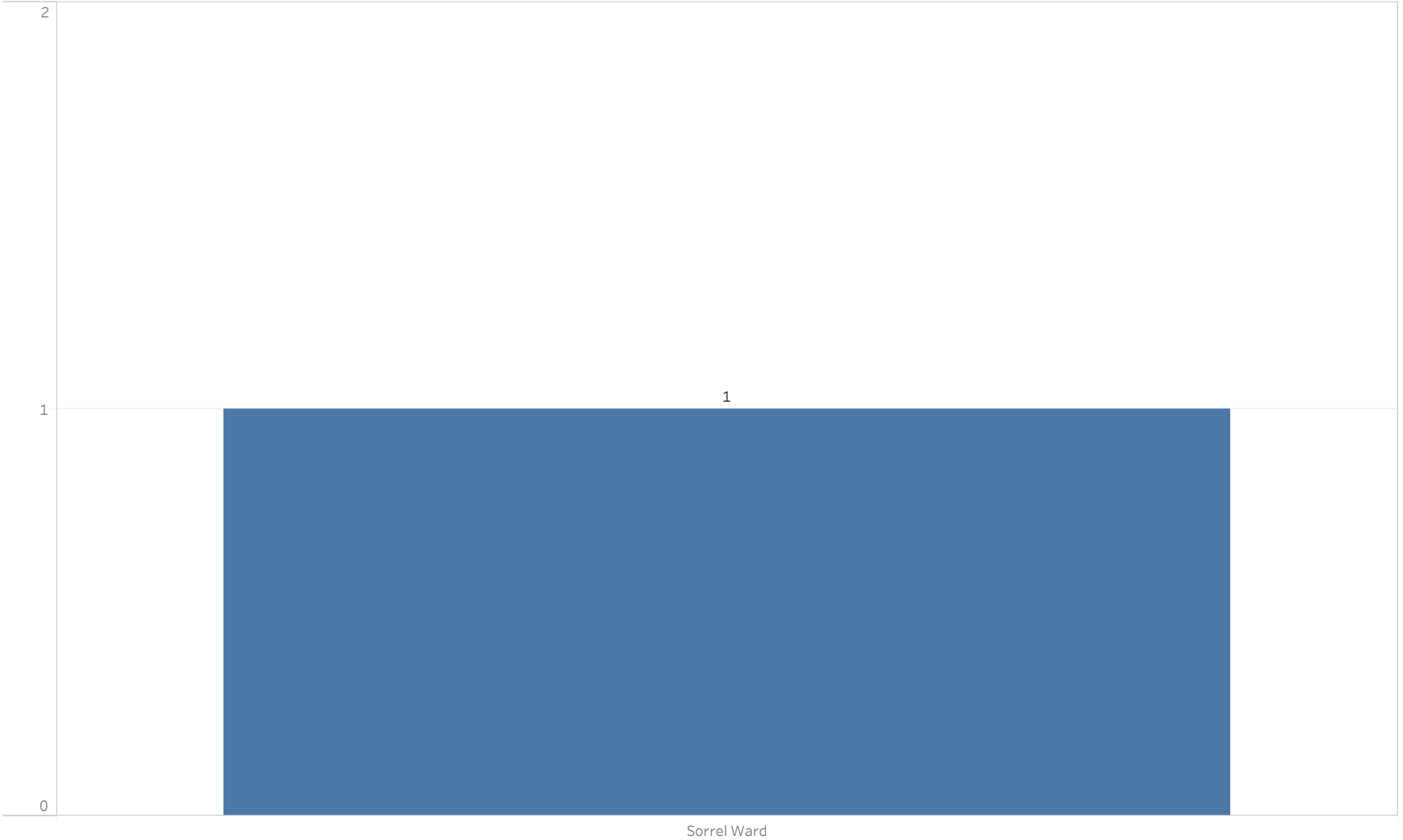


Patient Experience Driver: Mental Health: Prone (Face Down) Restraint incidents (Dec 19 to Oct 20)

(All approval statuses)

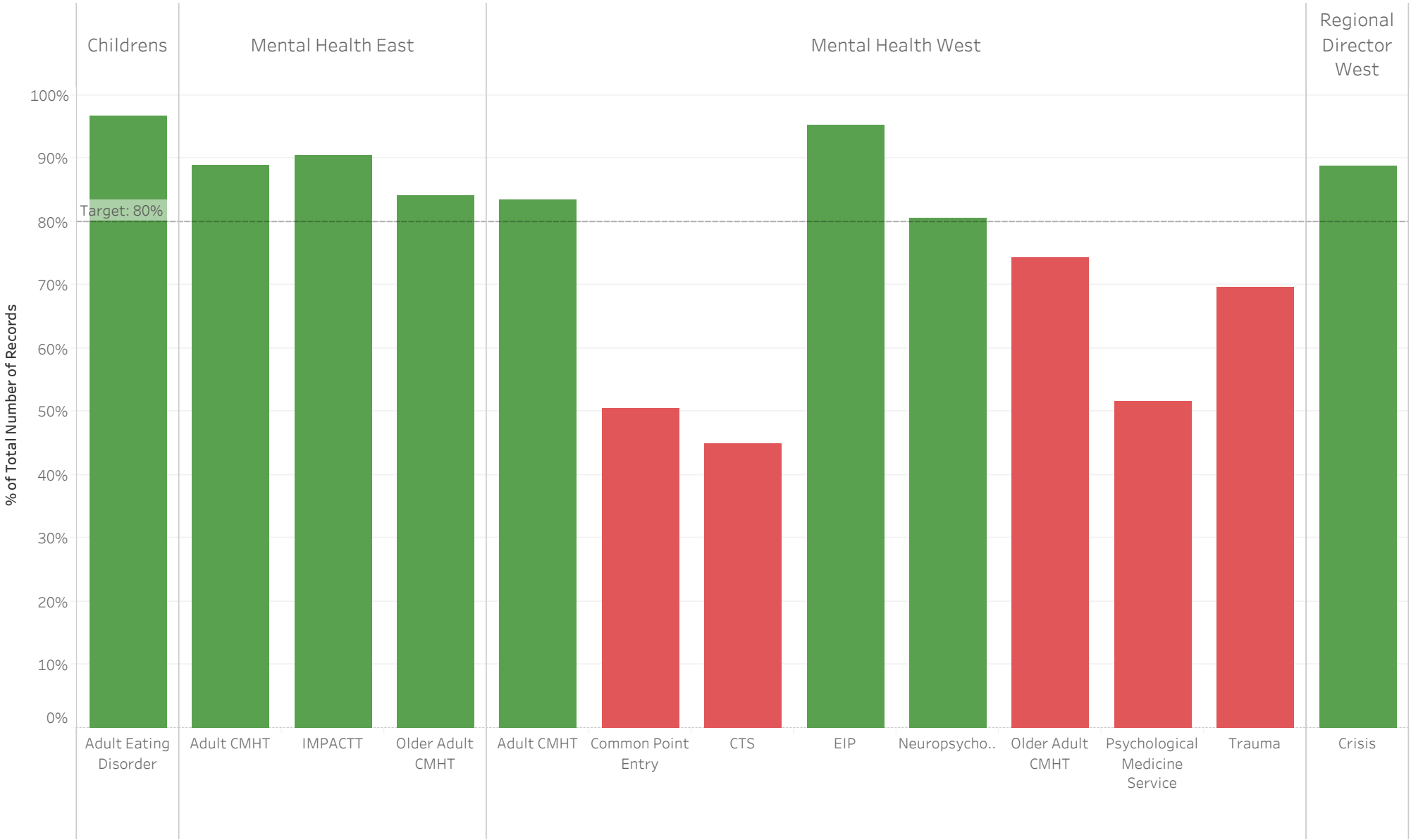


Patient Experience Driver: Mental Health: Prone (Face Down) Restraint incidents by location (October)



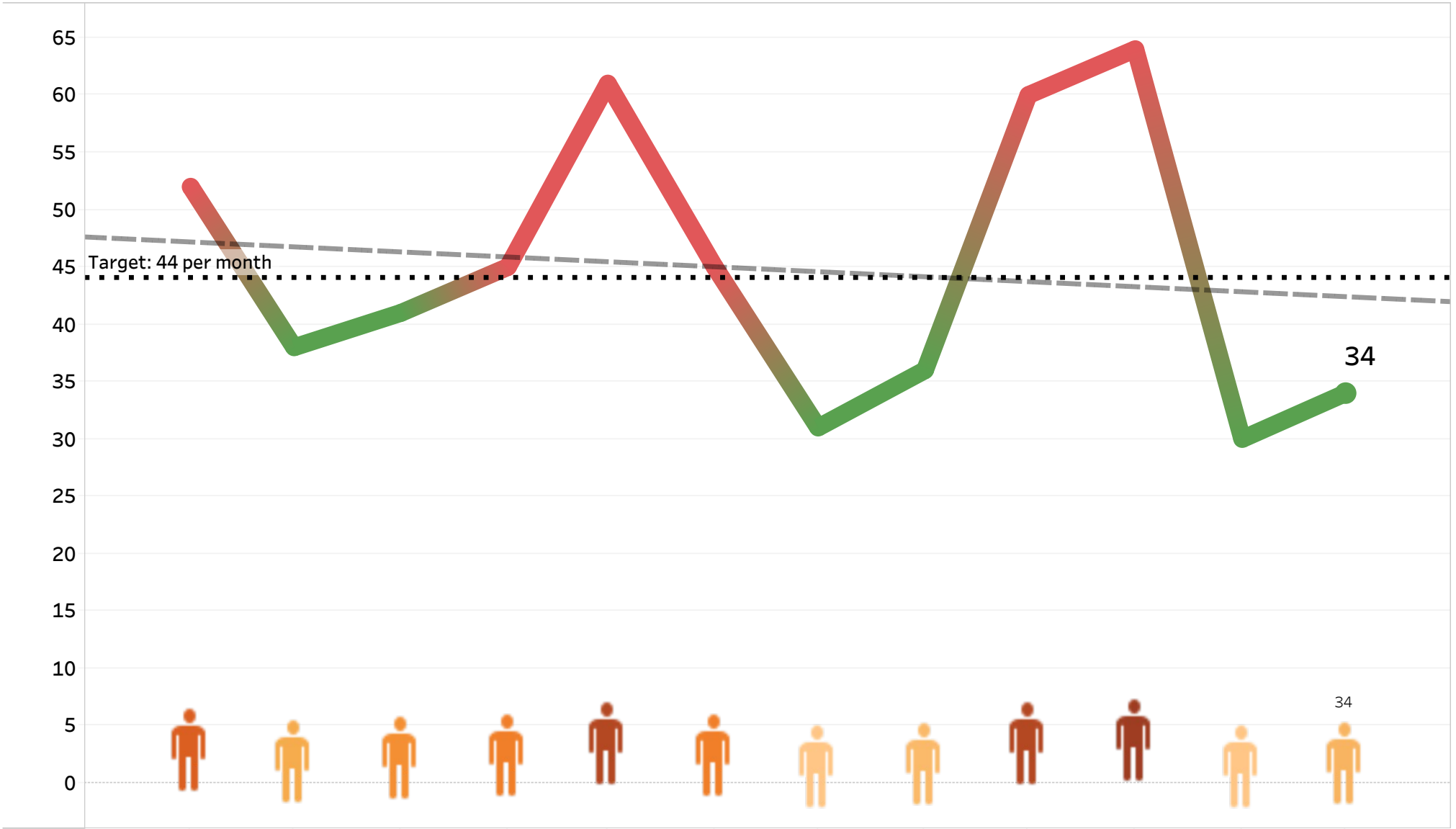
Patient Experience: Clustering breakdown (October)

Outpatient Cluster Status (by Service)

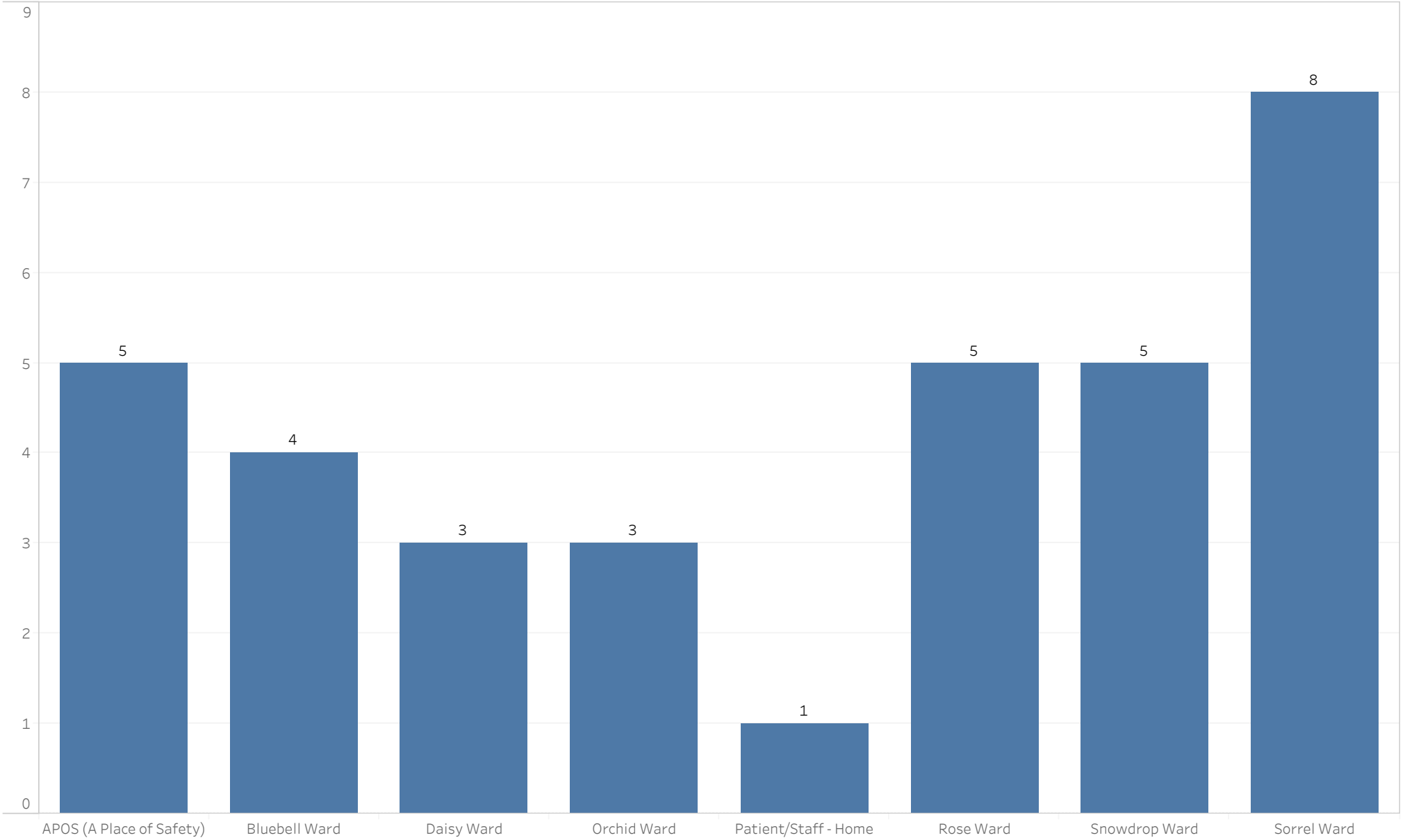


Supporting Our Staff Driver: Physical Assaults on Staff (Nov 19 to Oct 20)

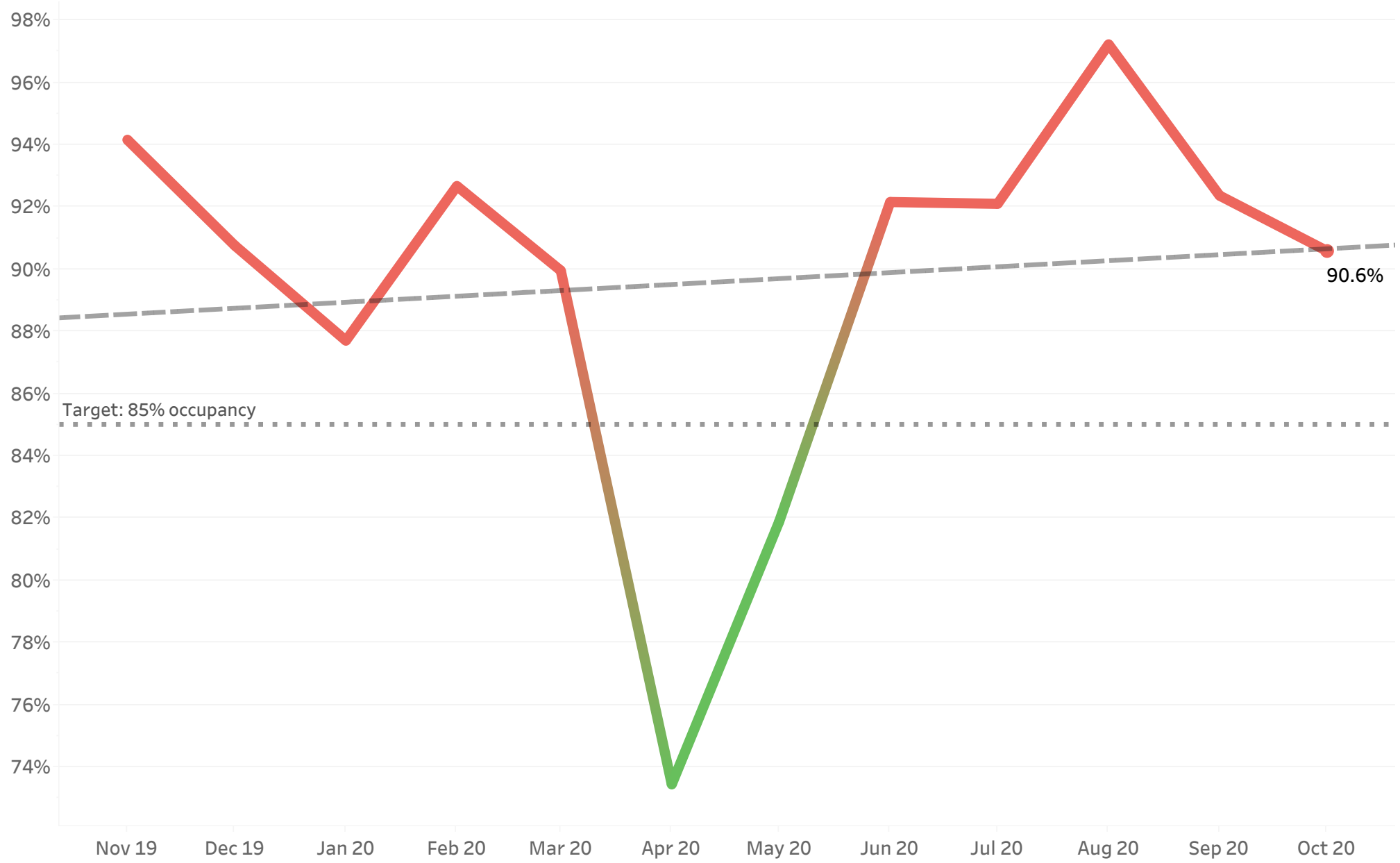
Any incident where sub-category = assault by patient and incident type = staff



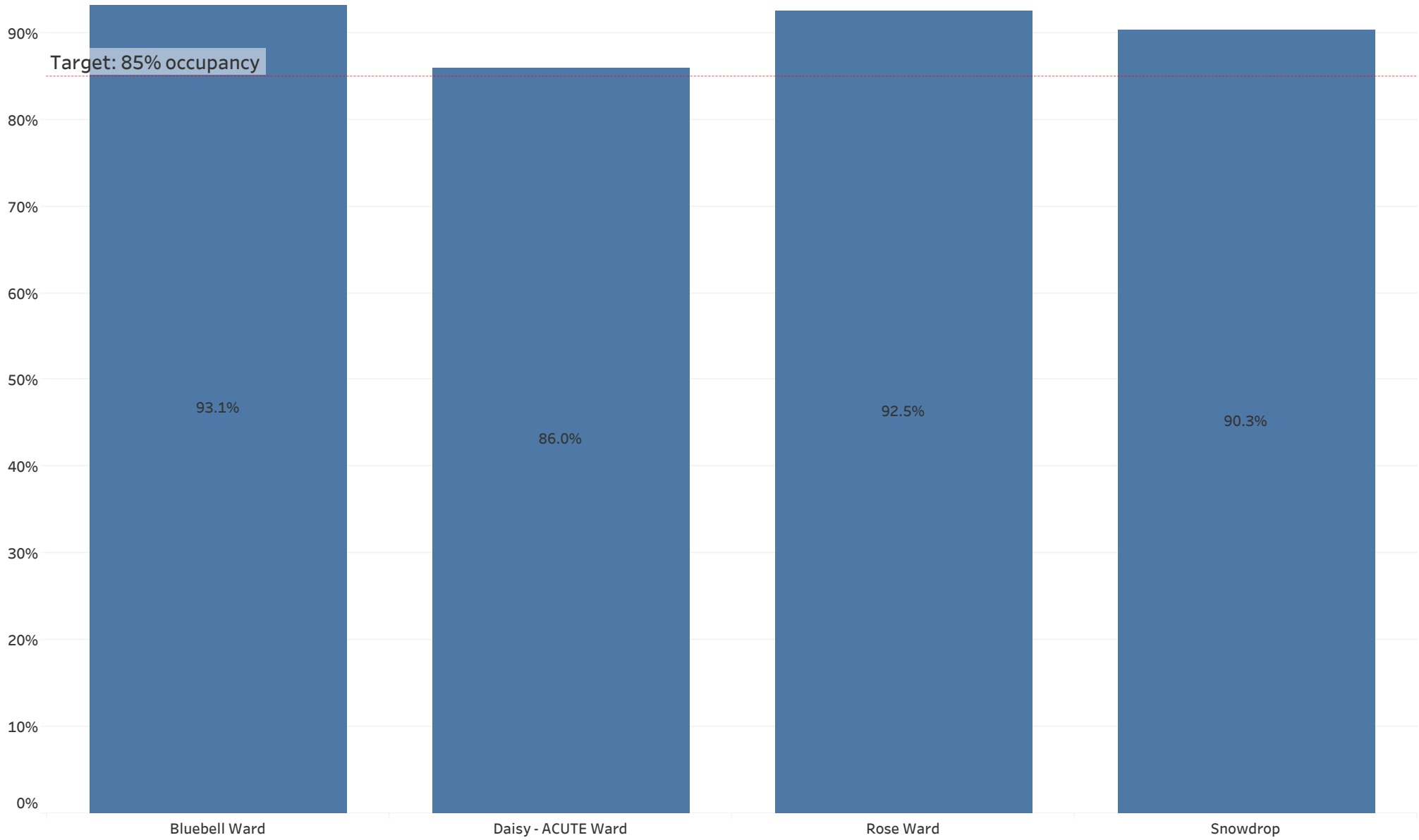
Supporting Our Staff Driver: Physical Assaults on Staff by Location (October 2020)



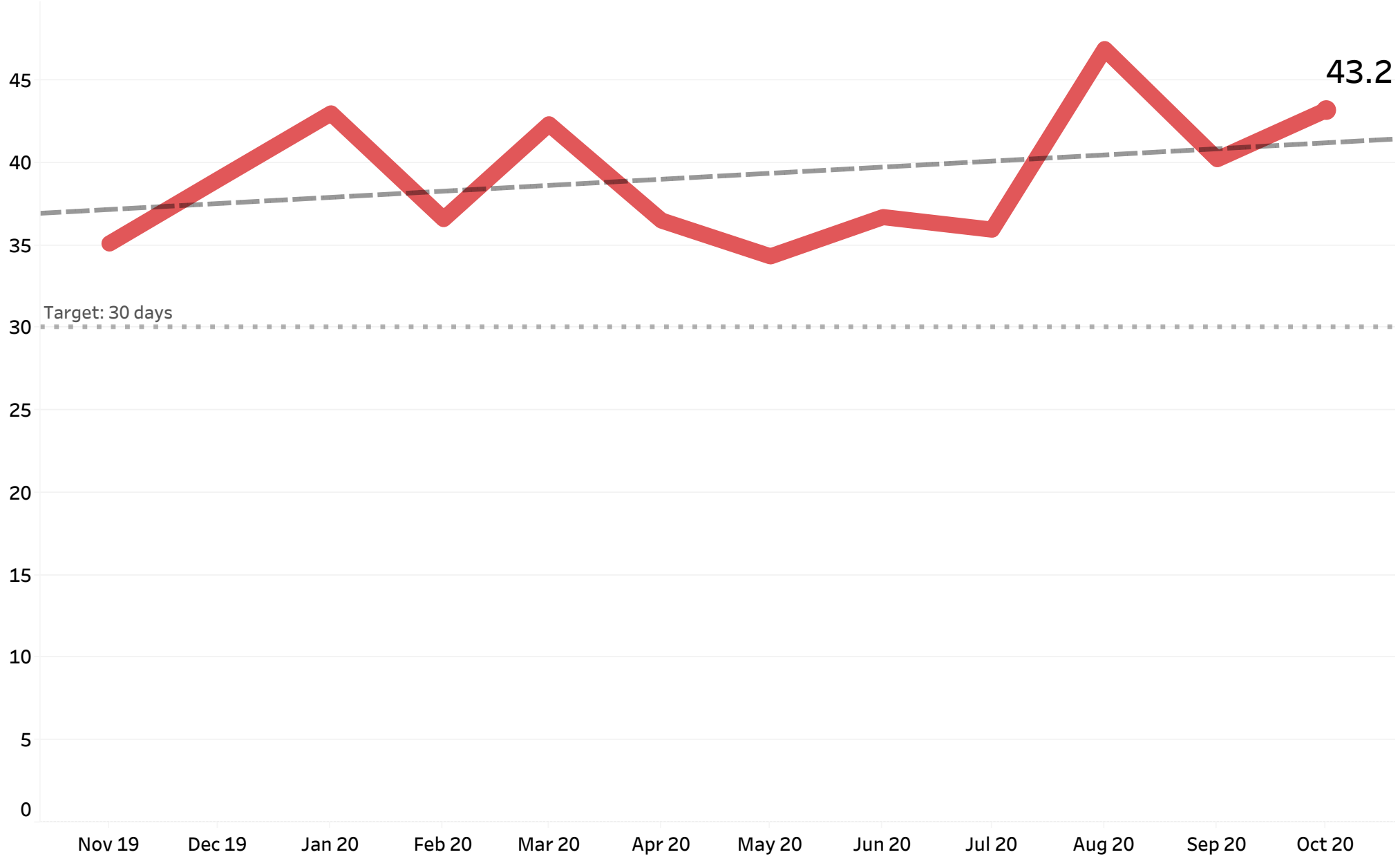
Money Matters: Mental Health Acute Bed Occupancy Rate (Nov 19 to Oct 20)



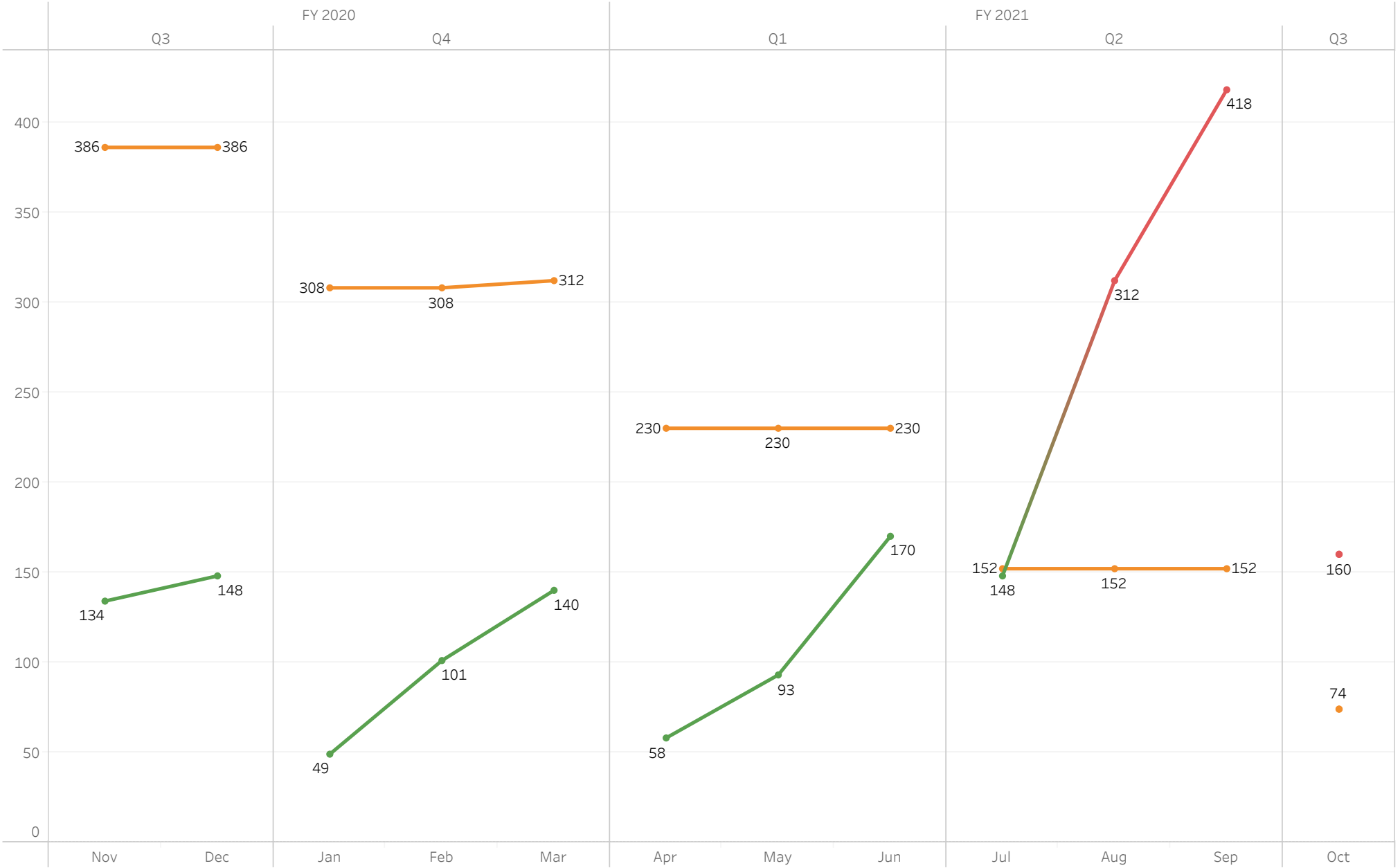
Money Matters Driver: MH Acute Bed Occupancy by Unit (October)



Money Matters: Mental Health: Acute Average Length of Stay (bed days) (Nov 19 to Oct 20)



Money Matters Driver: Inappropriate Out of Area Placements



True North Harm Free Care Summary

Tracker Metrics

Metric	Threshold / Target	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20
Pressure ulcers acquired due to lapse in (Inpatient Wards)	<10 incidents	2	3	0	2	0	1	0	0	0	0	0	0
Pressure ulcers acquired due to lapse in (Community East)	< 6 incidents	3	0	1	0	1	0	0	0	0	0	0	0
Pressure ulcers acquired due to lapse in (Community West)	< 6 incidents	0	0	2	0	0	0	0	0	0	0	0	0
Mental Health: AWOLs on MHA Section	16 per month	6	8	8	5	2	2	3	3	9	2	2	3
Mental Health: Absconsions on MHA Section	8 per month	2	5	2	5	6	5	3	4	6	3	4	4
Mental Health: Readmission Rate within 28 days: %	<8% per month	5.63	5.26	5.97	5.09	4.42	4.29	5.42	5.86	5.22	4.95	6.33	7.43
Patient on Patient Assaults (LD)	4 per month	0	2	0	0	0	3	3	4	4	4	2	0
Uptake of at least one patient outcome measure (ReQoL) in adult Mental Health for new referrals from April 2019[Suspended centrally due to COVID]	15% by March 2020; 20% by June 2021	12.5%			14.0%	13.6%	13.4%	13.3%	13.8%	13.5%	13.6%	13.7%	13.4%
Suicides per 10,000 population in Mental Health Care (annual)	8.3 per 10,000		6.9	5.2	5.2	5.2	5.2	5.2	5.2	5.2	5.2	5.2	5.2
Self-Harm Incidents within the Community [Suspended centrally due to COVID]	31 per month	26	0	1	0	0	1	2	3	3	0	2	1

True North Patient Experience Summary

Tracker Metrics

		Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20
Patient on Patient Assaults (MH)	38 per month	27	15	17	14	15	15	15	20	24	12	21	7
Health Visiting: New Birth Visits Within 14 days: %	90% compliance	93.8%	90.6%	82.1%	93.9%	88.4%	89.1%	91.9%	92.6%	93.4%	91.1%	91.1%	92.7%
Mental Health: Uses of Seclusion	13 in month	7	11	4	18	12	4	7	17	15	16	8	15

True North Supporting Our Staff Summary

Tracker Metrics

		Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20
Gross vacancies: % [Suspended centrally due to COVID]	<10%	6.70%	7.09%	6.5%	6.09%	5.89%							
Statutory Training: Fire: %	95% compliance	93.3%	93.9%	93.3%	91.5%	90.1%	88.4%	85.9%	87.3%	90.1%	91.3%	92.9%	92.4%
Statutory Training: Health & Safety: %	90% compliance	96.6%	96.6%	96.7%	96.4%	95.5%	96.0%	94.3%	95.5%	95.3%	95.6%	95.9%	96.0%
Statutory Training: Manual Handling: %	90% compliance	92.8%	90.2%	93.1%	93.3%	92.5%	90.0%	88.7%	90.3%	90.1%	91.1%	92.3%	92.5%
Mandatory Training: Information Governance: % [Suspended centrally due to COVID]	95% compliance	95.2%	95.4%	94.4%	93.3%	93.9%	92.5%	90.0%	92.1%	92.6%	92.2%	94.7%	94.0%
PDP (% of staff compliant) Appraisal: %	95% compliance 'Extended from 19/20. Reset in June 20'	86.7%	86.4%	85.1%	83.9%	81.7%	80.5%	80.5%	42.1%	88.6%	87.3%	95.5%	95.3%

Mental Health Inpatient Services – Fire training compliance

		Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20
Fire Safety Training - Whole Service	95%	91.4%	93.9%	93.4%	93.2%	88.3%	88.4%	84.6%	90.6%	94.8%	96.9%	98.5%	96.7%
Org L7	**Target**												
371 Bluebell Ward PPH	95%	88.0%	87.5%	87.5%	82.6%	71.4%	75.0%	72.0%	77.8%	95.5%	100.0%	100.0%	100.0%
371 Daisy Ward PPH	95%	91.3%	92.0%	96.4%	95.8%	100.0%	92.3%	92.0%	88.5%	92.3%	96.2%	93.8%	100.0%
371 Orchid Ward PPH	95%	89.7%	83.9%	81.3%	82.8%	80.0%	76.9%	76.9%	84.6%	92.3%	92.0%	96.2%	82.8%
371 Rose Ward PPH	95%	88.9%	96.0%	92.0%	100.0%	92.0%	91.3%	83.3%	91.3%	96.2%	96.3%	100.0%	100.0%
371 Rowan Ward PPH	95%	100.0%	100.0%	100.0%	97.1%	85.3%	80.0%	70.0%	77.4%	92.9%	100.0%	100.0%	94.1%
371 Snowdrop Ward PPH	95%	86.7%	93.3%	93.1%	93.1%	90.3%	93.3%	93.3%	100.0%	96.7%	96.9%	100.0%	96.6%
371 Sorrell Ward PPH	95%	88.9%	96.4%	100.0%	100.0%	100.0%	100.0%	100.0%	96.2%	96.3%	93.3%	100.0%	100.0%

Community Health – Fire training compliance

371 Community Health East Services	Fire Safety Training - Whole Service	95%	94.8%	93.6%	95.1%	94.4%	93.1%	93.2%	92.4%	93.1%	94.8%	96.4%	97.8%	96.0%
371 Community Health West Services	Fire Safety Training - Whole Service	95%	94.3%	95.4%	94.8%	92.6%	89.2%	87.2%	86.3%	86.9%	90.5%	93.8%	95.6%	97.0%

CH IP Fire Safety Breakdown

Org L7	Target	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20
371 Henry Tudor Ward	95%	91.7%	88.9%	92.9%	96.4%	96.6%	96.0%	96.6%	96.7%	93.1%	89.7%	100.0%	92.9%
371 Jubilee Ward	95%	90.0%	86.7%	93.1%	100.0%	96.9%	96.8%	100.0%	81.3%	96.8%	93.5%	100.0%	100.0%
371 Oakwood Ward	95%	100.0%	97.4%	97.6%	90.5%	87.2%	88.6%	89.5%	94.9%	100.0%	95.2%	95.7%	95.5%
371 WBCH Inpatient Wards	95%	93.9%	96.3%	95.2%	89.2%	84.5%	80.7%	77.8%	93.7%	93.9%	96.3%	96.2%	96.1%
371 Wokingham InPatient Unit	95%	91.2%	92.2%	95.5%	89.1%	88.9%	87.9%	82.8%	64.8%	86.7%	93.5%	96.7%	98.4%

Campion & Willow House – Fire training compliance

True North Money Matters Summary

Tracker 1

		Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20
Mental Health: Delayed Transfers of Care (NHSI target) Monthly and Quarterly [Suspended centrally due to COVID]	7.50%	6.70	9.30	11	7.59			7.5	5.29	4.29	2.60	4.29	9

Tracker Metrics

Community Inpatient Occupancy: % [Suspended centrally due to COVID]	80-85% Occupancy	78.7%	82.5%	88.0%	90.5%	84.5%		75.4%	49%	57.3%	73.5%	72.8%	74.7%
Mental Health: Non-Acute Occupancy rate (excluding Home Leave): % [Suspended centrally due to COVID]	80% Occupancy	78.03%	77.29%	84.87%	83.09%	82.79%		63.39%	64.04%	84.74%	67.06%	75.68%	75.68%
DNA Rate: % [Suspended centrally due to COVID]	5% DNAs	4.79%	5.20%	5.09%	4.70%	5.20%		4.20%	3.79%	4.39%	4.29%	4.59%	4.29%
Community: Delayed transfers of care Monthly and Quarterly [Suspended centrally due to COVID]	7.5% Delays	10.5%	10.8%	13.4%	17.8%			4%	2.10%	7.5%	6.5%	5.29%	10.1%

Regulatory Compliance - Tracker Level 1 Summary

Metric	Threshold / Target	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20
Mental Health: 7 day follow up (Quality Domain): %	95% seen	97.5	96.2	95.2	100	95.5	95.3	95.7	96.2	94.5	94.1	95.3	98.6
C.Diff due to lapse in care (Cumulative YTD)	0	0	0	0	0	0	0	0	0	0	0	0	0
Ensure that Cardio Metabolic assessment and treatment for people with psychosis is delivered routinely in inpatient wards: %	90% treated	42.1	42.1	42.1	42.1	42.1	42.1	42.1	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	88.4	88.4	88.4	88.4	88.4	88	88	88	88	88	88	88
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	21	21	21	21	21	21	21	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	1	0	0	0	0	0	0	0	0	0
Meticillin-susceptible Staphylococcus aureus (MSSA) bacteraemias	0	0	0	0	0	0	0	0	0	0	0	0	0
Mixed-sex accommodation breaches [Suspended centrally due to COVID]	Zero tolerance	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	80	100	100	88.9	100	90.9	100	90.9	100	100	91.7
A&E: maximum wait of four hours from arrival to admission/transfer /discharge: %	95% seen	97.4	95.8	97.9	96.2	94.0	92.9	98.0	97.9	96.0	98.2	98.7	97.8
People with common mental health conditions referred to IAPT will be treated within 6 weeks from referral: %	75% treated	95	96	95	94	95	95	94	96	95	96	98	98
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 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20
People with common mental health conditions referred to IAPT completing a course of treatment moving to recovery: %	50% treated	57.7	56.0	60.3	57.1	54.4	53.4	53.2	55.4	56.6	56.1	57.4	58.5
% clients in Mental Health Services in Settled Accommodation	58% in Settled Accommodation	60	60	59	59	59	59	59	59	59	59	59	59
% clients in Mental Health Services in Employment [Suspended centrally due to COVID]	9% in Employment	11	11	12	12	12	12	12	12	12	12	12	12
Proportion of patients referred for diagnostic tests who have been waiting for less than 6 weeks (DM01 - Audiology): % [Suspended centrally due to COVID]	99% seen	100	100	99.7	100			100	100	100	97.8	98.2	100
Diabetes - RTT (Referral to treatment) waiting times - Community: incomplete pathways (how many within 18 weeks): %	95% seen	100	100	100	100	100	100	96.2	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	100	100	100	98	100	100	100	100	100
Sickness Rate: %	<3.5%	4.75	5.04	4.88	4.10	4.39	5.89	4.08	3.40	3.49	3.23	3.25	
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	83	83	83	83	83	83	83	83	83
Finance Score - Was Continuity of Services Risk Rating now Use of Resources [Suspended centrally due to COVID]	Month 1=3, months 2 to 5 =2 then month 6 onward=1	1	1	1	1	1							
MHSDS DQMI score (Figures reported are 3 months in arrears)	95% achieved	97.8	98.2	98.2	98.4	98.1	98.7	98.7	98.4	98.2	98.9	98.7	98.9
Patient Safety Alerts not completed by deadline	0	0	0	0	0	0	0	0	0	0	0	0	0

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	8th December 2020
Title	Board Vision Metrics Update
Purpose	To provide the board with a performance update on metrics agreed in measuring progress towards achieving our vision: ***"To be recognised as the leading community and mental health service provider by our staff, patients and partners"***
Business Area	Performance
Author	Deputy Chief Executive and 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	2020/21 vision metric performance is provided at appendix 1 of the paper. Indicators are YTD October 2020 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. • Prior to suspending FFT collection due to the pandemic, response rate was inconsistent. Programme underway to design and commission new system for collecting patient experience

	information across Mental Health and Community services. Tender due to be awarded to partner. • CQC overall rating of “Outstanding” achieved in March 2020, including “Outstanding” for well led. Ratings report included six “must do” compliance actions, noted here in the vision metrics update. • Segment 1 regulatory autonomy maintained since segmentation began. Trust financial position delivering lowest financial risk rating of 1 YTD as planned to end of March 2020. Rating performance now suspended due to covid financial regimes. • Benchmark positions to be refreshed once detailed analysis toolkits are available for 2019/20 (delayed by the pandemic, expected to be available during December 2020).
ACTION REQUIRED	The Board is asked to note the update, and that we expect to review the vision metrics in light of the current development of the Trust’s three year strategy.

Board Vision Metrics: Performance Update to end October 2020

Supporting delivery of the Trust's Vision

Trust Board – public meeting

Alex Gild, Deputy Chief Executive and Chief Financial Officer
30th November 2020

Purpose

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

Document control

Version	*Date*	*Author*	*Comments*
1.0	26/11/2020	I Hayward & C Magee	

This document is considered to be *BHFT staff only* and is therefore restricted to current BHFT employees only.

Distribution

Trust Board

Document references

Document title	*Date*	*Published by*

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) over the next three years. 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 57 English providers and the 32 Combined Mental Health and Community Trust respondents in 2018/19 (2019/20 data due soon).

2. Rationale for Metric Inclusion

Sections

2.1. By dashboard section (appendix 1) the following metrics were identified as having an impact on assessing our level of performance in delivering our vision. These metrics were agreed with the Board and the first performance report provided to the April 2017 in committee Board meeting. Supporting vision transparency and accountability, this paper is the first-time vision delivery performance is reported to the Board in public, alongside the usual Board summary performance report.

Quality

2.2. 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.

2.3. 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 2018/19 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 above the mean and for 2018/19 but above the median per 100,000 occupied bed days excluding leave and is ranked 44th out of 57 English Mental Health respondents. The Trust ranks 23rd out of 32 combined Mental Health & Community Health Trust respondents. This is a worsening in our performance from our 2017/18 position, where the Trust was ranked 19th out of 55 Mental Health trusts and 11th 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 above the mean for 2018/19 and is in the upper quartile per 100,000 occupied bed days, excluding leave. The Trust is ranked 42nd out of 57 English Mental Health benchmarking respondents. Trust ranks 22nd out of 32 combined Mental Health & Community Trust respondents. This is a worsening in our performance from our 2017/18 position, where the Trust was ranked 24th out of 55 Mental Health trusts and 15th 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 and improvements are expected in the 2019/20 benchmarking.

- **Mental Health Use of Restraint** – The benchmark position target shown here is a long-term stretch target. The Trust was above the mean for 2018/19 and the Trust is ranked 49th out of 57 English benchmarking respondents. The Trust ranks 27th of 32nd joint Community and Mental Health Trusts. This is a worsening of our performance. In 2017/18, the Trust ranked 20th out of 55 Mental Health Trusts and 12th out of 32 combined Mental Health & Community respondents. Absolute and benchmark improvement in this area is a driver metric (seeking "breakthrough" improvement) within our QI programme.

- The Trust's reporting of the incidents in these categories has increased because of the focus on QI and Harm Free Care, together with other Trusts reporting fewer incidents has led to the apparent change in position.

- The next update on this section will be Quarter 4 2020/21.

Safety

2.4. 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. The process for identifying where falls with significant harm have been the result of a lapse in care was developed and approved by the Safety Experience and Clinical Effectiveness Group in April 2017. There were no

incidents in 2020/21 year to date and none were identified in 2019/20. There were 2 in 2018/19. Reduction in falls is a focus for a QI programme breakthrough objective.

- **Mental Health Inpatient Deaths as a consequence 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.

- **Mental Health Bed occupancy** – for mental health acute beds. The figure shown is the occupancy rate in October 2020 reporting 91% against a target of 85%. This is an increase from 90% in March 2020.

- **Never Events –** This is all never events that occur in the Trust. None have been reported in the year to date to October 2020.

- **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 increased from 4.3 per 10,000 under mental health care in 2017/18 to 5.2 per 10,000 people in contact with mental health services. 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 and has achieved a 43.5% reduction on this rate. The next update will be in Quarter 4 2020/21. Our zero-suicide initiative and QI programme around self-harm provide complementary improvement activity in this critical safety area.

Engagement

2.5. 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 –** For 20/21 we have agreed post-covid response part year contract and bid funding that supports appropriate levels of growth funding required for the mental health investment standard and Frimley/BOB ICS MH LTP transformation, alongside system funding earmarked for the BOB ageing well programme and rapid community discharge initiative BHFT is supporting in Berkshire West.

- **Stakeholder Satisfaction - Survey of System Partners –** a survey was developed in the second half of 2017/18; the survey closed on 8th February 2018. The survey was repeated in December 2019 and the results were very positive with only 9.2% (11% in 2018) of the 24 respondents 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. No target agreed, next survey to be planned.

- **Patient Friends & Family Test Response Rate –**This was suspended at the start of the pandemic and formal reporting will not restart until December 2020, therefore there is no update for this report and has been greyed out in the table in Appendix 1. This was a QI driver metric.

- **Staff Survey Engagement Rating –** latest available performance ranking published on 18th February 2020. Our position remains unchanged from last year but Trust Staff Engagement Score of 7.4 and is an increase from 7.3 in 2018/19. Next update will be in Quarter 4 2020/21

Regulatory Compliance

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

- **Care Quality Commission Rating** – Outstanding rating achieved in March 2020.
- **NHSI Segmentation** - maintained segment 1 of the Single 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) in line with plan.
- **Number of CQC Compliance Actions** – There remains 6 compliance actions from the most recent CQC inspection, which are as follows:
    1. CAMHS - The provider must continue to work with commissioners to ensure waiting times are not excessive, thereby putting young people waiting to receive treatment at increased risk. Particular attention needs to be paid to ensuring timely access to services for those referred to the attention deficit hyperactivity disorder pathway and autism assessment pathway.
    2. Adult Acute Wards - The trust must ensure that ligature risks are managed appropriately (Regulation 12). This was in relation to fire doors with hinges on the wards
    3. The trust must ensure that the ward environment is always adequately furnished and maintained. (Regulation 15).
    4. The trust must ensure that patients are kept safe. For example, promoting the sexual safety of people using the service (Regulation 12).
    5. The trust must ensure restrictions are necessary and proportionate responses to risks identified for individuals (Regulation 13).
    6. The trust must ensure an alarm system is easily accessible to patients and visitors and that they are made aware of how to use them (Regulation 12).

Appendix 1 – Board Vision Metrics

Trust Board Vision Metrics

As at: October 2020

		Quality			Safety					
		Mental Health Patient on Patient Assaults	Mental Health Patient on Staff Assaults	Mental Health Use of Restraint	Falls Due to Lapse in Care	Mental Health Inpatient Deaths from Self Harm	Mental Health Bed Occupancy	Never Events	Pressure Ulcers	Suicide Rate per 10,000 under Mental Health care
Target		Top 3	Top 3	Top 3	0	0	85%	0	10% Reduction	10% Reduction Target 8.2
	Performance trend since last report (October 2018)	↓	↓	↓	↔	↔	↓	↔	↑	↓
Actual	All English NHS Mental Health Providers (out of 57)	44th	42nd	48th	0	0	91%	0	2	5.2
	Joint English Mental Health and Community Trusts (out of 32)	23rd	22nd	27th						
	Map to True North Domains	Harm-free care - Tracker metric	Supporting our staff - Driver metric	Harm-free care - Tracker metric	Harm-free care - Driver metric	Harm-free care	Money Matters - Tracker metric	Harm-free care / Regulatory Compliance	Harm-free care - Driver metric	Harm-free care - Driver metric

		Engagement				Regulatory Compliance		
		CCG Net Investment	CCG Satisfaction Survey	Patient FFT Response Rate	Staff Survey Engagement Rating (out of 32)	CQC Rating	CQC Compliance Actions	NHSi
Target		Green	To be defined	15%	3rd	Outstanding	0	Segment 1
		↔	-		↔	↔	↔	↔
Actual		✓	✓	Suspended	3rd	Outstanding	6	✓
		-	-	Patient Experience - Driver Metric	Supporting our staff - Drive Metric	-	-	

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	8 December 2020
Title	COVID 19 Recovery Programme Highlight Report
Purpose	The purpose of this report is to provide the Board with an update on the Recovery and Restoration process for BHFT
Business Area	All
Author	Jenny Jones, Head of Strategic Development
Relevant Strategic Objectives	All
CQC Registration/Patient Care Impacts	People who use our services experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.
Resource Impacts	Yes, currently unquantified
Legal Implications	N/A
Equality and Diversity Implications	We will have started to build the Reducing Health Inequalities Action plan. The expectation is that this will replace the need for individual service based EIAs except the requirement to complete an EIA for remote access to services.
SUMMARY	We are currently in Wave 2 of COVID-19 and continue to mobilise workforce to support frontline services looking after patients with COVID whilst maintaining our community physical and mental health services. The outstanding three Mental Health Services that were paused or partially closed are now open and have been signed off by chairs action. However, in response to Wave 2 we are now considering what services may have to be paused or reduced again.

ACTION REQUIRED	The Board is asked to: Note the report and progress.

Recovery Project Highlight Report	Month: Nov 2020

Programme Title	COVID-19 Recovery Programme

Summary Description	The scope of programme covers the whole of Berkshire and the Trust's commissioned service delivery across Children's and Families, Community Health, Mental Health, Inpatients and Corporate services. **The programme aims are:** • Restore full capacity, quality and resilience of our physical and mental health services to meet ongoing and emerging post COVID-19 community needs. A key aim is to stabilise our workforce with a particular focus on retention, providing support to staff and team resilience and wellbeing following the social and psychological shock of responding to COVID-19. • Enable physical and mental health services to meet the health needs of individuals, staff, and the community including the new models of care tested during the COVID-19 period • Promote self-sufficiency and continuity of the health and wellbeing of affected individuals; particularly the needs of children, seniors, people living with disabilities, whose members may have additional functional needs, people from diverse origins, people with limited English proficiency, and underserved populations, including oversight of Implementation of Phase 3 of the NHS response to the COVID-19 pandemic • Provide reassurance to our patients regarding their care and reconnect displaced populations with essential physical and mental health services • Work co-productively with commissioners and partners to embed new ways of working as a part of the standard operating model

Deployment Status: M/I	Mission Critical	**Project Life Cycle Status:**	In Progress	**Planned Completion Date:**	September 2021

I = Mission Critical I = Important Initiation/ In Progress/ Moving to Business as Usual/ Closed

Author	Kathryn MacDermott, Acting Executive Director of Strategy	**Overall Project Status*:**	

***Show status as Red / Amber / Green.**

Summary Commentary re status & progress:	**Overall Progress** We are currently in Wave 2 of COVID-19 and continue to mobilise workforce to support frontline services looking after patients with COVID whilst maintaining our community physical and mental health services. The outstanding three Mental Health Services that were paused or partially closed are now open and have been signed off by chairs action. However, in response to Wave 2 we are now considering what services may have to be

paused or reduced again.

A number of staff continue to support wards and the Hospital Discharge service on top of their substantive posts. We recognise that this is not sustainable in the long term and in line with Wave 2 response plans corporate staff are being redeployed to support front line services. We are also currently negotiating with NHSP for a bank of temporary staff.

Following on from the Capacity and Demand Task and Finish Group it was agreed that a piece of work should commence regarding the prioritisation of services to support with capacity and demand planning to understand the capacity (e.g. additional clinics, appointments, workforce) to enable the services to return to pre-COVID near normal levels of service. In considering the priority order we are also taking into account the levels of stress services are reporting, the potential harm to patients of extended waits and patient volume.

SILVER Calls have now commences to support Wave 2 Surge and GOLD Command.

The Recovery Workbook will continue to be updated with relevant guidance and actions relating to this and the Phase 3 letter with associated leads and timelines identified to feed into BHFTs existing governance structures for simplicity.

Impact on staff

Staff redeployment has commenced lead by Jayne Reynolds, the impact on recovery trajectories is as yet unknown and will need to be considered.

Digital Technology

There has been a significant increase in the use of remote working across all services. This has included telephone triage to direct patients to the right service/professional, follow up appointments and diagnostics completed via One Consultation or Teams, assessments completed via One Consultation and Teams. The recovery and restoration process include services considering any new or additional digital requirements.

Equality Impact Assessments/Reducing Health Inequalities

The phase 3 guidance includes a commitment to understand and minimise the impact of COVID on BAME communities, people living with diabetes, cardiovascular disease and respiratory disease. The Acting Exec of Strategy is the Exec lead for this work and will bring the appropriate action plan to Trust Board for approval. We are working on the basis that the Health Inequalities action plan replaces the need to also complete EIAs except for digitally enhanced services.

Benefit	Timescale / date to be realised	Responsibility	Achieved Yes/No	Comment
Services restored	October 2020	Divisional Directors	Yes	All but two mental health services are now operational. The last two services are expected to be approved imminently.
New ways of working embedded	March 2021	SRO/Divisional Directors/Director People	In progress	New ways of working include positive opportunities such as remote appointments increasing access opportunities and decreasing patient transport and waiting times. Negative impacts include the reduced capacity of our services due to COVID-19 cleaning guidance and social distancing in our clinics/services.
Digital technology incorporated into Business as Usual	March 2021	Deputy Chief Executive and Chief Financial Officer	In progress	Uptake in digital technologies across services has been significant with staff engaging with technology in a way many thought not possible pre COVID-19. Staff Survey indicates that working from home significantly enabled by Microsoft Teams.
Transparent modelling of capacity required to clear waiting list backlogs and implementation plans agreed.	Approval end Sept, modelling completed end October/ November 2020	SRO / Divisional Directors	In progress	Task and Finish group has been established to oversee the delivery of the Capacity and Demand tool. Group presented recommendations on the model to the October and November Recovery Programme Board meetings. This work is still current.
Restored services provide equality of access	December 2020	Divisional Directors	In progress	Equality Impact Assessments to be completed on digitally enabled services. Patient experience and patient outcomes to be included in the Health Inequalities Action Plan. Mental Health East has completed and shared a framework to consider when using remote rather than face 2 face contacts.
Phase 3 requirements	October 2020	Divisional Directors	Yes	Allocation of phase 3 requirements with associated leads and agree timescales complete with organisational governance and reporting to provide Trust Board with assurance.

Risks to highlight

Title / Description	Current Status (RAG)	Mitigating actions	By when	Comment
Board Assurance Framework – Risk 8B		• There is a risk that the Trust may be unable to maintain the standards of safe and high-quality care for patients we aspire to as an organisation because standing services back up during the recovery phase of COVID-19 whist also responding to system and regional pressures for information and support. • There is a risk that there may be insufficient staff to provide safe care due to staff to staff transmission/impact of test and trace on need for staff to self-isolate. • The impact of COVID-19 and the service response, upon staff and their ability to remain resilient and at work needs to be a continued focus.	Various sub task dates	For the purpose of this report this risk provides a summary of that included within the Board Assurance Framework 2020-21 (received 22092020)
COVID-19 – Risk of second wave de-railing the recovery process – leading to delay in recovery programme progress		Work closely with Wave 2 Lead, Divisional Directors and Project Managers to understand current state and implications on progress	March 21	Second wave now Live. The Recovery Programme Board receives an update from Wave 2 on the potential impact on Recovery.
Capacity and Demand Planning - to support Recovery		Capacity and Demand modelling to determine capacity required to return to pre COVID near normal state and manage backlog within new service models/ covid constraints	Revised to December 2020	Further information regarding a prioritisation list will discussed at the next Programme Board.
Mass Vaccination Programme		Staff Vaccination to commence as early as December 2020. Due to the side affects of the vaccination staff availability to deliver services may be impacted	December 2020	Ensure that staff are not all vaccinated from the same service on the same day.

Current Milestones Report

Milestone	Due date	Current Status (RAG)	Actions / Comments
Stakeholder Engagement and Communications Plan in place.	June 2020		To work with colleagues to determine requirements and best way forward regarding the Recovery Comms Group identified messages.
QIA and EFM Complete for all services	June 2020 [Revised to Oct 20]		All Community physical and mental health services have completed and approved QIA and EFM templates.
Plan for Corporate Services new ways of working developed	July 2020 [Revised to Nov 20]		Plan developed. To be considered by Remote Working Steering Group.
Use of the Capacity and Demand modelling tool to assess future capacity of services and resources required to clear waiting list backlogs.	June 2020 [Revised to Dec 20]		Prioritisation list in development to consider the outcomes of the Harm Review and volume of activity at service level.
Review all Phase 3 requirements and build necessary action plans.	End Sept 20 [Revised to Oct 20]		Identify organisational actions from Phase 3 and ensure these are owned and tracked. Completed and now to be transferred to Recovery Actions List.

	Complete		On Track		On Track / Known risks being managed		Off Track

Key Activity during Next Period

Activity/Product to be delivered	Action/notes	By when
Capacity and Demand Prioritisation List	Programme Board considering outcomes of In-House C&D Work, Heatmap and information already provided to other meetings to inform priority list of services (to also consider workforce, harm and patient volume)	December 2020
Assessment of Wave 2 on Recovery	To be considered in divisional recovery highlight reports	December 2020
Recovery workbook to be updated	To include Recovery guidance	December 2020
Health Inequalities Action Plan	Plan to be drafted, BOB has established a dedicated workstream. Frimley to confirm.	January 2021

Completed Milestones

Milestone	Due date	Current Status (RAG)	Actions / Comments
Service lessons Learned and feedback collated	June 2020		Lessons learned summary collated. Services lessons learned included in QIAs – currently being used to inform case studies for the Recovery newsletter
Second Wave Planning Group established	Sep 2020		JR will lead this work. A planning group is in place if significant risks are identified with regards to progress of recovery should Wave 2 occur depending on the severity.
Recovery milestones and activity included in the two system refreshed plans.	21st Sep 20		KM coordinating this work, combination of recovery and phase 3 milestones and activity.
Template for patient letters	July 20		Comms to provide template, letters now being used by operational teams– services to use as appropriate and save in Teams folders.
Prioritisation and approval of community health services for recovery complete with start dates or phasing identified.	Aug 2020		Prioritisation group now meeting weekly with approvals being made at every meeting. Near 100% of CHS restored.
Prioritisation and approval of health services for recovery complete with start dates or phasing identified.	Aug 2020		Remaining will be approved by Chairs Actions

Milestone	Due date	Current Status (RAG)	Actions / Comments
Capacity & Demand Task and Finish Group recommendations to Recovery programme board	October 2020		Inhouse Capacity and Demand tool to be used for adult services. Berks East CCG have requested use of the Attain tool for children's services.

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	10th November 2020
Title	BHFT 3 Year Strategy
Purpose	To provide Trust Board with a final draft and presentation of the final format for the 3 Year Strategy.
Business Area	All
Author	Kathryn MacDermott, Acting Executive Director of Strategy
Relevant Strategic Objectives	All
CQC Registration/Patient Care Impacts	N/A
Resource Impacts	N/A
Legal Implications	N/A
Equalities and Diversity Implications	N/A
SUMMARY	Since June 2020 Trust Board and the Council of Governors have been considering revisions to this strategy. This builds on the work completed in 2019 by the Strategy Planning task and finish group that acted as a reference group overseeing the drafting of a revised three-year strategy for BHFT. Membership included the Regional and Divisional Directors, representation from HR, IT, BI and EDI. This earlier version of the refreshed three-year strategy was considered by Trust Board in March 2020 and agreed with some amendments.

	However, this was followed by the COVID-19 pandemic which necessitated the pause of a number of operational and corporate services. At the same time the BHFT response to the pandemic required the acceleration of several of the ambitions set out in the earlier strategy. The attached refreshed three-year strategy reflects the changed starting point for BHFT post March-June 2020 and highlights a number of changes that have been made both operationally and corporately in the last nine months. Pages 4 and 5 set out the vision for 2024. The Annual Delivery plan (drafted in the spring) will underpin this strategy and set out clear KPIs that track progress. Progress on these KPIs Our vision and True North Goals have remained and provide a consistent thread from the previous strategy to this new strategy. Page 8 and 9 provide examples of ways of working that have changed due to COVID and flag a number of new ways of working that will continue to be part of our operating model in the future. We have set three strategic objectives: Our Patients, Our Population and Our Workforce. A previous draft included Our People rather than Our Workforce and Trust Board is asked to consider amending Our Workforce back to Our People. For Our Patients we will focus on three key areas of Outstanding Patient Care: Improving Patient Safety and Improving Health Outcomes and Experience. For Our Populations we will focus on the three key areas of Integrated Care; Improving the Health and Wellbeing of our Communities and Delivering Sustainable Services. For Our Workforce (People) we are focusing on Looking after Our Staff; Diversity; New Ways of Working and Collaborating with Partners. Appendices one to four give an illustration of what the strategy will look like in its printed format.
ACTION REQUIRED	The Trust Board is asked to: Approve the 3 Year Strategy Content and Approve the proposed Format.

NHS
Berkshire Healthcare
NHS Foundation Trust

Three Year Strategic Plan

2021/22 – 2024/25

Working together,
we can be
outstanding
for everyone

Working together,
we can be
outstanding
for everyone

Our new three year strategy

This document outlines our revised Berkshire Healthcare Foundation Trust strategy and sets out our vision for 2024. It replaces the earlier three-year plan we worked on throughout 2019 to 2020. This strategy will be used to guide our entire way of working over the next three years and sets out a challenging and transformational change agenda to ensure that BHFT remains a healthy and sustainable organisation into the future.

Why we're revising our plans

Throughout 2019 and early 2020, we worked with our staff and local communities to develop a three-year strategy built on our vision and True North Goals. It set out our ambitions, including the transformation of community health services and integrated community and mental health services with primary care networks (PCNs). This was approved by the February Trust Board.

Responding to COVID-19

However, in March 2020, alongside the whole of the NHS, we responded to the COVID-19 pandemic. This meant accelerating our planned transformation of our community and mental health services so we could safely meet the needs of our patients while supporting and protecting our workforce.

I'm personally hugely proud at how our workforce responded to the challenges COVID-19 presented and continues to present. I see incredible dedication, innovation and flexibility as teams adapt, finding and developing new ways to care for our patients, including embracing online platforms to maintain care and contact with patients remotely.

Solid platform for development

In the months that have passed since COVID-19 first emerged, we have already adopted many of the longer-term strategic initiatives and ambitions set out in our original three-year plan.

COVID-19 has both accelerated our planned changes and highlighted their importance. This development of our strategy now includes strong foundations upon which we can build on over the next three years.

Our new strategic framework

The new strategic plan continues to reflect our vision and values and will continue to be delivered through our four True North Goals. The detail of delivery has changed to acknowledge the accelerated pace of change responding to COVID-19 has promoted.

Making our vision a reality

Working together across our teams and services, and building on our quality improvement approach, we will continue to transform the way we work and seeing our strategy become a reality. Community and mental health services will look and feel very different, for example, virtual consultations will play a much larger part in our service offer allowing our teams to work across geographical boundaries. Support to patients and carer's through education and digital platforms is significantly increased. Patterns of work have changed for significant numbers of staff.

Julian Emms,
Chief Executive

Martin Earwicker
Chair

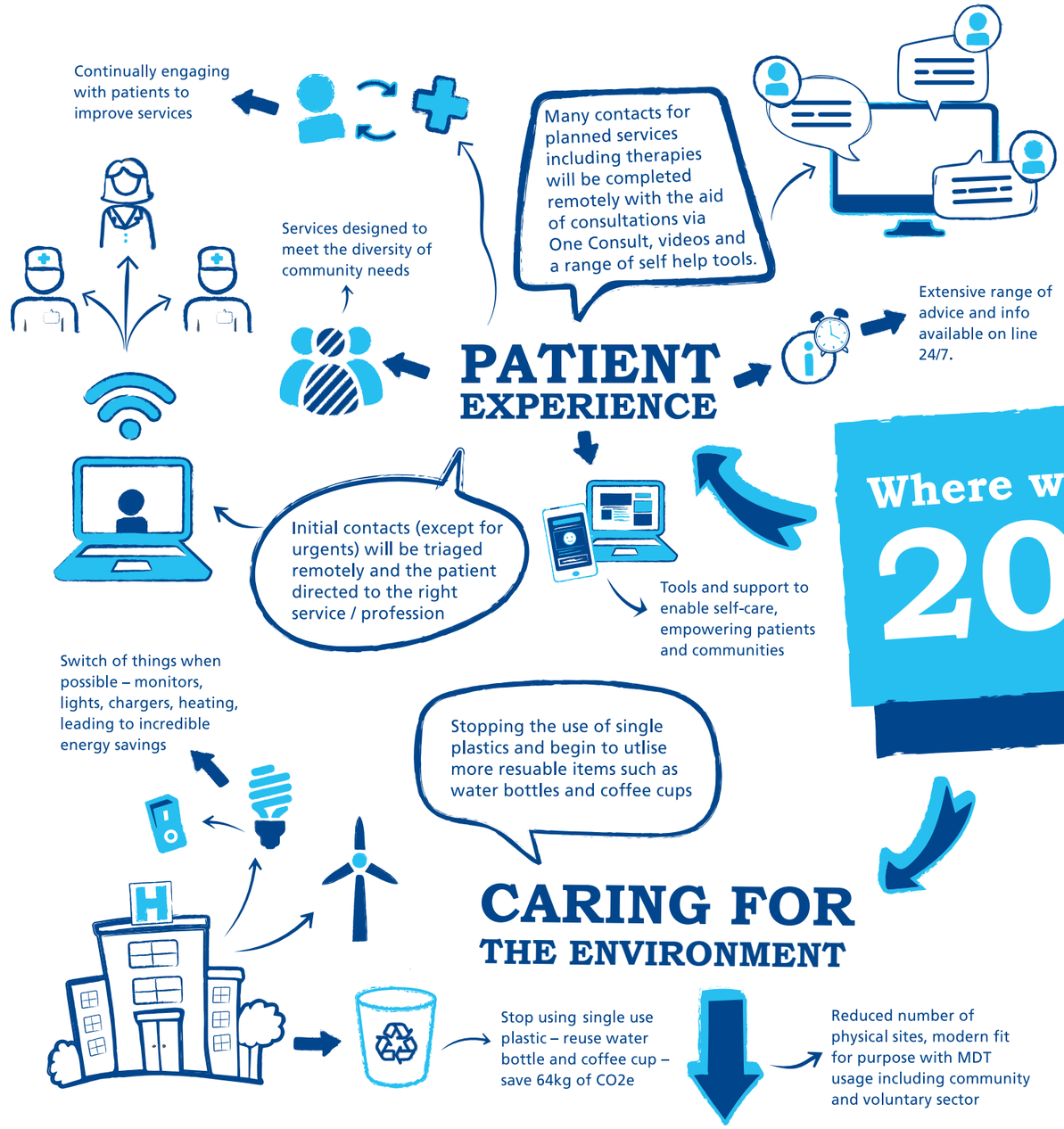
Our starting point:

Berkshire Healthcare Foundation Trust

- Rated as Outstanding by the Care Quality Commission
- Provider of community inpatient services in Reading, Newbury, Maidenhead, Slough and Wokingham and mental health inpatient service at Prospect Park Hospital in Reading
- Provider of community physical health services for children and adults across Berkshire and beyond
- Operating specialist clinics for physical and mental health across the county
- Employing around 4,500 staff operating from approximately 100 sites
- An NHS Leader in imbedding a culture of continuous Quality Improvement and empowering and giving genuine opportunities for staff and patients to identify areas for improvement and make changes
- Embedding quality improvement methodologies throughout the Trust from ward to Board
- Supporting staff to innovate and develop new ideas
- Adapting to new ways of working necessitated by COVID
- Mature and stable leadership
- Relatively mature relationships with Buckinghamshire, Oxfordshire and West Berkshire (BOB) Integrated Care System and partnerships and Frimley Integrated Care System (for East Berkshire)
- A history of financial sustainability
- An NHS leader in designing, adapting and imbedding technology to improve patient care
- Continuing to build on our status as a 'Global Digital Exemplar'
- Working with six Local Authority partners delivering services to children and young people in schools and children's centres, providing a range of specialist services and home visits
- But an area where the cost of living is high and chronic workforce shortages in critical services
- And low population funding based on population health need

Where we want to get to; the 2024 vision

The overall aim of our three-year strategy can be summarised in our long-held vision. To be recognised as the leading community and mental health service provider by our staff, patients and partners.



Making our vision a reality

Our vision is supported by our core three Values that underpin our approach to how we will make our Vision a reality:

Caring for and about **you** is our **top priority**

Committed to providing **good quality, safe** services

Working together to develop **innovative solutions**

Our three strategic objectives

We aim to achieve our Vision by focussing on three strategic objectives relating to our Patients, Population and Workforce.

Over the next three years, we will:

1

Improve access, safety, quality and experience of care for all of **Our Patients**

2

Work with partners to deliver integrated and sustainable services to improve health outcomes for all of **Our Populations**

3

Build on the Trust Outstanding CQC rating by striving to make Berkshire 'Outstanding for Everyone' by delivering the best staff experience possible and a sustainable workforce model for all **Our Workforce**

Our True North Goals

We have four True North Goals. These set the direction of travel for the Trust and are underpinned by a set out outcome measures to enable us to demonstrate our progress. The outcomes measures are listed in table one in the appendices.

True North goal 1: Harm-free care

✓ To provide safe services by eliminating avoidable harm

True North goal 2: Supporting our staff

✓ To support our people and be a great place to work

True North goal 3: Good patient experience

✓ To provide good outcomes from treatment and care

True North goal 4: Money matters

✓ To deliver services that are efficient and financially sustainable

Everything we do is designed to deliver harm free care, support our staff, provide a good patient experience and ensure that we are a sustainable organisation.

How COVID-19 has accelerated change in line with our strategy

Many of the initiatives outlined in our original strategy have been accelerated due to our response to COVID-19, often having a positive impact and delivering benefits for our patients, population and workforce.

Virtual consultation is now the preferred model for all clinically appropriate contacts

96,000 virtual contacts

In the last five months of the COVID-19 response, our Clinical Transformation team has worked with our community and mental health teams to deliver a range of appointments and services remotely. Since March 2020, we've delivered over 96,000 virtual contacts. Children's services have delivered over 8,000, community health has delivered over 46,000 and mental health services over 42,000.

Benefits of virtual consultation

Online consultations, telephone calls, emails and SMS messages avoid unnecessary face to face contact and removes the need for patients to travel to a site

Healthcare professionals can continue to care for thousands of patients safely in their own homes

Accelerated use of enhanced digital functionality across additional services

Builds resilience in teams and facilitates cross boundary working

Using technology to support multi-disciplinary team working

All services have highlighted the benefits of online technologies in supporting multi-disciplinary teams (MDTs) and the Care Programme Approach (CPAs).

Benefits of technology in MDT working

Health and care partners have access to the same digital record and information

Patients and their families and carers benefit from an approach that covers their health and social care needs

Information only needs to be given once

Creates the ability for the MDT to hear different perspectives and improve care offer to patients

Ability to identify and target at risk groups for prevention and care

New working methods for delivering services

In response to social distance and infection control, we have changed how we provide many services.

Greater flexibility

Since March 2020, for safety reasons, all our workforce (except those on wards and in urgent or essential services) have been working from home. The vast majority of clinics, support services, education, patient and community engagement has moved to online methods, giving patients and colleagues greater flexibility.

Benefits of new working methods

Increased range of treatment options offers greater choice to patients

Greater flexibility in methods of contact has seen more dads and teenagers engaging with our services

Video use for interpreting patients' needs has reduced waiting times

Microsoft Teams enables health and social care professionals to engage faster

Reduced carbon footprint

Remote working has fast tracked the use of Microsoft Teams across the organisation, significantly improving our carbon footprint and reducing our need for back office space.

Benefits of remote working

Significantly reduced the stress of travel time and costs for thousands of our staff and patients

Enabled our staff to achieve a better work/life balance

Reduced our carbon footprint and our need for office space

Supporting staff wellbeing

Our staff are our most important asset, which is why we established, at speed, a new support service to maintain staff wellbeing. All members of staff were able to access psychological support throughout these challenging times. A range of training has been designed and rolled out to support our managers and leaders to help them learn new skills to manage and lead remote teams, with a focus on staff wellbeing.

Psychological support

All members of staff were able to access psychological support throughout these challenging times.

Benefits of supporting staff

Creates a culture where our staff are recognised as central to the trust

Reducing the impact on our staff of the challenging times COVID-19 represents

Creates a resilient workforce reinforcing that BHFT is a great place to work

Offered this expert service to system colleagues and Acute Trusts

Provided Risk Assessments for all BAME and high-risk staff to ensure health and wellbeing requirements were discussed with line managers and ensure everyone had exactly what they needed to be safe while at work

Our three strategic objectives

Over the next three years, we are focusing on three strategic objectives.

Continue to improve access, quality and experience of care for all of **Our Patients**

Work with partners to improve the health outcomes of all of **Our Populations**

Make Berkshire Healthcare a great place to work for all of **Our Workforce**

Our Patients

In achieving our objective to improve access, quality and experience of care for all of our patients, we will focus on three key areas.

1. Delivering outstanding patient care

We aim to maintain our 'outstanding' CQC rating by embedding our Quality Improvement (QI) approach to service improvements. We'll focus on the four Long Term Plan priority areas – urgent community response and re-ablement services, integrated community and mental health services with primary care networks local GP practices and community teams, support for people living in care homes, and supporting people to age well – each designed to transform the out of hospital care landscape.

Continuing to build a culture of continuous improvement

We'll continue to use QI methodology, to support service improvements, and data and national benchmarking tools such as Getting It Right First Time (GIRFT) to reduce variation and improve outcomes. The accelerated take up of digital opportunities represents a significant opportunity to improve access to our services and the ability to triage remotely. Remote working provides us with the opportunity to provide a greatly enhanced service offer.

2. Improving patient safety

We will continue to build on our culture across our organisation that encourages staff to report incidents and raise concerns. Our safety culture score is near the top and highest across the local systems. We will continue to learn from these and reduce potential for future harm. And we'll continue to use 'staff huddles' across our services to improve safety for staff and patients on a daily basis. We will use digital tools to remove unwarranted variations in clinical practice by delivering automated workflow and decision support including active alerting to changes in a patient's condition.

Delivering care in a safe environment

Delivering care in a safe environment is a fundamental part of delivering safe care. Our Estates Infection Prevention and Control (IPC) teams will continue to support our staff and partners making our sites safe for patients and providing guidance and training to enable all to follow COVID-19 guidance and procedures. We will continue to ensure we have the right staff in place to deliver consistently high-quality care using QI methodology to identify areas for action and improvement.

3. Improving health outcomes and experiences

We'll work with patients across our physical and mental health services to enable them to manage their health and wellbeing, and ensure their care is focused on them. We'll do this in partnership with Primary Care Networks, offering bespoke services to communities or areas where the demographic requires. We will use digital services like Silver Cloud, SHaRON, and other guided self-care methods etc. to do provide self-care and support resilience in communities and individuals.

Ensuring access for all

We've already increased the use of virtual clinics and significantly extended our remote offer on self-care and self-help. We'll continue to build on this and ensure equity of access for all. Supporting remote and self-care is likely to be the biggest change over the next few years. We will support this through a range of digital tools supporting remote triage, self-management, education tools (videos, online courses etc), information, and peer support. We will build our self-care offer in collaboration with patients and their carer's.

Increasing patient feedback

We've commissioned a dedicated programme of work to establish a systematic approach to securing patient feedback. We'll use this as an important part of the data we consider when focussing on the services to improve. We'll develop new ways of providing digital feedback so we can capture patient experience of our new ways of working.

Measuring our success

We'll know we've been successful because we will:

- Further reduce falls, pressure ulcers, and self-harm in inpatient services and suicide across all of our services
- Proactively recognise and respond promptly to physical health deterioration on our inpatient wards
- Continue to strengthen our safety culture to empower staff and patients to raise safety concerns without fear and to facilitate learning from incidents
- Protect our patients and staff from contagious diseases by making sure our staff have received all relevant immunisations, including COVID and the flu vaccine.
- Increase the Friends and Family Test patient and carer reported satisfaction rate
- Use patient and carer feedback to drive improvements in our services
- Manage patient flow effectively with minimum delays so that patients don't stay within our services for no longer than is clinically appropriate

With our health and care partners, we will redesign and integrate services to improve patient experience and outcomes.

Our Populations

In achieving our objective to work with partners to improve the health outcomes of all of our populations, we will focus on three key areas.

1. Providing integrated care closer to home

Working with Primary Care Networks
Working with Local Authority partners we will deliver integrated health and social care services to people in their own neighbourhoods. We'll use the Connected Care shared record and the national spine records to synchronise our patient demographic data with the GPs to ensure patients only have to give their information once and all professionals have the latest patient information to hand. We'll support integrated services with digital technologies and new job opportunities.

Transforming community and mental health services
We'll deliver an integrated community physical and mental health offer for neighbourhoods aligned to Primary Care Networks. Community services will provide a rapid response service for those in need and work with social care to provide reablement services. We'll work with our hospital services to ensure timely discharge of patients to community services supported by integrating digital records and care transfer from acute to community settings. Community health services will offer remote consultations providing greater choice and ease of access. Working virtually also creates resilience in our services and enables to work across boundaries. Working with our Local Authority partners and Primary Care Networks we will embed an integrated approach to children's and young people's services at the neighbourhood level.

2. Improving the health and wellbeing of our communities

Taking a Population Health Management approach, we'll work with health and care partners to ensure equity of access to services and offer bespoke services to communities and neighbourhoods where there are variations in outcomes. Population Health Management also provides us with digital analytics from the shared care record that support community based bespoke care. We'll work with our communities to establish service delivery models that build community and individual resilience.

Addressing health inequalities
COVID-19 has highlighted the impact of structural inequalities on health. We'll work with partners to take a system wide approach to reducing these inequalities. We have a new Equalities, Diversity and Inclusion Strategy within Berkshire Healthcare and have accelerated the work on a BAME people transformation strategy. Working at neighbourhood level with Primary Care Networks we will be able to provide services tailored to the need of the local community.

Reducing environmental impact
Our response to COVID-19 included a seismic shift in the number of patients that no longer have to travel to clinics. This created a significant drop in our carbon footprint through reduced travel and reduced paper and office waste. We'll continue to keep our impact on the environment as low as possible by using digital opportunities where possible and appropriate.

3. Delivering sustainable services

We will make the best use of our resources to ensure sustainability. Working with our ICS and ICP colleagues, we'll develop and maintain a sustainable health and care system. We'll make the best uses of our financial resources, making investment decisions aligned to our strategic priorities. We'll secure new appropriate business and make the most of our assets and estates.

And, at service level, we'll ensure we continue to focus on delivering best value for patients by improving our efficiency and productivity. And, at service level, we'll ensure we continue to focus on delivering best value for patients by improving our efficiency and productivity.

Measuring our success

We'll know we've been successful because we will:

- Achieve better coordinated, integrated care across community, mental health and primary care
- Contribute to reducing health inequalities locally
- Increase our contribution to the environment
- Achieve our budget for the year
- Make all of our services more efficient and reduce waste
- Continue to reduce our reliance on agency staff
- Deliver further efficiencies in corporate and support services

With our health and care partners, we will improve efficiency and reduce waste through collaboration.

Our Workforce

In achieving our objective to make Berkshire Healthcare a great place to work for all our staff, we will focus on four key areas.

1. Looking after our staff

Focussing on staff wellbeing

We want everyone at Berkshire Healthcare to feel positive about themselves and their work and for this to be an outstanding place to work for everyone. Therefore, we focus specifically on the actions we must all take to keep our staff safe, healthy and well – both physically and psychologically. We'll do everything we can to provide the best experience possible. We'll ensure our workforce and their families continue to have access to a comprehensive wellbeing offer. We will continue to embed compassion into our leadership behaviour. And we'll focus on a team-based approach where everyone works together to build and maintain a culture of wellbeing.

Developing fulfilling careers

We want our staff to stay and grow with us. Our strategic initiative on recruitment, retention and development will help us better understand what our staff want, why they leave and what we can do to address underlying problems. We'll focus on supporting new members of staff in their first 12 months. We'll improve their onboarding experience to build early engagement and loyalty. And we'll provide a better work/life balance for everyone through more flexible working options.

2. Belonging to the Trust

Valuing our diversity

We're proud of the diversity of our 4,500 staff and want everyone to feel valued and important. It is important that our leader's model inclusive behaviours and take action to create a culture within BHFT where everyone feels they belong. We believe in fairness and equity. We value diversity and aim to provide accessible services that respect the needs of individuals and exclude no one. We'll continue to strengthen a just culture where everyone is respected equally, where everyone feels able to give feedback and that their ideas and concerns will be listened to and acted upon. We want to create an outstanding culture for everyone and see tackling pockets of inequality and discrimination as a top priority.

This commitment is reinforced in our Equality, Diversity and Inclusion Strategy, which includes a number of equality improvement plans and supports three staff networks: BAME for Black and Minority Ethnic staff; PRIDE for Lesbian, Gay, Bisexual and Transgender staff; and the Purple Network, which promotes understanding of disability, carers, mental wellbeing and challenges such as homelessness. We are proud of our staff networks and those members of staff who come forward to lead and support the work of our BAME, PRIDE and Purple networks.

3. New ways of working and delivering care

Building teams fit for the future

Our response to COVID-19 has accelerated a range of new ways of working based on digital technology. During the early months of COVID-19, many of our staff were redeployed and trained in new roles with new skills. Looking to the future, we'll create new roles that support more flexibility and variety. We'll provide greater deployment opportunities and support the learning of new skills across our organisation. We'll be proactive in designing the workforce of the future, looking at skill mix changes, growing apprenticeships and supporting our staff through appropriate training and development.

Growing for the future

Recruiting and retaining a solid workforce continues to be one of the biggest challenges we face at Berkshire Healthcare. We know that appointing the right staff in the right numbers is key to sustaining our services, which is why we not only seize the opportunity to recruit directly into entry-level clinical roles, apprenticeships and non-clinical roles but also look at how we can offer clear ongoing pathways for career development once we have recruited new staff. We consider and review our HR policies on recruitment, training and development through an Equality, Diversity and Inclusion lens. And we proactively update our policies to reflect our commitment to actively promoting equality and diversity.

4. Collaborating across our health and social care systems

We continue to work in collaboration with our local health and social care systems, including BOB, Frimley and the Berkshire Primary Care Networks. We support system approaches to workforce planning, recruitment, retention, leadership, development, talent management and wellbeing, and we learn from and support each other.

Collaboration and co-production are broader than the traditional health and social care partners. We have worked hard to establish strong links with our local communities and will build on these links to provide a solid foundation for a co-productive approach to improving services, gaining patient and community feedback and engagement. We believe that working with our communities is the right and sustainable approach to sustainable and resilient communities and services. We will lead by example.

Measuring our success

We'll know we've been successful because we will:

- Maintain high levels of staff engagement across all our services
- See an increase in the number of staff who feel they have an influence on how we work and make decisions
- Achieve year on year improvement in our Workforce Race and Workforce Disability Equality Standard surveys results
- See an increase in the number of staff recommending us as a place to receive care and treatment
- Improve recruitment, retention and satisfaction of our staff
- Improve the health and wellbeing of our staff and reduce sickness absence
- Have zero tolerance to bullying and harassment
- Reduce violence and aggression towards our staff
- Strong, positive feedback from our community partners that engagement and co-production is real and making a difference

With our health and care partners, we will enhance career development opportunities and collaborate with our partners to identify ways we can work together to plan for and address our workforce and skills needs.

Working with our local communities we will strengthen our community offer and deliver services that respond to local community needs.

Our partnerships

We will continue to work with our numerous healthcare partners across Berkshire, Buckinghamshire and Oxfordshire and Frimley to deliver the best integrated care possible across community, mental health, hospital and social care. We will continue to build interoperability across the various systems, use analytics to understand our patients and outcomes, and support digital pathway management across sectors. We will work with our communities, patients and carers to build resilient communities.

Our local communities

We will strengthen our approach to community engagement and proactively work with communities to co-produce services that meet the needs of local people.

Primary Care Networks

Our partnerships with Primary Care Networks across Berkshire will enable us to deliver integrated community physical and mental health services at neighbourhood level. Working in partnership assists the transformation of community and primary care services. This holistic approach allows Multi-disciplinary Teams to provide support to elderly people and those living with long term health conditions at home and in care homes.

Royal Berkshire & Frimley Hospitals

Our partnerships with the Royal Berkshire and Frimley Hospitals helps provide rapid discharge from both hospitals for those patients who don't need to stay. We will continue to deliver integrated care pathways to ensure patients can move easily between different departments and providers.

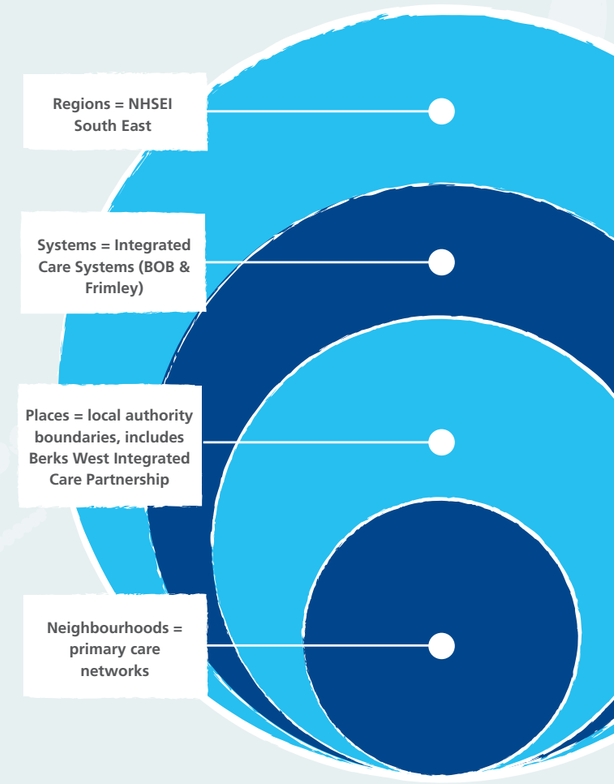
Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our partnerships with community providers and local authorities across Buckinghamshire, Oxfordshire and Berkshire West (BOB) will help us deliver the Ageing Well transformation for community services, aiding significant changes in rapid response and reablement services.

We will continue to work with health, social care and voluntary sector partners across BOB Integrated Care System (ICS) to deliver integrated care for people in Berkshire West. We also collaborate across Berks West Integrated Care Partnership (ICP), working with colleagues in local government, primary care, and other health care and community providers to improve care for our local populations.

Frimley Integrated Care System

Working with the health, social care and voluntary partners across Frimley Integrated Care System, we provide integrated care for people in both Berkshire West and East, including neighbourhoods in Bracknell Forest, Slough, Windsor and Maidenhead.



Thank you

Email@togohere.com

berkshirehealthcare.nhs.cuk

Three Year Strategic Plan

2021/22 – 2024/25

Patients Populations Workforce

https://berkshirehealthcare.nhs.uk

Three Year Strategic Plan

2021/22 – 2024/25

 Patients  Populations  Workforce

Published by Berkshire Healthcare NHS Foundation Trust 2020

BHC219 v1.0 (Dec 2020)


Three Year
Strategic Plan
2021/22 – 2024/25
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- But an area where the cost of living is high and chronic workforce shortages in critical services
- And low population funding based on population health need

Where we want to get to; the 2024 vision

The overall aim of our three-year strategy can be summarised in our long-held vision. To be recognised as the leading community and mental health service provider by our staff, patients and partners.

Where we'll be in 2024


Our Populations
In achieving our objective to work with partners to improve the health outcomes of all of our populations, we will focus on three key areas.
1. Providing integrated care closer to home
Working with Primary Care Networks
2. Improving the health and wellbeing of our communities
Addressing health inequalities
Transforming community and mental health services
Reducing environmental impact
3. Delivering sustainable services
Measuring our success
We'll know we've been successful because we will:
With our health and care partners, we will improve efficiency and reduce waste
Three Year Strategic Plan 2021/22 – 2024/25

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	08 December 2020
Title	**Appointments and Remuneration Committee – Changes to Terms of Reference**
Purpose	To ratify the proposed changes to the Committee's Terms of Reference as highlighted in red type.
Business Area	Corporate
Author	Company Secretary on behalf of Mark Day, Committee Chair
Relevant Strategic Objectives	True North Goal – Supporting Our Staff
CQC Registration/Patient Care Impacts	N/A
Resource Impacts	None
Legal Implications	Meeting requirements of terms of reference.
Equalities and Diversity Implications	N/A
SUMMARY	The Committee has reviewed its terms of reference and has identified a number of minor changes (highlighted in red type).
ACTION REQUIRED	The Trust Board is requested to ratify the proposed changes to the Committee's Terms of Reference.

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Appointments and Remuneration Committee

Terms of Reference

Purpose
This document describes the terms of reference for the Trust's Appointments and Remuneration Committee, a standing Committee of the Trust Board.

Document Control

Version	Date	Author	Comments
1.0	Feb 08	Philippa Slinger	
2.0	May 09	John Tonkin	Updated to reflect changes to draft agreed at Trust Board meeting on 12 February 2008
3.0	Feb 10	John Tonkin	Revised following review by Remuneration Committee on 25 February 2010
4.0	Feb 11	John Tonkin	Revised following review by Remuneration Committee on 25 January 2011
4.0	Feb 11	John Tonkin	Approved by Board 8 February 2011
5.0	August 2018	Julie Hill	Terms of Reference re-drafted to include the Appointments role. The Committee's membership has also been extended to include all Non-Executive Directors

Document Title	Date	Published By
NHS Foundation Trust of Governance	July 2014	Monitor
Guidance on VSM Pay in NHS Foundation Trusts	Mar 2018	NHS Improvement
Regulation 5 – Fit and Proper Persons Regulations	Jan 2018	CQC

Trust Board Appointments and Remuneration Committee Terms of Reference

1. Constitution

The Board of Directors (the "Board") hereby resolves to establish a Committee of the Board to be known as the Trust Board Appointments and Remuneration Committee (the "Committee"). The Committee has no executive powers other than those specifically delegated in these Terms of Reference.

2. Appointments Role

The Committee shall, in respect of appointments:

2.1 The Chief Executive shall consult with the Committee annually about the structure, size and composition of the Executive Team and staff on Very Senior Manager contracts (including skills, knowledge and experience) and agree any changes.[1]

2.2 Ensure that the Trust has robust succession plans in place by reviewing the feedback provided by the Talent Management Review Board.

2.3 Oversee the identification and nomination of a candidate, for approval by the Council of Governors, to fill the position of Chief Executive.

2.4 Ensure that there is a formal, rigorous and transparent procedure in place to identify suitable candidates to fill Executive Director and Very Senior Manager vacancies as they arise.

2.5 Ensure that the appointments process for Chief Executive, Executive Director and Very Senior Manager posts includes the requirements of the 'Fit and Proper' Persons Test.

2.6 Consider any matter relating to the continuation in office of the Chief Executive, any Executive Director at any time, including the suspension or termination of service of an individual as an employee of the NHS Foundation Trust.

2.7 Consider the engagement or involvement of any suitably qualified third party or advisers to assist with any aspects of the Committee's responsibilities.

3. Remuneration Role

The Committee shall in respect of remuneration:

3.1 Establish and keep under review a remuneration policy for Chief Executive, Executive Director and Very Senior Manager posts.

3.2 Consult the Chief Executive about proposals relating to the remuneration of Executive Directors and Very Senior Managers.

3.3 In accordance with all relevant laws, regulations and the NHS Foundation Trust's policies, determine the terms and conditions of office of the Chief Executive, Executive Director and Very Senior Manager posts, including all aspects of salary and any performance related pay or bonus and the provision of other benefits (for example, cars, allowances or payable expenses).

3.4 Determine the levels of remuneration and terms of employment for the Chief Executive, Executive Director and Very Senior Manager posts.

[1] The Council of Governors' Appointments and Remuneration Committee are responsible for reviewing the structure, size and compositions (including skills, knowledge and diversity) in respect of the Non-Executive Directors)

3.5 Ensure that the Chief Executive, Executive Directors and Very Senior Managers are fairly rewarded for their individual contribution to the NHS Foundation Trust – having proper regard to the NHS Foundation Trust's circumstances and performance and to the provisions of any national arrangements for such staff.

3.6 Use national guidance and market benchmarking analysis in the annual determination of remuneration of the Executive Directors.

3.7 Approve the arrangements for the termination of employment of the Chief Executive, Executive Directors and Very Senior Managers and other contractual terms, having regard to any national guidance.

3.8 Approve contractual payments over £100,000 to all staff. Contractual payments between £50,000-£99,000 will be approved by an Executive Committee and reported to the Committee for information.

3.9 Approve any non-contractual payments that have to be reported to HM Treasury (via NHS Improvement.

3.10 Monitor and evaluate the performance of the Chief Executive, individual Executive Directors and Very Senior Managers ensuring that they each receive an annual appraisal and that they continue to meet the requirements of the Fit and Proper Persons Test.

4. Procure remuneration benchmarking from suitably qualified organisations as required from time to time.
5. Approve the application of the Trust's Pensions Alternative Payment Policy in respect of all eligible staff.

~~3.10~~5.1

~~4.~~6. Membership and attendance

The Committee shall comprise the Trust Chair and all of the Non-Executive Directors.

The Committee shall appoint a Chair.

The Chief Executive shall be a member but will withdraw from the meeting during any discussions regarding his/term terms of condition and remuneration.

The Director of People shall provide advice to the Committee as required.

Other members of staff and external advisers may attend all or part of a meeting by invitation of the Committee Chair where required.

For any decisions relating to the appointment or removal of the executive directors, membership of the Committee should include the Chief Executive as required under Schedule 7 of the NHS Act 2006.

The Company Secretary will be in attendance and will minute the meetings.

~~5.~~7. Quorum

~~5.1~~7.1 The quorum shall be three Non-Executive Directors.

~~6.~~8. Frequency of meetings

~~6.1~~8.1 The committee shall meet at least once a year.

~~7.~~9. Authority

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~~7.1~~9.1 The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

~~7.2~~9.2 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience if it considers this necessary.

~~7.3~~9.3 The Committee will consider the latest guidance produced by NHS Improvement and the annual Senior Salary Review (NHS) report and where appropriate seek the necessary opinion and/or approval.

~~8.~~10. Monitoring Effectiveness

~~8.1~~10.1 The Committee will undertake an annual review of its performance against its work plan in order to evaluate the achievement of its duties.

~~9.~~11. Other Matters

~~9.1~~11.1 The Committee shall be supported and minuted by the Company Secretary

~~9.2~~11.2 These terms of reference will be reviewed as part of the monitoring effectiveness process.

October 2018

Reviewed in ~~October 2019 – no changes~~ December 2020

Next Review: ~~October 2020~~December 2021