BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

TRUST BOARD MEETING HELD IN PUBLIC

10:00am on Tuesday 11 July 2017
Boardroom, Fitzwilliam House,
Skimped Hill Lane, Bracknell, RG12 1BQ

AGENDA

No	Item	Presenter	Enc.
OPENING BUSINESS			
1.	Chairman's Welcome	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 09 May 2017	Martin Earwicker, Chair	Enc.
5.2	Action Log and Matters Arising	Martin Earwicker, Chair	Enc.
QUALITY			
6.1	Quality Board Visit: Snowdrop Ward, Prospect Park Hospital	Ruth Lysons, Non-Executive Director	Enc.
6.2	Quality Assurance Committee – 19 May 2017 a) Minutes of the meeting b) Changes to the Committee's Terms of Reference	Ruth Lysons, Chair of the Quality Assurance Committee	Enc.
6.3	Revalidation Annual Report 2016/17	Minoo Irani, Medical Director	Enc.
6.4	Freedom to Speak Up Guardian Report	Elaine Williams, Freedom to Speak Up Guardian	Enc.
EXECUTIVE UPDATE			
7.1	Executive Report	Julian Emms, Chief Executive	Enc.
PERFORMANCE			
8.1	Month 2 2017/18 Finance Report	Alex Gild, Chief Financial Officer	Enc.
8.2	Month 2 2017/18 Performance Report	Alex Gild, Chief Financial Officer	Enc.
8.3	a) Finance, Investment & Performance Committee – 31 May 2017 and 28 June 2017 b) Changes to the Committee's Terms of Reference	Mark Lejman, Chair of the Finance, Investment and Performance Committee and Ruth Lysons, Member of the Finance, Investment and Performance Committee *(Ms Lysons chaired the meeting on 31 May 2017)*	Verbal/ Enc.
STRATEGY			
9.0	Equality Strategy Annual Report	Bev Searle, Director of Corporate	Enc.

No	Item	Presenter	Enc.
		Affairs	
CORPORATE GOVERNANCE			
10.1	Audit Committee Minutes – 24 May 2017	Chris Fisher, Chair of the Audit Committee	Enc.
10.2	Trust Seal Update Report	Alex Gild, Chief Financial Officer	Enc.
10.3	Council of Governors Update	Martin Earwicker, Chair	Verbal
Closing Business			
11.	Any Other Business	Martin Earwicker, Chair	Verbal
12.	Date of the Next Public Trust Board Meeting – 08 August 2017 (*if required*) 2 September 2017	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

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Berkshire Healthcare NHS
NHS Foundation Trust

AGENDA ITEM 5.1

Unconfirmed minutes

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

Minutes of a Board Meeting held in Public on Tuesday 09 May 2017

Boardroom, Fitzwilliam House

Present:	Martin Earwicker	Chairman
	Mark Day	Non-Executive Director
	Julian Emms	Chief Executive
	Chris Fisher	Non-Executive Director
	Alex Gild	Chief Financial Officer
	Dr Minoo Irani	Medical Director
	Mark Lejman	Non-Executive Director
	Ruth Lysons	Non-Executive Director
	Helen Mackenzie	Director of Nursing and Governance
	Mehmuda Mian	Non-Executive Director
	Bev Searle	Director of Corporate Affairs
	David Townsend	Chief Operating Officer
In attendance:	Julie Hill	Company Secretary

17/076	**Welcome** (agenda item 1)
	The Chair welcomed everyone to the including the Governors: Bet Tickner, Appointed Governor and June Carmichael, Staff Governor.
17/077	**Apologies** (agenda item 2)
	Apologies were received from: David Buckle, Non-Executive Director.
17/078	**Declaration of Any Other Business** (agenda item 3)
	There was no other business declared.
17/079	**Declarations of Interest** (agenda item 4)
	i. Amendments to Register – none
	ii. **Agenda Items -** none
17/080	**Minutes of the previous meeting – 11 April 2017** (agenda item 5.1)
	The Minutes of the Board meeting held in public on Tuesday 11 April 2017 were approved after a minor correction.

17/081	**Action Log and Matters Arising** (agenda item 5.2)
	The schedule of actions had been circulated. The following action was discussed further: **Guardians of Safe Working – Annual Student Satisfaction Survey** The Medical Director reported that a summary of the key themes from the clinical trainee satisfaction survey would be presented to the July 2017 Trust Board meeting. The Chief Executive said that Health Education England were scheduled to make their annual visit to the Trust in June 2017 and that the paper would also include feedback from the visit. **Action: Medical Director and Director of Nursing and Governance** **The Trust Board**: noted the schedule of actions.
17/082	**Quality Board Visit Report – The Assessment and Rehabilitation Centre (ARC) at Upton Hospital, Slough** (agenda item 6.1)
	Mark Day, Non-Executive Director reported that he had visited the Assessment and Rehabilitation Centre (ARC) at Upton Hospital, Slough on 13 April 2017. Mark Day, Non-Executive Director reported that this was his first Quality Board visit and said that ARC delivered a fully integrated multi-disciplinary service that was designed around the needs of the patient. Mr Day said that he met with the Head of Community Rehabilitation and he was very impressed by his strong leadership and by the dedication of the team. Mr Day reported that he had an opportunity to talk to patients who were waiting for the transport service who all gave very positive feedback about the ARC service. The only negative feedback related to lengthy waits for the patient the transport service. Ruth Lysons, Non-Executive Director asked whether the Trust could do anything to resolve the patient transport issues. The Chief Executive reported that South Central Ambulance Service NHS Foundation Trust held the contract for providing non-urgent patient transport across the Thames Valley area and said that he had raised concerns about lengthy delays with the Commissioners. It was noted that lengthy waits for transport was particularly stressful for dementia patients and their families. Mehmuda Mian, Non-Executive Director commented that her father used the service and he particularly valued the patient centred approach and was highly complimentary about the staff. The Chief Executive said that patients used to move around the building in order to be seen by the various clinicians. The current service model used the Formula 1 “pit stop” approach which meant that a multi-disciplinary team came to the patient. The Chief Executive said that this was an example of a *Listening into Action* service re-design that had been developed from the bottom up by front line staff. Mark Day, Non-Executive Director reported that the Head of Community Rehabilitation had commented that he felt empowered and supported by the Executive Team and in particular by the Chief Operating Officer to implement changes to the service.

	The Trust Board: Thanked Mark Day, Non-Executive Director for sharing his reflections about his Quality Board Visit to the Assessment and Rehabilitation Centre (ARC) at Upton Hospital, Slough.
17/083	**Patient Experience Quarter 4 Report** (agenda item 6.2)
	The Director of Nursing and Governance presented the report and highlighted the following points: • The services with the highest number of complaints were also those services which cared for the most unwell patients and which had the most acute staffing challenges; • The top reasons for complaints made during 2015-16 and 2016-17 were: care and treatment; attitude of staff; and communication; • The Trust was taking steps to be clearer with patients about what level of service they could expect to receive. Staff whose attitude was the subject of more than one complaint were flagged and referred to their line manager. • The Trust's serious incident investigation process was focusing on human factors in order to gain a greater understanding about when and why incidents happen. • The independently commissioned deep dive survey into the patient experience of the Crisis Resolution Home Treatment Team service had consolidated the Trust's understanding of the issues but had not identified any new themes or trends. Chris Fisher, Non-Executive Director said that the format and consistency of the graphs made the information in the report very accessible and easy to understand. The Director of Nursing and Governance thanked Mr Fisher for his comments and agreed to forward the positive feedback to the Head of Engagement and Service User Experience. **Action: Director of Nursing and Governance** The Chair referred to page 47-8 of the agenda pack and commented that the Friends and Family Test benchmarking data highlighted that there was not much variation in the percentage of patients recommending the different local trusts and asked whether the indicator was good measure of patient satisfaction. The Director of Nursing and Governance said that to be useful, the Trust's response rate would need to increase to at least 15%. The Director of Nursing and Governance said that the Trust sought and received patient feedback via a number of different routes, including through local patient surveys. The Director of Nursing and Governance said that Avon and Wiltshire Mental Health Partnership Trust had achieved a 15% response rate by including the Friends and Family Test form with the patient's discharge letter and that this was something the Trust was going to trial. Ruth Lysons, Non-Executive Director referred to page 43 of the agenda pack and commented that the review of patient experience of the Crisis Resolution Home Treatment Team Service had highlighted that carers sometimes felt out of the loop and asked what more the Trust could do to keep carers better informed. The Director of Nursing and Governance said that better communication with carers was part of the Zero Suicide programme of work which was encouraging carers and families to be involved in the new patient safety plan. It was noted that there was now a Nurse Consultant supporting the Crisis Resolution Home Treatment Team service.

	Mark Lejman, Non-Executive Director commented that the ward breakdown of the Friends and Family Test excluded the Campion Unit and Sorrel Ward. The Director of Nursing and Governance agreed to review the ward breakdown and agreed that in future all wards would be listed even if there was a nil return. **Action: Director of Nursing and Governance** **The Trust Board**: noted the report.
17/084	**BHFT Quality Accounts 2016-17** (agenda item 6.3)
	The Medical Director presented the draft Quality Accounts 2016-17 and highlighted the following points: • The Quality Assurance Committee had received and reviewed quarterly Quality Accounts reports. • The presentation of this year's Quality Accounts had been changed to reflect feedback from the Council of Governors about making the report more readable. The changes included the addition of blue coloured information notices at appropriate points in the report to better explain and signpost its content to the reader. • The External Auditors would present their opinion and give their assurance on the Quality Accounts 2016-17 at the Audit Committee meeting on 24 May 2017. • The Trust Board was requested to consider the Statement of Directors' Responsibilities in the report of the Quality Accounts (page 53 of the Quality Accounts) and ensure that they were satisfied with the Quality Accounts in relation to the requirements as detailed in the Statement. Chris Fisher, Non-Executive Director referred to page 73 of the agenda pack and said that it was disappointing that data from the Trust Patient Survey indicated that the percentage of patients who rated the service they received as very good or good had declined from 83% of mental health inpatients in 2014-15 to 81% in 2015-16 to 72% in 2016-17. The Chief Operating Officer said that the decline in satisfaction rates reflected the staffing challenges and increased demand in relation to mental health in-patient services. The Chair said that the Trust's Placement Support Employment Service was excellent and commented that he hoped that the service would continue to be funded. The Chair asked Ruth Lysons, Chair of the Quality Assurance Committee whether she was content for the Trust Board to confirm the Statement of Directors' Responsibilities in respect of the Quality Accounts and Ms Lysons confirmed that this was the case. **The Trust Board:** a) Confirmed that to the best of their knowledge and belief that they had complied with the requirements as set out in the Statement of Directors' Responsibilities set out in report of the Quality Accounts (page 53 of the Quality Accounts); b) Gave approval for the Chair and the Chief Executive to sign the Statement of Directors' Responsibilities in the report of the Quality Accounts.
17/085	**Executive Report** (agenda item 7.1)
	The Executive Report had been circulated. The following issues were discussed further: **Care Quality Commission** On behalf of the Trust Board, the Chair congratulated the Trust for achieving a Care Quality Commission rating of "good" across all domains (caring, responsiveness, safety,

effectiveness and well-led). It was noted that the Care Quality Commission had not yet updated their website to reflect the new rating.

Quality Improvement Programme
The Chair reported that there would be a presentation on the Quality Improvement programme for Non-Executive Directors at the June 2017 Discursive Board meeting.

Royal Berkshire Hospital NHS Foundation Trust and Berkshire Healthcare NHS Foundation Trust Joint Tendering of a Replacement Temporary Staffing Bank
Chris Fisher, Non-Executive Director asked whether the reason behind going out to tender was because the Trust was dissatisfied with the current service provided by NHS Professionals or whether it was to comply with procurement rules.

The Director of Nursing and Governance said that the current contract needed to be re-procured as part of the Accountable Care System work and therefore the Trust had decided to jointly tender the service in order to achieve economies of scale. It was noted that it would only be the back office support function which was shared between the two organisations.

Health Care Assistants Agency Ban
The Director of Nursing and Governance reported that the ban on using agency Health Care Assistants came into effect on 1 April 2017 and paid tribute to the Chief Operating Officer and his teams for successfully implementing the ban. The Director of Nursing and Governance particularly paid tribute to the Acting Locality Director for Mental Health In-Patient Services for her leadership in deploying staff more flexibly across Prospect Park Hospital.

The Chief Executive commented that although the ban on using agency Health Care Assistants had been successfully implemented and that safe staffing had been achieved by moving staff around, the Clinical Director of In-Patient Services at Prospect Park Hospital had fed back that some staff were unhappy about the changes, and that it was important to recognise that it would take time for the changes to be embedded.

The Director of Nursing and Governance reported that the Trust had held a recruitment day yesterday with 27 interviews for band 1-2 posts.

The Director of Corporate Affairs said that the Trust was planning to do more cohort recruitment at fixed times during the year. It was noted that cohort recruitment was popular with new recruits and it also enabled to the Trust to provide an intensive induction programme tailored to the particular job role.

The Chief Executive said that recent research by NHS Providers had highlighted that the prolonged period of wage constraint in the NHS was particularly impacting on lower banded staff and that there was evidence that staff were leaving the NHS to find alternative work areas such as retail. It was noted that the re-development of the Bracknell Town Centre would create a significant number of new jobs and that this might impact on the Trust's ability to recruit and retain lower banded staff.

The Chair asked whether it was possible to offer an enhanced salary package. The Chief Executive said that although NHS foundation trusts were able to opt out of the national Agenda for Change pay system, those trusts who had explored this had experienced significant opposition from the unions.

The Chief Operating Officer said that one of the key selling points of the new Band 4 posts was that the Trust was offering a range of development opportunities for staff to progress

	through the Trust. **The Trust Board**: noted the report.
17/086	**Month 12 2016-17 Finance Report** (agenda item 8.1a)
	The month 12 financial summary report had been circulated. The Chief Financial Officer presented the paper and reported that the year-end position was a net surplus of £1.6m. Mark Lejman, Chair of the Finance, Investment and Performance Committee paid tribute to the work of the Trust in reducing the cost of agency staff over the year and for achieving cash balances of £20m. Mr Lejman said that he was pleased that the Trust had received an additional bonus from NHS Improvement for delivering the sustainability and transformation funding control total. Mr Lejman said that going into 2017-18, it would be important that the Trust reinvested in services and delivered its capital investment in the estate. Chris Fisher, Non-Executive Director suggested that the Trust needed to strategically review whether its bed base reflected the future needs of its population. The Chief Executive said that the last Finance, Investment and Performance Committee had discussed the issue in some detail and reported that the Trust would be commissioning a strategic review of the bed base later in the year once the Chief Operating Officer had completed his work around the Bed Optimisation project. **The Trust Board noted:** the following summary of financial performance and results for Month 12 2016/17. The "use of resource" metric came into effect from 1 October 2016. A rating of 1 is the highest rating possible with 4 being the lowest. The metric incorporates visibility on agency control. **Year to Date (Use of Resource) metric:** • Rating 2 (plan 2) o Capital Service Cover 2.19 (rating 2) o Liquidity metric 5.20 (rating 1) o Income and Expenditure Margin 0.61% (rating 2) o Income and Expenditure Variance 0.38% (rating 1) o Agency 17.45% (rating 2) **Year to Date income and expenditure** (including sustainability and transformation funding): • Plan: £514k net surplus • Actual: £1,608k net surplus • Variance: £1,094k favourable **Month 12: -£105k deficit (including sustainability and transformation funding) +£74k variance from plan:** Key variances: • CQUIN provision increase: -£525k net increase for re-provisioning for 2016/17; • CIPs: -£188k pay savings lower in month 12 by c£125k;

	• Short term overspill: -£158k; - principally due to 19 acute/psychiatric intensive care unit placements required due to bed pressures; • Independent Hospital Placements: -£30k due to observations in budgeted placements and new additional placements; • Westcall: -£77k due to continued high spend on locums; • Mental Health Inpatients: -£95k – net pay spend in month largely due to vacancy cover and observations. To assure sustainability and transformation funding, £577k of cash reserves was released in month. The Trust achieved £776k sustainability and transformation funding and £136k sustainability and transformation "match" funding. The in-month underlying position, excluding sustainability and transformation funding is: -£1,170k deficit. **Cash**: Month 12: £20.7m (plan £17.8m) The variance to plan was primarily due to an underspend in the Capital Plan and re-profiling to 2017-18 (£2.7m); receipt of £0.5m from the Royal Berkshire NHS Foundation Trust; and a receipt from Health Education England of £0.4m. **Capital expenditure**: Month 12: £3.1m (plan £5.8m)
17/087	**Month 12 2016/17 Performance Report** (agenda item 8.2)
	The Month 12 2016/17 Performance Summary Scorecard and detailed Trust Performance Report had been circulated. It was noted that the "People" and "Contractual" Performance indicator groupings were RAG rated as "amber" and Service Efficiency and Effectiveness was RAG rated as "red". Mark Lejman, Chair of the Finance, Investment and Performance Committee reported that the Committee had reviewed the month 12 performance report in detail and commented that the addition of the trend lines in the report was helpful in tracking performance. Chris Fisher, Non-Executive Director referred to page 194 of the agenda pack and commented that NHS England had asked the Clinical Commissioning Groups to reduce out of area placements with a view to their elimination by 2020-2121 and asked whether there was a joint plan between the Commissioners and the Trust to achieve this target. The Chief Financial Officer said that the Commissioners were required to report to NHS England on their plans to reduce out of area placements. Mehmuda Mian, Non-Executive Director referred to page 195 of the agenda pack and commented that attendances at Slough Walk In Centre had increased this month and the use of the Place of Safety had also increased. The Chief Executive said that the Trust would monitor the use of the Place of Safety over the next six months and would report back to the Trust Board if there was a significant increase in the use of the Place of Safety. **Action: Chief Operating Officer**

	The Chief Executive said that there would be discussion about the Slough Walk in Centre later today as part of the In Committee meeting. **The Trust Board**: noted the month 12 2016/17 Trust performance report.
17/088	**Finance, Investment and Performance Committee – 26 April 2017** (agenda item 8.3)
	Mark Lejman, Chair of the Finance, Investment and Performance Committee reported that in addition to the standing items, the Finance, Investment and Performance Committee meeting in April 2017 had discussed the following key issues: • The year-end financial position including the additional sustainability and transformation funding. • Six monthly safe staffing report as well as the monthly safe staffing report – the Committee had noted that although safe staffing on the wards had been achieved, the high use of temporary staff was sub-optimal. • An update on the bed optimisation programme – the Committee had discussed the plans that had been put in place to manage the bed pressures, including daily (and twice daily during periods of high demand) multi agency bed calls. The Chair thanked the Chair of the Finance, Investment and Performance Committee for his update.
17/089	**Strategy Implementation Plan 2017-18** (agenda item 9.1)
	The Director of Corporate Affairs presented the report and highlighted the following points: • Significant progress had been made towards the achievement of the Trust's strategic aims during 2016-17; • The Strategic Implementation Plans for 2017-18 were framed around the refreshed four strategic goals. The Plans represented a comprehensive and stretching set of initiatives which focused on providing services which were safe, highly regarded by the people who accessed them and achieved good or outstanding Care Quality Commission ratings whilst continuing to deliver significant improvements to productivity, particularly in the use of digital technology. • The Strategy Implementation Plan would also be used to monitor the Trust's progress in meeting its strategic goals during 2017-18 through bi-monthly reports to the Business and Strategy Executive and three progress reports to the Trust Board. The Chair said that as part of the Quality Improvement programme the Trust would build upon the Vision Metrics and would aim to simplify the overall planning process. Mark Day, Non-Executive Director asked for more information about the "estates enabling our people programme". The Chief Financial Officer said that this programme aimed to provide a consistent offer in terms of the working environment. **The Trust Board**: noted the report.
17/090	**Mental Health Strategy Update Report** (agenda item 9.2)
	The Director of Corporate Affairs reported that the paper set out the progress against the key priorities within the Mental Health Strategy approved by the Trust Board in December 2016. The Chief Executive said that it would be helpful if future reports set out an estimate of the

	Trust's contribution to meeting national targets, for example, reducing the number of suicides and providing perinatal services based on its population size. **Action: Director of Corporate Affairs** The Chair reported that he had sat in on the suicide prevention training for Prospect Park Hospital staff which had included role playing by actors. The Chair said that the training had been emotionally engaging and effective in raising awareness. The Chief Executive said that it would be helpful to include a discussion at the October 2017 Trust Board Away Day about whether community services which represented 50% of the Trust's business received sufficient focus. It was noted that the national focus on mental health had meant that there was a mandated direction of travel but this was not the case of community services. The Chair said that it was important that the Trust addressed issues such as unwarranted variation which led to inefficiencies in Community Services across the different localities. The Company Secretary agreed to add a discussion around community services to the agenda of the October 2017 Trust Board Away Day. **Action: Company Secretary** **The Trust Board**: noted the report.
17/091	**Annual Report 2016-17 (agenda item 10.1)**
	The draft Annual Report 2016-17 had been circulated. It was noted that the Audit Committee on 24 May 2017 would approve the final accounts on behalf of the Trust Boards. The Chief Executive asked members of the Committee to forward any corrections to the Annual Report to the Company Secretary. The Trust Board: a) Approved the draft Annual Report for submission subject to any final necessary additions and amendments; b) Delegated authority to the Chair and Chief Executive to give Trust Board approval to the final document in the light of the timetable for submission to NHS Improvement.
17/092	**NHS Improvement Board Declarations** (agenda item 10.2)
	The Trust Board considered the certifications in support of the 2017/18 Licence condition compliance assurance process outlined by NHS Improvement. **The Trust Board**: Confirmed the positive assurance statements attached with the report in relation to the provider licence conditions (General Condition 6, Continuity of Services Condition 7, Corporate Governance Statement Condition 4 and Certification on training of governors) and approved the signing of the Statements by the Chair and Chief Executive.
17/093	**Audit Committee Minutes – 26 April 2016**
	The minutes of the Audit Committee held on 26 April 2017 had been circulated. Chris Fisher, Chair of the Audit Committee reported that next Audit Committee meeting on

	24 May 2016 would approve the Annual Accounts on behalf of the Trust Board. Mr Fisher proposed that the Trust Board approve the appointment of Mark Day, Non-Executive Director to the Committee to deputise for Mehmuda Mian, Non-Executive Director who would be on annual leave for the meeting. Mr Fisher reported that the Audit Committee meeting on 26 April 2017 had discussed the following issues in addition to the standing items on the agenda: • The Committee's work plan was updated to include "Deep Dives" into individual risks on the Board Assurance Framework; • The July 2017 meeting would discuss the systems and processes around learning from serious incidents, whistleblowing concerns etc; • The Committee had requested further information about the Apprenticeship Levy; • The governance arrangement in relation to the Global Mental Health Digital Exemplar funds was discussed and it was agreed that a copy of the Trust's bid which set out the proposed governance arrangements be circulated to members of the Trust Board; • During the discussion about an internal audit report on localities undertaken in September 2016, the Committee had raised a concern about the levels of compliance with mandatory fire training in respect of Daisy Ward, Prospect Park Hospital; • Members of the Committee held a short private meeting with KPMG, the Trust's External Auditors after the formal business of the meeting. It was noted that the Trust's new External Auditors would be Deloittes. Ruth Lysons, Non-Executive Director reported that the Finance, Investment and Performance Committee received monthly updates on mandatory training compliance and were assured that the compliance rate was increasing. The Chief Operating Officer agreed to forward the end of year mandatory fire training compliance rate for each of the Trust's ward. **Action: Chief Operating Officer** The Trust Board: a) Approved that Mark Day, Non-Executive Director be appointed as a member of the Audit Committee for the meeting on 24 May 2017 to deputise for Mehmuda Mian, Non-Executive Director; b) Noted the minutes of the Audit Committee on 26 April 2017.
17/094	**Council of Governors – Update** (agenda item 10.3)
	The Chair reported that there was a meeting of the Council of Governors Appointments and Remuneration Committee on 18 May 2017 to discuss the recruitment process for a new Non-Executive Director to replace Mark Lejman whose term of office would expire in December 2017. It was noted that the Committee would also consider the re-appointment of Chris Fisher, Non-Executive Director. The Chair reported that following the feedback from the Council of Governors' effectiveness questionnaire and the discussion at the last Joint Trust Board and Council of Governors meeting, he and the Company Secretary had drafted some proposals to change the current Council of Governors' meeting structure and to increase the opportunities for Governors to interact with Non-Executive Directors. The Chair reported that the draft proposals had been discussed with the Lead Governor and there was a meeting later in the month with the Lead and Deputy Lead Governors and the Chairs and Co-Chairs of the Governor Working Groups,

	The Trust Board: thanked the Chair for his update.
	Use of the Trust Seal (agenda item 10.4)
	The Chief Financial Officer reported that the Trust Seal had been affixed to a five year lease between the Thames Valley Science Park Ltd and BHFT relating to part of the Science and Technology Centre, University of Reading, Whiteknights, Reading. It was noted that the lease would enable the Children and Young People's Integrated Therapies Team to be decanted from their current offices to Cremyll Road, Reading temporarily and moving back following refurbishment of the offices by the University of Reading. **The Trust Board**: noted the use of the Trust Seal.
17/095	**Any Other Business** (agenda item 11)
	There was no other business.
	The Chair concluded the meeting and thanked the observers for attending.
17/096	**Date of Next Meeting** (agenda item 12)
	11 July 2017
17/097	**CONFIDENTIAL ISSUES:** (agenda item 13)
	The Board resolved to exclude press and public from the remainder of the meeting on the basis that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted.

I certify that this is a true, accurate and complete set of the Minutes of the business conducted at the Trust Board meeting held on 09 May 2017.

Signed……Date……
(Martin Earwicker, Chair)

Berkshire Healthcare NHS
NHS Foundation Trust

AGENDA ITEM 5.2

BOARD OF DIRECTORS MEETING: 11/07/2017

Board Meeting Matters Arising Log – 2017 – 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	Status
14.02.17	*17/009*	Guardians of Safe Working Hours	The Medical Director and the Director of Nursing and Governance to provide a summary of the key messages from the annual student satisfaction survey as part of the Executive Report when the report was published later in the year.	12.09.17	**MI/HM**	On the agenda for the September TB meeting.
11.04.17	*17/049*	Quality Assurance Committee – 21 February 2017	An update on the use of prone restraint to be presented to the August 2017 Quality Assurance Committee meeting.	15.08.17	**HM**	
11.04.17	*17/053*	Financial Plan	The Finance, Performance and Investment Committee to discuss NHS England's commissioning intentions in relation to the Berkshire Adolescent Unit.	26.06.17	**DT**	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Status
11.04.17	17/057	Workforce Implementation Plan	The next update report to identify the initiatives aimed at specific staff groups together with the impact of the actions taken.	12.12.17	**BS**	
09.05.17	17/083	Patient Experience Report	The Trust Board's positive comments about the format of the report and in particular, the consistency of the graphs to be fed back to the Head of Engagement and Service User Experience	11.07.17	**HM/JH**	Completed
09.05.17	17/083	Patient Experience Report	In future reports, all wards to be included in the ward breakdown of the Friends and Family Test even if there was a nil return.	12.07.17	**HM**	
09.05.17	17/087	Month 12 Performance Report	The use of the Place of Safety to be monitored over the next six months and a report to be presented to the Trust Board if there was a significant increase in its use.	14.11.17	**DT**	
09.05.17	17/090	Mental Health Strategy	Future reports to include an estimate of the Trust's contribution to meeting national targets, eg reducing the number of suicides and providing perinatal services based on its population size.	14.11.17	**BS**	
09.05.17	17/090	Mental Health Strategy	The balance between mental health services and community services to be	10.10.17	**JH**	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Status
			added to the agenda of the Trust Board's Away Day in October 2017.			
09.05.17	17/093	Audit Committee minutes – Mandatory Fire Training	The end of the financial year mandatory fire training compliance rate for each of the wards to be forwarded to members of the Trust Board.	11.07.17	**DT**	An email was circulated to the Trust Board on 31 May 2017. The fire training compliance rates as at 29 May 2017 at set out at appendix 1.

Appendix 1

Figures and details below are from the Fire training compliance report for 29th May 2017

Ward	Number of permanent staff	% Fire Safety statutory training compliance
Bluebell	24	91.67
Snowdrop	21	95.24
Sorrell	20	85.00
Rose	28	92.86
Orchid	22	90.91
Daisy	24	95.83
Rowan	26	96.15

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	11 July 2017
Title	**Quality Board Visit Report – Snowdrop Ward: Prospect Park Hospital**
Purpose	To receive the report of the Quality Board Visit undertaken by Ruth Lysons, Non-Executive Director
Business Area	Corporate
Author	Company Secretary
Relevant Strategic Objectives	1. To provide safe services, good outcomes and good experience of treatment and care
CQC Registration/Patient Care Impacts	Providing additional Board level assurance on patient safety and quality of care
Resource Impacts	None
Legal Implications	None
SUMMARY	Board members conduct Quality Visits to Trust services and Localities throughout the year and reports are produced which are circulated to all Board members for information. At regular intervals during the year, a Board Quality Visit report is selected for inclusion on the agenda for discussion.
ACTION REQUIRED	To receive and note the report and discuss any matters raised.

Berkshire Healthcare NHS
NHS Foundation Trust

BERKSHIRE HEALTHCARE BOARD QUALITY VISIT TO SNOWDROP

WARD, Prospect Park Hospital, 5 June 2017.

People participating:
Ruth Lysons, NED
Alex Afoakwah, Ward Manager
Michelle Mbayiwa, Senior Nurse

Introduction

I was met at the Hospital reception by Michelle, who took me to her office and gave me a general overview before introducing me to Alex, who took me down to Snowdrop ward. On the day I visited, Michelle told me that there were no free beds at Prospect Park Hospital (PPH), and so the daily conference call, due later that morning, was going to be particularly challenging.

The call involves the Community Mental Health teams from all 6 localities, the Crisis team (which is responsible for bed requests) as well as Michelle from PPH, and a number of other senior managers, often including the Director, David Townsend. During the call they discuss patients' discharge plans, whether they can be looked after in the Community and if not, whether an Out of area placement is required. I asked whether increasing the number of Wards at PPH would help to ease the situation, but Michelle and Cris Spring (who shares the office with Michelle) told me that this is not a practical option since they would not be able to staff it adequately. Cris also felt that an increase in the number of beds would lead to a reduction in stringency of admission criteria, so that any extra beds would be rapidly filled.

The work of Snowdrop Ward

- **The Clientele.** This is an acute adult Mental Health ward with 22 beds (though a programme of routine maintenance means that the capacity is currently 21 beds). The team cares for male and female patients suffering from varied Mental Health problems, some of whom are voluntary whilst others are detained under the Mental Health Act. They are admitted for assessment of their health and housing needs, and this enables a care plan to be developed for them. Most patients are between 18 and 75 years of age. Occasionally, if there are no beds in the Berkshire Adolescent Unit, 16–18 year olds are cared for on Snowdrop ward, on an interim basis whilst an age-appropriate bed is sought. They have a dedicated member of staff with them at all times, and have frequent (Level 2) nursing observations to provide safeguarding.
- **The Ward.** The ward was busy but calm and clean when I visited. Alex showed me around, highlighting the clinic room (used for medical assessments & emergencies), the de-escalation room, the activity room, patient kitchen, laundry, separate male and female lounges and the enclosed gardens, one of which has been newly planted. The bedrooms have a flexible "lock-off" system to permit varying numbers of male

and female patients to be appropriately accommodated. All rooms were in use, but most patients were in the communal sitting area, or walking around the corridors, when I visited.

- **The service.** The ward provides medical and nursing care, and administers medication, psychological and occupational health therapies. Various activities are time-tabled for patients, including access to the Gym and Therapy Centre, which are shared between the wards in PPH. Psychological treatments include mindfulness, relaxation and cognitive behavioural therapies. In addition, each Mental Health ward takes turns to staff the PPH Places of Safety (PoS). Under a recent initiative, dedicated staffing for the PoS is now in place between 12 noon and 07:00 am to relieve some of this pressure on the wards.

- **The team.** The ward has a multidisciplinary team comprising:
    - 1 x Ward manager (Alex)
    - Doctors (2 Consultants and 2 or 3 junior doctors)
    - 4 x Band 6 nurses (including the new "Clinical Lead" post and 1 vacancy expected to be filled in August,
    - 10 x Band 5 nurses (currently 4 of these are vacancies, but 3 students have been recruited to start in November)
    - 3 x new Band 4 posts supporting the Band 5 nurses
    - 7 x Band 2 healthcare assistants (currently 4 vacancies, but 4 have been recruited)
    - 1.5 x psychologists and 2 occupational health therapists (one vacancy), line-managed separately by the Therapy team.

Observations and Discussion points

- **Recruitment difficulties and staff complement.** Alex told me that maintaining staffing levels has been a persistent and time-consuming challenge. The situation is looking more promising now, but there have been previous occasions when newly recruited staff have failed to materialise due to other opportunities, and so this remains a concern. Alex emphasised the importance he attached to ensuring that staff are well supported. There are regular Space groups facilitated by the Clinical Nurse Specialist for reflective learning and peer support, as well as regular staff meetings, Case discussions and "post-incident" review meetings. Nevertheless shortage of qualified nurses remains an issue for which there is no obvious "quick fix".
- **Length of Stay.** Alex felt that longer stays tended to reflect patients with complex problems, where there is difficulty identifying and securing funding for care packages which meet their needs. He cited a recent case of a patient with uncertain immigration status, where there were extensive discussions about how his future care would be paid for and whether he was eligible for public funding. Clearly, unnecessarily long stays are bad for the patient, as well as adding to the pressures on beds.
- **Absconsions.** Alex said there had been 6 patients this year who had left the ward with permission, but had then failed to return. All had been retrieved without tragic consequences. Such an incident occurred during my visit, when a patient refused to

return from the local shopping centre, and a member of staff went out to retrieve them.

- **Fire.** A patient used a cigarette lighter to set a fire in their bedroom this year. Fortunately this was discovered and extinguished very quickly by nursing staff. Alex expressed concern that smuggling of cigarette lighters and cigarettes by patients is a real risk. He told me that patients are interviewed and can be checked by metal detector on admission to the ward and after every absence, in addition to random searches. Where staff remain concerned, patients may be placed on level 2 observations, which can lead to resentment and aggression towards staff. Alex explained that some patients have concealed lighters in their underwear or body cavities, which makes it extremely difficult. In addition, patients have used the hob or toaster in the patient kitchen to light cigarettes, which is a further hazard.

Conclusion

I visited Snowdrop Ward on a busy day when all its beds were fully occupied. As with the other wards in PPH, there is a considerable challenge in ensuring that sufficient beds are available to meet requirements. Alex felt that on Snowdrop ward the main issue was the management of length of stay. This tended to become extended due to increasing difficulty with the funding of onward placements for patients requiring complex care packages. Difficulties recruiting Band 5 nurses are a continuing problem, but the initiative to increase complement of Band 6 nurses and the creation of Band 4 staff was welcomed by Alex. In regard to the physical environment, the ward appeared clean and well managed.

The issue of fire-setting and the risks from smuggled cigarettes and lighters is difficult. Alex and I discussed whether installation of cameras might be of assistance. Whilst it is clear that patient privacy and dignity must be preserved, it does lead to the question of whether cameras might assist with patient and staff safety, if installed selectively, possibly for example, in the patient kitchen.

I was very pleased when I asked Alex, to hear that he enjoys his work, in spite of finding it stressful at times. He told me that he feels well supported by his manager and had found working for BHFT to be a positive experience.

I should like to thank Alex and Michelle for their time with me, and more importantly, for the expertise and dedication they demonstrate to try and ensure the best possible outcomes for BHFT patients. Both of them made me feel welcome and answered my questions fully and willingly.

Ruth Lysons 10 June 2017.

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	11 July 2017
Title	**Quality Assurance Committee – 19 May 2017**
Purpose	To receive the unconfirmed minutes of the meeting of the Quality Assurance Committee of 19 May 2017 and to ratify changes to the Committee's Terms of Reference
Business Area	Corporate
Author	Company Secretary for Ruth Lysons, Committee Chair
Relevant Strategic Objectives	1. To provide safe services, good outcomes and good experience of care
CQC Registration/Patient Care Impacts	Supports ongoing registration
Resource Impacts	None
Legal Implications	Meeting requirements of terms of reference.
SUMMARY	The unconfirmed minutes of the Quality Assurance Committee meeting held on 19 May 2017 are provided for information. The Committee's Terms of Reference with proposed changes (shown in red type) are also attached for ratification.
ACTION REQUIRED	The Trust Board is requested to: a) To receive the minutes and to seek any clarification on issues covered. b) To ratify the proposed changes to the Committee's Terms of Reference as shown in red type.

Berkshire Healthcare NHS
NHS Foundation Trust

Unconfirmed

Minutes of the Quality Assurance Committee Meeting held on Friday, 19 May 2017, Fitzwilliam House, Bracknell

Present:	Ruth Lysons, Non-Executive Director (Chair) David Buckle, Non-Executive Director Julian Emms, Chief Executive Minoo Irani, Medical Director Helen Mackenzie, Director of Nursing and Governance Amanda Mollett, Head of Clinical Effectiveness and Audit
In attendance:	Martin Earwicker, Trust Chair Julie Hill, Company Secretary Sue McLaughlin, Locality Clinical Director *(present for agenda item 5.1)*

1 Apologies for absence and welcome

Apologies had been received from: Mehmuda Mian, Non-Executive Director and David Townsend, Chief Operating Officer.

The Chair welcomed everyone to the meeting and in particular welcomed Sue McLaughlin, Locality Clinical Director and Lead for the Zero Suicide Project and Martin Earwicker, Trust Chairman.

2. Declaration of Any Other Business

There were no items of Any Other Business.

3. Declarations of Interest

There were no declarations of interest.

4.1 Minutes of the Meeting held on 14 February 2017

The minutes of the meeting held on 14 February 2017 were confirmed as an accurate record.

4.2 Matters Arising Log

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

Quality Account Waiting Times – the Head of Clinical Effectiveness and Audit reported that the waiting time figures were correct in the draft Quality Accounts report, but the section had been revised in the final document to highlight that although waiting times were longer than the Trust would want, waiting times had been reduced.

The Chair asked whether there was any further action the Trust could take to improve waiting times.

The Medical Director said that waiting times were closely monitored and were reported to the Trust Board and to the Finance, Investment and Performance Committee as part of the Performance Assurance Framework Report. The Medical Director reported that overall waiting times had improved and although there continued to be particularly long waits for ADHD and ASD diagnoses.

The Chief Executive said that it would be helpful for the Committee to receive a paper to the next meeting on CAMHS waiting times which set out the waiting times trajectory and the increased referral rates.

Action: Chief Operating Officer

David Buckle, Non-Executive Director asked whether the Trust could make a case to the Commissioners for more funding to reduce CAMHS waiting times. The Chief Executive commented that resources were tight and that if additional money was diverted to improve CAMHS waiting times, this would reduce the amount of money for other services.

The Medical Director said that he was not in favour of diverting money from other Child and Adolescent Mental Health services and pointed out that the waiting time was in relation to getting a diagnosis and stressed that the Trust was very responsive to providing urgent treatment for serious mental health conditions such as depression.

The Committee noted the schedule of actions.

5. Patient Safety and Experience

5.1 Zero Suicide Project Update Presentation

The Chair welcomed and introduced Sue McLaughlin, Locality Clinical Director and lead for the Zero Suicide Project.

Sue McLaughlin gave a presentation on the Zero Suicide Project and highlighted the following points:

- The Trust had started the Zero Suicide Project a year ago and it was based on a model initially developed in Detroit, United States and adopted by Mersey Care NHS Foundation Trust.
- The core propositions for the Trust's Zero Suicide Project were:
  - Suicide deaths for people under mental health care can be prevented;
  - The organisational aspiration should always be zero suicides;
  - Quality improvement methodologies should inform system change.
- The four priorities identified to achieve the vision were: leadership; optimising systems (for example, RiO, data and audit); training; and support for service users and their families and staff).
- The Trust had developed a comprehensive training package for staff. The content and course materials had been co-produced with service users and carers.
- The aim of the training was to develop staff skills and confidence in identifying and working with suicidal patients. Counselling, clinical supervision and reflective peer review were available to support staff affected by a suicide.

- The Trust had developed an approach to risk management which included moving away from a tick box and check list approach to using a RiO risk assessment, management and safety plan all in one place which put service users and carers at the centre.
- A recent audit of the risk management tool had highlighted that more work was needed to embed the new risk management system.
- All the actions and interventions which formed part of the Zero Suicide Project would be vigorously measured to provide assurance that the actions and interventions put in place were having an impact.

The Trust Chair asked about the timescales for the Zero Suicide Project. Sue McLaughlin said that the one of the key performance indicator targets was that 80% of patients would have a safety plan in place by December 2017. It was noted that service users needed to want to have a safety plan.

It was noted that the Five Year Forward View for Mental Health included a national reduction target in the number of suicide of 10% by 2020.

David Buckle, Non-Executive Director asked which patients were included in the Trust's Zero Suicide Project. Sue McLaughlin said that the scope of the project was all patients who received mental health services from the Trust.

The Chair asked whether patients who used the Talking Therapies Service were included in the scope of the project. Sue McLaughlin said that a lot of the practice and training was shared with the Talking Therapies Service but at the moment patients who used the Talking Therapies Service were outside the scope of the project.

On behalf of the Committee, the Chair thanked Sue McLaughlin for her presentation.

5.2 Quality Concerns Status Report

The Director of Nursing and Governance reported that one new concern had been added since the last meeting: Slough Walk-in Centre which was due to patient and staff safety risks.

It was noted that three concerns had been removed as action plans had been successfully implemented and outcomes achieved (Daisy Ward; Berkshire Adolescent Unit; and CQC compliance concerns with learning disabilities and mental health inpatients and Berkshire Adolescent Unit).

The Director of Nursing and Governance reminded the meeting that the quality concerns in relation to the Slough Walk-in Centre had been discussed at the May 2017 Trust Board meeting.

The Director of Nursing and Governance reported that following the meeting, the Trust had met with the Commissioners to discuss the Slough Walk-in Centre and the Trust had agreed to continue to run the service until the end of August 2017 and to support the Commissioners in developing a transition plan for the service. It was likely that the Slough Walk-in Centre would be co-located as part of the Accident and Emergency Department which would reflect the national direction of travel.

The Chief Executive pointed out that there were currently two services co-located: the Slough Walk-in Centre and a GP practice. The Director of Nursing and Governance said that the GP practice was working well and

there were no plans to stop running the service in the near future. The Chief Executive said that in the longer term, the Trust would work with the Commissioners to transfer the GP Practice to another provider.

It was noted that the Commissioners would not make any public announcement regarding the Slough Walk-in Centre until after the General Election in accordance with the pre-election "purdah" rules.

The Director of Nursing and Governance reported that she had added medical staff to the staff vacancy concerns at Prospect Park Hospital in view of the high number of locum doctors.

The Chair asked whether the review by the Royal College of Psychiatrists had made any useful recommendations on how to mitigate the risk around the national shortage of Psychiatrists.

The Medical Director said that the Trust had implemented the recommendations and was reviewing a number of additional options, for example, split posts etc. The Medical Director said that it was important to note that the locum doctors were fully trained and qualified and that the risk in using locum doctors was around reducing ward leadership capacity and not in terms of patient safety.

The Director of Nursing and Governance reported that during the Easter period following the departure of two interim managers on Campion Ward, the Trust in consultation with the University of Hertfordshire agreed not to place students on the Unit because there would not be any senior managers present. It was noted that from 15 May 2017 students were back on the Campion Unit.

The Trust Chair asked what steps the Trust was taking to manage the staffing situation on the Campion Unit. The Director of Nursing and Governance said that the Clinical Director had developed a plan to mitigate the risk and the plan was monitored on a weekly basis and in addition, a Nurse Consultant was providing additional leadership support.

The Chair said that she was concerned about the administration of the Mental Health Act Manger hearings. The Director of Nursing and Governance said that Andrew Burgess, Deputy Director of Nursing was working closely with the interim Clinical Director for Mental Health Inpatient Services to resolve the issues.

5.3 Board Assurance Framework (Risk 1, 2 and 5)

The Committee reviewed the quality related risks. It was noted that responsibility for overseeing risk 1 (workforce) was now shared with the Finance, Investment and Performance Committee.

The Committee made the following comments:

Risk 1 (workforce)
It was noted that there was a paper on Return to Practice elsewhere on the agenda.

The Chair suggested adding an action to reflect the Trust's work in supporting the University of Reading's bid for a medical school.

Action: Director of Nursing and Governance

Risk 2 (involving clinicians and patients)
It was agreed that the Zero Suicide Project should be listed in the assurance section as the work involves clinicians and patients at every stage.

Action: Director of Nursing and Governance

Risk 5 (clinical standards)
The Chair asked whether in view of the positive outcome of the Care Quality Commission re-inspection the risk rating should be reduced. The Director of Nursing and Governance agreed to review the risk rating.

Action: Director of Nursing and Governance

5.4 Serious Incidents Report – Quarter 4

The Quarter 4 Serious Incident Report had been circulated.

The Chair said that the report was particularly helpful in identifying the trends, themes and learning from serious incidents.

The Chair asked about the links between the serious incident investigation process and the mortality review process. The Medical Director explained that Debbie Fulton, Deputy Director of Nursing managed the serious incident investigation process and said that the Trust's mortality review process looked at all deaths. It was noted that some deaths which were initially flagged as serious incidents were downgraded if it was found that the person had died from natural causes.

The Committee noted the report.

5.5 Sorrel Ward Absconsion Serious Incident – Action Plan Update

An update on the action plan in response to the Sorrel Ward Absconsion Serious Incident had been circulated.

The Director of Nursing and Governance said that all actions had been completed on the action plan with the exception of two staffing related actions relating to building a consistent and effective multidisciplinary clinical leadership team for the ward (rated as Amber) and recruiting permanent staff to Sorrel Ward, including initiatives such as the skill and professional mix where safe and appropriate to do so (rated as Red).

The Director of Nursing and Governance said that the Trust recently held a couple of successful recruitment days and that the staffing situation at Prospect Park Hospital was moving in the right direction.

The Committee noted the report

5.6 Return to Practice Scheme Report

The Director of Nursing and Governance presented a paper which set out the progress in relation to the Trust's return to practice campaign.

David Buckle, Non-Executive Director said that it was a helpful report but said that he was disappointed by the low numbers returning to practice following the national campaign.

The Director of Nursing and Governance said that the Trust had a small team responsible for recruiting registered staff and it was important that those staff

focussed their efforts on the initiatives which were likely to be successful in recruiting the largest number of staff.

The Chair asked whether the Nursing and Midwifery Council would share the contact details of registered staff whose registration had lapsed. The Director of Nursing and Governance said that this was unlikely because of data protection.

The Chair asked whether the Trust could be more proactive around contacting those staff who had decided not to return to work after their maternity leave to see if they could be encouraged back into the workforce.

The Director of Nursing and Governance said she would find out what was involved in doing this and if it was practicable, she would ask the team to progress this.

Action: Director of Nursing and Governance

The Committee noted the report.

Clinical Effectiveness and Outcomes

6.1 Quality Accounts Report 2016-17

The Committee noted that the Trust Board meeting on 9 May 2017 had approved the final Quality Accounts 2016-17.

6.2 Clinical Audit Reports

i) Monitoring of Patients Prescribed Lithium

The Head of Clinical Effectiveness and Audit presented the report and said that following the audit, the shared care agreement between the Trust and Primary Care had been updated to include the new standards for monitoring serum calcium and the responsibility of Primary Care to undertake the monitoring.

David Buckle, Non-Executive Director asked whether the Clinical Audit Team was liaising with the Medicines Optimisation Team about the monitoring of lithium. The Head of Clinical Effectiveness and Audit confirmed that this was the case.

David Buckle, Non-Executive Director agreed to email the Primary Care Clinical Lead for the DXS system to see if they were aware of the update to the Shared Care agreement in relation to the monitoring of patients prescribed lithium.

Action: David Buckle

ii) Slough Walk-In Centre

The Head of Clinical Effectiveness and Audit presented the report and explained that the audit concerned the GP Practice and not the Walk-in element of the Slough Walk-in Centre. It was noted that the Committee had requested a local re-audit following the outcome of the last national primary care diabetes clinical audit.

The Committee expressed disappointment that 11 areas showed a decline in compliance levels with 7 of these relating to documentation.

It was noted that the Trust had developed an action plan in response to the clinical audit findings. The next national clinical audit was due to take place in July 2017.

iii) Mental Capacity Assessment Audit

The Head of Clinical Effectiveness and Audit presented the report and said that the clinical audit demonstrated that there was a good understanding of the Mental Capacity Act across the Trust and its use was becoming embedded within the Mental Health Inpatient Unit.

It was noted that within community physical health wards, there was understanding of patient consent but the use of the Mental Capacity Act within wider decision making was not implemented in the majority of incidents. In addition, when it was implemented, the documentation of the assessments was poor.

David Buckle, Non-Executive Director asked about the process for deciding which audits would be reported the Committee. The Head of Clinical Audit and Effectiveness explained that the Committee received the clinical audit reports of the priority 1 and 2 audits on the quality schedule and any local audits.

The Committee noted the report.

Corporate Governance

7. Quality Assurance Committee Annual Review of Effectiveness

The Company Secretary presented the report and said that the outcome of the annual review of the Committee's effectiveness was very positive with only a few areas identified for further improvement.

The Company Secretary said that one of the areas identified for improvement concerned inducting new members into the work of the Committee. The Company Secretary said that she would take responsibility for ensuring that new members received an appropriate induction.

The Chair said that she had taken on board the comments relating to the chairing of the Committee but pointed out that as a Non-Executive Director she did not have the same knowledge as the Executive Directors and therefore needed to ask questions in order to clarify particular issues.

David Buckle, Non-Executive Director said that there was an understandable tension between Executive Directors who were steeped in the operations of the Trust and Non-Executive Directors who wanted more background information.

The Company Secretary said that following the feedback, she had reordered the agenda so that the items for discussion were placed at the start of the meeting and the information items were at the end.

The Director of Nursing and Governance said that the reordering of the agenda was helpful and would ensure that if meetings did overrun, the Committee was not rushing to discuss the key items at the end.

The Chief Executive said that Executive Directors could help the Committee by making sure that the report front sheets contained a clear summary of the report and set out what action was expected of the Committee.

The Chair echoed the Chief Executive's comments about the quality of some of the report cover sheets and said that it was reasonable to expect that there would be occasions when a Non-Executive Director wanted to "turn over a stone" and delve into an issue in more detail.

The Committee reviewed the Terms of Reference and the proposed changes by the Company Secretary highlighted in red type. It was agreed that the purpose section of the terms of reference should be amended to include staffing issues. It was also agreed that the duties of the Committee should be amended to include the Committee's responsibility for endorsing the criteria for the scope of the Trust's mortality review process. The Company Secretary agreed to revise the Terms of Reference which would be submitted to the Trust Board for ratification.

Action: Company Secretary

The Committee:

a) Noted the results of the annual review of effectiveness; and

b) Approved the proposed changes to the Committee's Terms of Reference which would be further amended as above.

Update Items for Information

8.1 Guardians of Safe Working Quarterly Report

The Medical Director reported that one exception report was received in this quarter from a higher trainee who worked 3.45 additional hours on a shift to support patient safety.

The Committee noted the report.

8.2 Mortality Review Processes Update Report

The Medical Director reported following the publication of the National Guidance on Learning from Deaths (National Quality Board), the Trust had updated its mortality review systems and processes to reflect the guidance.

The Medical Director said that the national guidance recommended that from April 2017, Trusts should submit mortality review reports on a quarterly basis to the public Trust Board. It was noted that prior to the publication of the national guidance, the Trust Board had agreed that the Quality Assurance Committee would review the quarterly mortality review reports on its behalf.

The Committee agreed that the Quality Assurance Committee would continue to receive the quarterly mortality review reports and that the reports would then be submitted to the Trust Board along with the minutes of the meeting.

Action: Medical Director/Company Secretary

The Committee noted that with further national guidance specific to mental health trusts expected in the near future, the Trust may need to allocate additional resources to support the mortality review process.

The Medical Director reported that the Trust's internal auditors would be auditing the Trust's mortality governance process in the autumn of 2017 and

asked whether the Committee would also like to receive a copy of the Internal Auditor's report.

The Chief Executive said that the Audit Committee's minutes were presented to the Trust Board and suggested that if the Internal Auditors raised any issues of concern, the Auditors report together with the management response could be forward to the Committee.

Action: Medical Director

The Committee noted the report;

8.3 CQC Compliance Action Plan: Prospect Park Hospital Acute and Psychiatric Intensive Care Unit Wards

The Committee noted the report.

8.4 Quality Executive Committee Minutes – February 2017, March 2017 and April 2017

The minutes of the Quality Executive Committee meetings held on 13 February 2017, 13 March 2017 and 10 April 2017 were noted.

Closing Business

9. Standing Item – Horizon Scanning

The Chair asked whether it would be helpful to have a paper on clean air and the health impact of pollution at a future meeting. The Chief Executive said that the Trust's Annual Report included a section on sustainability and asked the Company Secretary to circulate a copy to members of the Committee.

Action: Company Secretary

The Chief Executive said that the Trust Board would need to consider whether reports on the impact of the Quality Improvement Programme would be submitted to the Quality Assurance Committee or to the Trust Board.

Action: Trust Chair

10. Any Other Business

There was no other business.

11. Date of the Next Meeting

15 August 2017

These minutes are an accurate record of the Quality Assurance Committee meeting held on 19 May 2017.

Signed:- _____

Date: - _____

Berkshire Healthcare NHS
NHS Foundation Trust

TRUST BOARD

Quality Assurance Committee

Terms of Reference

Purpose

This document describes the terms of reference for the Trust's Quality Committee, a standing Committee of the Board.

Document Control

Version	Date	Author	Comments
1.0	25.7.12	John Tonkin	Initial draft
2.0	31.7.12	John Tonkin	Amendments following Exec Discussion on 30 July 2012
3.0	20.8.12	John Tonkin	Amendments following Exec Discussion on 16 August 2012
4.0	11.9.12	John Tonkin	Post Board approval – 11 September 2012
5.0	5.4.14	John Tonkin	Post review with Director of Nursing & Governance
6.0	3.6.14	John Tonkin	For Board approval post QAC discussion 22 May 2014 APPROVED AT JUNE 2014 Board meeting
7.0	21.2.17	Julie Hill	Updated to include the Committee's new responsibilities in relation to receiving the Guardians of Safe Working reports and providing oversight of the Trust's mortality review process.

This document is unrestricted.

Distribution:

No restriction.

Document References

Document Title	Date	Published By

Quality Assurance Committee - Terms of Reference

1. Constitution

Berkshire Healthcare NHS Foundation Trust (BHFT) Board has established a Quality Assurance Committee which will act as a formal sub-committee of the Board with terms of reference as set out in this document and approved by the Trust Board.

2. Membership

The Committee's membership will comprise:

3 Non-Executive Directors
Chief Executive
Chief Operating Officer
Medical Director
Director of Nursing & Governance

The Lead Clinical Director will routinely attend Committee meetings and other directors and managers will attend meetings when requested by the Committee.

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The Board will nominate the Committee Chair from amongst the NED members of the Committee. In the Chair's absence, another NED will chair the Committee.

The Chair of the Quality Assurance Committee will be the designated Non-Executive Director with responsibility for providing oversight of the Trust's mortality review systems and processes.

The Lead Clinical Director will routinely attend Committee meetings and other directors and managers will attend meetings when requested by the Committee.

In order for the meeting to be quorate, 3 members must be present, including at least one NED and one Executive Director. The Board will approve any changes in membership and will approve any changes to these terms of reference.

3. Frequency of Meetings

The Committee will meet on not less than four occasions a year. The Chair may agree requests for additional meetings according to business requirements and urgency.

4. Purpose

The Quality Assurance Committee fulfils a scrutiny role on behalf of the Board on service quality. This will include, but not be restricted to, review of infection control performance, organisational learning from serious incidents, performance against quality priorities, CQC inspection reports,

~~and~~ Trust safeguarding assurance, quality concerns relating to staffing and mortality review systems and processes assurance.

- The Committee will also review any quality indicators as requested by the Trust Board
- Progress in implementing action plans to address shortcomings in the quality of services, should they be identified

The Quality Assurance Committee will provide assurance to the Trust Board as to the quality of service delivery with particular focus on the areas of patient safety, clinical effectiveness and patient experience. The Trust Board may request that the Quality Assurance Committee reviews specific issues where it requires additional assurance about the effectiveness of the governance, risk management and internal control systems in place relating to quality.

On behalf of the Trust Board, the Quality Assurance Committee will receive the update report from the Guardians of Safe Working and will report any issues of concern to the Trust Board.

The Quality Assurance Committee will also be responsible for reviewing, on behalf of the Trust Board, the quality improvement targets set in the annual plan and Quality Account. It will provide assurance to the Trust Board that improvement targets are based on achievable action plans to deliver them and that quality performance issues are followed up and acted on appropriately.

The Trust's Audit Committee will have overall responsibility for independently monitoring, reviewing and reporting to the Trust Board on all aspects of governance, risk management and internal control. On behalf of the Trust Board, the Audit Committee has overall responsibility for overseeing the Board Assurance Framework. The Quality Assurance Committee will be responsible for reviewing the quality related risks on the Board Assurance Committee. Any comments made by the Committee will be reported to the Audit Committee as part of the Board Assurance update report.

Section 5 of these terms of reference sets out the reporting arrangements which will support the Audit Committee in discharging this responsibility.

5. Reporting

The Quality Assurance Committee will receive ~~-~~exception reports covering issues escalated from the Executive quality governance process.

The minutes of the Quality Assurance Committee's meetings will be received by the Trust Board and the Chair of the Committee will provide an oral report to the next convenient Trust Board after each Committee meeting. The Chair of the Committee shall draw to the attention of the Trust Board any issues that require disclosure to the full Board.

The minutes of Quality Assurance Committee meetings will be included on the Audit Committee agenda for information and comment.~~-~~

6. Duties

a. Governance, internal control and risk management

To provide indepth scrutiny on behalf of the Trust Board of the delivery of high quality care through an effective system of governance in relation to clinical services.

b. Audit

To receive and review the findings of Internal and External Audit reports covering patient safety, quality and experience. If there is any perceived ambiguity regarding the relative roles of the Audit Committee and the Quality Assurance Committee in this respect, the committee chairs will liaise to agree a satisfactory approach. Through its reporting to the Audit Committee, the Quality Assurance Committee will ensure that the Audit Committee is informed of its work in this area

To review the annual Clinical Audit programme and receive assurances from Internal Audit, as necessary, regarding the effectiveness of the Trust's clinical audit function.

To receive ~~by exception~~ summary reports ~~details~~ of national clinical audits. ~~where the Trust is identified as an outlier or a potential outlier.~~

c. Quality and safety

To receive reports on compliance with the Care Quality Commission's Fundamental Standards. ~~Essential Standards of Quality and Safety.~~

To receive all reports on the Trust produced by the Care Quality Commission and to seek assurance on the actions being taken to address recommendations and other issues identified.

To ensure that the Trust learns from national and local reviews and inspections and implements all necessary recommendations to improve the safety and quality of care.

To receive reports on significant concerns or adverse findings highlighted by external bodies in relation to clinical quality and safety and the actions being taken by management to address these.

To receive and consider reports from the Health Service Ombudsman.

To monitor and review the systems and processes in place in the Trust in relation to Infection Control and to review progress against identified risks to reducing hospital acquired infections.

To review aggregated analyses of adverse events (including serious incidents), complaints, claims and litigation to identify common themes and trends and gain assurance that appropriate actions are being taken to address these.

To receive reports on clinical audit outcomes and on research and development activity within the Trust.

To review available benchmarking information on quality, safety and patient experience in support of the realisation of continuous improvement.

To review summary reports from Board quality visits and to determine any appropriate action arising from any issues identified.

To review and contribute to the Trust's annual Quality Account and make recommendations as appropriate for Trust Board approval.

To be responsible for endorsing the Trust's criteria for the scope of the mortality review process.

To review the quarterly reports from the Trust's Mortality Review Group.

7. Reporting to the Board

The minutes of the meetings of the Committee will be presented to the Trust Board.

Version 76 – 03.06.1421.02.17

Approved by Trust Board – 10 June 2014

For review: August 2015 February 2017

Trust Board Paper

Board Meeting Date	11 July 2017
Title	Revalidation Annual Report 2016/17
Purpose	To provide the Board with assurance with respect to Revalidation in line with NHS England requirements
Business Area	Medical Directorate
Executive Director	Minoo Irani, Medical Director, Responsible Officer for Revalidation
Relevant Strategic Objectives	1 – To provide accessible, safe and clinically effective services which improve patient experience and outcomes of care.
Resource Impacts	The Board is required to support the provision of necessary resources to assist the Responsible Officer (RO) with respect to Medical Revalidation requirements. The RO is currently supported by a 0.5 wte Band 5 appraisal and revalidation administrator to manage the process.
Legal Implications	Compliance with The Medical Profession (Responsible Officers) Regulations, 2010 (as amended 2013) and the GMC (Licence to Practise and Revalidation) Regulations 2012
SUMMARY	The annual report provides details for the 2016/17 year of revalidation with respect to doctor numbers, appraisal numbers, revalidation recommendations and governance arrangements to support revalidation. The Responsible Officer believes that the revised policy and enhanced processes lead to compliance with the requirements of a good medical appraisal process in BHFT and will also support doctors' development which would eventually improve the quality of patient care.
ACTION REQUIRED	The Board is asked to receive the annual board report on medical revalidation and to agree to the submission of an annual statement of compliance to the NHS England higher level Responsible Officer prior to 30th September 2017, signed by the Chair or Chief Executive.

Contents

Medical Revalidation Annual Report 2016/17

1. Executive Summary

The annual report provides details for the year of revalidation 2016/17 with respect to doctor numbers, appraisal numbers, revalidation recommendations and governance arrangements to support revalidation. Engagement with medical appraisal and revalidation from doctors has been high. The Responsible Officer (RO) believes that the revised policies and enhanced processes in place satisfy the requirements for a good and robust medical appraisal process and these necessary changes have now been implemented.

With respect to medical revalidation regulations, Berkshire Healthcare is a 'designated body' with associated statutory responsibilities. Doctors working within the Trust are referred to as having a 'prescribed connection' with respect to medical revalidation. There were a total of 117 doctors with a prescribed connection with the Trust for revalidation in 2016/17.

GPs and trainees have alternative arrangements and do not have a prescribed connection with the Trust. There are also doctors employed by the acute Trust who work within the services delivered by Berkshire Healthcare (Geriatricians working in Berkshire West) and their prescribed connection is with the Acute Trust.

Doctors with a prescribed connection to BHFT in 2016/17 include 71 consultants, 34 Specialty doctors and 12 doctors with temporary or fixed term contracts. The number of completed medical appraisals for doctors with a prescribed connection with the Trust during the year was 114 (71 consultants, 31 specialty doctors and 12 fixed term doctors). 3 doctors were in the category of 'approved incomplete or missed appraisal' at the end of the year with adequate reason provided (2 have been on medium to long term sick leave, 1 was under investigation).

Doctors require revalidation every five years. 11 doctors were due for revalidation in 2016/17. All 11 doctors were recommended for revalidation during the year and there were no deferrals. All recommendations were accepted by the GMC. There were no declarations of non- engagement. There were no delays in the recommendations made by the RO to the GMC.

The Responsible Officer is confident that the governance processes in the Trust to support revalidation are robust and these have been enhanced in 2016/17 following recommendations arising from the 'Independent Verification Visit' in May 2015. Engagement from doctors has significantly improved compared to 2015/16 and the RO aims to consolidate all the improvements implemented in 2016/17. The RO is confident that the medical appraisal process in BHFT complies with all national good practice requirements and can provide this assurance to the trust Board to submit the annual statement of compliance.

2. Purpose of the Paper

Medical revalidation is a requirement for all licensed doctors listed on the General Medical Council (GMC) register in both the public and independent sectors. Its purpose is to improve patient care by bringing all licensed doctors into a governed system that prioritises professional development and strengthens personal accountability.

Medical revalidation is central to how NHS England and the Health System at large are meeting their responsibilities to both patients and staff in improving safety and the quality of care.

Responsible officers have a role to ensure that the doctors linked to their organisations are up to date and fit to practice. NHS England requires assurance that designated bodies are discharging their statutory duties. This paper provides the basis on which to demonstrate that the appropriate resource and systems are in place, that they work effectively and that they meet the agreed national standards.

An 'Annual Organisational Audit' has been completed by the Responsible Officer and submitted to NHS England in April 2017. This sets out numbers with respect to medical appraisal and revalidation and confirms that the necessary systems, policies and resources are in place to support the process.

The Board is required to approve submission of an annual statement of compliance to the higher level Responsible Officer who is employed by NHS England.

3. Background

Medical revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations[1] NHS England expects that provider boards will oversee compliance with respect to:

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking there are effective systems in place for monitoring the conduct and performance of their doctors;
- confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors;
- Ensuring that appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

[1] The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (License to Practice and Revalidation) Regulations Order of Council 2012'

4. Governance Arrangements

The governance arrangements for revalidation are supported by the robust Quality Governance systems in the Trust with respect to incident reporting and investigation, complaints, errors, patient experience and clinical audit. Since July 2016, all doctors are provided with a Datix summary of their governance record for the past 12 months, prior to their appraisal meeting. This includes information about the doctor being named in any reported incidents, complaints and Serious Incidents. This process has been subsequently extended to doctors who do not have a prescribed connection to BHFT (GPs employed by BHFT, other doctors employed elsewhere and working in BHFT).

The revalidation team is led by the Medical Director who is the Responsible Officer (RO) for the organisation. From May 2016, the Appraisal Leads support the RO with this function. The administrator for medical appraisal revalidation (and medical education) compiles and monitors appraisals and supports doctors in preparing for these. Details and links on the Trust intranet also guide doctors on the requirements for revalidation.

The medical staffing lead has a key role in supporting the Responsible Officer with respect to employment checks and recruitment requirements, disciplinary or performance concerns and in developing and reviewing relevant processes and policies.

The Head of Clinical effectiveness and audit supports doctors with respect to engagement in quality improvement activity (NICE Guidance, audits).

A ‘lay’ representative has been appointed to the revalidation team to provide a public/patient perspective on revalidation arrangements. This is not a statutory requirement and BHFT have engaged with this good practise in advance of other NHS organisations in the region. This representative will gain assurance about the appraisal and revalidation processes in the Trust through engagement with the appraisers forum and ‘decision making group’ meetings (with the RO and appraisal leads, medical staffing lead and revalidation administrator).

All doctors have been supported and funded to engage with multisource feedback including patient and colleague feedback required for revalidation, using approved processes linked to the GMC and relevant Royal Colleges.

All doctors use an approved and validated electronic ‘Medical Appraisal Guide’ MAG form to record medical appraisals which includes all revalidation requirements. All medical appraisers within the organisation have attended approved appraisal training. The RO arranged an appraiser refresher training (18 October 2016) which was attended by medical appraisers in BHFT and this training was well received.

All psychiatrists working in the Trust are members of a Personal Development (PDP) group linked to the Royal College of Psychiatrists. These groups provide assurance around continual professional development (CPD) and authorise learning activities, monitoring appropriateness with respect to the individual’s personal developmental priorities. Other doctors have similar CPD requirements associated with their Colleges. Each year doctors are expected to provide a certificate from the Royal College to confirm that they are ‘in good standing’ with respect to CPD.

A process of locality manager review of the Trust 'plan on a page' including values and objectives, with individual doctors, contributes to improved alignment between individual, team and organisational objectives.

The Responsible Officer (RO) has attended all relevant training and is a member of a network of Responsible Officers which shares best practice and discusses cases and examples relating to fitness to practice concerns and revalidation recommendation decisions. He has also been part of the GMC RO reference group. There are regular meetings with the GMC employer liaison advisor to discuss any concerns related to doctors and any GMC proceedings relating to doctors working for the Trust if these occur.

The RO meets the appraisal leads, revalidation administrator and medical staffing lead monthly to discuss revalidation issues, update the list of prescribed connections and anticipate any challenges for individual doctors in achieving revalidation requirements. The lay Representative joins this meeting quarterly. Assurance about the recruitment process for doctors is provided by the medical staffing lead.

A sample of MAG forms is subject to Quality Assurance by the appraisal leads using the PROGRESS tool. The RO receives this information. Additionally, the RO Quality Assures a sample of the completed MAG and PROGRESS forms. This way, the Responsible Officer scrutinises a sample of Medical appraisal forms in detail to monitor quality and consistency and liaises with the appraisal leads where necessary. For all doctors with a prescribed connection the final appraisal documentation prior to revalidation is reviewed by the Responsible Officer prior to a recommendation being made.

The Responsible Officer can provide assurance to the Board that governance arrangements to support revalidation are adequate.

5. Policy and Guidance

Appraisal Policy for Medical Staff (ORG 084) was revised in 2016 and the revised version was published on the Trust intranet (December 2016) and communicated to all doctors in the trust. The revised policy was also discussed at the trust appraiser forum (18 January 2017).

6. Medical Appraisal

6.1 Appraisal and Revalidation Performance Data 2016/17

Detailed activity levels of appraisal outputs:

- Number of doctors **117**
- Number of completed appraisals: **114**
- Approved incomplete or missed appraisal: **3**
- Unapproved incomplete or missed appraisal: **0**
- (Number of doctors in remediation and disciplinary processes: **1)**

A review of missed or incomplete appraisals has been carried out. The main reasons for delayed appraisals with adequate reason are sickness (2 doctors) and investigation (1 doctor). The Board can be assured that the appraisals provide a sound basis for supporting revalidation recommendations.

6.2 Appraisers

The recommended proportion of trained appraisers in a designated body is between 1:5 and 1:20. There are 30 trained medical appraisers in the Trust which is more than sufficient, given the number of doctors with a connection to the trust. The appraisal forum meeting (chaired by the RO) occurs three times a year to provide peer support and updates with respect to revalidation and appraisal requirements. Appraisers have been historically performing variable number of appraisals per year and with a system of allocation now introduced, they are expected to appraise at least 4 doctors annually.

6.3 Quality Assurance

The Appraisal Policy for Medical staff has clear guidelines for doctors, appraisers, and the revalidation team to ensure that good quality appraisal documentation is produced in line with the requirements for revalidation. Primary responsibility for providing this information is with the doctor being appraised.

Since 2016, appraisal leads assess the quality of a sample of completed appraisal MAG forms using a standardised tool (PROGRESS). The appraisal leads have presented a summary of their quality reviews to the appraiser forum to facilitate improvement in practice and standardisation of the appraisal content and output. The RO has reviewed a small sample of the appraisal leads PROGRESS reports and corresponding MAG forms and is satisfied with the current process.

Feedback about the appraisal process from doctors is received and coordinated by the revalidation administrator. The medical appraisers reflect on this to improve appraisal quality.

There have been no complaints or significant events associated with the appraisal and revalidation process to date. The Responsible Officer, with support from the revalidation administrator ensures that all revalidation recommendations are made by the due date.

6.4 Access, security and confidentiality

The process for managing access, security and confidentiality of information, is safe and appropriate. No information governance breaches associated with the process have been identified during the year. All doctors and appraisers are aware that patient identifiable information should not be included in appraisal documentation.

6.5 GPs in BHFT

Although GPs employed by BHFT do not get appraised within the Trust, the Medical Director of Westcall has provided assurance that the scope of GP practice in Westcall feeds into their appraisal process in primary care. Additionally, since 2016,

the revalidation administrator provides Westcall GPs employed by the trust with a Datix summary of their governance data for use in their appraisal process.

7. Recruitment and engagement background checks

All medical staff recruited by the Trust are done so by following NHS Employers six safer recruitment standards. Before making an unconditional offer of employment medical staffing check:

1. Identity
2. Employment history & reference checks
3. Work health assessment
4. Professional registration & qualifications
5. Right to work
6. Criminal records check

We also check the General Medical Council Alerts Register. Candidates must satisfy these pre-employment checks prior to employment.

As part of the medical appointments interview process we have introduced a duty on the chair of the panel to obtain the panel's consensus that they are satisfied with the language competency of the doctor being offered the post. This assessment is based upon the interview panel noting the doctor's language and written application skills as part of the interview.

Locums are only sourced from framework agencies that follow the 6 checks above; Medical Staffing also double check professional registration and the Alerts Register.

8. Revalidation Recommendations

11 recommendations for revalidation were completed between April 2016 and March 2017. All were completed in time. All positive recommendations were accepted by the GMC. There were no deferral requests and no non-engagement notifications.

9. Monitoring Performance

The performance of doctors is monitored through a system of line management coupled with professional accountability to the Medical Director. The quality governance systems for the Trust, including with respect to incidents and complaints support the monitoring of doctors' performance. PDP groups and peer groups also act to provide feedback to the psychiatrists on their performance and professional expectations. Doctors engage with clinical audit activities, including national audits to assess their performance in comparison with others. The process of enhanced medical appraisal has fostered improved engagement from doctors with respect to monitoring performance with improved visibility for appraisers and the Responsible Officer / Medical Director. This includes reflection on patient and colleague feedback.

10. Responding to Concerns and Remediation

Whilst individual doctors have reflected on incidents, complaints and prescribing errors where they have been involved, formal remediation programmes have not been required during this year for any doctor with a prescribed connection to the Trust. At the end of the year there was one doctor being investigated by the GMC in relation to a probity matter which had led to a deferral of their revalidation recommendation in previous years. This matter is now resolved.

11. Independent Verification Visit

The Revalidation Team from NHS England (South) visited BHFT on 12 May 2015 for a peer based Quality Assurance of the medical appraisal process in the Trust. The visiting panel made a number of recommendations for the Trust to implement:

i) Consider appointing a substantive Lead Appraiser who could support the RO in reading and Quality Assuring appraisals
ii) Consider more cross speciality appraisal
iii) Consider allocating appraisers on a random selection
iv) Ensure representation at the Lead Appraiser network to enable consistency checks with other similar organisations
v) Consider providing the available data sets from Clinical Governance and activity and outcome information (if available) to Appraisers and Appraisees so the RO is assured that all relevant information is discussed at appraisal, and automating the process to reduce the preparation task for doctors
vi) Ensure the whole scope of practice is covered in the appraisal
vii) Use of the MPIT form in all recruitment of doctors will obtain information relevant if any concerns arise, and to confirm fitness to practice

The Responsible Officer has engaged the trust doctors and has implemented these wide-ranging recommendations over 2016/17.

12. Audit of Medical Appraisal Process

The trust internal auditors (RSM) reviewed the medical appraisal process in July 2016 and reported in August 2016. The auditors identified one ‘Medium’ priority issue, requiring management action in relation to the design, application of and compliance with control framework: ‘The Appraisal Policy for Medical Staff (ORG084) and relevant guidance is outdated and does not reflect current operating practice’. The RO accepted this recommendation and acknowledged that the wide-ranging improvements in the medical appraisal process were not part of the existing policy. The policy was re-written and published by December 2016.

A low priority recommendation (number of PDP objectives) was also accepted and it was emphasised to appraisers that at least one objective should be identified as a Quality Improvement objective. The appraisal leads also presented examples of good quality objectives (and where improvement was required) at the June appraiser forum.

13. Improvements in 2016/17

i) Appointment to the Appraisal Lead post (April 2016): job share between 2 Consultant Psychiatrists

The role of the appraisal leads is to support the RO in providing leadership for the medical appraiser workforce, for training and development of appraisers and quality assurance of the appraisal process and outputs.

ii) 'Cross specialty' appraisals introduced in 2016: particularly noticeable in the smaller medical specialty groups in the Trust (community paediatricians and geriatricians, sexual health doctors) where doctors struggled to find appraisers from the same specialty. By the same measure this will involve some psychiatrists being appraised by a doctor from another specialty.

iii) Appraiser allocation: Historically, doctors were able to select their appraiser from the list of approved appraisers in the Trust. From December 2016, a system of allocation of appraisers has been phased in, so that all appraisals in 2017 will be completed by allocated appraisers. Allocation of appraisers will also facilitate cross-specialty appraisals.

iv) Appraisal leads have attended the NHS England (South) RO & Appraiser Network meetings

v) Reminders for arranging appraisals are sent to doctors at least 56 days in advance of the last day of their appraisal month. At the same time a request is sent to the Datix administrator to provide the appraiser and doctor with information about incidents, complaints and compliments recorded on Datix and specific to the doctor.

vi) It has been emphasised in the revised policy and at appraiser forum meetings that the whole scope of the doctor's practice should be covered in the appraisal discussion and outputs. This is monitored through the Quality Assurance of appraisal MAG forms by appraisal leads.

vii) Use of the Medical Practice Information Transfer (MPIT) form to obtain relevant information about all new 'connections' to the Trust has been introduced since May 2016.

14. Risk and Issues

In the opinion of the Responsible Officer there are currently no serious risks with respect to medical appraisal and revalidation which require the Board's attention. The current resource for administering the appraisal process is modest and the RO has Executive support to make a case for additional resource (if required) to enable continuation of the above improvements.

15. Recommendations

The Board is asked to receive the annual report. This will be made available to the higher level Responsible Officer from NHS England. The Board can be assured that the revalidation process is compliant with the regulations and is operating effectively within the trust.

The Trust Responsible Officer is confident that following implementation of the above improvement actions, the Trust is in line with good practice in similar organisations with respect to medical appraisals.

The Board is recommended to approve the 'statement of compliance' confirming that the organisation, as a designated body, is in compliance with the regulations. (**Appendix A Statement of Compliance**)

Dr Minoo Irani
Medical Director and Responsible Officer
July 2017

Appendix A – Statement of Compliance

Designated Body Statement of Compliance

The Board of Berkshire Healthcare NHS Foundation Trust can confirm that:

- An Annual Organisation Audit has been carried out and submitted
- BHFT is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013)
- And can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

   Comments: Dr Minoo Irani, Medical Director

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

   Comments: Revalidation administrator maintains an up to date list

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

   Comments: 30 trained appraisers for 117 doctors with prescribed connection is sufficient

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent);

   Comments: Medical Appraisers Forum is held 3 times a year, chaired by the RO, where appraisal updates and peer discussion and support is facilitated. Quality review of completed MAG forms by Appraisal Leads using PROGRESS. RO quality assures a sample of the PROGRESS reports from appraisal leads.

5. All licensed medical practitioners[2] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

   Comments: Medical appraisal rates monitored by RO (and Appraisal Leads). 3 delayed appraisals have been accounted for and all 3 doctors have been notified of appraisal dates.

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1], which includes [but is not limited to] monitoring: in-house training, clinical outcomes data, significant

[2] Doctors with a prescribed connection to the designated body on the date of reporting.

events, complaints, and feedback from patients and colleagues, ensuring that information about these is provided for doctors to include at their appraisal;

Comments: Quality Governance systems within the Trust are robust with respect to monitoring these aspects of performance. The Head of Clinical Effectiveness has a responsibility to support and facilitate the availability of quality outcome and clinical audit information for individual doctors. Summary of Datix enquiry (incidents, SIRIs, complaints) is available to all doctors from July 2016.

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

Comments: A robust policy for medical staff is in place which sets out the process for responding to these concerns. An effective system for managing complaints is in place.

8. There is a process for obtaining and sharing information of note about any licensed medical practitioners' fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work;

Comments: Medical staffing processes are in place to share information with other trusts for new appointments and on doctors leaving the Trust and these have operated effectively to date. It is expected that individual doctors working for the Trust provide evidence at appraisal with respect to the full scope of their practice and trained appraisers ensure that this is the case. The vast majority of doctors work exclusively for the Trust with a few engaging in private practice with a local provider. Use of the MPIT form has been implemented from May 2016.

9. The appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that all licenced medical practitioners[3] have qualifications and experience appropriate to the work performed; and

Comments: Medical staffing processes on recruitment ensure that this is the case. Competency in use of the English language is assessed informally during appointments process and interview.

10. A development plan is in place that addresses any identified weaknesses or gaps in compliance to the regulations.

Comments: Improvement actions arising from previously identified weaknesses have been implemented in 2016/17.

[3] Doctors with a prescribed connection to the designated body on the date of reporting.

Signed on behalf of the designated body

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ _

[chief executive or chairman a board member (or executive if no board exists)]

Date: _ _ _ _ _ _ _ _ _ _

Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

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

June 2017

Freedom to Speak up Guardian - Report of first 3 months (March – May 2017) of the role in the Trust

For: Information

Executive Summary

The Freedom to Speak up Guardian is a new role in the NHS and was a recommendation of the Freedom to Speak up Review by Sir Robert Francis published in 2015. The Freedom to Speak up Guardian came into post in this Trust in March 2017. This is a report directly to the Board on the first three months activity.

The Freedom to Speak up Guardian is a part-time post, two days a week, which provides independent and confidential support to staff that want to raise concerns and promotes a culture in which feel staff safe to raise those concerns. There have been zero cases of concerns raised over the first three months of the role. However, staff have raised concerns in groups informally that the FTSUG has responded to, e.g. night staff at Prospect Park Hospital said they didn't feel listened to or valued by managers'. The FTSUG raised this with the senior leadership team (SLT) and as a consequence the SLT have established a rota for them to work into the night once a month. The first of the dates has already happened and the SLT found this to be a positive experience.

In addition, other activities have been undertaken to raise awareness of the role and to encourage cultural change in the Trust. The post holder attends the regular induction, essential knowledge for new managers, junior doctor's rotation and plans to join a group session with students. An idea to capture the experience and reflections of new starters, suggested by Dr Tamsin Marshall is to be piloted at Prospect Park Hospital. The post holder has attended regional and national networking events and conferences.

Whilst it is too early to evaluate the impact of the role, anecdotal feedback received suggests that this role is welcome within Berkshire Healthcare, '*thanks for coming over the other day to share the Freedom to Speak up materials, the posters are up in OPMH and Liaison staff areas, cards have been dotted about and I'm wearing the lanyard you left to get people asking about it. ….. And they are! We've had some interesting conversations, with all sorts of staff, and it has proved an ice breaker to talk about things like whistleblowing (I don't think there is anything imminent!) but also freeing people to speak up about things they might feel they can't approach a senior person about. One Dr, two admin, and a few CPN's have talked about it with me. Your example of addressing an issue head on in your previous post, direct but firm and clear was really useful to hear about'.*

CQC are moving to unplanned or short notice visits, which will be more focussed on one core service and will attend to how well led that service is. CQC are also intending to have a new 'well led' inspection that will only focus on that domain. In relation to the FTSU the CQC will look at

1. How trusts support FTSUG (access to board and CEO)

2. How trusts respond to concerns raised by workers

3. Evidence of a positive speaking up culture – including how we support minority groups (students are included in minority groups)

For colleagues who would like to understand more about this role please refer to the board report presented in April 2017. There are multiple ways in which staff can raise concerns, details at appendix A. There will be a presentation from the post holder at the Audit Committee on 25th July 2017.

Recommendation

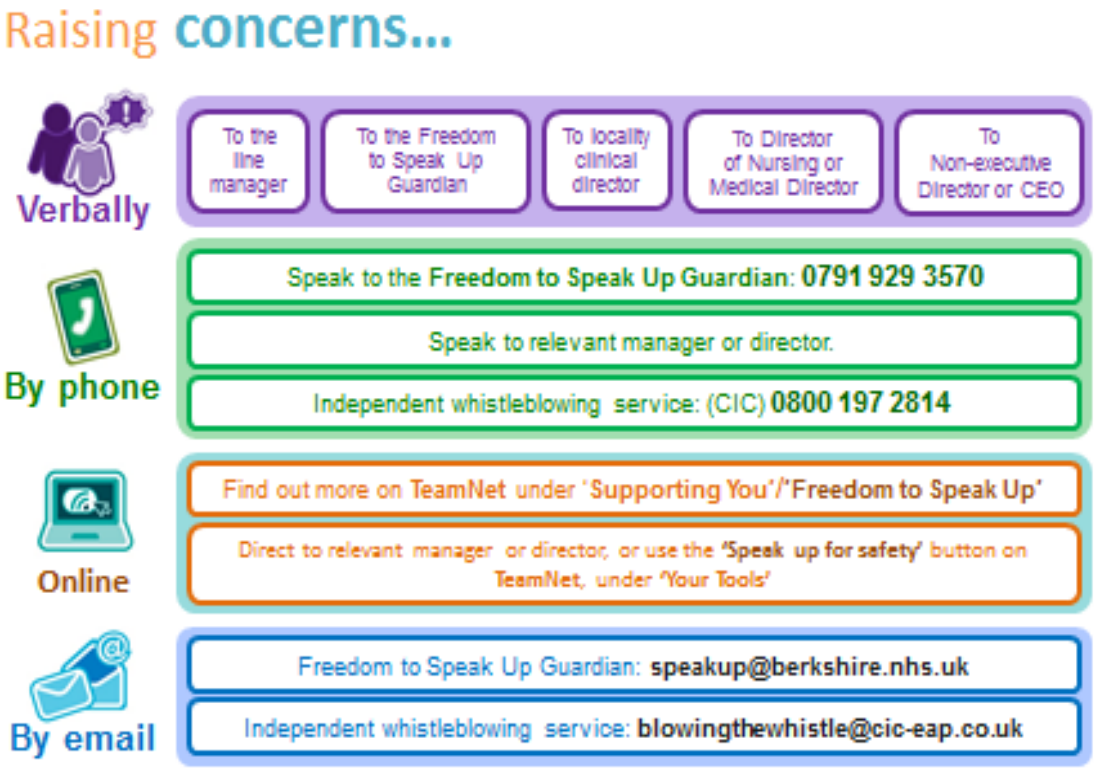
The Trust Board is asked to note the contents of this first report by the Freedom to Speak up Guardian.

The Board is asked to approve that in the future the Freedom to Speak up Guardian provides an annual public report to the Board and a mid-year report to the Quality Assurance Sub Committee and Quality Executive Group.

Author and Title:

Elaine Williams, Freedom to Speak Up Guardian

Appendix A


Raising concerns...
Verbally
To the line manager
To the Freedom to Speak Up Guardian
To locality clinical director
To Director of Nursing or Medical Director
To Non-executive Director or CEO
By phone
Speak to the Freedom to Speak Up Guardian: 0791 929 3570
Speak to relevant manager or director.
Independent whistleblowing service: (CIC) 0800 197 2814
Online
Find out more on TeamNet under 'Supporting You'/'Freedom to Speak Up'
Direct to relevant manager or director, or use the 'Speak up for safety' button on TeamNet, under 'Your Tools'
By email
Freedom to Speak Up Guardian: speakup@berkshire.nhs.uk
Independent whistleblowing service: blowingthewhistle@cic-eap.co.uk

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	11 July 2017
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
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.

Trust Board Meeting 11 July 2017

EXECUTIVE REPORT

1. Never Events

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

Executive Lead: Helen Mackenzie, Director of Nursing and Governance

2. Quality Improvement Update

The Quality Improvement (QI) programme continues to make good progress. The Executive Team has completed a series of "road mapping" workshops. An overall programme of four work streams has been agreed, each led by an Executive Director. Three of the work streams have had activities completed this month:

- QI Office (previously known as the 'Centre of Excellence') led by Helen Mackenzie, Director of Nursing and Governance:
    - Recruitment to the QI Office is now complete. Caroline Attard, Nurse Consultant at Prospect Park Hospital has been appointed to the Head of Quality Improvement, supported by five other members of staff in the QI team. The QI team is expected to be in post by the end of September 2017.
- Quality Management and Improvement System (QMIS) led by David Townsend, Chief Operating Officer and Alex Gild, Chief Financial Officer:
    - Training of the first "wave" of five teams has commenced. The following wards are involved:

        Snowdrop
        Rose
        Donnington
        Highclere
        Henry Tudor

This is a six month training programme with the next wave commencing in September 2017.

- Strategy Deployment led by Julian Emms, Chief Executive and Bev Searle, Director of Corporate Affairs:
    - Development of the Trust's "True North" is progressing.

- The fourth work stream (Improvement Projects, led by Minoo Irani, Medical Director) does not have any activities scheduled until late July 2017.

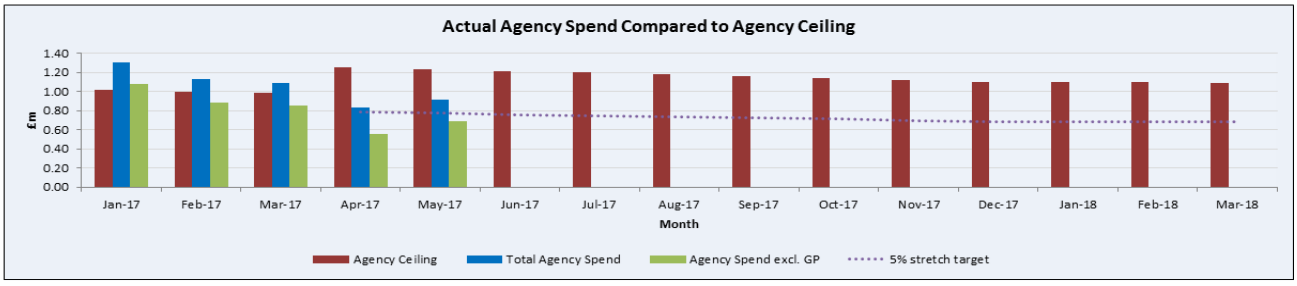
- Other supporting activities, such as communication events (e.g. presentations to key stakeholder groups, development of intranet site) are also progressing.

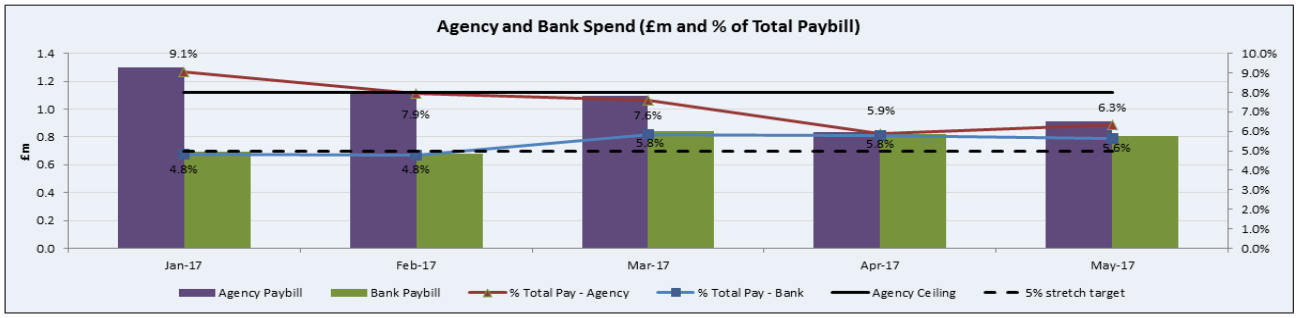
Executive Lead: Helen Mackenzie, Director of Nursing and Governance

3. Temporary Staffing Programme

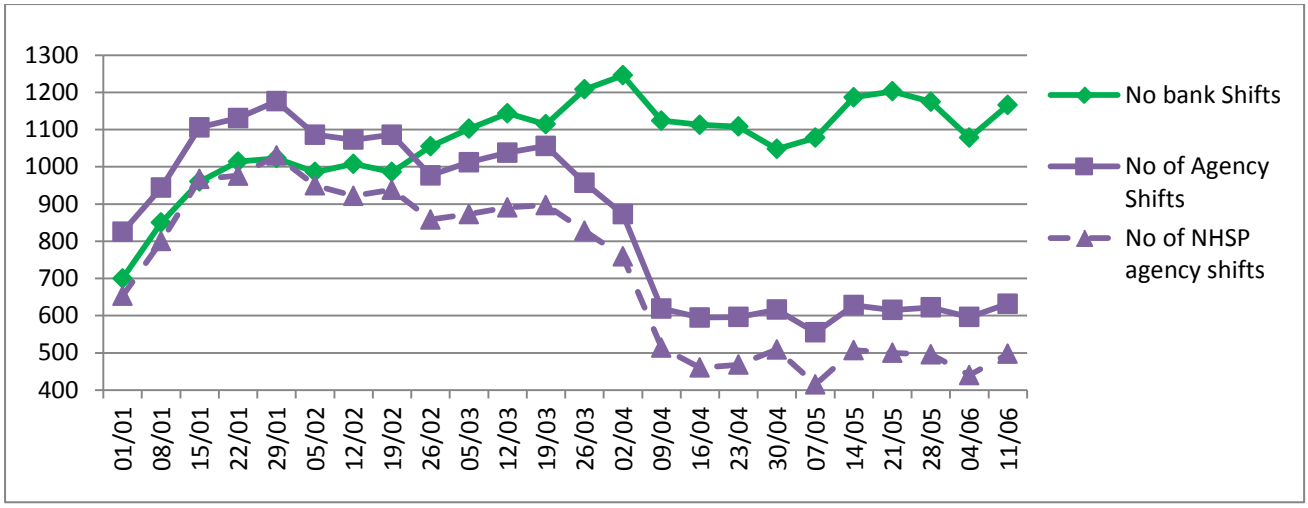
Use of agency v NHSP bank staffing and associated issues

- Spend on Agency staff in April 2017 (month 1) was £834k, down from £1,093k in March 2017. This equates to 5.9% of total staff pay costs, which is below the 8% NHS Improvement cap (on Agency usage), but above the Trust's 5% stretch target. It should be noted that this was the first month following the Agency Health Care Assistant ban, and that historically there are less staff on leave in this month.
- Spend on Agency staff in May 2017 (month 2) was £911k – an increase of £77k from month 1, and was attributed to increased Agency usage in east Berkshire Adult Physical Health Services (Slough Walk in Centre (SWIC), Physiotherapy and District Nurses) and Children's Services. This equates to 6.3% of total staff pay costs, but again below the NHS Improvement cap. There were two bank holidays in May 2017 which led to higher agency rates being paid in services such as WestCall and SWIC.
- NHSP Bank usage which was 5.8% in March 2017 remained unchanged in April 2017, and marginally decreased in May 2017 to 5.6%.





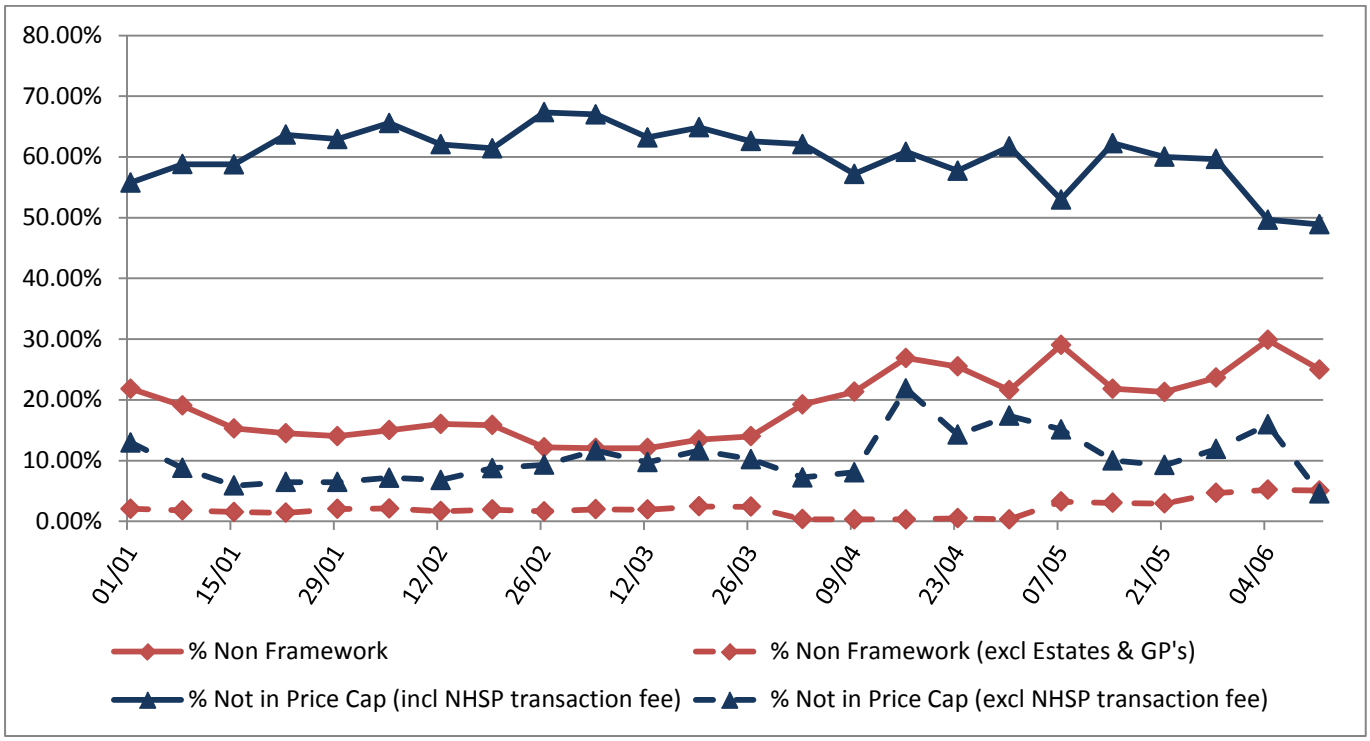
- The number of agency and bank shifts used during 2017 is shown in the table overleaf:



- The Trust's decision to ban the usage of Agency Health Care Assistants (HCA) across services from the start of April 2017 led to a significant drop in the usage of agency shifts, which is demonstrated in the table above.
- There has not been a compatible increase seen in NHSP shifts being booked, and this is attributed to significant recruitment of substantive HCAs across in-patient services, and other on-going initiatives.

To note, the number of agency shifts includes all those booked through NHSP and those which were not (Westcall, SWIC, Mental Health medical staff and a small number of children services staff and nursery nurses).

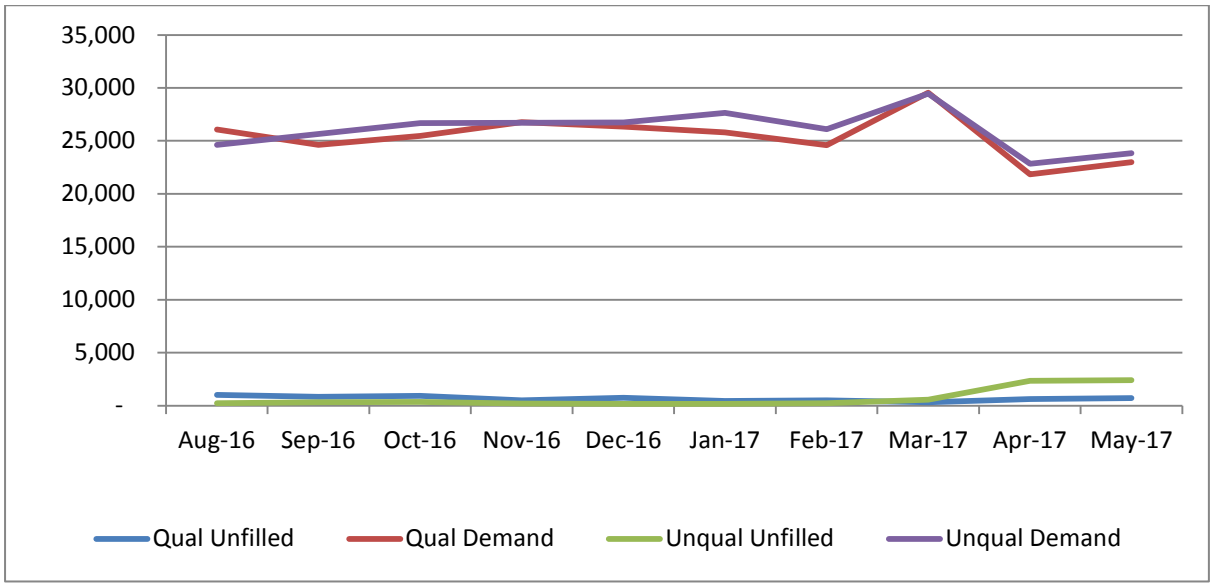
- As noted previously, the NHSP transaction charge levied per hour (40p an hour for NHSP workers and 70p per hour for an approved agency worker) to the shifts booked through their platform leads to a significant proportion of shifts breaching the price cap. The latest table (below) covers the first five months of 2017.



- It can be seen that there has been an increase in the percentage usage of non-framework staff used since April 2017 overall, and an increase from May 2017 for those used in non-estate/GP services (red solid line).
- An increase between May 2017 in agency shifts booked outside the NHSP system where the price capped hourly rate was breached (blue dashed line).
- As the Board will be aware, the current extension to the NHSP Contract for Temporary staffing ends in November 2017. The Trust will be jointly retendering this with the Royal Berkshire NHS Foundation Trust, where it is expected that there will be the benefits of economies of scale, from the provider awarded the tender.
- The Temporary Staffing Service Specification and Evaluation Criteria will be going to both Trusts' Temporary Staffing Boards in early July 2017 for final approval, to allow the formal tendering process to begin, and for a final timetable to be drafted.

Ban on the use of Agency Healthcare Assistants from the 1st April 2017

- As previously reported, the ban on the use of HCAs was successfully implemented on Saturday 1st April 2017.
- A significant number of regular HCA agency staff have now joined and are working through NHSP (recent figures from NHSP showed 321 HCA had joined NHSP between December 2016 and May 2017. Of this number 126 were former agency HCAs who worked regularly in Trust services).
- The following table shows the demand (hours) for both qualified and unqualified staff, and shows the level of unfilled shifts.



- Also shown is the continuing residual level of unfilled hours in May 2017, which was comparable to the April level.

IR35 and Personal Service Contracts [PSC]

IR35 is tax legislation that is designed to combat tax avoidance by workers supplying their services to clients via an intermediary, such as a limited company, but who would be an employee if the intermediary was not used.

- Since the last update to the Board, NHS Improvement amended their guidance on how Trusts should approach this issue, with a view that there should not be a blanket rule implemented (ie that everyone falls into IR35 requirements) and that each person should be individually assessed.
- Although the Trust did take the approach that everyone did fall into the IR35 requirements, there were always individual assessments carried out using the HMRC approved assessment tool, which when accurately completed always indicated that the person did fall into the requirements.
- No further changes to processes were required to be taken by the Trust.
- A number of GPs used in WestCall remain engaged through a Personal Service Company but are now having tax deducted at source by the Trust. Work continues with the GPs and Locality and Finance Managers about the introduction of a GP bank as well as developing the introduction of Advanced Nurse Practitioner roles into the Service.

Executive Lead: Helen Mackenzie, Director of Nursing and Governance

Presented by: Julian Emms
Chief Executive
July 2017

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Summary Finance Report

Financial Year 2017 / 18

Month 2 (May 2017)

Purpose

This document provides the Board with information giving the financial performance as at 31st May 2017 (Month 2).

Document Control

Version	Date	Author	Comments
1.0	12.06.2017	Donna O'Leary	Draft
2.0	14.06.2017	Tom Stacey	Review & 2nd Draft
3.0	21.06.2017	Tom Stacey	Revised format for Board
4.0	04.07.2017	Alex Gild	Final

Distribution:

Board Directors

Overview: month 2

The Trust reports a surplus of £98k in month 2 2017/18 (May 2017), £83k better than plan. The Trust's underlying surplus in month 2, excluding NHSi S&T funding (-£72k), is a surplus of £11k.

The Trust reports a YTD surplus of £207k, £230k better than plan. The Trust's YTD underlying surplus, excluding NHSi S&T funding (-£174k), is a surplus of £33k.

The Trust held £21.0m of cash at the end of month 2. This was higher than the plan of £19.4m, by £1.6m, primarily due to IM&T capital expenditure phasing to later quarters.

The NHSi oversight framework Use of Resources rating is a "1" at month 2. This is the lowest risk rating and is in line with plan, driven by positive revenue and cash performance.

To note, the planned monthly profile of income and expenditure is weighted to achieve larger surpluses in the latter part of the year, with an average surplus of £377k per month expected in Q4. This profile reflects the timing of Recurrent Cost Improvements (RCI's) and cost pressure reduction required in mental health acute OAPs, independent hospital OAPs and inpatients.

1.0 Income & Expenditure Summary: month 2

Description	Current Month			Year to Date		
	Budget (£'000)	Actual (£'000)	Variance (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)
Operating Income	**20,695**	**20,720**	**24**	**40,979**	**41,038**	**59**
Operating Expenditure						
Pay	(14,665)	(14,378)	287	(29,212)	(28,575)	637
Non Pay	(5,122)	(5,405)	(283)	(9,973)	(10,549)	(576)
Total Operating Expenditure	**(19,787)**	**(19,783)**	**4**	**(39,185)**	**(39,124)**	**61**
EBITDA	**908**	**937**	**28**	**1,794**	**1,914**	**120**
Non-Operating Income/Expenditure						
Interest Receivable	3	3	(0)	7	6	(1)
Interest Payable	(299)	(299)	(0)	(598)	(598)	(0)
Depreciation & Amortisation	(496)	(441)	55	(1,023)	(912)	111
PDC Dividend	(101)	(101)	0	(203)	(203)	(0)
Total non-operating income/expenditure	**(893)**	**(839)**	**55**	**(1,817)**	**(1,708)**	**110**
Net Surplus/(Deficit)	**15**	**98**	**83**	**(23)**	**207**	**230**
Net Surplus/(Deficit) excl. S&T Funding	**(72)**	**11**	**83**	**(197)**	**33**	**230**
RCIs Achievement	**392**	**6**	**(386)**	**783**	**11**	**(772)**

In month highlights

The Trust reports a surplus of £98k in month 2 2017/18 (May 2017), £83k better than plan. The Trust's underlying surplus in month 2, excluding NHSi S&T funding (-£72k), is a surplus of £11k.

Income (majority block contract) is broadly in line with plan.

Pay is underspent by £287k with the main reasons being:-

- Mental Health Inpatients (-£44k) Net pay overspend across wards due to vacancy cover, escort duties and the level of observations.
- Children's Services (£146k) High vacancy levels.
- IAPT (£139k) Net vacancies inclusive of non-recurrent investment benefit.
- Adult East services (£125K) High vacancy levels.
- Westcall (£3k) Noted as an improved area. Lower shift premium rate paid only on the bank holiday itself, reduction in Locum usage relating to retirement cover.
- To note, Trust underlying vacancy benefit offsets the evenly profiled RCI target in month of £386k.

Non Pay is overspent by -£283k with the main reasons being:-

- Acute overspill (-£277k) principally due to 19 acute/PICU placements (-£243k) required in month resulting from bed pressures and two placements not suitable for PPH (-£34k). These costs are against a budget of £43k. Activity shows a decrease of four OAPs from April with further reductions noted in June.

Depreciation (£55K) Depreciation is lower due to lower IT replacement spend in Q4 (programme moved into 2017/18). Depreciation is likely to be under plan going into Q2, with a month 2 capital underspend.

Year to date highlights

Income is broadly in line with plan.

Pay is underspent by £637k with the main reasons being:-

- MH Inpatients (-£78K) Pressures have continued due to high observations and agency premium
- CRHTT (-£111K) including over establishment costs to cover increased workload, sickness and vacancies
- Adult East Services (£350K) Mainly due to vacancies
- Children's Service (£254K) Mainly due to vacancies
- To note, Trust underlying vacancy benefit offsets the evenly profiled RCI target year to date of £772k. This target will be matched against specific savings opportunities, when appropriately identified, quality impact assessed and removed from budget.

Non Pay is overspent by -£576k with the main reasons being:-

- Acute Overspill (-£499K) total of 40 acute/PICU placements across April and May (-£475K), 5 placements not suitable for Prospect Park at (-£67k)

Recurrent Cost Improvements (RCIs)

Of the £4.7m RCI target for FY17/18; £1.3m has had an opportunity identified subject to review & QIA and a further £0.2m released from budgets. In terms of the phasing of the budgets over the year only £11k is realised year to date at month 2, leaving a gap of £772k which is offset by vacancies across the trust. Progress is being made in identification with further opportunities being confirmed during June and July. An updated programme risk assessment will be made in line with the Q1 forecast review noted above.

2.0 NHSi Use of Resources Rating

Use of Resource Metric (M2)	YTD Plan		YTD Actual		Forecast	
Metric	Metrics	Rating	Metrics	Rating	Metrics	Rating
Capital Service Cover	1.8	2	1.9	2	2.2	2
Liquidity days (>0 = 1)	2.2	1	6.4	1	1.6	1
I&E margin	0.00%	2	0.50%	2	1.00%	1
I&E variance from plan	-	1	0.50%	1	-	1
Agency (distance from cap)	0.00%	1	-29.90%	1	0.00%	1
Use Of Resources Rating		1		1		1

The Use of Resources rating reports the lowest risk score of 1 in month and year to date, driven by cash cover re liquidity, delivery of a net surplus margin and high performance against NHSi's agency cap.

Agency

Agency spend was £0.9m in month 2, and £1.7m YTD. This run rate is below the NHSi agency ceiling of 8% / £2.5m YTD. Agency spend in Q4 of the last financial year was an average of £1.2m per month. The majority of financial benefit impact has been achieved via the Trust wide HCA agency ban from April 2017.

Risk to forecast

The continued cost pressure from Acute Overspill OAPs is a significant risk to the Trust's financial plan this year.

Achievement of RCI's is required to secure the Trust's financial stability into subsequent year(s).

To note, the Trust must be achieving an average monthly surplus of £377k per month by quarter 4, which, without cost pressure reduction and RCI identification will be difficult to achieve.

A detailed forecast review will be undertaken in line with Q1 reporting, assessing risk and upside opportunity to delivering the planned outturn of £2.4m surplus (1% surplus margin), supported by £1.7m S&T funding.

4.0 Balance Sheet Summary

STATEMENT OF FINANCIAL POSITION	31st March 2018 (Plan) £'000's	31st May 2017 (Actual at Date) £000s	31st March 2017 (Final last year) £000s
Non-Current Assets (Intangible, Property, Plant and equipment)	89,725	87,753	88,483
Inventory	109	124	113
Current receivables (Trade and Other Debtors)	10,194	10,571	11,977
Cash	19,468	21,028	20,698
Current Payables (Trade and Other Creditors)	(25,914)	(23,901)	(26,049)
Other Liabilities (Deferred Income)	(1,469)	(2,228)	(2,012)
Provisions (Current & Non-Current)	(1,612)	(2,001)	(2,098)
PFI Finance Lease Creditor (Current & Non-Current)	(30,753)	(31,545)	(31,704)
Total Net Asset / (Liabilities)	**59,749**	**59,801**	**59,408**
Financed By:			
Public Dividend capital	14,210	14,210	14,210
Revaluation Reserve	30,294	31,243	31,243
Income & Expenditure Reserve	15,245	14,348	13,955
Financed by Reserves	**59,749**	**59,801**	**59,408**

Cash

The closing cash balance for Month 2 was **£21.0m**, against a plan of £19.4m resulting in a favourable variance of 1.6m. The main reasons for the positive variance is an under spend on capital YTD of £1.3m and receipt of 2016/17 S&T incentive and bonus funds of £0.9m.

Trade Receivables

The overall debtors balance has decreased by £3.9m in May to **£2.9m**.

The main reason for the decrease in Month 2 is S&T funding of £1.4m (bonus & Q4 payment) included in last month's balance, which has been paid during the current month. Debts aged between 30 to 60 days have decreased by £1.7m, of which the main items related to NHSP £0.7m, Slough CCG £0.3m, WAM CCG £0.2m and Royal Berkshire FT £0.2m.

To note debts over 90 days stand at £0.4m.

Trade Payables

Trade Payables decreased by £2.3m to **£5.4m**, mainly due to decrease in current payables of which the main items were: NHS Professionals balance down to £0.7m (was in April: £1.4m), NHS Litigation Authority £0m (April: £0.7m), Leeds Direct Distribution £0.1m (April: £0.3m) and CQC £0 (April: £0.2m).

To note payables over 90 days stand at £0.3m.

Capital

CAPITAL EXPENDITURE	Current Month			Year to Date			Forecast Out turn		
	Bud	Act	Var.	Bud	Act	Var.	Bud	Act	Var.
	(£'000)			(£'000)			(£'000)		
Maintenance & Replacement									
Trust Owned Properties	3	(4)	7	5	(6)	11	120	120	0
Leased Non Commercial (NHSPS)	8	12	(5)	15	12	3	540	560	(20)
Leased Commercial	1	2	(1)	2	1	1	82	230	(148)
Statutory Compliance	0	(1)	1	0	(1)	1	640	640	0
Locality Consolidations	65	3	61	134	6	128	820	1,276	(456)
PFI	467	0	467	469	3	466	2,223	1,105	1,119
Subtotal	**543**	**12**	**530**	**625**	**15**	**610**	**4,425**	**3,931**	**495**
Development Expenditure									
IM&T Refresh & Replacement	0	1	(1)	808	7	801	2,076	2,076	0
IM&T Business Intelli. & Reporting	25	0	25	25	0	25	378	378	0
IM&T System & Network Developments	0	0	0	0	0	0	795	60	735
IM&T RiO	0	9	(9)	0	46	(46)	447	447	0
IM&T Other	0	35	(35)	0	40	(40)	151	151	0
IM&T Locality Schemes	16	46	(30)	32	49	(17)	200	200	0
IM&T GDE	0	9	(9)	0	9	(9)	0	735	(735)
Other Locality Schemes	16	0	16	0	4	(4)	100	100	0
Subtotal	**57**	**100**	**(43)**	**865**	**155**	**710**	**4,147**	**4,147**	**0**
Total	**600**	**113**	**487**	**1,490**	**170**	**1,320**	**8,572**	**8,078**	**495**

Capital Programme

The Trust is reporting against a plan of £8.5m in line with the annual plan to NHSi. In Month 2, the total monthly capital spend was under budget by £0.5m, and the under spend for the year to date was £1.3m.

Estates projects were under spent by £0.5m, mainly due to extended timescales for agreeing plans related to ward reconfiguration works at Prospect Park Hospital (PFI).

The IM&T year to date under spend of £0.7m is mainly due to an IT replacement programme being moved from 2016/17 into this financial year, linked to procurement activity. £0.7m of budget was profiled in month 1, but expenditure will not now be incurred until after Q1.

Berkshire Healthcare NHS
NHS Foundation Trust

11/07/PMXXX

Trust Board Paper

Board Meeting Date	11 July 2017
Title	Financial Summary Report – Month 2 2017/18
Purpose	To provide the Month 2 2017/18 financial position to the Trust Board
Business Area	Finance
Author	Director of Finance, Performance & Information
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
SUMMARY	The Financial Summary Report included provides the Board with a summary of the Month 2 2017/18 (May 2017) financial position.
ACTION REQUIRED	The Board is invited to note the following summary of financial performance and results for Month 2 2017/18 (May 2017): The Trust reports to NHSi its 'Use of Resources' rating, which monitors risk monthly, 1 is the highest rating possible and 4 is the lowest. **YTD (Use of Resource) metric:** • Overall rating 1 (plan 1) o Capital Service Cover 1.9 (rating 2) o Liquidity days 6.4 (rating 1) o I&E Margin 0.50% (rating 2) o I&E Variance 0.50% (rating 1) o Agency -29.9% (rating 1)

	YTD income & expenditure (including S&T funding): • Plan: -£23k net deficit • Actual: £207k net surplus • Variance: £230k favourable **Month 2: £98k surplus (including S&T funding), +£83k variance from plan:** Key variances: • Children's Services and Adult East Services have pay underspends due to high vacancy levels, +£146k and £125k respectively. • IAPT underspend of +£139k due to the net vacancy position inclusive of non-recurrent investment benefit. • Acute overspill overspend of -£277k, principally due to 19 acute/PICU placements required in month resulting from bed pressures. To note, the Trust's underlying vacancy benefit offsets the evenly profiled RCI target in month of £386k. **Cash:** Month 2: £21m (plan £19.4m) The variance to plan is primarily due to: • YTD capital underspend due to IM&T re-phasing £1.3m • S&T 2016/17 incentive and bonus funds £0.9m **Capital expenditure YTD:** Month 2: £170k (plan £1.49m) The variance to plan is primarily due to: • Estates, extended timescales regarding ward configuration at PPH (PFI) £0.5m • IM&T, re-phasing of IT replacement programme £0.7m The variances are due to timing of spend rather than a reduction in the overall requirement.

Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

11/07/PM342

Trust Board Paper

Board Meeting Date	11th July 2017
Title	**Summary Board Performance Report M2 2017/18**
Purpose	To provide the Board with a performance summary dashboard, including narrative and KPI exception highlights.
Business Area	Trust-wide Performance
Author	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
Summary	The enclosed summary performance report provides information against the Trust's performance dashboard for May 2017. **Month 2** **2017/18 EXCEPTIONS:** **The following Trust Performance Scorecard Summary indicator groupings are Red rated:** The "red" indicator grouping has been rated on an override basis, related to 1 specific indicator; • Service Efficiency and Effectiveness - RED **The following Trust Performance Scorecard Summary indicator groupings are Amber rated:**

	• People • Contractual Performance Further detail on the AMBER dashboard ratings is narrated within the section commentaries of the summary performance report. **The following individual performance indicators are highlighted by exception as RED with their link to the Trust Performance Dashboard Summary identified in brackets:** • **US-5 -** Self-harm incidents: Number **(User Safety)** • **US-06** - AWOLs on MHA section **(User Safety)** • **PM-01 -** Staff Turnover **(People)** • **PM-02** – Gross Vacancies (% WTE) **(People)** • **SE-03 -** Mental Health: Acute Average LoS (bed days) **(Service Efficiency & Effectiveness)** • **SE-03a** - Mental Health: Acute Average LOS Snapshot **(Service Efficiency & Effectiveness)** • **SE-06A -** Mental Health: Acute Occupancy rate (EX HL) **(Service Efficiency & Effectiveness)** • **SE-06B -** Mental Health: Acute Occupancy rate by Locality (EX HL) **(Service Efficiency & Effectiveness)** • **SE-09 -** MH: Crisis Plans for Clients on CPA **(Service Efficiency & Effectiveness)** • **SE-10 -** Mental Health Clustering within target **(Service Efficiency & Effectiveness)** Further RED KPI performance detail and trend analysis is provided in the summary performance report.
ACTION REQUIRED	The Board is asked to note the above.

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Berkshire Healthcare NHS
NHS Foundation Trust

Board Summary Performance Report

M2: 2017/18 May 2017

Performance Scorecard Summary: Month 2: 2017/18

Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

Board Summary

Ref	Mapped indicators	Indicators	Overall Performance	Over ride	Subjective
US	US-01 to US-20	User Safety	Green	No	N/A
P	PM-01 to PM-08	People	Amber	No	Yes
MA	MA-01 to MA-15 & MA 17-23	NHS Improvement (non-financial)	Green	No	N/A
	MA-16	NHS Improvement (financial)	Green	No	N/A
SE	SE-01 to SE-11	Service Efficiency & Effectiveness	Red	No	No
CP	CP-01	Contractual Performance	Amber	No	Yes

Key :

Red	Red indicates the measures for this indicator are not meeting planned target levels for the current period being measured
Amber	Amber indicates the measures for this indicator are at risk of meeting planned target levels for the current period being measured
Green	Green indicates the measures for this indicator are meeting or exceeding the planned target levels for the current period being measured
R A G	The trajectory will either be green, amber or red depending on whether the measures for this indicator are moving towards or achieving the target by year end.

Mapping Rules to be applied to the indicator set for the performance scorecard summary

The mapping rules to be applied to the performance scorecard categories are detailed below:

MA-01, 04, 06, 09, 10, 11, MA-15, 17, 18 & 19

% rules based approach

- SE-01 to SE-11
- Where 50% or more of the mapped indicators are RED rated, the summary performance scorecard indicator will be RED.
  For example:
  A performance scorecard category has 5 indicators mapping into these indicators have the following performance reported in the month:
  2 RED rated (40%)
  2 AMBER rated (40%)
  Based on the first two mapping principles, the 50% rule would not apply but clearly the scorecard category should not be GREEN.

Overriding prinicples based approach

There are indicators within the detailed performance indicator report where the over ride rule applies.
This is driven by severe sanction or breach usually linked to regulatory compliance requirements within the Trust.
Year 2017 - 2018; M2 May 2017

- Mental Health 7 day follow up
- Mental Health new EIP cases seen within 2 weeks
- Mental Health Home Treatment Team gate keeping
- MHSDS – Identifiers
- MHSDS – Priority Metrics
- A&E maximum waiting time of 4 hours
- RTT Incomplete Pathways
- IAPT 6 weeks and 18 weeks

Red performance against any of the above indicators turns the summary performance scorecard indicator red.

Subjective

Where appropriate, Lead Directors may override mapping rules and this will be indicated on the performance scorecard summary.

Exception report

Summary of Red Exceptions M2: 2017/18			
Indicator	**Indicator No**	**Comments**	**Section**
Self-Harm incidents	US 05	Increased from 159 to 183 in the month	User Safety
AWOLS	US 06	Increased from 18 to 23 in the month	User Safety
Staff Turnover	PM 01	Decreased from 17.7% to 17.1% in the month	People Management
Gross Vacancies	PM 02	Increased from 12.4% to 12.6% in the month	People Management
MH Acute Length of Stay	SE 03	Increased from 37 to 38 days	Service Efficiency
MH Average Length of Stay Snapshot	SE 03a	Increased from 50 to 51 days	Service Efficiency
MH Acute Occupancy Rate by Locality and Ward	SE 06 a & b	Decreased from 93% to 92%	Service Efficiency
MH Crisis Plans for Clients on CPA	SE 09	Increased from 71% to 87%	Service Efficiency
Clustering	SE 10	Decreased from 87.5% to 86.9%	Service Efficiency

User Safety Commentary

There were 4 serious incidents including 1 suspected suicide of a Talking Therapies client (IAPT), 1 attempted suicide (Reading CMHT), 1 unexpected death of a Mental Health Inpatient (Orchid ward), and a breach of confidentiality (CAMHS).

The number of assaults on staff increased to 65 in the rolling quarter to May 2017 and is now rated as amber against a local target. In the rolling quarter, 20 incidents were reported on Sorrell ward (same as last month) 16 on Daisy ward (6 last month), 5 incidents on Bluebell ward (4 last month), 3 on Snowdrop ward (last month 4) and 2 on Rowan ward (last month 4), and 2 incidents were reported on Rose Ward (3 last month). 4 incidents were reported at the Berkshire Adolescent Unit (3 last month) now called Willow House. 32 clients committed assaults against mental health inpatient staff in the rolling quarter to May 2017, including one patient who has committed 8 assaults and another who has committed 5. All incidents in May were rated as low or minor risk. This shows an increasing trend. Assaults will be an initial area of focus in the Quality Improvement (QI) initiative.

For Learning Disabilities there was a decrease in the number of assaults on staff from 56 in the rolling quarter to April 2017 to 46 in the rolling quarter to May 2017. All incidents in May 2017 were rated as low or minor risk. 8 patients have carried out assaults on staff in the rolling quarter, including one patient who has carried out 12 assaults and another who carried out 10 assaults. This shows an increasing trend.

Patient to Patient Assaults - In Mental Health services this has increased to 22 in the rolling quarter to May 2017 and remains green rated against a local target. 7 incidents took place on Sorrel ward (8 last month), 3 each on Rowan ward (2 last month) and Daisy Ward (0 last month), 2 on Rose ward (3 last month), 1 each on Snowdrop ward (same as last month), Bluebell ward and Orchid ward (same as last month). 15 clients committed assaults on other inpatients including 1 service user responsible for 4 incidents. All incidents are rated as low or minor risk. One low risk incident was reported by Reading Older Persons service in May 2017. This shows a decreasing trend.

Learning Disability - Patient to Patient Assaults increased to 16 (previously 15) in the rolling quarter to May 2017. All incidents were rated as low or minor risk and the assaults were carried out by 6 clients, including one client responsible for 7 incidents. This shows a decreasing trend.

Slips Trips and falls – In May 2017 Orchid ward (9 falls) was above target; the service have investigated and confirmed that one patient has been placing themselves on the floor. One incident on Ascot ward is rated as moderate, where a patient fell and sustained a fracture which did not require surgery.

Self-Harm incidents - These have increased to 183 in the rolling quarter to May 2017, and moves to a red rating. In the rolling quarter, 60 incidents (increased from 53 last month) have been reported by Willow House (Berkshire Adolescent Unit) with one client responsible for 27 incidents and two others responsible for 7 each. All of the incidents reported in May 2017 at Willow House (Berkshire Adolescent Unit), were rated as low or minor risk. There were a total of 102 incidents reported in the rolling quarter to May 2017 by Mental Health Inpatients; an increase from 92 from the preceding month. Of these, 8 incidents were reported on Rose Ward (14 last month), 45 incidents on Bluebell ward (increased from 40) and 31 on Snowdrop ward (increased from 30), 11 on Daisy ward (1 last month), and 1 on Rowan Ward (same as last month). There were also incidents reported as follows; 1 in place of safety and 1 in an interview room at Prospect Park Hospital. All incidents in May were rated as low or minor risk. In the Community in the rolling quarter, 1 incident was reported by CAMHS, 11 for the Crisis team, 2 for Perinatal services, 1 each for Reading CMHT, Slough CMHT, and Wokingham CMHT, and 3 for Common Point of Entry. All self-harm incidents in May were rated as low or minor risk. This shows an increasing

trend which could be viewed as positive as increased reporting from our inpatient wards.

Learning Disability Self-Harm – decreased to 8 in the rolling quarter to May 2017; however no incidents were reported in May 2017.This shows an increasing trend.

AWOLS and Absconsions - This data covers only those clients detained on a mental health section and is measured against a local target. AWOLS increased from 18 to 23 and Absconsions remained at 16 in the rolling quarter to May 2017. In May 2017, there were 11 AWOLs reported; 4 from Bluebell ward, 3 from Daisy ward, 1 each from Willow House (Berkshire Adolescent Unit), Snowdrop ward and 1 from Hospital grounds, where the ward is not recorded and 1 from an unknown location. All incidents were rated as low risk. In May 2017, there were 6 absconsions, 4 from Snowdrop ward, 1 from Bluebell ward, and 1 from Campion Unit. All were rated as low risk. Both AWOLs and Absconsions show a decreasing trend. New fencing is being erected at Prospect Park Hospital to remove ligatures risk and mitigate Absconsions.

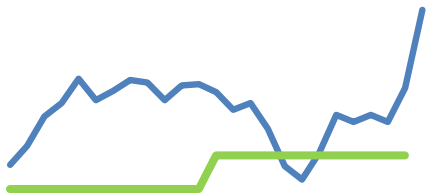
PMVA (Control and Restraint of Mental Health patients) – In May 2017, there were 31 uses on 13 clients; this includes 1 client with 5 uses (client was on Daisy ward and then moved to Sorrel) and another with 3. There were 7 uses each on Bluebell and Snowdrop wards, 6 on Daisy ward, and 5 on Sorrel ward, 1 each on Rose ward, 1 at Place of Safety, 1 at Willow House (Berkshire Adolescent Unit) and 3 where no ward could be allocated. All incidents were rated as low or minor risk.

There were 14 incidents of prone restraint in May 2017 – 5 each for Bluebell ward and Snowdrop ward, 1 each for Sorrel ward and Daisy ward, and Willow House (Berkshire Adolescent Unit). The Nurse Consultant at Prospect Park is undertaking a review to ascertain how assurance on restraint practices can be provided and an update will be provided to the August 2017 Quality Assurance Committee. The trend for use of prone restraint is downwards, when measured over a 3 year period.

SCIP (Strategy for Crisis Intervention and Prevention) – There were 6 uses of SCIP (all at Campion Unit) in May 2017 on 3 learning disability clients. All incidents were rated as low or minor risk.

Seclusion: There were a total of 10 incidents of seclusion in May 2017 for Mental Health Inpatients for 6 clients; the longest incident was for 204 hours 20 minutes (8 days). The patient was then transferred to a Medium Secure unit. The risks to other patients and staff were the reason why the seclusion lasted so long. In Learning Disability Inpatient services, there was a decrease in the use of seclusion from 8 in April 2017 to 1 in May 2017, which lasted for 1 hour 15 minutes.

User Safety Exception Report Month 2: 2017/18

KPI	Target	May	Trend	Context/Reasons	Commentary of Trend
Self Harm incidents	<75	183		**Increase in Self-Harm driven by an increase in reported incidents on Rose ward, Willow House (Berkshire Adolescent Unit), Bluebell ward and Daisy ward.**	
AWOLs on MHA section	<15	23		**Increase in AWOLS this month driven by an increase in reported AWOLS on Bluebell ward, where 50% of reported incidents occurred.**	**Overall decreasing trend**

Other Key Performance Highlights for this Section

There has been a decline in performance in the following metrics:

- Mental Health Physical Assaults on staff increased from 51 in the rolling quarter to April 2017 to 65 in the rolling quarter to May 2017.
- Mental Health Physical Patient to Patient Assaults increased from 17 in the rolling quarter to April 2017 to 22 in the rolling quarter to May 2017.
- Mental Health Self-Harm incidents increased from 159 in the rolling quarter to April 2017, to 183 in the rolling quarter to May 2017.
- Mental Health AWOLs increased from 18 in the rolling quarter to April 2017 to 23 in the rolling quarter to May 2017.
- Learning Disability Physical Patient to Patient Assaults increased from 15 in the rolling quarter to April 2017 to 16 in the rolling quarter to May 2017.

There has been an improvement in performance in the following metrics:

- Learning Disabilities Physical Assaults on staff improved from 56 in the rolling quarter to April 2017 to 46 in the rolling quarter to May 2017.
- Learning Disabilities Self-Harm reduced from 15 in the rolling quarter to April 2017 to 8 in the rolling quarter to May 2017.
- Mental Health Preventing and Managing Violence and Aggression (PMVA) reduced from 43 in the rolling quarter to April 2017, to 31 in the rolling quarter to May 2017.
- Prone Restraint reduced from 15 uses in April 2017 to 14 in May 2017.
- Seclusion reduced from 22 uses in April 2017 to 11 uses in May 2017.

People Commentary

Performance in this category drives an ""amber"" rating on the performance scorecard summary on a subjective basis. Sickness, turnover, and gross vacancies are stretch targets internally and PDP is a local target. Of the 8 indicators, 2 are red (Staff turnover and Gross Vacancies), 2 are amber (Fire and Information Governance), 3 are green including (Statutory training - Manual Handling and Health and Safety and sickness). PDP does not have a rating at present but target of 95% should be achieved by June 2017.

Sickness Absence

• The confirmed Trust monthly sickness rate for May is 3.39%, following the transfer of sickness data from the eRoster system to ESR. This is the second consecutive month that the final sickness rate has been below the Trust target of 3.5%.

•The final sickness rates for May show a slight increase in the short-term sickness rate in the last month, although there remains a downward trend since January. The long-term sickness rate is showing a slight decrease in May (1.95%), after remaining consistent over the previous three months (at 2.02%-2.08%).

• The data indicates that the overall improvement seen in the sickness rate attributed to anxiety/stress/depression in April has been sustained in May, with a further reduction in the long-term sickness rate for this reason (to 0.50% in May from 0.67% in April).

• There has also been a further reduction in the overall sickness rate attributed to musculoskeletal/back problems in May (to 0.71% in May from 0.83% in April), with reductions evident in both the medium-term and long-term sickness rates for this reason. There was a notable increase in the number of referrals to the early intervention physiotherapy service in May, with the highest number of referrals since November 2016. This follows focused work on ensuring appropriate and timely referrals to the service and this work will be on-going to ensure these improvements are sustained.

• A number of initiatives are being implemented within the localities, which will be reviewed in terms of their impact on sickness rates and the learning will be shared. These include; a Health and Wellbeing Newsletter which focuses on physical activity, encouraging staff to be active and take a break away from their desk/workplace, 10 minute briefing sessions for managers on the ‘basics’, e.g. return to work discussions, informal sickness management to ensure issues are effectively managed at an early stage; and ‘keeping in touch’ agreements with staff on sick leave to facilitate an earlier return and ensure the effective management of individual cases.

Turnover

• There has been a reduction in the Trust turnover rate to 17.25% in May, and the improvements in the turnover rate in Mental Health Inpatients continue to be sustained. The turnover rate in Oxford Health for March 2017 was 17.73%.

• A recent initiative in one service with high turnover, whereby leavers in the previous six months received a letter from the Locality Director requesting feedback, has had a positive impact on both the quantity and quality of feedback received and will therefore be replicated in other services with high turnover and/or a low response rate to the survey monkey questionnaire.

Recruitment

• A recruitment open day in May at Prospect Park, which targeted unqualified staff and focused on career development pathways, has resulted in 24 offers of employment. Recruitment to the remaining vacancies at Prospect Park is being managed collectively to improve effectiveness.

• The Trust is hosting the Reading RCN conference in June with representation from a number of services. A new approach will be piloted whereby candidates will be 'shortlisted' on the day and interview slots booked for the week after the conference.

• The new applicant management system (TRAC) allows for quarterly external benchmarking with other Trusts who also use the system. The first of these reports indicates that BHFT compares favourably with other Trusts with regard to the internal efficiency of the recruitment administration process, and was the best performing organisation for speed of shortlisting.

People Exception Report Month 2: 2017/18

KPI	Target	May	Trend	Context/Reasons	Commentary of Trend
Staff Turnover (% YTD) : Percent	**<15.2%**	**17.12%**		**Increase in turnover figure from September 2016. This remains a challenging stretch target however this is the lowest figure since May 2016.**	**This includes end of fixed term contracts, retirements as well as voluntary resignations.**
Gross vacancies (% WTE) : Percent	**<10%**	**12.60%**		**This figure includes areas where there has been difficulty recruiting such as CHS inpatients and nursing, LD and MH inpatients, Children's and Young Persons Integrated Therapies and Crisis Services.**	**New staff structures being implemented including an increase in Band 4 and 6 and a reduction in Band 5s.**

Other Key Performance Highlights for this Section

- Staff Turnover has improved from 17.7% in April 2017 to 17.12% in May 2017.
- Sickness has remained below target in May 2017 3.39%

NHS Improvement Non-Financial and Financial Commentary

The precise construction of all the metrics in the Single Oversight Framework has still not been published, however in the NHSi bulletin of 11th January 2017 advised that the measurement against the complete and valid submission of the Mental Health Services Data Set (MHSDS) which stated that this would comprise of settled accommodation, employment status and ethnicity. The Trust had until the end of 2016/17 to achieve the target of 85%, however despite continuing improvements we have not achieved this. NHSi and NHS Digital have advised that all codes are valid; for the May 2017 Primary submission the levels were:

- Ethnicity 90.85%
- Employment Status 79.32%
- Accommodation Status was 81.97%

Due to Purdah no data has been published to allow comparison with other Trusts. Localities have been asked to increase collection of settled accommodation and employment in particular and weekly reports are being sent to support this. At this stage the impact is minimal for not achieving the target, but if 3 quarters are missed there may be an issue.

The Single Oversight Framework also included the Cardio Metabolic CQUIN designed to reduce premature mortality rates amongst people with severe mental illness. The Trust rates show that we are above targets published in the Single Oversight Framework.

Inpatients – 96% compliance against 90% target
Community – 87% compliance against 65% target
EIP services - 100% compliant against 90% target

For May 2017 the Use of Resources score is 1 for both the year to date figure and forecast.

There was 1 MRSA case attributed to the Trust due to lapse in care. At the post infection review meeting the importance of podiatry input for this patient was considered essential. This had not been provided because the correct process for referral to podiatry had not been followed and therefore the podiatry service were not aware of the referral.

Service Efficiency And Effectiveness Commentary

There are 13 indicators within this category, 5 are rated as “Green” including DNA rates, CHS Length of Stay Mental Health Readmissions, and Mental Health Non Acute Occupancy and New Birth Visits. None are rated as “Amber”; 7 are rated “Red”, MH Average and Snapshot Length of Stay, CHS Occupancy, Mental Health Acute Occupancy by ward and by Locality, Clustering, and Mental Health Crisis plans and 1 of which does not have a target (place of safety). As more than 50% of indicators are rated as red, this section is rated as red.

The DNA rate reduced from 4.91% in April 2017 to 4.68% in May 2017 and is rated as green. WAM at 5.17% and West Berkshire at 5.08% are rated amber. A recent data quality audit found that there is still a high level of error by staff when entering a DNA instead of a cancellation even when the patient has advised that they will not be attending an appointment.

In CPE, the DNA rate decreased from 14.09% in April 2017 to 9.65% (108/1119) in May 2017.

In Children and Families services the DNA rates saw decreases in West Berkshire 9.26% (last month 9.47%), Wokingham 5.77% (last month 5.79%) Reading 8.37% (last month 9.66%) and Slough 4.53% (last month 4.86%), but an increase in Bracknell at 4.48% (last month 4.19%). CAMHS services DNA rates showed a decrease to 7.35% in May 2017 (last month 8.57%).

For Mental Health, there has been some improvements with; Slough 7.15% (last month 7.17%), West Berkshire 6.45% (last month 6.59%), WAM 6.45% (last month 6.50%), but Reading 9.87% (last month 8.67%) and Wokingham 3.82% (last month 3.48%) and Bracknell 7.67% (last month 6.82%) worsened. SMS text messaging can be used for reminders for appointments which take place in clinics provided that a mobile number is collected and entered into RiO in the correct format. In May 2017, 20,166 text messages were sent.

CHS Inpatient Average Length of Stay – reduced to 28 days which is at target, with WAM 32 days and West Berkshire at 41 days the only areas above target. Delayed transfers have an adverse impact on length of stay. By ward there has been worsening in West Berkshire (24.8%), Slough 15.5%, Reading 19.9% and Windsor and Maidenhead 8.4% with only Wokingham showing an improvement to 7.1%. A total of 54 patients discharges were delayed in May 2017 with a split in the agency responsible as follows; 22 awaiting health and social care, 18 social care, 25 were awaiting further NHS care. The most common reason for delay was awaiting care package in own home (32 in total, 19 both health and social care, 5 health and 9 social care), this was followed by 9 who were awaiting further NHS non acute care.

CHS Occupancy increased to 84%.

Mental Health Acute Occupancy excluding home leave reduced to 92% in May 2017, which shows a decreasing trend.

The Average Length of Stay for Mental Health increased from 37 days in April 2017 to 38 days in May 2017 and the acute snapshot length of stay (50 days in April 2017 to 51 days in May) and continues to remain above target. Of the 252 clients discharged between March 2017 to May 2017, 173 had lengths of stay below the Trust target of 30 days, 27 clients were discharged in the period had lengths of stay above 90 days, including 24 above 100 days and 3 above 300 days. There are a number of clients who have accommodation needs for which funding must be obtained and placements sought before they can be discharged from the ward. There are cases where there is no recourse to public funding. At 15th June 2017 there were a total of 17 clients on acute wards (a reduction from 19), 10 of which have been confirmed as delayed discharges and a further 7 are classed as potential delays due to accommodation issues. Including the potential delays by Locality, there were 5 delays for Slough, 4 for West Berkshire, 2 each for Reading and WAM, and 1 for Wokingham. Including potential delays by ward there were 7 on Snowdrop, 5 on Bluebell ward, 3 on Daisy ward, 2 on Rose ward and 1 on Sorrell ward. The acute average length of stay (bed days) shows an increasing trend, but the snapshot views shows a reducing trend.

An additional metric on bed occupancy by Locality has been included and work has been developed to facilitate Localities managing their allocation of beds and out of area placements. Slough and West Berkshire were above target. Slough has a high number of clients detained on Mental Health Act Section together with those who are ineligible for public funding.

The Trust has appointed a Bed Optimisation Programme lead which has looked at the procedures around admissions particularly in relation to the purpose of admission, with reviews taking place each day of admissions to Prospect Park from each Locality. This includes from gatekeeping prior to admission including a pilot in the West where a consultant was involved in the gatekeeping process, using alternatives to admission such as Yew Tree Lodge, to the involvement of Localities in discharge planning.

As at the 15th June 2017 there were a total of 7 out of area clients, 6 of which required an adult acute mental health bed and 1 for Older Persons. For the national return there were 16 OAPs in May 2017. NHS England have asked CCGs to reduce OAPS spends by Quarter 4 2016/17 with a view to elimination by 2020/21 as per the requirements of the 5 Year Forward View.

Older Adults Mental Health wards length of stay is 32 days for Rowan ward and 45 days for Orchid ward for clients discharged.

Mental Health Readmission rates increased to 9% in May 2017, which is a 1% increase from last month and is at target and the 2015/16 benchmarking figure of 8.8%.

Learning Disability – Benchmarking reports have been received and distributed to the service. A fuller report has been provided to the July Finance Performance and Risk Executive Committee.

Community Services benchmarking – The project opened on 22nd May 2017 and the submission is due by 31st August 2017.

Mental Health Benchmarking – the data collection for the 2016/17 benchmarking is underway and submission is due on 30th June 2017. This year there is an extensive request for information on employment services.

CAMHS – the data collection opened on 8th May 2017 with a submission date of 14th July 2017.

Clustering – remained at 87% compliant which is below the 95% target. With the exception of IMPACTT (99.2%) and Psychotherapy (100%) all services are below target with Common Point of Entry at 68.6% (81 out of 118 clients clustered) and Eating Disorders at 69.4% (196 out of 277 clients clustered in date), Older Adult Liaison 67.3% (76 out of 112 clients clustered) and Neuropsychology has 1/14 (6.3%) clients clustered that are amongst the lowest compliance levels. Focus is on ensuring that services not only change the date of the cluster but rather look at underlying scores covering the type and level of needs that determine the cluster allocation ("red rules") and ensure that staff assign clusters appropriately; compliance against the red rules has increased to 92% of those clustered. Early Intervention in Psychosis clients must remain in Cluster 10.

Place Of Safety – This reduced to 37 uses in May 2017 with 3 uses for minors. Of the 37 uses of the place of safety, 17 were admitted following assessment including 10 under Section 2 of the Mental Health Act. 9 clients waited over 8 hours for an assessment. The reasons for the delays in assessment include Bed availability, Patient intoxication, and availability of AMHP/assessing Doctor. 4 of the 37 assessments were carried out by Berkshire Healthcare NHS Foundation Trust Section 12 Doctors, with a further 31 not recorded. The most common time to be brought to the place of safety was between 6pm to 9pm and then 3pm to 6pm and 9pm to midnight. The most common day for detention in May 2017 was Monday and Wednesday's with 9 detentions each followed by 6 detentions on Friday's.

Crisis plans – this report has been revised and shows the compliance against the new risk assessment tool introduced on 10th January 2017. This has improved to 87% but remains below the 90% target.

Health visiting – The Trust has increased to 96% in May 2017 with only Wokingham below target. For Wokingham, there were families not in at the time of the visit, and babies in Special Care Baby Units which affected the service achieving the target.

System Resilience – Waiting times at Frimley North (Wrexham Park) achieved 88.9% A&E 4 hour waits in May 2017 with an average of 352 attendances against a plan of 300 attendances. Compliance with the A&E 4 hour target had improved in the week ending 12th June 2017 with the service achieving 91.2%. However Sunday 11th June the service achieved 77.1%. The average number of attendances at the Slough Walk in Centre was 98 per day against a plan of 80 attendances with Tuesday 5th June 2017 having 120 attendances. There was also pressure on East Community Health ward beds at the beginning of June in comparison with the preceding week in May 2017.

In the West – no A&E data has been published since September 2016. The system wide report showed capacity in Reading CRT and Rapid Response teams. Other relevant teams also had capacity. In terms of inpatients there were 3 males waiting for beds at Oakwood Unit on 16th June 2017 with one male and one female bed available. There were no waiting lists for any other wards in the West.

Service Efficiency And Effectiveness Exception Report Month 2: 2017/18

KPI	Target	May	Trend	Context/Reasons	Commentary of Trend
Mental Health: Acute Average LoS: Number	**<30 Days**	**38**		**Decrease in length of stay. Bed optimisation project underway to look at alternatives to admission, productive stay and productive discharge, still above target.**	**Delayed transfers and lack of onward accommodation have impacted on this metric. In the 2015/16 NHS Benchmarking Exercise the Trust was at the national mean with an average length of stay of 33 days. This shows an increasing trend.**
MH Acute Length of Stay Snapshot	**<30 Days**	**51**		**As above. This is a reduction on the preceding month and continues a reducing trend.**	

KPI	Target	May	Trend	Context/Reasons	Commentary of Trend
MH Acute Occupancy rate (exc. HL - by Ward/ Locality)	**< 90%**	**92%**		**Reading, Slough and West Berkshire were above target.**	**High numbers of Slough patients are detained under the Mental Health Act. Daily teleconference calls taking place between Inpatients and Localities. This shows a decreasing trend.**
MH Crisis Plans for Clients on CPA	**95%**	**87%**		**The Community Mental Health Services have been asked to complete a new Safety plan which includes the Crisis Plan. This was launched in January 2017.**	
Clustering within target	**95%**	**87%**		**There are frequent reviews required for certain clusters which mean it is challenging to achieve the target.**	**Teams with high numbers of outliers are being targeted. Clustering Lead is attending the Locality Managers Business Meeting to ensure that focus is maintained.**

Other Key Performance Highlights for this Section

- CHS Length of stay decreased from 29 days in April 2017 to 28 days in May 2017.
- DNA rates have improved from 4.91% in April 2017 to 4.68% in May 2017.
- Mental Health Average Length of Stay increased from 37 days in April 2017 to 38 days in May 2017.
- Mental Health Acute Length of Stay Snapshot increased from 50 days in April 2017 to 51 in May 2017.
- Mental Health Acute Occupancy decreased from 93% in April to 92% in May 2017.
- Health Visiting increased from 95% in April 2017 to 96% in May 2017.
- MH Crisis Plans for Clients on CPA increased from 71% in April 2017 to 87% in May 2017.

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	11 July 2017
Title	**Finance, Investment & Performance Committee – Changes to the Committee's 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 Lejman, Committee Chair
Relevant Strategic Objectives	3. - Strategic Goal: To deliver services that are efficient and financially sustainable
CQC Registration/Patient Care Impacts	N/A
Resource Impacts	None
Legal Implications	Meeting requirements of terms of reference.
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 as agreed by the Committee on 31 May 2017.

Berkshire Healthcare NHS
NHS Foundation Trust

Finance, Investment & Performance Committee

Terms of Reference

Document Control

Version	Date	Author	Comments
1.0	28 Jan 08	Philippa Slinger	
2.0	5 Feb 08	Philippa Slinger	Following comments by F&I Chair
3.0	5 March 08	Garry Nixon	Following Approval by Board
4.0	7 May 09	John Tonkin	Amendments following F&I Committee meeting 29 April 2009
5.0	16 August 2010	John Tonkin	Amendments following F&I Committee meeting 28 July 2010
6.0	10 March 2011	John Tonkin	Amendment to include scrutiny of integrated performance information following agreement at Board meeting 8 March 2011
7.0	8 May 2012	John Tonkin	Amendment to membership on recommendation of Committee following Board consideration on 8 May 2012
8.0	25 February 2015	John Tonkin	Amended following review by F,I&P Committee – for Board approval – June 2015
9.0	22 February 2017	Julie Hill	Amended following review by F,I&P Committee – for board approval July 2017

1. Authority

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

1.2 The Committee is authorised by the Trust Board ~~of Directors~~ to request the attendance of individuals and authorities from within and outside the Trust if it considers this necessary to discharge its duties.

2. Purpose

2.1. To conduct independent and objective review of financial and investment policy and to review financial and operational performance information and issues. To discharge this duty the Committee will:

2.1.1 scrutinise and review current financial performance, ensuring that there are robust plans in place to correct any material adverse variances from financial plan.

2.1.2 scrutinise and review both tier 1 and tier 2 organisational performance as reported within the Trust's ~~Integrated~~ Performance Assurance Framework report ensuring that there are robust plans in place to correct any material adverse variances from target.

2.1.3 review the Trust's Investment Strategy and Policies and maintain scrutiny and oversight of investments and significant transactions ensuring compliance with the regulator and Trust Policy.

2.1.4 examine the Trust's medium term financial strategy and provide assurance that the Trust's future strategic service plans support continued compliance with ~~the~~NHS Improvement's Provider Licence and the Single Oversight Framework. ~~Terms of Authorisation and the Risk Rating required by the Board of Directors.~~

2.1.5 review the progress against national requirements for maintaining safe staffing on the Trust's inpatient wards.

2.1.6 review the relevant risks on the Board Assurance Framework.

3. Membership

3.1 The members of the Committee shall be as follows:

- Three Non-Executive Directors
- Chief Executive
- Director of Finance, ~~&~~ Performance & Information (Lead Executive Director)
- Chief Operating Officer
- Director of Nursing & Governance or Deputy Director of Nursing

3.2 The Chair of the Audit Committee shall not be a member.

3.3 The Chair of the Committee will be a Non-Executive Director.

3.4 A quorum shall be three members, including at least two Non-Executive Directors.

4. Frequency and Administration of Meetings

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

4.2 The Committee will be supported by the Company Secretary who will agree the Agenda for the meetings and the papers required, directly with the Chair.

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

5. Remit

5.1 Financial Policy & Performance

5.1.1 To review and scrutinise current financial performance and assess adequacy of proposed rectification to bring performance in line with plan (where necessary).

5.1.2 To scrutinise projected financial performance with particular reference to reviewing sustainability against Board objectives on risk ratings and liquidity.

5.1.3 To examine the Trust's annual financial plan and maintain an oversight of Trust's income sources and contractual safeguards.

5.1.4 To initiate in-depth investigations and receive reports on key financial, ~~and~~ investment and performance issues affecting the Trust.

5.1.5 The committee will review long term financial projections, those overarching the more detailed review of annual budget proposals.

5.2 Investment Policy & Performance

5.2.1 To assess whether adequate systems are in place to ensure that financial considerations are properly incorporated within capital investment decisions.

5.2.2 To scrutinise all investment proposals for financial implications and consistency with strategic plans prior to submission to the Board when required.

5.2.3 To receive and scrutinise future service and business development proposals, including enhancements to existing contracts, acquisitions, etc to ensure proper financial evaluation, including impact on future risk ratings.

5.2.4 To ensure adequate safeguards on investment of funds.

5.2.5 To receive reports as appropriate on actual or potential breaches of the Prudential Borrowing Code.

5.2.6 To review, at least annually, credit ratings, report on benchmarking of investments and borrowing activities since the date of the last review.

5.2.7 To review investment performance and risk.

5.3 Organisational Performance Assurance

5.3.1 To review and scrutinise tier 1 and 2 organisational performance as reported within the Trust's ~~integrated~~ Pperformance Assurance Framework report.

5.3.2 To assess the appropriateness of remedial action to address material variances from target and to monitor progress.

5.3.3 To consider the overall adequacy of the performance assurance framework and the monitoring metrics and to recommend changes as necessary to maintain appropriate levels of Board assurance.

Amended: ~~February~~ May 201~~5~~7

Approved by Trust Board: ~~9 June 2015~~ 11 July 2017

For review: ~~February~~ June 201~~8~~6

Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper

Meeting Date	11 July 2017
Paper Title	Annual Equality Report 2017
Purpose	The production of an Annual Equality report is required as part of our compliance with the Equality Act 2010, and provides an important overview of information about the people who use our services, our staff and our progress against key objectives.
Business Area	Corporate Affairs
Author	Stef Abrar, Equality Manager; Louella Johnson, Director of Human Resources
Presented by	Bev Searle, Director of Corporate Affairs
Relevant Strategic Objectives	Goal 1: To provide safe services, good outcomes and good experience of treatment and care. Goal 2: To strengthen our highly skilled and engaged workforce. Goal 4: Understanding and responding to local needs as part of an integrated system.
CQC Registration/Patient Care Impacts	CQC 'well-led' domain
Budget/Resource Impacts	Any agreed actions require full costing approval prior to implementation.
Commissioner Implications	Required by our core contracts.
Brief Executive Summary	This report consists of five sections: 1. Introduction 2. A summary of our workforce and service user diversity 3. A summary of our performance against the NHS Equality Delivery System, our benchmarking tool 4. Actions taken to progress our equality objectives – as required

	by the Equality Act 2010 5. Recommendations The specific duties of the Act require the Trust to publish relevant and proportionate information relating to our workforce and service users. Detailed data tables for the period 1 April 2016 - 31 March 2017 are available to view on our website.
	Board members are asked to consider: 1. A time-frame for peer review of Goal 4 of the Equality Delivery System in order to be fully compliant. It is proposed that this is incorporated in the Board Equality and Inclusion workshop planned for July 11th 2 2017. 2. Board assurance of equality impact assessment in relation to strategic planning to ensure that strategy is inclusive from the outset. This is also a potential action to be considered at the Board workshop. 3. Any additional action that may support the achievement of our equality objectives and reinforce our ethos of fairness as an employer.

Annual Equality Report 2017

How we meet the public sector duty

Contents

1. Introduction

As a NHS Foundation Trust providing community and mental health services, Berkshire Healthcare needs to understand and respond to the needs of a wide range of people. We employ approximately 4,300 people and operate from over 100 bases, with most of our contacts with patients and service users in their own homes.

1.1 The Public Sector Equality Duty

The public sector equality duty is a general duty on public bodies and others that carry out public functions. It ensures that public bodies consider the needs of all individuals in their day to day work in shaping policy, in delivering services, and in relation to their own employees.

The equality duty has three aims. It requires public bodies such as Berkshire Healthcare to have due regard to the need to:

- eliminate unlawful discrimination, harassment, victimisation and any other conduct prohibited by the Equality Act 2010
- advance equality of opportunity between people who share a protected characteristic and people who do not share it
- foster good relations between people who share a protected characteristic and people who do not share it.

The protected characteristics covered by the equality duty are:

- age
- disability
- gender reassignment
- marriage and civil partnership (but only in respect of eliminating unlawful discrimination)
- pregnancy and maternity
- race—this includes ethnic or national origins, colour or nationality
- religion or belief—this includes lack of belief
- sex
- sexual orientation.

The general equality duty is supported by two specific duties which require public bodies such as Berkshire Healthcare to:

- publish information to show their compliance with the equality duty
- set and publish equality objectives, at least every four years.

Our seven equality objectives are shown in Box 1 below.

Box 1
Equality Objectives agreed for the 2016 - 2020 Equality Strategy (published September 2016)

1. Increase representation of black and minority ethnic (BME) staff in (Agenda for Change) bands 7 and 8a-d, aiming for 20% representation at each of these grades. This reflects the Berkshire population demographic.

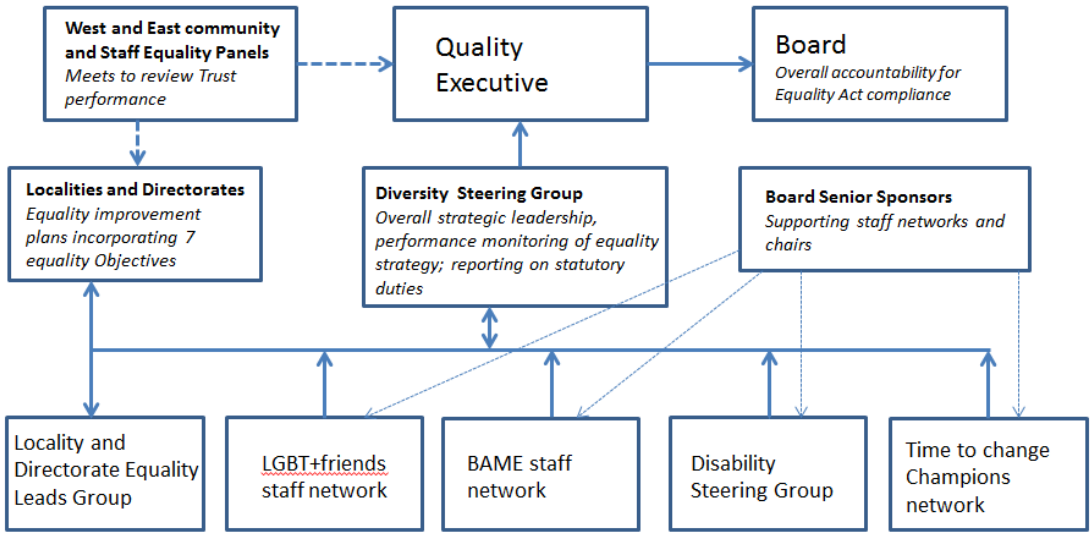
2. Ensure there is no difference in perceptions of equal opportunity in career progression between white and BME staff (as measured by our annual staff survey)
3. Reduce harassment and bullying as reported in the annual staff survey, in particular by BME staff. We are aiming to reduce experiences of harassment and bullying to lowest quartile rankings compared with other mental health Trusts in the NHS staff survey index. We also wish to achieve equity in reporting between BME and white staff
4. Deliver a more robust approach to making reasonable adjustments for disabled people – in particular implementation of the NHS Accessible Information Standard
5. Improve the well-being of disabled staff and reduce the proportion of staff experiencing stress related illness
6. Maintain Top 100 Workplace Equality Index Employer status and achieve a ranking in the top five health and social care providers by 2020
7. Engage with diverse groups in particular BME, Lesbian, Gay, Bisexual or Transgender (LGBT and disabled people to inform our understanding of their needs, with a view to ensuring good patient experience and equity of access in both mental and community health services.

1.2 Our approach to governance on equality and inclusion

Our equality strategy 2016-20 ensures that we have systems in place across the organisation to consider equality for our workforce and regarding service delivery. The Diversity Steering Group, with Executive and Non-Executive membership, provides strategic leadership and performance monitoring to ensure that we fulfil our equality duty. The Diversity Steering Group is chaired by the Executive Director of Corporate Affairs.

The Trust also has 4 senior sponsors, 11 equality leads, over 100 equality champions, four staff networks, and three equality panels. Designated staff such as the Equality Manager and the Equality Human Resources Manager, Marketing and Communications, Workforce Information and Information analysts provide support. The diagram below shows our overall governance framework, enabling coordination of our work and monitoring of progress. NB. The Time to Change network is focussed on tackling mental health discrimination.

Figure 1: Berkshire Healthcare governance of equality and inclusion



1.3 Compliance with the equality duty

This summary report describes the progress we have made since the publication of the last Annual Equality Report in January 2016, highlighting key achievements and activity towards fulfilling our equality objectives. It also provides recommendations for next steps.

This report consists of four sections:

- A summary of our workforce and service user diversity
- A summary of our performance against the NHS Equality Delivery System, our benchmarking tool
- Actions taken to progress our equality objectives
- Recommendations.

The specific duties of the Act require the Trust to publish relevant and proportionate information relating to our workforce and service users. Detailed data tables for the period 1 April 2016 - 31 March 2017 are available to view on our website. In line with NHS data protection standards we cannot publish data that relates to less than five people.

This report covers all protected characteristic data we hold on job applications, short-lists, appointments, pay, turnover, harassment and disciplinary processes. This year we have also published data on the following services: mental health inpatients, crisis response and home treatment, community mental health services, Improving Access to Psychological services (IAPT), Memory Clinics, rehabilitation wards, community health services, hearing and balance services, Slough walk-in centre.

Following our equality strategy recommendation, we have changed our reporting time-frame this year to reflect the financial year, in this case 1 April 2016 – 31 March 2017, in line with all other Trust reports.

2. Data headlines

2.1 Berkshire demographic

Berkshire is a county of around 861,870 people (2011 Census), living in six local authority areas. In the East - Bracknell Forest, Royal Borough of Windsor and Maidenhead and Slough; in the West - Reading, Wokingham and West Berkshire.

According to the 2011 census, the population distribution is as follows: 50% women and 50% men; 25% of the population aged 0 – 19 years; 61% aged 20 – 64 years; 12% aged 65 – 84 years; 2% aged 85 years and over. 0.3% of the population have severe learning disability (Berkshire Learning Disability Register). 1.7% of respondents to the Annual Population Survey (2016) identify as lesbian, gay and bisexual. The most accurate assessment of British same sex experiences is the National Survey of sexual attitudes and lifestyles (2010) which estimates same sex experiences to be between 8-16% for women and 5-7% for men.

20% of the Berkshire population are from an ethnic minority background. When we refer to 'Black and minority ethnic' (BME) in this report we are counting only non-white ethnic minorities. In terms

of age bands, the proportion of minority ethnic people is significantly less for older age groups: 7.2% at 65-84 years and 3% for those aged over 85 years.

We have used the following summary categories in this report:

Summary ethnic categories	*2011 Census population estimate*[1]
White British	73.0%
White Other (including EU nationals, Irish, Gypsies & Travellers)	7.0%
Asian (Indian, Pakistani, Bangladeshi, Chinese, any other Asian)	13.0%
Black (African, Caribbean, any other Black background)	3.5%
Mixed	2.6%
Other ethnic group (Arab and any other ethnic group)	1.0%

Religion and belief	*2011 Census*
Christian	56.2%
Atheist	0.1%
Islam	6.5%
Hindu	2.7%
Other	27.7%
Not Declared	6.9%

2.2 Workforce data summary

2.2.1 Workforce diversity

The Trust employed 4,283 staff as at 31 March 2017. Workforce diversity is outlined below:

- 83.5% female and 16.5% (705) male
- 74.7% white, 21% (901) black and minority ethnic, 4.2% unknown ethnicity
- 4.8% (206) disabled staff
- 1.4% (62) lesbian, gay, bisexual or transgender; 80% heterosexual; 18.5% unknown sexual orientation
- 52.7% of our workforce identify themselves as Christian, 11.1% (474) Atheist, 3.2% (139) Muslim, 2.5% (07) Hindu, 8.8% other religious belief, 21.7% do not declare
- 5.1% were under 25 years, 20.9% were 25 – 34 years, 24.4% were 35 – 44years, 40.8% were 45 – 59 years, 8.8% were 60 years old and over.

[1] Due to rounding upwards the ethnic breakdown adds up to 100.1%

- 44% of staff were married, 1.1% (49) were in a civil partnership, 22.6% (969) were single, 4.3% were divorced, 0.7% legally separated, 0.6% were widowed and 26.6% were of unknown status. Co-habiting partners are not recorded
- 41.4% of the workforce were part-time staff ; of these 92.7% were female.

The workforce profile has remained broadly similar for six years. This year there has been 0.6% increase in the proportion of male staff, a 1% increase in BME staff compared with last year. Efforts to encourage staff to review equality data held on their staff record this year led to a very small 1 – 2% increase in data completeness in data fields relating to sexual orientation, disability and religion and belief.

2.2.2 Recruitment and selection

In the financial year 2016/17 there were a total of 13,455 job applicants, 3,917 shortlisted applicants and 819 newly appointed staff. Applicant data is collected by NHS Jobs on gender, age, ethnicity, disability, religion and belief and sexual orientation.

- There was a change in success rates for minority ethnic short-listed candidates this year. Whilst white applicants were 1.2 times more likely to be shortlisted than minority ethnic applicants; once short-listed, ethnic minority applicants were 1.1 times more likely to be appointed. This is compares with 2014/15 when white candidates were 1.6 times more likely to be appointed from short-list than ethnic minority candidates.
- Female applicants were 1.2 times more likely to be shortlisted than male, and women were 1.1 times more likely to be appointed than male.
- Applicants aged 45 years or more were 1.4 times more likely to be shortlisted than those who were 44 years and under. Having been shortlisted, those who were under 44 years of age, were 1.1 times more likely to be appointed.
- Disabled applicants were equally likely to be shortlisted compared with non-disabled staff, but non-disabled staff are 1.5 times more likely to be appointed
- Christian applicants are 1.2 times more likely to be shortlisted and 1.1 times more likely to be appointed
- Staff who declare that they are LGBT are equally likely to be shortlisted compared with heterosexual staff; however, heterosexual staff are 1.4 times more likely to be appointed.

Figures comparing success rates for disability, sexuality, religion and belief are less reliable than other categories, as around a quarter of the data in these categories is not recorded.

2.2.3 Career development

In common with many other NHS trusts, ethnic minorities are under-represented in our workforce at senior grades. 74% of BME staff hold posts in job bands 1 – 6. Under-representation starts at Band 7 for clinical (16.7%) and 8a for non-clinical posts (11.5%).

2.2.4 Grade increase

369 internal candidates achieved a grade increase this year. Of these, 76.4% were white, and 20.6% were BME. This in line with the workforce average. More men achieved a grade increase compared to women; and more younger staff compared to older staff.

2.2.5 Continuing professional development

Continuing professional development (CPD) opportunities and/or training and development are linked to career progression. 564 staff in Bands 5 through to 9 had access to CPD training this year. White staff were 1.4 times more likely to receive CPD funded training than BME staff. The position has not changed compared with 2015/16.

2.2.6 Equal Pay

The majority of the Trust's posts are on the Agenda for Change pay banding system, which is designed, together with the policy on starting salaries, to reduce pay inequality between the sexes. Based on average hourly rates of basic salaries, the average pay gap between female and male staff on Agenda for Change was 6.9%, which is 1.7% lower than in the previous year. Men earned on average £15.81 per hour compared with the average for women of £14.72. When those who are not on Agenda for Change are included (medical doctors and directors), the gap increased to 19.6%; the average hourly rate for men was £19.07 and for women it was £15.34.

2.2.7 Disciplinary

There has been national concern for some years around levels of BME disciplinary cases in the NHS. Over the last 12 months, 53 staff were formally disciplined. This included closed and current cases. 35 (66%) were white staff, 17 (32%) were BME staff. BME staff were 1.73 times more likely to be disciplined compared to white staff.

2.2.8 Harassment and victimisation

In the 12 month period, there were six formal complaints brought under the Dignity at Work policy, which addresses allegations of harassment, bullying or victimisation. All six were brought by white staff.

2.2.9 Turnover

Over the reporting period, 776 staff left the Trust, giving an average turnover rate of 17.6%. The turnover rate for men (18%) was slightly higher than for women (17.5%). The turnover rate for BME staff varied from a low of 14.6% for Black staff, to a higher rate of 17.9% for Asian staff. For White staff the turnover rate was 17.2%.

The turnover rate varied across the age bands. The highest rate was for those under 25 years old (31.7%). The turnover rate was 23.3% for those aged 25 to 34 years and 22.1% are aged 60 years plus. The LGB turnover reduced this year to 17.7% (it had been 34% in 2016). The turnover for disabled staff was 17.1%.

Box 2: Launch of the Black Asian Minority Ethnic (BAME) Staff network

In June 2016 the Trust launched its Black Asian Minority Ethnic staff network with a conference at the Hilton Hotel Reading. Numbering over 100 staff the network now has an active organising committee with links to all directorates. The network held an Awayday, organised Black History Month celebrations and held its second conference on 31 March 2017. There has been a focus on role modelling throughout, and the network is making a real contribution to the achievement of our goals.

2.3 Service Delivery

The Trust provides over 100 services, and in order to provide a good overview, the data analysis in this section is focussed on key mental health and community services including: mental health inpatients, community mental health, crisis response, Improving Access to Psychological Therapy (IAPT), rehabilitation services, and generic community health services.

2.3.1 Age

We provide universal health visiting to families of children aged 0-5 years and a range of other services targeted at children and young people, adults and older people. We also provide a number of services open to all age groups. Some of these are disproportionately used by older people as a result of disability or ill health in older age. For example, rehabilitation services, diabetic retinopathy screening, memory clinics, hearing and balance. Activity at our walk-in services such as the Slough Walk-In centre, a minor injury and illness service, is broadly in line with Slough's younger demographic.

Box 3: IAPT reaching out to older people

Improving Access to Psychological Services, which was originally designed to meet the needs of working age adults, has been adapting its service provision to meet the mental health needs of older people. It has seen a 2% (418) increase in its service offering to people over 65 years compared with the period reviewed by the last report. 8% of IAPT service users are now aged 65 plus compared with 13.5% of the Berkshire population. This brings the total number of over 65s seen by the service this year to 1,322. The service has also provided services to 20 people over the age of 90 years.

2.3.2 Gender

Patterns of service access by gender are in line with previous years, with women slightly outnumbering men as adult service users in many key services. Women's service usage increases with age. For example in our inpatient rehabilitation[2] services, 62% of those service users aged over 85 years were women. This also mirrors the higher prevalence of disability among women of this age. There are proportionately more men using hearing and balance services aged 85 than might be expected - this may be explained by the higher prevalence of hearing loss among men.[3]

Historically men have been over-represented in tertiary mental health services and under-represented in primary mental health services. This pattern continues this year. Men comprise 56% of mental health inpatient service users aged 20-64 years of age, 42% of community mental health service users and 33% of Improving Access to Psychological Therapy service users.

2.3.3 Ethnic minorities

Data quality

One of the main problems in assessing equality of access according to ethnic background has been recording of accurate data. We have had modest success in improving our data in this area and this is being addressed through locality equality improvement plans. Data from mental health inpatients and Improving Access to Psychological services continues to be exemplary (with un-coded or 'not

[2] These services cover Henry Tudor, Jubilee wards in the East and Oakwood, Donnington, Highclere, Ascot and Windsor wards in the West.

[3] From the age of 40 onwards a higher proportion of men than women develop hearing loss. This may be because men and more likely to be exposed to industrial noise. (Reference Action on Hearing Loss website.)

stated' data rates of 1.7% and 5.2% respectively). Community mental health service ethnicity data capture has improved from 16% 'not stated' data in 2014/15 to 10% in 2016.

Over the past three years steps have been taken to address ethnicity data gaps in community health services generally. 19.4% of community health ethnicity data is now 'not stated', an improvement of 5% compared to 2014/15. Capturing ethnicity data from services where the user group is older continues to prove difficult. Corporate initiatives have focused on our main patient data base Rio. Improving ethnicity data quality in other smaller patient databases remains a challenge.

Mental health

An area of national concern over the past 20 years is the over-representation of people from a Black background (i.e. people from an African, African-Caribbean and other Black background) in mental health inpatient services. Data from the Mental Health Foundation shows that in England people from a Black background are 3 to 5 times more likely than any other group to be diagnosed and admitted to hospital for schizophrenia. In Berkshire, people from a Black background comprise 5.6% (58) of the mental health inpatient population in 2016/17 – this compares with 3.5% of the population according to the 2011 census.

Rates of Crisis Response and Home Treatment and community mental health service usage by people of a Black background are in line with population averages but may not reflect need. People from a Black background are also slightly under-represented as IAPT service users (2.7%) and have lower than average treatment completion rates of 55% compared with the average of 62%.

People from an Asian background comprised 9.6% of mental health hospital admissions this year (a 3% rise) though this was just 10 more people compared to the 2014/15 headcount. A similar proportion used Crisis Response and Home Treatment (8.5%), community mental health (9%) and IAPT (9.3%). Completion rates for IAPT treatment were 53% for Asian compared to the average of 62%.

Memory clinics appear to be under-used by minority ethnic communities with only 7% of service users from minority ethnic backgrounds. However, analysis by age band shows that in fact, ethnic minorities are using these services in line with the demographic. 7% of service users over 65 years are from a minority ethnic background compared with 7.2% of the population aged 65 years plus; 3.9% of service users over 85 years are from a minority ethnic background compared with 3.02% of the population at this age.

Community health

Overall, ethnic minority usage of generic community health services appears in line with expected levels. Ethnic minorities appear to be slightly under-represented (up to 2%) in services with an older service user population such as rehabilitation wards. Although service usage was not analysed, patient experience data for both health visiting and community nursing demonstrated high levels of satisfaction with the overall service by all ethnic and religious groups.

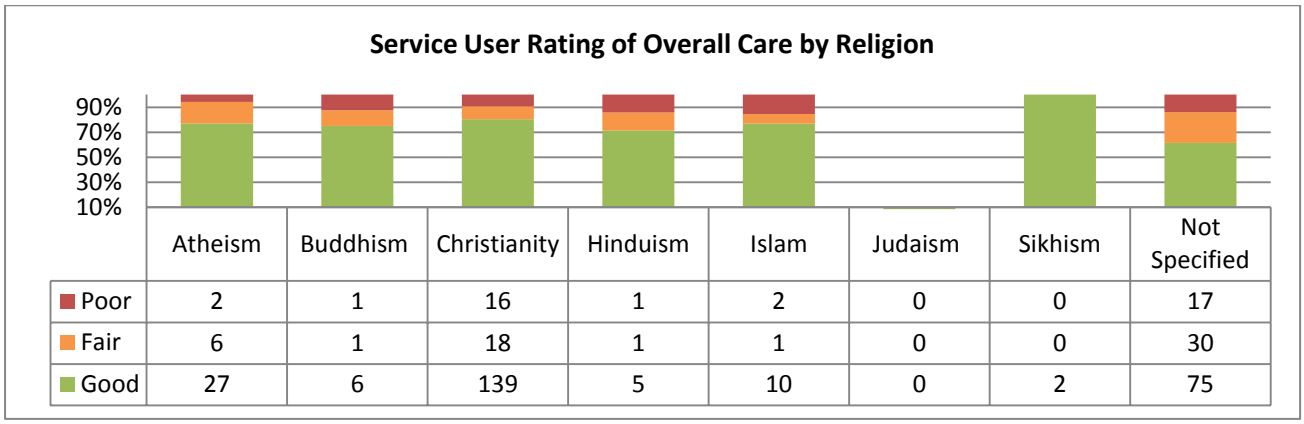
2.3.4 Religion and belief

Religious belief data is collected inconsistently as it is not a mandatory data requirement. The most reliable data in this area is from IAPT where 52% of service users declared they had no religious belief, 26% were Christian, 3% were Muslim, 1.4% were Hindu, 1.6% were Sikh, 0.2% were Jewish. 1.8% declined to disclose. Treatment completion rates for people of different religious beliefs were

in line with average. There were slightly lower rates compared to the average for people from a Muslim background (58%).

Mental health inpatient services (Prospect Park Hospital) collect patient data on religion and belief and provides a multi-faith chaplaincy. 66% of the 360 inpatients who undertook the patient experience survey filled out the data on religion and belief.

The results are presented below.



	Atheism	Buddhism	Christianity	Hinduism	Islam	Judaism	Sikhism	Not Specified
Poor	2	1	16	1	2	0	0	17
Fair	6	1	18	1	1	0	0	30
Good	27	6	139	5	10	0	2	75

2.3.5 Disability

Disability codes are rarely used at the Trust since many of our patients attend specific services dealing with long-term or disabling conditions. Following the implementation of the NHS Accessible Information Standard in July 2016, 2,058 records were established by staff to record the communication needs of disabled service users. The highest rate of completion was in Wokingham locality (25%), the lowest was in North West Reading (7% of the total records). This new data forms a baseline to compare performance year on year.

Results of the community mental health patient experience survey were also reviewed. These showed that 13.4% (23) of the 171 disabled service users surveyed were not completely satisfied with information provided to them in the course of their treatment. 2% disagreed that they had been given all required information.

The Trust continues to provide British Sign Language interpretation for BSL speakers whenever required. A small number of Braille requests were also received this year.

2.3.6 Sexual orientation

IAPT, Prospect Park Hospital and our sexual health services collect information on the sexual orientation of their service users.

Mental health inpatient data shows that 2% (22) of inpatients were gay or lesbian, 1.4% (14) were bisexual, 0.3% defined as 'other' and 1.6% (14) preferred not disclose their status. Although numbers are very small and not statistically significant, on average LGB and bisexual patients appeared more likely than heterosexual patients to rate the service overall as fair or poor – 44% compared to 21% in our mental health inpatient experience survey.

Improving Access to Psychological (IAPT) services work with the LGBT community is one of the Trust's successes. 4% (599) of the IAPT service users identified as lesbian gay or bisexual this year;

1.2% (178) were gay, 1% (152) were lesbian and 1.8% (269) were bisexual. Overall this is a 2% (200) increase in LGB IAPT service users compared with 2014/15. This level of declaration is higher than the average of 1.7% as recorded by the Annual Population Survey which may indicate that patients feel safe in declaring their sexual orientation to their IAPT counsellor. However, IAPT treatment completion rates are a few percentage points lower for LGB service users than for heterosexuals.

2.3.7 Interpretation services

To promote equality and ensure people who use our services are not discriminated against in clinical assessment and care planning, we provided around £106,000 of interpretation services for people whose first language is non-English or who are hard of hearing/deaf. This is a £16,000 increase on the levels reported in 2014/15 due to increased demand.

2.3.8 Patient experience

Patient experience data is collected for six protected characteristics. However, although they provide valuable insights, numbers of respondents with protected characteristics are often small. Minorities are significantly under-represented in all samples. Where pertinent, results have been noted in the sections above. Consideration will be given to potential use of qualitative methods such as focus groups or group interviews to learn more about patient experience from the perspective of those with protected characteristics. A more conventional survey design may not be appropriate to capture useful information from these respondents.

2.3.9 Complaints

202 formal complaints were made this year. 12.4% or 25 were from ethnic minorities, of these 4% were from 'other white' minorities. 46% of complaints data on ethnicity was not available.

3. NHS Equality Delivery System

The Equality Delivery System was introduced by the NHS in England to assist NHS organisations in complying with the public sector duty: it is the NHS's equality benchmarking tool. It drives improvements and strengthens the accountability of services to patients and the public.

Equality Delivery System grades are agreed at panel meetings where detailed evidence is reviewed. Our last panel meetings took place in Spring and Summer 2016. Each of the outcomes listed below are graded against a range of criteria. Grades are awarded at four levels: Underdeveloped - Red; Developing - Orange; Achieving – Green; Excelling – Purple.

The Trust has yet to grade on EDS Goals 4.1 and 4.2 which covers Inclusive leadership and equality impact assessment. EDS guidance recommends these areas for peer review.

Box 4 Taking steps to embed inclusive leadership

Trust leaders have taken significant steps to increase their leadership profile on diversity this year. Julian Emms, Chief Executive Officer (CEO), delivered the key note speech to the equality conference on his vision for inclusivity by 2020 and showcased the Trust's new staff diversity video. David Townsend, Chief Operating Officer, delivered a speech on unconscious bias to 200 senior leaders at the September Trust leadership forum. A number of executive directors became senior sponsors of staff networks and many have undertaken reverse mentoring with members of the LGBT&friends

staff network. Board members participated in a workshop on diversity and inclusion in February 2017.

Our progress against the Equality Delivery System goals and outcomes is shown in the table below.

Goals and Outcomes of the EDS2 Toolkit			2013	2014/15	2016	Priority
Goal 1 **Better Health Outcomes**	1.1	Services are commissioned, procured, designed and delivered to meet the health needs of local communities			*Not graded this year*	
	1.2	Individual people's health needs are assessment and met in appropriate and effective ways				
	1.3	Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed				✓
	1.4	When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse				
	1.5	Screening, vaccination and other health promotion services reach and benefit all communities				
Goal 2 **Improved Patient Access and Experience**	2.1	People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds.				✓
	2.2	People are informed and supported to be as involved as they wish to be in decisions about their care				✓
	2.3	People report positive experiences of the NHS				
	2.4	People's complaints about services are handled respectfully and efficiently.				
Goal 3 **A represent-ative and supported workforce**	3.1	Fair NHS recruitment and selection processes lead to a more representative workforce at all levels				✓
	3.2	The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to fulfil their legal obligations				
	3.3	Training and development opportunities are taken up and positively evaluated by staff				
	3.4	When at work, staff are free from abuse, harassment, bullying and violence from any source				✓
	3.5	Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives				
	3.6	Staff report positive experiences of their membership of the workforce/health and wellbeing				
Goal 4 **Inclusive Leadership**	4.1	Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations				
	4.2	Papers that come before the Board and other major committee identify equality-related impacts including risks, and say how these risks are to be managed	*New outcome*	*Not graded*	*Not graded*	✓
	4.3	Middle managers and other line manager support their staff to work in culturally competent ways within a work environment free from discrimination.				

Priority areas have been agreed for re-grading by panels in 2018. These relate to improving transitions between services, access to services, information and involvement in decisions about care, fair employment and reducing harassment and bullying. These priorities have been integrated into locality equality improvement plans and the HR Equality Delivery System plan.

4. Public Sector Equality objectives

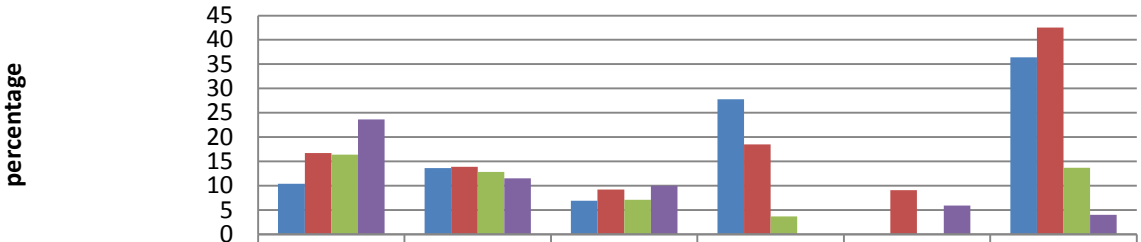
The Trust's equality objectives for the period 2016 - 2020 were agreed by the Board in September 2016. These were introduced to over 100 Equality Champions by Julian Emms, CEO, at the Trust's first equality conference on 13 October 2016.

The first phase of the strategy implementation involved nominating equality leads, conducting audits and setting local key performance indicators. Following consultation in Spring 2017, the Trust is launching an employment focused programme – *Making it Right* to address issues of fairness in employment. This programme pledges: fair recruitment for all; career progression for all; zero tolerance of bullying and harassment; prioritising staff health and wellbeing; and all are valued and feel included. The pledges will be delivered through a series of internal development centres for BME staff. Health and wellbeing modules will prioritise the needs of disabled staff.

Objective 1: Increase representation of black and minority ethnic (BME) staff in (Agenda for Change) bands 7 and 8a-d, aiming for 20% representation at each of these grades.

Since the last Equality report (September 2015 data), there has been a 7.2% increase in representation of BME staff in Band 7 non-clinical managerial jobs (now 23.6%) and a 6.3% increase in Band 7 clinical managers (16.7%). There is now some BME representation (9.1% clinical and 5.9% non-clinical) at Band 8d where previously there was no representation.

Figure 2: % of BME clinical and non-clinical staff September 2015 – March 2017



	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Other
Sep-15 Clinical	10.4	13.6	6.9	27.8	0	36.4
Mar-17 Clinical	16.7	13.9	9.2	18.5	9.1	42.5
Sep-15 Non-clinical	16.4	12.8	7.1	3.7	0	13.7
Mar-17 Non-clinical	23.6	11.5	10	0	5.9	4

Action taken: *Locality and Directorate Equality improvement plan targets were set in April 2017 based on detailed local audits of current performance. Equality leads worked with the Workforce Race Equality Standard (WRES) project lead and the Equality HR Manager to address deficits. A number of training and awareness interventions on the topic of 'unconscious bias' took place in 2016/17.*

Objective 2: Ensure there is no difference in perceptions of equal opportunity in career progression between white and BME staff (as measured by our annual staff survey)

According to the October 2016 Staff survey, 90% of white staff believe the Trust provides equal opportunities for career progression compared with only 68% of BME staff. Our data shows that White staff are more likely to access continuing professional development opportunities at work. However, this year short-listed BME candidates were slightly more successful at interview compared with White candidates.

Action taken: *We have taken steps to include BAME Staff Network members in recruitment processes, and provided unconscious bias training. Our internal development programme 'Making It Right' is designed to address barriers and perceptions of unfairness. This launches mid-2017.*

Objective 3: Reduce harassment and bullying as reported in the annual staff survey, in particular by BME staff.

In the 2016 NHS staff survey, 26% of BME staff reported experiencing harassment and bullying from a colleague, compared with 18% of white staff. The gap was similar in the 2015 survey. During this period no formal harassment claims were raised by BME staff.

Action taken: *The 'Making It Right' programme will address harassment channels and a new HR Equality Manager was appointed by the Trust in March to handle harassment complaints. The new BAME staff network now acts as a first point of contact for BME staff.*

In 2016, the Trust stepped up its efforts to address hate crime against staff and patients. Mandatory recording of incidents of a racial and sexual nature is now required by our incident database DATIX.

14% of overall assaults to patients and staff recorded in the financial year involved a racial or sexual element. A number of hate crime awareness champions were trained.

Objective 4: Significantly improve the well-being of disabled staff and a reduction in the proportion of staff experiencing stress related illness

Our recorded sickness absence due to stress related illness was a fifth (0.87%) of total sickness absence (4.0%) for 2016/17 and is reducing. Stress related sickness absence has reduced from 25.3% of days lost through sickness absence in 2015/16 to 21.6% in 2016/17. The staff survey also showed a small (4%) reduction in stress experienced by respondents.

In terms of disability, 52% of disabled respondents felt stress due to work and 32% of non-disabled staff also experienced stress. 27% of disabled survey respondents felt that they did not have adequate reasonable adjustments in place. A third of disabled respondents felt support from their immediate line manager was lacking.

Action taken: *In March 2017, the Trust established a Disability Steering Group chaired by the Director of Finance. The group is currently engaging with disabled staff prior to developing and implementing an action plan. The 'Making It Right' also programme targets wellbeing of staff with a disability. The Trust continues to offer stress reduction workshops and monitors sickness absence monthly through the Performance Assurance Framework. The Time to Change (anti-mental health stigma) champions organise the Trust's mental health awareness day - Time to Talk.*

Objective 5: Take a more robust approach to making reasonable adjustments for disabled people – in particular implement the NHS Accessible Information Standard.

2,058 patient records specifically recording reasonable adjustments were established in 2016/17.

Action taken: *Our accessible information standard was launched in July 2016 and new patient data codes were created to capture service user data. The standard has been publicised widely and is promoted by local equality leads.*

Objective 6: Maintain the Top 100 Workplace Equality Index Employer (WEI) status with a ranking in the top five WEI health and social care providers by 2020

The Trust was ranked 122 out of 439 entrants in the 2017 Stonewall Workplace Equality Index (WEI). We remain in the top quartile of health and social care providers and are ranked 11 out of 48 health and social care providers this year, compared to position 13 in 2016.

Action taken: *In May 2016, the Trust established the Thames Valley LGBT employers good practice network with Reading University to spread good practice across the region. Work to produce clinical guidance for staff working with transgender service users and changes to the patient database to facilitate appropriate recording of transgender service user status was undertaken in 2017. This was launched with the post-card entitled 'Mr Ms Mx'. A task and finish group is in place to meet the requirements of the 2018 WEI Index. This focuses on LGBT career development, training, LGBT staff network activities, role modelling and leadership.*

Objective 7: Engage with diverse groups in particular BME, LGBT and disabled people to inform our understanding of their needs, with a view to ensuring good patient experience and equity of access in both mental and community health.

In spring 2016, our Equality Delivery System (EDS) panels awarded us an average of 100% Green (Achieving) for the EDS Goal 'Patient Access and Experience'.

Action taken: *Objective 7 is devolved to locality improvement plans and guided by the Equality Delivery System service priorities. In the West, a community engagement lead post was established to engage with local BME groups across the region, in particular to improve take up of primary and secondary mental health services. Such engagement is also part of an initiative to address the over-representation of people from a Black background in mental health inpatient services. In the East, the focus is on improving the patient experience of those with hearing impairments and improving transitions across services. The Trust's LGBT&Friends network continued to engage with the LGBT community – transgender speakers were invited to address the plenary at the Trust's equality conference.*

5. Recommendations

Board members are asked to consider:

5.1 A time-frame for peer review of Goal 4 of the Equality Delivery System in order to be fully compliant. It is proposed that this is incorporated in the Board Equality and Inclusion workshop planned for July 11th 2 2017.

5.2 Board assurance of equality impact assessment in relation to strategic planning to ensure that strategy is inclusive from the outset. This is also a potential action to be considered at the Board workshop.

5.4 Any additional action that may support the achievement of our equality objectives and reinforce our ethos of fairness as an employer.

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	11 July 2017
Title	**Audit Committee – 24 May 2017**
Purpose	To receive the unconfirmed minutes of the meeting of the Audit Committee of 24 May 2017
Business Area	Corporate
Author	Company Secretary for Chris Fisher, Audit Committee Chair
Relevant Strategic Objectives	2. - Strategic Goal: deliver sustainable services based on sound financial management
CQC Registration/Patient Care Impacts	N/A
Resource Impacts	None
Legal Implications	Meeting requirements of terms of reference.
SUMMARY	The unconfirmed minutes of the Audit Committee meeting held on 24 May 2017 are provided for information.
ACTION REQUIRED	To receive the minutes and to seek any clarification on issues covered.

Berkshire Healthcare NHS
NHS Foundation Trust

Minutes of the Audit Committee Meeting held on

Wednesday, 24 May 2017, Fitzwilliam House, Bracknell

Present:	Chris Fisher, Non-Executive Director, Committee Chair Mark Day, Non-Executive Director
In attendance:	Alex Gild, Chief Financial Officer Graham Harrison, Head of Financial Services Monika Paluszek, Financial and Capital Accountant Minoo Irani, Medical Director Amanda Mollett, Head of Clinical Effectiveness and Audit Fleur Nieboer, External Auditors, KPMG Stefan Stefanov, External Auditors, KPMG Julie Hill, Company Secretary

Item	Title	Action
1.A	**Chair's Welcome and Opening Remarks**	
	Chris Fisher, Chair welcomed everyone to the meeting. The Chair reported that the May 2017 Trust Board meeting had appointed Mark Day, Non-Executive Director as a member of the Committee to deputise for Mehmuda Mian, Non-Executive Director who was unable to attend the meeting.	
1.B	**Apologies for Absence**	
	Apologies were received from: Mehmuda Mian, Non-Executive Director, Mark Lejman, Non-Executive Director and Satinder Jas, External Auditors, KPMG.	
2.	**Declaration of Interests**	
	There were no declarations of interest.	
3.	**Mortality Review Assurance Process Report**	
	The Chair explained that he had agreed to include the Mortality Review Assurance process on the agenda because national guidance had been issued since the Committee had last discussed the Trust's mortality review process in January 2017. It was noted that one of the requirements set out in the national guidance was to develop and publish an updated policy by the end of September 2017 setting out how the Trust responded to the death of patients who died under its care. The Medical Director reported that the Trust's policy for mortality review was in development and was due to be approved by the Quality Assurance Committee in August 2017. The Chair of the Quality Assurance Committee	

	would then present the policy to the September 2017 Trust Board meeting for approval. The Medical Director reminded the meeting that the Trust's internal auditors would be reviewing the mortality review governance arrangements in October 2017. The Medical Director proposed that the Audit Committee would not receive an additional local audit in July 2017 as agreed at the January 2017 meeting. The Committee: a) noted the timescale for the development of the Trust's updated mortality review policy in line with national guidance; and b) agreed that there would not be an additional local audit in July 2017.	
4.	**Annual Accounts 2016-17, including the Annual Governance Statement**	
	The Annual Accounts 2016-17 and Annual Governance Statement had been circulated. The Committee noted that the Chair had been given the opportunity to review the draft accounts prior to the meeting. The Chair confirmed that his queries had been satisfactorily answered (the questions and answers are annexed to the minutes but are excluded from minutes to the Public Trust Board meeting because of the confidential nature of some of responses). The Committee reviewed the Annual Accounts 2016-17 page by page and the following additional points were highlighted/questions answered: **Revaluation of the Trust's estate**: it was noted that the Trust's estate was re-valued every five years. An interim re-valuation was scheduled in 2018-19. The Chair asked about the likely impact of the re-valuation exercise. The Chief Financial Officer said that he was not expecting the re-valuation to make a significant impact on the Trust. **Segmental reporting**: the Chair reminded that meeting that it was agreed at the May 2016 Audit Committee that in future, the split between pay and non-pay would not be broken down by geographical area as this could provide potential competitors with useful commercial information. It was noted that the change was reflected in the Annual Accounts for 2016-17. **Note 4 – Other operating income (page 30 of the Annual Accounts**): it was noted other income was reduced compared with 2015-16 because property income was now separated out and therefore it was necessary to aggregate property income and other income in order to make a comparison between the two financial years. **Agency costs (page 34 of the Annual Accounts):** it was noted that the Agency Programme had resulted in savings on agency costs of around £5m. **Note 20.2 Clinical Negligence Liabilities (page 51 of the Annual Accounts):** the Chair asked for further information about the Trust's provisioning in respect of clinical negligence liabilities. **Action: Chief Financial Officer**	

	The Committee noted the questions and answers on the Annual Accounts 2016-17 and the Annual Governance Statement.	
5.A	**ISA 260 Audit Memorandum**	
	Fleur Nieboer, External Auditors, KPMG, referred to the ISA 260 Memorandum which summarised the key issues identified during KPMG's audit of the Trust's financial statements and quality accounts. She reported that that the External Auditors intended to give an unqualified audit opinion on the financial statements. Fleur Nieboer said that it was relatively rare for External Auditors to give an unqualified opinion on an NHS provider's accounts. It was noted that the External Auditors had completed the majority of their audit. The outstanding areas were: completing the audit work in relation to the completeness of the related party disclosures and the final review of the financial statements before signing the ISA 260 Audit Memorandum. It was noted that the External Auditors had concluded that the Trust had adequate arrangements to secure economy, efficiency and effectiveness in its use of resources. It was also noted that the External Auditors' Value for Money opinion had been informed by the Annual Governance Statement, a review of the Trust's sustainable resource deployment and by the 2016/17 regulatory reviews, including the outcome of the latest Care Quality Commission inspection and the ratings under NHS Improvement's single oversight framework. It was confirmed that there were no matters in the public interest that the External Auditors wished to raise. The report made one low priority recommendation in respect of the financial statements: • **Review of petty cash balance**: the testing identified that the Trust had not completed a spot check on any of the petty cash floats in the sample. The Chief Financial Officer confirmed that the Trust had accepted the recommendation and that plans had been put in place to address the issue. On behalf of KPMG, Fleur Nieboer thanked the Chief Financial Officer, the Finance Team for their work in finalising the Trust's financial statements. On behalf of the Committee, the Chair echoed those comments and also thanked KPMG for their support in the annual accounts process. The ISA 260 Audit Memorandum was received and noted.	
5B.	**External Assurance Report on the 2016/17 Quality Report**	
	Fleur Nieboer, External Auditors, KPMG, introduced the report which summarised the findings of KPMG's external assurance work completed on the 2016/17 Quality Report. It was noted that the work was mandated by NHS Improvement and that the work had been completed in line with the requirements laid out in the detailed guidance for external assurance of Quality Reports.	

	Members noted that the report's conclusion was that KPMG were satisfied that there was sufficient evidence to provide a limited assurance opinion on the content of the Quality Report. KPMG highlighted their findings in relation to the two mandated indicators. Based on KPMG's work it was confirmed that there was sufficient evidence to provide a limited assurance opinion in respect of both mandated indicators. It was noted that KPMG identified some data recording issues in relation to the locally identified indicator (delayed transfers of care). The report made three medium priority recommendations in respect of the Quality Accounts: • **Delayed transfers of care: discharge/admission dates on RiO being inconsistent with patient notes**: the sample identified five patients where either the discharge or admission dates recorded on RiO did not agree with the date recorded in the patients' notes. • **7 day follow up: patient follow up via phone** – on testing, the auditors identified one case where the follow up occurred via phone and the staff member discussed the follow up with a relative of the patient which was recorded as being compliant with the indicator; • **100% enhanced Care Programme Approach patients receiving follow up contact within seven days of discharge from hospital**: the sample identified 12 patients where the patients' notes did not correspond to the data recorded on RiO. The Chief Financial Officer confirmed that the Trust had accepted the recommendations and that plans had been put in place to address the issues. On behalf of KPMG, Fleur Nieboer thanked the Trust's Quality Accounts Team for their support.	
6.	**Independent Auditor's Report and Management Representation Letters in respect of the Financial Statements and the Quality Accounts**	
	Fleur Nieboer, KPMG presented the Independent Auditor's report which would be presented to the Council of Governors. Fleur Nieboer said that the Trust was required to sign management representation letters in respect of the Financial Statements and the Quality Accounts.	
7.	**Formal Approvals**	
	It was noted that the Trust Board had delegated full authority to the Audit Committee to issue all necessary approvals in respect of the 2016/17 Annual Accounts on its behalf. It was also noted that the Trust Board had approved the Quality Accounts and that Quality Assurance Committee had provided detailed scrutiny of the Quality Accounts on behalf on the Trust Board. The Committee noted and approved the following relating to the Annual Accounts for 2016/17:	

	• *Audit Memorandum* The ISA 260 Audit Memorandum was received and noted together with the long form audit opinion. • *Annual Accounts 2016/17* The Annual Accounts for 2016/17 were approved: • *Management Representations* The proposed Trust Management Representations response to KPMG was approved: • *Annual Governance Statement* The Annual Governance Statement was approved.	
8.	**Chair's Closing Remarks**	
	The Chair thanked the Finance Team for producing a good set of accounts and working papers. The Chair reminded the meeting that this was the last meeting, KPMG would be attending. It was noted that the Governors had appointed Deloittes as the Trust's External Auditors. The Company Secretary asked KPMG if they would be presenting their report on the Quality Accounts and Financial Accounts to the Council of Governors. Fleur Nieboer said that KPMG would be happy to attend a Council of Governors meeting to present their reports. It was agreed that KPMG would be invited to attend the Council of Governors meeting on 13 September 2017. **Action: KPMG/Company Secretary** Mark Day, Non-Executive Directors asked KPMG for a rough estimate for the percentage of Trusts who received an unqualified opinion on their accounts. Fleur Nieboer, KPMG said that around 15% of Trusts received an unqualified opinion. Mr Day suggested that the Governors be informed about the External Auditors unqualified opinion. The Company Secretary said that she would ask the Chief Executive to include this in his next highlight report to the Council of Governors which formed part of the Performance Report. **Action: Company Secretary** On behalf of the Trust, the Chair thanked Fleur Nieboer, Partner at KPMG and her colleagues for the excellent support they had provided over the last ten years as the Trust's External Auditors. The Chief Financial Officer echoed the Chair's comments. On behalf of KPMG, Ms Nieboer thanked the Chair and said that it had been a pleasure to work with the Trust.	
9.	**Date of the Next Meeting**	
	26 July 2017 at 2pm	

These minutes are an accurate record of the Audit Committee meeting held on 24 May 2017.

Signed:- _____

Date: - _____

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	11 July 2017
Title	**Use of Trust Seal**
Purpose	This paper notifies the Board of use of the Trust Seal
Business Area	Corporate
Author	Chief Financial Officer
Relevant Strategic Objectives	N/A
CQC Registration/Patient Care Impacts	N/A
Resource Impacts	None
Legal Implications	Compliance with Standing Orders
SUMMARY	The Trust's Seal was affixed to a lease in relation to accommodation the Trust is leasing from the University of Reading to accommodate the Child and Adolescent Mental Health Service.
ACTION	To note the update.