Berkshire Healthcare NHS
NHS Foundation Trust

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

TRUST BOARD MEETING HELD IN PUBLIC

10:00am on Tuesday 12 September 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 11 July 2017	Martin Earwicker, Chair	Enc.
5.2	Action Log and Matters Arising	Martin Earwicker, Chair	Enc.
QUALITY			
6.1	Quality Board Visit: Hazelwood Unit	Chris Fisher, Non-Executive Director	Enc.
6.2	Quality Assurance Committee Meeting Minutes -15 August 2017	Ruth Lysons, Chair of the Quality Assurance Committee	Enc.
6.3	Learning from Deaths Policy and Quarter 1 Report	Minoo Irani, Medical Director	Enc.
6.4	Patient Experience Quarter 1 Report	Helen Mackenzie, Director of Nursing and Governance	Enc.
6.5	Feedback from Training Doctors and Student Nurses Report	Minoo Irani, Medical Director and Helen Mackenzie, Director of Nursing and Governance	Enc.
6.6	Slough Health Visiting and School Nursing Position Statement	Helen Mackenzie, Director of Nursing and Governance	Enc.
EXECUTIVE UPDATE			
7.1	Executive Report	Julian Emms, Chief Executive	Enc.
PERFORMANCE			
8.1	Month 4 2017/18 Finance Report	Alex Gild, Chief Financial Officer	Enc.
8.2	Month 4 2017/18 Performance Report	Alex Gild, Chief Financial Officer	Enc.
8.3	Finance, Investment and Performance Committee Meeting on 26 July 2017	Mark Lejman, Chair of the Finance, Investment and Performance Committee	Verbal
STRATEGY			
9.1	Strategy Implementation Plan Update Report	Bev Searle, Director of Corporate Affairs	Enc.

No	Item	Presenter	Enc.
9.2	Workforce Race Equality Standard 2017 and Action Plan	Bev Searle, Director of Corporate Affairs	Enc.
CORPORATE GOVERNANCE			
10.1	Audit Committee Minutes – 26 July 2017 Appendix 1 - Board Assurance Framework "Deep Dive" into risks 4 and 7 Appendix 2 – Learning from Incidents Slides	Chris Fisher, Chair of the Audit Committee	Enc.
10.2	Trust Seal Report	Alex Gild, Chief Financial Officer	Enc.
10.2	Council of Governors Update	Martin Earwicker, Chair	Verbal
10.3	Schedule of Meetings	Martin Earwicker, Chair	Enc.
Closing Business			
11.	Any Other Business	Martin Earwicker, Chair	Verbal
12.	Date of the Next Public Trust Board Meeting – 14 November 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
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AGENDA ITEM 5.1

Unconfirmed minutes

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

Minutes of a Board Meeting held in Public on Tuesday 11 July 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
	David Buckle	Non-Executive Director
In attendance:	Louise Arnold	Deputy Office Manager/Executive Assistant

17/110	**Welcome** (agenda item 1)
	The Chair welcomed everyone to the meeting including the Governors: Suzanna Rose, Appointed Governor and Ruffat Ali-Noor, Public Governor for Slough.
17/111	**Apologies** (agenda item 2)
	Apologies were received from Julie Hill, Company Secretary.
17/112	**Declaration of Any Other Business** (agenda item 3)
	There was no other business declared.
17/113	**Declarations of Interest** (agenda item 4)
	i. Amendments to Register – none
	ii. **Agenda Items** - none
17/114	**Minutes of the previous meeting – 09 May 2017** (agenda item 5.1)
	The Minutes of the Trust Board meeting held in public on Tuesday 09 May 2017 were approved.

17/115	**Action Log and Matters Arising** (agenda item 5.2)
	The schedule of actions had been circulated. The following action was discussed further: **Financial Plan** The Chair asked whether the action in respect of NHS England's future commissioning intentions for Berkshire Adolescent Unit (Willow House) had been allocated to the correct Executive Director (the Chief Operating Officer) and whether the action would be completed within the stated timescale. The Chief Operating Officer confirmed that this action was his responsibility and he said that he would update the Finance, Performance and Investment meeting in July 2017 with NHS England's intentions. **Fire Training Compliance Report** It was noted that the staff fire training compliance percentage in respect of Sorrel ward, Prospect Park Hospital was significantly less compared to other wards. The Chief Operating Officer explained that this data was retrieved in May 2017 and if the report was run again now, the statistics would be considerably higher due to an increase in substantive staff being recruited into the service. It was noted that all staff who worked on the wards, including Bank staff, needed to complete fire training. **The Trust Board**: noted the schedule of actions.
17/116	**Quality Board Visit Report – Snowdrop Ward, Prospect Park Hospital** (agenda item 6.1)
	Ruth Lysons, Non-Executive Director, reported that she had visited Snowdrop ward at Prospect Park Hospital on 5 June 2017. The report highlighted that staff shortages combined with high bed occupancy continued to be a problem. It was noted that there had been a recent successful recruitment drive but that it would take several months before the substantive posts were filled permanently. Ruth Lysons reported that staff had raised a concern around patients smuggling in cigarettes and lighters. These items could not be found through metal detectors and can be difficult to find when searching belongings. Chris Fisher, Non-Executive Director highlighted the response from the Senior Nurse about not being able to staff additional wards and asked whether the team needed to be clearer on the admission criteria. Ruth Lysons said that she had challenged the team on this and the response was that operationally this would not work. Mark Day, Non-Executive Director confirmed that the Finance, Investment and Performance Committee had discussed the admission criteria in detail and it had been agreed that this was a complex area and that there was not a simple solution which would resolve all the issues. **The Trust Board**: Thanked Ruth Lysons, Non-Executive Director for sharing her reflections about her Quality Board Visit to the Snowdrop Ward, Prospect Park Hospital.
17/117	**Quality Assurance Committee – 19 May 2017** (agenda item 6.2)

	Ruth Lysons, Chair of the Quality Assurance Committee reported that the Quality Assurance Committee meeting on 19 May June 2017 had received a presentation from Sue McLoughlin, Locality Clinical Director on the Trust's Zero Suicide Project which aimed to reduce the number of deaths from suicide, with a long term aspiration of zero suicides. It was noted that a key focus of the project was co-production with service users and families and carers. The Chief Financial Officer asked how this work would be reported to the Trust Board and how it would be aligned to the Quality Improvement work. It was agreed that progress on the Zero Suicide project would be reviewed by the Quality Assurance Committee and that the Chair would consider how best to update the rest of the Trust Board. **Action: Chair** **Quality Assurance Committee's Terms of Reference** The Committee's terms of reference showing proposed revisions in red tracked changes had been circulated. Ruth Lysons, Chair, Quality Assurance Committee reported that the main change was to reflect the Committee's new role in providing assurance about the Trust's mortality review systems and processes. **The Trust Board**: noted the minutes of the meeting and ratified the changes to the Terms of Reference.
17/118	**Revalidation Annual Report 2016/17** (agenda item 6.3)
	The Medical Director presented the paper and reported that the Revalidation Annual Report was a national requirement from NHS England. The Chair queried whether the positive summary was a fair reflection of the overall process. The Medical Director confirmed that the revalidation process had been developed over time and was in line with established good practice. David Buckle, Non-Executive Director asked whether the 100% appraisal rate was realistic. The Medical Director reported that from April 2016 to March 2017, every doctor eligible for appraisal (excluding the 3 doctors who were on long term sick leave) had been appraised. Ruth Lysons, Non-Executive Director asked how the Lead Appraiser Network worked. The Medical Director explained that NHS England South hosted four meetings a year for the ROs and Lead Appraisers. These meetings provided an opportunity for the Lead Appraisers to network and to share best practice. In addition, the General Medical Council provided updates and complex cases were also reviewed together with practical table top exercises. The Medical Director said that he found these meetings extremely useful and that he has attended all but one of these meetings. The Medical Director reported that the Trust currently employed around 120 Doctors, 30 of which were appraisers. It was noted that there had been a new process implemented this year which ensured that each appraiser had responsibility for conducting the appraisals of four members of staff in order to spread the workload. Mark Day, Non-Executive Director asked how the colleague feedback section worked. The Medical Director said that the General Medical Council set the standards for obtaining feedback from patients and colleagues. It was noted that the 360 feedback process had

	been standardised across the Trust. This enabled the Trust to benchmark performance nationally. The Trust Board: noted the report and agreed to its submission of an annual statement of compliance to the NHS England Higher Level Responsible Officer prior to the 30th September 2017 deadline.
17/119	**Freedom to Speak Up Guardian Report** (agenda item 6.4)
	It was noted that the Freedom to Speak Up Guardian Report was written by the Freedom to Speak Up Guardian (Elaine Williams) and was not reviewed by any member of the Executive Team prior to being submitted into the Trust Board agenda pack. The report set out what the Freedom to Speak Up Guardian had been working on in the first three months of the role (March-May 2017). It was noted that the post was part-time (two days a week) and provided independent and confidential support to staff who wanted to raise concerns. There had been no formal concerns raised with the Freedom to Speak Up Guardian in the first three months, however staff had raised concerns in groups informally which the Freedom to Speak Up Guardian had raised with the Senior Leadership Team. For example, the Senior Leadership Team had established a rota for working a late shift once a month at Prospect Park Hospital following comments from night staff that they did not feel valued and listened to by managers. In addition, the Freedom to Speak Up Guardian had undertaken a range of activities aimed at raising awareness of the role and encouraging cultural change to create an environment where staff felt more confident in raising concerns. The Chair said that he hoped that the roll-out of the Quality Improvement Programme would support a more open culture across the Trust. It was noted that Mehmuda Mian was the Trust's designated Non-Executive Director for staff whistleblowing allegations and she would be working closely with the Freedom to Speak Up Guardian. Ruth Lysons, Non-Executive Director asked what the Freedom to Speak Up Guardian did two days a week to raise awareness of this work. The Chief Executive reported that the work of the Freedom to Speak Up Guardian would be reviewed in 12 months as raising awareness about the role across the Trust and changing the reporting culture would take time take time and patience. It was noted that the Freedom to Speak Up Guardian worked full-time for the Trust and was able to juggle the role alongside her other duties. Mark Day, Non-Executive Director asked whether night staff would benefit from visits from Non-Executive Directors joining the visits being undertaken by Executive Directors. The Chief Executive said that Non-Executive Directors were welcome to join Executive Directors, but he would not encourage additional visits as there were less staff available on the wards at night. The Director of Nursing and Governance agreed to organise these visits with the Interim Locality Director for Prospect Park. **Action: Director of Nursing and Governance** The Trust Board agreed that the Freedom to Speak Up Guardian would provide an annual public report to the Trust Board and a mid-year report to the Quality Assurance Sub Committee and Quality Executive Group. **Action: FTSUG/Company Secretary**

17/120	**Executive Report** (agenda item 7.1)
	The Executive Report had been circulated. The following issues were discussed further: **Quality Improvement Update** The Chair asked whether the roles of those who had been successfully recruited into the Quality Improvement team would be back filled in time for a seamless transition. The Director of Nursing and Governance confirmed that these were permanent positions and that all the roles would be recruited into as soon as possible. **Slough Walk-in Centre Contract** It was noted that the Trust's contract to run the Slough Walk-in Centre would finish at the end of June 2017. The Trust would continue to provide services for the next two months until the new provider was able to take run the service. The Trust's priority was supporting the staff through the transition process and maintaining safe staffing. **Temporary Staffing Programme** The Chair noted that the temporary staffing programme had significantly improved. **The Trust Board**: noted the report.
17/121	**Month 2 2017-18 Finance Report** (agenda item 8.1)
	The month 2 financial summary report had been circulated. The Trust Board confirmed that the new format for the report was much improved. Mark Lejman, Chair of the Finance, Investment and Performance Committee confirmed that the financial summary had been reviewed in detail at the June 2017 Finance, Investment and Performance Committee meeting. The Chief Financial Officer introduced the report and drew the attention of the Trust Board to the continued Out of Area placement pressures which were being currently offset by the reduction in agency spend. It was noted that the Trust's cash position was strong due to the Sustainability and Transformation funding which had been received in the last financial year. The Chair requested an update on the long term financial forecast and the actions that were being considered. The Chief Financial Officer confirmed that there were ongoing discussions internally and national target areas were also being identified. It was noted that once the Quality Improvement Programme had been embedded, it would hopefully reduce some service costs. **The Trust Board noted:** the following summary of financial performance and results for Month 2 2017/18 (May 2017): **Year To Date (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 Income and Expenditure Margin 0.50% (rating 2) o Income and Expenditure Variance 0.50% (rating 1) o Agency -29.9% (rating 1)

	Year To Date Income and Expenditure (including Sustainability and transformation funding): • Plan: -£23k net deficit • Actual: £207k net surplus • Variance: £230k favourable **Month 2: £98k surplus (including Sustainability and Transformation funding), +£83k variance from plan:** Key variances: • Children's Services and Adult East Services had 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 Recurrent Cost Improvement target in month of £386k. **Cash:** Month 2: £21m (plan £19.4m) The variance to plan was primarily due to: • Year to Date capital underspend due to IM&T re-phasing £1.3m • Sustainability and Transformation funding 2016/17 incentive and bonus funds £0.9m **Capital expenditure Year To Date:** Month 2: £170k (plan £1.49m) The variance to plan was primarily due to: • Estates, extended timescales regarding ward configuration at Prospect Park Hospital (PFI) £0.5m • IM&T, re-phasing of IT replacement programme £0.7m The variances were due to timing of spend rather than a reduction in the overall requirement. **The Trust Board**: noted the report.
17/122	**Month 2 2017-18 Performance Report** (agenda item 8.2)
	The Month 2 2017-18 Performance Summary Scorecard and detailed Trust Performance Report had been circulated. The Chief Financial Officer informed the Trust Board that there was not a Contract section included in the Performance report as there was nothing to update. It was noted that the Finance, Investment and Performance Committee had already seen this report and had reviewed it in detail. The Chair asked whether the staff sickness and absence data could be broken down for individual staff groups. The Chief Executive confirmed that this information was available and was regularly reviewed. The Chair asked whether there were any trends in why staff were leaving the Trust. The

	Chief Executive explained that there were no trends which suggested an unhappy workforce, but the data did suggest that younger staff were relocating due to house prices and were going to organisations with better prospects. It was noted that any issues relating to poor management were reviewed during exit interviews and any issues raised were investigated separately. The Chief Executive referred to the NHS Improvement statistics which had been released in relation to national nurse turnover and this allowed the Trust to benchmark its performance. It was noted that the South of England's turnover rate was nearly double compared to other areas. The Director of Corporate Affairs reported that there would be multiple recruitment days which will be run by the Trust during the year. It was noted that by the end of July 2017, bands 2 – 4 positions would be fully staffed. **The Trust Board**: noted the report.
17/123	**Finance, Investment and Performance Committee – May and June 2017** (agenda item 8.3a)
	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 May and June 2017 had discussed the following key issues: • The Board Assurance Framework risks were being reviewed quarterly by the sub-committee. • An update on the Bed Optimisation project. The Chair thanked the Chair of the Finance, Investment and Performance Committee for his update.
17/124	**Finance, Investment and Performance Committee – Changes to the Committee's Terms of Reference** (agenda item 8.3b)
	Mark Lejman, Chair of the Finance, Investment and Performance Committee reported that following the Committee's review of its effectiveness, the Committee had agreed to reduce the number of meetings from 12 to 8. Proposed minor changes to the Committee's Terms of Reference (shown in red tracked changes) had been circulated. **The Trust Board**: noted the report and ratified the changes to the Terms of Reference.
17/125	**Equality Strategy Annual Report** (agenda item 9.0)
	The Director of Corporate Affairs presented the report. During the discussion, the following points were discussed: **BAME Recruitment** The number of newly appointed staff from a BAME background had increased, specifically in Band 7 roles. Further progress on the other banding positions was still be required and this was being monitored. **Disciplinary** Ruth Lysons, Non-Executive Director asked why BAME staff were more likely to be

	disciplined. The Director of Corporate Affairs acknowledged that this was an area of concern and explained that there was no easy answer to explain the trend. It was noted that additional support was being given to Management in the Trust to ensure fair treatment within services and to address concerns prior to formal disciplinary action being taken. **Mental Health** Ruth Lysons, Non-Executive Director asked whether there was evidence which explained why people of a black background had a great prevalence of schizophrenia. The Director of Corporate Affairs explained that this was part of a review which was ongoing and early intervention was being targeted to avoid admission into hospitals later in life. The Medical Director reiterated that this data suggested that early diagnosis and support in people of a black background was especially important. It was noted that mental health disorders were often harder to diagnose than physical health issues and work continued to review how the Trust could better support patients in the Community. **Workforce Summary** The Chair questioned whether more work should be done to target men to join the Trust's workforce. It was noted that currently 83% of the Trust's staff were women. The Director of Corporate Affairs confirmed that the Trust was committed to achieving a diverse workforce and was open minded when recruiting. The Director of Corporate Affairs said that there were other priorities which would be targeted prior to this one, but indicated that she would be happy to review the figures. Chris Fisher, Non-Executive Director noted that there had been significant improvement in the recruitment statistics and asked whether there had been any particular pieces of work which had contributed to this. The Director of Corporate Affairs confirmed that there had been a mixture of ongoing work from top down and bottom up which had had an impact. The Chief Financial Officer shared that there had been great engagement with the teams and staff wanted to contribute to these changes. The staff networks were developing and helping us to improve. **The Trust Board**: noted the report.
17/126	**Audit Committee Minutes – 24 May 2017 (agenda item 10.1)**
	The minutes of the Audit Committee held on 24 May 2017 had been circulated. Chris Fisher, Chair of Audit Committee thanked Mark Day, Non-Executive Director for attending the May meeting. It was noted that this meeting was specifically arranged to approve the Annual Accounts on behalf of the Trust Board. Chris Fisher reported that he had also 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. Chris Fisher reported that the Annual Accounts had been approved and that KPMG (the Trust's External Auditors) had complimented the Trust on the quality and efficiency of producing the final accounts. It was noted that the Trust's new External Auditors would be Deloittes. Chris Fisher thanked the Chief Financial Officer and the Medical Director and their teams for the work they had done to achieve all deadlines and a seamless end of year accounts completion.

	The Trust Board thanked Chris Fisher for his update.
17/127	**Trust Seal Update Report (agenda item 10.2)**
	The Trust Board noted this item.
17/128	**Council of Governors Update** (agenda item 10.3)
	The Chair informed the Trust Board that there was a revised Council of Governor meeting structure. The Governor Strategy Group meeting had been disbanded and that in future, strategic updates will be included as part of the joint Trust Board and Council of Governors meetings. The Chair reported that the Council of Governors had approved the re-appointment of Chris Fisher, Non-Executive Director for another three year term of office. It was noted that the Council of Governors had also agreed that Non-Executive Directors who also acted as Mental Health Act Managers would receive the same fee for attending hearings as the other Mental Health Act Managers. The Trust Board: noted the update.
17/129	**Any Other Business** (agenda item 11)
	There was no other business.
	The Chair concluded the meeting and thanked the observers for attending.
17/130	**Date of Next Meeting** (agenda item 12)
	Tuesday, 12 September 2017 The August meeting date has been cancelled.
17/131	**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 11 July 2017.

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

Berkshire Healthcare NHS
NHS Foundation Trust

AGENDA ITEM 5.2

BOARD OF DIRECTORS MEETING: 12/09/2017

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
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**	NHSE have confirmed by email that they support our need to build a new CAMHs Tier 4 unit at PPH and intend to continue commissioning 9 beds from us beyond the current 2 year contract. This is what we requested from them

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Status
						in a letter sent to them in January This has provided the assurance we needed to proceed with our design and business case for this development.
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	17/087	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	12.09.17	**JH**	This is will discussed as part of the

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.			strategic context section on the Trust Board Away Day agenda.
11.07.17	17/117	Quality Assurance Committee	The Chair to consider how best to update the Trust Board on progress in respect of the Trust's Zero Suicide Project.	12.09.17	**Chair**	Progress reports on the Zero Suicides Programme will be presented to the Quality Assurance Committee. The Trust Board will be updated as part of the QAC Chair's update report.
11.07.17	17/119	Freedom to Speak Up Guardian Report	Non-Executive Directors to be invited to accompany Executive Directors on night visits to Prospect Park Hospital.	12.09.17	**HM**	The Executive Directors have not been on any night time visits yet.
11.07.17	17/119	Freedom to Speak Up Guardian Report	The Trust Board Report Planner to be updated to include an annual Freedom to Speak Up Guardian Report. The Quality Assurance Committee work plan to be updated to include a mid-year report.	12.09.17	**JH**	Completed

Berkshire Healthcare NHS
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Trust Board Paper

Board Meeting Date	12 September 2017
Title	**Quality Board Visit Report – Hazelwood Unit**
Purpose	To receive the report of the Quality Board Visit undertaken by Chris Fisher, 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
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BERKSHIRE HEALTHCARE BOARD QUALITY VISIT TO HAZELWOOD UNIT,

Prospect Park Hospital, 11 August 2017.

People participating:

Chris Fisher, Non-Executive Director, David Aboagye Senior Nurse, Debbie Sheward Consultant Clinical Psychologist, Dalia Hanna and Jules Mason Older People Consultant Psychiatrists

Introduction

The Hazlewood Unit occupies the standalone unit on the Prospect Park Hospital site previously occupied by the Rehabilitation Unit. Hazelwood has been very well refurbished in order meet the needs of the services by replacing bedrooms with clinical rooms, therapy rooms and offices. I was met at the Unit reception by David and during the half day I was with them I had one to one sessions with David and the three clinical leaders and was introduced to a number of administrative and nursing staff.

The Unit houses a number of related services, seeing patients of any age who have a diagnosis of dementia or those who need a diagnosis of dementia. However, for functional patients i.e. for patients who are ill with depression/anxiety disorders/psychosis, they see people aged 75 and above. The service also sees patients who are frail and/or have cognitive impairment issues related to ageing or end of life or indeed those who feel their needs would be best met by the Older Persons Mental Health service.

Support is provided to service users through a mixture of home visits, Hazelwood clinics and telephone support. Services are provided exclusively to Reading residents and 2 clinical localities (north and south) are in place to enable relationship management between referring GPs and our consultants and these are supported by joint teams of therapists and community mental health nurses.

The Services

A standardised process is in place, whereby GPs refer to the Common Point of Entry service who then review and refer on. Referrals are immediately triaged between Urgent and Non Urgent cases. For urgent cases there is an almost 24 hour, 7 days a week and 365 days a year philosophy in place which means that there is the potential for crisis situations to be addressed straightaway. Non Urgent referrals are reviewed in a weekly Multi-Disciplinary Team style session and allocated to community mental health nurses.

Memory Service (MS)

Initial assessments and reviews are made by psychiatrists, memory clinic nurses and non-medical prescriber/nurse practitioner as appropriate.

They provide neuropsychological assessments, speech and language therapy assessments, mental state examinations, complex carer support, and memory strategies. Post diagnostic support includes cognitive stimulation therapy, an understanding dementia course and other carer support.

Groups of clinicians involved in the memory services include Psychology, Speech and Language Therapists, Occupational Therapists and Support Workers. They have access to an Admiral Nurse for younger people with dementia (YPWD) and two dementia care advisors, one for younger people with dementia.

The Memory Clinic works closely with the Crossroads Charity, supporting people with maintenance cognitive stimulation therapy and day time respite care for carers. They also work closely with Age UK, Alzheimer's Society using in particular their befriending service and the local Reading organiser as dementia care advisor alongside Parkinson's UK, Berkshire Carers' Service and Younger Person with Dementia – Berkshire West.

Home Treatment Team (HTT)

Functions of the Home Treatment Team include crisis gate keeping of inpatient beds, crisis response, hospital at home, providing intensive treatment to people in the least restrictive setting during an acute phase of mental illness, carer support and bed management/facilitation to allow timely discharge from hospital.

The team is responsible for providing crisis services and for preventing avoidable admissions to hospital for people with psychosis/agitated depression or challenging behaviour due to dementia. The HTT comprises community psychiatric nurses, community support workers and psychiatrists. HTT is committed to providing a responsive, comprehensive and flexible service to enable older people with mental health issues, for example, dementia, depression, psychotic symptoms etc. to regain the best quality of life achievable.

Community Mental Health Team (CMHTe)

This is a "step down" service after HTT, supporting patients who require less intense input which may involve, weekly or fortnightly support over a time limited period (usually less than 6 weeks) and uses community psychiatric nurses, support workers, psychologists and psychiatrists who manage depression, anxiety, psychosis, bereavement, pain, multiple long term conditions, dementia, challenging behaviour and carer support. Occupational therapists provide home assessments while psychologists provide 1:1 therapy and assessments for challenging behaviour.

The Overall Team

Service Manager, Consultants x 2, Specialty doctor x 0.6, Consultant Psychologist x1

Clinical Psychologist x1 – works 2 days only, Assistant Psychologist x 1,Community Psychiatric Nurses x10,Memory Clinic Nurses x4,Support workers x4, Speech and language therapist x1,Clinical Team Lead x1,Social worker x 2, Medical secretaries x 2, Administrators/receptionists x 2

Quality and Service Metrics

A weekly Multi-Disciplinary Team session is the central communication/prioritisation/ quality control process. The Unit was the first memory service accredited as excellent by the Royal College of Psychiatrists and is one of only 3 services in the United Kingdom who have achieved an excellent accreditation. Subsequently, changes in the grading system changed this rating to good. The service was recently rated as Outstanding by Care Quality Commission.

<u>WAITING LIST</u>

Memory clinic – 6-10 weeks

Psychology – 4 weeks

CPN's – under a week

Current team work load – 906 patients

Observations and Discussion points

1. The overall impression that you get from being on the Unit is that morale is high, the team ethic strong and staff are happy, with everyone I met smiling and engaging.

2. Teams based at Hazlewood are not reliant on agency workers at all and are largely fully staffed.

3. RiO has been well received, although the administrative burden on risk assessment, in particular for low risk memory clinic clients, is seen as excessive. Some support from the RIO team to lighten the load would be appreciated.

4. Dementia clients are likely to be stabilised by the teams based at the Unit, but the prognosis is often that they will return for further treatment later as their disease changes. Clients and carers can be reluctant to be fully discharged as the process to re-enter is seen as "start again". Relationships with GPs could allow a truncated process of re-entry (via the Common Point of Entry) and allow more confident partial discharge.

5. The three key leaders I met (Jules, Dalia and Debbie) are clearly critical and there is a danger that the combination of rising referral levels and the decision of a 0.6 specialty doctor to move on, could drag them away from leadership and into more routine service delivery. Given the difficulty of hiring to fractional wte posts, it would seem appropriate to consider a business case for increasing the specialty doctor to a full wte.

6. The Team have been informed that they will be relocated shortly and are assuming that this will be to the University campus. Whilst of course this news has been professionally accepted, there is concern that accessibility could

affect residents of the west and south of the town in particular and the loss of adjacency to the inpatient wards is also a factor to be considered.

7. Whilst not formally a joint team, the current location of 2 social workers employed by the local authority alongside Trust staff, benefits clients who often have social care as well as health needs. The decision by Reading Borough Council to take these posts out of Hazelwood is likely to make it harder to meet those needs in an integrated way.

I would like to thank Dalia, David, Debbie and Jules for giving me such an interesting and motivating morning

Chris Fisher, Non-Executive Director

August 2017.

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	12 September 2017
Title	**Quality Assurance Committee – 15 August 2017**
Purpose	To receive the unconfirmed minutes of the meeting of the Quality Assurance Committee of 15 August 2017
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 15 August 2017 are provided for information.
ACTION REQUIRED	The Trust Board is requested to receive the minutes and to seek any clarification on issues covered.

Berkshire Healthcare NHS
NHS Foundation Trust

Minutes of the Quality Assurance Committee Meeting held on Tuesday, 15 August 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 David Townsend, Chief Operating Officer
In attendance:	Julie Hill, Company Secretary Jen Knight, Clinical Audit Manager *(deputising for Amanda Mollett, Head of Clinical Effectiveness and Audit)*

1 Apologies for absence and welcome

Apologies had been received from: Mehmuda Mian, Non-Executive Director and Amanda Mollett, Head of Clinical Effectiveness and Audit.

The Chair welcomed everyone to the meeting and proposed that agenda items 5.4 (Serious Incidents) and 6.2B (Learning from Deaths quarter 1 report) would be taken together.

The Chair pointed said that the agenda had been ordered in consultation with the Director of Nursing and Governance and section 7 were items for noting unless members of the Committee wished to raise any particular points.

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 19 May 2017

The minutes of the meeting held on 19 May 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:

Board Assurance Framework Risk 5 – the Director of Nursing and Governance reported that she had reviewed the risk scoring and had decided

that the risk should remain as high because of the impact a negative Care Quality Commission report would have on the Trust's reputation.

Return to Practice Scheme – the Chair said that she was pleased that the Trust was now proactively contacting registered staff who had taken a career break. The Chair asked whether it would be possible to capture the reasons people gave for not wanting to return to practice.

Action: **Director of Nursing and Governance**

Clinical Audit Lithium – David Buckle, Non-Executive Director said that he had contacted 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 but as yet he had received no response. The action remained open.

Action: Dr Buckle

Mortality Review Process – it was agreed that the Learning from Deaths quarterly reports would be discussed at the Quality Assurance Committee and that the reports would be submitted to the Trust Board along with the minutes of the Committee for information.

Action: Company Secretary

The Committee noted the schedule of actions.

5. Patient Safety and Experience

5.1 Improving Patient Safety by Reducing Prone Restraint in Prospect Park Hospital

The Director of Nursing and Governance presented the report and highlighted the following points:

- The Trust had been identified as an outlier for the use of prone restraint when compared to other similar trusts. The Trust Board had requested that the Trust investigate the reasons for being an outlier.
- Caroline Attard, Nurse Consultant had undertaken a review into the use of prone restraint and had made a number of recommendations with the aim of reducing its use.
- Between 1 January 2017 and 31 May 2017 there were 50 prone restraints. 40 of the prone restraints were for the administration of sedation via injection and 5 prone restraints were to enable staff to exit safely from a seclusion room.
- Following the review, the Trust was introducing a new training programme for staff which focussed on supine restraint rather than prone restraint for seclusion exit and sedation.
- The Trust had also implemented a new reporting system so that there was a clearer understanding of the use of prone restraint and this information would feed into patient risk and management plans.
- The use of prone restraint would continue to be reported as part of the Performance Assurance Framework reports which were submitted to the Finance, Investment and Performance Committee and the Trust Board. It was hoped that the use of prone restraint would start to reduce from November/December 2017.

David Buckle, Non-Executive Director commented that the report was very helpful in understanding the reasons why the Trust was an outliner in terms of its use of prone restraint.

The Chair agreed to update the Trust Board on the actions being taken to reduce the incidence of prone restraints when she presented the minutes of the Committee to the Trust Board.

Action: Chair

On behalf of the Committee, the Chair thanked Caroline Attard, Nurse Consultant for undertaking the review.

The Committee noted the report.

5.2 Quality Concerns Status Report

The Director of Nursing and Governance reported that two concerns had been removed since the last meeting:

- Crisis Response and Home Treatment Team – concerns had significantly reduced with the strong and stable leadership in place.
- Slough Walk-in Centre – the new provider was supporting the staffing of the Centre and since this change, shifts had been adequately covered and consequently, the risks had significantly reduced.

The Director of Nursing and Governance reported that two new concerns had been added:

- Bluebell Ward – in response to the Care Quality Commission's concerns around the safety of the ward;
- Reading Community Mental Health Team – in response to concerns about staffing vacancies and complaints.

The Director of Nursing and Governance reported that recruiting permanent medical staff at Prospect Park Hospital was becoming more challenging. It was also difficult to recruit to Community Nursing vacancies. The Director of Nursing and Governance reported that the Trust was continuing to focus on the skills mix.

The Chief Operating Officer said that the Trust was holding a series of workshops with Community Nurses to find out what the Trust could do to make the job more attractive in order to retain staff.

David Buckle, Non-Executive Director asked whether it would be worth considering investing in more administrative support for doctors. This would free up more time for doctors to spend with patients.

The Chief Operating Officer agreed to give further consideration to using more administrative support to both doctors and very senior nurses.

Action: Chief Operating Officer

The Medical Director reported that the Trust was reviewing the Mental Health Act Office at Prospect Park Hospital with a view to providing additional support which in turn would reduce the administrative burden on doctors at Prospect Park Hospital.

The Chair reported that as a Mental Health Act Manager, she had first-hand experience of the administration of the Mental Health Act Office and asked whether it would be possible to produce standard operating systems in order to improve its operation.

The Director of Nursing and Governance agreed to take this forward as an action.

Action: Director of Nursing and Governance

The Director of Nursing and Governance reported that NHS Improvement had identified the Trust as an outlier in terms of staff turnover and the Trust was in the first wave of trusts who would receive additional support from NHS Improvement. It was noted that NHS Improvement had allocated two members of staff to work with the Trust to help to develop and deliver a 90 improvement plan.

The Director of Nursing and Governance reported that the Care Quality Commission was continuing in their investigation of the Sorrell Ward serious incident.

The Director of Nursing and Governance reported that Bluebell Ward was a 27 bedded ward and that it was unusual for a mental health ward to be so large. It was noted that following the death of a detained patient on Bluebell Ward, the Trust had decided to close five beds and to put in additional staffing resources.

David Buckle, Non-Executive Director asked whether the Trust was considering splitting Bluebell Ward.

The Chief Operating Officer said that the Trust was reviewing options.

The Trust Board noted the report.

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)
The key controls section needed to be updated to make reference to the Trust's return to practice scheme which involves writing to registered staff who have taken a career break to encourage them to return to work.

Action: Company Secretary

Risk 2 (involving clinicians and patients)
Nothing further to add.

Risk 5 (clinical standards)
Nothing further to add.

The Committee noted the report.

5.4 Serious Incidents Report – Quarter 1

The Quarter 1 Serious Incident Report had been circulated. (The Committee discussed the report alongside the Learning from Deaths Quarter 1 Report – minute 6.2B)

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 advised that if any Board members were visiting Sorrel Ward they should view the courtyard area which was much improved. It was noted that the Trust had successfully recruited a permanent Consultant for the ward and the Ward Manager was supported by Band 6 nurses.

The Director of Nursing and Governance reported that there was good progress in delivering the action plan.

The Committee noted the report

5.6 Child and Adolescent Mental Health Waiting Times Report

The Chief Operating Officer presented the report and highlighted the following points:

- There had been an increase in the number of referrals into the service and a spike in quarter 1 following the introduction of the integrated Common Point of Entry referral hub in May 2017 combined with a marketing campaign.
- Numbers waiting for assessment and treatment had reduced, with the number waiting over 12 weeks halving over the last 15 months and a 7% reduction for all waiters in the last quarter.
- The number of face to face and telephone contacts was increasing. The number of patients not attending appointments was below the national average.
- The service had continued to improve its delivery and further service developments were planned.
- The service was performing well despite the challenges of increased demand and staffing vacancies.

David Buckle, Non-Executive Director congratulated the service for halving the number of patients waiting over 12 weeks. Dr Buckle said that he was reassured that although some patients were waiting over 12 weeks for autistic spectrum diagnostic testing, patients requiring urgent treatment were seen within the 12 week target.

Dr Buckle referred to the over 12 week waiters, and asked how long they had to wait for treatment. The Chief Operating Officer said that from memory there were relatively few patients waiting over 12 weeks and the ones who did tended to be hard to engage patients. The Chief Operating Officer agreed to circulate the over 12 week wait figures.

Action: Chief Operating Officer

The Chair thanked the Chief Operating Officer for his report. The Committee noted the report and agreed that the Committee would receive an update on CAMHS waiting times in 12 months' time.

Action: Chief Operating Officer

5.7 Mental Health Act Annual Report

The Director of Nursing and Governance presented the report and highlighted the following points:

- There was a 41% increase in the number of patients on a section order at the point of admission and a 21% drop in the total number of informal admissions;
- There was a 58% increase in the number of informal patients being detained following admission.
- There was an increase in the number of Mental Health Tribunals and Mental Health Act appeals.
- The Trust was reviewing the administration of the Mental Health Act Office.

The Chair agreed to highlight the increase in the acuity of patients when admitted when she presented the minutes to the Trust Board.

Action: Chair

The Director of Nursing and Governance reported that the Quality Executive Committee meeting on 14 August 2017 had discussed the report and the Deputy Director of Nursing (Andrew Burgess) had agreed to review the data for quarter 1 to see whether the number of detained patients was continuing on an upward trajectory.

Action: Director of Nursing and Governance

David Buckle, Non-Executive Director asked how the Trust's data compared with other similar mental health trusts. The Director of Nursing and Governance said that the Care Quality Commissioned published an annual benchmarking report but the data for 2016-17 had not been published.

The Committee noted the report.

Clinical Effectiveness and Outcomes

6.1 Quality Accounts Report 2017-18 – Quarter 1

The Medical Director presented the report and advised that the updated information from last year's report was highlighted in yellow.

The Chair asked whether the drafting of the Quality Accounts was on time. The Medical Director said that a number of different teams contributed to the final Quality Accounts and said that the Trust always met NHS Improvement's timescale for submitted the Quality Accounts.

The Committee noted the report.

6.2 a) Learning from Deaths Policy and Procedure

The Medical Director presented the policy and reported that in March 2017, the National Quality Board published a framework for identifying, investigating and learning from deaths. A key recommendation of the framework was that all Trusts have a locally defined Learning from Deaths policy and procedure in place by September 2017.

The Medical Director reported that the Trust's Learning from Deaths policy and procedure was developed in July 2017 to meet the mandated requirements. It was noted that the Chair was the Trust's Non-Executive Director Lead for learning from deaths and had inputted into the final policy.

The Medical Director reported that in response to the Independent Review of deaths of people with a learning disability or mental health problem in contact with Southern Health NHS Foundation Trust, Southern Health had developed robust mortality review policies and procedures. It was noted that the Trust had used Southern Health's approach as the basis for developing the Trust's policy.

The Medical Director pointed out that the Learning from Deaths Policy and Procedures were aligned to the Trust's Serious Incident investigation processes which were overseen by the Director of Nursing and Governance.

David Buckle, Non-Executive Director said that the Trust had developed a robust policy. Dr Buckle asked if a family member raised a concern or complaint about the death of their loved one, whether that death would be reviewed. The Medical Director confirmed that all complaints relating to the death of a patient were reviewed and an initial findings report would be produced. If the death met the criteria, a serious incident investigation would be initiated.

Dr Buckle asked about the audit process. The Medical Director said that deaths which did not meet the criteria for reporting (as set out in section 6.2 of the policy) and where the patient had been in contact with one or more of the Trust's Community Services in the past 12 months would be reported in the quarterly mortality data report and would be subjected to a quarterly random sampling for learning and improvement purposes.

The Committee approved the Learning from Deaths Policy and Procedure. It was noted that the Policy would be submitted to the September 2017 Trust Board meeting for ratification.

b) Learning from Deaths Quarter 1 Report

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

- From April 2017, Trusts must collect new quarterly information on deaths, including: the total number of patient deaths; the number of deaths subject to a case report review; the number of deaths investigated as serious incidents; an estimate of the number considered more likely or not to have been caused by problems in care; the main themes and trends emerging from review and investigation; and what the Trust was doing to address those themes and tends in order to improve care.
- From quarter 3 2017-18 onwards, Trusts must publish information on deaths, reviews and investigations quarterly via an agenda item and paper to their public board meetings.
- From June 2018, Trusts must publish an annual summary of this data in their quality accounts.
- Information about deaths which were classified as Serious Incidents was contained in the more detailed quarterly Serious Incident Report (agenda item 5.4).
- The purpose of the report was to provide assurance that all deaths within scope were being reported and reviewed at an appropriate level and that learning was identified and was being implemented.

The Chair welcomed the format of the report and in particular, the detailed section on learning from deaths and the actions which had been put in place to improve care even when the patient's death may not be preventable.

The Committee noted the report.

6.3 Clinical Audit Reports

Summary reports of four clinical audits had been circulated as follows:

- National Diabetes Audit – Foot Care
- Re-Audit of Antimicrobial Prescribing
- Cardio Metabolic CQUIN for Mental Health
- Audit of VTE Assessment and Prophylaxis on Orchid and Rowan Wards

The Chair reported that the Clinical Audit report was presented in a new format which included a summary of the clinical audit's findings rather than presenting the full report.

It was noted that the Chair and Dr Buckle had received the full Clinical Audit Reports alongside the summary report via email two weeks ahead of the meeting.

The Medical Director referred to the Committee's terms of reference, which states 'to receive summary reports of national clinical audits'.

David Buckle, Non-Executive Director said that he was happy for the Committee to receive a summary providing he could still have access to the full report.

The Committee agreed that the full clinical audit report would be presented to the Committee and that the report cover sheet would set out any key actions taken to address any issues highlighted by the clinical audit. The Committee also agreed that only national clinical audits were required to be brought to the Committee.

Action: Medical Director

David Buckle, Non-Executive Director asked why the VTE Assessment and Prophylaxis audit which was a student doctor project had been presented to the Committee.

The Medical Director said that this was not a national audit and would normally not be presented to the Committee. In this case, initially the audit had been rated as "low risk" but after review at the Clinical Effectiveness Group meeting, the audit rating had been changed to "high risk".

The Committee noted the report.

Update Items for Information

7.1 Guardians of Safe Working Quarterly Report

The Chair said the Guardians of Safe Working Quarterly Report was reassuring because there were only two exception reports which did not appear to represent a pattern of any concern.

The Committee noted the report.

7.2 Annual Complaints Report

The Annual Complaints Report had been circulated.

David Buckle, Non-Executive Director said that it was a comprehensive report but requested that in future reports, it would be helpful to provide more examples of changes to practice and or improvements that had been made in response to complaints.

Action: Director of Nursing and Governance

The Committee noted the report.

7.3 Infection Prevention and Control Annual Report

The Committee noted the report.

7.4 Place of Safety Annual Report

The Director of Nursing and Governance reported that the year on year increase in the number of times the place of safety had been used may have plateaued in 2016/17 as there was a 4% decrease in the number of uses in comparison to the previous year. The decrease may reflect the success of the street triage process.

The Committee noted the report.

7.5 Quality Executive Committee Minutes

David Buckle, Non-Executive Director asked for more information about demand management for beds and the strategic sizing of wards at Prospect Park Hospital.

The Chief Operational Officer reported that the Trust's Bed Optimisation project was reviewing a range of issues, including better bed management, admission avoidance, reducing the length of stay and productive discharge.

Dr Buckle asked whether the Trust's decision to divest itself of the Diabetic Eye Screening service and the Slough Walk-in Centre were taken for financial reasons and or quality reasons.

The Chief Operating Officer said that changes in national policy meant that the Slough Walk-in Centre would need to move to an acute site in 12 months' time and that the Trust's decision to serve notice now was taken because of quality concerns about safe staffing of the service. It was noted that the decision to serve notice on the Diabetic Eye Screening Service was taken because the funding from NHS England was insufficient to run the service safely.

The minutes of the Quality Executive Committee meetings held on 08 May 2017, 12 June 2017 and 10 July 2017 were noted.

Closing Business

8. Standing Item – Horizon Scanning

There were no issues highlighted.

9. Any Other Business

There was no other business.

10. Date of the Next Meeting

21 November 2017 at 10.00

These minutes are an accurate record of the Quality Assurance Committee meeting held on 21 November 2017.

Signed:-

Date: - 21 November 2017

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	12 September 2017
Title	**Learning from Deaths Policy and Quarter 1 Report**
Purpose	To provide assurance to the Trust Board that the trust is compliant with the learning from deaths national policy.
Business Area	Clinical Trust Wide
Authors	Head of Clinical Effectiveness and Audit, Medical Director
Relevant Strategic Objectives	1 – To provide safe services, good outcomes and good experience of treatment and care
CQC Registration/Patient Care Impacts	The policy is in line with the recommendations made by the CQC in their report "Learning, Candour and Accountability"
Resource Impacts	N/A
Legal Implications	The policy meets all relevant statutory requirements
SUMMARY	When the National Quality Board launched its Learning From Deaths policy in March 2017 in response to the CQC's report '*Learning, candour and accountability*', it was made clear that Trusts should be developing their systems and processes relating to how to review and learn from the deaths of patients under their care. The policy set out several key requirements including: • From April 2017, trusts must **collect** new quarterly information on deaths including: the total number of patient deaths; the number of deaths subject to case record review; the number investigated as SIs; an estimate of the number thought more likely than not to have been caused by problems in care; the main themes and trends emerging from review and investigation; and what the trust is doing to address those themes and trends in order to improve care • By September 2017, trusts should **publish an updated policy** on how they respond to and learn from the deaths of patients in their care • From Q3 2017 onwards they must **publish information** on deaths, reviews and investigations quarterly via an agenda item and paper to their public board meetings. • From June 2018, trusts must **publish an annual summary** of this data in their quarterly accounts. In line with national guidance, BHFT has taken a proportionate approach to determine the scope of deaths to be reviewed. This is detailed within the Learning From Deaths Policy. The Q1 report for 2017 details the data available on deaths in BHFT and the learning from reviewing the deaths. Information about deaths which are classified as Serious Incidents has

	been obtained from a more detailed quarterly report on SIs, prepared by the Nursing and Governance Directorate. Learning from non-SI deaths has been contributed by the services involved in the care of the patients who died. The policy and Q1 report have been considered at the Quality Executive Group and the Quality Assurance Committee. The Board should be assured that BHFT has a published policy and all deaths within scope are being reported and reviewed at an appropriate level, and learning is identified and being implemented.
ACTION REQUIRED	The Board is invited to: Note the policy and Quarter 1 report.

Table of Contents

1.0 Purpose

It has become increasingly important for trusts to evidence that they are systematically and continuously reviewing patient outcomes including mortality (patients who have died). It is acknowledged that most deaths do not occur as a result of a direct patient safety incident. None the less, it is important that opportunity for learning from deaths and learning from the review of the care provided and the experience of our services in the period prior to the person's death are not missed and that when deaths are deemed not to require any further investigation the rationale and justification for this is clearly documented.

2.0 Scope

This report supports the Trust learning from deaths policy which is published in August 2017. The Trust policy identifies a number of metrics which are reported within.

3.0 Introduction

Berkshire Healthcare NHS Foundation Trust (BHFT) provides specialist mental health and community health services to a population of around 900,000 within Berkshire. We operate from more than 100 sites across the county including our community hospitals, Prospect Park Hospital (mental health inpatients), clinics and GP Practices. The vast majority of the people we care for are supported in their own homes. We have 216 mental health inpatient beds and 180 community hospital beds in five locations.

4. Data

4.1 Total Number of deaths in Q1

The trust electronic patient record (RiO) is directly linked to the national spine which allows information regarding deaths to be shared amongst providers of health care. Figure 1 uses this information and is generated from our Rio system.

It identifies all deaths where a patient had any contact in the preceding 365 days before their death and was on an active caseload of the service.

Figure 1 Number of deaths who were open to services and had contact in the preceding 365 days before death.

Service provided to patient (As categorised on RiO)	**April 2017**	**May 2017**	**June 2017**	**Total**
Nursing episode	125	159	114	398
Dietetics	28	49	29	106
Old age psychiatry	23	27	15	65
Speech and language therapy	20	26	10	56
Community health services medical	22	18	12	52
Podiatry	15	18	10	43
Palliative medicine	10	11	8	29
Adult mental illness	7	6	5	18
Rehabilitation	4	5	3	12
General medicine	7	4		11
Physiotherapy	4	3	3	10
Respiratory medicine	2	4	2	8
Cardiology	3	3	2	8
Clinical psychology	2	1	2	5
Learning disability	2	3	1	6
Geriatric medicine		2	2	4
Community paediatrics		1	1	2
Intermediate care		2		2
Genito-urinary medicine	1	1		2
Grand Total	**274**	**343**	**219**	**837**

4.2 Deaths reported for review

In April 2016 the trust identified a number of criteria against which a death should be reported by the service on the trust incident management system (Datix) for review. This has been further clarified with the clinical services and the reporting requirements by services are listed within the learning from deaths policy and procedure (August 2017). Figure 2 identifies the total number of deaths reported as a Datix by quarter for 2016/17.

The new policy will be launched in August 2017 and as a consequence of this the reporting on Datix in 2017/18 may continue to increase.

Figure 2 Number of deaths reported per quarter on the Datix System.

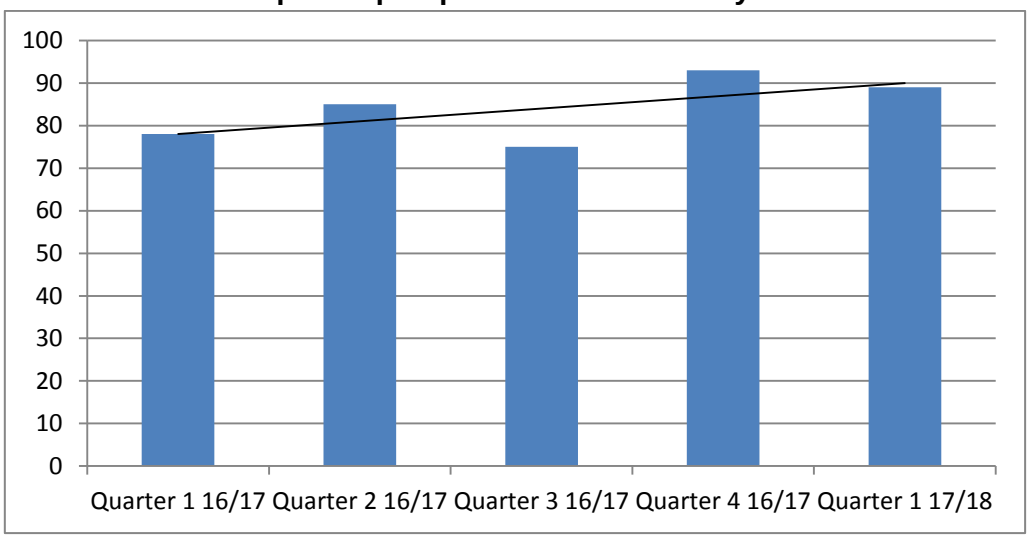

Figure 3 breaks down the deaths reported on the Datix system by the service the patient was in contact with. These are all reviewed weekly by the Executive Mortality Group (EMRG) which consists of the Medical Director, Director of Nursing and Governance, Lead Clinical Director, Deputy Director of Nursing and Quality and the Head of Clinical Effectiveness & Audit.

Figure 3 – Datix reported deaths by service which the patient had contact with.

	April	May	June	**Total**
MH inpatients	2	2 (1T)	2	**6**
Community MH	3	2	7	**12**
CRHTT	-	-	1	**1**
Talking Therapies	1	-	3	**4**
Common point of entry	-	1	-	**1**
CTPLD	2	4	1	**7**
Psychological Medicine Service	-	1	2	**3**
Hard to reach homeless	-	1	-	**1**
CYFP	2	-	3	**5**
Community Hospital Inpatient	4	19 (5T)	17 (4T)	**40**
District Nursing /intermediate care	-	2	2	**4**
Palliative care	-	-	1	**1**
Community Based Neuro Rehab	-	-	1	**1**
Podiatry	1	-	1	**2**
Westcall	-	-	1	**1**
Total Datix	**15**	**32**	**42**	**89**
Total SI detailed in Q1 BHFT SI report	**2**	**2**	**7**	**11**

T = patients who were transferred due to a decline in physical health and subsequently died in the acute setting within 7 days of transfer.

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

1. Datix form advised to be closed, no further learning to be gained from further review.
2. Further information requested to be able to make a decision, to be reviewed at following EMRG
3. Identified as a serious incident (SI)
4. Identified as a sub SI
5. Identified as requiring an Initial finding review (IFR)

All deaths classified as SI will follow the existing SI investigation process and learning will be shared within this report.

The following sections of the report will detail the outcomes from the EMRG and subsequent learning.

Figure 4. Outcome following review at EMRG

	Number
Datix Closed no further action required	49
Classified as a serious Incident SI	11
Classified as a sub SI	3
Initial findings report requested	22
Other case review (e.g. IPC or children's)	2
Open awaiting further information	2
Total	89

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

Figure 5 Number of SI relating to a patient death in Q1

Service Source Q1 Serious Incident Report (n=11)	**Number**
Mental Health Inpatients	3
Community Mental Health	2
Crisis Resolution and Home Treatment Team	1
Talking Therapies	3
Health Visiting	1
Community based Neuro Rehabilitation	1

At the time of writing this report, none of the incidents of suspected suicide or unexpected death reported in Q1 have yet been to inquest. Learning from these deaths will be reviewed and included following completion of internal trust investigation.

Suicide cases: In Q1 there were 5 SIs reported as suicides/suspected suicides.

- 2 of the incidents reported as a suicide/ suspected suicide were from Talking Therapy Services.
- 1 incident was on the acute admission mental health ward.
- 1 was within Wokingham CMHT
- 1 was a patient not known to Mental Health services but was receiving community neuro rehabilitation services.

Unexpected Deaths: There were 6 unexpected deaths reported as SIs in Q1.

Of these deaths, 2 were incidents of choking that occurred on the Inpatient Mental Health wards (Bluebell and Orchid Ward),

1 was within Talking Therapy services,
1 was a 19 week old baby this is currently under police investigation.
1 was known to CRHTT
1 was known to CMHT.

4.4 Deaths which are determined as Sub Serious Incidents (Sub SI)
Figure 6: Deaths classified as Sub SI's

Service	Total
Mental Health Inpatients	1
Talking Therapies	1

5. Involvement of families and carers in reviews and investigations

5.1 For all deaths which are categorised as an SI
The family is contacted in line with our duty of candour policy and informed of the process of investigation. Someone from the service (usually a senior clinician or manager) must make contact with the family as soon as it is known that an incident causing death has occurred. At this time they must offer a face to face meeting which will include:

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

Where the meeting is accepted this is then followed up in writing. Following the appointment of an investigating officer they will contact the family and arrange to meet with them to ensure that they are part of the investigation process and hear any questions or concerns that they have for inclusion in the investigation. The investigating officer should provide contact details and explain that they will be in touch further during the investigation and once it is finished to share the findings of the investigation.

Once the investigation is completed the investigating officer must make contact with the family to agree how they would like to receive feedback and findings of the investigation. A face to face meeting is offered to do this and a copy of the report then provided to the family if they would like one. This meeting must also be followed up in writing. This level of contact and involvement has been offered to all families involved in an SI investigation in Q1.

5.2 For non SI deaths
Following notification of a death of a patient with a learning disability the team will contact the family. This is usually telephone contact, but follow up visits and support has also been undertaken when requested. The Head of Learning Disability Services sends a card of condolence to the family with information on how to contact the team, if the family would like to discuss the persons care and treatment prior to death. One family member has made contact following receiving the card. No concerns regarding care were highlighted.

6. Mortality Review Group

6.1 Reviews Conducted

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

The mortality review group meets monthly and is chaired by the Medical Director; the following reviews (IFRS) have been received and considered by the group in Q1.

Figure 7 Reviews Conducted in Q1

	Total Number	**Services**
April	8 IFRs reviewed	Learning Disability – 6 cases Children's services – 1 case Community Hospital Transfer and died within 7 days – 1 case
May	3 IFRs reviewed	Mental Health Inpatients transfer to acute -1 case Community Hospital transfer to acute and died within 7 days – 1 case Bracknell Community Mental Health – 1 case
June	8 IFRs reviewed	Learning Disabilities – 3 cases Mental Health Inpatients transfer to acute hospital -1 case Psychological medicines services – 1 case Community Hospital transfer to acute and died within 7 days – 1 case Reading Community Mental Health – 1 case

Note: these are cases reviewed in Q1 and will include cases reported in previous quarters.

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

- Request further information from trust services or other providers
- Agree to close the case and note any actions on the action log
- Agree to close and make recommendation for service level learning and improvements

An action log is maintained and reviewed by the group to ensure that all actions are completed. The following section details the recommendations and learning which have been identified in Q1.

6.2 Deaths of patients receiving community nursing care including palliative care

Figure 1 shows that the highest proportion of deaths of people who have been under the care of one of our services in the year before they died were under the care of nursing or palliative medicine, where death may be expected. For Inpatients we require all deaths to be reported on the Datix system including those patients who are expected to die and receiving palliative care.

In Q1 31 expected deaths were reported on our community health inpatient wards. These were reviewed by the executive mortality review group where sufficient information had been provided to give assurance that appropriate care had been given; all 31 one cases were closed with no further review required.

In Q1 in line with our criteria 4 deaths were reported by community nursing, all were reviewed by the executive mortality group. 2 deaths were unexpected, 1 patient sadly died in a house fire and the other patient was found at home, both cases were closed from a trust perspective. 2 deaths were reported relating to patients receiving palliative care, sufficient information had been provided to give assurance that appropriate care had been given and the cases were closed with no further review required.

6.3 Deaths of people with a learning disability

Since April 2016 we have reviewed and completed an IFR for all deaths where the patient was known to the learning disability service and also when we have been notified of a death of a patient accessing other trust services who had a learning disability.

From September 2017 we will be participating in the Learning Disabilities Mortality Review (LeDeR) Programme, a national programme run by Bristol University and coordinated by the Clinical Commissioning Groups (CCGs).

Demographics

In Q1 we were notified of 7 people who died, 2 were male and 5 were female.

Age

The age at time of death ranged from 49 to 77 years of age (median age: 67yrs & mode: 71yrs**)**

Ethnicity

All 7 people who have died in this period were from a White British background.

Figure 8 Severity of Learning Disability

Mild	2 (27.5%)
Severe	3 (43%)
Not known	2 (27.5%)

Does the death appear to be Premature?

6 out of the 7 deaths (86%) recorded within this period have been identified as premature (defined as <75 years). 1 individual died at 77 (the patient was under the care of Palliative community nursing).

Number of deaths reviewed/investigated

To date, 6 out of the 7 deaths have undergone review by the service clinical review group (CRG), and of those reviewed all of these individuals were known/open to the specialist learning disability services in the 12 months prior to their death. For the 1 death (yet to be reviewed) this individual was not open to the specialist learning disability services but did receive care from BHFT in the previous 12 months, primarily from the district nursing service but latterly from the specialist palliative care community nurses. The IFR is currently being completed and will be included in Q2.

4 of these have been reviewed by the mortality review group in Q1, none have been declared as SIRI's or Sub-SIRI's or resulted in onward escalation for further investigation by external bodies such as the police, safeguarding team or Clinical Commissioning groups (CCG's).

Figure 9 All learning disability deaths are categorised using the Mazars classification system.

Mazars Classification (As determined by the CRG)	
Unexpected Natural (UN1) UN1: any unexpected death which are from a natural cause (cardiac, stroke)	6

Respiratory disorders (pneumonia, aspiration pneumonia and bronchopneumonia) were identified as the most frequent cause of death (3),the second most frequent cause of death was heart and circulatory disorders (2).1 death was attributable to diseases of the nervous system and 1 death to cancer.

It is pertinent to note that whilst there has been no indication of further internal investigation required within this reporting period, examples of learning have been identified, as acknowledged within subsequent sections of this report.

7. Learning from Deaths

The aim of the policy and procedure is to ensure that we learn from deaths and to improve care even when the death may not be preventable. The following section details the learning that had occurred.

7.1 Learning from SI Investigations where the patient died Q1 (Source SI Q1 report)

All SI's are reviewed to establish whether there are any trends or themes in terms of learning and reflection. In addition, the action plans are reviewed to identify evidence of some of the actions that the services have taken to address recommendations.

Learning is shared through incident summaries and action plans with teams and through Patient Safety and Quality meetings, there is also an increased focus on holding of learning events to cover both individual incidents and more generic/ wider learning from incidents that have occurred within the trust. These events are proving to be very successful in supporting teams in the review of incidents, discussion of learning and agreement of improvements to mitigate similar incidents occurring in future.

Main themes and evidence of actions are summarised below.

- **Communication between Mental Health Inpatient Services and Community Mental Health Services**
  A couple of the investigations noted that work is required to improve the communication and sharing of information between the Trust's inpatient and community mental health services. This applies both on discharge from the ward to ensure that CRHTT and/or the CMHT are informed in a timely manner but also during admission and when a patient is granted leave during this time.

  A new discharge template is now being implemented across the inpatient wards to assist in improved communication and planning.

  There is also work being undertaken as part of the bed optimisation project to review the care/ treatment and experience of a patients first 7 days ion hospital, this will include supporting improved communication between community and inpatient services.

- **Overall quality of documentation of risk**
  There continues to be a theme around risk management plans being documented in sufficient detail. In addition, some of the investigations identified that the assessment of risk was not necessarily appropriately assessed and was underestimated.

  Alongside the new RiO Risk Assessment tool which was launched after these incidents happened, the Trust has made significant improvements to the risk training and supervision to equip staff with skills and competence (measured with the zero suicide surveys) to practice recovery focussed, compassionate approaches to suicide risk assessment. This should enable positive risk management and safety planning as well as addressing issues of confidentiality and consent.

  Training continues across the Trust alongside the Zero Suicide programme of work and a Suicide risk guide has been developed to accompany training. This includes a message from CEO and links to film clip to help staff with information sharing

- **Clinical Documentation**
  In relation to clinical documentation staff are to be reminded of the need to:
    - Manually ensure that the preferred contact number is marked as primary on the demographic page.
    - Medical staff must document a formulation and diagnosis in the RiO record.
    - Admin staff to ensure that when a client discloses suicidal ideation they ask appropriate safety questions and ask for the reason for any cancellations to support appropriate escalation.

- Staff especially locum staff need to be reminded to use the prompts on the Progress note template to reflect the discussion that has been had with the patient/ carers in relation to the medication etc.

7.2 Learning from deaths of patients with a learning disability
Main themes and evidence of actions are summarised below.

Identifying people with learning disabilities and their need for reasonable adjustments:

Information continues to suggest that individuals with learning disabilities experience difficulties in accessing reasonable adjustments – particularly in relation to the provision of healthcare in acute settings. During this reporting period there has been one example where it was identified that the absence of a dedicated Learning Disability liaison position within one of the acute hospital settings resulted in difficulties around delivery of the individual's care. This was identified by the individual's sister who made contact with a CTPLD social worker in order to express her view. This resulted in a referral for LD community nursing input who followed up these concerns and provided additional support.

The Consultant Nurse (LD) has previously made contact with the local acute hospitals to support more effective joint working between acute hospital trusts and streamline communication & joint working with CTPLDs. This work is currently being strengthened by work being undertaken by the health team leads and the interim Service development lead (LD).

As of June 2017 the health team lead for both Bracknell and Slough CTPLDs has set up bi–monthly meetings with a key individual from the acute hospital in order to review cases of individuals who are known to BHFT and have / are currently receiving treatment within the acute setting. The aim of these meetings is to strengthen joint working between the two organisations and to ensure a consistent route to enabling lessons to be learnt. It is understood that the first of these meetings occurred in June 2017.

Members of the CRG, in liaison with the two local acute providers, are in the process of exploring opportunities for further joint working in relation to completion of mortality reviews of individuals known to both services.

The particular patterns of ill-health of people with learning disabilities:

A chest management working group has been established, and will feed into the Profound Intellectual and Multiple Disabilities work stream within Learning Disability Services.

Joint nutrition and speech and language therapy (SaLT) clinics for joint assessment / review of individuals with dysphagia are now being held across all 6 localities. People across these localities are invited to attend a clinic nearest to them. Invites are sent on appointment basis but there is also a 'drop in' facility for weights, this is advertised via a flyer.

These clinics are being combined with a one hour training slot in order to address key themes. A range of Allied Health Professionals have been invited to support the delivery of this training in order to address the wide ranging clinical predictors of aspiration.

BHFT SaLT services (LD; Community: Acute and Rehab) continue to work towards the development of a risk assessment tool for dysphagia. This has been trialled to test the proposed methods of recording and scoring, the results of which will be discussed at next meeting.

Communication between providers of care

Within the current period there appear to be fewer instances, with the majority of cases showing positive examples of good joint working including overall effective communication between all stakeholders. In one particular instance, good practice took place across the continuum of care and range of services providing input to the individual. Following the individuals death invites were extended by the Royal Berkshire Hospital, to members of the family and CTPLD to attend a Schwartz round.

This was in recognition of the complexity of this case and the need to provide closure to all had been involved.

Where queries/concerns have arisen and the CRG have been unable to ensure sufficient clarity due to the inability to access information around the care of patients outside BHFT, requests for additional information have been conducted to allow specific questions to be answered.

Members of the CRG, in liaison with the two local acute providers, are in the process of exploring opportunities for joint working in relation to completion of mortality reviews of individuals known to both services. The LD CRG now has access to information provided within the Connected Care portal. This is a joint venture by all the main Health and Social care providers and commissioners within Berkshire, to provide a single joint clinical information record. Currently only GP information can be viewed, however in time information from other providers and local authorities will be accessible.

Adherence to legislation and guidance:
Whilst there was one example of good practice in this area there is a continued need to ensure that when BHFT staff are involved in the process whereby capacity decisions are being made they should ensure appropriate recording (of the decision and how it was reached) using the processes agreed by BHFT. Continue to monitor adherence to this standard and ensure appropriate updates / alerts to staff via the bi-monthly Learning Disability Service Patient Safety Quality and Governance Meeting.

7.3 Learning from all other deaths
Mental health and physical health are closely connected. Mental health plays a major role in people's ability to maintain good physical health. People with severe mental illnesses also have significantly higher rates of physical illness – with a dramatic effect on life-expectancy.

In response to deaths where patients were under the care of community mental health services a learning event was held with staff focusing on supporting patients physical health, following on from this staff asked for an at a glance guide to be developed to help them with physical health screening. This was implemented and shared with staff in May 2017.

Learning was identified specifically regarding a case where a patient was transferred from the acute hospital to our mental health ward and then back to the acute hospital within a few hours. The patient had a physical health condition which can present as an apparent acute mental health crisis, but which requires management of the physical health condition first. The clinical Director for Mental Health Services will discuss the case with the acute trust as a reflective exercise for learning.

Specific learning was identified around a patient receiving care from the clozapine clinic, this included having:

- Clear standard operating procedures (SOPs) around physical health monitoring
- To check that all blood pressure (BP) machines in clinics are calibrated and if not working to action repairs
- To ensure that there is a backup machine BP in each CMHT should the Clozapine machine fail to work during clinic
- To ensure that staff review historical readings and flagging up any discrepancies as they arise

A Sub SI involving the psychological medicines service identified the following learning points:

- Ensuring difficult conversations particularly in relation to intent and family involvement are reflected in entries.
- To include static factors in reflective sessions being led by Psychiatrists
- For Service manager to book ALL PMS staff onto the trust 3 day suicide prevention training course.

7.4 Learning from Complaints where the patient died

Complaints from bereaved families are investigated in line with the complaints policy. The mortality review group received a summary of the complaint responses and as of Q3 will review the IFR supporting the complaint investigation. The main learning to be taken from complaints which were closed in Q1 is around communication, specifically in regards to communication with relatives of patients receiving palliative care. It is a fine balance when communicating with family members at this difficult time and the level of communication should be evaluated regularly by the team providing the care and documented clearly within the patient's record.

8. Conclusion

This is the report from a review of deaths in Q1 of 2017/18. In line with national guidance, BHFT has taken a proportionate approach to determine the scope of deaths to be reviewed. All inpatient deaths are reported via the trust Datix system for Executive level scrutiny. All deaths of individuals with a learning disability are reviewed by the service CRG. All deaths classified as SIs are investigated using a Root Cause analysis methodology and learning from the investigation of these deaths is implemented at service and trust level.

The report provides the board with assurance that all deaths within scope are being reported and reviewed at an appropriate level, learning is identified and being implemented.

Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

CCR157

LEARNING FROM DEATHS

Policy& Procedure

Berkshire Healthcare NHS Foundation Trust

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Please be advised that Berkshire Healthcare discourages the retention of hard copies of policies and can only guarantee that the policy on the intranet is the most up-to-date version.

Issued: **August 2017**
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Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

Policy Number: **Title of Policy:**	**CCR157** **LEARNING FROM DEATHS**
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Designated Leads:	Medical Director & Head of Clinical Effectiveness & Audit
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POLICY DEVELOPMENT

CCR157 – LEARNING FROM DEATHS

History:	Version 1: New policy and procedure developed to meet national requirements.
Designated Leads:	Medical Director and Head of Clinical Effectiveness & Audit
Policy Consultants/ Distributed for Comments:	Medical Director Director of Nursing Lead Clinical Director Deputy Director of Nursing for Patient Safety & Quality Members of the Mortality Review Group Lead Non-Exec Director for Learning from Deaths Policy Quality Executive Group
Endorsed by:	Policy Scrutiny Group - 14th July 2017

This policy has been assessed for compliance with CQC Fundamental Standards.

Contents

1. INTRODUCTION

1.1 It has become increasingly important for Trusts to evidence that they are systematically and continuously reviewing patient outcomes including mortality.

1.2 The CQC report: Learning, Candour, and Accountability (2016) identified inconsistencies in: the process of identifying and reporting the death; how decisions to review or investigate a death were made; variation in the quality of reviews and investigations; and variation in the governance around processes and questionable demonstration of learning and actions. In March 2017 the National Quality Board published its guidance on Learning from Deaths which provides a framework for identifying, reporting, investigating and learning from deaths in care.

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

1.4 Since the 1990s, there have been a number of reports and case studies which have consistently highlighted, that in England, people with learning disabilities die younger than people without learning disabilities. The Confidential Inquiry of 2010-2013 into premature deaths of people with learning disabilities (CIPOLD) reported that for every one person in the general population who died from a cause of death amenable to good quality care, three people with learning disabilities would do so. Overall, people with learning disabilities currently have a life expectancy at least 15 to 20 years shorter than other people

1.5 This document sets out the procedures for reporting, reviewing and investigating deaths of people who have been in receipt of services from Berkshire Healthcare NHS Foundation Trust (hereinafter referred to as Berkshire Healthcare). It provides staff with information in relation to which deaths should be reported internally on the Berkshire Healthcare incident management system (Datix), subsequent review and the level of investigation that is required.

1.6 This policy and procedure supports Berkshire Healthcare's Policy for Incidents/Near Misses, Serious Incidents Requiring Investigation and Coroner Requirements (ORG007) and should be read in conjunction with this.

1.7 For ease of reference, the term 'patient' is used throughout this procedure document. This is intended to refer to all people who make use of any of the health care services provided by Berkshire Healthcare.

2. SCOPE

2.1 This policy and procedure is applicable to all staff whether they are employed by Berkshire Healthcare permanently, temporarily, through an agency or bank arrangement, are students on placement, are party to joint working arrangements or are contractors delivering services on behalf of Berkshire Healthcare.

3. AIM

3.1 The aim of this policy is to ensure:-

- A consistent approach to undertaking mortality reviews.
- Learning from these reviews is identified and shared.
- Compassionate and professional engagement with patients' families when any death occurs and when a death is reviewed.
- Berkshire Healthcare complies with the reporting requirements of NHS Improvement and other external agencies.

4. ROLES AND RESPONSIBILITIES

4.1 Chief Executive

The Chief Executive has overall responsibility for ensuring there are effective and robust governance processes in place within Berkshire Healthcare. They have accountability for the actions of staff providing they act within the framework of their codes of professional conduct as well as in accordance with Berkshire Healthcare policy.

4.2 Medical Director

The Medical Director is the Executive lead for mortality review and is responsible for the implementation of this policy. They will provide assurance to the Board that the mortality review process is functioning in line with this policy, escalating any concerns identified.

4.3 Chair of Quality Assurance Committee (QAC)

The Chair of the Quality Assurance Committee is the nominated Non Executive Board lead for Mortality review. They have responsibility to challenge and have oversight of the process through the quarterly reports to the QAC and provide assurance to the Board on this.

4.4 The Director of Nursing and Governance

The Director of Nursing and Governance has the lead accountability for implementing and monitoring the risk management process including the reporting, management and learning from serious incidents (SI).

4.5 The Deputy Director of Nursing Patient Safety and Quality

The Deputy Director of Nursing Patient Safety and Quality has responsibility for determining when an incident is designated as a SI and when an internal investigation should be carried out, or when an incident is to be investigated or notified externally including the requirement under Regulations 17 that any death of a patient detained under the Mental Health Act (1983) is reported to the Care Quality Commission without delay. Their team is responsible for the management of the incident reporting process across localities and ensuring that localities implement the action plans from SI's and monitor that families have been informed and had an opportunity to be involved in the SI investigation (Duty of Candour). They will have oversight of the Datix process and ensure that all reviews are completed.

4.6 Head of Clinical Effectiveness & Audit

The Head of Clinical Effectiveness & Audit has delegated responsibility on behalf of the Medical Director for the operational implementation and further development of Berkshire Healthcare's mortality process. This includes being responsible for:

- All aspects of the Berkshire Healthcare Mortality Review Group (TMRG).
- Collation of review findings, learning points and actions for improvement for each mortality meeting.

- Ensuring participation in the Learning Disabilities Mortality Review (LeDeR) programme supporting requests for case note reviews and that learning is shared within the organisation.
- Review and analysis of data to inform quarterly reporting and identify any areas of concern.
- Production of the quarterly reports.

4.7 Clinical Directors and Heads of Service

Clinical Directors and Heads of Service are responsible for ensuring that appropriate investigations and reviews are completed in line with this policy. That where appropriate these are reviewed by a multi-disciplinary team and that any learning which is identified is then shared within their own services and where relevant across localities.

4.8 Medical Staff

All medical staff are expected to participate fully in mortality reviews that are relevant to their practice.

4.9 Nurses, Allied health Professionals and other Clinical Staff

All healthcare professionals should be involved in mortality reviews meetings, as part of their clinical practice. This involvement could range from simply being aware of the outcome of such reviews insofar as they affect their area of practice, to full involvement in the production of data, reports and implementation of recommendations.

All Staff have a duty to follow this policy by reporting any death which meets the criteria in figure A and B **within 24 hours**, according to the procedures outlined in this document. This will be through completion of an Adverse Event Reporting Form on Datix (the Berkshire Healthcare incident reporting system)http://10.210.81.119/datix/live/index.php

A Guidance booklet on completion of Datix can be sought from any line or senior manager or from the Risk Team or Patient Safety Team. Training in this process is mandatory and is provided as part of the induction process for all staff at Trust and departmental level.

Where a member of staff is informed of a death, of an inpatient or patient under our direct care at the time of death they should also inform any other providers of care who have an interest if this is known including the deceased person's GP.

5. GROUPS AND COMMITTEES WITH OVERARCHING RESPONSIBILITY

5.1 Berkshire Healthcare Board

For effective implementation of this policy, there must be active support from the most senior members of Berkshire Healthcare. Therefore the Chief Executive and Board will receive a quarterly report on a number of specific metrics outlined on p15. They will also gain assurance through the activities and minutes of the relevant groups and committees as detailed in the Berkshire Healthcare governance structure (Appendix A). Deaths which are classified as Serious Incidents will be reported to and overseen by the Board in line with the Serious Incident Policy ORG007.

5.2 Quality Assurance Committee

The Quality Assurance Committee has delegated authority by the Board to receive the quarterly mortality report (containing information on deaths, case reviews and investigations)

and to scrutinise, challenge, and subsequently provide assurance to the Board that appropriate governance processes are in place, that Berkshire Healthcare is providing safe care with systems existing to detect, investigate and learn lessons from avoidable deaths, in order to minimise the possibility of similar occurrences in the future.

5.3 Quality Executive Group

The Quality Executive is responsible for ensuring that any learning surrounding mortality has been implemented and shared throughout the organisation, and that any concerns are acted upon or escalated. They will do this through the review of the quarterly incident/SI report and quarterly mortality report for the organisation. They will scrutinise the contents; ensure that any action plans surrounding the report have been implemented; and ensure learning has been shared throughout the organisation.

5.4 Executive Mortality Review Group

The Executive mortality review group consists of the Medical Director, Director of Nursing and Governance, Lead Clinical Director, Deputy Director of Nursing for Patient Safety and Quality and the Head of Clinical Effectiveness & Audit. On a weekly basis they will review all deaths which have been reported through the Datix system, they will agree the initial level of investigation/review required, and if, in their opinion, no further investigation or review is required they will approve closure of the Datix form.

5.5 Berkshire Healthcare Mortality Review Group

The Mortality Review Group (TMRG) will meet on a monthly basis and will ensure:

- Correct Governance of investigation of unexpected deaths.
- Review of all deaths reported in the prior month.
- Review of all Initial findings review (IFR)/ Case reviews / Sub SI reports.
- Identify if there was a lapse in care which contributed to a death.
- Recommend to Medical Director and Director of Nursing if any of the deaths require further investigation.
- Report quarterly to the identified committees, providing assurance about mortality review process.
- Promote learning from themes arising from unexpected deaths via Clinical Directors.
- Advising Clinical Directors of implementation of actions required at service level in the localities, following review of deaths.
- Identification of areas for further review which do not meet the criteria identified in Figure A and B, will be considered Quarterly by the TMRG and will take into account the areas identified in the Berkshire Healthcare quality concerns report.
- Identification of Quality improvement required in Berkshire Healthcare services, arising from learning from the mortality review process.

5.6 Locality Patient Safety and Quality Groups (PSQ's)

Locality PSQ's are responsible for ensuring that there is a mechanism for sharing learning from the mortality processes with the wider staff teams.

5.7 Working with Commissioners

Berkshire Healthcare will work with commissioners to review and improve our local approaches following the death of people receiving care from our services. Provider organisations and commissioners must work together to review and improve their local

approach following the death of people receiving care from their services (Recommendation 7: Learning, Candour and Accountability).

5.8 Working with other Healthcare Providers

Berkshire Healthcare will engage with GPs, acute hospital providers in Berkshire (and other providers of mental health and community services as appropriate), to respond to their requests for information related to their review of deaths and will similarly request information to facilitate review of deaths in Berkshire Healthcare in relevant cases. In some cases, information will be requested from Local Authorities and Care Homes to facilitate learning from deaths.

6. PROCEDURE OF REVIEW

6.1 Figures A and B identify the criteria for reporting a death on the Berkshire Healthcare Datix system for review. Figure A highlights the specific requirements which should also be considered for reporting in line with the serious incident policy (ORG007). At any point a death reported in line with Figure B may be escalated if it is believed to be a SI.

6.2 **All Staff in clinical services** have a duty to follow this policy by reporting any death (which meets the criteria for reporting) **within 24 hours**, according to the procedures outlined in this document. This will be through completion of an Adverse Event Reporting Form on Datix. http://10.210.81.119/datix/live/index.php

Figure A

Criteria for deaths which must be reported in line with the SI ORG007 policy as potential Serious Incidents	**Including**
Mental Health Inpatients	All inpatient deaths.
All Mental Health Services	All suicides or suspected suicides that occur within 12 months of last contact (regardless of whether an open referral or discharged). Unexpected deaths. Any death of a patient being treated under the Mental Health Act.
All Services (Mental Health and Physical Health) (Adults and Children's)	Where the death has been reported to the Coroner, or concerns have been raised by any individual or organisation as to the circumstances surrounding the death. If the death is unexpected or believed to be avoidable. If any acts, omissions or concerns in care provided by Berkshire Healthcare services are suspected.

Figure B

Criteria for reporting all other deaths	Including
All services (Mental Health and physical health)	There was an open safeguarding referral relating to the patient at the time of their death All deaths where bereaved families and carers, or staff, have raised a concern about the quality of care provision Where another organisation notifies us and suggests that Berkshire Healthcare should review the care provided to the patient but who were not under our care at the time of death.
Adult Mental Health	Inpatients: The patient was transferred from a Berkshire Healthcare inpatient unit to an acute hospital and they died within 7 days of this transfer. At the time of their death, the patient had an open/ active referral to Berkshire Healthcare MH services.
Older Persons Mental Health	The patient was an inpatient at the time of their death (informal and those identified as receiving end of life care) Inpatients: The patient was transferred from a Berkshire Healthcare inpatient unit to an acute hospital and they died within 7 days of this transfer. Community patients At the time of their death, the patient had an open/ active referral to Home Treatment Team or Care Programme Approach.
Adult Learning Disabilities	Any patient under the care of Learning Disability (LD) services (Inpatient or Community teams) at the time of death Any patient on the LD caseload within the last year prior to death.
Children with a Learning Disability	Any child with an identified learning disability who dies whilst under the care of any of our children's services (see section 8.3 for definition of LD)
Children's Services: Mental and Physical Health,	Infant or Child death should be reported in line with CCR072 Child Protection(Safeguarding and Promoting the Welfare of Children)
Community Physical health	The patient was an inpatient at the time of their death (including patients whose death may be expected and identified as receiving end of life care) Inpatients: The patient was transferred from a Berkshire Healthcare inpatient unit to an acute hospital and they died within 7 days of this transfer.

6.3 Exclusions

In principle, no services are excluded from reporting deaths and criteria identified above are based on risk and the opportunity for learning. Deaths which will not be routinely reported via the Datix system include:

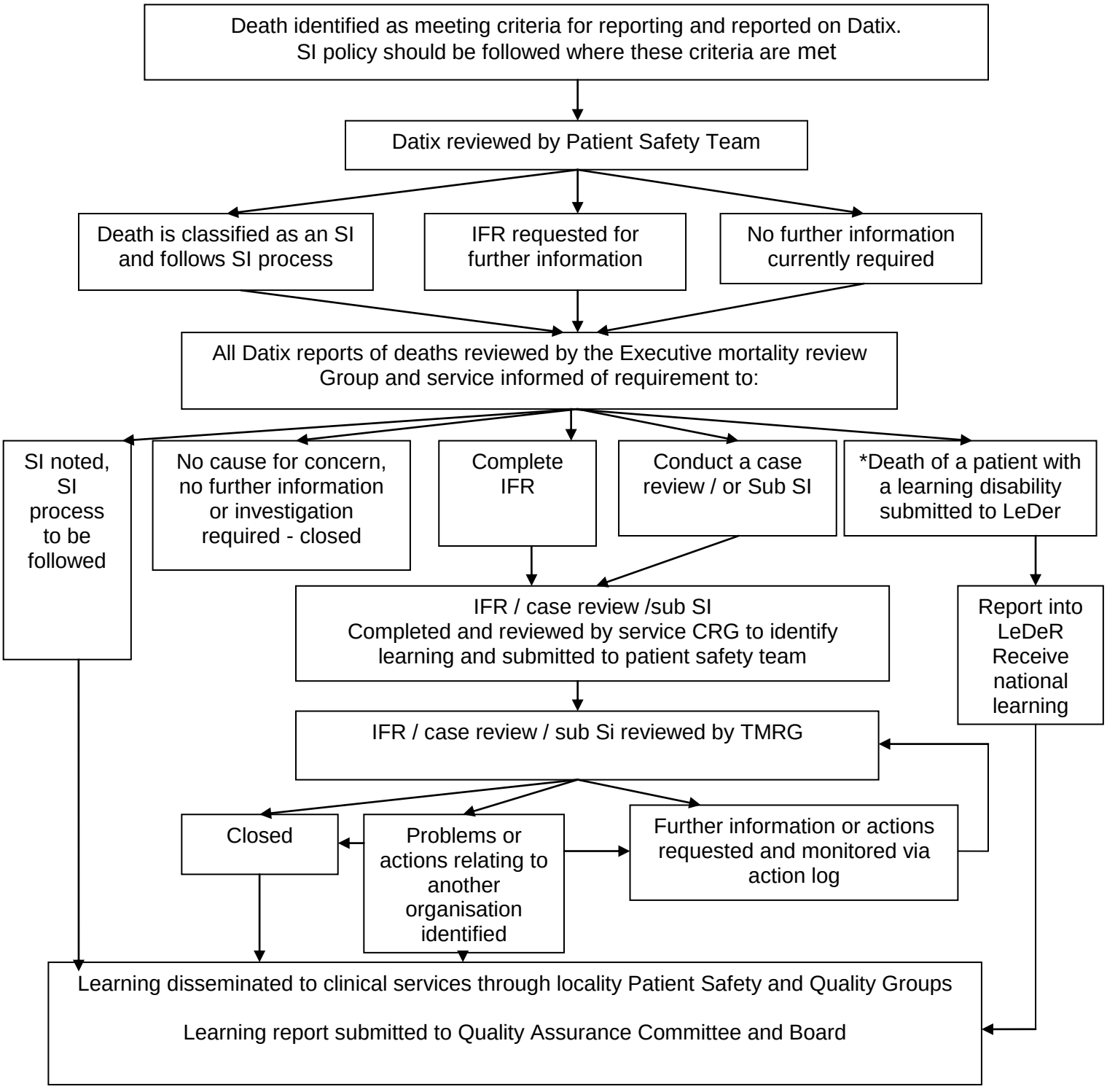
1. Deaths during the neonatal period.

2. Deaths which do not meet the criteria for reporting as above and where the patient has been in contact with one of the Berkshire Healthcare's community services in the past 12 months. These deaths will be reported in the quarterly mortality data report and will be subjected to the quarterly random sampling for learning and improvement.

3. Patients who are transferred and we are not notified of the death. In this case deaths within 7 days will be reported retrospectively on Datix and are subject to notification of the death on the central spine being uploaded to the RiO system.

7. MORTALITY REVIEW PROCESS

Figure C



**Death of a patient with a learning disability is required to be submitted to LeDeR; this will not be a barrier to an SI, Sub Si or Case review being conducted.*

At any point an incident may be deemed an SI and will then follow that process.

8. PURPOSE AND TYPE OF REVIEW TO BE CONDUCTED

The purpose of the local reviews of death is to identify any potentially avoidable factors that may have contributed to the person's death and to develop plans of action that individually or in combination, will guide necessary changes in health and social care services in order to reduce premature deaths of people with learning disabilities.

The type of review will be decided in line with the flowchart outlined Figure C. At any point the type of review may be escalated by a member of the executive mortality group or the TMRG if there is a gap in information or a cause for concern.

Case review should be led by a clinician or service lead who did not provide direct patient care. The specific methodology for case review is different across services and this is line with the evidence base and national guidance. Services will be informed of the type of review they are required to conduct and where required, will receive appropriate training in the methodology.

Case reviews should be discussed and shared with the relevant clinical team prior to being received by the Berkshire Healthcare Mortality Review Group. Feedback of good care should be shared with both the individual staff and the wider teams, concerns should also be discussed with services to identify areas for learning and improvement.

8.1 Initial Findings Report (IFR) for SI

A 72 hour/ initial findings report is carried out by the service(s) following a request from the Governance (Patient Safety & Compliance) Team for all cases considered to be potential or actual SIs. The aim of this review is to take any immediate clinical or managerial action necessary to ensure safety or make any necessary urgent changes to policies and procedures. A further purpose of this review is to identify any immediate support needs for patients; carers or staff and put in place such support. Also to determine the initial facts and identify which staff will be required to give a statement to the Coroner for unexpected deaths. The template can be obtained from the Governance Team. The Coroner's statement template and guidance documents are embedded in the initial 72 hour/ initial findings report.

8.2 Root Cause Analysis

All deaths which are classed as a serious incident (SI) will follow the review methodology set out in the serious incident policy (ORG007).

Sub SI the appropriate methodology for review will be undertaken based on service, this will then be used to complete the Sub Si to identify service and care delivery problems. The documentation to be used will be the SI template.

8.3 Deaths of People with Learning Disabilities (all will be subject to this process)

From September 2017 all reported deaths of patients with an identified learning disability will be submitted for review to the learning disabilities mortality review programme (LeDeR). All deaths should be notified. This is in order to ascertain nationally the numbers of people with learning disabilities who die each year, and their characteristics.

All deaths of people with learning disabilities aged 4 years and over will be reviewed, regardless of whether the death was expected or not. The link below details the current most recognised definition of what it is to have a learning disability as well as some groups who do not fall within this delineation. It also explains who will and who will not be included in the LeDeR review programme.

http://www.bristol.ac.uk/media-library/sites/sps/leder/Briefing%20paper%201%20-%20What%20do%20we%20mean%20by%20learning%20disabilities%20V1.2.pdf

8.5 Deaths of Children and Young People (all will be subject to this process)

Infant or Child death will be reviewed in line with CCR072 Child Protection (Safeguarding and Promoting the Welfare of Children) and Chapter 5 of the statutory guidance document, Working Together to Safeguard Children. Learning from these deaths will be included in the quarterly report.

8.6 All other services (requirement determined by the Executive Mortality Group)

Case review methodology will use the IFR template (Appendix B). This template has been adapted to include relevant elements of structured judgement review (SJR) to critically review cases and identify if there was a lapse in care which attributed to a death.

8.7 All deaths where family, carers or staff have raised a concern about the quality of care provision

Case review methodology will use the IFR template, this will feed into and inform the complaints investigation process and outcome.

8.8 All deaths in a service on the Quality Concerns list

Case review methodology will use the relevant methodology as identified in 8.1 -8.7.

8.9 Cross-System Reviews & Investigations

Where it is identified that more than one organisation is involved in the care of any patient who dies, or where possible problems are identified relating to other organisations, the mortality review group will ensure notification.

9. INVOLVEMENT OF FAMILIES AND CARERS

9.1 We recognise the importance of communicating openly and effectively with families, that if they have any concerns/questions that these should be addressed wherever possible by the review, and that they should be involved or kept informed as much as they want to be in the process.

9.2 The Berkshire Healthcare Open Communication “A Duty to be Candid” should be followed for the involvement of families where:

- The SI process is being followed

- A concern over care has been raised
- The patient is an inpatient or receiving direct care at the time of death

9.3 For patients not under our direct care at the time of death it is the responsibility of the clinician undertaking the review to make a judgment of involvement based on when the patient last had contact. This should be clearly documented as part of the review process and advice sought from the patient safety team if there is any uncertainty.

10. QUARTERLY MORTALITY REPORT

10.1 It has been recognised that whilst services can learn from each case, more can be learnt from the aggregation of cases, where patterns of poor care and good care emerge.

10.2 A report will be generated by the Head of Clinical Effectiveness & Audit and submitted to the identified committees on a quarterly basis. This will include information on the following:

- The total number of deaths recorded on RiO (by service lines) where the patient was seen within the last 365 days before death.
- The total number of deaths recorded on Rio of patients seen by the Community Team for People with a Learning Disability (CTPLD) within the last 365 days before death.
- The number of people who died with a learning disability who were seen by another service in the preceding 365 days before death who were not under the care of CTPLD.
- The number of deaths reported in line with figure A and B including those which follow the SI /Safeguarding or complaints process. Of these deaths subjected to review, we will provide estimates of how many deaths were judged more likely than not to have been due to problems in care.
- Details of family and carer involvement in reviews.
- Evidence of good practice and learning identified as a result.
- Details of reviews which are escalated or shared with other organisations.
- Identifying areas for further review which do not meet the criteria, taking into account the areas identified in the Berkshire Healthcare Quality Concerns Report and areas of existing or planned improvement work (see Audit section).

11. AUDIT

11.1 To ensure that Berkshire Healthcare can take an overview of where learning and improvement is needed most overall, the following actions will be taken:

- The numbers of all deaths recorded on RiO (the patient electronic record) where the patient has had contact with a Berkshire Healthcare service in the 365 days preceding death will be included within the quarterly data report to the Board, detailing the total number of deaths recorded by service

- Of these, a sample of deaths that do not fit the identified categories (Figure A&B) will be reported on retrospectively in line with Figure C. This random sample which are not classified as SIs or LD service deaths, will be identified by the Berkshire Healthcare Mortality Review Group, additional requests may be made by the Chief Executive, Board or Quality Assurance Committee and should take into account the areas identified in the Berkshire Healthcare Quality Concerns Report.

- Deaths recorded by the Westcall Out of Hours Service which meet the criteria for SI will follow the SI investigation process. Westcall Medical Director will review on a weekly basis all deaths identified on the Adastra system, identify any learning for the Mortality Review Group or escalate as appropriate.

- The WestCall Medical Director will also investigate, and when appropriate report upon, the death of any patient for whom a WestCall Adastra case has been closed where a subsequent death has been notified by another healthcare provider and which may in some way be related to the WestCall clinical activity recorded in the case.

12. REFERENCES

Learning Disabilities Mortality Review (LeDeR) programme http://www.bristol.ac.uk/sps/leder

https://www.gov.uk/government/speeches/cqc-review-of-deaths-of-nhs-patients]

Care Quality Commission (CQC) report Learning, candour and accountability: A review of the way NHS Trusts review and investigate the deaths of patients in England.

National Quality Board: National Guidance on Learning from Deaths March 2017.

University of Bristol: Confidential Inquiry into premature deaths of people with learning disabilities (CIPOLD). March 2013.

Trust Policy: ORG007 Incidents/near misses, serious incidents requiring investigation and Coroner requirements 2016

Berkshire Healthcare links to Safeguarding
http://teamnet.berkshire.nhs.uk/clinical/safe/children/policies/Pages/home.aspx
http://teamnet.berkshire.nhs.uk/clinical/safe/Documents/Forms/Adult.aspx

Berkshire Healthcare links to Complaints
http://teamnet.berkshire.nhs.uk/ss/pc/complaints/Pages/home.aspx

Berkshire Healthcare Protocol for responding, reporting and reviewing the death of people with learning disabilities.

Appendix A **Reporting Structure**

Appendix B – IFR Template

Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

Serious Incident Initial Findings Report (IFR)

(To be returned to the Patient Safety Team within 72 working hours)

Please note that a full investigation will still be required if a Serious Incident is identified following the submission of this form.

The Patient Safety Team will confirm what level of investigation is required.

A Datix form should also have been completed

This form should be completed by the relevant Service Manager

.

SI Reference Number:	
Datix WEB Reference Number:	
Date / Time / Location of incident including Hospital / Ward / Team level:	
Name of Patient / Client:	
NHS Number:	
Age & DOB:	
GP Name and Address:	
Diagnosis/ medical conditions	
Incident Type:	
Brief description of incident and immediate action taken:	

Brief description of care delivery and events leading up to the incident including reason for admission and diagnosis (for mental health please include Mental Health Act status and date of referral and last contact):	
Was the patient open to any other services?	**YES / NO**
If yes please detail here and ensure the other services are included in the completion of the IFR.	
Have any clinical or patient safety risks been identified which require immediate action to mitigate further risk to others (including environmental factors and staffing issues)?	
Please include immediate actions taken to mitigate risk if not detailed above.	
Have any other clinical or patient safety concerns been identified that require further investigation (including environmental factors and staffing issues)?	
Were any trainee doctors or dentists involved in the care and treatment of the patient?	**YES / NO**
If yes, please give the name of the trainee doctor(s) or dentist(s); this is so that the Director of Medical Education can make contact to offer support in advance of any investigation interviews *Trainee Doctor's (or Dentist's) Name:*	
<u>For patient deaths:</u> **State names and job titles of staff closely involved in the patient's care who may need to complete a witness statement for the Coroner.**	
Note: The names of the following individuals should be detailed as statements will be taken from the following staff: • *Last professional to have seen the deceased alive* • *Patient's Consultant* • *Care Coordinator or Support Worker* • *Any other relevant key individuals who made a decision around care.*	

STAFF NAME	Job Title

<u>Communication with Patient or Family/Carers:</u> **Please detail the evidence of following the Being Open Policy when a patient has been harmed whilst in receipt of care or treatment from BHFT (ORG072) and the Duty of Candour Process**
Our Duty of Candour is to the Patient. In cases where the patient lacks capacity or is deceased then Duty of Candour should be undertaken to the next of kin.
Ensure that you have documented on RIO a record of the incident and that Duty of Candour has been undertaken.

Was the patient known to Drug and Alcohol Services:	**YES/NO**
Have they been informed?	**YES/NO**

Details of other organisations/individuals notified
Details of any police or media involvement/interest

Report Completed By:	
Designation:	
Date / Time report completed:	

Please insert below a **brief** chronology of key events that have led to the incident from the past 12 months. Include key events/detail from previous years if relevant.

Date / Time	Event	Care Delivery Problems	Good Practice	Staff member involved from whom additional information

				may be required

For Deaths that are not progressing to full SI –this should be completed by Service Manager / Senior Clinician not involved in the direct care of the patient or Clinical Director

Overall assessment of care Please record your explicit judgements about the quality of care the patient received by the patient and whether it was in accordance with current good practice (for example, your professional standards/ NICE guidance/ expected Berkshire Healthcare protocols and policies). If there is any other information that you think is important or relevant that you wish to comment on then please do so
Please rate the care received by the patient

1 = very poor care 2 = poor care 3 = adequate care 4 = good care 5 = Excellent care Please circle only one score
Have any concerns/ complaints about the patients care been raised Yes / no If yes please give details below:

COMMENTS / FEEDBACK (This form can be photocopied as needed)

CCR157 – LEARNING FROM DEATHS

Name _____ Date _____

Address _____

Return comments for consideration three months prior to review date to the designated Policy Lead or Governance Administration Manager, 2nd Floor, Fitzwilliam House, Skimped Hill Lane, Bracknell, RG12 1BQ.

Page: Paragraph:	
Page: Paragraph:	
Page: Paragraph:	
General comments:	

Healthcare from the heart of your community

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Equality Analysis – Template
'Helping you deliver person-centred care and fair employment'

1. Title of policy/ programme/ service being analysed Mortality Review Policy and Procedure	
2. Please state the aims and objectives of this work and what steps have been taken ensure that Berkshire Healthcare has paid <u>due regard</u> to the need to eliminate discrimination, advance equal opportunities and foster good relations between people with protected characteristics. To ensure that we learn from deaths of patients receiving our services, including and with specific focus on vulnerable groups including patients with a learning disability, Mental health and children's where the case review will also consider protected characteristics.	
3. Who is likely to be affected? e.g. staff, patients, service users Policy is relevant to all staff and is being implemented to improve patient care	
4. What evidence do you have of any potential adverse impact on groups with protected characteristics? **Include any supporting evidence e.g. research, data or feedback from engagement activities**	
4.1 Disability *People who are learning disabled, physically disabled, people with mental illness, sensory loss and long term chronic conditions such as diabetes, HIV)*	No adverse impact identified.
4.2 Sex *Men and Women*	*No adverse impact identified.*
4.3 Race *People of different ethnic backgrounds, including Roma Gypsies and Travelers*	*No adverse impact identified.*
4.4 Age *This applies to people over the age of 18 years. This can include safeguarding, consent and child welfare*	*No adverse impact identified.*
4.5 Trans *People who have undergone gender reassignment (sex change) and those who identify as trans*	*No adverse impact identified.*

4.6 Sexual orientation *This will include lesbian, gay and bi-sexual people as well as heterosexual people.*	*No adverse impact identified.*
4.7 Religion or belief *Includes religions, beliefs or no religion or belief*	*No adverse impact identified.*
4.8 Marriage and Civil Partnership *Refers to legally recognised partnerships (employment policies only)*	*No adverse impact identified.*
4.9 Pregnancy and maternity Refers to the pregnancy period and the first year after birth	*No adverse impact identified.*
4.10 Carers *This relates to general caring responsibilities for someone of any age.*	*No adverse impact identified.*
4.11 Other disadvantaged groups This relates to groups experiencing health inequalities such as people living in deprived areas, new migrants, people who are homeless, ex-offenders, people with HIV.	*No adverse impact identified.*

5 Action planning for improvement

5.1 Please outline what mitigating actions have been considered to eliminate any adverse impact?
N/A

5.2 If no mitigating action can be taken, please give reasons.

5.3 Please state if there are any opportunities to advance equality of opportunity?
N/A

An Equality Action Plan template is appended to assist in meeting the requirements of the general duty

Sign off

Name of person who carried out this analysis (Policy Lead): Amanda Mollett Head of Clinical Effectiveness

Date analysis completed: June 2017

Date analysis was approved by responsible Director: Ratified by the Safety, Experience and Clinical Effectiveness Group on 1st August 2017

Berkshire Healthcare NHS
NHS Foundation Trust

Board Meeting Paper

Board Meeting Date	12 September 2017
Title	Patient Experience Quarter 1 report
Purpose	The purpose of this report is to provide the Board with information on patient experience within the trust
Business Area	Nursing and Governance
Author	Liz Daly, Head of Engagement and Service User Experience Helen Mackenzie, Director of Nursing and Governance
Relevant Strategic Objectives	1 – To provide accessible, safe and clinically effective services that improve patient experience and outcomes of care
CQC Registration/Patient Care Impacts	Supports maintenance of CQC registration and supports maintaining good patient experience
Resource Impacts	N/A
Legal Implications	N/A
SUMMARY	Boards are required to review patient feedback in detail. In quarter one, the Trust received 42 formal complaints. The top reasons for complaints being made during quarter four continue to be: • care and treatment • attitude of staff • communication The formal complaint response rate, including those within a timescale re-negotiated with complainants was 100% for the quarter which continues to be exceptional performance. **Patient and Public Involvement** 93% of patients rated our services as good or better in the trust's internal patient survey.
ACTION REQUIRED	The Board is asked to: • Consider the report and reflect on the patient feedback received

Overview

This overview report is written by the Director of Nursing and Governance so that Board Members are able to gain her view of services in light of the information contained in the quarter one patient experience report. In my overview I have considered elements of the feedback received by the organisation and drawn conclusions.

The Board is required to consider detailed patient feedback because it provides insight into how patients, families and carers experience our services.

During quarter one, the trust continued to achieve a complaint response rate of 100%.
The average number of days taken to resolve a complaint was 27 with five complaints taking longer than 40 days because of complexity. Days to response are an important indicator for the responsiveness CQC key line of enquiry. Just over 72% of complaints closed in quarter one were upheld or partially upheld.

In quarter one the trust received 42 complaints across a range of services. Based on trend information over the last three years the following services receive more complaints than others and therefore remain a focus for the board. When considering which services to monitor other quality indicators are also considered:

- Community Mental Health Teams (CMHTs) –themes associated with clinical care. Reading and Wokingham teams received the highest number of complaints. Leadership and staffing concerns exist in the Reading team, the locality director and clinical director are working with the local authority and team leaders to address this issue. CMHTs are under pressure however work is underway to review caseloads and discharge processes.
- Crisis Resolution Home Treatment Team (CRHTT) four complaints received. The clinical director continues to monitor trends and themes working with the hub managers on communication and telephone skills.
- Child and Adolescent Mental Health Services - Bracknell and Wokingham teams received 2 and 3 complaints respectively. For Wokingham these were all associated with clinical care. I have asked the clinical director for the service to review these complaints for trends. None of the complaints were about access to services.
- Acute Mental Health Inpatients – Bluebell received 3 complaints associated with care and treatment. Other concerns exist around Bluebell, including how physical health is managed, ward management and medical cover. The ward currently has 5 beds closed to enable staff to focus on 22 patients. Since January, 60 new staff have been recruited for the wards, there is still a lack of qualified nurses however permanent support staff will alleviate some of the pressure.
- Community Health Inpatients –All three clinical directors overseeing these wards are reviewing the details of the complaints to see if there are common themes.

These services will continue to be monitored closely in 2017/18. Community nursing services will also be monitored during the year. The service, particularly in Reading, is under significant pressure with staff working over and above their hours to meet demand.

MP enquiries during quarter one continued to relate predominantly to mental health services. Two concerns were raised about access to CAMHs.

The top reasons for complaints being made during quarter one was:

- Care and treatment
- Attitude of staff
- Communication

Each service takes complaints seriously and implements new ways of working if appropriate. The service and staff directly involved in the complaint are asked to reflect on the issues raised and consider how they will change their practice.

The trust has received notification from the Parliamentary Health Ombudsman Service (PHSO) that they are intending to investigate a complaint associated with West Berkshire CMHT. The trust tries to avoid referrals to the PHSO by giving patients the opportunity to come back to the trust if they are unhappy with the response they receive initially.

The national audit for schizophrenia showed that the trust needed to improve its engagement with patients so a deep dive was commissioned. Only small numbers of patients responded and therefore the results are not necessarily reliable however the need to focus on managing physical health was a key theme. This work will be supported by the national CQIN in place this year.

The overall Friends and Family Test response rate for the trust in quarter one was 7% so there is a long way to go to achieve our target of 15%. Community hospital inpatient wards have achieved over 15% response rates with recommendation rates of 100% except Henry Tudor with 93%. This is level of response rate means the results are valid. For mental health wards the situation was variable and the response rates were low. The national benchmarking for the Friends and Family Test (FFT) with local similar trusts indicates all are struggling to achieve a 15% response rate. Actions are in progress to increase our response rate.

The patient and public involvement information collection is our long standing internal patient survey which asks patients how they rate their experience, 93% reported the service they received as good or better.

Conclusion

Patient experience is an important indicator of quality and this report provides good intelligence when considering quality concerns. In terms of volume, the level of positive feedback received by services far outweighs the negative feedback received. At this point of the year there are no new emerging trends with communication being an absolute and underlying issue in most complaints.

I believe that services and individuals strive to provide the best possible care and generally patients have a good experience in our services but as a result of a number of variables, for some patients their experience is not good and care falls below the standard of care expected.

I do not take these lapses in care lightly and it is important services recognise and take steps to prevent similar incidents and that this is shared across the organisation. This continues to be work in progress.

Helen Mackenzie, Director of Nursing and Governance

Introduction

Berkshire Healthcare Foundation Trust is committed to improving patient experience through the use of feedback, to better understand the areas where we perform well and those areas where we need to do better.

This report details feedback from a number of sources including complaints, Patient Advice and Liaison Service (PALS), compliments, NHS choices and the Friends and Family Test data received during quarter one (April to June 2017). The report also compares this data with that of previous quarters allowing trends and themes to be identified which helps both the Trust and individual services better understand the experience of patients and enables the monitoring of the impact of changes made as a result of feedback received.

1. Formal Complaints

1.1 Formal complaints received

The Trust has received 42 formal complaints in quarter one; as detailed in table one, this is a decrease in comparison to the previous quarter, but continues to be lower than those reported in quarter one in the previous two years.

In addition to the complaints detailed in this section of the report, the Trust monitors the number of multi-agency complaints where they contribute but are not the lead organisation (such as NHS England and Acute Trusts). There was one new complaint regarding the Criminal Justice Liaison and Diversion Service during quarter one which is being led Oxford Health.

Table One: *Formal complaints received by Locality tables*

	2017/18	2016/17				2015/16						
	Q1 17/18	Q4 16/17	Q3 16/17	Q2 16/17	Q1 16/17	Q4 15/16	Q3 15/16	Q2 15/16	Q1 15/16	16/17 Annual	15/16 Annual	14/15 Annual
Mental Health Inpatients	4	4	5	11	10	8	15	3	10	30	36	47
Bracknell	4	6	6	7	4	10	4	6	8	23	28	37
West Berkshire	4	7	8	2	5	3	2	6	7	22	18	28
Reading	10	9	7	12	13	16	9	12	9	41	46	28
Slough	3	4	4	4	7	5	3	3	3	19	14	19
Windsor, Ascot & Maidenhead – CYPF	8	8	2	10	9	8	3	13	11	29	35	36
Wokingham	9	10	4	10	17	13	10	8	9	41	40	41
Other inc Corporate	0	3	0	0	1	0	1	0	0	4	1	8
Total	42	51	36	56	66	63	47	51	57	209	218	244

For reporting purposes a complaint is logged under the Locality that the service receive their line management from, therefore services that operate trust wide, for example Child and Adolescent Mental Health Services (CAMHS), although providing services in all localities, will have any complaints about their services logged under Windsor & Maidenhead, The Children Young People and Families (CYPF) locality and not the locality where the services were received.

Table Three shows formal complaints received grouped by service. By showing the information in this way, we are able to draw comparisons across our inpatient and community health services.

Table Three: *Number of formal complaints received by individual services*

	2017/18		2016/17						2015/16				
Service	Q1	% of total received	Q4	Q3	Q2	Q1	Total	% of total received	Q4	Q3	Q2	Q1	Total
CMHT/Care Pathways	11	26.19	8	7	8	9	32	15.31	11	6	6	7	30
CAMHS - Child and Adolescent Mental Health Services	7	16.67	5	2	5	6	18	8.61	5	2	11	10	28
Crisis Resolution & Home Treatment Team (CRHTT)	4	9.52	4	3	4	10	21	10.05	2	7	2	2	13
Adult Acute Mental Health Admissions	4	9.52	4	4	7	5	20	9.57	4	7	1	6	18
Community Nursing	4	9.52	1	3	2	3	9	4.31	3	7	3	0	13
Community Hospital Inpatient	3	7.14	4	3	3	7	17	8.13	5	2	2	7	16
Common Point of Entry	2	4.76	4	0	1	0	5	2.39	2	2	0	1	5
Out of Hours GP Services	2	4.76	1	1	3	4	9	4.31	5	1	5	3	14
Walk in Centre	0	-	4	0	0	3	7	3.35	1	0	0	1	2
GP - General Practice	0	-	0	1	4	4	9	4.31	7	1	5	6	19
PICU - Psychiatric Intensive Care Unit	0	-	0	1	3	1	5	2.39	1	0	0	2	3
Minor Injuries Unit (MIU)	0	-	0	0	1	2	3	1.44	1	2	0	2	5
10 other services – no trends identified	5		16	11	16	15	58		19	12	16	12	59
Grand Total	42		51	36	56	66	209		63	47	51	57	218

As with quarter four, the service with the highest number of formal complaints during quarter one was CMHT/Care Pathways. CAMHS and Community Nursing have both seen an increase in formal complaints. The increase for the Slough Walk in Health Centre in quarter four has reduced back to none.

The complaints about the Community Nursing service were not about one specific team, they were received in Bracknell, West Berkshire, Windsor Ascot and Maidenhead and Wokingham. All were about care and treatment, which included how quickly the team visited an end of life patient, a mix up with visit dates and a concern about a pressure sore.

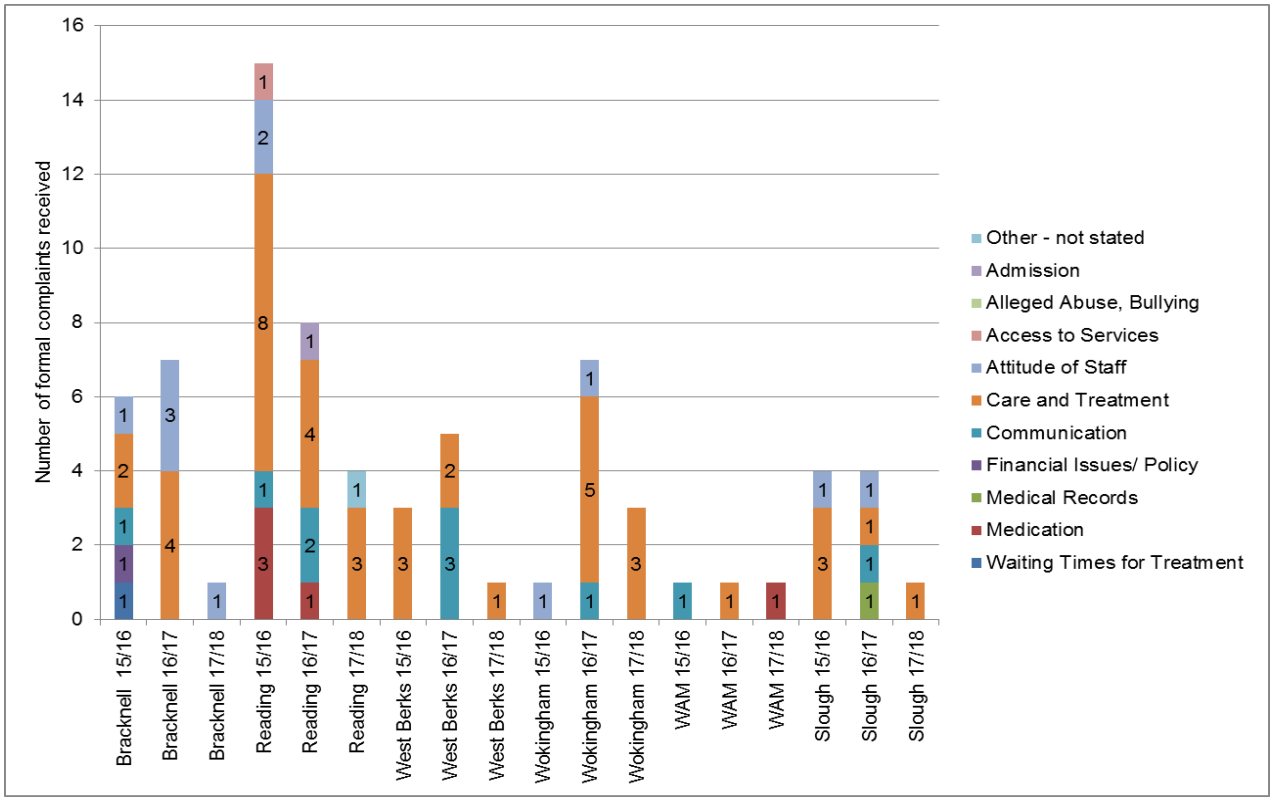
The numbers of complaints for CRHTT continue to remain at a lower level than the original peaks noted two years ago. The Clinical Director for CRHTT continues to review all of the complaints received to ensure that there are no particular themes or trends that require specific action. For Adult Acute Mental Health inpatients and Community Hospital inpatients, the number of complaints was similar to the number received in previous quarters, and the number for CMHT has increased.

During 2016/17 a number of services were specifically highlighted within this report because they received a higher number of complaints and/or there have been quality concerns. The services identified are CMHT; mental health inpatients, community inpatient wards; CRHTT and CAMHS.

CMHT/Care Pathways

During quarter one, CMHTs received 11 formal complaints compared to 8 in quarter four, 7 in quarter three, 8 in quarter two, 9 in quarter one and 11 in quarter four 2015/16. This equates to three about the Reading team, two for both the Bracknell and Wokingham teams, and one for the team in West Berkshire. Overall in 2016/17 there were 32 complaints for CMHT's compared to 30 in 2015/16.

Graph One: *Number of formal complaints received for CMHT/Care Pathways by location of the service*



This shows that whilst all of the teams received a formal complaint between April and June 2017, the teams in Reading and Wokingham had the highest number, with four and three respectively. Care and treatment still remains the main theme of complaints across the CMHTs and the table below compares the theme and location of complaints during quarter one 2015/16, 2016/17 and 2017/18.

Table Four: *Comparison of complaints receved during quarter one 2015/16, 2016/17 and 2017/18*

	Bracknell			Reading			Slough		
Theme	15/16	16/17	17/18	15/16	16/17	17/18	15/16	16/17	17/18
Alleged Abuse, Bullying				1					
Attitude of Staff			1				1	1	
Care and Treatment	1			1		3			1

	Bracknell			Reading			Slough		
Communication	1							1	
Financial Issues/Policy	1								
Medical Records								1	
Medication									
Other - not stated						1			
Waiting Times for Treatment	1								

	WAM			West Berkshire			Wokingham		
Theme	15/16	16/17	17/18	15/16	16/17	17/18	15/16	16/17	17/18
Alleged Abuse, Bullying								3	
Attitude of Staff									
Care and Treatment						1		2	3
Communication								1	
Financial Issues/Policy									
Medical Records									
Medication			1						
Other - not stated									
Waiting Times for Treatment									

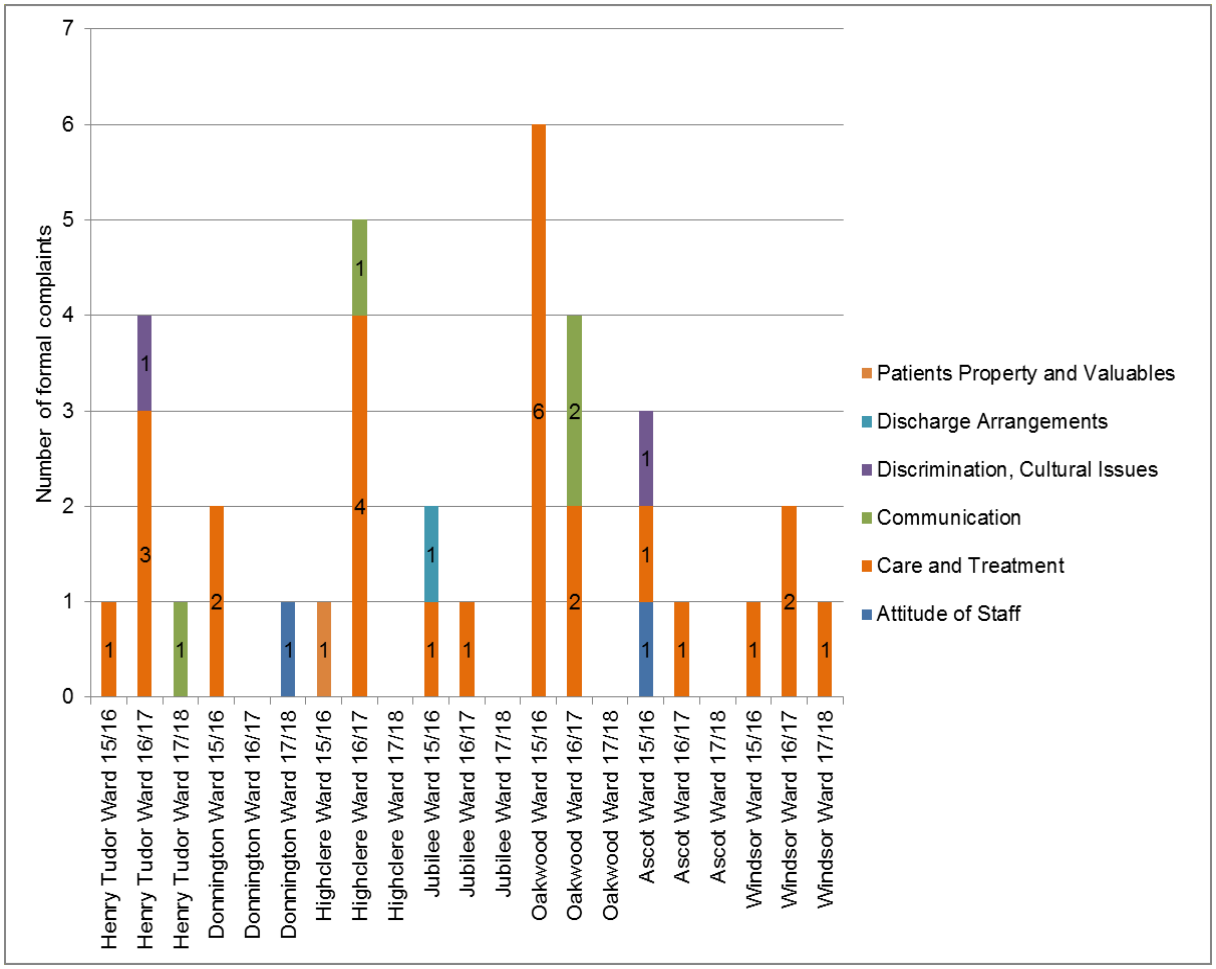
Community Hospital Inpatient Wards

During quarter one there were 3 formal complaints received about the community wards, this is a decrease from 4 received in quarter four and the same as the 3 received in both quarters two and three and a sustained decrease compared with 7 in quarter one.

There were no themes to the complaints and were received about Henry Tudor Ward at St Marks Hospital, Donnington Ward at West Berkshire Community Hospital and Windsor Ward at Wokingham Community Hospital. Communication, clinical care and attitude of staff were aspects to these complaints.

The investigation was on-going for all of these complaints at the end of quarter one.

Graph Two: *Number of formal complaints received for Community Hospital Inpatient wards by location of the complaint and theme*



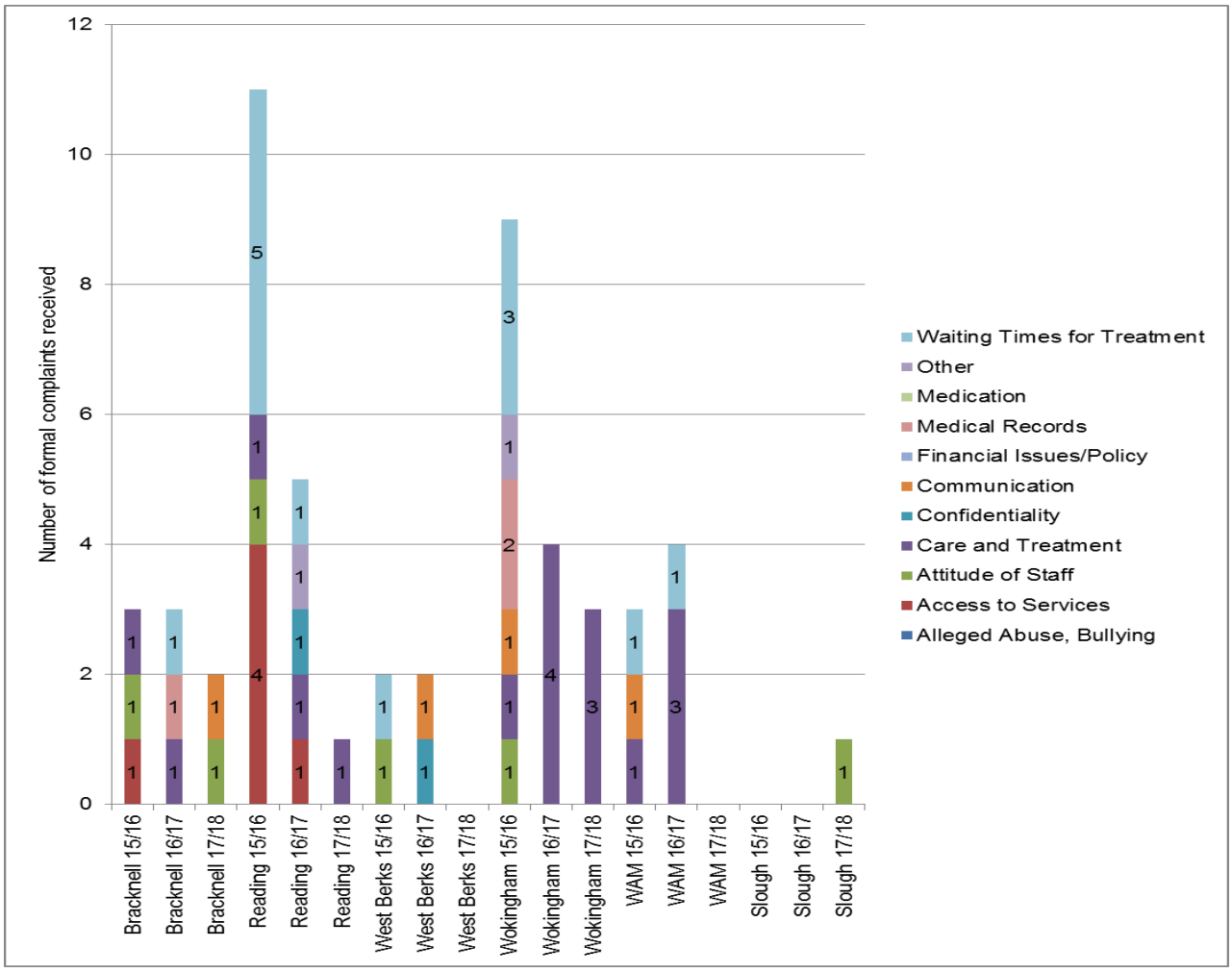
CAMHS - Child and Adolescent Mental Health Services

CAMHS has seen an increase in formal complaints in quarter one to 7 from 5 in quarter four and 2 in quarter three. This is in comparison to 5 in quarter two and 6 in quarter one in 2016/17; the number of complaints received remains lower than those received during quarters one and two in 2015/16.

Although for reporting purposes in table 1, CAMHS is reported under the Windsor, Ascot and Maidenhead Locality. Graph three shows the geographical locality where the service is based.

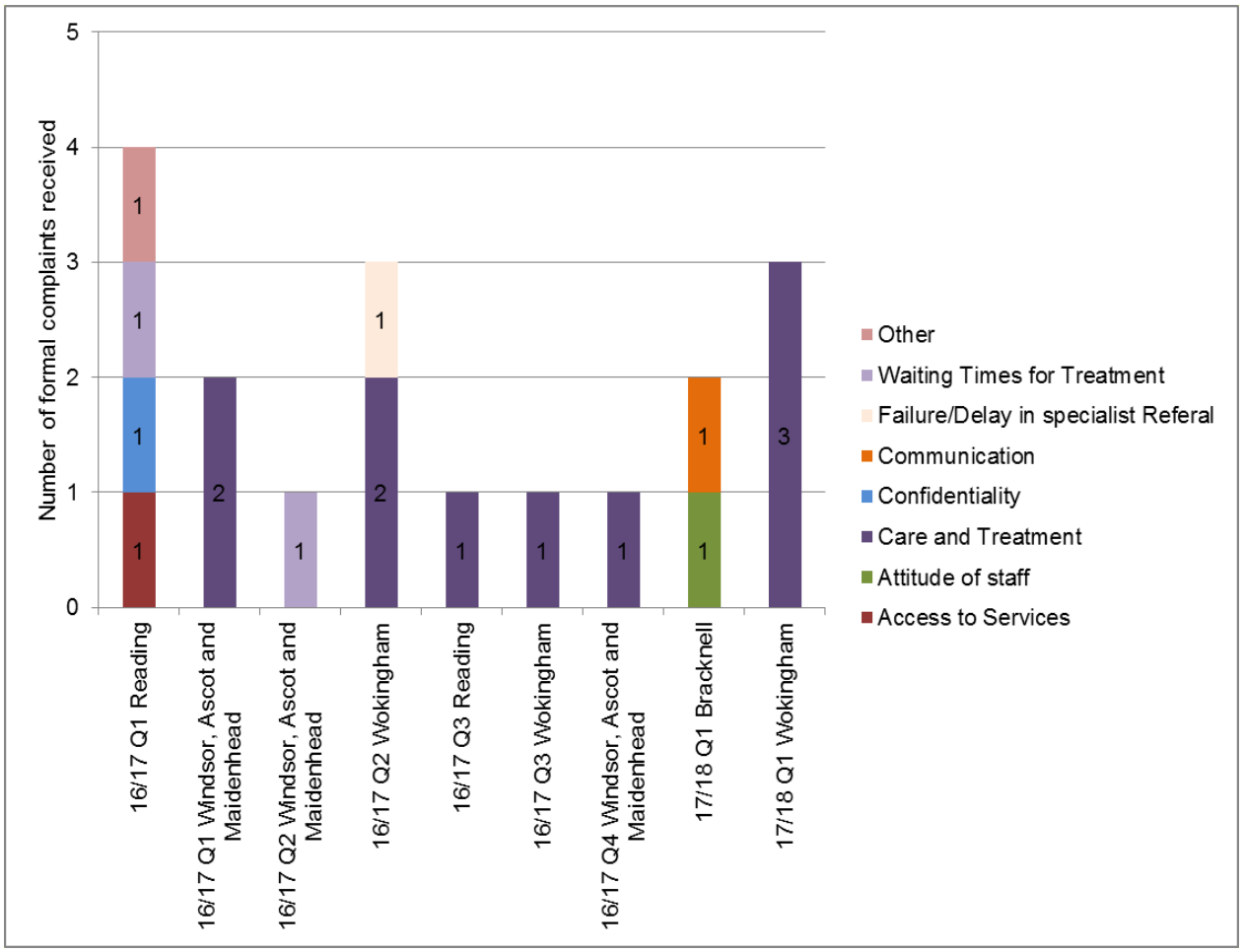
Clinical care and treatment in the Wokingham team is showing the highest level of activity in quarter one, compared to no complaints received about this team in quarter four. There were no complaints received between April and June about waiting times for treatment; there were two complaints about attitude of staff and these were in the Bracknell and Slough teams.

Graph Three: *Number of formal complaints received for CAMHS by location of the service*



The service based in Slough had consistently not received any formal complaints for the last two financial years up to quarter one where it received a complaint about attitiude of staff.

Graph Four: *Number of formal complaints received for top three services, by quarter received and theme*

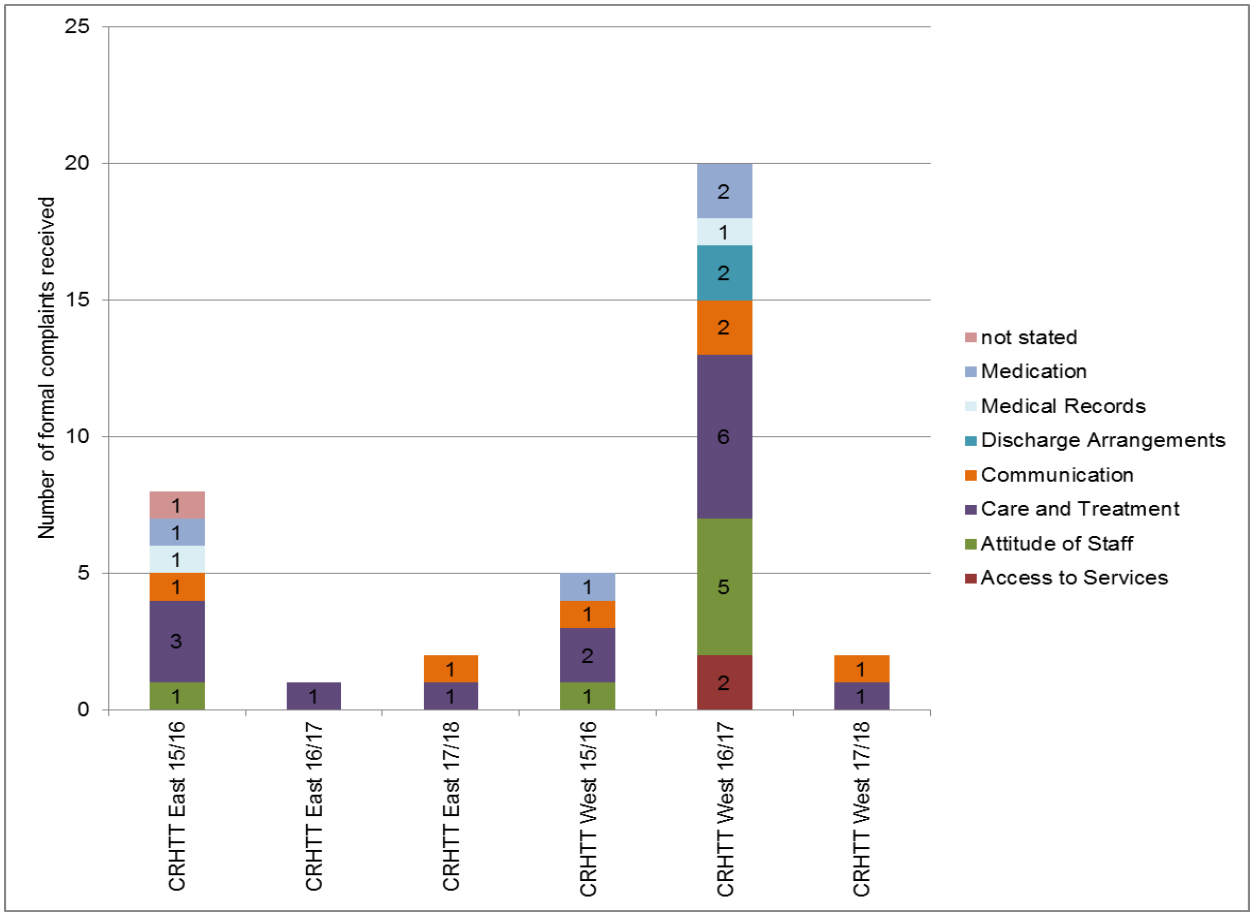


Themes within CAMHS continue to be monitored to ensure that this positive reduction in complaints around wait times and access, continues.

Crisis Resolution/Home Treatment Team (CRHTT)

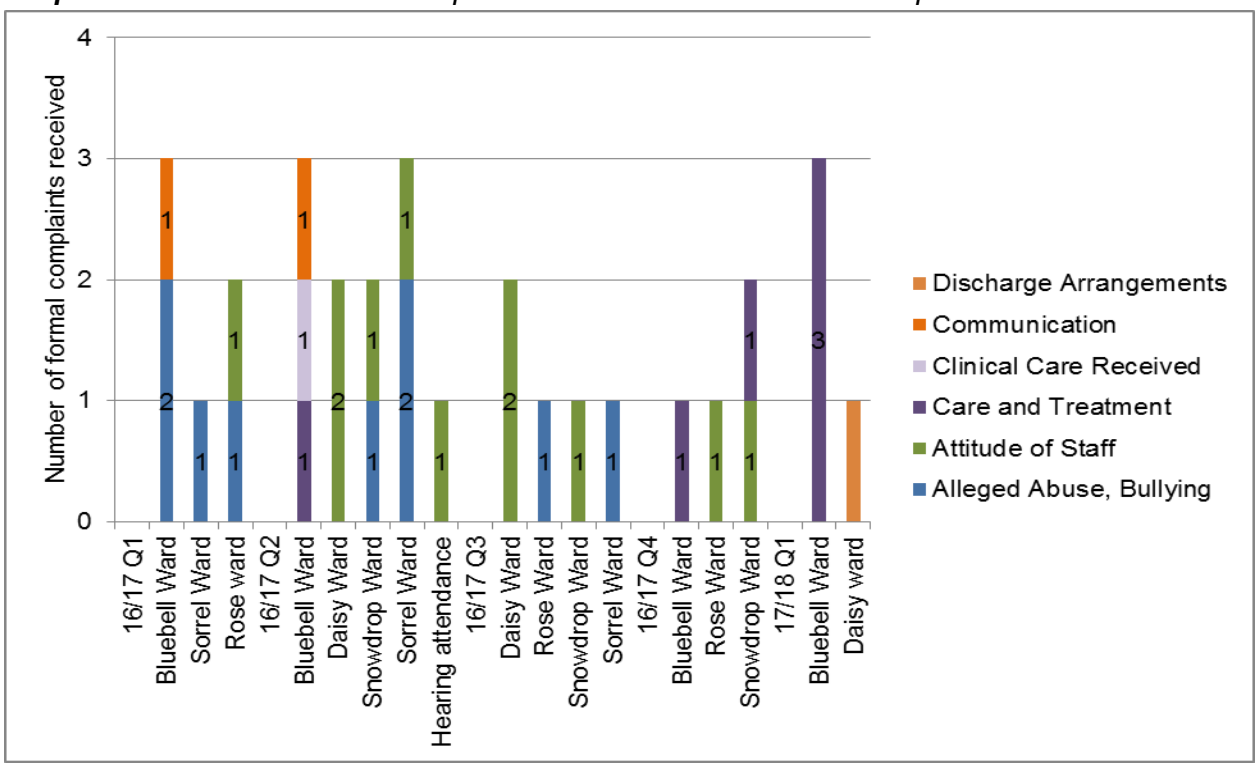
CRHTT received 4 formal complaints in quarter one, compared to 4 in quarter four, 3 in quarter three, 4 in quarter two and 10 in quarter one 2016/17.

Graph Five: *Number of formal complaints received for CRHTT by location of the service (East and West)*



Mental Health Inpatients - Adult
All of our mental health inpatient wards are based at Prospect Park Hospital in Reading.

Graph Six: *Number of formal complaints received for mental health inpatient wards*



The graph below shows the number of formal complaints received by ward.

Graph Seven: *Number of formal complaints received by quarter and ward*

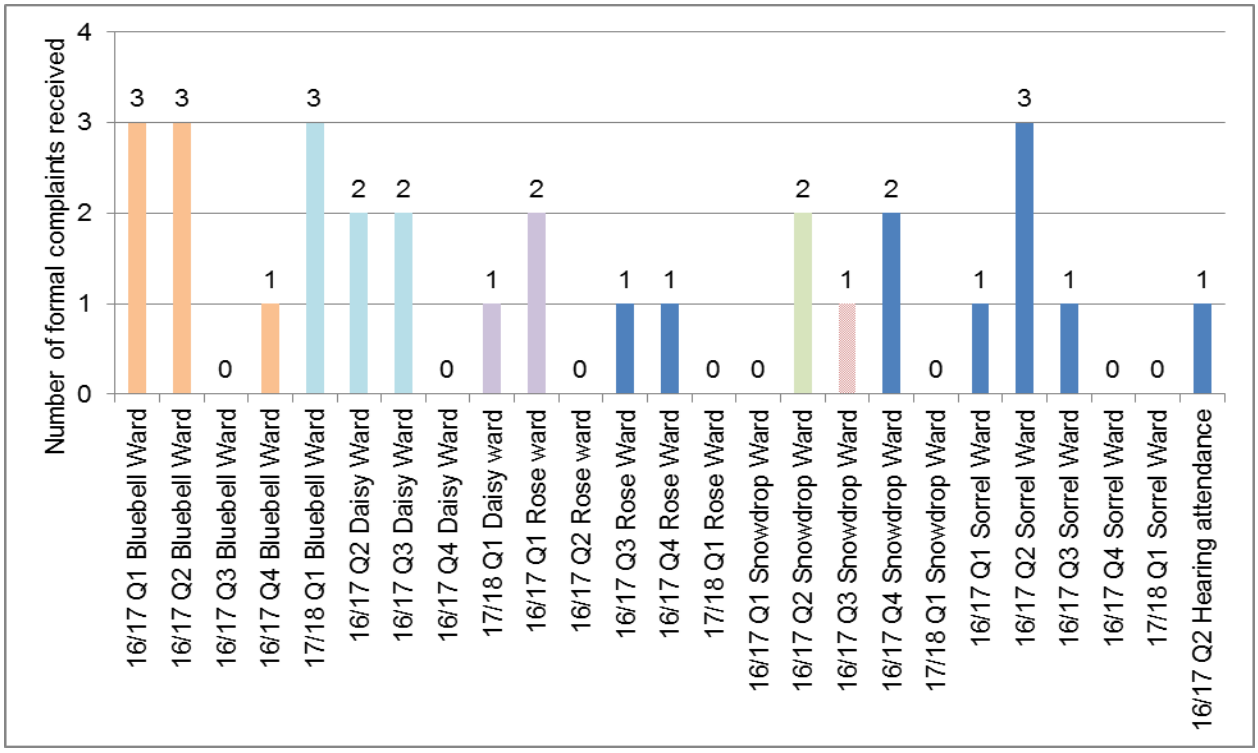


Table Five: *Themes of all formal complaints received*

	2017/18	2016/17					2015/16				
Theme	Q1	Q4	Q3	Q2	Q1	Total	Q4	Q3	Q2	Q1	Total
Care and Treatment	**26**	26	19	22	26	93	27	17	15	19	78
Attitude of Staff	**9**	8	7	12	14	41	16	11	10	9	46
Communication	**4**	7	7	4	8	26	4	3	2	9	18
Alleged Abuse, Bullying	0	2	2	3	4	11	0	1	1	2	4
Access to Services	0	3	0	0	4	7	4	2	6	5	17
Medical Records	0	3	0	0	4	7	0	1	4	0	5
Medication	1	0	0	2	2	4	4	3	1	1	9
Confidentiality	0	0	0	3	1	4	3	0	1	0	4
Discharge Arrangements	1	0	0	3	1	4	0	0	2	0	2
Waiting Times for Treatment	0	1	0	3	1	5	1	0	7	8	16
Support Needs (Including Equipment, Benefits, Social Care)	0	0	1	0	0	1	0	0	0	0	0
Management and Administration	0	1	0	0	0	1	0	0	0	0	0
Other/not stated	1	0	0	4	1	1	4	9	2	4	11
Grand Total	42	51	36	56	66	209	63	47	51	57	218

The top reasons for complaints being made during 2015/16 and 2016/17 and continued in 2017/18 were:

- Care and treatment

- Attitude of staff
- Communication

More detail about complaints received can be found in appendix one.

1.2 Formal complaints closed and action taken

As part of the process of closing a formal complaint, a decision is made around whether the complaint is found to have been upheld (referred to as an outcome). The table below shows the outcome of complaints over time.

Table Six: *Outcome of formal complaints closed*

	2017/18		2016/17						2015/16					
Outcome	Q1	% of 17/18	Q4	Q3	Q2	Q1	Total	% of 16/17	Q4	Q3	Q2	Q1	Total	% of 15/16
Case not pursued by complainant	1	2.78	1	5	1	4	11	5.19	4	1	1	6	12	5.43
Consent not granted	0	0	3	4	1	1	9	4.25	2		1	1	4	1.81
Local Resolution	3	8.33	4	0	1	4	9	4.25	3	3	3	5	14	6.33
Not Upheld	6	16.67	9	7	16	14	46	21.7	15	16	21	17	69	31.22
Partially Upheld	18	50.00	14	18	24	22	78	36.79	17	11	17	19	64	28.96
Referred to other organisation	0	0	0	0	0	0	0	0	1	0	0	2	3	1.36
Upheld	8	22.22	14	7	18	20	59	27.83	19	17	12	7	55	24.89
Grand Total	36		45	41	61	65	212		61	48	55	57	221	

The percentage of complaints upheld has continued to decrease into quarter one 2017/18. Partially upheld complaints have increased to 50% from 36.79% in quarter four and 38.32% in quarter three.

The main themes of complaints found to be upheld or partially upheld are:

- Care and treatment (62%) – consistent with quarters three and four
- Attitude of staff (27%) – an increase from 7% in quarter four and 12% in quarter three
- Communication (8%) – a decrease from 14% in quarter four and more aligned with 8% in quarter three
- There was one complaint (4%) upheld about access to services (CMHT). There were no complaints upheld in quarter four and 8% of complaints upheld or partially upheld in quarter three.

Table Seven below shows the services with upheld or partially upheld complaints during quarter one.

Table Seven: *Upheld and Partially Upheld formal complaints*

	Outcome of complaint		
Service	Partially Upheld	Upheld	Grand Total
Adult Acute Admissions	4		4
CAMHS - Child and Adolescent Mental Health Services	2	1	3
Children's Speech & Language Therapy - CYPIT	1		1
CMHT/Care Pathways	5	1	6

	Outcome of complaint		
Service	Partially Upheld	Upheld	Grand Total
Common Point of Entry	2	1	3
Community Hospital Inpatient	1		1
Crisis Resolution & Home Treatment Team (CRHTT)		2	2
District Nursing		1	1
Hearing and Balance Services		1	1
LDS Community Patients		1	1
Neuro Rehab (CHC)	1		1
Sexual Health	1		1
Walk in Centre	1		1
Grand Total	18	8	26

Further information about the outcome of complaints about our mental health inpatient wards, community mental health teams and Crisis Resolution/Home Treatment service can be found below:

Table Eight: *Outcome of formal complaints by service*

	Outcome of complaint					
Service	Case not pursued by complainant	Local Resolution	Not Upheld	Partially Upheld	Upheld	Grand Total
Adult Acute Admissions		1		4		5
CMHT/Care Pathways			2	5	1	8
Crisis Resolution & Home Treatment Team (CRHTT)	1				2	3
Grand Total	1	1	2	9	3	16

All services review the findings from complaint investigations and these are discussed in the locality patient safety and quality meetings with actions identified and monitored to affect positive change.

1.3 Response rate for formal complaints

Whilst the Complaint Regulations 2009 state that the timescales for complaint resolution are to be negotiated with the complainant, the Trust monitors performance internally against both a 25 working day timeframe and the renegotiated timescale. The investigating managers continue to make contact with complainants directly to renegotiate timescales for complaints where there has been a delay and these are recorded on the online complaints monitoring system.

The table below shows the response within re-negotiated timescale as a percentage total, it demonstrates the commitment of both the complaints office and clinical staff to work alongside complainants. There are weekly open complaints situation reports sent to Clinical Directors and Service Managers, as well as ongoing communication with the complaints office throughout the span of open complaints to keep them on track as much as possible.

This is reflected in the 100% cumulative percentage achieved for the 2016/17 and the sustained 100% response rate achieved to date.

***Table Nine**: Response rate within timescale negotiated with complainant*

2017/18	2016/17				2015/16			
Q1	Q4	Q3	Q2	Q1	Q4	Q3	Q2	Q1
100%	100%	100%	100%	100%	97%	85%	92%	95%

The average number of days taken to resolve formal complaints during quarter one was 27, an increase from 24 in quarter four. This was a significant decrease in comparison with 33 in quarter three.

There were 5 complaints closed that took longer than 40 working days, an increase from 1 in quarter four, and reduction from 9 in quarter three, 8 in quarter two, 10 in quarter one 2016/17 and 15 in quarter four 2015/16.

1.4 MP Enquiries

In addition to raising formal complaints on behalf of their constituents, Members of Parliament (MPs) can also raise service and case specific queries with the Trust. A review of the activity has been included in this report.

During quarter one, we received 7 enquiries from MPs, compared to 16 in quarter four, 13 enquiries in quarter three and 11 enquiries during quarters one and two 2016/17 combined.

6 of these were about mental health services, compared to all 16 of the enquiries in quarter four. 10 of the enquiries in quarter three were about mental health services, which is a continued trend as the majority of enquiries (8) were about mental health services in quarter two, whilst there were 2 enquires related to these services in quarter one.

***Table Ten:** Subject of MP enquiries received during quarter one*

	Subject of enquiry					
Service	Access to services	Attitude of Staff	Care and Treatment	Financial Issues/Policy	Waiting Times for Treatment	Grand Total
CAMHS - Child and Adolescent Mental Health Services	1		1		1	3
CMHT/Care Pathways			1	1		2
Integrated Pain and Spinal Service			1			1
Psychotherapy & Complex Needs (PDPT)		1				1
Grand Total	1	1	3	1	1	7

2. Parliamentary and Health Service Ombudsman (PHSO)

The Trust continues to work with the PHSO as the second stage within the complaints process. The table below shows the Trust activity with the PHSO as at the end of quarter one 2017/18.

Table Eleven: *PHSO Activity*

Month open	Service	Month closed	Current Stage
Dec-15	District Nursing	Jan-17	Not a BHFT complaint - community nursing records requested to inform investigation about a different Trust.
Jan-16	Talking Therapies	Jan-17	Not Upheld.
Jun-16	GP General Practice	Dec-16	Not Upheld.
Sep-16	CAMHS	n/a	Investigation underway.
Oct-16	District Nursing	Jun-17	Not Upheld.
Oct-16	Community Inpatient ward	Jun-17	Not Upheld.
Jan-17	District Nursing	n/a	Investigation underway.
Feb-17	Psychological Medicine Service	Apr-17	Not Upheld.
May-17	CMHT/Older Adults	May-17	Not a BHFT complaint - records requested to inform investigation about Social Care. This case was closed after the notes were sent.
Jun-17	CMHT	n/a	Investigation underway.

The Patient Experience and Engagement Group monitor the action plans that arise from PHSO investigations on a quarterly basis, this provides a forum to share practice and learning across the different specialities and geographical localities.

3. Informal Complaints/Local Resolution

The complaints office will discuss the options for complaint management when people contact the service, to give them the opportunity to make an informed decision if they are looking to make a formal complaint or would prefer to work with the service to resolve the complaint informally. 6 informal complaints were received during quarter one.

The complaints office has been working with services to devise ways of resolving complaints in a way that meets the expectation of patients and their families whilst capturing the information for staff to use in a friendly and manageable way. It is recognised that services are managing concerns effectively on a daily basis and an online form has been created as a mechanism for these concerns and any actions taken as a result, being captured.

The number of local resolution complaints that the Patient Experience team have been notified about has increased slightly to 49, compared with 48 in quarter four, 53 in quarter three, 42 in quarter two, 67 in quarter one and 52 in quarter four 2015/16.

4. NHS Choices

The internal monitoring of NHS Choices postings is an additional way of gathering feedback about our services. Similar to complaints, for an individual to take the time to post on our website about their experience, means they feel very strongly about their position and therefore the Trust needs to take these comments seriously and respond appropriately.

12 negative comments were received in quarter one. Three of these were about the Slough walk in Health Centre, 4 were about community services and 4 were about our inpatient wards (2 for mental health inpatients, 1 for a physical health ward and 1 for our adolescent ward).

There have been 4 positive posts. 1 was about our adolescent ward, 1 for a mental health inpatient ward and 2 for community based services; physiotherapy and community dental.

5. Compliments

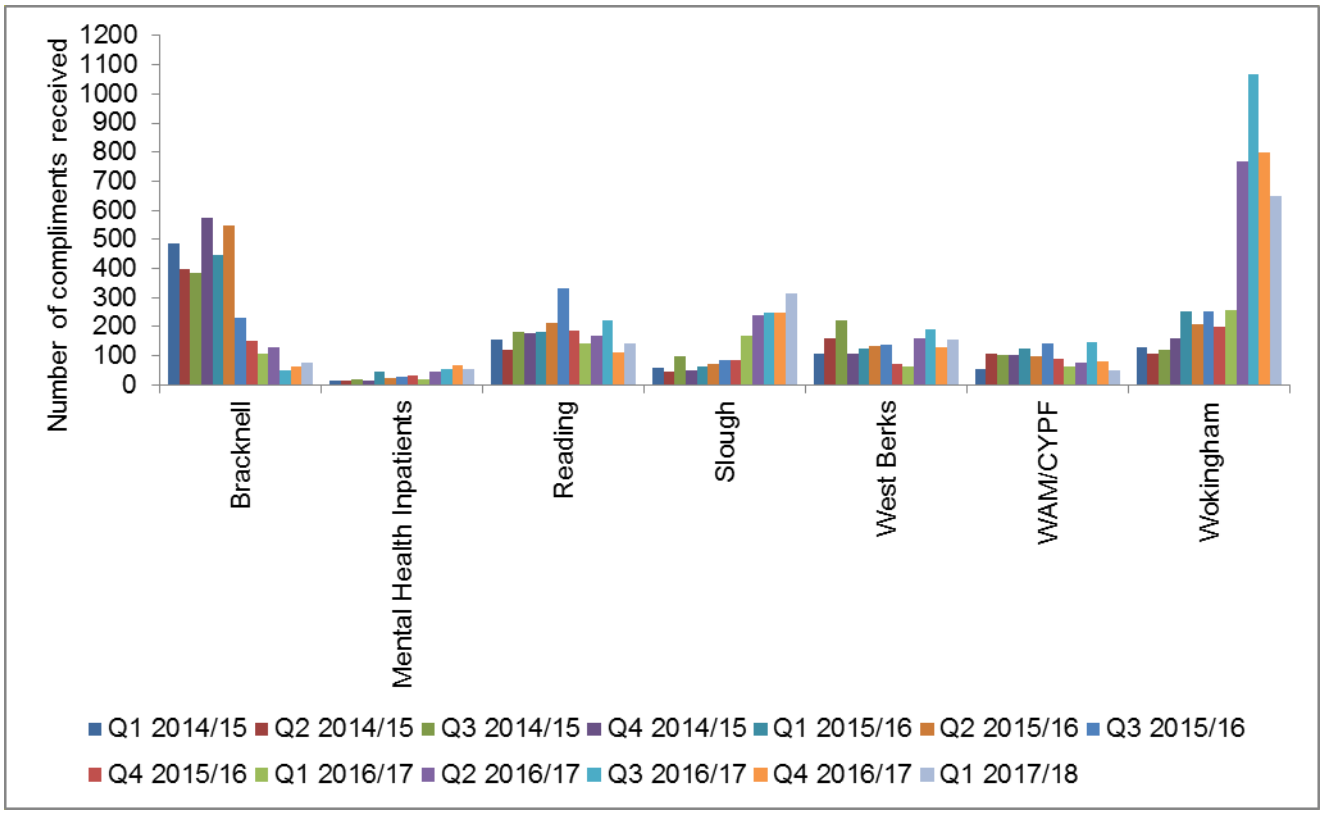
Graph eight shows the number of compliments received since quarter one 2014/15 by Locality. Since quarter four 2012/13 compliments have been routinely reported directly by services through the web based Datix system. This method of collating feedback enables the Trust to capture compliments, by means other than the traditional thank you card. We have listened to what our staff told us about improving the way this system works and there is now a batch upload option for multiple compliments to be entered into the system.

The majority of the compliments that we receive are thanking staff for their time and care and are not specific about what made the difference.

The number of compliments received continues to increase on an annual basis:

2013/14: 3050
2014/15: 4359
2015/16: 4620
2016/17: 5950

Graph Eight: *Number of compliments received since quarter one 2014/15*



There were 1488 compliments reported in quarter one, in comparison with 1534 in quarter four, 1993 in quarter three, 1602 in quarter two, 821 in quarter one, 826 in quarter four, 1219 in quarter three, 1313 in quarter two and 1262 in quarter one of 2015/16. Our IAPT (Talking Therapies Service) moved from the Bracknell locality to the Wokingham locality which has contributed to the change in activity.

The online compliment form enables people to add information such as staff group the compliment was received for and the theme. As this is not a mandatory part of the form, and you can add more than one for each compliment it needs to be remembered that this will not make up 100% of the compliments reported.

Table Twelve: *Top services to report compliments in quarter one*

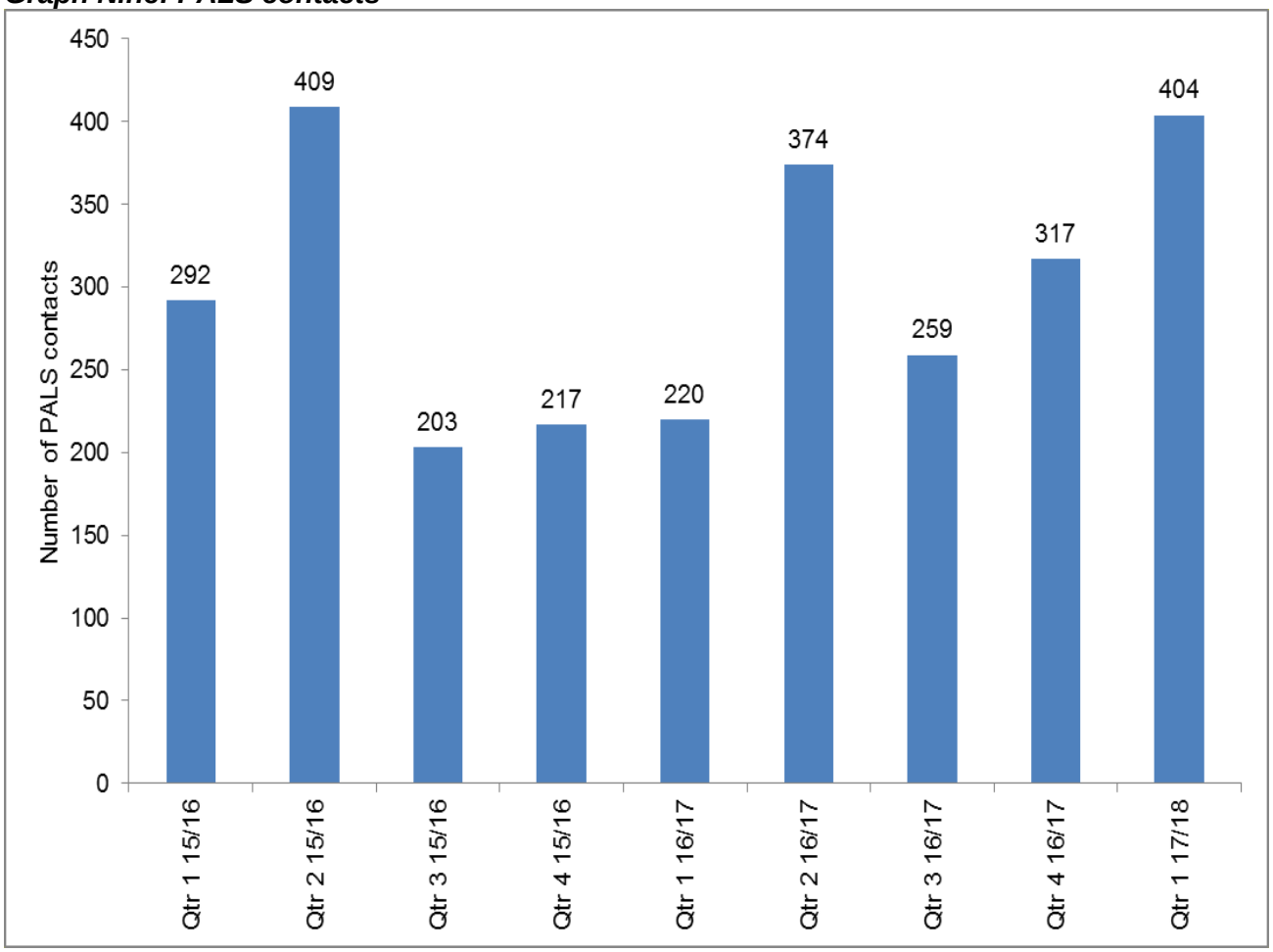
Service	Number of compliments
Talking Therapies	542
ASSiST	235
Community Hospital Inpatient	39
Community Based Neuro Rehab	34
District Nursing	32
Community Hospital Inpatient	32
CMHTOA/COAMHS - Older Adults Community Mental Health Team	24
Community Hospital Inpatient	24
Eating Disorders Service	24

In addition, there were 147 compliments logged that were from sources other than patients, carers and the public. These include students on placements, other organisations and services.

6. Patient Advice and Liaison Service

The role of PALS is to offer a signposting service as well as to facilitate the resolution of concerns with services at the first stage of the complaints process. PALS have established drop in clinics in sites across the localities and continue to promote these to raise further awareness and increase accessibility.

Graph Nine: PALS contacts



There are still a large proportion of people contacting our PALS office about issues relating to their GPs, external groups and organisations and education; 40 in quarter one. PALS are signposting these queries to the appropriate people.

Review of the data shows the themes which have attracted the highest number of queries / concerns continues to be:

- Communication

- Care and treatment
- Information requests

These have consistently remained the top reasons for contacting PALS since 2016/17. Many of the enquiries are, for example wanting a message to be passed to a service, advice and information on how to access services. There are no particular themes and the reason for calls into PALS is very variable

As with formal complaints, a pattern is showing of a reduced number of contacts between October and December (quarter three).

Patient and Public Involvement

Deep Dives

- **The experience of patients with Schizophrenia**

The key aim of the audit is to provide an essential picture and understanding of the views and experiences of services users in relation to their physical health in secondary and primary care. With specific emphasis on physical health monitoring, support and lifestyle interventions offered; in line with current guidelines. NICE guideline CG178 (NICE, 2016), the National Audit of Schizophrenia (RCOP, 2014) and the Positive Cardio-metabolic Health resource (RCOP, 2011).
In addition an underlying aim was to gain a better understanding of perceived physical health needs, feelings of involvement with their health planning, barriers to engagement and potential individual preferences for lifestyle interventions. This is a key step towards improving levels of preference-guided involvement and design of future Trust services and interventions.

The main recommendations from the Deep Dive are:

Trust & Community Physical Health Policy/Guidelines - Improvement in healthy literacy of service users could be achieved through a Personal Health Record. PHR would be a helpful tool for patients as it can help them keep a record of their own medication, health, and their test results.

Standardisation of Integrated Physical Health Pathway in CMHTs - In order to promote consistency of physical health monitoring in line with NICE guidance; This is supported by the national CQIN this year.

Standardisation of Physical Health Recording Forms, Tools & Referral Forms - There is a need for all partners to agree on standardised, short and simple electronic physical health recording sheet template.

Actions will be monitored through the quarterly Patient Experience and Engagement Group.

15 Steps

9 visits have taken place during quarter one; three clinic visits and six inpatient visits.

Appendix Two contains the full quarterly report showing the feedback and themes from the 15 Steps visits which took place during quarter one.

7. The Friends and Family Test

The NHS Friends and Family Test (FFT) gives an opportunity for patients and their carers to share their views in a consistent way across the Health Service. Berkshire Healthcare has set an aspiration of 15% response rate for the FFT in both physical and mental health service as one of our strategic objectives.

The monthly FFT results, for each service and reporting locality, are shared on our intranet to make them accessible to all staff. The comments are also available online and the patient experience team are currently exploring how to share these more visually.

Table Thirteen: *Number of Friends and Family Test responses*

		Number of responses	Response Rate
2017/18	Q1	4238	7.04%
2016/17	Q4	3696	5.10%
	Q3	4024	5.10%
	Q2	5357	2.20%
	Q1	6697	2.70%
2015/16	Q4	4793	2.10%
	Q3	5844	4.20%
	Q2	6130	4.50%
	Q1	7441	6.60%

The tables below show the percentage of patients that would recommend the service they received to friends or family

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

		2017/18	2016/17				2015/16			
Ward	Ward type	Q1 %	Q4%	Q3%	Q2%	Q1%	Q4%	Q3%	Q2%	Q1%
Oakwood Ward	Community Inpatient	100	100	-	85.7	89.47	95.16	94.55	88.71	91.94
Highclere Ward	Community Inpatient	100	96.6*	90	100	96.3	96.88	81.48	85.19	90.32
Donnington Ward	Community Inpatient			75.7	100	90.91	89.47	95.83	94.87	96.15
Henry Tudor Ward	Community Inpatient	93.5	97.1	89.3	95.7	95.92	87.27	95.71	100	86.49
Windsor Ward	Community Inpatient	100	100	92	94.7	93.94	100	96.61	98.08	100
Ascot Ward	Community Inpatient	100	100	80	100	88.89	90	93.55	97.14	100
Jubilee Ward	Community Inpatient	100	100	90	100	97.78	97.44	95	97.22	92.73
Bluebell Ward	Mental Health	40	80	60	100	78.79	80	75	0**	66.67

		2017/18	2016/17				2015/16			
Daisy Ward	Mental Health	50	50	-	66.7	85.71	68.42	75	71.43	77.78
Snowdrop Ward	Mental Health	60	78.6	66.7	50	66.67	85.71	0**	100	75
Orchid Ward	Mental Health	0**	-	0**	100	-	100	0**	100	66.67
Rose Ward	Mental Health	100	66.7	0**	80	33.33	54.55	58.82	100	75
Rowan Ward	Mental Health	100	-	0	-	72.73	100	-	-	-

* Highclere Ward and Donnington Ward collected the Friends and Family Test as West Berkshire Community Hospital Inpatients since quarter four 2016/17.

** Where an - is shown, there were no responses reported for the quarter. 0 means that there were responses but that 0% would recommend the ward to a friend.

Community inpatient wards have been consistent throughout this quarter with responses received. At the end of quarter one, the overall response rate increased from 41% in quarter four to 46% and the overall recommendation rate is 99%. All community inpatient wards have a response rate of 20% or above and all have recommendation rates above 90%.

From the Community Services that have responded, there is an overall recommendation rate of 97.3%. All but two services had a recommendation rate of over 85%. The palliative care team received one response where the response was neither likely nor unlikely, and our Integrated Pain Assessment and Spinal Service (IPASS) received 82.35%.

From the Mental Health Services that have responded, the majority have a recommendation rate of 85% or above, CMHT had 79.25% and community based Learning Disabilities had 83.72%.

Responses received from mental health inpatient wards have increased slightly to 12% in quarter one, from 11% in quarter four and 8% in quarter three. The overall recommendation rate is 58%, which is a reduction from 74% in quarter four and higher than 52% in quarter three. Orchid Ward had a 0% recommendation rate; however this was based on one response. There is still work on going to improve the response rate to the FFT on our mental health wards and it is hoped that the recruitment of patient experience volunteers will help.

Table Fifteen: *FFT for Walk-in services showing percentage that would recommend to Friends and Family*

	2017/18	2016/17				2015/16	
Walk-in Services	Q1%	Q4%	Q3%	Q2%	Q1 %	Q4 %	Q3%
MIU: West Berks	98.39	98.36	91.03	96.92	97.37	96.54%	95.81
SWIHC: Walk-in	91.79	96.35	79.54	89.69	88.45	81.23%	77.69

Table Sixteen: *FFT for GPs showing percentage that would recommend to Friends and Family*

	2017/18	2016/17				2015/16			
General Practice	Q1%	Q4%	Q3%	Q2%	Q1%	Q4 %	Q3%	Q2%	Q1 %
SWIHC - GP	80%	96.27	70.09	74.75	41.67	58.00%	58.87	58.21	63.01

A review of the national results for February 2017 shows that the collective percentage recommendation rate for GPs in Slough is 66% a reduction from the 82% reported in the previous

set of results in February. The nation recommendation rate is 77%, which has also reduced from 89% in the previous period.

The percentage of patients who would not recommend the GPs in Slough was 14% compared to 10% and the national rate was now 9% compared with 6%.

The patient experience team have recruited a volunteer to help with collecting feedback, based at St Marks Hospital in Maidenhead. The Voluntary Services Team is supporting recruitment with volunteers across other sites.

Table Seventeen: *Number of Carer Friends and Family Test responses*

Number of responses	
2017/18	
Q1	111
2016/17	
Q4	74
Q3	57
Q2	54
Q1	22
2015/16	
Q4	15
Q3	15
Q2	73
Q1	29

The responses received are generally positive; however response rates are low and we are aiming for 100 per locality per quarter. We are working on increasing awareness of Carer FFT cards within the trust and potential impact of the FFT on other carer feedback e.g. memory clinic accreditation.

8.1 FFT national benchmarking

Each month health services (both NHS and independent providing NHS services) submit a report to the Department of Health on their FFT results and activity. As each organisation differs in the services that they provide, and the guidance for calculating the response rate differs substantially.

Table Eighteen: *Number of Friends and Family Test responses*
Community health services FFT data for May 2017

	May-17				**Feb-17**		**Oct-16**	
Trust Name	**Total Responses**	**Total Eligible**	**Response Rate**	**% RR**	**Response Rate**	**% RR**	**Response Rate**	**% RR**
Berkshire Healthcare	1221	20408	6%	97%	4%	98%	5%	94%
Solent NHS Trust	1191	38963	3%	96%	2%	97%	2%	96%
Southern Health NHS FT	3502	42122	8%	94%	8%	95%	7%	96%
Oxford Health NHS FT	942	36907	3%	97%	1%	96%	2%	94%

%RR – Recommendation rate

Table Nineteen: *Number of Friends and Family Test responses*
Mental health services FFT data for May 2017

	May-17				Feb-17		Oct-16	
Trust Name	**Total Responses**	**Total Eligible**	**Response Rate**	**% RR**	**Response Rate**	**% RR**	**Response Rate**	**% RR**
Berkshire Healthcare	224	3388	7%	92%	2%	88%	9%	92%
Solent NHS Trust	91	1485	6%	92%	6%	92%	4%	89%
Southern Health NHS FT	363	12242	3%	89%	3%	91%	3%	80%
Avon and Wiltshire MH Partnership	838	6216	13%	89%	15%	89%	15%	88%
Oxford Health NHS FT	178	10831	2%	79%	1%	79%	3%	90%

%RR – Recommendation rate

The available information demonstrates that the collection methodology with the highest response continues to be paper/postcard at point of discharge. To support existing methods of collecting the Friends and Family Test, the Patient Experience Team are distributing hard copy cards and freepost envelopes which services are to include with the discharge letters that are send to patients.

8. Other Patient Feedback

We continue to work closely with Healthwatch organisations to gather feedback on the services we provide and explore ways that we can improve this further. From quarter two, the quarterly Patient Experience and Engagement Group and Healthwatch meeting are merging as a way to share intelligence and good practice.

During quarter one, there was a revised pilot infection, prevention and control (IFP&C) audit carried out at the two health centres in Bracknell. This is following a presentation and discussion by the Head of IFP&C to the Healthwatch meeting about Healthwatch involvement in reviewing and monitoring cleanliness in the Trust. The team consisted of the Head of IFP&C, Healthwatch Bracknell rep, Facilities and Estates management and the Head of Service Engagement and Experience. This will be rolled out across other health centres in the Trust during 2018/19 and the other Healthwatch organisations are looking forward to being involved.

Good or Better results

Total feedback relevant to the good or better rating has been received from 4181 patients and carers, compared with 2,754 in quarter four and 2,245 in quarter three. Of those that provided feedback 93% reported the service they received as good or better. 17 of the services carrying out the internal patient survey were rated 100% for good and better with a further 15 services rating 85% or above.

30 services in all failed to log any responses for quarter one. We believe some of these may be due to networking issues which is being addressed whereas others are not routinely collecting and therefore we are working them.

It is promising to see an increase in data collection as we have been working with a number of services. We also know that some services have worked hard to increase their numbers which is reflected in their results. An increase in awareness at PSQ meetings has also resulted in a positive outcome.

Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

Formal Complaints received during quarter one 2017/18

Geographical Locality	Service	Reporting Locality	First received	Complaint Severity	Description	Outcome code	Outcome	Subjects
Reading	CMHT/Care Pathways	Reading	22/06/2017	Minor	Pt's partner feels that we are very dismissive of patients with addictions and she feels it is unfair not to offer support when she says he is only addicted due to his MH issues. She wants pt to be reconsidered for Talking therapies if psychology is not an option. Clarity of also required as to the patients diagnosis.	Investigation currently underway		Care and Treatment
Reading	Adult Acute Admissions	Mental Health Inpatients	15/05/2017	Low	Pt states he was detained twice in 2014/15, and was under a section 2 in January 2017 when he initially raised his concerns with the CQC. Pt states he was forced drugs because he was 'talking too fast' he states the psychiatrist refused to talk to him whilst he was at PPH.	Partially Upheld	No failings in clinical care identified. However, we have acknowledged and apologised for the manner in which the patient was spoken to by staff and for the distress caused by giving of injections.	Care and Treatment
West Berks	Community Hospital Inpatient	West Berks	19/06/2017	Moderate	Son extremely concerned about his father who, he feels has become incoherent, confused as to who his son was and where he was and unable to string a sentence together. The son was rather shocked at the lack of assistance from the senior nurses when he asked them to look into what was wrong with his father. He wishes his father's condition and the 2 nurses attitudes investigated. Also concerned that he is being given a drug that he was taken off due to concerns over his liver	Investigation currently underway		Attitude of Staff
Wokingham	CAMHS - Child and Adolescent Mental Health Services	Windsor, Ascot and Maidenhead	15/06/2017	Minor	Opened as formal complaint on the 15th June following discussions with father. Father states he is unhappy with our response to him in February and that his daughter has still not been seen by anyone and that she is still very unwell.	Investigation currently underway		Care and Treatment

Geographical Locality	Service	Reporting Locality	First received	Complaint Severity	Description	Outcome code	Outcome	Subjects
Wokingham	District Nursing	Wokingham	29/06/2017	Minor	Pt unwell for 6 weeks and the family members have not been given the necessary information needed to contact the DN's. DN called to say she could not make apt but would come next day, daughter anxious as legs were 'leaking'. DN eventually decided she could come. Complainant received a call from different DN yesterday to discuss concerns but complainant says she was not at all interested and told her she had not followed the correct procedure.	Investigation currently underway		Care and Treatment
Wokingham	Community Hospital Inpatient	Wokingham	26/04/2017	Moderate	Pt fell from a hoist and was in pain for 2 days before she was transferred to the RBH where she was xrayed. Fractured ankle which was operated on the next day. Pt says she has lost her independence, has been forced to sell her flat.	Partially Upheld	Two elements to complaint. Investigation showed that pain was managed as expected but patient still complained of pain. No evidence to support patient was dropped form hoist. She did fall on transfer form bed to chair and HCA cushioned fall.	Care and Treatment
Reading	Community Team for People with Learning Disabilities (CTPLD)	Reading	22/05/2017	Low	Pt under LD Psychologist but mother feels no one is responsible for requesting, arranging or co-ordinating future care meetings.	Upheld	There are four main points to this complaint and significant learning outcomes have been identified under each point.	Care and Treatment
Reading	Out of Hours GP Services	Wokingham	19/06/2017	Minor	Pt received a call back from W/C Dr having spoken to 111. Pt convinced having a miscarriage, Dr was extremely dismissive. Eventually told her to come and see her at RBH where she continued to be dismissive.	Investigation currently underway		Attitude of Staff
Bracknell	District Nursing	Bracknell	21/06/2017	Low	Palliative pt seen by Dr and DN to increase dose in syringe driver. 30 mins later pt became distressed, wife called 3 times for an urgent visit, called GP who said thay would be there soon but no one came, then pt fell from bed and died. DN's did not arrive for 1hours 45 mins, and then 3 turned up. Pt wishes to know 1. why no one came 2. Why call was not transferred to a different as urgent 3. Why no contact re delay 4. why 3 turned up after he dies	Investigation currently underway		Care and Treatment

Geographical Locality	Service	Reporting Locality	First received	Complaint Severity	Description	Outcome code	Outcome	Subjects
Reading	Adult Acute Admissions	Mental Health Inpatients	22/06/2017	Moderate	Pt became unwell in 2000 and was diagnosed with Catatonia and received ECT with a successful outcome. Has had 3 relapses. Between Christmas and Easter Pt was in the community, kept saying he was struggling but had minimal support. Now inpatient. ECT prescribed but could not be given as the pt had been given a drink, why was 'Nil by mouth' not displayed? Pt's belongings have gone missing throughout his stay.	Investigation currently underway		Care and Treatment
Reading	Adult Acute Admissions	Mental Health Inpatients	29/06/2017	Moderate	No care package put in place for the second time following sectioning at PPH.	Investigation currently underway		Discharge Arrangements
Reading	Crisis Resolution & Home Treatment Team (CRHTT)	Reading	20/06/2017	Low	Pt wishes copies of a telephone call made from CRHTT to the pt on 11th June.	Case not pursued by complainant	Not investigated.	Communication
Wokingham	CAMHS - Child and Adolescent Mental Health Services	Windsor, Ascot and Maidenhead	09/05/2017	Low	Mother of pt unhappy at comments noted in reports. Feels things could have happened sooner for her son if services had listened to her. Mother says her son was offered support in June/July 2016 by Wokingham doctor, following a conversation with social worker mothers believes this was withdrawn. Mother wants to know 1. Were her concerns about the father recorded? 2. What did Dr share with CAFCASS guardian? Why was it reported that 'mother was feeding stories about father?' 3. why was the offer of therapy withdrawn?	Investigation currently underway		Care and Treatment
Wokingham	CMHT/Care Pathways	Wokingham	25/04/2017	Moderate	Following positive risk panel in February 2017 family have written to advise the impact that the lack of support now being offered to the patient has affect her and them as they do not know where to turn for help and they are struggling to watch the patient suffer.	Investigation currently underway		Care and Treatment
Wokingham	CMHT/Care Pathways	Wokingham	27/04/2017	Low	Pt recently requested her medical records and from that disagrees with the diagnosis of EUPD. Pt has produced 2 letters stating she is not BPD from psychiatrists. Pt wishes to be reassessed and what ever the outcome for a note to state she disagrees with the EUPD diagnosis to be put on her records.	Investigation currently underway		Care and Treatment

Geographical Locality	Service	Reporting Locality	First received	Complaint Severity	Description	Outcome code	Outcome	Subjects
Windsor, Ascot and Maidenhead	District Nursing	Bracknell	09/06/2017	Low	Pt due to have DN visit on the 7th June which didn't happen leaving the pt on the bed for the day waiting. Out of hours went out to see the patient and the pump was leaking with fluid coming out	Upheld	Investigation showed there had been conflicting info given.	Care and Treatment
Reading	CAMHS - Child and Adolescent Mental Health Services	Windsor, Ascot and Maidenhead	29/06/2017	Minor	Pt allegedly seen by clinician for his second assessment which mother and pt attended back. Complainant has now found out staff member has left and there are no notes on the system re previous meeting so they need to start again, meanwhile the pt has had serveral external and internal exclusions from school.	Investigation currently underway		Care and Treatment
Windsor, Ascot and Maidenhead	Common Point of Entry	Wokingham	12/06/2017	Low	Pt self referred to CPE spoke to staff member who seemed intent on making the point that the patient was not an urgent case.	Upheld	Patient was given incorrect advice re call times for CPE, which added to the overall frustration and it was difficult to find a time for an assessment. We have apologised for the poor experience she had.	Attitude of Staff
Bracknell	CAMHS - Child and Adolescent Mental Health Services	Windsor, Ascot and Maidenhead	26/06/2017	Minor	Pt has previously requested that all letters regarding appointments be sent directly to her and not her parents. She arrived home on Friday to see a letter had been sent to her parents and nothing had been sent to her at all, having previously raised this through PALS she now wishes it investigated as very upset.	Investigation currently underway		Communication
West Berks	CMHT/Care Pathways	West Berks	14/06/2017	Minor	Pt was advised by Dr in November that she would be able to access PTSD Therapies support via psychotherapy. When following this up with her CPN she was advised her line mgr was sorting, then she was advised Mgt had changed then she was advised that we would not give her any names and she was told to go to SEAP. Pt wants to know - - was the referral made? - was a note put of her records to ensure staff were aware? - A full explanation into everything since Dec re follow up on referral.	Investigation currently underway		Care and Treatment
Bracknell	CAMHS - Child and Adolescent Mental Health Services	Windsor, Ascot and Maidenhead	29/06/2017	Low	Father unhappy that the Trust still seems to only be engaging with Mum regarding the pt and not including the father which we previously said we would not do going forward.	Investigation currently underway		Attitude of Staff

Geographical Locality	Service	Reporting Locality	First received	Complaint Severity	Description	Outcome code	Outcome	Subjects
Slough	CAMHS - Child and Adolescent Mental Health Services	Windsor, Ascot and Maidenhead	27/04/2017	Low	Following overdose attempt mother took son to A&E. CAMHS worker arrived and she found staff to be hostile, abrupt in attitude. She said that when she was upset the staff had no compassion and staff told her to stop talking. Staff member covered her name badge with her hand after she said she was going to make a complaint. Mother feels the staff member did not afford her the basic courtesy that should be given to family members she then said the staff member had then lied in her documentation regarding the sequence of events.	Upheld	Not upheld issue regarding patient being seen without parent, as this was patient's request. However, upheld element about staff member hiding badge.	Attitude of Staff
Reading	CMHT/Care Pathways	Reading	12/06/2017	Low	Pt says Dr would not help him appeal to the benefits office about him being able to work. Pt feels he is too unstable to work and says he could of walked out in front of a bus after his meeting at PPH. He believes the Dr has broken his Hippocratic oath and duty of care	Not Upheld	No failings identified. Dr concerned was unable to complete request from patient as he had not assessed him and was unwilling to write a letter. Patient became verbally abusive, Dr felt threatened and had to ask patient to leave.	Other
Slough	Sexual Health	Bracknell	24/05/2017	Moderate	Pt seen for STI test she felt the Consultant was very judgmental and wishes the way she was spoken to to be looked into.	Partially Upheld	Patient feels she had a negative experience in the clinic and Dr is sorry that her actions were interpreted as judgemental. Dr's focus was on preventing a further unwanted pregnancy and she has apologised for the way she came across.	Attitude of Staff
Bracknell	CMHT/Care Pathways	Slough	03/04/2017	Low	Re-opened from 5440 Pt now able to identify staff member to which she raises 27 points to be addressed. Several other points raised about various members of staff and questions regarding the previous investigation into CMHT	Investigation currently underway		Attitude of Staff
Reading	Out of Hours GP Services	Wokingham	31/05/2017	Low	Pt presented at W/C on the 5th June 2016 and was diagnosed with a nerve ending headache and prescribed Amitriptyline, Dr unable to give any as none available, advised to get some from chemist in the morning when it opened. Following a visit to A&E where she was diagnosed with Bell's Palsy (not related to her headache) the pt was later diagnosis from her GP with Viral Encephalitis and spent 6 nights in hospital. The pt feels everything could have been avoided if she was diagnosis correctly on the sunday evening	Investigation currently underway		Care and Treatment

Geographical Locality	Service	Reporting Locality	First received	Complaint Severity	Description	Outcome code	Outcome	Subjects
Windsor, Ascot and Maidenhead	Community Hospital Inpatient	Bracknell	30/05/2017	Moderate	Family are struggling to get the staff to engage with them and they wish assistance to obtain the best care package for their sister.	Investigation currently underway		Communication
Slough	Crisis Resolution & Home Treatment Team (CRHTT)	Reading	25/04/2017	Moderate	Crisis team did not turn up to any of the numerously arranged meetings and put a card through the letter box when pt was in, she did not hear them knock and they did not phone. She has lost confidence in CRHTT but want an explanation as to why all the planned visits for help never materialised	Upheld	There was a breakdown in communication and a number of learning outcomes have been identified in the IO report.	Care and Treatment
Windsor, Ascot and Maidenhead	Crisis Resolution & Home Treatment Team (CRHTT)	Reading	19/04/2017	Low	Mother unhappy with contact with CRHTT, following which her daughter was detained on section. Mother also feels as a carer she was unsupported by staff.	Partially Upheld	There were no clinical care failings for the patient but mother did feel unsupported and we have acknowledged and apologised for that. Staff member has reflected and apologised.	Communication
Windsor, Ascot and Maidenhead	CMHT/Care Pathways	Slough	15/06/2017	Moderate	Pt says the medicine Aripiprazole gives him side effects. He has a cornea graft and extremely high blood pressure and he says this medication has contraindications to his other medication. He has been told if he does not have this injection he will be sectioned. SEAP have advised him there must be documentation in order to make him comply to having this medication.	Investigation currently underway		Medication
Slough	Health Visiting	Windsor, Ascot and Maidenhead	27/06/2017	Moderate	HV provided assistance for complainants partner and 2 children to depart the house without notice bound for a women's refuge. Father of the children believes the HV has put his children at risk as he states his partner was in fact the perpetrator of domestic abuse towards him.	Investigation currently underway		Attitude of Staff
Slough	CMHT/Care Pathways	Slough	07/04/2017	Moderate	Complaint that there has been a catalogue of failures by Slough CMHT. Family say they have been crying out for help but these have been ignored and patient has now damaged neighbour's property leading to him being arrested and sectioned.	Upheld	The investigation has shown a lack of documented support and evidenced conversation with family members. The primary carer of the patient was not identified as such and was not offered any support. The revised risk planning processes will improve this area of care and support. The clinical care offered to the patient was clinically appropriate.	Care and Treatment

Geographical Locality	Service	Reporting Locality	First received	Complaint Severity	Description	Outcome code	Outcome	Subjects
Wokingham	CAMHS - Child and Adolescent Mental Health Services	Windsor, Ascot and Maidenhead	23/05/2017	Moderate	Meeting June/July 2016, family advised they would get a report which they have yet to receive, they were also told there would be another meeting in 6 months which also has not happened. Mother has made many calls leaving messages which have not been returned	Local Resolution		Care and Treatment
Slough	LDS Community Patients	Reading	12/04/2017	Minor	Mother wants to know why her daughters epilepsy medication was increased when she had not had a fit for 10 years and why it took from diagnosis of Epilepsy in 2013 until Feb 2017 to be advised of this diagnosis.	Upheld	The root of the complaint is about communication with the named doctor. This person has left the Trust and record keeping in not clear that he communicated decisions with the family. Therefore complaint is upheld.	Care and Treatment
Reading	CMHT/Care Pathways	Reading	30/05/2017	Minor	Pt discharged from services but says she did not receive any notification of this. States she is struggling with her MH and needs help which she says is not on offer. She wants to 1.see a community Psychiatrist 2.be referred for specialist help, Trauma Service 3. Have a CPN if necessary 4. Meaningful liaison between MH and GP 5. recognition of sleep deprivation 6. recognition that 'inappropriate behaviour' is due to her condition. 7. recognition that she needs support not a judgmental approach 8. that she is recognised as a person not a condition	Partially Upheld	The patient did not engage with care co-ordinators after initial allocated one left. It is recognised that the initial relationship did not have the boundaries that were expected which would have impacted managing the expectation of future relationships with the team. Further appointments with the team have been offered.	Care and Treatment
Bracknell	Crisis Resolution & Home Treatment Team (CRHTT)	Reading	25/05/2017	Low	Pt referred to CRHTT in May 2015 following a visit to A&E. In Jan 2017 pt became distress contacted CRHTT who agreed to come out but did not causing further distress. Since that time pt says there have been many other occasions where CRHTT have said they will attend and have not.	Investigation currently underway		Care and Treatment
West Berks	District Nursing	West Berks	12/06/2017	Moderate	Mother wishes to know how and why her son's pressure ulcer ended up as it did?	Partially Upheld	Although no failings in nursing care and nurses acted appropriately, the investigation has identified a number of learning outcomes to improve the service going forward.	Care and Treatment

Geographical Locality	Service	Reporting Locality	First received	Complaint Severity	Description	Outcome code	Outcome	Subjects
Reading	Intergrated Pain and Spinal Service	West Berks	15/06/2017	Low	Pt unhappy about the letter summarising his assessment. He says it is full of half truths and conjecture and he wants it reviewed. He also states that throughout the meeting the clinician were dismissive of the pts expectations of recovery through the NHS.	Partially Upheld	A clear explanation has been given regarding the wording in the letter with an apology for the wording towards the end of the letter that stated patient was 'happy' to continue. Clinician has also apologised that he was perceived as condescending and mocking.	Attitude of Staff
Reading	CMHT/Care Pathways	Reading	30/03/2017	Low	Secondary complaint - Pt has received correspondence from NHS England saying they have not received an application from BHFT so patient wishes to know what is happening. He has responded to several of the points raised in our letter which need addressing ORIGINAL COMPLAINT Patient feels there has been a lack of provision of adequate and appropriate treatment for his MH and psychological condition from 2014 to the present day. Pt wishes to receive adequate and relevant treatment at Castle Craig Hospital and redress for damage to health and life and expense of alternative support.	Not Upheld		Care and Treatment
Bracknell	Common Point of Entry	Wokingham	06/03/2017	Low	Pt diagnosed with Asperger's wants to know why therapy has been refused by CMHT as this goes against the Autism Act and is not making reasonable adjustments under the Equality Act. Why does the Trust not provide ASD Pathway on a diagnosis service? Why can't services communicate with each other when using different systems?	Partially Upheld	No clinical failings identified. Care has been appropriate but patient cannot have the therapy she wants. However, PALS have apologised for the lack of responsiveness so this element upheld.	Care and Treatment
Wokingham	CMHT/Care Pathways	Wokingham	16/01/2017	Minor	Mother feels her son's Consultant Psychiatrist has neglected her son's wellbeing and has failed to give him the correct care and medication that he had required. She feels the cocktail of drugs he was on led to his nervous breakdown and she feels she questioned the pt in an inappropriate manner.	Partially Upheld	1.Dr will discuss with colleagues recently involved in care about the issues raised in the complaint and will reflect on any learning points. 2. Dr will continue having reflective notes and case based discussions as part of her annual appraisal. 3.The importance of involving and working together with patients families and carers will be shared with all team managers in the monthly patient safety and quality meetings at Wokingham locality meeting and discussed in the wider trust clinical governance meeting.	Care and Treatment

Geographical Locality	Service	Reporting Locality	First received	Complaint Severity	Description	Outcome code	Outcome	Subjects
Reading	Adult Acute Admissions	Mental Health Inpatients	06/03/2017	Moderate	Pt previously on a section now voluntary has been going out of the ward buying tablets / knives and bleech from Boots and Asda. Father believes pt is at high risk of self harm and suicide. Father does not understand why PPH are talking about discharge and feels we are neglecting our duty of care.	Partially Upheld	The main issue for this complaint is that the patient was allowed off the ward when she purchased items such as bleach, tablets and knives. Investigation showed that our record keeping was lacking and we are unable to say that the risk assessment was fully carried out. However, assessing risk briefly at the time of leave is considered to be part of a more overarching risk assessment.	Care and Treatment

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15 Steps Challenge

Quarter 1 2017/18

During this first quarter of 2017/18 a total of 9 visits have been carried out.

The team has enjoyed the support of volunteers in an impartial capacity giving a valuable patient/public perspective. There has been interest from new volunteers and we are planning to use them as soon as their recruitment checks have been successfully completed.

The team continue to ensure that the visits are unannounced, thus ensuring maximum benefit to both the service and Trust.

Attempts have been made to visit clinics on smaller sites but due to the irregular and changing clinic times, unannounced visits have had limited success. We are liaising with service leads to ensure any visits are adding maximum value for patients.

We are currently reviewing the toolkits to update them and make them bespoke to Berkshire Healthcare, to support the process and ensure their relevance.

Garden Clinic – Upton Hospital

A good visit to a busy clinic, the reception staff were very welcoming and impressed the team with their helpful and informative attitude.

Physio – Great Hollands Health Centre

The physio team showed good interaction between themselves and their patients in a well-run clinic, where staff are coping well in less than ideal surroundings.

Podiatry – Great Hollands Health Centre

This was a very good visit and the team were impressed by the professionalism and knowledge of the clinician on duty.

Donnington Ward

This is a friendly ward with a good atmosphere, all the staff were welcoming and were fully engaged with their patients.

Highclere Ward

An excellent visit to a well-run friendly ward, all patients spoken to gave high praise about the staff and the care they received.

Oakwood Unit

The staff on the unit were, without exception, helpful, friendly and willing to assist in whatever way they could. The ward had a calm atmosphere and all the patients appeared happy and well cared for.

Orchid Ward

The team were impressed by the facilities on the ward and the dedication of the staff to the care of their patients.

Snowdrop Ward

The ward was clean and clutter free and the patients appeared to be well cared for but the ward felt “clinical” and unloved.

Rowan Ward

This was an exceptional visit, the team were very impressed by the atmosphere of the ward, the overall attitude of the staff and the obvious pride they felt in their ward. The team wanted to make special mention of the deputy ward manager for his open and professional attitude and his natural behaviour with staff and patients alike.

Friends & family team discussion: In all the areas visited the teams were confident in the safe professional care being delivered should a family member or friend be admitted to the care of the ward or clinic.

Pam Mohomed-Hossen & Kate Mellor
Professional Development Nurses
June 2017

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	12 September 2017
Title	Junior Doctors and Nursing Student feedback in BHFT
Purpose	To assure the trust board of the quality of training in BHFT and that a range of measures are employed to obtain feedback from our nursing students and medical trainees.
Business Area	Medical and Nursing Directorate
Relevant Strategic Objectives	1 – To provide accessible, safe and clinically effective services that improve patient experience and outcomes of care
CQC Registration/Patient Care Impacts	N/A
Resource Impacts	None
Legal Implications	N/A
SUMMARY	BHFT have a variety of pre and post registration non-medical students on placements and junior doctors in training who learn in our clinical environment. By far the largest group are the second to third year pre-registration programmes in Nursing. We have approximately 240 students per year group from the Adult Nursing, Child Nursing, Mental Health Nursing and Learning Disability Nursing branches. This is in comparison with a total of 112 Allied Health Professional students across the 3 year cohorts and branches. The trust has approximately 35 junior doctors in training at any one time. All non-medical students are required to complete a feedback evaluation on completion of their placement. This feedback is collected by the universities and shared with the Learning Environment Leads (LEL) for each of the branches. Generally our placements are well evaluated. Where a concern is raised this is addressed directly with the team or service manager and the university. Examples of feedback have been included in the appendices. Medical trainees are invited to give feedback on their education and training through the following processes: • GMC national trainee survey (annually) • Formal feedback requested by the specialty school programmes in HEE TV • Formal feedback requested by BHFT for GPVts and FY trainees The Health Education England Thames Valley Quality Review on 12 June 2017 was very positive and the report from this visit is

	appended for information.
ACTION REQUIRED	The Trust Board is requested to: Note the report and seek clarification if required.

Non- medical Student placements

1.1. BHFT have a variety of pre and post registration non-medical students on placements in our clinical environment. These include(but not exclusively)

Pre-registration adult nurse

Pre-registration mental health nurse

Pre-registration learning disability nurse

Pre-registration occupational therapist

Pre-registration physiotherapist

Undergraduate audiologist students

Master degree scientific training programme

1.2. By far the largest group are the second to third year pre-registration programmes in Nursing. We have approximately 240 students per year group from the Adult Nursing, Child Nursing, Mental Health Nursing and Learning Disability Nursing branches. This is in comparison with a total of 112 Allied Health Professional (AHP) students across the 3 year cohorts and branches.

1.3. All students are required to complete a feedback evaluation on completion of their placement. This feedback is collected by the universities and shared with the Learning Environment Leads (LEL) for each of the branches. Currently the evaluation questionnaires pose slightly different questions depending on the university and the profession. This variety is being discussed at a Thames Valley level and a national plan is being developed so that we can begin to measure the feedback using a comparative approach.

1.4. The LEL's collect the feedback and share this with all the placements on a quarterly basis, RAG rating and dealing with RAG rated orange or red issues immediately with the services, units and university.

1.5. It is a transparent partnership approach which culminates in the yearly Education Quality Review meeting with the Oxford Deanery and Thames Valley which addresses all the elements of student placements in Berkshire Healthcare NHS Trust and which is co-chaired by the BHFT CEO.

1.6. Generally our placements are well evaluated. Where a concern is raised this is addressed directly with the team or service manager and the university. Examples of feedback have been included in the appendices.

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Appendix 1

MH nurse placement evaluations Sept 2016 – Mar 2017

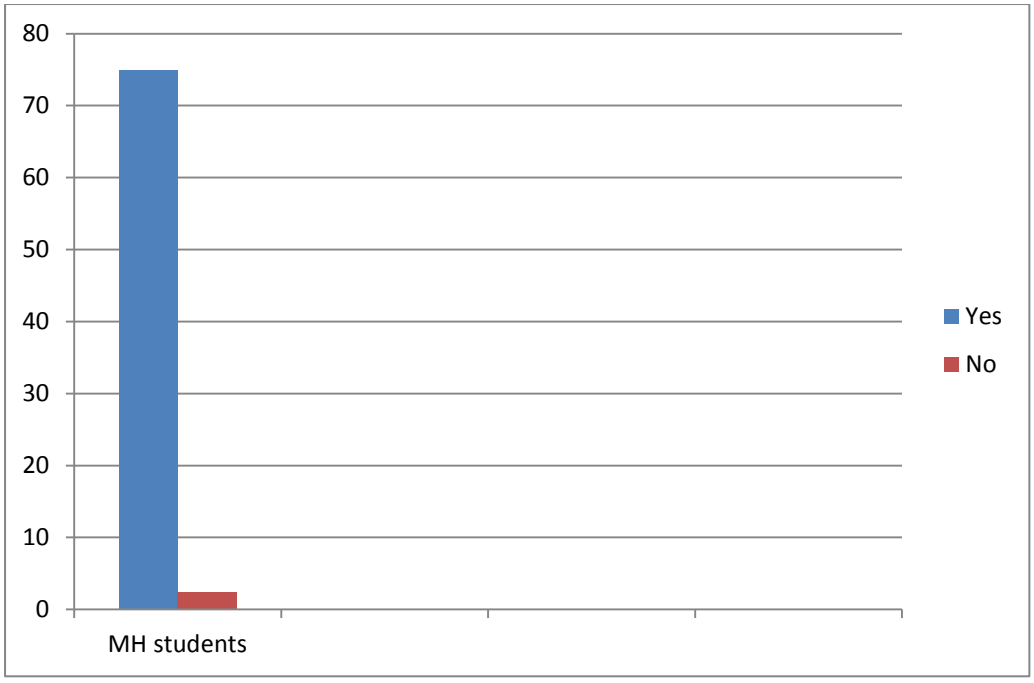
The trust has placed 78 pre-registration MH & 28 LD students from Sept 2016 to March 2017 within clinical areas across the Trust.

Each student is provided with an evaluation form, from their HEI to complete post-placement. Each higher education provider uses its own placement evaluation.

100% of MH students and 57% of LD students completed and returned post placement evaluation.

Examples of feedback received from MH student nurses

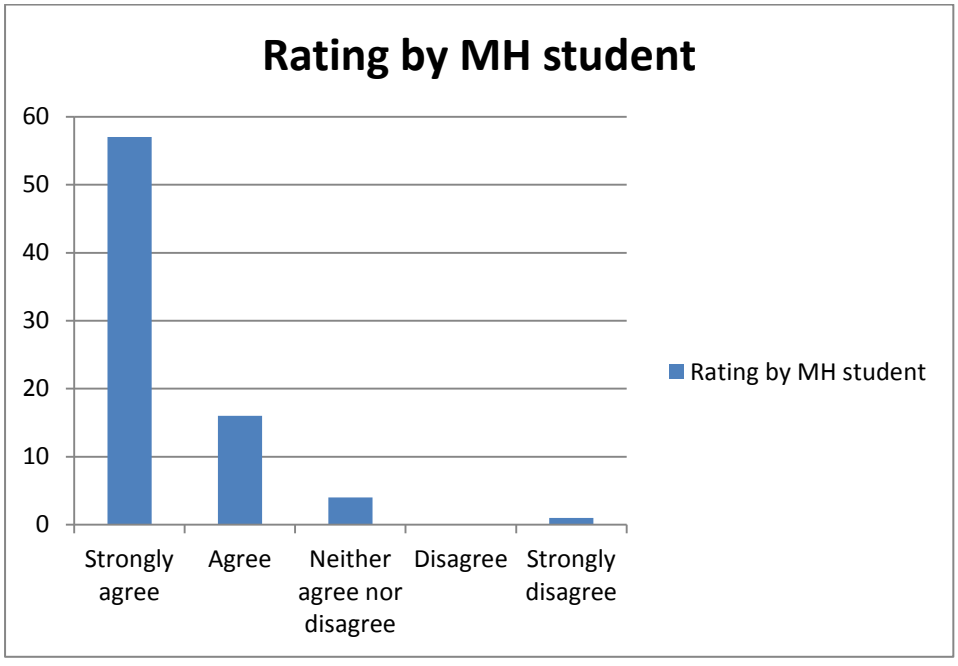
Question: Would you recommend this placement as a valuable learning experience? (No question in LD students questionnaire)



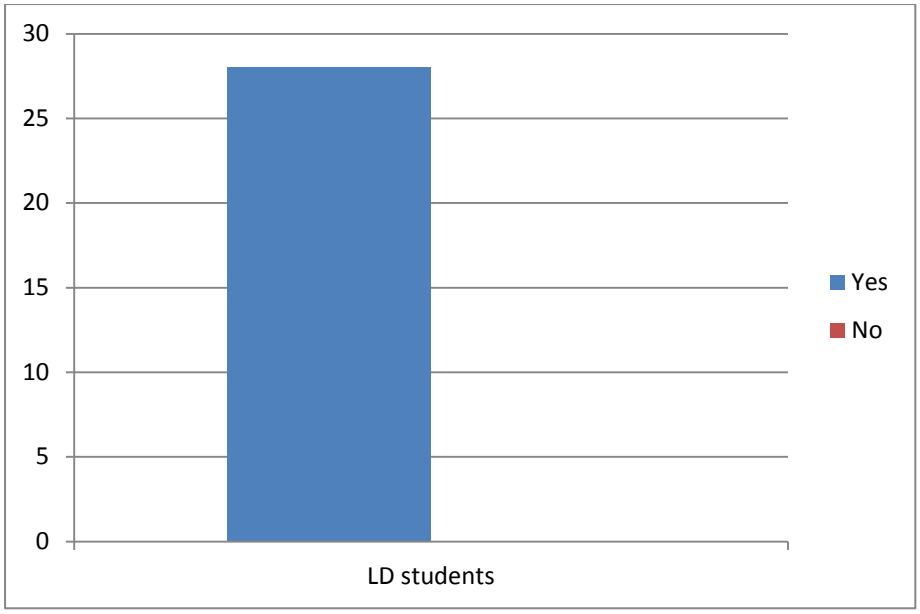
Positive comments	Negative comments
"The staff work as a team to give quality care to patients and comprehensive risk assessment is done for every patient." **"Good person-centred care towards patients. Well experienced staff"** **"Practice was evident based and person-centred focused. Evidence of good interprofessional working for best interest of care receivers. Patients were supported to**	**"There was a shortage of staff, this could impact on patients care and also staff well-being as they will be working under pressure."** **I felt that the environment exacerbated the poor mental health of the patients on the ward rather than being a place where effective nursing was used in order to promote person centred care."**

make decisions about their care and make choices. Support and care offered to clients to live well or best possible quality of life." **"Although I found the induction process average the placement and the work ethics within the ward was excellent. The staff are supportive of each other and all the qualified staff were very helpful and eager to involve students in everything they do. The level of patient care was always exceptionally good with patients being treated with utmost respect and dignity."**	
Action taken: Verbal feedback to team mentors; Written feedback to lead nurse/manager.	**Action taken: Discussion with teams** ***In context, the above areas had more than one student (the majority responded with positive comments)*** **Mentor support by LEL/CPE team** **CPE support for student during initial weeks in placement and ongoing weekly group support meetings in locality.** **Anonymised and discussed in updates and workshops for mentors.**

Statement: Overall, I was provided with a range of learning opportunities which were appropriate to my stage of training and allowed me to meet my learning outcomes (MH)



Question: Were opportunities made available for you to meet your learning outcomes? (LD: 100% Yes)



What were the most positive aspects of the placement?	
MH students: What were the strengths/most valuable aspects of this placement? Please give examples of good practice	**LD students: Please comment on the positive aspects of your experience**
- Excellent delivery of care to all service users and excellent teamwork **- To learn to respect the difficulty of the job and the pressure on the individual professionals. To understand and be able to work with the different aspects of positive risk taking.** **- Collaborative working inter professionally and with family and carers. Informed chioces made available to patients and carers. Education provided to other partners involved in care provision to improve care quality.** **- Able to learn about MDT members and spend time with OTs and psychologists,** **- Communication with adults in acute care,** **- Learning about Mental Health Act,** **- Extra support provided at the end of the placement from Clinical Nurse Specialist**	**- Learnt a lot regarding MCA, mortality, how social care and health work together** **- Learnt a lot about epilepsy, close working of health and social care staff** **- having the opportunity to learn leadership skills** **- mental health experience- learnt so much from a lovely team (elective in PPH)** **- being given the opportunity to observe and experience many different clinical aspects of the placement**

Is there anything else that would have improved your placement?	
MH Students: In summary, if there was one area that you could suggest to improve the learner experience on this placement what would it be?	**LD Students: Please comment on any areas for development that could help to improve the experience in this practice area**
- Difficult to limit it to one but allocation of mentors to students, i.e. not putting mentors on night shifts for the whole placement **- I didn't find much to suggest for improvement apart from having rest room where we could have lunch.** **- More nursing staff** **- If the University could avoid summer holidays for placements that would be beneficial, otherwise a fantastic placement.** **- More access cards needed for students. I didn't have one as they were all being used by other students.**	**-on the whole a good placement, just didn't have the opportunity to take any leadership role** **- the team to be able to invite students on more visits, have work for the students during quiet times in the office** **- for the team to involve me more regarding meetings and for more staff to take us out on visits**

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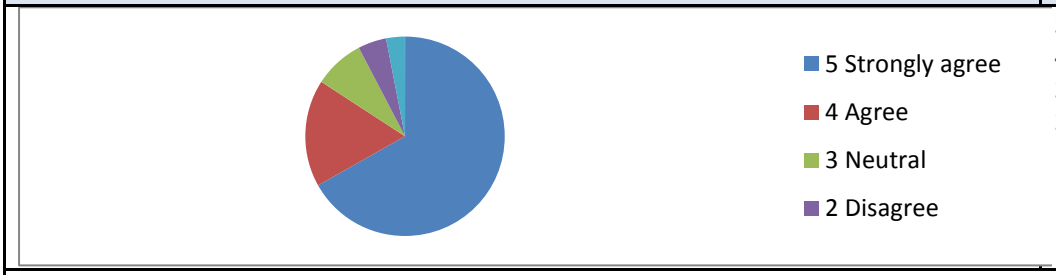
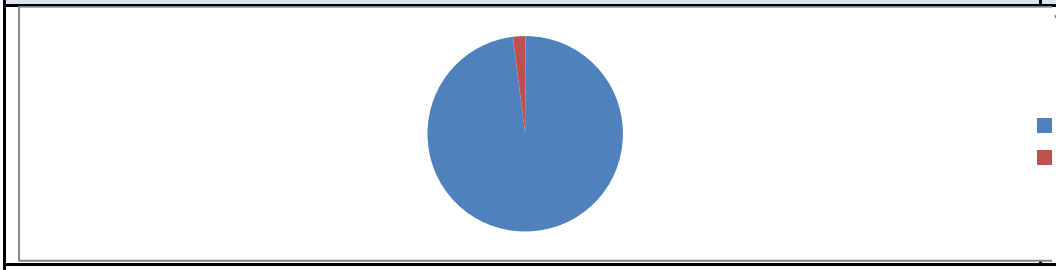
Examples of feedback received from Adult student nurses

Appendix 2

Student Evaluation Evaluations Adult and Child September 2016 to March 2017 Number Students evaluations: 194 % Student response : 100%	**% Number Evaluations**
Quantitative Question: (Question 10) **Overall the quality of the supervision I have received in this placement was excellent.**	**% No Student Evaluation**
	5- 67% 4 -17.4% 3- 8.2% 2 -4.6% 1- 3.%
A very positive response in regard to mentor support. We examine carefully any negative responses and monitor for reoccurring themes. Any actions arising from these evaluations are reported in the quarterly report to the BHFT Director and Deputy Director of Nursing and the Head of Clinical Education and the relevant clinical teams. During this period we had no issues requiring further work with the teams for this question.	
Quantitative Question: (Question 24) **Would you recommend this placement as a valuable learning experience?**	**% No Student Evaluation**
	Yes- 98% No -6%
A very positive response to this question. The small number who did not agree, were invariably adult students placed within the 0-19 teams who could not see the relevance of this placement for their branch of nursing. This is an on-going issue, which can be seen in our quarterly reports action plans mentioned above. However the reduction in 0-19 placements will mean that moving forward these placements will be allocated to the most suitable students on request or to child branch students who have the most relevant learning objectives.	
Qualitative Question: (Question 25)	
What skills, values and behaviours have you learnt on this placement that you will take to your next placement, or first post?	
Qualitative Student Comments "I have acquired quite a lot of skills which includes wound dressing, identifying pressure area and how to deal with it before it get out of hand. Have been able to build up my confidence in carrying out manual observation for patients, referrals to other team, services in the community provided to patient especially those discussed in the cluster meeting. Confidentiality and respect." "I have improved on my communication skills and have been to exposed to situations where i had to advocate	

for a patient. I have learnt to accommodate people from all backgrounds whether they were staff, patients and relatives."

Qualitative Question: (Question 26)

What were the strengths/most valuable aspects of this placement? Please give examples of good practice.

Qualitative Student Comments

"Giving good care to patient's example stabilising a patient condition to celebrate Christmas with her family members before going to the hospital."

"Holistic care was second to none. Patient centred care was excellent. Knowledge and understanding of lots of different clinical skills. Community matron was extremely experienced and knowledgeable, gave good guidance on where to find things."

Qualitative Question: (Question 27)

What were the weaknesses/least valuable aspects of this placement? Please give examples.

Qualitative Comments

"Lack of computers/office space made it hard to access the intranet."

"I wasn't informed my mentor was transferring which was disrupting. Hence there was luck of communication. It was later resolved and the team leader apologised."

Qualitative Question: (Question 28)

In summary, if there was one area that you could suggest to improve the learner experience on this placement what would it be?

Qualitative Comments

"Having a laptop for the students to use for their learning."

"I think the qni website was very helpful because it explains what community nursing is all about. It would be great if student get to have a read on that website first, before coming on placement."

"more exposure to the MDT"

"Nothing. I loved my time with the Swallowfield team. They each gave me so much support and helped me develop my skills as a nurse, allowing me to really get involved with every patient. The team that they have is so strong and supported right from the management of the team, to the nurses and to the HCA, they support, respect and look out for each other everyday. Cathy was my mentor and she was fantastic with me continually asking me questions to keep me thinking and letting me take more of a lead while treating patients. Katie who I spent most of my time with while Cathy was on her days off and really supported me and encouraged me to take the lead. Katie will be a great mentor. I was particularly thankful as they took me on three days before my placement was due to start. Please can you make sure the swallowfield team get this feedback"

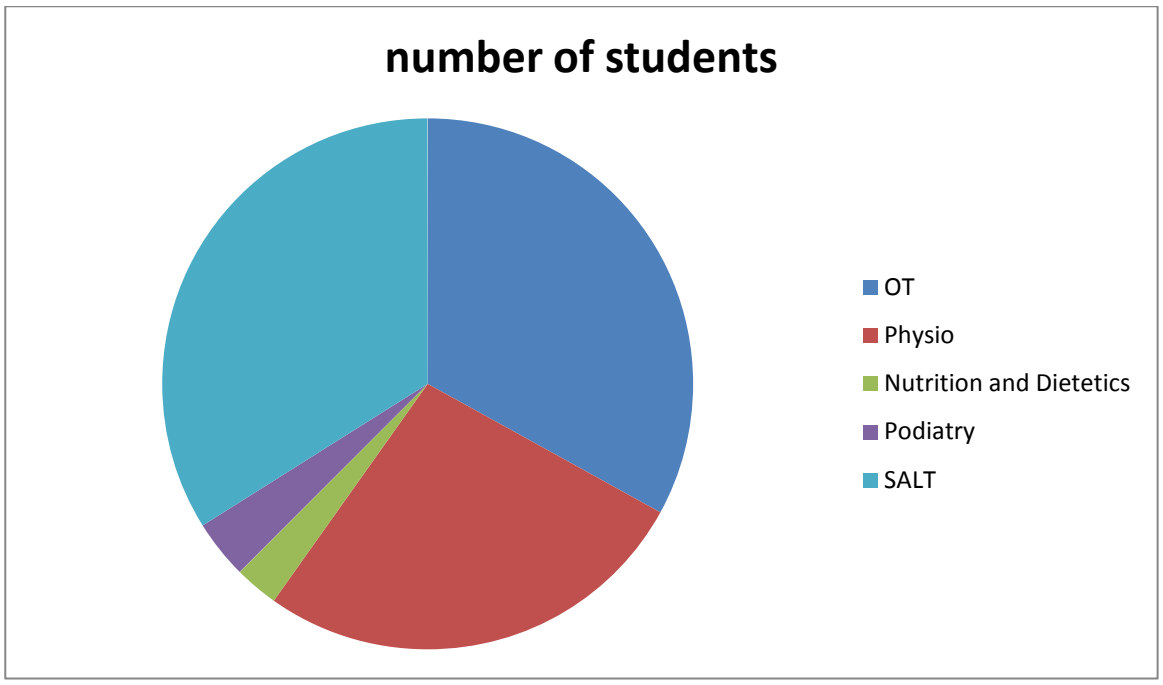
AHP student placement evaluations January to December 2016

BHFT have placed **112** AHP students from January to December 2016.

60% of these students completed and returned post placement evaluations:

- 92% in Occupational Therapy
- 60% in Physiotherapy
- 26% in SALT- student placements are over a few days and not blocks of weeks so obtaining feedback is difficult
- 67% in Podiatry
- 100% in Dietetics

By profession the student numbers were as follows:



Preparation/induction

1	**I had a named Clinical Educator/ Educators**	Yes 100%	No
2	**I felt I was sufficiently prepared for the placement by my University(if no please expand)** Students comments: • I would like to know where my placement is at least 1 month in advance to arrange accommodation and prepare • The University did not inform my Practice educator of my dyslexia or childcare issues • In some areas I felt well prepared such as my knowledge, particularly in anatomy and physiology. However I did not feel very confident in actually applying it to an assessment of a patient. Some of the concepts behind treatment I was taught in uni are not applicable any more or were not up to date. • I didn't feel that we had enough time between our final exam and starting placement in order to give us enough time to prepare as I was focusing on revising for the exam. • University did not give me any details about placement, only found out about placement from the head physiotherapy at the placement Actions taken: This concern has been raised with a number of the Universities but it is not likely that advance notice of placements will be guaranteed. Universities all agree it is the students responsibility to inform placement of any health or childcare needs themselves	Yes 79%	No 21%
3	**I got enough information about the placement before starting including receiving a student welcome pack/ placement profile(if no please expand)** Students comments: • I did not get the placement profile • My Practice educator was on holiday before the start of my placement • I only received the University handbook • Last minute University change to placement so only	Yes 87%	No 13%

<table>
<tr><td></td><td colspan="4">placement address was given
• I did not receive a welcome pack or placement profile however I arranged to visit and was able to discuss the placement face to face prior to starting

<u>Actions taken:</u>

Where possible the Professional Leads send out placement profiles to students prior to starting placement giving details of the clinical area as it has been noted this is not consistently done by the Universities.</td><td></td><td></td></tr>
<tr><td>4</td><td colspan="5">I had an induction to the work place including fire regulations, health and safety issues, resuscitation equipment, policies and routine</td></tr>
<tr><td></td><td>Strongly Agree

55%</td><td>Agree

40%</td><td>Disagree

5%</td><td colspan="2">Strongly Disagree</td></tr>
<tr><td></td><td colspan="5"><u>Student comments:</u>

• We did complete an induction but PE was unsure about the paperwork as unit has recently changed ownership. Some of the form wasn't relevant.
• Not shown where resuscitation equipment was located
• A comprehensive checklist was covered at the start

<u>Actions taken:</u>

The Professional leads have shared this feedback with their clinical teams and reminded them that there is a Trust induction form for students. The specific areas where this student feedback was received from where spoken to directly. The Trust induction template will be included in a generic letter that will go out to all students prior to starting their placement</td></tr>
<tr><td>5</td><td colspan="5">I was told how to report concerns if I observed unsafe clinical practice or any other incident or near miss</td></tr>
<tr><td></td><td>Strongly Agree

55%</td><td>Agree

36%</td><td>Disagree

8%</td><td colspan="2">Strongly Disagree

1%</td></tr>
<tr><td></td><td colspan="5"><u>Student comments:</u>

PE ensured that I had opportunities to feed back issues. However, there were sometimes difficulties on days when PE wasn't on site and I did sometimes feel isolated. Also there was an incident that I got ahead of myself as a worker and should have sought the views of PE. We discussed and reflected on this to resolve it.</td></tr>
</table>

	I did have the confidence to speak with her about any unsafe practices I observed. Actions taken: The specific areas where this student feedback was received from where spoken to directly. The ways to report concerns as well as the contact details for the Trust Freedom to speak up Guardian will be included in a welcome letter that will go out to all students prior to starting their placement			
	learning opportunities			
6	**The placement offered me learning opportunities appropriate to my stage of education that allowed me to meet my placement aims**			
	Strongly Agree 60%	Agree 37%	Disagree 3%	Strongly Disagree
	Student comments: • I was given many opportunities to learn and develop throughout this placement. My clinical educators and members of the team took the time to teach and demonstrate skills and knowledge which was really helpful. Actions taken: None- when investigated further the students saying they disagree did not have learning opportunities they wanted due to the nature of their placement and shadowing opportunities in other areas had been offered.			
7	**My Clinical Educator/s supported me in facilitating integration of Theory into practice**			
	Strongly Agree 68%	Agree 30%	Disagree 2%	Strongly Disagree
	Student comments: • Spent a lot of time and effort helping me to understand and connect theory and practice. I was having a lot of difficulty with this aspect but she has been very supportive and I now understand the links between theory and practice • I did feel supported; we discussed how I could show my theory of			

practice more in supervision, particularly after the half way assessment. But I felt this was only recognized as an aim after they had graded me and realized they wanted more evidence of this to show.

- So they tried to give more opportunities for me to be able to show my knowledge after this and I produced several pieces of work for them also.
- I would have liked to have been given some information about useful text books or documents that discussed the points being recognized. I was often told to research into something but would spend a lot of my time looking for a reliable and useful source that this limited my time completing the research itself. I made this point at my half way review, but nothing improved in this aspect following the conversation.
- My clinical educators encouraged me to look at evidence and integrate this into practice. They provided me with useful resources and information which I was able to utilize in practice.

Actions taken:

The OT Professional Lead is running training for practice educators on evidence based practice and how to keep updated to meet student's needs but it is acknowledged this integration of theory into practice is difficult in some clinical areas where AHP's are working in generic care management posts.

8	**My learning needs were identified, personal placement aims discussed and learning objectives jointly set with the Clinical Educator/s**			
	Strongly Agree 72%	Agree 27%	Disagree 1%	Strongly Disagree

Student comments:

- PE was very understanding of my learning needs. I sometimes do not understand initially or omit a word then misunderstand. I am more of a hands on/ visual learner. PE took time to support me in a way appropriate to my learning needs. I really appreciated this as often at university I miss the thread and then struggle to make sense of things. PE has helped me to clarify many aspects of theory and practice.

9	**There were sufficient opportunities for inter professional working and / or liaison**		
	Too Much 1%	Too Little 5%	Just Right 94%

	Student comments: • All members of the team were enthusiastic and approachable, my clinical educators encouraged me to talk to and work with different members of the team. This enabled me to observe how different clinicians approach things and enhanced my learning.			
10	**I was encouraged to ask questions**			
	Strongly Agree 73%	Agree 26%	Disagree 1%	Strongly Disagree
	Students comments: • My clinical educators were so approachable and encouraging. They made me feel I could ask them questions and gave me constructive answers, which was really helpful and enabled me to learn. All members of the team were happy to answer questions and were very helpful throughout the placement.			
11	**There was a range of learning resources available on placement**			
	Strongly Agree 42%	Agree 51%	Disagree 6%	Strongly Disagree
	Students comments: • We used Recovery Through Activity by Sue Parkinson to plan a weekly group. This was an activity I hadn't been engaged in previously so found this very beneficial and interesting. There were also various MOHO tools available for me to explore. I could also access the library at Prospect Hospital. We also completed to cooking assessments • There is a student resource file, an OT resource file and of course, the rest of the team were a helpful learning resource • There were a range of resources for learning regarding specific Ward rehabilitation. However, a range of learning resources in general, there were not. • The team shared resources with me and directed me to available resources. Actions taken: Students will be reminded that they can access the Trust library at PPH while on placement			

	assessment and feedback			
12	**There was enough time every day for feedback/ discussion between me and the Clinical educator/s/ clinician in the work place**			
	Strongly Agree 60%	Agree 34%	Disagree 6%	Strongly Disagree
	Students comments: • Owing to both my Educators only working part time, it was difficult for us all to have group feedback and discussion each day. Although they kept in touch between themselves on my progress through email, Tuesday was the only day both Pauline and Naomi were in, so communication between all 3 of us was limited. Owing to the nature of being part time, the days my educators did work were always very busy and full on, I didn't always feel comfortable or that it was appropriate for me to try and discuss the day if they were busy in the office • I was also left to my own devices a lot of the time, particularly in the afternoon as both Practice educators would finish their day at 3pm. Although they tried their best, I feel having two part time educators was a bit of a disadvantage. Direction of my working was not always clear and of course neither of them was sure what the other was doing with me so I felt, rightly or wrongly, I was sometimes forgotten about in term of opportunities for practice. • My clinical educators provided me with constructive feedback and throughout the placement I felt there was always someone who I could approach and discuss queries with. Actions taken: Part time working cannot be avoided but when sharing a student practice educators are advised that only 1 leads on the assessments for consistency and that they regularly (at least weekly) discuss the student's progress.			
13	**I received regular supervision and clear feedback on my progress and areas for development**			
	Strongly Agree 67%	Agree 30%	Disagree 3%	Strongly Disagree
	Students comments: • We always had regular time for supervision, which I found invaluable. PE gave me good constructive feedback. We discussed areas of			

	concern or strengths and completed a lot of reflection, which I found very helpful. I never felt rushed or pressured during supervision and PE allowed me time to discuss what I felt I needed to • This factor was really brilliant throughout the placement, the supervision I received was the most constructive and most beneficial of all the placements I have had. • <u>Actions taken:</u> There were no comments on the evaluations disagreeing with this statement All Practice Educators have been reminded that students should have weekly supervisor while on placement			
14	**My objectives were monitored, reviewed and modified to meet my learning needs**			
	Strongly Agree 61%	Agree 35%	Disagree 4%	Strongly Disagree
	<u>Actions taken:</u> None- There were no comments on the evaluations disagreeing with this statement This was discussed with the relevant Universities who confirmed no action was required			
15	**My midway/formative assessments give me feedback and identify how to progress my learning**			
	Strongly Agree 61%	Agree 39%	Disagree	Strongly Disagree
16	**My final assessment was given in a timely way, allowing time for me to comment on the assessment. All my learning objectives were met**			
	Strongly Agree 68%	Agree 30%	Disagree 2%	Strongly Disagree
	<u>Actions taken:</u> None- There were no comments on the evaluations disagreeing with this statement			

17	**My clinical educator/s was knowledgeable about my course and assessment paperwork/ requirements**			
	Strongly Agree 55%	Agree 41%	Disagree 4%	Strongly Disagree
	Students comments: • The entire placement was extremely well organized and I felt the clinical educators were very knowledgeable with regards to my learning needs and development. Actions taken: None- There were no comments on the evaluations disagreeing with this statement			
	overall comments			
18	**The provision of care in my placement area reflected respect for privacy, dignity, cultural beliefs and evidence based practice**			
	Strongly Agree 83%	Agree 17%	Disagree	Strongly Disagree
17	**What were the most positive aspects of the placement?** • I felt that I was constantly given opportunities to improve my knowledge throughout placement which really helped my confidence in unfamiliar situations. I was also given time to spend with specialist Dietitians. • The opportunity to spend some time in the community doing clinics, in addition to acute setting which I felt was particularly useful because I had not experienced community on my last placement. Also felt it was very valuable that I was able to see a wide range of different patients in clinic and specialist patients on wards. Was also happy to have been given the opportunity to carry out a number of talks which has increased my confidence. • Becoming more confident with a wide range of client groups and being able to experience areas that I potentially want to work in. • The support given by the clinical educators and how welcoming and patient all the staff were. The educators had gone to a lot of effort to make sure I got to experience a wide variety of things whilst on placement. • MDT work, verbal reasoning • variety of patients, PE knowledge			

	• gained confidence • fun, safe and inclusive, developed confidence • excellent team, v different lots of equipment • welcoming team, understanding of paediatric OT • Group work. Autonomous learning • friendly team, diff teams, PPH visit, service users • CST group • plan activities, other professionals, groups, notes • increased community skills • knowledge, support, MDT working, patients • split placement & long arm supervision good • variety of conditions, MDT work • PE pushed the perfect amount • Fortunate to have a placement on PICU • wider care team, challenges with LD, clinical reasoning • friendly, IDT, great learning • encouraged learning experience, being encouraged and supported, taking on responsibilities • CMHT and PE supported learning • extra training sessions, visits etc., good team
18	**Is there anything else that would have improved your placement?** • I would have liked to opportunity to get more hands on experience particularly during nail surgery. • more visits • having 1 PE rather than 2 • reading list • midway assessment more timely • not enough work • longer placement • location from home • peer supervision • Not hot desking /More computer space
19	**Any advice for forth coming students?** • To make the most of all the opportunities given on placement. Also, to ask lots of questions and take note of terms for future reference. • Make the most of self-directed learning • get stuck in having a caseload • ask, don't be scared of fast paced ward • go on visits, have fun • research area before, questions • avoid long commute • be open-minded

	• not expected to know everything • listen to PE to improve practice • prepare written work in advance when in pt mode • offer to help staff when you can, get to know service users • use shadowing visits
20	**Any feedback for your clinical educator/s?** • Practice educators on placement were all very helpful and were consistent in providing feedback to allow me to improve my practice. I also felt I was able to ask them questions if I was unsure of something. • All of my clinical educators were engaging and supportive. • friendly, approachable, supportive • thank you!, placement wonderful • v good, enhanced skills • treated like a member of the team • I learnt so much • excellent interpersonal skills • training style superb • (She has) A gift for making people feel competent • strong passion towards her profession

Junior Doctors feedback of training experience: summary of process and examples

Appendix 4

Introduction

This report summarises current processes for seeking and reviewing feedback from postgraduate medical trainees who are employed by or spend time in a training placement in Berkshire Healthcare Foundation Trust.

As a Local Education Provider (LEP) for medical trainees in Health Education England Thames Valley (HEE TV), BHFT aligns with quality domains and standards from both HEE and the General Medical Council. Junior doctor feedback also makes an important contribution to the evidence in the Annual Trust Report to HEE TV (medical and pharmacy) and the Learning Development Agreement Report (multi professional learners) to HEE TV.

Postgraduate Medical Trainees in BHFT

BHFT is commissioned to provide post graduate medical training through the education tariff for the following HEE TV Specialty Schools:

HEETV School	**Placements**
School of Psychiatry	14 core psychiatry and 10 higher trainees in psychiatry
School of General Practice:	5 psychiatry placements and 1 sexual health placement for GP trainees
School of Medicine	1 higher trainee in Genito Urinary Medicine (GUM sexual health)
Foundation School	6 training placement in psychiatry to Foundation Trainees from the Royal Berkshire Hospital and Wexham Park Hospital Foundation programmes

Sources of feedback

Trainees are invited to give formal feedback on their education and training through the following processes:

- GMC annual national trainee survey
- Formal feedback requested by the specialty school programmes in HEE TV (which may be anonymised and collated for some programmes)
- Formal feedback requested by BHFT for GPVts and FY trainees

The importance of giving feedback and raising concerns related to quality of care and patient safety is emphasised at Junior doctor Induction and throughout training in BHFT. Trainees are encouraged to raise concerns regarding patient safety and care at induction through formal systems:

- Datix reporting
- Freedom to Speak up
- Guardian of Safe working hours

Trainees are also encouraged to raise issues/concerns with their Clinical Supervisor (CS), Educational Supervisor (ES), the tutors, DME and trainee representatives.

The General Medical Council (GMC) National Training Survey.

The national training surveys are a core part of the work the GMC carry out each year, to monitor and report on the quality of postgraduate medical education and training in the UK.

Each year the GMC runs the comprehensive surveys asking all doctors in training and trainers for their views. Their feedback helps the GMC make sure that doctors in training receive high quality training in a safe and effective clinical environment and trainers are well supported in their role.

The national training survey gives the GMC an opportunity to provide confidential feedback on our training that can be used to make improvements. Our deanery/HEE local team and local education provider use the survey results with other sources of information to review and improve their training programmes and posts.

The value of the GMC survey results is limited in community trusts with smaller numbers of trainees. The GMC tool requires n>3 (ie more than 3 trainee feedback in each of the Trusts' locations/ sites) to generate a valid survey score but for us this is often not possible because in BHFT we rarely have more than 3 trainees in each programme at the same location. Our GMC survey spreadsheet is often full of grey boxes meaning a score which is not valid because n<3 in most cases. However, we do manage to score in some areas eg Prospect Park Hospital where we generally have more than 3 trainees posted. The value of the result is further limited by the fact that it is not possible to identify which individual posts are being rated and the time delay in receiving the results.

However if there was any report from a trainee to the GMC, indicating a patient safety concern, this would be immediately sent to the trust with a request to respond. BHFT has not had any such concerns through the GMC survey.

The GMC annual survey results are available to the public on the GMC website. http://www.gmc-uk.org/education/surveys.asp

General Psychiatry feedback for BHFT from 2012-2017 is provided below as an example.

Post Specialty	Trust / Board	Indicator	2012	2013	2014	2015	2016	2017
General psychiatry	Berkshire Healthcare NHS Foundation Trust	Overall Satisfaction	84.92	84.80	80.00	82.40	85.67	85.87
		Clinical Supervision	91.23	94.15	87.37	93.33	88.48	93.21
		Clinical Supervision out of hours				87.38	86.66	84.58
		Reporting systems					66.35	79.20
		Work Load	50.00	57.92	50.48	63.19	53.65	60.55
		Teamwork						76.67
		Handover	52.78	41.67	41.07	54.69	68.52	65.48
		Supportive environment				76.67	73.33	75.67
		Induction	83.46	93.00	87.69	87.33	85.83	88.75
		Adequate Experience	85.38	80.00	75.38	81.33	81.67	80.00
		Curriculum Coverage						76.67
		Educational Governance						74.44
		Educational Supervision	96.15	95.00	88.46	90.00	87.50	93.89
		Feedback	88.46	90.63	88.54	85.00	86.11	86.11
		Local Teaching	71.08	75.80	75.71	72.67	64.20	71.80
		Regional Teaching	75.50	69.50	74.90	74.60	67.20	84.22
		Study Leave	74.44	49.00	85.00	81.88	72.27	66.04

HEE TV Specialty School feedback on individual posts and supervisors

The majority of trainees in BHFT are from the programmes of the School of Psychiatry (SOP). The SOP Training Programme Directors (TPDs) send feedback forms to every trainee after every attachment and this is collated by the TPD and sent to the DME annually who reviews it and sends it to the respective trainers. Trusts do not repeat this exercise because trainees do get survey fatigue and the feedback is standardised across all trusts so we can compare posts with greater accuracy. The DME and college tutors will note any issues arising in the formal feedback and make contact with the trainer directly to discuss actions to improve or to reinforce great quality training. Trainers will use this feedback in their own appraisals as evidence of their training roles.

There is a quantitative element to this feedback but often free text comments are more valuable and specific. Repeated low scoring posts will be reviewed and considered either suitable or unsuitable for training if issues are not addressed by the trainer and/or the wider team. Core psychiatry training annual collated feedback from the School of Psychiatry indicated that over 90% of post feedback elements in the questionnaires available were positive. Feedback from GP, Foundation and Medicine Schools relating to individual BHFT posts is not received regularly.

HEE TV Specialty School Survey:

The School of psychiatry identifies themes which go into an annual school survey. This is collated by the TPD. In 2016 access to psychotherapy was focus because of the changes to psychotherapy services in trusts. BHFT did very well in that small survey with 100% (n=10) scoring good or excellent experience in Balint Group work

Feedback on the Educational Supervisor Report:

Trust employed Educational Supervisors (ES) provide end of placement reports which are an important component of the Annual Review of Competency Progression (ARCP) panel at HEE TV. This panel makes a decision about a trainee's progress over 12 months. The panel will generate feedback on the quality of the report and this is sent to individual ES by the Head of School. This forms another piece of evidence for trainers about the quality of their work in this role that can be useful for personal development.

BHFT Formal Feedback Process for Foundation and GP trainees who spend 4-6 months in BHFT

We have developed our own feedback forms asking trainees to score against a number of relevant areas with additional free text boxes. The Medical Education Administrator sends these to all FY, GPvts and Sexual Health trainees at the end of their attachment. We use this feedback to identify good training practice, areas for improvement and to check if identified improvements have been made. The consultants receive the feedback directly. Feedback is stored in folders relating to period of the post and type of trainee. Trainees in sexual health have consistently rated their training as good to excellent. Foundation trainees have, in the past, raised issues of expectations of providing physical healthcare and phlebotomy workload on some inpatient wards at Prospect Park Hospital.

Informal feedback and Open Door approach

The College Tutors meet with the trainees regularly and this provides a forum for issues or concerns to be raised. In BHFT the trainee numbers are relatively small and this enables the education team to have an open door approach to trainees which is emphasised at induction. Tutors are available at the weekly academic meetings. Direct e-mails and door knocking gives us a real- time knowledge of what is happening for the trainees at any moment in time. All issues raised for or from trainees are registered alongside the actions/responses and are reviewed at the monthly Medical Education Meeting.

Formal Feedback for the Foundation Teaching Programme

We provide a 10 week rolling teaching programme for the FY trainees and request feedback after each session. This will inform the speaker so improvements can be made.

Conclusion

The HEE TV Quality Review on 12 June 2017 was very positive and did not raise any issues relating to medical training which were unknown to the trainers in BHFT.

HEE has recently published a new Quality Strategy, including the new Quality Standards with accompanying guidance. The trust reporting to HEE TV of concerns/issues for trainees will move from annual reporting to real time reporting along with risk rating of the issues. The first of these has been submitted.

NHS
Health Education England

Quality review outcome report

Local office name: HEE Thames Valley

Organisation: Berkshire Healthcare NHS Foundation Trust

Placements reviewed: 'The Learning Environment'

Date of Review: 12 June 2017

Date of report: 13 June 2017

Author: Tessa Candy

Job title: Quality Assurance Manager

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Review context

Background

Reason for review:	Senior Leader Engagement Visit
No. of learners met:	6
No. of supervisors / mentors met:	0
Other staff members met:	Chief Executive, Medical Director, Directors of Medical Education, Head of Clinical Education, Guardian for Safe Working, Freedom to Speak Up Guardian, Director of Nursing, Deputy Director of Nursing, Widening Participation Lead, AHP Professional Lead, Learning Environment Leads
Duration of review:	Half a day
Intelligence sources seen prior to review: *(e.g. CQC reports; NSS; GMC Survey)*	Standard *Education Quality Summary* collated by HEE-TV including details on: funding; supported programmes; Trust self-assessment against the LDA; HEI satisfaction rates; Trust satisfaction rates; NHS Friends & Family Test; NHS Choices; CQC Report; GMC Survey results, NHS Staff Survey results, details of progress to address open concerns.

Panel members

Name	Job title
Dr Michael Bannon	Postgraduate Dean, HEE-TV
Mrs Zoe Scullard	Health Dean, HEE-TV
Dr Simon Smith	Associate Dean for Quality Management
Miss Tessa Candy	Quality Assurance Manager, HEE-TV
Mrs Gillian Baker	Quality Improvement Lead, Practice Learning
Mrs Katharine Horrocks	Lay Representative, HEE-TV
Dr Sanyal Patel	Trainee Representative, HEE-TV

Executive summary

Health Education England [Thames Valley] undertook a Senior Leader Engagement Visit [SLEV] to Berkshire Healthcare NHS Foundation Trust [BHFT] on Monday 12 June 2017. The Visit followed a similar format to previous years 'Education Quality Visits', meeting with a number of Senior Trust Management Representatives as well as Learners, and discussing areas of excellence and notable practice, and progress to address issues and concerns.

Following implementation of the HEE Quality Strategy & Framework within Thames Valley, a decision was taken in 2016 to cease all Specialty Reviews for the 2017 Visit cycle with the exception of those Trusts where one or more departments had been awarded an overall Quality Management Grading of 'Major Concerns'. BHFT had no Major Concern gradings awarded by the Quality Management Committee in 2016, and subsequently no Specialty Reviews or School Visits were undertaken in advance of the SLEV.

This was an extremely positive visit. There is clear commitment at Trust Board-level to ensuring that the learning environment for all professions is of high quality, and this is reflected in the feedback and views of the learners who were positive about their training posts, their supervision, their teaching and their experience in general.

No areas were identified where the Trust is at risk of failing to meet HEE or regulatory body standards for education and training, and no educational requirements or recommendations were set.

Sign off and next steps

Report sign off

Outcome report completed by *(name)*:	Tessa Candy
Chair's signature:	
Date signed:	
HEE authorised signature:	
Date signed:	
Date submitted to organisation:	2 August 2017

Organisation staff to whom report is to be sent

Job title	Name
Review Team as above	
Julian Emms	Chief Executive
Minoo Irani	Medical Director
Mette Laszkiewicz	Head of Clinical Education and LDA Lead
Jane Da Roza Davis	Director of Medical Education - outgoing
Garyfallia Fountoulaki	Director of Medical Education - Incoming
James Jeffs	Guardian for Safe Working
Elaine Williams	Freedom to Speak Up Guardian
Helen Mackenzie	Director of Nursing
Nicky Howells	Head of Training and Organisational Development
Dipika Noble	Business Manager for Clinical Education
Jayne Reynolds	Deputy Director of Nursing
Nathalie Zacharias,	AHP Professional Lead
Katie Humphrey	Widening Participation Lead
Maggie Neale, LEL Debi Joyce, LEL Tina Lucas, LEL/CPE Gemma Wilson, LEL/CPE Sharon Andrews, LEL Kathryn Blair, LEL	Learning Environment Leads and Clinical Practice Educators

Action plan to be completed by Berkshire Healthcare NHS Foundation Trust

Email to tessa.candy@hee.nhs.uk within three weeks of receipt of report.	
To be returned to HEE by *(date)*:	n/a
To be completed by *(name)*:	

Findings and conclusions

Risk scores (*1 – 25; see Appendix 2 for breakdown*)

Scores prior to review:	n/a
Proposed scores following review:	n/a

Patient / learner safety concerns

Any concerns listed will be monitored by the organisation. It is the organisation's responsibility to investigate / resolve.

Were any patient/learner safety concerns raised at this review?	NO
To whom was this fed back at the organisation, and who has undertaken to action?	
Brief summary of concern	

Educational requirements

Requirements are set where HEE have found that standards are not being met; a requirement is an action that is compulsory.

Were any requirements to improve education identified?		NO
Reference no.	Programme / specialty:	Learner / professional group:
Related Domain(s) & Standard(s)		
Summary of findings		
Required action		
Risk Score		

Educational recommendations

Recommendations are a proposal as to the best course of action.

Reference no.	Programme / specialty:	Learner / professional group:
Related Domain(s) & Standard(s)	*n/a*	
Summary of findings		

Summary of discussions with groups

Senior Organisation team

The Review Team had asked to hear from Trust Representatives on a range of topics.

Freedom to Speak Up Guardian

The Freedom to Speak Up Guardian has been in post since March 2017, and has ensured networked involvement at both regional and national level. Local engagement with learners has included attending induction sessions for student nursing, and will include attendance at the forthcoming junior doctor induction in August 2017.

The Review Team heard that the Trust is keen to communicate the message that 'raising concerns is everyone's business' and are committed to creating a culture of talking. In particular, it was emphasised that whilst there are a number of internal routes available to learners to raise concerns, including supervisors, mentors, ward managers, and locality directors, the introduction of the Guardian is not intended to add an additional layer of reporting but instead provide signposting, and a source of guidance in helping individuals think through and reflect upon areas which may be of concern to them. The Review Team heard that the Guardian meets with the CEO fortnightly, although at the time of the visit, no learner had raised any concerns.

Guardian for Safe Working Hours

The Guardian for Safe Working Hours [GfSWH] has been in post since June 2016 and gave an overview of the role for the Review Team; good links have been established with other Guardians in the Thames Valley area and since February 2017 he has led on the arrangements for the Junior Doctor Contract within BHFT. There are approximately 33 medical learners in post at Berkshire Healthcare, ranging from FY1 to ST6. An Exception Reporting system has been implemented but to date only two exception reports have been submitted, both of which were for hours' variance as opposed to missed educational opportunities. The Trust was not aware of any obstacles to reporting, and the GfSWH attends induction sessions for all medical trainees to ensure they are all aware of how to report. In addition, a Trainee Forum was established in October 2016 and Trainee representatives were encouraged to attend; terms of reference have been developed and trainees choose how the forum runs.

The Review Team are aware of instances in other Trusts of 'unofficial TOIL' eg Trainees staying over their hours, but then being able to take them back at another time, without having to submit an exception report. The GfSWH did not feel that this was the case in Berkshire Healthcare.

The importance of both the GfSWH and the FTSUG roles is recognised but the Trust were keen to emphasise that the importance of raising awareness of the roles and encouraging appropriate reporting is from the bottom-up, involving all levels of the organisation.

2016-17 Trust SWOT Analysis

The Trust gave an update on the 'Opportunities' and 'Threats' from the 2016-17 SWOT Analysis.

Opportunities

- The Review Team heard that there is now a trainee in the Core Liaison Psychiatry post which is receiving positive feedback. Two Higher Specialty Liaison Psychiatry posts have been established and similarly, feedback has been positive. An additional FY1 post is working well. The Trust confirmed that there are some pending changes to the Foundation post due to a consultant having left and this will be monitored by the Education Team.
- Due to a new curriculum for the Child & Adolescent Psychiatry programme, the School of Psychiatry had asked that the Trust increase availability of placements; this has occurred and the Trust can now offer three posts in this

specialty. The Trust has been pleased by the amount of interest they have received from Consultants putting themselves forward to be Trainers.

- The Review Team heard that the Trust is developing a new Learning Disability service, Intensive Support for home treatment; it is hoped that this will provide opportunities for training in the future.
- There has been successful recruitment to the new community nursing pathway, with 73% of the first cohort filled. A second cohort will begin on the 13 June 2017.
- The Trust has piloted a Mentorship Training Programme which was targeted at all branches of nursing across the Trust. The response has been excellent and there has been good engagement. Emerging concerns appear to relate mostly to how mentors can best support those students who may have pastoral support needs. As a result, the Trust has piloted Coaching & Buddying Systems.
- The planned pilot for student drop-in sessions has begun and is now embedded in the locality. The Review Team heard that these are well attended and are a mix of reflective practice with some 'bite size' education included. Mentors are also finding the additional support helpful.
- The Trust is planning to fully utilise the Apprenticeship levy. 60% more apprenticeships were delivered last year.
- In partnership with HEE-TV, Berkshire Healthcare is taking part in the Nursing Associate Trainee Programme pilot which supports 105 Nursing Associates across the Thames Valley Region. Berkshire Healthcare NHS Foundation Trust is the Lead Employer for this pilot. It is anticipated that the majority of these will be mature students. There has been good engagement from UWL.

Threats

- CPD funding cuts continue to be a challenge for the Trust. 1-9 HEETV 'non-medical CPD preferred provider and flexible spend' funding reduced over 2 years from £547k to £155k
- Post fill rate – The Trust was disappointed to not have filled all medical training posts for August 2017. The outgoing Director of Medical Education has been looking at how other Local Education Providers identify their gaps. The Trust recognised that job descriptions and the training pathways need to be updated particularly to reflect specific details of where a trainee may be based and this work is ongoing.
- Due to the move of Health Visiting and School Nursing to unitary authorities, there has been a 61% drop in capacity within the Trust 0-19 Teams. In response, the Trust is working with HEIs, and are reorganising the mapping for community wards to increase capacity across the academic year. The Trust is also considering whether to pilot the Collaborative Learning in Practice (CLIP) Mentorship model in two teams.
- Staffing & resources: The Review Team heard that there continues to be concerns relating to staffing shortages and the impact this has on the ability for the Trust to deliver on internal training and programmes.

HEE-TV Quality Management Processes

Risk-based approach

The HEE-TV team was keen to hear the Trust's views in general on HEE's move towards a more risk-based model, and therefore the ability to close issues where there is no discernible evidence that they are negatively affecting education and training.

In 2015, a School of Psychiatry Visit to the Trust had noted some trainee concerns around the medical cover on the Old Age wards, as a result of rapid turnover of staff grade locum doctors. Between the time of the visit in 2015 and May 2017, the Trust has been reporting on progress to address these concerns. A further update from the Trust was received in May 2017; under the HEE Quality Strategy and Framework and on reviewing the concern against the HEE expected quality standards for education and training, it was the view of the QMC that whilst the issue around cover may not yet be resolved, it was unclear as to whether it continued to negatively impact on education or training quality particularly in light of satisfactory supervision levels for trainees [consultant level] and a lack of negative feedback from learners. The outgoing Director of Medical Education was able to confirm that it was not affecting training and so whilst the original issue was ongoing, it was agreed that this item should be closed.

School Visits

The HEE Quality Framework does not include 'School Visits' as one of the 'quality interventions' open to HEE local offices. The Trust has established good quality control processes and were of the view that the risk of issues being missed or overlooked on the basis that School Visits were no longer taking place, would not be realised; the Review Team heard that

the Trust has also moved to a more 'real-time' approach to Quality Control and are logging all trainee concerns as and when they arise. This log is also recording what feedback has been provided to Trainees.

Senior Leader Engagement Visits

The Trust acknowledged that Senior Leader Engagement Visits provide a route by which members of Trust Staff can be recognised for their hard work, commitment and input. It was the Trust's view however, that the visits, both in their preparation and on the day are both time and resource-heavy, and that there are existing routes already established for the contributions of staff to be recognised and celebrated. It was suggested that a bi-annual approach to SLV would be proportionate and appropriate. HEE-TV was happy to consider this suggestion.

Meeting with Learners

The Review Team met with 6 learners from the Trust, two 2nd Year Nursing Students, two Core Psychiatry Trainees, and two Psychiatry Registrars.

The Trainee Doctors were unanimous in their positive feedback about their training experience and the learning environment at Berkshire Healthcare. The Review Team heard that there is good clinical supervisor knowledge of medical Psychiatry curricula, an excellent academic programme, approachable consultants and a supportive environment.

The Trainees mentioned an incident on Rose Ward recently which appeared to relate to staffing levels. Trainees reported that this has been escalated to more senior members to manage. It was not clear whether any learners had been involved.

The Student Nurses were similarly positive about their experience at Berkshire Healthcare. The training was described as excellent, and there is a wide range of placements to choose from. The Community placements were highlighted in particular due to the input from the Consultants. Mentors are approachable and there are open links with the HEIs.

The Review Team heard that in some areas staffing levels are low, including at Consultant level. It was suggested that should the higher trainees be able to access 'Consultant taster opportunities' or some 'acting up' responsibilities it may help with decisions around if to apply for a Consultant position within the Trust.

The student nurses reported that at times they have found themselves being 'written into the rota' when they should be supernumerary; this has caused them to feel under pressure. The Trainees also reported that staffing shortages have led them to performing tasks not appropriate to their training level.

The Review Team was interested to hear of any multi-professional learning opportunities but the learners reported that there are no formal occasions where they learn together. The learners suggested that the recent work on autistic spectrum disorders would have provided a good opportunity.

Exception Reporting

The Review Team were interested to hear that there have been occasions where Trainees have had to stay late. On two occasions exception reports have been submitted. On the other occasions the Trainee has chosen not to report, or has agreement from their Consultant that they can take time off in lieu also without reporting the hour's variance. Whilst the Review Team recognises that to date there has been no stipulation around the specific amount of variance which would result in the requirement to exception report, it is important that Trainees understand the importance of the Trust being able to access and present accurate data for exception reporting. The HEE-TV Quality Team will be writing to all trainees in early July 2017 and will re-iterate this message.

Appendix 1: HEE Quality Framework Domains & Standards

Domain 1 - Learning environment and culture

1.1. Learners are in an environment that delivers safe, effective, compassionate care that provides a positive experience for service users.
1.2. The learning environment is one in which education and training is valued and learners are treated fairly, with dignity and respect, and are not subject to negative attitudes or behaviours.
1.3. There are opportunities for learners to be involved in activities that facilitate quality improvement (QI), evidence based practice (EBP) and research and innovation (R&I).
1.4. There are opportunities for learners to engage in reflective practice with service users, applying learning from both positive and negative experiences and outcomes.
1.5. The learning environment provides suitable educational facilities for both learners and educators, including space, IT facilities and access to quality assured library and knowledge services.
1.6. The learning environment maximises inter-professional learning opportunities.

Domain 2 – Educational governance and leadership

2.1 The educational governance arrangements measure performance against the quality standards and actively respond's when standards are not being met.
2.2 The educational leadership uses the educational governance arrangements to continuously improve the quality of education and training.
2.3 The educational leadership promotes team-working and a multi-professional approach to education and training, where appropriate.
2.4 Education and training opportunities are based on principles of equality and diversity.
2.5 There are processes in place to inform the appropriate stakeholders when performance issues with learners are identified or learners are involved in patient safety incidents.

Domain 3 – Supporting and empowering learners

3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in their curriculum or professional standards to achieve the learning outcomes required.
3.2 Learners are supported to complete appropriate summative and formative assessments to evidence that they are meeting their curriculum, professional standards and / or learning outcomes.
3.3 Learners feel they are valued members of the healthcare team within which they are placed.
3.4 Learners receive an appropriate and timely induction into the learning environment.
3.5 Learners understand their role and the context of their placement in relation to care pathways and patient journeys.

Domain 4 – Supporting and empowering educators

4.1 Those undertaking formal education and training roles are appropriately trained as defined by the relevant regulator or professional body.
4.2 Educators are familiar with the curricula of the learners they are educating.
4.3 Educator performance is assessed through appraisals or other appropriate mechanisms, with constructive feedback and support provided for role development and progression.
4.4 Formally recognised educators are appropriately supported to undertake their roles.
4.5 Educators are supported to undertake formative and summative assessments of learners as required.

Domain 5 – Developing and implementing curricula and assessments

5.1 The planning and delivery of curricula, assessments and programmes enable learners to meet the learning outcomes required by their curriculum or required professional standards.
5.2 Placement providers shape the delivery of curricula, assessments and programmes to ensure the content is responsive to changes in treatments, technologies and care delivery models.
5.3 Providers proactively engage patients, service users and learners in the development and delivery of education and training to embed the ethos of patient partnership within the learning environment.

Domain 6 – Developing a sustainable workforce

6.1 Placement providers work with other organisations to mitigate avoidable learner attrition from programmes.
6.2 There are opportunities for learners to receive appropriate careers advice from colleagues within the learning environment, including understanding other roles and career pathway opportunities.
6.3 The organisation engages in local workforce planning to ensure it supports the development of learners who have the skills, knowledge and behaviours to meet the changing needs of patients and service.
6.4 Transition from a healthcare education programme to employment is underpinned by a clear process of support developed and delivered in partnership with the learner.

Risk assessment

The HEE corporate risk matrix, detailed below, will support the HEE Quality Cycle by determining the level of risk to education and training quality.

Likelihood						
	5	G	A	A/R	R	R
	4	G	A	A/R	R	R
	3	G	G/A	A	A/R	R
	2	G	G/A	A	A	A/R
	1	G	G	G/A	G/A	A
		1	2	3	4	5
		Impact				

If a Quality Intervention should be required, the following table provides examples of proportionate interventions in line with the assessed level of risk:

Level of risk	Interventions
High	✓ Triggered visit ✓ Programme review
Medium	✓ Programme review ✓ Learner/educator meetings
Low	✓ Desktop review ✓ Programme review ✓ Learner/educator meetings

Score	Likelihood	Impact
1	**Rare:** • Will probably never happen • Could only imagine it happening in rare circumstances	**Negligible:** • Very low effect on service, project or business area • No impact on patients , learners, public or staff • No reputational impact (i.e. no press interest) • No financial loss
2	**Unlikely:** • Do not expect it to happen • It is possible that it may occur	**Minor:** • Minimal disruption to service, project or business area • Limited impact on patients, learners, public or staff • Minimal reputational impact • Limited financial loss
3	**Possible:** • Might occur • Could happen occasionally	**Moderate:** • Moderate impact on service, project or business area • Moderate level of impact on patients, learners, public or staff • Medium level of reputational impact • Medium financial loss
4	**Likely:** • Will probably happen in most circumstances • Not a continuing occurrence	**Major:** • Major effect on service, project or business area • Major level of impact on patients, learners, public or staff • Major impact on reputation (i.e. major press interest) • Major financial loss
5	**Almost certain:** • Expected to happen • Likely to occur in most circumstances	**Significant:** • Loss of service, project or business area • Detrimental effect on patients, learners, public or staff • National press coverage • Significant financial loss

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	12th September 2017
Title	Slough Health Visiting and School Nursing Position Statement
Purpose	The purpose of this report is to provide the Trust Board with an update on the Slough health visiting and school nursing service contract transfer.
Business Area	Nursing and Governance
Author	Helen Mackenzie, Director of Nursing and Governance
Relevant Strategic Objectives	1 – To provide safe services, good outcomes and good experience of treatment and care
CQC Registration/Patient Care Impacts	Supports maintenance of CQC registration and supports maintaining good patient experience
Resource Impacts	N/A
Legal Implications	N/A
SUMMARY	In July 2017 the trust heard that the health visiting and school nursing service in the Slough locality had been awarded by Sough Borough Council to Solutions 4 Health (S4H), a private company that currently provides health promotion services. This paper informs the Trust Board of a meeting that took place between Slough Borough Council and the Director of Nursing and Governance and Chief Operating Officer where the patient safety and quality concerns associated with the new contract were formally raised.
ACTION REQUIRED	The Trust Board is asked to: • Note the position

Slough Health Visiting and School Nursing Position Statement

In July 2017 the trust heard that the health visiting and school nursing service in the Slough locality had been awarded by Sough Borough Council to Solutions 4 Health (S4H), a private company that currently provides health promotion services.

Staff involved in the service began to raise concerns immediately with the Director of Nursing and Governance (DON) when they became aware of the decision. All nurses have a professional responsibility to formally raise concerns and therefore, in conjunction with Executive Colleagues, the DON began to raise concerns formally with Slough Borough Council.

A mediation meeting was held on Thursday 31st August 2017 with two officers from Slough Borough Council.

Quality and Safety Concerns

The following describes the concerns raised by the DON at the meeting:

Health visiting and school nursing practice is complex and it takes many years to ensure the values, skills and attitudes are in place and remain in place. They create opportunities for parents who otherwise have remained unaware of or unwilling to engage in the provision.

Health visiting and school nursing provide services to all children and families (known as a universal service). Finding the children and families that need help within a universal service is where the skills of the service lie.

The public recognise that the NHS aspires to the highest standards of excellence and professionalism and they know they can receive respect, dignity and compassion. Individuals, families and communities open doors for us knowing we work for the NHS. This relationship is built on trust and reputation. Families on the outskirts of mainstream and families transferring in from abroad already know they can trust the NHS. In Slough the children and families supported in bed and breakfast and guest houses are suspicious of services and reluctant to engage it is always less of a problem when you can say that you work for the NHS and this allows you access to the children.

It was explained about the professional responsibility to raise concerns following the numerous national inquiries and that as a consequence of the new contract award, the only stable children's service in Slough was being de-stabilised for the following reasons:

Patient Record

Two case studies were shared by Cathy Climpson, Health Visiting Manager to explain how the loss of access to NHS records will impact on the service provision to children and families and could put children at risk.

Case study 3

Homicides are rare and the example used today is not the current homicide under review in Slough, this occurred elsewhere in Berkshire. The perpetrator was known to mental health services, however at the time we did not have a joint record and the health visiting service did not know that the perpetrator was known to mental health services. The perpetrator's

children were not known to social or health services and as a consequence they did not receive the care they required. There was learning across the whole of health visiting in Berkshire, fundamentally access to the joint health records including GP and secondary care records provides BHFT health visiting and school nursing staff a privileged opportunity to understand the breadth of what's happening in families. This will be lost.

Recruitment and retention

Health Visitors chose to work for BHFT in Slough; they could be earning £3,000 more just over the border in Hillingdon. Previous Health Visitor students have wanted to stay working in Slough, once qualified, even though they know the work is tough and unpredictable; they know they will receive excellent support and experience for their careers. This has helped Slough maintain acceptable recruitment levels until recently.

Recent local experience shows that outside of the NHS maintaining a sufficient, quality workforce continuing is challenging. This will result in fewer staff wanting to work in Slough, the quality of work and ability for partnership work will be reduced, resulting in poorer outcomes for children and families in the area. The current Slough service has lost another 6/7 health visiting staff since contract confirmed and only 1.5 whole time equivalent school nursing staff will transfer.

Accessing other services

The Trust is conscious that clients who need onward referral get this completed quickly and efficiently as we have the referrals and paperwork and systems in place. Working as part of a wider team of NHS professionals means we can easily tap into others expertise which becomes more difficult as a stand-alone Health visiting/school nursing service. This includes any joint training we do. We automatically lose the networking available to us once moved out of NHS bases as planned by S4H.

Safeguarding arrangements (the trust acknowledged that S4H have employed a safeguarding lead, which is reassuring).

The Trust is concerned that safeguarding arrangements need to be robust from day 1, so that practitioners get the help and support they need to keep children safe in an area that has a high percentage of safeguarding and child protection. If this arrangement is not immediately effective it will cause immense extra pressure and stress to staff working face to face with vulnerable families which will impact on service quality. Lack of future access to our current NHS records and a move from our RiO patient records system to a system yet to be purchased by S4H means that S4H will no longer be able to see input from other health professionals working within the NHS. This will impact on efficiency to protect children even in the short term, for example completing Section 47, section 17 requests and case conference reports.

Example A recent S47 enquiry in Slough ascertained that the child was under community paediatricians and had a pattern of missed appointments which was unknown to social care. The ability to share health information and any parenting concerns will be compromised as a result of no longer having access to NHS information.

Professional support

An NHS Trust is able to provide significant professional support, examples include:

- Flexing national policy to meet local need. The trust has enabled the Slough health visiting services to develop a specific vitamin D pathway which differs to national policy to address identified health issues within the Borough.
- Learning from the death of Callum Wilson. Awful things do happen, providers have to respond appropriately at great financial and service cost.

Current performance

Service	Current Performance Slough locality	Current Performance Windsor and Maidenhead since the service has been provided by a community interest company
New birth visit	97%	49.4%
6-8 week follow up	89%	61%
12 month review	81%	49%

CQC registration

The Trust Board should note that S4H has applied for CQC registration to receive health visiting and school nursing services as without this the Trust cannot transfer the services into their care. (At the time of writing this was not in place).

Next steps

It was anticipated that Slough Borough Council will move quickly to sign the contract with S4H and following the meeting the trust followed up in writing the concerns raised and highlighting how much S4H have to achieve prior to the transfer of service in five weeks' time:

1. CQC accreditation
2. Premises for clinics
3. An electronic patients records system tailored to the 0 – 19 service
4. Adequate policies in place to ensure that the service is operated safely; and
5. Sufficient staff to provide the service.

Finally the Trust stated that with some amendments to the service specification, a safe service could be provided within the Council's proposed envelope and that unless that option is pursued, the Council will have a service which will put vulnerable people at even more risk.

Immediately following the meeting the DON and Chief Operating Officer met with affected staff and explained the current position of the trust.

The Trust has been and will continue to work with S4H on the safe transfer of the service.

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	12 September 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.

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Meeting 12 September 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. Care Quality Commission Area Reviews

Following the spring Budget announcement of additional funding for adult social care, the Department of Health approached the Care Quality Commission (CQC) to undertake a programme of targeted reviews of local authority areas. The reviews form part of a package of support measures to identify and support local systems that are challenged and to promote an integrated approach across adult social care and the NHS.

The CQC have now received a formal direction from the Secretaries of State requesting that the Regulator undertakes up to 20 reviews in 2017/18 under section 48 of the Health and Social Care Act 2008. The CQC will make recommendations to local system leaders, advise the Secretaries of State as to how improvements may be secured and publish a national report.

The CQC have been informed of the first 12 sites with a further 8 to be confirmed in the coming months. Bracknell Forest has been identified as one of the first 12 sites. The inspection will take place during September and the Trust, along with other health providers in the area will be part of the process.

Following each visit, the CQC will produce a bespoke report for the Health and Wellbeing Board setting out the findings and making recommendations for required improvements. This will be followed by a local summit for national partners and the local area to agree the improvement offer. At the end of the programme, the CQC will produce a national report summarising the findings and required system improvements.

Executive Lead: Julian Emms, Chief Executive

3. Care Quality Commission Focussed Inspections

In May 2017, the Care Quality Commission (CQC) undertook two focused inspections involving Bluebell Ward (acute adult mental health inpatients), Prospect Park Hospital and Willow House, previously known as Berkshire Adolescent Unit (adolescent mental health inpatients). Both wards received compliance actions as a result of these visits.

Bluebell Ward's visit was triggered as a result of a complaint and a Mental Health Act compliance concern. The report was not an easy read and the following compliance actions have been placed on the ward:

- The Provider must ensure incidents are always reported, reviewed, investigated and monitored and make sure that action is taken to remedy any situation, prevent recurrences and make sure that improvements are made as a result.
- The Provider must check that all areas of the ward are clean and free from malodour.
- The Provider must make certain that all patients' risk assessments, including physical health assessments are completed thoroughly and to the required quality standard. This must include updating patients' risk assessments after key events or incidents.
- The Provider must make sure that all patients have the service user safety plan section of their care records completed.
- The Provider must ensure the ward ligature risk assessment has detailed action plans identified in order to adequately manage or reduce the risks.
- The Provider must ensure there are sufficient and detailed entries in the patients' care records about decisions taken under the Mental Capacity Act and the Mental Health Act.
- The Provider must review governance systems, such as environmental audits and audits of care plans in order to establish that they are effective in highlighting risk and that they are consistently applied.

Willow House inspection was triggered as a result of an alleged serious safeguarding incident and resulted in one compliance action being placed on the Unit:

- The Trust must establish systems and processes to ensure that all safeguarding concerns are reported as safeguarding concerns and acted upon.

Many actions have already been taken in response to the inspection and resolved, however the action plan developed in response to the inspection will be monitored by the Quality Assurance Committee on behalf of the Board.

The full reports are now available on the CQC website at http://www.cqc.org.uk/provider/RWX

Executive Lead: Helen Mackenzie, Director of Nursing and Governance

4. Improving Patient Safety on Prospect Park Hospital Site

Anti-climb, anti-ligature and anti-contraband three metre high fencing is being installed around Daisy, Bluebell and Rose Ward courtyards during August and September to prevent patients absconding and injuring themselves. Snowdrop Ward does not have any external gardens and therefore does not need fencing.

The drainpipes and gutters are also being protected with guards that are anti-climb so that patients cannot get their fingers behind the drainpipes to climb them (as they can now). This step will hugely reduce the risk of absconsions over the single storey areas, for example Snowdrop Ward.

Both these steps have successfully worked elsewhere to improve patient safety.

Executive Lead: Helen Mackenzie, Director of Nursing and Governance

5. Quality Improvement Programme Update

The Quality Improvement (QI) Programme continues to meet the milestones in the plan agreed by the Executive Team during the June Road Mapping Workshops with KPMG.

Three of the work streams have had activities completed this month:

- QI Office: Four staff commenced in the QI office on 4th September 2017 ready to shadow KPMG in the delivery of the second wave of Quality Management and Improvement System (QMIS) teams. The second wave consists of Daisy and Rowan Wards, Prospect Park Hospital, Windsor and Ascot Wards, Wokingham Community Hospital and Maidenhead and Windsor Community Nursing team. The remaining two members of staff are expected to start in October but will join the team on occasions through September.

- Quality Management and Improvement System: The first "wave" of approximately 35 staff across five teams is progressing. Module 0 has been completed and Module 3 is half-way through (there five modules in total). Teams have been putting their training into practice by commencing "unit leadership team" meetings and use of "status exchange sheets" and daily "improvement huddles".

- "Green belt" training applications are currently under review. There were 43 applicants. The first three days of green belt training is due to be delivered in October.

- Strategy Deployment: The Trust's "True North" has been agreed (domains, metrics, ultimate goals). 2017/18 goals for each metric are being finalised. Visual management is a key element of this work and the team are currently working on the display planned for the Board room.

- Our project management process is also under review and with KPMG's support the Trust is undertaking a project de-selection process to ensure we are working on areas that help us achieve 'True North' and not over burdening the front line with the introduction of new ways of working concurrently.

Other supporting activities such as communication events (for example, presentations to key stakeholder groups, development of intranet site) are progressing.

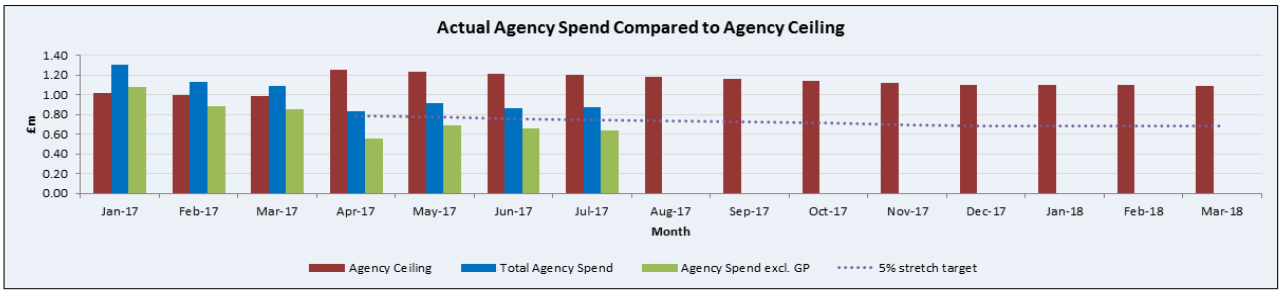
Executive Lead: Helen Mackenzie, Director of Nursing and Governance

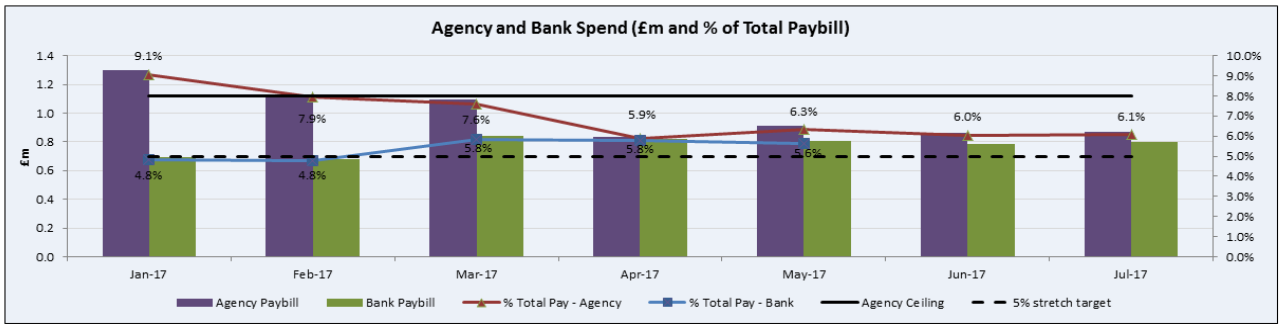
6. Temporary Staffing Programme

Use of agency v NHSP bank staffing and associated issues

- The Trust Board will recall that there was an NHS Improvement cap set for the Trust which was that a maximum of 8% of the total staff pay cost was to be spent on Agency staff during 2017-18. The Trust also had an internal stretch Cost Improvement Programme target of 5%. During April and May 2017, the percentage spent on Agency staff was 5.9% and 6.3% respectively.

- Spend on Agency staff in June 2017 was £861k (down from £911k in May 2017). This was 6% of the total staff pay cost. In July 2017 spend was up slightly at £866k – 6.1% of staff pay costs.
- The monthly spend on NHSP (as a percentage of the total staff pay cost) was 5.5% in June 2017 and 5.6% for July 2017.
- This meant that the monthly combined Agency and Bank usage percentages of the total staff costs so far in 2017-18 are: April 2017 – 11.7% and May 2017 – 11.9%, June 2017 – 11.5%, July 2017 – 11.6%.
- If the primary care GP medical staff (used in WestCall and the Slough Walk in Centre) are removed from the total spend, the percentages would be lower as can be seen in the table below.

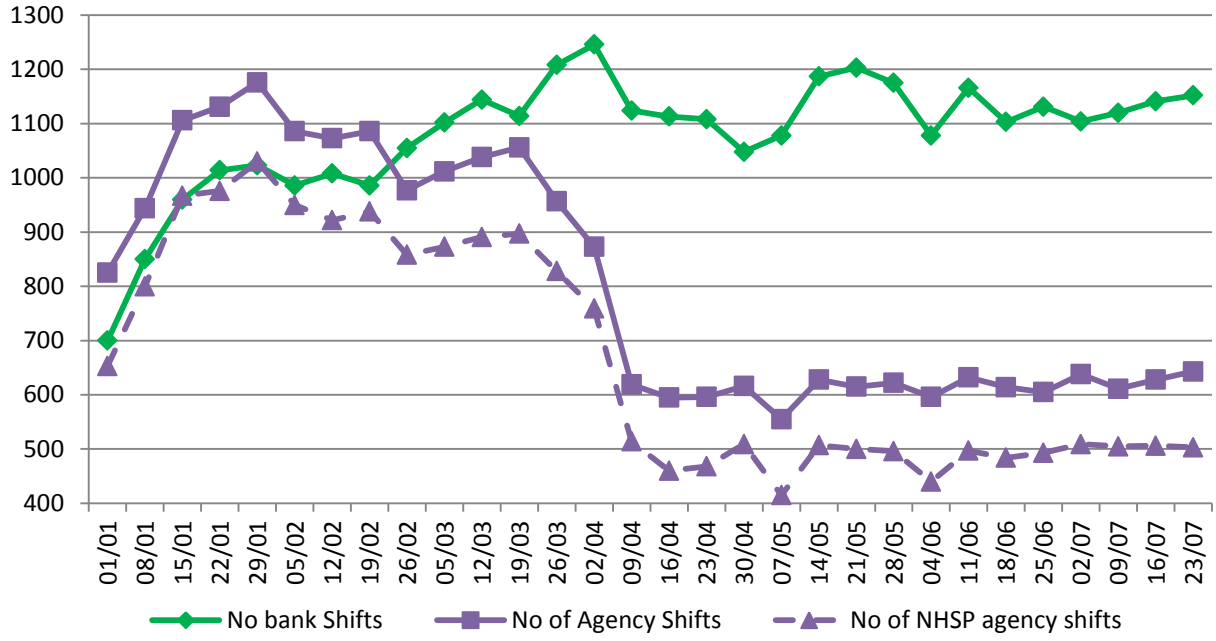




- With the transfer of Slough Walk in Centre to an alternative provider at the end of August 2017, there will be a drop in the level of total spend on agency in reports from September 2017 onwards.
- It should be noted however that in the first four months of 2017-18 there continues to be a significant sustained (albeit stabilising) lower level of spend on agency staff - £3.476m compared to £6.360m in the same timeframe in 2016-17 which is very positive.

Agency and Bank Shift Usage

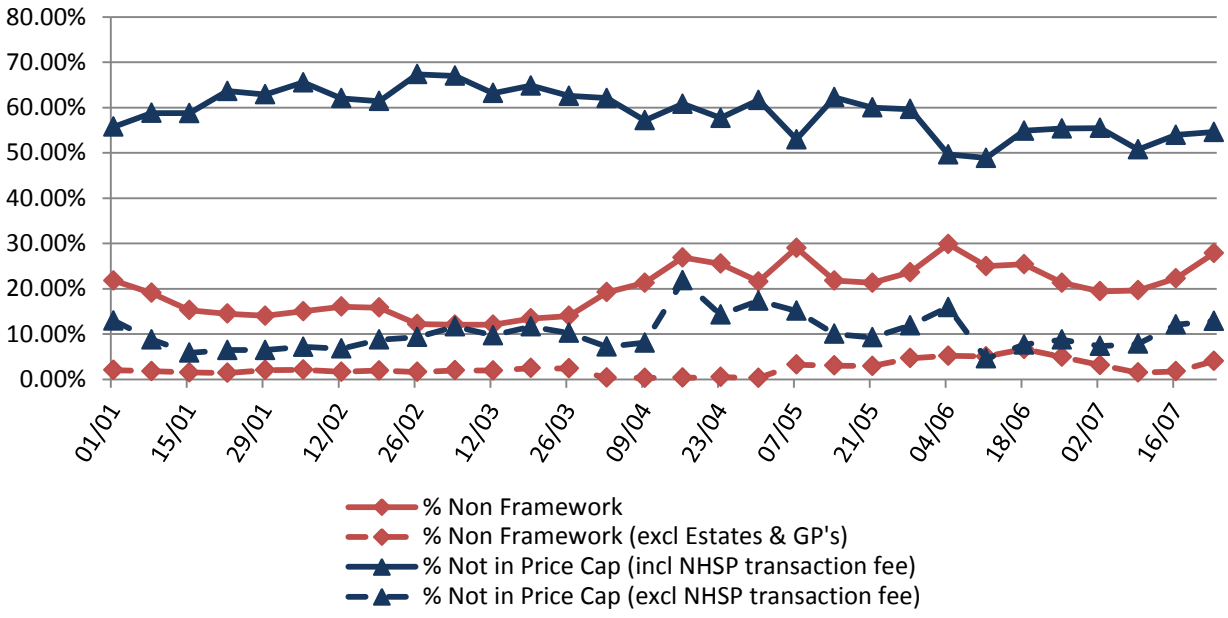
- The number of agency and bank shifts used during 2017 is shown in the table overleaf:



- It can be seen that since June 2017 onwards, the number of shifts being used has been more stable.
- To note, *the number of agency shifts* includes all those booked through NHSP and those which were not (Westcall, Sough Walk in Centre, Mental Health medical staff and a small number of children services staff and nursery nurses).

Framework and Price cap Issues

- As noted previously, NHSP apply a 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, which leads to a significant proportion of shifts breaching the price cap. The latest table (below) covers 2017 to date.



Notes

- % non-framework – total usage of agencies that are used to provide staff, which are not on an accredited framework, across all services.
- % non-framework (excluding Estates and GPs) clinical staff as well as staff used in corporate services such as IT, Finance and Human Resources (excluding estates and GP's) who are not through an accredited framework
- % not in price cap – as mentioned previously, the additional NHSP transaction fee for framework agency staff booked through their platform causes an hourly price cap breach (which otherwise wouldn't have been breached).
- % not in price cap (excluding NHSP transaction fee) – this covers locally agreed personalised rates for staff who are booked directly and not through NHSP, which will include medical and clinical staff.
- The increase in non-framework percentages from April 2017 was due to the decreased (framework) agency fill following the agency Health Care Assistant ban.
- Recent increases in the non-framework percentages are primarily from Westcall and Slough Walk in Centre GP and price cap breaches in Westcall and Slough Walk in Centre GPs and agency community nurses in a number of localities.

Temporary Staffing Contract

- The Board will recall that the Trust is retendering the Temporary Staffing Contract with the Royal Berkshire Hospital NHS Foundation Trust, where it is expected that there will be the benefits of economies of scale, from the provider awarded the tender.
- The current extension to the NHSP Contract for temporary staffing has been further extended until the end February 2018, to allow the retendering process to be completed and the provider awarded the contract introduced.
- The Tendering process is currently live with the submission date of 20th September 2017, following which there will be the formal evaluation of submissions undertaken and system demonstrations held, to which Trust staff will be invited.

Ban on the use of Agency Health Care Assistants (HCA) from the 1st April 2017

- As previously reported, the ban on the use of Agency HCAs was successfully implemented on 1st April 2017. Most former Agency HCAs have now either joined NHSP or work in other Trusts, whilst a small number applied for a substantive post.
- The following is of note from the most recent monitoring report for July 2017 (month 4 since the ban was introduced):
    - The demand for HCA shifts to be filled in July 2017 was 2450 compared to 2627 in June (so a drop of 177 - 7.6%) and the lowest since April 2017. This is related to the significant recruitment (and in some areas over recruitment) across all in-patient services of substantive HCA staff.
    - Mental Health in-patient services had the highest number of HCA unfilled shifts (176 up from 114 in June 2017) which is an increase following several

consecutive months when the number was reducing. Community Health Service (CHS) wards had the second highest number of shifts (124) and this had also increased from 101 in the previous month, however, there was a very low number of safe staffing breaches as a consequence of these unfilled shifts, with reports that staff were redeployed where possible across services to provide support.

- Unfilled shifts as a percentage of demand, increased in Mental Health in-patient services from 7.9% to 11.6%, and CHS also increased from 18.7% to 21.5% after having decreased in the two previous months.
- There was no use of the platinum key in July 2017. (The "platinum key" process is where an Executive Director gives permission to a Locality/Regional Director to contact the NHSP call centre, and request a HCA shift be unlocked to be filled by an agency worker).
- A monthly Datix report using certain key words connected with staffing issues, and after filtering, contained 22 reports related to shortfalls in HCAs.
- The safe staffing conference call on 10th August 2017 for July 2017 did not correlate Datix incidents (such as AWOL's, aggressive incidents or falls) with these Datix staffing incidents.
- There is on-going monitoring of the ban and feedback is given to managers to remind staff about the option to use a shortened Datix form to report staffing issues on.

- Planning is now underway to stop certain categories of agency administration and clerical staff from use over the next three months. Although this will not necessarily deliver great financial savings, it will continue to support the principle of the move towards using less agency staff within the Trust. The Board will be kept updated on the implementation of this plan.

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 Trust Board, there are no new issues to report.
- Work continues in WestCall to establish a GP bank and to get the agreement of the GPs to move onto it, as well as the introduction of Advanced Nurse Practitioner roles into the Service. It is envisaged this may be completed by the end of 2017.

Executive Lead: Helen Mackenzie, Director of Nursing and Governance

7. Expansion of Medical Student Intakes

The Secretary of State for Health has announced an increase of 1,500 medical school places a year from 2018/19.

Health Education England (HEE) and other stakeholders have welcomed this expansion as a key opportunity to expand the medical workforce to meet future needs whilst reducing the reliance on overseas doctors.

The introduction of these medical school places will be phased: 500 in 2018/19 and the remainder thereafter.

Higher Education Funding Council for England (HEFCE) informed medical schools of their allocations on 31 May 2017.

HEE say it is safe to assume most medical schools will be keen to increase their intakes and that applications may total more than the planned additional 1,000.

Executive Lead: Julian Emms, Chief Executive

8. Nursing Associate Trainees

Brief background

In December 2015, the Government announced a plan to create a new nursing support role (following the Shape of Caring Review). 2,000 Nursing Associate Trainees have now begun their two year Foundation Degree courses as part of a national pilot project.

Berkshire Healthcare is the lead employer for the Thames Valley Nursing Associate Partnership which consists of twelve employment partners, four universities and allocated 106 Nursing Associate Trainees.

The education and training model for Nursing Associates is based on the Nursing Associate national curriculum framework for work-based learning, developed by Health Education England in partnership with Skills for Health and Skills for Care. The framework acts as a benchmark for all employers and education providers. Following the completion of their studies, the Nursing Associates will have the breadth of skills and professional competence to support Registered Nurses to deliver high quality care now and in the future.

105 Nursing were recruited and started their course in April 2017 across the Thames Valley. Feedback from the 8 BHFT nursing associates about their work place and their 1 day a week University of West London experience is positive and inspiring.

Some of the challenges have been for staff to understand the role of the Nursing Associate Trainee and the difference from a student nurse. The nursing associate role is likely to be an apprenticeship in the near future and thus it may then be clearer to some managers as to how the link is with the employing unit.

Funded by HEETV, BHFT have developed a social platform for the Thames Valley Nursing Associates based on the SHaRON platform and this was launched in July providing the Nursing Associates from the whole region the ability to share their joint journey. This platform is being led and supported by BHFT.

Thames Valley Nursing Associate Partnership (TVNAP) Board meet monthly driving the joint programme and the curriculum forward ensuring the pilot has the best possible chance of success. Recruitment and retention feedback to the national team is required every quarter and this is collected by BHFT as the lead organisation.

Other feedback is periodically required and again the collection of this is led by BHFT.

Mette Laszkiewicz, Head of Clinical Education leads this work on behalf of BHFT and the Thames Valley system. Mette's contribution has been valued and recognised by the Thames Valley system and Health Education England as without her leadership the programme would falter.

Executive Lead: Helen Mackenzie, Director of Nursing and Governance

9. Sir Andrew Morris, Chief Executive, Frimley Health NHS Foundation Trust to Retire

Sir Andrew Morris will leave Frimley Health Foundation Trust in February, having led the organisation for 29 years. Andrew is one of the longest standing trust leaders in the NHS.

He will continue to run the Frimley Health and Care Accountable Care System (ACS) on a part time basis from 1 April 2018. He currently leads the ACS in addition to his Chief Executive role.

He joined the NHS in 1974 aged 19 and was appointed General Manager of Frimley Park Hospital in February 1989. He was appointed Chief Executive in 1991.

Executive Lead: Julian Emms, Chief Executive

10. Thames Valley Integrated Urgent Care/111 Service

Work has progressed well in preparation for the September 2017 launch of the new integrated 111 service, for which South Central Ambulance Service (SCAS) is the prime contractor and Berkshire Healthcare is a sub-contractor, along with Oxford Health and Buckinghamshire Healthcare.

An overarching collaboration agreement has been signed by all partners within the alliance, setting out the way that we intend to work together. This is supported by a more detailed contract between Berkshire Healthcare and SCAS, which covers the arrangements agreed regarding the role of our Health and Social Care Hub, as well as our Out of Hours Service – both of which are key contributors to the new way of working.

As part of the mobilisation process, work has been undertaken to test IT and telephony, Interoperability, GP assessment of triaged calls, and Direct Booking. This has enabled good progress in preparation for launch at the beginning of September.

The governance arrangements which were established during the initial procurement process have developed in line with the progress of the work, and are working well. They include Executive, Locality Director and Director of Strategic Planning and Business Development/Head of Service representation at the Steering Board and Mobilisation Boards as required. Progress Reports will continue to be provided to our Business and Strategy Executive, and will reflect the next phase of the programme which will focus on development of pathways and processes - moving from transactional process to work on optimal outcomes for patients.

Benefits to local people will build over time, and enable much easier and more straightforward access to the right service, which will improve outcomes and experience of services as well as achieve better use of resources. The pilot testing of GP calls with patients has already achieved really positive outcomes for a number of patients.

This has been a complex programme of work involving multiple partner providers, a collaborative commissioning model led by Berkshire West on behalf of Thames Valley CCGs and a NHS England assurance process. This has been taking place against a background of developing policy (the national Integrated Urgent Care Specification was released at the end of August) and workforce challenges across all providers.

Berkshire Healthcare has been able to make a valuable contribution to the development of the integrated service – which has been led by David Cahill, our Locality Director for Wokingham, with operational and clinical leadership contributions from our community and mental health services as well as our Out of Hours GP Service. There has been significant recognition of our Health and Social Care Hub, and the integrated service model in Wokingham within Berkshire, the region and nationally.

Executive Lead: Bev Searle, Director of Corporate Affairs

Presented by: Julian Emms
Chief Executive
September 2017

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	12 September 2017
Title	Financial Summary Report – Month 4 2017/18
Purpose	To provide the Month 4 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 4 2017/18 (July 2017) financial position.
ACTION REQUIRED	The Board is invited to note the following summary of financial performance and results for Month 4 2017/18 (July 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 2.0 (rating 2) o Liquidity days 8.4 (rating 1) o I&E Margin 0.60% (rating 2) o I&E Variance 0.40% (rating 1) o Agency -29.1% (rating 1)

	YTD income & expenditure (including S&T funding): • Plan: £195k net surplus • Actual: £506k net surplus • Variance: £311k favourable **Month 4: £94k surplus (including S&T funding), -£5k variance from plan:** Key variances: • District Nursing underspend +£182k due to high vacancy levels. • IAPT underspend of +£98k due to the net vacancy position inclusive of non-recurrent investment benefit. • Acute overspill overspend of -£234k, principally due to 32 acute/PICU placements required in month resulting from bed pressures. **Cash:** Month 4: £22.3m (plan £18.6m) The variance to plan is primarily due to: • YTD capital underspend due to re-phasing of Estates and IM&T expenditure +£2.6m • NHS Property charges not yet received +£1.5m **Capital expenditure YTD:** Month 4: £410k (plan £3m) The variance to plan is primarily due to: • Estates, extended timescales regarding ward configuration at PPH (PFI), the majority of the budget is likely to be spent next financial year. • IM&T, re-phasing of IT replacement programme £1.3m The variances are due to timing of spend rather than a reduction in the overall requirement.

Berkshire Healthcare NHS
NHS Foundation Trust

Board Finance Report

Financial Year 2017 / 18

Month 4 (31st July 2017)

Purpose

This document provides the Board with information giving the financial performance as at 31st July 2017 (Month 4).

Document Control

Version	Date	Author	Comments
1.0	14.08.2017	Donna O'Leary	Draft
2.0	22.08.2017	Tom Stacey	Review & 2nd Draft
3.0	22.08.2017	Tom Stacey	Alex Gild Review
4.0	23.08.2017	Tom Stacey	Alex Gild final for Executive Committee
5.0	05.09.2017	Alex Gild	Board report

Distribution:

All Directors

All staff needing to see this report.

Contents

1.0 Overview

The Trust reports a surplus of £94k in month 4, slightly worse than budget of £98k surplus, by -£5k. The Trust's underlying position in month 4, after removing S&T funding, is a deficit of -£22k.

The YTD surplus is £506k, better than budget of £195k surplus, by £311k. The Trust's underlying surplus YTD, after removing S&T funding, is £131k.

The Trust has £22.3m cash at the end of month 4. This is higher than the plan of £18.6m by £3.7m, and is largely due to timing of expenditure on the capital programme (£2.6m).

The overarching NHSi Use of Resources rating is maintained as a "1" for the Trust in line with plan, the lowest financial risk rating possible.

Key messages this month are:-

- Increased Independent Hospital specialist OAPs in month of -£108k adverse to budget, representing 6 patients over budget.
- On-going high acute overspill OAPs costs - £234k over budget.
- On-going work on the Recurrent Cost Improvement (RCI) programme with full year recurrently identified £1.5m of £4.7m target; although, the Trust is meeting its RCI target through vacancy benefit, whilst recurrent savings are identified.
- Forecast achievement of control total surplus of £2.4m, subject to containing expenditure risks on OAPs

2.0 Income & Expenditure Summary – Month 4 17/18

Description	Current Month Budget (£'000)	Current Month Actual (£'000)	Current Month Variance (£'000)	Year to Date Budget (£'000)	Year to Date Actual (£'000)	Year to Date Variance (£'000)
Operating Income	**20,681**	**20,651**	**(31)**	**82,211**	**82,541**	**331**
Operating Expenditure						
Pay	(14,702)	(14,626)	77	(58,500)	(57,444)	1,057
Non Pay	(4,960)	(5,096)	(136)	(19,884)	(21,210)	(1,325)
Total Operating Expenditure	**(19,662)**	**(19,721)**	**(59)**	**(78,384)**	**(78,653)**	**(269)**
EBITDA	**1,019**	**929**	**(90)**	**3,826**	**3,888**	**62**
Non-Operating Income/Expenditure						
Interest Receivable	3	3	(0)	13	11	(2)
Interest Payable	(299)	(299)	(0)	(1,197)	(1,197)	(0)
Depreciation & Amortisation	(523)	(438)	85	(2,043)	(1,791)	252
PDC Dividend	(101)	(101)	0	(405)	(405)	0
Total non-operating income/expenditure	**(921)**	**(836)**	**85**	**(3,631)**	**(3,382)**	**249**
Net Surplus/(Deficit)	**98**	**94**	**(5)**	**195**	**506**	**311**
Net Surplus/(Deficit) excl. S&T Funding	**(17)**	**(22)**	**(5)**	**(181)**	**131**	**311**
RCIs Achievement	**392**	**87**	**(305)**	**1,567**	**220**	**(1,346)**

In Month 4 (July 2017)

The Trust reports a month 4 surplus of £94k against a budgeted surplus of £98k, resulting in an adverse variance of -£5k.

Removing S&T funding of £115k, the Trust has an underlying deficit of -£22k in month 4.

Income is under achieved by -£31k with the main variances being:

- £80k Slough Walk-In Centre prior year over delivery of activity funding.
- £71k over plan achievement of MH Non Contracted Activity.
- -£282k reclassification of YTD income risk provision

Pay is underspent by £77k with the main reasons being:-

- £182k District Nursing - high vacancy levels.
- £75k Liaison & Diversion - net vacancies inclusive of investment slippage.
- £71k CMHT - vacancy levels.
- £98k IAPT - net vacancies inclusive of investment slippage.
- £64k Health Visiting – vacancy levels.
- -£333k reclassification of YTD restructuring provision from non-pay
- -£65k Westcall – GP annual leave cover.
- -£54k CRHTT - including over establishment costs to cover increased workload, sickness and vacancies.

- -£121k unallocated RCIs for operational management and unallocated / STP RCI schemes within pay. To note, unachieved corporate back office and operational establishment review savings are within those directorates / services, covered non-recurrently through vacancy benefit.

Non Pay is overspent by -£136k with the main reasons being:-

- -£234k acute overspill OAPs - principally due to 32 acute/PICU placements (-£258k) required in month resulting from bed pressures and 1 placement not suitable for PPH (-£19k). These costs are against a budget of £43k. Pressure of -£60k following the closure of 5 beds on Bluebell ward.
- -£108k Independent Hospital specialist OAPs, with placements reaching 5 higher than at the start of this financial year to date (and 6 patients over budget overall, having started 1 patient over).
- -£82k unallocated RCI targets including Estates, OAPs and procurement.
- +£615k – reclassification of YTD restructuring and income risk provisions to pay and income categories above.

Non-operating expenditure is underspent by £85k due to lower depreciation expense re delayed timing of IT replacement costs from FY16/17, moving beyond Q2 FY17/18, due to later than expected order timing in year.

Year to date Month 4

Income is over achieved by £331k with the main reason being:-

- £253k - additional investment in CAMHS (£100k) for Early intervention and Foster care services and prior year income that was not expected to be recovered, also for CAMHs of £153k.
- The Trust has assessed deferred income and other risk provisions within the overall net income position.

Pay is underspent by £1,057k with the main reasons being:-

- £669k District Nursing - mainly due to vacancies
- £337k IAPT - mainly vacancies, including expansion funding
- £230k Liaison & Diversion - vacancies and investment phasing
- £197k CMHT - mainly due to vacancies
- £162k Intermediate Care - vacancies and demand variation
- £154k Health Visiting - mainly due to vacancies
- £133k Learning Disabilities - mainly due to non-recurrent inpatient service vacancy benefit whilst a new intensive community service is established
- -£197k Westcall - including bank holiday cover and summer holiday cover.
- -£192k CRHTT - including over establishment costs to cover increased workload, sickness and vacancies.
- -£154k Medical Staffing - partly highlighted in this month due to split of medical secretaries back to localities (which had been underspent) the medical staffing has had various locum cover in place.
- -£483k unallocated RCI for operational management and unidentified / STP RCI schemes within pay.

Non Pay is overspent by -£1,325k with the main reasons being:-

- -£892k acute overspill OAPs - total of 87 acute/PICU placements year to date (-£960k), 7 placements not suitable for Prospect Park at (-£104k), against a budget of £172k.
- -£348k unallocated RCI including Estates, OAPs and procurement.
- -£165k Independent Hospital specialist OAPs, with placements reaching 5 higher than at the start of this financial year to date (and 6 patients over budget overall, having started 1 patient over).

Non-operating expenditure is underspent by £249k due to lower depreciation from lower IT replacement costs re timing of commitments moving to the second half of FY17/18.

Recurrent Cost Improvements (RCIs)

Scheme	Plan Month £k	Month £k	Var month £k	Plan YTD £k	YTD £k	Var YTD £k	Full Year £k	Identified £k	Var Full Year £k
Operational Vacancy	96	31	-65	383	124	-259	1,150	802	-348
Corporate Back Office	83	45	-38	333	77	-256	1,000	617	-383
Operational Mgmt. & Spprt	50		-50	200		-200	600		-600
Procurement	25	10	-15	100	19	-81	300	126	-174
Discretionary Spend	8		-8	33		-33	100		-100
Estates Strategy	17		-17	67		-67	200		-200
OAPs	42		-42	167		-167	500		-500
Unallocated / Possible STP	71		-71	283		-283	850		-850
Total	**392**	**87**	**-305**	**1,567**	**220**	**-1,346**	**4,700**	**1,545**	**-3,155**

£87k RCI has been recurrently secured in month 4, bringing the YTD to £220k. However, the Trust is offsetting its recurrent RCI challenge with underlying vacancy factor.

For the full year £1,545k has been either identified or released from budgets:-

- £880k has had an opportunity identified subject to review and Quality Impact Assessment (QIA) and a further
- £632k released from budgets
- with a further £33k being a FYE of some of the already released items.

Forecast & Risks

The early indications are that the Trust will meet its control total of £2.4m surplus in this financial year. The key risks are RCI target achievement, acute overspill OAPs (c. -£2.7m using recent trends) and maintaining the current significant reduction in agency costs; however, these forecast risks are largely offset by vacancies across a number of service lines.

A new risk emerging this month is the increase in costs (run rate) in Independent Hospital specialist OAPs at £108k. This is on the basis of 6 patients higher than budget YTD, having started the year on 1 patient higher than budget.

3.0 NHSi Use of Resources Metric and Summary

The use of resources metric is maintained at a "1"

Use of Resource Metric	YTD Plan		YTD Actual	
Metric	**Metrics**	**Rating**	**Metrics**	**Rating**
Capital Service Cover (times)	2.0	2	2.0	2
Liquidity (days)	1.3	1	8.4	1
I&E Margin (%)	0.3%	2	0.6%	2
I&E Variance From Plan (%)	-	-	0.4%	1
Agency (% above / below target)	0.0%	1	-29.1%	1
Use Of Resources Rating		1		1

The overall Trust surplus position and performance better than plan are key sensitivities to maintaining a "1" rating in the above table.

Agency

Agency costs were £869k in month 4 and £3,476k YTD. This is below the NHSi set ceiling of 8% or £4,904k YTD; by -29.1%.

Work on reducing agency spend, reducing agency spend rates and converting agency staff to bank staff or staff in post is the reason for this favourable result to the ceiling. The first four months has shown a significant reduction in spend (£3.476m) when compared with the same period in 16/17 (£6.360m). However, due to demand pressure and vacancies within the District Nursing services spend on nursing agency is anticipated to rise over the coming months.

Please see Annex Agency graphs which shows the trend of performance in this area.

Risk to Metric rating

The continued cost pressure in acute overspill OAPs is a significant risk to the Trust's financial plan in this year.

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

4.0 Balance Sheet Summary

STATEMENT OF FINANCIAL POSITION	31st March 2018 (Plan) £'000's	31st Jul 2017 (Actual at Date) £000s	31st March 2017 (Final last year) £000s
Non Current Assets (Intangible, Property, Plant and equipment)	89,725	87,196	88,483
Inventory	109	116	113
Current receivables (Trade and Other Debtors)	10,194	9,461	11,977
Cash	19,468	22,286	20,698
Current Payables (Trade and Other Creditors)	(25,914)	(22,969)	(26,049)
Other Liabilities (Deferred Income)	(1,469)	(2,119)	(2,012)
Provisions (Current & Non Current)	(1,612)	(2,670)	(2,098)
PFI Finance Lease Creditor (Current & Non Current)	(30,753)	(31,386)	(31,704)
Total Net Asset / (Liabilities)	**59,749**	**59,915**	**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	14,463	13,955
Financed by Reserves	**59,749**	**59,915**	**59,408**

Cash

The closing cash balance for July 2017 was **£22.3m**, against a plan of £18.6m, resulting in a favourable variance of £3.7m. The main reasons for the increased cash balance was slippage against the capital expenditure programme (£2.6m), and invoices from NHS Property Services for rental and services charges totalling £1.5m, not yet received.

Trade Receivables

The overall debtors balance has increased by £0.2m in July to **£3.9m**.

The main reason for the increase in Month 4 is due to invoices with the CCG's regarding IAPT expansion.

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

Trade Payables

Trade Payables decreased by £0.9m to **£4.2m**, there are currently no individual items of a significant value.

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

5.0 Capital Programme

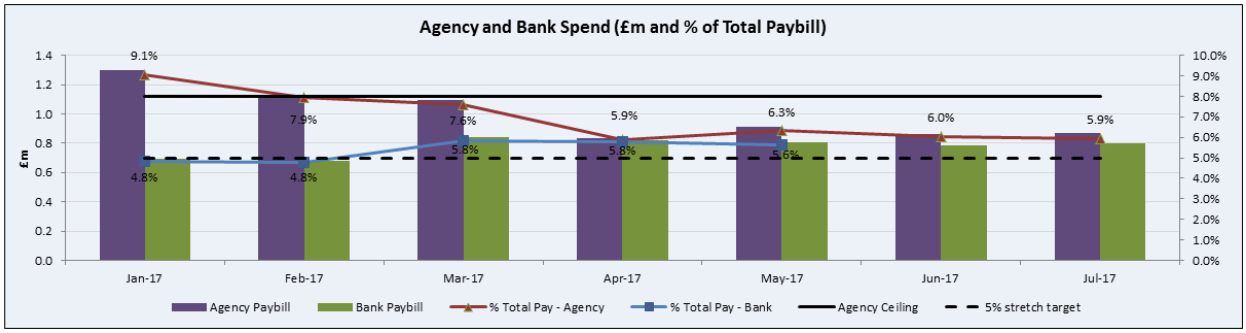
CAPITAL EXPENDITURE	Current Month			Year to Date			Forecast Out turn		
	Bud	Act	Var.	Bud	Act	Var.	Bud	Act	Var.
	(£'000)			(£'000)			(£'000)		
Maintenance & Replacement									
Trust Owned Properties	32	(1)	33	39	(8)	47	120	609	(489)
Leased Non Commercial (NHSPS)	8	11	(3)	123	18	105	540	621	(81)
Leased Commercial	21	3	18	30	5	25	82	113	(31)
Statutory Compliance	0	0	0	225	(1)	226	640	638	2
Locality Consolidations	65	(4)	69	263	14	249	820	1,290	(470)
PFI	117	1	116	796	54	742	2,223	1,082	1,141
Subtotal	**242**	**10**	**231**	**1,476**	**82**	**1,394**	**4,425**	**4,353**	**72**
Development Expenditure									
IM&T Refresh & Replacement	0	0	0	858	10	848	2,076	2,076	0
IM&T Business Intelli. & Reporting	25	16	9	95	15	80	378	378	0
IM&T System & Network Developments	50	0	50	312	0	312	795	60	735
IM&T RiO	0	24	(24)	245	93	152	447	447	0
IM&T Other	0	22	(22)	5	77	(72)	151	151	0
IM&T Locality Schemes	16	1	15	66	56	10	200	200	0
IM&T GDE	0	0	0	0	73	(73)	0	744	(744)
Other Locality Schemes	0	0	0	0	4	(4)	100	100	0
Subtotal	**91**	**62**	**29**	**1,581**	**328**	**1,253**	**4,147**	**4,156**	**(9)**
Total	**333**	**73**	**260**	**3,057**	**410**	**2,647**	**8,572**	**8,509**	**63**
Renal Unit at WBCH - Capital spend	0	73	(73)	0	94	(94)	0	1,260	(1,260)
Renal Unit at WBCH - Revenue spend	0	0	0	0	21	(21)	0	21	(21)
Sub Total Renal Unit WBCH	**0**	**73**	**(73)**	**0**	**115**	**(115)**	**0**	**1,281**	**(1,281)**

The Trust is reporting against a capital expenditure plan of £8.5m in line with the operating plan to NHSi. In July 2017, the total monthly capital spend was under budget by £0.3m, and the under spend for the year to date is £2.6m.

Estates projects were under spent by £0.2m in month, mainly due to the internal move of the Learning Disability (LD) inpatient service from Campion to Jasmine Ward phasing to next year and the delayed timing of building works commencing on Sorrel Ward. It is anticipated that only £0.1m of the total £1.35m LD project will be spent this year, with most of the spend moving into next year. This is offset in the plan by the relocation of Reading CAMHs and other clinical services to the University of Reading site, now expected to cost £0.48m more than in the plan.

The IM&T schemes are £1.3m under spent for the year to date due mainly to IT replacement activities expected to be committed in the second half of the year.

Annex – Agency Chart



The run rate for agency costs continues to be downwards.

Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

Board Summary Performance Report

M4: 2017/18 July 2017

Performance Scorecard Summary: Month 4: 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.

Performance Scorecard Summary: Month 4: 2017/18

Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

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; M4 July 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.

Performance Scorecard Summary: Month 4: 2017/18

Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

Exception report

Summary of Red Exceptions M4: 2017/18			
Indicator	**Indicator No**	**Comments**	**Section**
Self-Harm incidents	US 05	Decreased from 191 to 164	User Safety
AWOLS	US 06	Increased from 27 to 32	User Safety
Staff Turnover	PM 01	Increased from 17.2% to 17.7%	People Management
Gross Vacancies	PM 02	Increased from 12.4% to 13.3%	People Management
Sickness	PM 03	Increased from 3.36% to 3.52%	People Management
CHS Average Length of Stay	SE 02	Increased from 28 to 30 days	Service Efficiency
MH Acute Length of Stay	SE 03	Increased from 37 to 41 days	Service Efficiency
MH Average Length of Stay Snapshot	SE 03a	Increased from 46 to 50 days	Service Efficiency
Readmission Rate	SE 04	Increased from 8.7% to 9.4%	Service Efficiency
MH Acute Occupancy Rate by Locality and Ward	SE 06 a & b	Decreased from 97% to 96%	Service Efficiency
Health Visiting: New Birth Visits within 14 days	SE 08	Decreased from 96% to 94.57%	Service Efficiency
Clustering	SE 10	Increased from 87% to 88%	Service Efficiency

User Safety Commentary

There were 3 serious incidents in July 2017. These included an unexpected death of a Slough CMHT client, 1 pressure ulcer reported by Reading Community Nursing and an Information Governance breach by the Diabetic Eye screening Service.

The number of assaults on staff decreased to 57 in the rolling quarter to July 2017 and is now rated green against a local target. In the rolling quarter 11 incidents were reported on Sorrel ward (17 last month), 18 on Daisy ward (21 last month), 2 incidents on Bluebell ward (4 last month), 5 on Snowdrop ward (1 last month) and 6 on Rowan ward (5 last month), 7 incidents were reported on Rose ward (3 last month), 1 on Orchid ward and 1 at the Place of Safety. In addition 2 incidents occurred at Royal Berkshire Hospital were reported by Adult Acute Admissions and 1 on hospital grounds. 2 incidents were reported at the Willow House (3 last month) previously known as the Berkshire Adolescent Unit. One incident was reported by the CAMHS service at Fir Tree House, where a patient kicked a Consultant Psychiatrist during an outpatient appointment. All incidents in July were rated as low or minor risk except for one incident on Snowdrop ward which has was initially rated as moderate risk but will be re-graded to low risk. This shows a decreasing trend.

For Learning Disabilities there was a decrease in the number of assaults on staff from 30 in the rolling quarter to June 2017 to 13 in the rolling quarter to in July 2017. All incidents in July 2017 were rated as low or minor risk. This shows a decreasing trend.

Patient to Patient Assaults - In Mental Health services this has increased to 40 in the rolling quarter to July 2017 and is now rated as amber against a local target. Six incidents took place on Sorrel ward (7 last month), 5 on Rowan ward (same as last month) and 10 on Daisy Ward (5 last month), 2 on Rose ward (1 last month) and 4 each on Snowdrop ward (3 last month) and Bluebell ward (2 last month). In addition 1 incident was reported in the car park and 1 in the Hospital Grounds. Three incidents were reported at Willow House. In the Community, 1 moderate incident was reported by Criminal Justice Liaison and Diversion service, and 2 by Reading CMHT and 1 by Reading Older Persons services. A total of 35 clients carried out assaults on other patients including 3 patients who carried out more than one assault. All incidents are rated as low or minor risk. This shows a decreasing trend.

Learning Disability - Patient to Patient Assaults decreased to 17 (previously 20) in the rolling quarter to July 2017. All incidents were rated as low or minor risk and the assaults were carried out by 8 clients including 1 client responsible for 4 incidents and another two with 2 each.

Slips Trips and falls – In July 2017 Rowan ward (3 falls) was above target. Two falls have been rated as moderate; 1 on Oakwood where a patient was found to have sustained a fracture and 1 on Orchid ward where the patient was taken to A&E. All other falls are rated as low or minor risk.

Self-Harm – The number of patients detained under a mental health section has increased by 40% which has resulted in an increase in self-harm. These have decreased to 164 in the rolling quarter to July 2017, but remains red rated. In the rolling quarter, 21 incidents (decreased from 57 incidents last month) have been reported by Willow House by 7 clients. One client was responsible for 11 incidents and another for 4. All of the incidents reported in July 2017 at the Willow House were rated as low or minor risk. There were a total of 126 incidents reported in the rolling quarter to July 2017 by Mental Health Inpatients; an increase from 114 from the preceding month. Of these, 2 incidents were reported on Rose ward (3 last month), 54 incidents on Bluebell ward (decreased from 60), 22 on Snowdrop ward (increased from 21) and 36 on Daisy ward (23 last month). There were also incidents reported as follows: 1 in Royal Berkshire Hospital, 7 at home after client had been given home leave as part of their discharge plan, 1 each at Prospect Park Hospital and Place of Safety and 2 at 'other' location. 25 inpatients self-harmed during the rolling quarter with one

client responsible for 28 incidents, another with 26 incidents and another with 21 incidents. In the Community in the rolling quarter the incidents reported were as follows; one incident was reported by the Criminal Justice Liaison and Diversion service, 1 incident was reported by CAMHS, 11 incidents reported by the Crisis team, 2 incidents each for Perinatal services and Slough CMHT, 1 incident each for WAM and Bracknell CMHTs and West Berkshire Older Persons Mental Health services. All self-harm incidents for mental health services in July 2017 were rated as low or minor risk with the exception of one moderate incident on Bluebell ward where a service user required sutures to a wound. Self- Harm will be part of the Quality Improvement initiative by Rose ward, Willow ward, Bluebell ward, and Snowdrop ward.

Learning Disability Self Harm – increased to 7 in the rolling quarter to July 2017 with one client was responsible for 5 of the incidents. Three low risk incidents were reported in July 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. Both AWOLS (27 to 32) and Absconsions (15 to 19) increased in the rolling quarter to July 2017. In July 2017, there were 9 AWOLs reported; 3 each from Snowdrop ward and Daisy ward and 2 from Rose ward and 1 from an unknown location. All incidents were rated as low or minor risk. In July 2017, there were 12 absconsions, 3 each from Snowdrop ward and Daisy ward, 2 from Rose ward, and 1 from an unknown location. All were rated as low risk. AWOLs show an increasing trend and Absconsions shows a decreasing trend. New fencing is being erected week commencing 14th August 2017 at Prospect Park Hospital to remove ligatures risk and mitigate Absconsions.

PMVA (Control and Restraint of Mental Health patients) in July 2017, there were 32 uses on 26 clients including 6 uses on 1 client and 3 uses on another. There were 6 uses on Daisy ward, 7 on Snowdrop ward, 5 on Bluebell ward, 3 each on Rose and Sorrel wards, 3 on Bluebell ward, 2 on Orchid ward and 1 at Prospect Park Hospital (but no ward has been specified). All incidents were rated as low or minor risk. For PMVA :

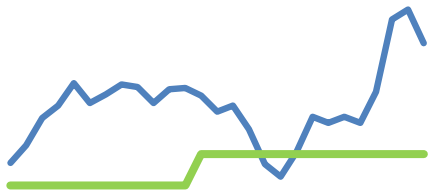
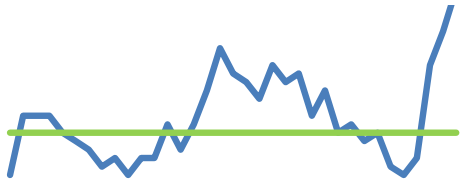
- A new reporting system has been implemented so that there is a clearer understanding of incidents that occur. This information will feed into patient risk management plans
- A new training system which focuses on supine restraint for seclusion exit and sedation
- Post incident review meetings will be held on each ward

Work will begin on Sorrel ward in September 2017 recognising that they have the most challenging patients and then be rolled out to the other acute wards.

There were 9 incidents of prone restraint in July 2017 on 6 clients, including 1 client with 2 uses; there were 3 for Sorrel ward, 2 for Bluebell ward and 1 each for Daisy, Rose and Snowdrop ward and 1 at Prospect Park Hospital. 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 submitted to the August 2017 Quality Assurance Committee. The trend for use of prone restraint is downwards, when measured over a 3 year period.

Seclusion: There were 9 uses of seclusion for 5 patients in July 2017. The longest episode of seclusion was for 13 hours and 50 minutes. There were no uses in Learning Disability Services.

User Safety Exception Report Month 4: 2017/18

KPI	Target	July	Trend	Context/Reasons	Commentary of Trend
Self-Harm incidents	<75	164		**Increase in Self-Harm driven by an increase in reported incidents on Bluebell ward, Daisy ward and Snowdrop ward in the rolling quarter. This is however a reduction on the previous month reflecting the reduction at Willow House.**	
AWOLs on MHA section	<15	32		**Increase in AWOLS driven by an increase in reported AWOLS on Bluebell ward.**	

Other Key Performance Highlights for this Section

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

- Mental Health Physical Patient to Patient Assaults from 27 in the rolling quarter to June 2017 to 40 in the rolling quarter to July 2017.
- Learning Disability Self-Harm increased from 4 incidents in the rolling quarter to June 2017 to 7 in the rolling quarter to July 2017.
- Mental Health AWOLs increased from 27 in the rolling quarter to June 2017 to 32 in the rolling quarter to July 2017.
- Mental Health Absconsions increased from 15 in the rolling quarter to June 2017 to 19 in the rolling quarter to July 2017.
- Use of Preventing and Managing Violence and Aggression increased from 21 in the rolling quarter in June 2017 to 32 in the rolling quarter in July 2017.

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

- Mental Health Physical Assaults on Staff improved from 60 in the rolling quarter to June 2017 to 57 in the rolling quarter to July 2017.
- Learning Disability: Physical patient to patient assaults from 20 in the rolling quarter to June 2017 to 17 in the rolling quarter to July 2017. Mental Health Self-Harm reduced from 191 incidents in the rolling quarter to June 2017 to 164 incidents in the rolling quarter to July 2017.
- Seclusion reduced from 12 uses in June 2017 to 9 uses in July 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, 3 are red (Staff turnover, Gross Vacancies and sickness), 2 are amber (Fire and Information Governance), 4 are green including (Statutory training: Manual Handling and Health and Safety, and PDP).

Sickness Absence

• The final Trust-wide monthly sickness rate for July is 3.53%. The final sickness rate for June (following the data transfer from HealthRoster to ESR) was 3.38%, which was consistent with the final rate in May and represents the third consecutive month that the final sickness rate has been below the Trust target of 3.5%.

• The final sickness data for June shows continued downward trends in both the short-term and long-term sickness rates, with decreases in the monthly rates (short-term to 0.86% and long-term to 1.94%). Some localities have identified particular services where the long-term sickness rate is increasing, and the HR Managers will be working with their locality sickness leads to ensure that individual cases are being effectively managed in these areas.

• The final data for July indicates that the overall improvement seen in the sickness rate attributed to anxiety/stress/depression has been sustained for a further month (at 0.78%). The overall sickness rate attributed to musculoskeletal/back problems in July has remained consistent with the previous month at 0.85%. The long-term sickness absence rate for this reason has increased slightly to 0.52% (against an average of 0.41% over the previous six months) and therefore this will be an area of focus for the HR Managers and locality sickness leads over the next month. The number of new episodes of musculoskeletal absence in July has returned to average levels, following a significant increase in June.

• Specific initiatives that have been piloted in previous months are now being extended due to the positive feedback received from managers and individual staff members. For example, the individual Health and Wellbeing plans are being rolled out across other localities, and the ten minute briefing sessions for managers are being expanded to include more topic areas. As these initiatives are implemented more widely, any identified quantifiable impact on the sickness rate will be highlighted.

Recruitment

• Further recruitment events are scheduled for September for the remaining Band 2 vacancies at Prospect Park and an action plan is being developed to ensure that the Trust is able to attract Band 5 nurses on an on-going basis.

• The RCN conference hosted by the Trust in June has now resulted in six offers of employment.

• Action planning is underway following a Community Nursing Workshop, with a view to addressing the challenges faced in attracting and retaining community nurses,

including the development of a cohesive plan for recruitment drives and job fairs.

• Some focused work has taken place in Children's Services, including reviewing adverts and job descriptions to attract candidates to nursing vacancies. As a consequence, applications from some strong candidates have been received for forthcoming Band 6 interviews.

Turnover

• The Trust-wide turnover rate in July has increased further to 17.65% (June was 17.24%). The turnover rate in Oxford Health (May 2017) was 19.22%.

• Some localities are undertaking a detailed analysis of turnover (including feedback from exit data and other management intelligence information) with a view to monitoring trends and developing action plans. In some areas this analysis is part of the NHSI Retention Support Programme.

• The effectiveness of the career advice clinics at Prospect Park is currently being reviewed, following a three month extension of the pilot. Some initial feedback from the review indicates that the clinics resulted in the retention of three staff.

Statutory and Mandatory Training

Statutory Training – Fire Training - has increased to 92% with Mental Health Inpatients and Bracknell locality at target. Weekly reports are still being sent to Locality Directors and for Corporate staff reports on non-compliance have been sent to the relevant Heads of Service.

Mandatory Training - Information Governance (85%) has remained below target for compliance. For Information Governance, the reporting has changed to reflect the requirement for annual "refresher" training for all staff. Again weekly reports are being sent to Locality Directors and for Corporate staff reports on non-compliance have been sent to the relevant Director/Heads of Service. Within the IG Toolkit we achieved 96%, as the metric was updated by HSCIC to include everyone who had completed the training between 1st April 2015 and 31st March 2017 based on our current staff list. The PAF indicator is staff who have been trained or refreshed within the last 12 months, which places us at 87%.

PDP - Target for June 2017 has been achieved.

People Exception Report Month 4: 2017/18

KPI	Target	July	Trend	Context/Reasons	Commentary of Trend
Staff Turnover (% YTD): Percent	**<15.2%**	**17.77%**		**Increase in turnover target from September 2016. This remains a challenging stretch target for the Trust.**	**This includes end of fixed term contracts, retirements as well as voluntary resignations.**
Gross vacancies (% WTE) : Percent	**<10%**	**13.30%**		**This figure includes areas where there has been difficulty recruiting such as CHS inpatients and nursing, LD and MH inpatients, Children 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. 6 Nurses recruited during a recent RCN conference in Reading.**

KPI	Target	July	Trend	Context/Reasons	Commentary of Trend
Sickness	**<3.5%**	**3.53%**		**The short-term sickness has increased to 0.90%, and the long-term sickness to 2.03%**	**First increase in 4 months. HR managers working with services where long-term sickness is increasing.**

Other Key Performance Highlights for this Section

- Staff Turnover has worsened from 17.2% in June 2017 to 17.77% in July 2017.
- Information Governance training has worsened to 86%.

NHS Improvement Non-Financial and Financial Commentary

NHS Improvement are consulting on proposed metrics for the 2017/18 Single Oversight Framework, the consultation opened on 8th August 2017.

The proposed changes would include the removal of:

- CRHTT Gatekeeping
- MHSDS identifiers and priorities metrics

The proposal introduces the following metrics:

- Introduction of the Data Quality Maturity Index (MHSDS dataset score), this will cover the following (published scores for Quarter 4 2016/17 are):
    - Ethnic Category (100%)
    - GMC practice code (patient registration) (99.9%)
    - NHS Number (98%)
    - Organisation code (code of commissioner) (99.9%)
    - Person stated gender code (100%)
    - Postcode of usual address (99.9%)

The Trust was given an overall score of 86.6 which was published by NHS Digital in August 2017. This was lower than Oxford Health at 96.8 and Surrey Borders at 93.0. No thresholds for Performance have been published yet.

- Inappropriate out of area placements - Total number of bed days patients have spent out of area in the preceding quarter. The latest published data on NHS digital shows that the quarter ending March 2017 - 469 beds days were used by patients sent out of area. The guidance on NHS Digital advises of the need to "eliminate the practice of inappropriately sending patients out of area to receive acute inpatient care". In the directions letter, published on the same website, states that "An inappropriate out of area placement is defined as a situation in which a person with assessed acute mental health needs, who requires adult mental health acute inpatient care, is admitted to a unit that does not form part of the usual network of services (an inpatient unit that does not usually admit people living in the catchment of the persons local community mental health service), and where a person cannot be visited regularly by their care co-ordinator).
- Proportion of people completing treatment who move to recovery (from IAPT minimum dataset).

In addition there is a proposal to include Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI).

The Single Oversight Framework will continue to include an annual rating on the Cardio Metabolic CQUIN which is designed to reduce premature mortality rates amongst people with severe mental illness. The Trust rates for Q4 2016/17 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

The consultation closes on 18th September 2017.

For July 2017 the NHSi Use of Resources score is 1 for both year to date and forecast, the lowest possible financial risk rating. The Trust retains its position in Segment 1; acquiring the highest level of provider autonomy with no oversight or regulatory concerns from NHSi.

Service Efficiency And Effectiveness Commentary

There are 13 indicators within this category, 4 are rated as "Green" including DNA rates, Mental Health Non-Acute Occupancy, Crisis plans and New Birth Visits. None are rated as "Amber", 8 are rated "Red", MH Average and Snapshot Length of Stay, CHS Length of Stay and CHS Occupancy, Mental Health Acute occupancy by ward and by locality, New Birth Visits and Clustering 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 decreased from 4.98% in June 2017 to 4.90% in July 2017 and is rated as green. Bracknell at 5.62%, WAM 5.64% and West Berkshire at 5.05% are rated amber. This indicator shows a decreasing trend.

In CPE, the DNA rate decreased from 12.11% in June 2017 to 9.38% (80/853) in July 2017.

In Children and Families services the DNA rates, there were increases in West Berkshire 9.44% (last month 9.41%), Wokingham 9.44% (last month 9.41%), Reading 9.54% (last month 9.19%), Bracknell 7.89% (last month 7.39%), but a decrease in Slough 3.93% (last month 4.31%). CAMHS services DNA rates showed an increase to 10.04% in July 2017 (last month 8.06%).

For Mental Health, there has been some worsening with; Slough 11.10% (last month 7.92%), Bracknell 8.03% (last month 7.67%) and Reading 9.07% (last month 8.53%) and Wokingham 4.04% (last month 3.96%). WAM improved to 2.82% (last month 4.88%), and West Berkshire 6.96% (last month 7.03%) improved. 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 July 2017, 19,950 text messages were sent.

CHS Inpatient Average Length of Stay increased to 30 days and is above target, with West Berkshire at 39 days and WAM at 30 days above target. Delayed transfers have an adverse impact on length of stay. By ward there has been some improvements in West Berkshire (9.5%) and Slough 13.5%, but Reading 22.5%, Wokingham at 14.6% and Windsor and Maidenhead at 13.6% all worsened. A total of 62 patients' discharges were delayed in July 2017, 27 of these are the responsibility of the NHS, 18 to social care and 16 to joint health and social care. The most common reason for a delay was awaiting care package in own home (a total of 10 was the NHS responsibility, 10 joint responsibility health and social care and 6 social care). 15 are awaiting a care home placement (8 the responsibility of social care, 3 NHS and 4 both). A workshop will take place between Informatics and Inpatient areas to help ensure consistent reporting going forward, as there have been challenges from the Unitary Authorities.

This workshop will be crucial as there in an NHS Mandate to reduce delays to 3.5% from September 2017, though different CCG areas have different targets in Berkshire. The calculation will be based on occupied bed days blocked by delays per 100,000 population.

CHS Occupancy increased to 86% and is green rated.

Mental Health Acute Occupancy excluding home leave reduced to 96% in July 2017. There has been an increase noted in the number of detentions under the Mental Health Act with 2016/17 seeing a 41% increase in formal admissions than in 2015/16 and Quarter 1 2017/18 is 20% higher than the same period last year.

The Average Length of Stay for Mental Health increased from 37 days in June 2017 to 41 days in July 2017 and the acute snapshot length of stay also increased (from 46 days in June 2017 to 50 days in July 2017) and continues to remain above target. Of the 227 clients discharged between May 2017 to July 2017, 85 had lengths of stay above the Trust target of 30 days, 24 clients that were discharged in the period had lengths of stay above 90 days, including 19 above 100 days and 1 at 295 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 17th August 2017, there were a total of 13 clients on acute wards (a decrease from 22), 7 of which have been confirmed as delayed discharges. There are however a total of 19 confirmed and potential delays, including the potential delays by locality; there were 6 delays for Slough, 5 for Bracknell, 3 for Reading, 4 for Newbury and 1 for Wokingham. By ward on 17th August 2017 there were 5 on Rose ward, 4 on Snowdrop ward, 2 on Daisy ward and 1 on Bluebell ward.

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. Reading and Slough remain above target. Slough has a high number of clients detained on section together with those who are ineligible for public funding.

At the 17th August 2017 there were a total of 14 out of area clients, 10 of which required an adult acute mental health bed, 2 for Older Persons and 2 for PICU. For the national return there were 25 OAPs in July 2017 including those discharged in month from their placement. 5 beds were closed on Bluebell ward. 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 and there will be enhanced scrutiny in the Single Oversight Framework.

Older Adults Mental Health wards length of stay is 52 days for Rowan ward and 87 days for Orchid Ward for clients discharged.

MH Readmission rates increased to 9.4% in July 2017, with only Slough locality below target, this is also above the 2015/16 benchmarking figure of 8.8%.

Learning Disability benchmarking for 2016/17 data collection will open in September 2017.

Community Services benchmarking project opened on 22nd May 2017 and has been submitted in August 2017.

Mental Health Benchmarking – The Trust has submitted data for this and draft reports are due in September 2017.

CAMHS – data has been submitted for this return and draft reports should be available in late September 2017.

Clustering –increased to 88% compliant which is below the 95% target. With the exception of IMPACTT (97.2%) and Psychotherapy (100%) - all services are below target with Common Point of Entry 74% (73 out of 99 clients clustered) and Eating Disorders at 74.1% (174 out of 228 clients clustered in date), Older Adult Liaison 79.3% (22 out of 28 clients clustered) and Neuropsychology has 3/18 (17.6%) clients clustered are amongst the lowest compliance levels. Focus is on ensuring that services do 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 remains at 92% of those clustered. Early Intervention in Psychosis clients must remain in Cluster 10.

Place Of Safety – This reduced to 41 uses in July 2017 with 0 uses for minors. Of the 41 uses of the place of safety, 19 were admitted following assessment including 13 under Section 2 of the Mental Health Act. 3 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. 31 of the 41 assessments were carried out by Berkshire Healthcare NHS Foundation Trust Section 12 Doctors, with a further 8 not recorded. The most common time in July 2017 to be brought to the place of safety was between 3am to 6am and then 6pm to 9 pm. The most common day for detention in July 2017, was Thursday with 10 detentions and 8 detentions each on Thursday and Sunday.

Crisis plans – This has now moved above target to 92% overall with only Slough below target at 88%.

Health visiting – The Trust was at 94.57% in July 2017 with Reading and Wokingham below target. Some new born babies required care in Special Care Baby Unit, Reading have a high vacancy rate and 2 staff on long-term sickness.

System Resilience – Waiting times at Frimley North (Wrexham Park) achieved 91.3% A&E 4 hour waits in July 2017 with an average of 351 attendances against a plan of 300 attendances. The average number of attendances at the Slough Walk in Centre was 103 per day against a plan of 80 attendances. There was capacity on our community health wards throughout July 2017.

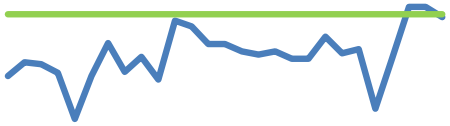
In the West – no A&E data has been published since September 2016. The system wide report showed capacity in all of the west Rapid Access teams on 18th August 2017. In terms of inpatients on 18th August 2017, 3 males were waiting for beds on Oakwood Unit on 18th August 2017 with 1 female and 1 male discharge planned on this day. There were no waiting lists for any other wards in the West; however Highclere ward has been rated as black due to lack of availability and no planned discharges on that day.

Service Efficiency And Effectiveness Exception Report Month 4: 2017/18

KPI	Target	July	Trend	Context/Reasons	Commentary of Trend
Readmission Rate	**<9%**	**9.45%**		**Readmission rates - all localities were above target with the exception of Slough and Bracknell.**	**Non-engagement with CMHT/Crisis Teams and co-morbid mental health and substance misuse are drivers for the increase in readmissions.**
CHS Inpatient: Average LoS (bed days): Number	**<28 Days**	**30**		**Increase in length of stay.**	**Delayed transfers due to lack of onward accommodation/care packages in own home have impacted on this metric.**

KPI	Target	July	Trend	Context/Reasons	Commentary of Trend
Mental Health: Acute Average LoS: Number	**<30 Days**	**41**		**Increase in length of stay. Bed optimisation project underway to look at alternatives to admission, productive stay and productive discharge.**	**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.**
MH Acute Length of Stay Snapshot	**<30 Days**	**50**		**As above. This is an increase on the preceding month but below the 12 month average of 55 days.**	

KPI	Target	July	Trend	Context/Reasons	Commentary of Trend
MH Acute Occupancy rate (exc. HL - by Ward/ Locality)	**< 90%**	**96%**		**Reading and Slough were above target. 5 beds were closed on Bluebell ward during July 2017 reducing capacity from 27 beds to 22 beds and this change is reflected here.**	**Increase in the number of patients detained under the Mental Health Act. For 2016/17 there was a 40% increase in detained patients in comparison with 2015/16. Quarter 1 -2017/18 shows a further 20% increase in detained patients.**
MH Acute Occupancy rate (exc. HL - by Ward)	**< 90%**	**96%**		**Increased admissions for clients assessed under the Mental Health Act and high numbers of delayed transfers of care are affecting this metric.**	**Daily teleconference calls taking place between Inpatients and Localities.**

KPI	Target	July	Trend	Context/Reasons	Commentary of Trend
Health Visiting: New Birth Visits Within 14 days	95%	94.6%		The number of vacancies within the Health Visiting services. Vacancies have not been filled due to re-tendering process for services. Reading and Wokingham were below target. High vacancies, long-term sickness and babies being placed in Special Care Baby Units are the main reasons for non-compliance.	The Trust is above the 88.3% England average in Quarter 4 2016/17, which is the latest data available from Public Health England on New Birth Visits.
Clustering within target	95%	88%		There are frequent reviews required for certain clusters which mean that 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

- DNA rates have improved from 4.98% in June 2017 to 4.90% in July 2017.
- CHS Length of stay worsened from 28 days in June 2017 to 30 days in July 2017.
- Mental Health Average Length of Stay increased from 37 days in June 2017 to 41 days in July 2017.
- Mental Health Acute Length of Stay Snapshot increased from 46 days in June 2017 to 50 days in July 2017.
- Mental Health Acute Occupancy decreased from 97% in June to 96% in July 2017.
- Health Visiting decreased from 96% in June 2017 to 94.6% in July 2017.
- MH Crisis Plans for Clients on CPA increased from 87% in June 2017 to 92% in July 2017.

Contractual Performance Commentary

For 2017/19 this section has been revised to provide focus and traction on contract monitoring.

- CQUIN 16/17: CCG have advised full attainment. CQUIN 17/18: first submission made 22nd July 2017, awaiting feedback.
- CPE action plan and funding discussions on-going. Trust sign-off of joint action plan with David Townsend, being monitored monthly at Executive level between CCG and BHFT, but referral demand is not reducing so additional action has been requested to produce business case for an updated service model. Interim funding from West for Quarter 3 to be discussed by Finance leads from BHFT and West CCGs.
- All SDIPs have been agreed and first submissions underway. CCG have confirmed Q1 milestones were met.
- AQP conversations underway to move into the block contract and align service offering to funding (East MSK, Podiatry and Audiology).
- Dental services: NHSE and BHFT are having productive conversations to future proof the service and address waiting lists/times, NHSE expect to give us an investment decision in October 2017.
- NHSE funding challenges regarding CAMHS Tier 4 services, with on-going review and discussions on safe staffing; David Townsend leading.
- Local Authority Sexual Health (all East) and School Nursing (Wokingham) requested contract extensions. Contract positions reviewed and extensions agreed.
- Berkshire West ACS contracting discussions are continuing with a view to the development of an alliance contract, new payment mechanisms and risk/reward sharing across the local healthcare system, all dependent on regulatory pre-conditions required in planning guidance e.g. individual organisations being regulated as part of a system, within system financial control totals.

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	12 September 2017
Title	Strategy Implementation Plan 2017/18 Progress Report
Purpose	This paper provides a progress report on the implementation of the Board's strategy at the end of July 2017.
Business Area	Corporate
Author	Director of Corporate Affairs
Relevant Strategic Objectives	Supports all strategic objectives
CQC Registration/Patient Care Impacts	N/A
Resource Impacts	None
Legal Implications	None
SUMMARY	The attached paper sets out the progress at the end of July to deliver the Trust's business strategy expressed as the 2017/18 Strategy Implementation Plan. The Director of Strategic Planning and Business Development is responsible for reviewing and updating the plan every two months. It is reviewed by the Business and Strategy Executive meeting and is presented to the Board regularly during the course of the year. The Strategy Implementation Plan Progress Report at the end of July 2017 shows that good progress is being made, with most the initiatives being delivered to the expected time frames or with minor slippage. There are no material risks to the delivery of the main elements of the plan.

ACTION REQUIRED	The Board is asked to note the progress made against the plan, and revised target dates.

Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

Strategy Implementation Plan 2017/18

Progress Report to 31 July 2017

Author: Jenny Vaux, Director of Business Development and Strategic Planning

Director: Bev Searle, Director of Corporate Affairs

Date: 4 September 2017

Purpose

This document has been prepared to update the Trust Board on progress to deliver the Strategy Implementation Plan 2016/17 at the end of February 2017.

Members of the Trust Board are asked to review and note the report.

Document Control

Version	Date	Author	Comments
1	04.09.17	Jenny Vaux	Based on progress report presented to Business and Strategy Executive on 21 August 2017.

Distribution:

All Trust Board Members

Document References

Document Title	Date	Published By
Strategy Implementation Plan 2017/18 presented to the Board	May 2017	Business & Strategy Executive
Business Development Strategy	May 2016	Business & Strategy Exec Trust Business Group Finance Investment & Risk Committee

CONTENTS

INTRODUCTION

Background

1. The Strategy Implementation Plan 2017/18 captures the key activities required over this financial year and beyond to ensure successful implementation of our strategy, and annual plan. The Board receives a summary exception report to the plan.

2. Detailed progress reports are produced every two months for presentation to the Business and Strategy Executive. The Business and Strategy Executive also receives summary updates on all major programmes and projects through the Projects report.

3. A 'Plan on a Page' was published in March 2017 to provide our staff and key stakeholders with an accessible version of the 2017/18 Strategy Implementation Plan and to support staff with their annual Personal Development Plans and Objectives.

Reports to the Board

4. The Board received a high level summary of the changes to the 2016/17 Plan rolling forward to this year, and the approved 2017/18 Strategy Implementation Plan, at the May 2017 Board meeting. This is the first progress report presented to the Board in this financial year.

Exception report

5. The summary exception report provides a RAG rated overview of initiatives to identify trends and highlight areas of risk. Initiatives are conservatively RAG rated in this paper. An initiative will only receive a green RAG rating if all workstreams and activity gateways are green rated in the detailed report. If there are ratings other than green, the initiative will be rated according to lowest RAG rating, to highlight areas of risk.

CHANGES TO ACTIVITIES AND DATES

6. Text in **blue** in the summary exception report shows where initiatives in the Strategy Implementation Plan have been updated since the May meeting. These refer to our Quality Improvement and Global Digital Exemplar programmes, which were in development when the Plan was approved.

7. Within Strategic Goal 1, to provide safe services, good outcomes and good experience of treatment and care, the following initiatives have changes in their end-dates:

    - In the Optimising Estates programme
        - Options for Trust headquarters, which has been delayed by 3 months reflecting changes in the Bracknell regeneration programme
        - Development of the University of Reading as a primary Trust site where some earlier stages of the Phase 1 programme experienced some minor delays however the relocation of IAPT (Talking Therapies) services is expected in September, and children's services in January 2018. The Phase 2 programme also has some

delays. All of the delays are primarily due to agreeing the design and fitting out of the internal structures of the building.

- In the Prospect Park Hospital Development programme, the new seclusion suite and staff office on Sorrel Ward has been delayed by 2 and 4 months respectively due to negotiating the changes with the PFI organisations, and then appointing contractors to carry out the work. The new suite is expected to be completed by the end of December, and the staff office in February 2018
- Within the Mental Health Pathways initiative, the implementation of the Cluster 8 pathway has been delayed for about 3 months, to the end of March 2018, while the investment case is further developed and approval obtained from the executive to proceed
- The Electronic Prescribing and Medicines Administration (EPMA) initiative has been delayed for two months to provide more time for staff to accommodate the change management required. The full roll out should be completed by the end of the financial year
- The Health and Wellbeing Toolkit within the Children Young People and Families (CYPF) Service integration initiative has been delayed until November due to the complexity of this innovative approach to providing an online resource for staff, young people and families. Additional resource has been allocated to support the delivery of this project. The revised CYPF management structure is also delayed until December while we await the outcomes of recent contract tenders to ensure the most appropriate and efficient structure is implemented.

8. Within Strategic Goal 2, to strengthen our highly skilled and engaged workforce, the following initiative has a change in its end-date:
    - In our Embracing Diversity initiative, the Disability Staff Network has delayed the publication of their action plan by 5 months to November 2017 to provide more time for wider engagement and refinement.
9. Within Strategic Goal 4, understanding and responding to local needs as part of an integrated system, the following initiative has a change in its end-date:
    - In the Development of the Health Hub, there was a delay of 3 months signing the contract with the South Central Ambulance Service for the provision of clinical hub services for the Thames Valley 111/Urgent Care service. This was due to detailed negotiations to ensure the terms of the contract were deliverable in this key development area. Contracts are now signed and the new service commences on 5 September.

SUMMARY OF PROGRESS TO DATE

10. Good progress is being made in most areas at this early stage of the year, including the:

    - Quality Improvement Programme
    - Mental Health Strategy
    - Suicide Prevention initiative
    - Agency & Bank programme
    - Workforce Strategy including building our strategic workforce capability
    - Equality and Inclusion Strategy
    - Information Technology Architecture Strategy
    - Connected Care – our local systems' interoperability programme
    - Learning Disability Strategy
    - Vanguard Accountable Care System/Organisation initiatives in Berkshire West and the Frimley Sustainability and Transformation Partnership
    - Integrated IAPT (Talking Therapies)
    - Development of our Health Hub.

11. There are some initiatives showing minor slippage (amber ratings – activity is delayed but delivered or will be delivered). These are mostly reflected in the section above showing changes in target dates. In addition there is some slippage in the Cost Improvement Plan, where we are achieving our overall targets with some delays in specific efficiency programmes.

12. There are no initiatives with red rated activities (significant risk that action will not be delivered or serious delays to project being delivered).

13. There is one purple rated activity (action will not be achieved), in the One Public Estate programme, where we are working with our system partners to ensure publicly owned buildings are used in the most effective ways. This relates to an initiative which on further investigation would not provide the return expected and has therefore been cancelled.

CONCLUSION

14. The Strategy Implementation Plan Progress Report at the end of July 2017 shows that good progress is being made with most of the initiatives being delivered to the expected time frames or with minor slippage. Where we have delays, particularly around our estates programmes, progress continues to be made and these are expected to be delivered, in revised timeframes. There are no material risks to the delivery of the main elements of the plan.

15. Most of the slippage and delays to delivery are primarily due to factors external to the Trust, and where we are taking additional time to ensure we have the best possible outcomes.

ACTION

16. Members of the Trust Board are asked to:

    - review and note the report.

Berkshire Healthcare NHS
NHS Foundation Trust

2017/18 Strategy Implementation Plan Exception Report to end of July 2017

INITIATIVE	Apr/May	June/Jul	Aug/Sep	Oct/Nov	Dec/Jan	Feb/Mar
Strategic Goal 1: To provide safe services, good outcomes and good experience fo treatment and care.						
QUALITY IMPROVEMENT PROGRAMME						
Strategy Deployment						
Quality Management Improvement System (QMIS)						
Improvement Projects						
Quality Improvement Office						
Benefits Realisation						
Comments:						
OPTIMISING ESTATES						
Options for Trust Headquarters						
Development of University of Reading as a primary Trust site						
Sale of Craven Road						
Comments:						
Development of UoR as primary Trust site - work has started on site for Phase 1, with relocation of children's services expected in January 2018. Relocation of services in Phase 2 now expected to be in December 2018.						
MENTAL HEALTH SERVICE DEVELOPMENT						
Mental Health Strategy Implementation (initiatives not covered elsewhere)						
Prospect Park Hospital Development Programme						
Out of Area Placements - non-acute						
Mental Health Pathways						
Comments :						
Centre of Excellence: new exclusion suite and staff office delays while agreements with funders concluded. Seclusion suite completion date Dec 2017, office accommodation February 2018						
MH Pathways - a delay on the implementation of new Cluster 8 Pathway, dependent on approval of investment case due for submission for approval at end of August.						
ZERO SUICIDE INITIATIVE						
Comments:						
ELECTRONIC PRESCRIBING AND MEDICINES ADMINISTRATION (EPMA)						
Comments: All workstreams delayed for 2-3 months to resolve issues.						
CHILDREN YOUNG PEOPLE AND FAMILIES (CYPF) SERVICE INTEGRATION:						
Comments: Health & Wellbeing on toolkit delayed due to scale of project. Additional resource deployed. Management restructure delayed during round of 0-19 service tenders, to reflect their outcome and ensure delivery of efficiencies.						
CAMHs DEVELOPMENT						
Future in Mind						
Tier 4 proposed move from Wokingham Hospital to Prospect Park Hospital						
Comments : *Both projects awaiting national developments and commissioner intentions.*						
AGENCY AND BANK PROJECT						
Comments:						
Strategic Goal 2: To strengthen our highlight skilled and engaged workforce.						
WORKFORCE STRATEGY						
Staff recruitment and retention						
Comments:						
BUILDING OUR STRATEGIC WORKFORCE CAPABILITY						
Comments:						
EMBRACING DIVERSITY - Delivering our Equality and Inclusions Strategy 2016-20						
Mandatory & Statutory Reporting						
Other priorities						
Comments:						
Other priorities: Disability Steering Group action plan delayed for further consultation and development.						
Strategic Goal 3: To deliver services which are efficient and financially sustainable.						

INITIATIVE	Apr/May	June/Jul	Aug/Sep	Oct/Nov	Dec/Jan	Feb/Mar
COST IMPROVEMENT PLANS						
Comments: Overall on target however slippage on specific projects.						
INFORMATION TECHNOLOGY ROADMAP						
Information Technology Architecture Strategy						
Comments:						
Strategic Goal 4: Understanding and responding to local needs as part of an integrated system.						
GLOBAL DIGITAL EXEMPLAR						
Direct patient access and communications						
Digital wards and services						
Digital workforce						
Research and quality improvement						
Comments: *Specific programmes will be reported when fully underway*						
CONNECTED CARE (Interoperability)						
Comments:						
LEARNING DISABILITY (LD) STRATEGY						
LD Service Optimisation and Redesign						
Comments:						
SUSTAINABILITY AND TRANSFORMATION PLANS						
Frimley Health and Social Care						
Buckinghamshire, Oxfordshire and Berkshire - *to be updated when details known*						
Bekshire West Accountable Care System						
Comments:						
INTEGRATED IAPT						
Comments:						
HEALTH AND SOCIAL CARE INTEGRATION (by 2020/21)						
Details to be added when known.						
ONE PUBLIC ESTATE						
Berkshire East (Frimley Health and Social Care)						
Berkshire West (ACS Programme)						
Comments: Some elements of the Berkshire West plans are being revisited to consider the efficacy of delivery.						
DEVELOPMENT OF THE HEALTH HUB						
NHS 111/Urgent Care Clinical Coordination Hub - Alliance with SCAS						
Comments: Some delays in signing the subcontract with SCAS; heads of terms agreed. (*Postscript: contracts signed and mobilisation on track for 5 September 2017)*						

Berkshire Healthcare NHS
NHS Foundation Trust

12/04/SE151

Trust Board Paper

Board Meeting Date	12 September 2017
Title	Workforce Race Equality Standard (WRES) 2017
Purpose	To outline the 2017 WRES results and progress in implementing the 2016 WRES Action Plan; and to seek approval of the 2017 WRES template report and Action Plan in readiness for its submission to NHS England.
Business Area	Corporate
Author	Director of Human Resources.
Relevant Strategic Objectives	The WRES supports the Equality Strategy and is relevant to all strategic objectives.
CQC Registration/Patient Care Impacts	The WRES is relevant to the CQC "Well-led" domain.
Resource Impacts	N/A
Legal Implications	N/A
SUMMARY	This paper presents the 2017 WRES template report and action plan that, once approved by the Board, will be submitted by 30 /09 / 2017 to NHS England. The 2017 WRES results are mixed. There has been encouraging improvement in two of the nine WRES indicators: Black, Asian and Minority Ethnic (BAME) representation in the clinical and non-clinical workforces at Bands 7 and 8A; and fairness in recruitment). We have continued to improve our performance in terms of likelihood of BAME staff accessing continuous professional development. There was a one per cent improvement in the experience of bullying and harassment from staff; however we need further improvement to achieve

	above national averages. Our results for four indicators are worse than 2016. Our results are compared with averages for all Trusts and with Community and Mental Health Trusts for all indicators using the 2016 benchmark information provided by NHS England in April 2017. Since the approval by the Board of the 2016 WRES Action Plan, a more detailed plan has been developed through a WRES Task and Finish team, who have researched best practice in other Trusts. This has been expanded into the Equality Employment Programme (EEP) to address all employment objectives, including those derived from our Equality Strategy and Equality Delivery System requirements. We have made good progress in implementing the EEP, particularly the four work streams that are WRES related. Of particular note is the Internal Development Centre Pilot – branded *Making it Right*. Other achievements are the delivery of Unconscious Bias (UB) training and the development of a new IT system for monitoring the protected characteristics of applicants for continuous professional development, those shortlisted, and those successful. There are a number of HR-employee relations pilots being developed with the BAME staff network and Equality-HR teams, which will be run in October 2017. These are aimed at enabling scrutiny of the fairness of the HR case management process when BAME staff are involved, and the use of mediation as an alternative to formal action. The paper recommends we continue with the EEP-WRES work streams, evaluate the current initiatives, and consider how we will embed the good practice, before starting anything more projects. A communications campaign is also recommended to help promote and sustain the EEP work. Note: The category BME as used by NHS England and BAME as used by the Trust cover the same group of staff.
ACTION REQUIRED	The Board is asked to note and approve the 2017 WRES template report and action plan; to note the progress made in delivering the 2016 WRES action plan; and to confirm the Director of Corporate Affairs has delegated authority to sign-off the 2017 WRES template report and action plan on behalf of the Board.

Workforce Race Equality Standard

Board paper

Presented by: Bev Searle
Title: Director of Corporate Affairs

September 2017

1. Background

1.1. The Workforce Race Equality Standard was introduced in April 2015 by NHS England to assist NHS organisations and NHS service providers in reviewing their data against nine key indicators; and producing action plans to close the gaps in workplace experience between white and Black and Ethnic Minority (BME) staff and improve BME representation, including at board level.

1.2. There are nine WRES indicators. Four of the indicators focus on workforce composition and people management, four are based on data from the national NHS Staff Survey questions, and one indicator focuses upon BAME representation on boards.

1.3. The Trust has completed an annual submission for 2015 and 2016. A high level WRES action plan was developed and approved by the Board in September 2016.

1.4. Following this, a WRES Task and Finish team was set up with a dedicated project lead, sponsorship by the Chief Operating Officer and membership from the newly established BAME staff network.

1.5. The Task and Finish team researched best practice and highlighted a number of themes requiring detailed action plans to: make recruitment fairer; support and enable career progression; reduce bullying and harassment; reduce unconscious bias in disciplinary case management; improve the health and wellbeing experience of disabled staff; and promote inclusivity and value diversity.

1.6. The WRES themes overlapped with employment objectives in the Trust's Equality Strategy 2016-2020 and recommendations from the Equality Delivery System (EDS) 2. To reflect this and avoid multiple plans, the more detailed themed action plan developed by the WRES Task and Finish Team became the basis for addressing all the Trust's employment equality objectives. This plan, entitled the Equality Employment programme (EEP), was approved by the Diversity Steering Group in January 2017.

1.7. The four EEP workstreams relevant to WRES are set out at Appendix 2 to this document, and will be attached as an appendix when we submit the WRES template report to NHS England.

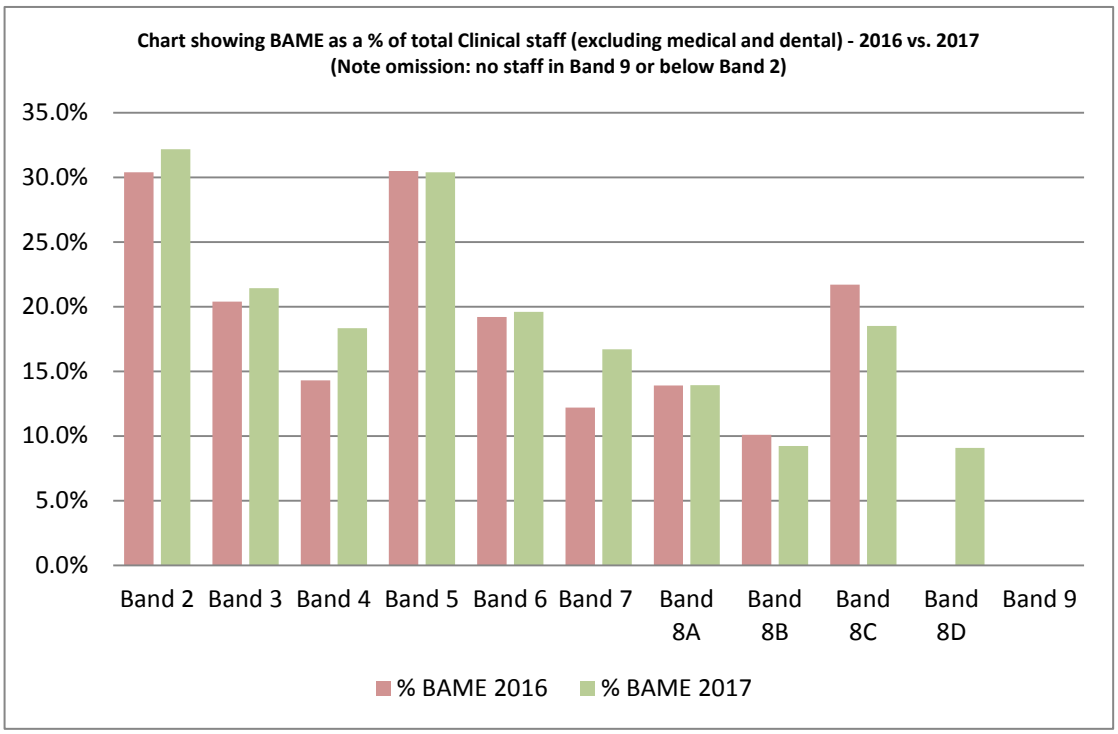
2. 2017 WRES results: findings and conclusions

2.1. Appendix 1 sets out the Trust's 2017 results in full. The content will be transferred to the NHS England template report together with the required action plan. Both the report and plan will be published on the Trust's website and intranet as well as submitted to the national WRES team before the deadline of 30 September 2017.

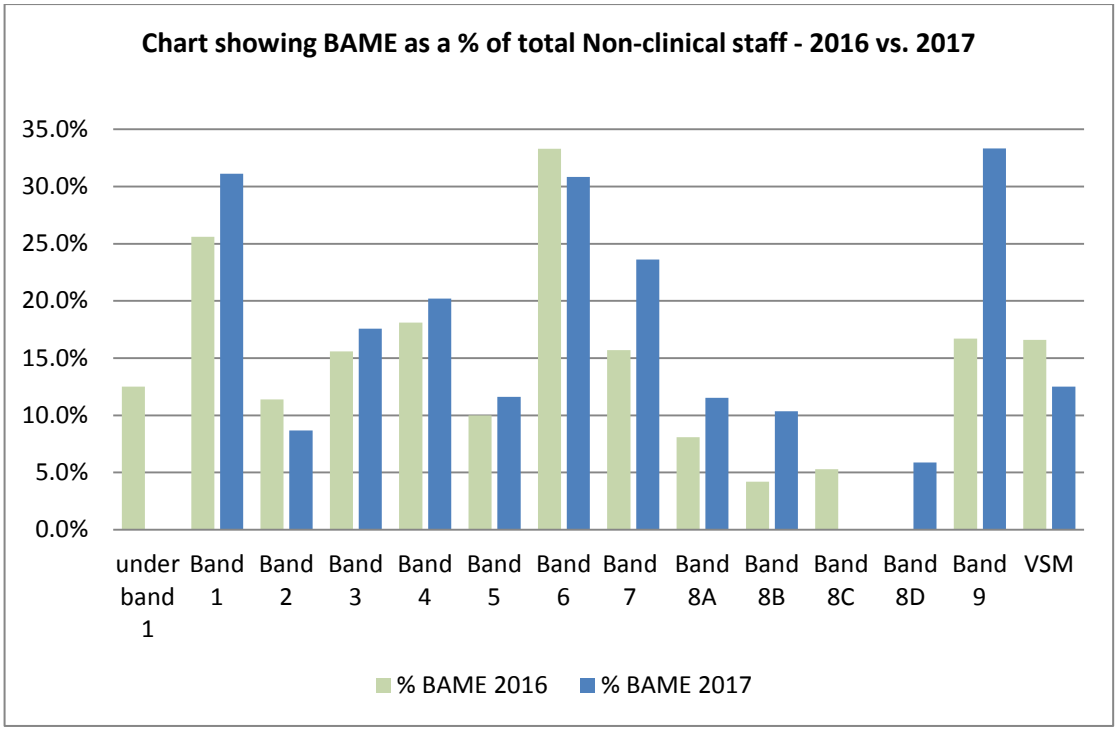
2.2. The charts below relate to WRES indicator 1, the workforce composition. For context, the total populations include staff who have not declared their ethnicity. For the Trust as a whole this is just under 5%. The medical and dental population

(excluding trainee doctors) is a small proportion of our overall workforce (136 in 2017 and 176 in 2016). The percentage of BAME staff for consultant grade is a steady 48% and for non-consultant grades has gone down from 38% to 31%. Neither of these changes is seen as a cause for concern.

2.3. The first chart below shows the positive increase in BAME staff in clinical posts (excluding medical and dental). The increased percentage in Band 7 contributes to our strategic equality objective of bringing BAME representation in this grade in line with the Berkshire BAME population (20%). The increase or holding steady of percentages for "feeder" groups (Bands 4, 5 and 6) and for Band 8A is also encouraging. Bands 8B, 8C, and 8D have lower numbers of staff, and therefore the holding steady or reduced numbers of BAME staff in these bands is less significant than the growth in Band 7.



2.4. The next chart shows the percentage of BAME staff in non-clinical posts. There are 8 non-clinical Very Senior Manager posts in 2017 compared with 6 in 2016, which accounts for the apparent decrease in BAME staff at this level. The key changes are: the percentages for Bands 7, 8A, 8B, 8D and 9 are up; Bands 8B, 8C, 8D and 9 are smaller populations, but the trend is positive. The feeder groups (Bands 4 and 5) have also increased; for Band 6 there is a decrease, which may be related to the internal promotion of staff into Band 7 roles.



2.5. The key changes in WRES indicators 2 to 9 are summarised below. [Note: the national averages for all Trusts and for Combined Mental Health and Community Trusts are based on 2016 WRES results (i.e. for the previous financial year 2015/16), which were published by NHS England in April 2017]:

2.5.1. **Indicator 2:** A white member of staff was 0.92 times as likely to be appointed as a BAME member of staff. This is a continuation of improvement over the last 3 years and is better than the national average for all NHS Trusts (1.57 times) and the average for Combined Mental Health and Community trusts (2.43 times)

2.5.2. **Indicator 3**: A BAME member of staff was 1.73 times more likely to be disciplined than a white member of staff. This represents a reversal of an improving trend over the last 3 years. We are performing below (worse) than the 2016 national average (1.56 times) but better than the average for Combined Mental Health and Community Trusts (2.43 times)

2.5.3. **Indicator 4:** A white member of staff was 1.35 times more likely to access non-mandatory training and CPD (continuous professional development). This is a continuation of an improving trend. We are performing worse than the 2016 national average (1.1 times) and the average for Combined Mental Health and Community trusts (0.76 times)

2.5.4. **Indicator 5:** Based on the 2016 National Staff Survey (NSS), Key Finding 25, there was an increase in the percentage of BAME staff experiencing harassment, bullying and abuse from patients, relatives or the public (27% in the 2016 National Staff Survey (NSS) versus 25% in the 2015 survey. There was a decrease for white staff (22% down from 23%). We performed

better than the national average 29% and slightly better than the average for Combined Mental Health and Community trusts (27%)

2.5.5. **Indicator 6:** Key Finding 26 in the 2016 NSS (the percentage of BAME staff experiencing harassment, bullying and abuse from staff) showed 26% in the 2016 NSS, a decrease of 1 per cent on the previous year (27%). For a white member of staff the percentage was 18%, down from the previous year (19%). We performed better than the national average for BAME staff (27 %) and white staff (24%), but worse than the national average for Combined Mental Health and Community trusts (24%)

2.5.6. **Indicator 7:** For Key Finding 21 (the percentage of BAME staff who believed that the Trust provided equal opportunity for career development and / or promotion) the score decreased 6 per cent from 74% to 68%. The percentage for white staff was down 1% from 91% to 90%. We performed worse against the national average for BAME staff (74%) and Combined Mental Health and Community trusts (76%). The gap in the experiences / perceptions of white and BAME staff widened from 16 per cent to 22.

2.5.7. **Indicator 8:** The percentage of staff that personally experienced discrimination from a manager, team leader or colleague (Questions 17b in the NSS) adversely increased from 14% to 17%. The percentage remained the same for white staff - 5%. We performed worse than the national average for BAME staff (14%) and against Combined Mental Health and Community Trusts (12%)

2.5.8. **Indicator 9:** The percentage of BAME Board members has increased from 7.7% to 15.3% the previous year.

2.6. Although we have made improvements in some indicators, where we are above national averages, we have either not improved enough in comparison with other trusts or deteriorated in some indicators. This is disappointing but not unexpected. Whilst there has been good progress made in implementing plans (see Section 3 below), it is too early to expect an impact on the WRES results.

3. Progress in implementing the EEP and WRES related work streams

3.1. The EEP is seeking to bring about a sustained change in attitudes and behaviours using interventions that will develop and empower BAME staff as well increase the competence of managers. As with our other organisational development initiatives, implementation and realisation of the benefits will take time.

3.2. Although the WRES results have not improved in some key areas, we are in a much better place than 12 months ago, with an action plan informed by best practice in other NHS Trusts and managed by a dedicated full-time Equality HR Manager. In implementing the plan, there has been wide consultation and involvement of staff

and managers at all stages. The Making it Right initiative, described below, has accelerated delivery of the EEP-WRES related work.

3.3. In March 2017, the Diversity Steering Group approved the proposal to pilot internal development centres, branded as the Making it Right (MiR) initiative, to address several of the EEP / WRES objectives. Drawing on best practice, the content is aimed at: 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. There has been wide consultation and input from staff into the design and development of the content of MiR.

> It is encouraging to know that a report commissioned by the Trust and one which has the full backing of the Black, Asian and Minority Ethnic (BAME) Network is being taken with the seriousness it deserves. We are hopeful that the implementation of the recommendations would begin the process of removing some of the inequities BAME staff face in their employment right here in the Trust. (Stephen Zingwe Chair BAME) Network

3.4. MiR is made up of four one day workshops which are aimed at developing participants' attitude, knowledge and skills, enabling them to: communicate in a range of professional settings; compete effectively for jobs; and feel empowered to conduct themselves constructively when faced with discrimination or conflict at work.

3.5. Applications for the first MiR pilot have been advertised, and the first cohort of 20 BAME staff will be selected by the end of September.

3.6. In addition, the BAME Network agreed with Human Resources to pilot a number of changes to HR management and practice as follows:

3.7. **Include BAME representation in the shortlisting and interviews for all posts at Band 7 and above**. A pilot will be run in October 2017 to test the process for identifying and including the BAME staff network. The process and protocols have been developed with the network members who will undertake Values Based Recruitment (VBR) training and Unconscious Bias (UB) training

3.8. **Enhanced Application and Interview Skills Workshop**. This was developed and satisfactorily tested in July 2017. The workshop will be one of the four workshops in the Making it Right internal development centre being piloted in Quarter 3

3.9. **Involvement of a senior BAME manager in HR case management:** In January 2017, the HR case management process was amended so that where the case (disciplinary, performance management, bullying or grievance) involved a BAME member of staff, the Commissioning Manager should consider bringing in an independent senior BAME manager to observe the fairness of the process.

3.10. **Mediation in employee relations issues**: The BAME staff network are working with the Equality HR Manager and HR Operational Managers to develop the process and

protocols for using mediation to resolve employee relations issues and avoid formal HR case management.

3.11. **Training for BAME Network members - Mediation and Investigation Officer.** This is aimed at increasing the diversity of our pool of investigating officers. Once trained, individuals can be nominated by the BAME Network to help mediate or support the fairness of the investigation process where a BAME member of staff is involved.

3.12. **Unconscious Bias (UB) training:** Since January 2017, we have been implementing unconscious bias training. We have trained trainers, who deliver statutory, mandatory and core management training, in how to avoid unconscious bias in their training materials and delivery. They have reviewed and amended their courses accordingly, adding a UB section as necessary. This review has included Leadership programmes such as Excellent Manager, Essential Knowledge for New Managers, Values Based Recruitment and HR case management and investigations.

3.13. For those managers who had already undertaken these courses, one-off training has been delivered at a range of events such as the session run for 200 people by the Chief Operating Officer at the Trust Leadership and Managers Forum, the ENEI (Employers Network for Equality and Inclusion) led session run at South Hill Park (20 attendees) and the 'How to run a UB workshop' delivered as a breakout session to 10 people at the Trust's 2016 Equality Conference. We have also run some standalone UB sessions.

3.14. It is estimated that 300 managers have received UB training through one of these events or training programmes.

3.15. **Continuous Professional Development (CPD):** A system is being introduced and user tested to manage and monitor the access of staff to CPD training. The system improves the current arrangements, by allowing us more readily to monitor the protected characteristics of applicants, those shortlisted or not by their managers and those whose applications are approved or not by the Learning and Development managers. This was an area staff told us in focus groups was important to them and where they felt important opportunities for personal and career development were being missed.

3.16. **Mentoring and coaching skills training**: working with the BAME staff network, the Training and OD team have been expanding the number and diversity of the pool of mentors available, encouraging members of the BAME staff network to register and 'sign up' for the training. A member of the BAME Staff network committee has been trained to help encourage take-up of the training by BAME staff. The pool will be key to supporting the participants in the MiR pilot, who will all have a mentor and access to coaching.

3.17. The aim is to complete the MiR and other pilots referenced above and then evaluate their effectiveness using the 2018 WRES, 2017 NSS and event specific feedback from staff and managers. If effective, a business case for rolling the pilots out more widely and embedding them as business as usual will be developed,

taking into account the pace at which change is needed and the required staff and management time.

4. Recommendations

4.1. We now have in the EEP, a workable plan that we are delivering at pace with dedicated expert resources. We have Executive Director sponsorship, an enthusiastic BAME staff network and Equality Leads across the Trust, who are all committed to working together to improve the workplace experience of BAME staff.

4.2. It is recommended that we continue with the four WRES related work streams in the current EEP, and maintain progress in implementing the MiR pilot. We should also continue with the other pilots aimed at improving HR case management and employee relations - described in section 3.

4.3. However before initiating any more work under the EEP, it is recommended we evaluate the effectiveness of what we have already started to develop and pilot. The case for embedding these solutions as business as usual needs to be considered taking into account the competing demands on staff and management time, and the pace at which change can be sustained.

4.4. It is also recommended that the progress of the last 12 months, needs to be sustained with on-going communication and engagement with all our stakeholders. The development of a communication campaign is being informed by Marcomms and includes a number of planned road-shows across our different localities.

5. Actions requested of the Board and next steps

5.1. The Trust Board is asked to:

5.1.1. Note the 2017 WRES findings and progress in implementing the EEP

5.1.2. Approve the WRES template report and action plan (Appendix 1) and the recommendations set out in Section 4

5.1.3. Confirm the Director of Corporate Affairs has authority to sign-off the WRES template report and action plan for submission and publication

5.2. With the approval of the Board, the WRES template report and action plan will be submitted to NHS England, WRES team by the deadline of 30 September.

Appendix 1

WRES Reporting Template 2016/17

1. Name of organisation
Berkshire Healthcare NHS Foundation Trust

2. Date of report
Month: August
Year: 2017

3. Name and title of Board lead for the Workforce Race Equality Standard
Bev Searle, Corporate Affairs Director

4. Name and contact details of lead manager compiling this report
Louella Johnson Director of Human Resources

5. Names of commissioners this report has been sent to
n/a

6. Name and contact details of coordinating commissioner this report has been sent to

7. Unique URL link on which this Report and associated Action Plan will be found

To be inserted. The report will also be included on the Trust Intranet pages: About Us - Equality and Diversity – Our performance and accountability

8. This report has been signed off by on behalf of the board on

Date: [to be inserted]
Name: Bev Searle

Background narrative
9. Any issues of completeness of data
None

10. Any matters relating to reliability of comparisons with previous years
None

11. Total number of staff employed within this organisation at the date of the report
4288

12. Proportion of BME staff employed within this organisation at the date of the report?
21%

13. The proportion of total staff who have self–reported their ethnicity?
95.8%

14. Have any steps been taken in the last reporting period to improve the level of self-reporting by ethnicity?

On 2/5/2017, an All-Staff email headed 'the Equality and Diversity of our staff is important to us' was sent by the Director of Corporate Affairs encouraging all staff to use ESR Self Service to update their personal details, specifically around diversity data

15. Are any steps planned during the current reporting period to improve the level of self-reporting by ethnicity?
At the session on Equality and Inclusion Awareness delivered at the monthly induction of new starters, the Equality HR Manager presenting, will encourage attendees to use ESR Employee Self Service to complete their diversity details.

Workforce data
16. What period does the organisation's workforce data refer to?
1 April 2016 – 31 March 2017

Workforce Race Equality Indicators
For each of these workforce indicators, compare the data for White and BME staff.
17. Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff

Clinical Staff

Band	Data for reporting year 2016/17	Data from previous year 2015/16	Implications and additional background explanatory narrative	Action taken and planned - EDS or Equality objective
Under 1	BME 0% White 28.6%	BME 11.1% White 44.4%	**Clinical Staff:** There has been a positive increase in BAME staff in clinical posts in the higher bands (Band 7, 8A and 8D) The increase in the percentage of BAME staff in 'feeder' groups (Bands 4, 5 and 6) is also encouraging. Both will help achieve our strategic equality objective of bringing BAME representation in line with BAME representation in Berkshire and the Trust as a whole ``````````````````````(20%). Note: Bands 8C, 8D and 9 have low numbers of staff.	**Action Planned: see section 27**
1	BME 0% White 0%			
2	BME 32.2% White 63.8%	BME 30.4% White 63.5%		
3	BME 21.4% White76.9%	BME 20.4% White 77.2%		
4	BME 18.3% White 78.6%	BME 14.3% White 83.1%		
5	BME 30.4% White 65%	BME 30.5% White 65.7%		
6	BME 19.6% White77.6%	BME 19.2% White 78.0%		
7	BME 16.7% White 80.2%	BME 12.2% White 84.6%		
8A	BME 13.9% White 84.2%	BME 13.9% White 85.4%		
8B	BME 9.2% White 89.2%	BME 10.1% White 85.5%		
8C	BME 18.5% White 77.8%	BME 21.7% White 74.0%		
8D	BME 9.1% White 90.9%	BME 0.0% White 100.0%		
9	BME 0%	BME 0.0%		

	White 0%	White 100.0%		
VSM	BME 100% White 0%	BME 0.0% White 100.0%		
Consultant	BME 47.6% White 42.9%	BME 48.2% White 44.7%		
Non consultant (career grade)	BME 31% White 57.1%	BME 42.1% White 42.1%		
M&D other	BME 90% White 10%	BME 29.6% White 51.9%		

Non Clinical Staff

Band	**Data for reporting year 2016/17**	**Data from previous year 2015/16**	**Implications and additional background explanatory narrative**	**Action taken and planned - EDS or Equality objective**
Under 1	BME 0% White 37.5%	BME 12.5% White 50.0%	Non-Clinical staff: the percentage of BAME staff in Bands 7and 8A are up; Bands 8B, 8C, 8D and 9 are smaller populations, but the trends are positive. The feeder groups (Bands 4, 5 and 6) show no real increase or have decreased slightly.	**See section 27**
1	BME 31.1% White 64.4%	BME 25.6% White 69.8%		
2	BME 8.7% White 87.3%	BME 11.4% White 71.6%		
3	BME 17.6% White 79.5%	BME 15.6% White 80.2%		
4	BME 20.2% White 75.4%	BME 18.1% White 77.4%		
5	BME 11.6% White 82.1%	BME 10.0% White 82.7%		
6	BME 30.8% White 68.2%	BME 33.3% White 62.9%		
7	BME 23.6% White 75%	BME 15.7% White 82.9%		
8A	BME 11.5% White 80.8%	BME 8.1% White 89.2%		
8B	BME 10.3% White 75.9%	BME 4.2% White 91.7%		
8C	BME 0% White 95.5%	BME 5.3% White 94.7%		
8D	BME 5.9% White 88.2%	BME 0.0% White 100.0%		
9	BME 33.3% White 33.3%	BME 16.7% White 50.0%		
VSM	BME 12.5% White 62.5%	BME 16.6% White 83.3%		

18. WRES Indicator 2 Relative likelihood of staff being appointed from shortlisting across all posts.

Data for reporting year 2016/17	Data from previous year 2015/16	Implications and additional background explanatory narrative	Action taken and planned - EDS or Equality objective
BME 0.222 White 0.204	BME 0.110 White 0.160	BME staff were more likely to be appointed than white staff. In 2016/17, a white staff member is 0.92 times more likely to be appointed than a BME staff member. In 2015/16, a white staff member was 1.454 times more likely to be appointed than a BME member of staff. The improvement can be attributed to better HR processes and the effect of our unconscious bias and value base training for all our managers.	See section 27

19. Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. This indicator will be based on data from a two year rolling average of the current year and the previous year.

Data for reporting year 2016/17	Data from previous year 2015/16	Implications and additional background explanatory narrative	Action taken and planned - EDS or Equality objective
BME 0.188 White 0.109	BME 0.123 White 0.118	A BME member of staff was more than 1.73 times more likely to enter the formal disciplinary process This is a reversal of an improving trend over the last three	See section 27

		years. In 2015/16 a BME member of staff was 1.278 times more likely to enter the formal disciplinary process. In 2014/15 it was 1.374 times	

20. Relative likelihood of staff accessing non-mandatory training and CPD

Data for reporting year 2016/17	Data from previous year 2015/16	Implications and additional background explanatory narrative	Action taken and planned - EDS or Equality objective
BME 0.106 White 0.143	BME 0.123 White 0.174	A white member of staff was 1.35 times more likely to access non-mandatory training and CPD This is a continuation of a trend of improvement for BME staff. In 2015/16 a white member of staff was 1.41 times more likely to access and in 2014/15 it was 1.43 times more likely to access	See section 27

National NHS Staff Survey indicators (or equivalent).
For each of the four staff survey indicators, compare the outcomes of the responses for White and BME staff

21. KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

Data for reporting year 2016/17	Data from previous year 2015/16	Implications and additional background explanatory narrative	Action taken and planned - EDS or Equality objective
White 21.94% BME 26.77%	White 23.09% BME 25.11%	There was an increase in the percentage of BME staff experiencing	See section 27

		harassment, bullying and abuse from patients, relatives or the public This is a reversal of an improving trend for BME staff: In 2015/15 25%; 2014/15 32% and 2013/14 35%	

22. KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

Data for reporting year 2016/17	Data from previous year 2015/16	Implications and additional background explanatory narrative	Action taken and planned - EDS or Equality objective
White 18.13% BME 25.73%	White 18.56% BME 26.94%	BME staff experiencing harassment, bullying and abuse from staff was 25.73% a decrease from last year (27%). For a white member of staff the percentage was 18.73% down from 19%.	See section 27

23. KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion

Data for reporting year 2016/17	Data from previous year 2015/16	Implications and additional background explanatory narrative	Action taken and planned - EDS or Equality objective
White 89.99% Black 68.02%	White 90.76% BME 73.86%	There was a 6% decrease in the percentage of BME staff who believed that the trust provided equal opportunity for career development	See section 27

		and promotion, down from 74% to 68.02%.	

24. Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues

Data for reporting year 2016/17	Data from previous year 2015/16	Implications and additional background explanatory narrative	Action taken and planned - EDS or Equality objective
White 5.34% BME 17.26%	White 5.09% BME 13.76%	The percentage of staff who personally believed that they experienced discrimination from a manager, team leader or colleague increased from 14% to 17.26%. This represents a worsening trend, with implications for staff morale and potentially service quality.	See section 27

25. Percentage difference between the organisations' Board voting membership and its overall workforce

Data for reporting year 2016/17	Data from previous year 2015/16	Implications and additional background explanatory narrative	Action taken and planned - EDS or Equality objective
White 83.3% BME 16.7%	White 83% BME 17%	Percentages have remained the same as the previous year. BME are under-represented on the Board. There is a -13.3% difference between the board voting membership and the overall workforce	See section 27

26. Are there any other factors or data which should be taken into consideration in assessing progress?
None

27. Organisations should produce a detailed WRES action plan, agreed by its board. It is good practice for this action plan to be published on the organisation's website, alongside their WRES data. Such a plan would elaborate on the actions summarised in this report, setting out the next steps with milestones for expected progress against the WRES indicators. It may also identify the links with other workstreams agreed at board level, such as EDS2. You are asked to provide a link to your WRES action plan in the space below

Action taken and planned - EDS or Equality objective

The Trust will continue to implement its Equality Employment Programme (EEP) which addresses our strategic equality objectives for 2016-2020, the WRES objectives and the EDS2 employment objectives. EEP is aimed at making recruitment fairer; supporting and enabling career progression; reducing bullying and harassment; reducing unconscious bias in disciplinary case management; improving the health and wellbeing experience of disabled staff; and promoting inclusivity and valuing diversity. The EEP-WRES related workstreams are set out in an Appendix to this report.

We will implement the *Making it Right* pilot (a key delivery mechanism for the EEP) from October through to December 2017. Making it Right is an internal development centre for BAME staff, which is aimed at: developing participants' mind-set, know-how and skills, enabling them to: communicate in a range of professional settings; compete effectively for jobs; and feel empowered to conduct themselves constructively when faced with discrimination or conflict at work

Also through the EEP, in the last 12 months, the Trust has introduced, piloted or are scheduled to pilot the following:

1. Training our trainers (delivering statutory, mandatory and management programmes) and 300 managers in how to recognise and avoid unconscious bias. This will continue
2. Including BAME representation in the shortlisting and interviews for all posts Band 7 and above. A pilot will be run in October 2017
3. Running an *Enhanced Application and Interview Skills* Workshop. This was developed and satisfactorily tested in July 2017. The workshop will be one of the four workshops in the Making it Right internal development centre being piloted in Quarter 3
4. Introducing involvement of a senior BAME manager to observe the fairness of the HR case management process involving a BAME member of staff. (January 2017)
5. Mediation in employee relations issues: the BAME staff network are working with the Equality HR Manager and HR Team to develop the process and protocols for using mediation to resolve employee relations issues and avoid formal HR case management.
6. Mediation and Investigation Officer training for BAME Staff Network members. Once trained the Network can nominate individuals to mediate or scrutinise the investigation process involving BAME staff for fairness.
7. Currently user testing a new system for staff to apply for continuous professional development (CPD), which is seen as key to personal and career development. The

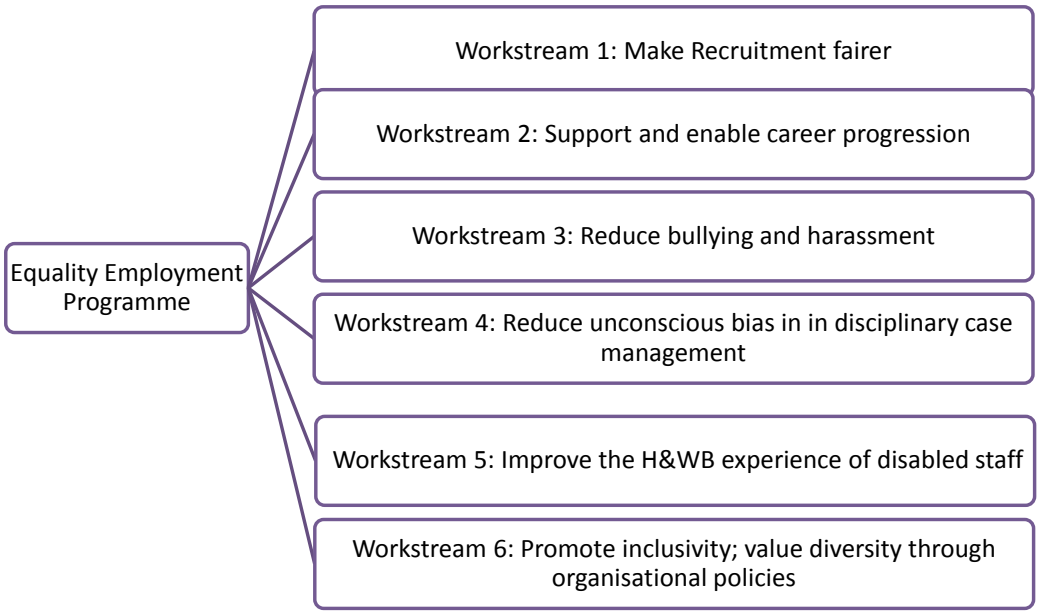
system will allow us to monitor the protected characteristics of applicants, those shortlisted by their managers for CPD and those who are successful in having their application approved by the Learning and Development teams.

The Equality Employment Programme – WRES related workstreams is appended.

Appendix 2: Equality Employment Programme, WRES related workstreams

Note this document will be an appendix to the WRES template report and action plan

The equality employment programme: six workstreams to achieve objectives under Equality Strategy, WRES and ESD2



Workstream 1: Make recruitment practices fairer	
Objectives addressed by workstream - **Equality Strategy objectives** Increased representation of BME staff in Bands 7 and Bands 8A to 8D, aiming for 20% representation at each of these grades, as this mirrors the Berkshire population - No difference in perceptions of equal opportunity in career progression between white and BME staff (as measured by our annual staff survey). - **WRES Action Plan objectives**: Improve: i) **Indicator 2** (Likelihood of BME staff being appointed from shortlisting) ii) **Indicator 7**: Percentage believing that trust provides equal opportunities for career progression/ promotion. iii) **Indicator 8**: Percentage of staff who In the last 12 months have personally experienced discrimination at work from their Manager/team leader or other colleagues **- EDS2 Action plan objectives**: Reduce the risk of unconscious bias in recruitment decisions; audit impact on BME applicants	Task 1 a- Train BME staff network in interviewing skills and unconscious bias. Network member will act as a guardian of a fair process by participating in shortlisting and interviewing processes Task 1b - Amend Recruitment process so that HR will alert the BME staff network of band 7-9 job vacancies and request participation in the recruitment process. Task 2 – Ensure job adverts and website clearly welcome applications from BME people Task 3 - HR to monitor recruiting panels and ensure that panel has had training in unconscious bias or anti discriminatory interviewing techniques . Task 4 - Accountability – Recruitment Admin. to monitor and inform COO / CEO of interviewing panels that did not appoint a BME candidate to a Band 7 to 9 post; and provide Chair's contact details Task 5 - In collaboration with PALS , recruiting panel chair and HR to ensure that service user is on recruiting panel as an observer .

Workstream 2: Support and enable career progression	
Objectives addressed by workstream - **Equality Strategy objectives** No difference in perceptions of equal opportunity in career progression between white and BME staff (as measured by our annual staff survey). - **WRES Action Plan**: Improve Indicator 4: Relative likelihood of staff accessing non-mandatory training and CPD.) **- EDS2 Action plans**: Training and development opportunities are taken up and positively evaluated by all staff	Task 1 – Training and OD to devise training packages in interviewing skills and application writing , these trainings to be offered centrally and via the BME staff network.. Task 2 – Training and OD to develop coaching and mentoring training to enable colleagues and BME Staff Network members to act as internal coaches and mentors. Task 3 - Career development / progression plans to be made an integral part of appraisal, all staff to have a clear progression plan, these to be audited by Training and OD randomly for quality Task 4 - Managers to consider putting adverts out internally as secondments or acting up posts within to promote career progression and experience internally . Task 5 - Launch the completed online and L&D systems for monitoring training requests (para 1; para 3; Figure 1) and manage the information this provides. Develop TNA based on personal development and Trust needs free from unconscious bias

Workstream 3: Reduce bullying and harassment	
Objectives addressed by workstream - **Equality Strategy objectives** A reduction of harassment and bullying as reported in the annual staff survey, in particular by BME staff. - **WRES Action Plan**: Improve Indicator 6: Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months **- EDS2 Action plans**: Training and development opportunities are taken up and positively evaluated by all staff	Task 1 – HR Operations to review exit interview and report regularly into Diversity Steering Group on reasons for staff leaving , highlighting numbers of leaving due to harassment or bullying. Task 2 – Training and OD to review Investigator training and amend as necessary to bring good focus on Equality and Diversity issues and remove unconscious bias Task 3 – Ensure list of Investigating Officers (IO) is representative of the BME population in the BHFT workforce; have secondary list of available BME Staff Network volunteers to assist IO and Commissioning Managers (CM) and HR Panels Task 4 – Create a neutral anti bullying officer role. The role will provide a safe space for staff to go to initially, consider option of training investigating officers in mediation , so that this option is considered before formal proceedings Task 5 - BME staff to have option of approaching the BME staff network in the first instance , network and locality director then go and address issue , with aim of resolving it informally

Workstream 4: Reduce unconscious bias in in disciplinary practices	
Objectives addressed by workstream **WRES Action Plan**: Improve Indicator 3: Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation	Task 1 – introduce explicit step in the application of the formal case management process for disciplinary and performance management cases for Commissioning Manager to review and decide need for participation of BME staff network as observers of the process.
	Task 2 –Training and OD to review HR Management and Investigator training and amend as necessary to bring good focus on Equality and Diversity issues and remove unconscious bias
	Task 3 – Ensure list of Investigating Officers (IO) is representative of the BME population in the BHFT workforce; have secondary list of available BME Staff Network volunteers to assist IO and Commissioning Managers (CM) and HR Panels
	Task 4 – Audit a sample of cases

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	12 September 2017
Title	**Audit Committee – 26 July 2017**
Purpose	To receive the unconfirmed minutes of the meeting of the Audit Committee of 26 July 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 26 July 2017 are provided for information. The Audit Committee's deep dive into the Board Assurance Framework's risks 4 and 7 is appended to the minutes for information at appendix 1. The slides from the Learning from Incidents are appended at appendix 2.
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, 26 July 2017, Fitzwilliam House, Bracknell

Present: Chris Fisher, Non-Executive Director, Committee Chair
Mark Day, Non-Executive Director *(deputising for Mark Lejman, Non-Executive Director)*

In attendance: Alex Gild, Chief Financial Officer
Minoo Irani, Medical Director
Debbie Fulton, Deputy Director of Nursing
Ben Sheriff, Deloittes, External Auditors
Clive Makombera, Internal Auditors, RSM
Jennifer Knight, Clinical Audit Manager *(deputising for Amanda Mollett, Head of Clinical Effectiveness and Audit)*
Julie Hill, Company Secretary
Bev Searle, Director of Corporate Affairs *(present for items 5 and 6)*

Item	Title	Action
1.A	**Chair's Welcome and Opening Remarks**	
	Chris Fisher, Chair welcomed everyone to the meeting and in particular, welcomed Ben Sheriff, Deloittes, External Auditors to his first Audit Committee meeting. The Chair thanked Mark Day, Non-Executive Director for deputising for Mark Lejman, Non-Executive Director.	
1.B	**Apologies for Absence**	
	Apologies were received from: Mark Lejman, Non-Executive Director Mehmuda Mian, Non-Executive Director Debbie Kinch, Counter Fraud, TIAA Amanda Mollett, Head of Clinical Effectiveness and Audit	
2.	**Declaration of Interests**	
	There were no declarations of interest.	
3.	**Minutes of the Previous Meetings held on 26 April 2017 and 24 May 2017**	
	The Chair reported that annexed to the minutes of the meeting held on 24 May 2017 were the questions he had raised on the final accounts 2016-17 ahead of the meeting together with the Finance Team's responses. The Minutes of the meetings held on 26 April 2017 and 24 May 2017 were approved as a correct record.	

4.	**Action Log and Matters Arising**	
	Fire Training Compliance - the Chair referred to the fire training compliance figures as at 29 May 2017 which had been annexed to the action log and said that he was pleased that the compliance rate had significantly improved. The Committee noted the Action Log.	
5.	**Board Assurance Framework Risk Deep Dive – Risks 4 and 7**	
	The Chair welcomed the Director of Corporate Affairs to the meeting. The paper set out the current position regarding risks 4 and 7 on the Board Assurance Framework: ***Risk 4*** *- Failure of the Sustainability and Transformation Plans to deliver transformational change and required investment in mandated national priorities, including in the mental health five year forward view, could result in the local health economy not being able to safely keep pace with the rising costs and demand for services.* ***Risk 7*** *- Failure to develop collaborative working relationships with key strategic partners could result in the Trust losing influence in key decisions leading to less effective services for local people* The Director of Corporate Affairs presented the paper and highlighted the following points: • The Trust was part of two Sustainability and Transformation Partnerships (STPs) (Frimley Health and Care System and Buckinghamshire, Oxfordshire and Berkshire West). There was Executive representation on both STPs. • NHS England had selected Frimley STP and the Berkshire West Accountable Care System (ACS) to be national exemplars. • The governance arrangements for the Berkshire West ACS were well advanced and Frimley STP had recently implemented changes which had strengthened oversight of priority initiatives, including mental health. • The fragmented commissioning environment remained a challenge to strategic partnership working. The Director of Corporate Affairs said that in her view, the Trust was successful in influencing the STPs but it was challenging, in particular, because the acute and primary care sectors tended to dominate. In addition, developing positive working relationships required a significant amount of Executive time. The Chair asked whether the Trust had received any new money for mental health services. The Chief Financial Officer said that the Commissioners had invested in mental health services over the last two financial years ahead of the Government's focus on parity of esteem for physical and mental health services. The Chief Operating Officer commented that the strategic direction of travel for the STPs was around collaboration rather than competition between organisations, but Slough Borough Council's recent decision to award the contract for Public Health Nursing to a private provider pulled in the opposite direction. The Chair asked about clinical engagement in the STP/ACS work. The Director	

	of Corporate Affairs said that this was improving and reported that the Director of Nursing and Governance and the Medical Director were involved with the Berkshire West Clinical Group and were involved in the integrated health hubs in the East. Mark Day, Non-Executive Director commented that it would be very challenging for organisations to collaborate and deliver the system-wide cost improvement plan control target. The Director of Corporate Affairs reported that the Trust was planning to conduct a 360 degree stakeholder survey in September 2017 to ascertain how the Trust was viewed by its partners. The Chair thanked the Director of Corporate Affairs for attending the meeting and requested that the paper be circulated to the Trust Board along with the minutes for information.	**JH**
6.	Board Assurance Framework 2017-18	
	The full Board Assurance Framework together with a matrix which set out the comments from the other Board Sub-Committees and Executive Committees had been circulated. The Committee reviewed each of the risks: **Risk 1 – Workforce** The Chair asked about the likelihood of Reading University succeeding in their bid to have a Medical School. The Medical Director said that there was strong competition from other universities. **Risk 2 – Clinical and Patient Engagement in the Development of new Pathways of Care** No further comments were made in respect of this risk. **Risk 3 – National Benchmarks** It was noted that the Cost Improvement Plan position would be discussed later in the meeting. **Risk 4 – Sustainability and Transformation Partnerships** Discussed earlier as part of the deep dive paper. **Risk 5 – Maintenance of Clinical Standards** No further comments were made in respect of this risk. **Risk 6 – Other providers acquiring adult and children's services** The Chief Financial Officer said that the learning from the Slough Public Health Nursing tender process was the importance of undertaking a thorough service modelling exercise in order to determine the cost of providing a quality service as the Trust was not prepared to compromise on quality. **Risk 7 – Collaborative working with strategic partners** Discussed earlier as part of the deep dive paper. **Risk 8 – Other providers not delivering services to the required standard** The Chair asked what the Trust was doing to cope with the increased demand for the Common Point of Entry service. The Chief Financial Officer reported that the Trust was in discussions with both the East and West Commissioners and said that he hoped Commissioners would agree additional funding.	

	The Chair asked the Committee whether they would prefer to receive the full Board Assurance Framework at each meeting, a rotating deep dive report on two or three risks or whether it would be more useful to have a report on the gaps in controls and the actions being put in place to mitigate these gaps. The Chief Financial Officer said that it would be helpful to have a mix of approaches. The Chair suggested that a paper reviewing the gaps in control should be presented to the next meeting. The Committee noted the Board Assurance Framework.	**JH**
7.	Learning from Serious Incidents, Near Misses and Staff Concerns/Whistleblowing	
	Copies of the Care Quality Commission's presentation on the role of the Freedom to Speak Up Guardian had been circulated. The Chair said that it was important that the Trust had robust systems and processes in place to capture and disseminate the learning from serious incidents, near misses, Care Quality Commission concerns, Coroner investigations and staff concerns/whistleblowing etc. The Deputy Director of Nursing gave a presentation (the slides are attached to the minutes) on how the Trust learnt from incidents and concerns and highlighted the following points: • The Trust recorded around 800-1000 incidents and near misses on DATIX system each month, most of which will be graded as no or low harm; • An initial findings review was undertaken in respect of all serious incidents to identify whether there were any immediate actions which needed to be implemented. This would be followed by a full investigation by an external reviewer and a written report would be produced which would set out any recommendations; if relevant, a copy of the report would then be forwarded to the Coroner, together with the action plan; • Sub serious incidents were investigated internally. Incidents which had resulted in no or low harm were reviewed locally. • The Nursing Governance team reviewed all DATIX reports to identify any missed opportunities for learning and also to identify any broader themes. The Chair asked whether complaints were recorded onto the DATIX system. The Deputy Director of Nursing said that complaints would not be put onto the DATIX system and would be processed in accordance with the Trust's complaints process. It was noted that the Patient Safety Lead and the Complaints Team were co-located and the two teams worked closely together. The Chair thanked the Deputy Director for her presentation and said that he was more assured about the robustness of the systems and processes in place to capture the learning from incidents. The Medical Director reported that Elaine Williams had been appointed as the Trust's Freedom to Speak Up Guardian and she was proactive in raising awareness of the new role.	

	Clive Makombera, RSM asked how the Trust measured the degree to which any learning was embedded. The Deputy Director of Nursing acknowledged that ensuring that learning was embedded remained a key challenge. The Deputy Director of Nursing said that in her experience, it was better to identify 2 or 3 key messages rather than bombarding staff with a plethora of different action plans. It was noted that the Trust was holding more staff "Learning Events" which provided an opportunity for a wider discussion about why changes were needed. The Chair thanked the Deputy Director of Nursing for her presentation.	
8.	**Single Waiver Tenders Report**	
	A paper setting out the single waivers approved between April 2017 and June 2017 had been circulated. The Chief Financial Officer reported that Optima Health appeared twice on the list because of the need to extend the current Occupational Health contract to allow for more implementation time in the event of a change of provider following the tender exercise. The Committee noted the report.	
9.	**NHSI Quarter 1 Submission 2017/18**	
	The Chief Financial Officer presented the paper and said that the Audit Committee received the NHSI quarterly submissions for approval because this was a requirement under Monitor's Risk Assessment Framework. It was noted that under the Single Oversight Framework, NHS Improvement required monthly reporting. The Chair said that the Finance, Investment and Performance Committee reviewed the Trust's financial and performance at every meeting and therefore it was not necessary for the Audit Committee to continue to receive the NHS Improvement submission data. The Audit Committee noted the NHSi Quarter 1 submission.	
10.	**Information Assurance Framework**	
	The Chief Financial Officer presented the report and highlighted the following points: • A total of three data assurance and three data quality audits were conducted this quarter, providing high levels of assurance for the quality and completeness of the three indicators tested. • From the three data quality audits, there was one indicator that was rated as moderate (user safety – US19 – Mental Health: Prone (Face Down) Restraint). Corrective actions and improvements had been put in place to address the issues. • The use of prone restraints would be discussed at the Quality Assurance Committee meeting on 15 August 2017. • Two indicators were being reviewed monthly as an external audit recommendation following the 2015-16 Quality Accounts audit review,	

	namely MA-01 – Mental Health seven day follow up and MA-09 Mental Health Crisis Resolution Home Treatment Team gate keeping of inpatient admissions. • The Trust received positive overall assurance on the Internal Data Quality Audit and Data Quality elements of the 2016-17 Quality Accounts as part of an external audit review. • Appendix 1 of the report set out a list of new indicators that had been included as part of the Single Oversight Framework. The Chair referred to page 85 of the agenda pack and commented that from a small sample of 20 rota staff reporting sickness, there were 3 instances where the sickness was not recorded on the Electronic Staff Record system and this represented a 15% error rate. The Chief Financial Officer stressed that it was a small sample size and reminded the Committee that KPMG had conducted a payroll analytics exercise last year and had provided positive assurance. The Committee noted the report.	
11.	**Losses and Special Payments Report**	
	There were no material losses or special payments to report.	
12.	**Clinical Audit Progress Report**	
	The Clinical Audit Manager presented the report and highlighted the following points: • There had been no new national audits published since the last meeting which in part was due to the pre-election period (purdah). • The Trust had conducted one locally identified project: Audit of VTE assessment and prophylaxis on Orchid and Rowan Wards (Prospect Park Hospital). The audit had been given a risk grading of “high” because of the potential impact on patients. • Actions had been taken by the Clinical Director for Prospect Park Hospital and the audit was due to be reviewed at the next Quality Assurance Committee meeting on 15 August 2017. • The Clinical Audit Annual Plan for 2017-18 was attached at appendix A of the report and had been delayed because of the period of purdah. • In total there were 22 national quality account reportable projects, 13 national projects with the majority linked to CQUINs and 1 project requested by the Quality Assurance Committee. • There were currently no risks identified with the implementation of this programme of work. The Chair referred to page 98 of the agenda pack and commented that 2016 VTE compliance had declined since the 2013 audit. The Medical Director acknowledged that there had been a marginal decline in compliance and said that further work was required to raise awareness amongst the Trust’s clinicians about the policy changes in NICE guidance in relation to VTE. The Chair asked the Clinical Audit Manager whether the Trust was on track to deliver the 2017-18 Clinical Audit Plan. The Clinical Audit Manager confirmed that this was the case. The Committee noted the report.	

13.	Mental Health Global Digital Exemplar Governance Arrangement Report	
	The Chief Financial Officer presented the paper which set out the governance arrangements for the Trust's Mental Health Global Digital Exemplar work. It was noted that the Treasury had agreed to provide £5m of match funding to support the work. The Chief Financial Officer said that the Business and Strategy Group would receive the minutes of the Global Digital Exemplar Programme Board. The Committee noted the report.	
14.	**Cost Improvement Programme Delivery Progress Report**	
	The Chief Financial Officer presented the paper and reported that the paper had also been submitted to the Finance, Investment and Performance Committee. The Chief highlighted the following points: • In the last two financial years, the Trust had relied on non-recurrent efficiencies to support its fiscal position. Moving into the next two years, there was a renewed focus on securing recurrent savings. • The 2017/18 Annual Plan set out a recurrent cost improvement target of £4.7m. • At the end of quarter 1, £1.2m of recurrent cost improvements (RCIs) had been identified. All RCIs would be reviewed under the quality impact assessment process which required the Director of Nursing and Governance and Medical Director sign off. • The Trust's review at the end of quarter 1 identified 2017-18 risk of -£2.0m and 2018-19 risk of -£3.8m. • The Accountable Care System was reviewing the corporate "back office" as a whole with a view to identifying savings by doing things differently and/or by sharing services. The Committee noted the report.	
15.	**Internal Audit**	
	Clive Makombera, Internal Auditors, RSM, presented the Internal Audit Progress Report and highlighted the following points: • The paper provided a progress update of the audit assignments on the 2017-18 Internal Audit Plan. • To date, the Cost Improvement Programme – Part II report (amber green) and the Westcall report (amber red) had been finalised. • Work had started on the following audits: Travel and expenses; staff risk assessment for lone working; project planning and business cases; and location visits. • Section two of the report provided information about the follow up of internal audit actions. 26 actions were followed up and of these 12 were medium and 14 were low. 5 actions (3 medium and 2 low) were overdue. • Section three of the report highlighted changes to the audit plan and provided briefings on national policy developments. The Chair said that it was disappointing receive an amber red report in respect of Westcall. It was noted that a number of issues were identified relating to medicines	

	management. The Medical Director clarified that references to the "Medical Director" in the report referred to Westcall's Medical Director. The Medical Director reported that he had discussed the audit report's recommendations with the Trust's Chief Pharmacist and confirmed that the Chief Pharmacist would be supporting Westcall to ensure that the recommendations were implemented. The Committee noted the report.	
16.	**Counter Fraud Progress Report**	
	The Counter Fraud Progress Report had been circulated. The Committee noted the report.	
17.	**External Audit Progress Report**	
	Ben Sheriff, Deloitte presented the paper and reported that following the completion of the 2016-17 audit, Deloitte had been liaising with KPMG (former External Auditors) and had arranged meetings with key members of the finance team. The Chair asked whether the team was co-operating with Deloitte and Mr Sheriff confirmed that this was the case. The Chair referred to page 222 of the agenda pack and asked for more information about "Spotlight" which was Deloitte's analytics platform. Ben Sheriff said that Spotlight would be used for financial and analytic reviews and in particular to identify any anomalies. The Chair asked how the Trust's data was migrated over to the Spotlight system and was informed that this would be done by downloading the Trust's general ledger into the Spotlight system. The Committee noted the report.	
18.	**Minutes of the Finance, Investment and Performance Committee held on 26 April 2017, 31 May 2017 and 28 June 2017**	
	The minutes of the Finance, Investment & Performance Committee meetings of 26 April 2017, 31 May 2017 and 28 June 2017 were received and noted. It was noted that these had already been presented to the Trust Board. The Chair reported that he had attended the Finance, Investment and Performance Committee meeting on 31 May 2017 to deputise for Mark Lejman, Non-Executive Director. The Chair referred to page 239 of the agenda pack and asked whether the external strategic review of the Trust's bed base had been commissioned. The Chief Financial Officer said that the review had not yet been commissioned because the Chief Operating Officer was still working on the Bed Optimisation Project and in addition, the Accountable Care System was also undertaking a bed modelling exercise. It was noted that the external review was likely to be commissioned in the autumn.	

19.	**Minutes of the Quality Assurance Committee held on 19 May 2017**	
	The minutes of the Quality Assurance Committee meeting of 19 May 2017 were received and noted. It was noted that these had already been received by the Trust Board. The Chair referred to page 257 of the agenda pack and asked which Committee reviewed service waiting times. The Chief Financial Officer said that the Finance, Performance and Risk Executive Committee received reports about waiting times.	
20.	**Minutes of the Quality Executive Committee held on 10 April 2017, 8 May 2017 and 12 June 2017**	
	The minutes of the Quality Executive meetings of 10 April 2017, 8 May 2017 and 12 June 2017 were received and noted. The Committee noted the minutes of the Quality Executive Committee.	
21.	**Board Sub-Committees: Annual Assessments**	
	The Company Secretary presented the outcome of the annual review of effectiveness in respect of the Finance, Investment and Performance Committee and the Quality Assurance Committee. The Company Secretary reported that overall the feedback on the effectiveness of the Committees had been very positive and there were only a few areas identified for improvement. Both Committees had agreed actions to address the areas identified for improvement. The Committee noted the report.	
22.	**Annual Work Plan**	
	The Chair asked members of the Committee to let him know if they had any topics for future “deep dive” reports. The Audit Committee noted the Annual Work Plan.	
23.	**Any Other Business**	
	The Committee noted that no other business was raised.	
24.	**Date of Next Meeting**	
	25 October 2017 2pm	

These minutes are an accurate record of the Audit Committee meeting held on 26 July 2017.

Signed:- _____

Date: - _____

Appendix 1

Deep dive report for Audit Committee July 25th

Board Assurance Framework Risks 4 and 7

1.0 Introduction

The purpose of this paper is to outline the current position regarding risks 4 and 7, to facilitate Audit Committee consideration of controls, assurance and further action in progress.

2.0 Risk 4

Failure of the Sustainability and Transformation Plans to deliver transformational change and required investment in mandated national priorities, including in the mental health five year forward view, could result in the local health economy not being able to safely keep pace with the rising costs and demand for services.

2.1 Background

Berkshire Healthcare is part of 2 Sustainability and Transformation Plans – now being referred to as Sustainability and Transformation Partnerships:

- Buckinghamshire, Oxfordshire and Berkshire West (BOB)
- Frimley Health and Care

In "Next Steps on the Five Year Forward View" published by NHS England earlier this year, Frimley, Berkshire West and Buckinghamshire were named as 3 of 9 potential national "exemplar" Accountable Care Systems which are now seen as a logical progression from STPs.

The refresh of the Berkshire Healthcare Five Year Strategy, highlighted the requirement for system solutions to financial and clinical sustainability – and risk 4 relates to our Strategic Goal to "deliver sustainable services based on sound financial management".

The inception of STPS, and subsequently ACSs provide a clear opportunity to carry this ambition forward, but the work is complex and "emergent" in nature: there is no national blueprint for implementation, and there are a number of significant challenges inherent in system working. In particular, our financial, contractual and regulatory frameworks were developed within an environment which incentivised competition rather than collaboration to drive up quality and efficiency.

In Berkshire, there is a relatively good track record of commissioner investment in priorities identified in the Five Year Forward View for Mental Health in comparison to other areas. We have been successful in securing national funding, (which required bids to be submitted through STPs) for our Perinatal Service and our East Berkshire Mental Health Liaison Service. Our IAPT Service had already secured "Early Implementer" status with additional funding to support delivery of Five Year Forward View for Mental Health access targets and services for people with long term physical conditions. However, there are some targets which will be challenging to deliver and require support from local systems:

- *Elimination of out of area placements for people needing acute inpatient care by 2021*. Containing OAPs has proved extremely challenging in recent months, with growth in length of stay and delayed transfers of care from our inpatient services requiring support from partners in terms of housing and other support.
- *Building capacity in Individual Placement Services*. We have established these services, to provide employment opportunities for people with mental health problems; however they are not recurrently funded at present.

In addition, addressing the demand challenges being faced by a number of our services also requires collaborative working with partners – in particular achieving a sustainable model of working for our Common Point of Entry will require joint working between GPs and our own services.

2.2 Controls

There is Executive representation in both STPs as well as within the Berkshire West ACS (which also includes Chair and CEO membership of the ACS Leadership Team). The governance arrangements for Berkshire West are well advanced, and Frimley has recently implemented changes which have strengthened oversight of priority initiatives.

In terms of delivery of required transformational change, Berkshire West and Frimley have both identified key work streams, and are supported by finance groups comprising Chief Finance Officers. In Berkshire West, joint finance and contracting reporting has now been developed to include:

- ACS efficiency plans to provide assurance on the progress in identifying and achieving system efficiency to address the system financial gap
- An ACS Finance and Contracting Programme – to provide an overview of the high level programme of work identified by the CFOs group

It is anticipated that a similar approach will be taken in Frimley, and both systems will be undertaking work to align assumptions regarding the financial benefits of priority initiatives with system financial gaps.

It is important to note that, while a good foundation of collaboration has been established, that STPs are not legal entities and therefore Board approval from individual organisations is required for key decisions. Constituent members also need to agree to work together effectively to deliver the plans.

Berkshire West has recently established a Mental Health Strategy Steering group (2nd meeting on 13th July), reporting into the Berkshire West 10 Integration Board. Both forums provide an opportunity to highlight areas of risk to delivery requiring a system response, and the Integration Board provided a helpful means of securing funding for Street Triage from Better Care Funding earlier this year.

Frimley STP Board has approved establishment of a Mental Health Steering Group which will enable a focus on delivery of FYFV for MH priorities. This is a welcome development, as the previous approach which attempted to embed mental health within the priority work streams would have omitted some key areas of work – particularly that focussed on meeting needs of people with the most acute or complex problems.

Completion of our own Mental Health Strategy has enabled communication of clear priorities into system working.

2.3 Assurance on Controls

Internal Assurance

Berkshire West ACS Leadership Group minutes are circulated to the Trust Board and a regular update is provided by our Chief Executive as part of the Executive Report to the Trust Board at each meeting.

Supporting this, there is a standing agenda item on system working enabling information sharing and coordination of effort in our Business and Strategy Executive. This is also the Executive meeting which has oversight of risk 4.

Our managers and clinicians are engaged in system work streams and initiatives, enabling us to influence and contribute to implementation of plans. This enables us to understand progress in practice, and identify issues needing leadership action.

External Assurance

The Sustainability and Transformation Plans have been published and subject to assessment by regulators.

NHSI and NHSE are part of leadership discussions in both Berkshire West and Frimley, as ACS governance and discussions focussing on contractual and payment mechanisms continue. From September this year, NHSI and NHSE will establish regional director roles with joint responsibilities for the NHS in the South East and South West.

2.4 Gaps in Controls and Assurance

No gaps in controls and assurance regarding this risk have been highlighted in the Board Assurance Framework to date. Although it is acknowledged that the system work in progress presents many challenges, the assessment thus far has been that we are doing all that we can to maximise the opportunity presented by the ACSs to achieve a sustainable response to rising demand and costs.

2.5 Further Action Identified

We have highlighted the need to maximise the opportunities presented by the STPs and ACS and minimise and make transparent emerging risks – and are taking the following action to achieve this:

- The Director of Corporate Affairs and Regional Directors working together to ensure Berkshire Healthcare representation in key work streams is appropriate and proportionate
- Participation in appropriate work streams, and ensuring that mental health is included in scope(particularly focussing on Integrated Hubs in Frimley, Bed Modelling in Berkshire West and Connected Care across the whole of Berkshire)
- Supporting development of system financial modelling and reporting processes which enable identification of risks and action required as a result.

In addition, to continue to influence the delivery of the STP and ACS plans we have:

- Facilitated the approval to establish the Frimley Mental Health Steering Group. This will provide assessment of progress against Five Year Forward View for Mental Health Targets, and proposals regarding priorities for action at STP level which would add value.
- Participated in Berkshire West "back office" review of opportunities to achieve efficiencies by working together to deliver corporate functions. In the first instance, this work is focussed on transactional processes, for example, procurement of a common temporary staffing provider.

3.0 Risk 7

Failure to develop collaborative working relationships with key strategic partners could result in the Trust losing influence in key decisions leading to less effective services for local people

3.1 Background

As a provider of community and mental health services, much of our work is done in partnership with other service providers –notably local authorities, Acute NHS Provider Trusts and voluntary sector organisations. We also have important relationships with South Central Ambulance Trust, Thames Valley Police, and neighbouring NHS Provider Trusts. Our working relationships with commissioners are of crucial importance, and are developing in response to the collaborative approaches required for effective system working.

We are operating within a complex environment of evolving partnerships – and working to maximise the benefits of collaborative working relationships and avoid duplication of effort and poor use of leadership capacity.

The development of system working through STPs and ACSs underlines the importance of our strategic goal "understanding and responding to local needs as part of an integrated system", to which risk 7 relates.

The Trust Executive and many other members of the Senior Leadership Team have long standing working relationships with peers in partner organisations, and we derive significant benefit from the stability and experience of our leadership team. However, challenges include:

- Competing demands for time required for partnership/system working
- Lack of stability in leadership teams of some local authority partners
- Financial and demand pressures within partner organisations driving decisions which may adversely affect others
- Complexity of commissioning landscape resulting in potential for fragmentation of pathways

3.2 Controls

The Executive Team, Locality Directors and Head of Contracting all have positive relationships with their local counterparts in partner organisations. There is a good understanding of the need to invest in these relationships and maintain a mutual respect alongside honest dialogue – including the ability to challenge where required. Risk 4, described above, includes the approach taken to Trust representation in STP and ACS work, and we maintain good engagement with multi-agency groups in our 6 localities.

Our Trust Growth Strategy and Business Development Process, informed by the Trust Board, have enabled prioritisation of effort in terms of commercial opportunities.

Our Equality and Inclusion Strategy and Communication and Engagement Strategy inform engagement activity in localities which is led by Locality and Clinical Directors and their local leadership teams.

3.3 Assurance on Controls

Internal Assurance

Regular Business Development Pipeline and Contract reports are provided to our Business and Strategy Executive Group and to the Finance, Investment and Performance Committee.

The Business and Strategy Executive includes a standing item on system working for review of key opportunities and risks.

External Assurance

Sustainability and Transformation Plans reflect the system priorities identified by local partners for collaborative action. These are published and subject to regulatory review.

Our Equality Delivery System reporting enables perspectives of partner organisations on our performance. This is particularly important in terms of our working relationships with community and voluntary sector representatives.

The contracts we agree with commissioners reflect the effective working relationships that have been established by our finance and contracts team. These are supported by work undertaken by clinical leaders to facilitate understanding of key risks and priorities between partners.

3.4 Gaps in Controls and Assurance

As identified for risk 4, engagement of local authorities and the high levels of financial savings they are required to make, present a significant challenge to partnership working. In addition, commissioner capacity in terms of mental health is limited, although interim cover has been secured in East Berkshire.

3.5 Further Action Identified

Discussions with East Berkshire Commissioners were held in March to address a number of outstanding issues requiring resolution, and these have subsequently been followed up and resolved. Work is in progress to confirm sustainable solutions to demand and financial pressures in our mental health common point of entry.

Progress has been made to confirm governance arrangements for Frimley STP, with the establishment of a Board, Delivery Group and a Mental Health Steering Group.

Bev Searle, Director of Corporate Affairs.

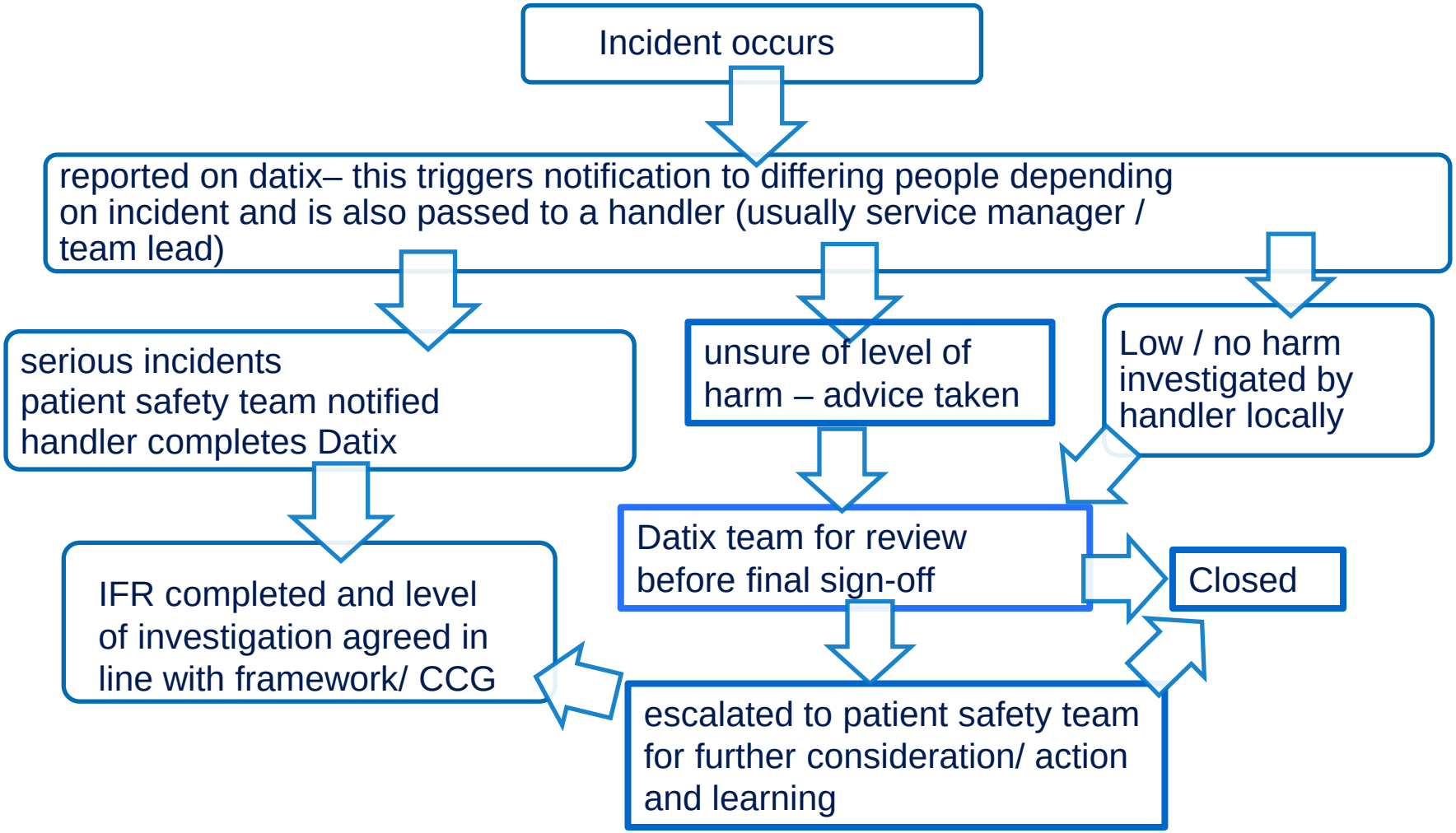
Berkshire Healthcare NHS
NHS Foundation Trust

Learning from Incidents

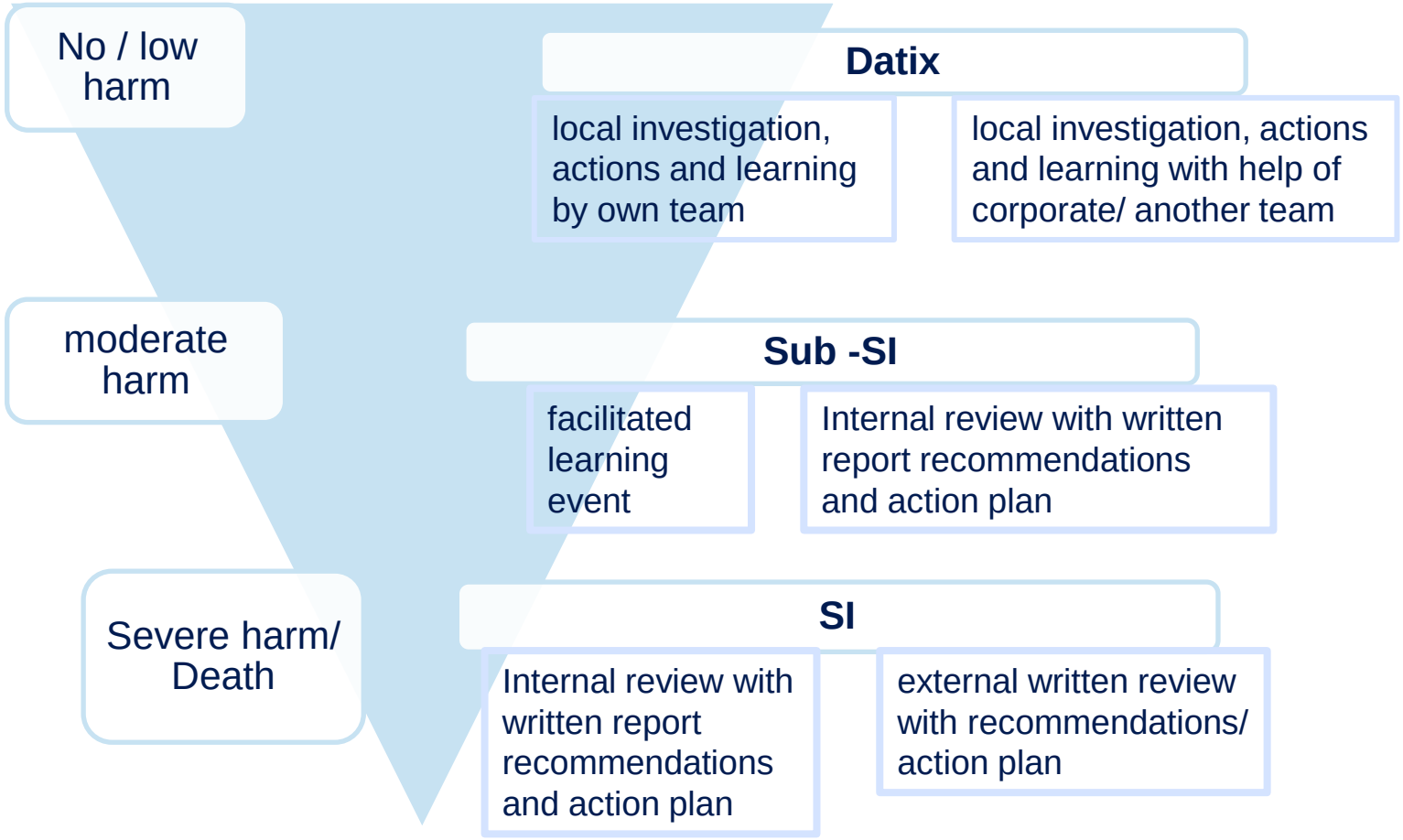
Healthcare from the heart of your community

www.berkshirehealthcare.nhs.uk

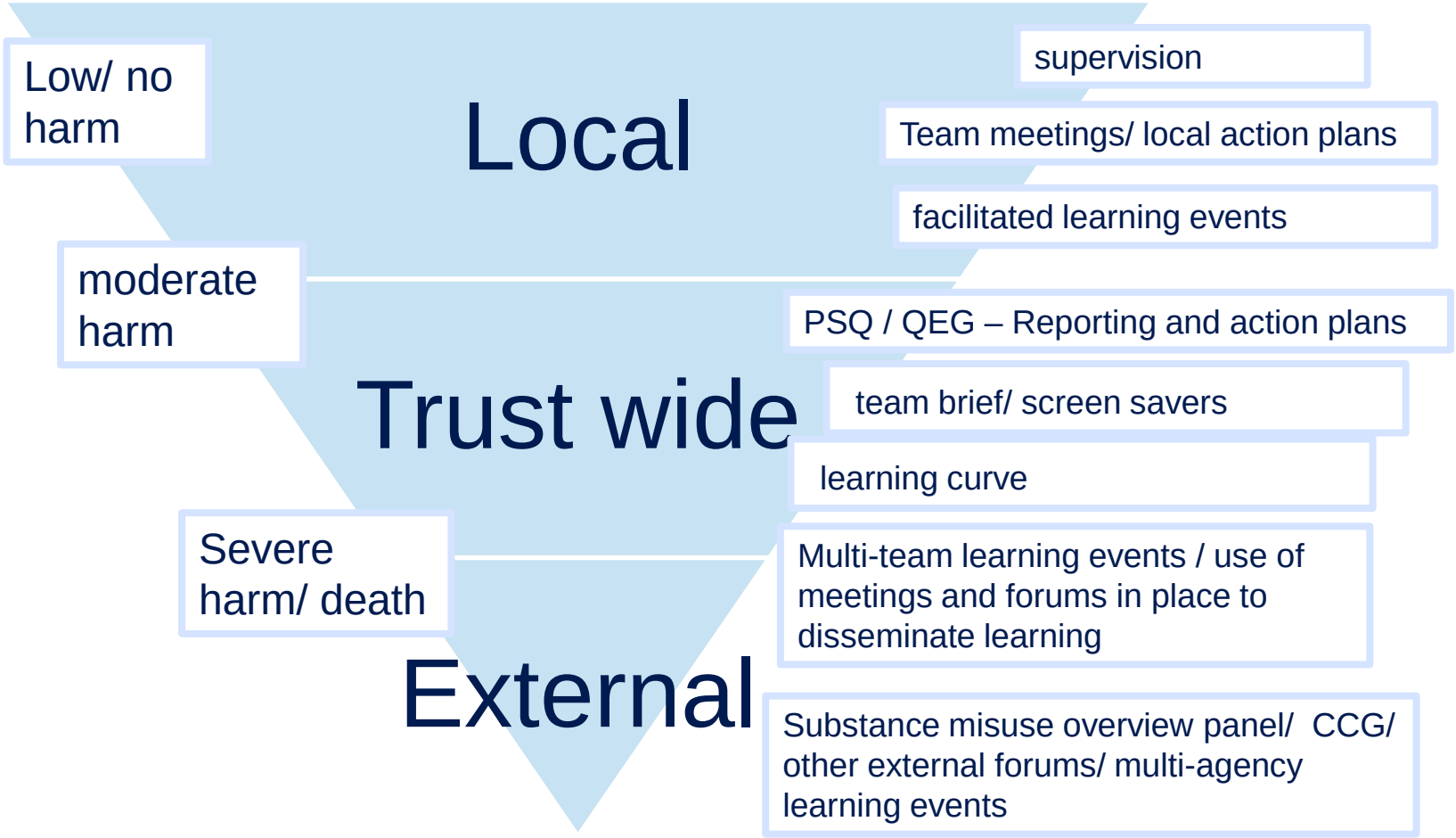
Reporting an incident



Levels of incident investigation



Learning from incidents



Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	12 September 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 the following documents: • Supplementary Agreement and Deed of Variation between BHFT and Prospect Healthcare (Reading) in respect of ward upgrade works to Sorrell Ward, Prospect Park Hospital; • Integrated Hub Supply of Services Agreement between BHFT and Slough Borough Council; and • Intermediate Building Contract for the West Berkshire Renal Unit between BHFT and Cuffe PLC.
ACTION	To note the update.

Trust Board Meeting Dates 2018

Meeting	January	February	March	April	May	June	July	August	September	October	November	December
Discursive Trust Board	9		13			12				9		
Trust Board		13		10	8		10	14 *(If needed)*	11		13	11
Audit Committee	31			25	23		25			31		
Finance, Information and Performance (FIP)	31 *(If needed)*	27	28	25	30 *(If needed)*	27	25	29 *(If needed)*	26	31	28	26 *(If needed)*
Quality Assurance Committee (QAC)		20			15			21			20	

Council of Governors Dates 2018

Meeting	January	February	March	April	May	June	July	August	September	October	November	December
Formal Council Meeting			21			20			19 (+AGM)			12
Trust Board / Council Meeting		21 (NED)			16 (Board)		18 (NED)				21 (Board)	

Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

Formal Complaints received during quarter one 2017/18

Geographical Locality	Service	Reporting Locality	First received	Complaint Severity	Description	Outcome code	Outcome	Subjects
Reading	CMHT/Care Pathways	Reading	22/06/2017	Minor	Pt's partner feels that we are very dismissive of patients with addictions and she feels it is unfair not to offer support when she says he is only addicted due to his MH issues. She wants pt to be reconsidered for Talking therapies if psychology is not an option. Clarity of also required as to the patients diagnosis.	Investigation currently underway		Care and Treatment
Reading	Adult Acute Admissions	Mental Health Inpatients	15/05/2017	Low	Pt states he was detained twice in 2014/15, and was under a section 2 in January 2017 when he initially raised his concerns with the CQC. Pt states he was forced drugs because he was 'talking too fast' he states the psychiatrist refused to talk to him whilst he was at PPH.	Partially Upheld	No failings in clinical care identified. However, we have acknowledged and apologised for the manner in which the patient was spoken to by staff and for the distress caused by giving of injections.	Care and Treatment
West Berks	Community Hospital Inpatient	West Berks	19/06/2017	Moderate	Son extremely concerned about his father who, he feels has become incoherent, confused as to who his son was and where he was and unable to string a sentence together. The son was rather shocked at the lack of assistance from the senior nurses when he asked them to look into what was wrong with his father. He wishes his father's condition and the 2 nurses attitudes investigated. Also concerned that he is being given a drug that he was taken off due to concerns over his liver	Investigation currently underway		Attitude of Staff
Wokingham	CAMHS - Child and Adolescent Mental Health Services	Windsor, Ascot and Maidenhead	15/06/2017	Minor	Opened as formal complaint on the 15th June following discussions with father. Father states he is unhappy with our response to him in February and that his daughter has still not been seen by anyone and that she is still very unwell.	Investigation currently underway		Care and Treatment

Geographical Locality	Service	Reporting Locality	First received	Complaint Severity	Description	Outcome code	Outcome	Subjects
Wokingham	District Nursing	Wokingham	29/06/2017	Minor	Pt unwell for 6 weeks and the family members have not been given the necessary information needed to contact the DN's. DN called to say she could not make apt but would come next day, daughter anxious as legs were 'leaking'. DN eventually decided she could come. Complainant received a call from different DN yesterday to discuss concerns but complainant says she was not at all interested and told her she had not followed the correct procedure.	Investigation currently underway		Care and Treatment
Wokingham	Community Hospital Inpatient	Wokingham	26/04/2017	Moderate	Pt fell from a hoist and was in pain for 2 days before she was transferred to the RBH where she was xrayed. Fractured ankle which was operated on the next day. Pt says she has lost her independence, has been forced to sell her flat.	Partially Upheld	Two elements to complaint. Investigation showed that pain was managed as expected but patient still complained of pain. No evidence to support patient was dropped form hoist. She did fall on transfer form bed to chair and HCA cushioned fall.	Care and Treatment
Reading	Community Team for People with Learning Disabilities (CTPLD)	Reading	22/05/2017	Low	Pt under LD Psychologist but mother feels no one is responsible for requesting, arranging or co-ordinating future care meetings.	Upheld	There are four main points to this complaint and significant learning outcomes have been identified under each point.	Care and Treatment
Reading	Out of Hours GP Services	Wokingham	19/06/2017	Minor	Pt received a call back from W/C Dr having spoken to 111. Pt convinced having a miscarriage, Dr was extremely dismissive. Eventually told her to come and see her at RBH where she continued to be dismissive.	Investigation currently underway		Attitude of Staff
Bracknell	District Nursing	Bracknell	21/06/2017	Low	Palliative pt seen by Dr and DN to increase dose in syringe driver. 30 mins later pt became distressed, wife called 3 times for an urgent visit, called GP who said thay would be there soon but no one came, then pt fell from bed and died. DN's did not arrive for 1hours 45 mins, and then 3 turned up. Pt wishes to know 1. why no one came 2. Why call was not transferred to a different as urgent 3. Why no contact re delay 4. why 3 turned up after he dies	Investigation currently underway		Care and Treatment

Geographical Locality	Service	Reporting Locality	First received	Complaint Severity	Description	Outcome code	Outcome	Subjects
Reading	Adult Acute Admissions	Mental Health Inpatients	22/06/2017	Moderate	Pt became unwell in 2000 and was diagnosed with Catatonia and received ECT with a successful outcome. Has had 3 relapses. Between Christmas and Easter Pt was in the community, kept saying he was struggling but had minimal support. Now inpatient. ECT prescribed but could not be given as the pt had been given a drink, why was 'Nil by mouth' not displayed? Pt's belongings have gone missing throughout his stay.	Investigation currently underway		Care and Treatment
Reading	Adult Acute Admissions	Mental Health Inpatients	29/06/2017	Moderate	No care package put in place for the second time following sectioning at PPH.	Investigation currently underway		Discharge Arrangements
Reading	Crisis Resolution & Home Treatment Team (CRHTT)	Reading	20/06/2017	Low	Pt wishes copies of a telephone call made from CRHTT to the pt on 11th June.	Case not pursued by complainant	Not investigated.	Communication
Wokingham	CAMHS - Child and Adolescent Mental Health Services	Windsor, Ascot and Maidenhead	09/05/2017	Low	Mother of pt unhappy at comments noted in reports. Feels things could have happened sooner for her son if services had listened to her. Mother says her son was offered support in June/July 2016 by Wokingham doctor, following a conversation with social worker mothers believes this was withdrawn. Mother wants to know 1. Were her concerns about the father recorded? 2. What did Dr share with CAFCASS guardian? Why was it reported that 'mother was feeding stories about father?' 3. why was the offer of therapy withdrawn?	Investigation currently underway		Care and Treatment
Wokingham	CMHT/Care Pathways	Wokingham	25/04/2017	Moderate	Following positive risk panel in February 2017 family have written to advise the impact that the lack of support now being offered to the patient has affect her and them as they do not know where to turn for help and they are struggling to watch the patient suffer.	Investigation currently underway		Care and Treatment
Wokingham	CMHT/Care Pathways	Wokingham	27/04/2017	Low	Pt recently requested her medical records and from that disagrees with the diagnosis of EUPD. Pt has produced 2 letters stating she is not BPD from psychiatrists. Pt wishes to be reassessed and what ever the outcome for a note to state she disagrees with the EUPD diagnosis to be put on her records.	Investigation currently underway		Care and Treatment

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Windsor, Ascot and Maidenhead	District Nursing	Bracknell	09/06/2017	Low	Pt due to have DN visit on the 7th June which didn't happen leaving the pt on the bed for the day waiting. Out of hours went out to see the patient and the pump was leaking with fluid coming out	Upheld	Investigation showed there had been conflicting info given.	Care and Treatment
Reading	CAMHS - Child and Adolescent Mental Health Services	Windsor, Ascot and Maidenhead	29/06/2017	Minor	Pt allegedly seen by clinician for his second assessment which mother and pt attended back. Complainant has now found out staff member has left and there are no notes on the system re previous meeting so they need to start again, meanwhile the pt has had serveral external and internal exclusions from school.	Investigation currently underway		Care and Treatment
Windsor, Ascot and Maidenhead	Common Point of Entry	Wokingham	12/06/2017	Low	Pt self referred to CPE spoke to staff member who seemed intent on making the point that the patient was not an urgent case.	Upheld	Patient was given incorrect advice re call times for CPE, which added to the overall frustration and it was difficult to find a time for an assessment. We have apologised for the poor experience she had.	Attitude of Staff
Bracknell	CAMHS - Child and Adolescent Mental Health Services	Windsor, Ascot and Maidenhead	26/06/2017	Minor	Pt has previously requested that all letters regarding appointments be sent directly to her and not her parents. She arrived home on Friday to see a letter had been sent to her parents and nothing had been sent to her at all, having previously raised this through PALS she now wishes it investigated as very upset.	Investigation currently underway		Communication
West Berks	CMHT/Care Pathways	West Berks	14/06/2017	Minor	Pt was advised by Dr in November that she would be able to access PTSD Therapies support via psychotherapy. When following this up with her CPN she was advised her line mgr was sorting, then she was advised Mgt had changed then she was advised that we would not give her any names and she was told to go to SEAP. Pt wants to know - - was the referral made? - was a note put of her records to ensure staff were aware? - A full explanation into everything since Dec re follow up on referral.	Investigation currently underway		Care and Treatment
Bracknell	CAMHS - Child and Adolescent Mental Health Services	Windsor, Ascot and Maidenhead	29/06/2017	Low	Father unhappy that the Trust still seems to only be engaging with Mum regarding the pt and not including the father which we previously said we would not do going forward.	Investigation currently underway		Attitude of Staff

Geographical Locality	Service	Reporting Locality	First received	Complaint Severity	Description	Outcome code	Outcome	Subjects
Slough	CAMHS - Child and Adolescent Mental Health Services	Windsor, Ascot and Maidenhead	27/04/2017	Low	Following overdose attempt mother took son to A&E. CAMHS worker arrived and she found staff to be hostile, abrupt in attitude. She said that when she was upset the staff had no compassion and staff told her to stop talking. Staff member covered her name badge with her hand after she said she was going to make a complaint. Mother feels the staff member did not afford her the basic courtesy that should be given to family members she then said the staff member had then lied in her documentation regarding the sequence of events.	Upheld	Not upheld issue regarding patient being seen without parent, as this was patient's request. However, upheld element about staff member hiding badge.	Attitude of Staff
Reading	CMHT/Care Pathways	Reading	12/06/2017	Low	Pt says Dr would not help him appeal to the benefits office about him being able to work. Pt feels he is too unstable to work and says he could of walked out in front of a bus after his meeting at PPH. He believes the Dr has broken his Hippocratic oath and duty of care	Not Upheld	No failings identified. Dr concerned was unable to complete request from patient as he had not assessed him and was unwilling to write a letter. Patient became verbally abusive, Dr felt threatened and had to ask patient to leave.	Other
Slough	Sexual Health	Bracknell	24/05/2017	Moderate	Pt seen for STI test she felt the Consultant was very judgmental and wishes the way she was spoken to to be looked into.	Partially Upheld	Patient feels she had a negative experience in the clinic and Dr is sorry that her actions were interpreted as judgemental. Dr's focus was on preventing a further unwanted pregnancy and she has apologised for the way she came across.	Attitude of Staff
Bracknell	CMHT/Care Pathways	Slough	03/04/2017	Low	Re-opened from 5440 Pt now able to identify staff member to which she raises 27 points to be addressed. Several other points raised about various members of staff and questions regarding the previous investigation into CMHT	Investigation currently underway		Attitude of Staff
Reading	Out of Hours GP Services	Wokingham	31/05/2017	Low	Pt presented at W/C on the 5th June 2016 and was diagnosed with a nerve ending headache and prescribed Amitriptyline, Dr unable to give any as none available, advised to get some from chemist in the morning when it opened. Following a visit to A&E where she was diagnosed with Bell's Palsy (not related to her headache) the pt was later diagnosis from her GP with Viral Encephalitis and spent 6 nights in hospital. The pt feels everything could have been avoided if she was diagnosis correctly on the sunday evening	Investigation currently underway		Care and Treatment

Geographical Locality	Service	Reporting Locality	First received	Complaint Severity	Description	Outcome code	Outcome	Subjects
Windsor, Ascot and Maidenhead	Community Hospital Inpatient	Bracknell	30/05/2017	Moderate	Family are struggling to get the staff to engage with them and they wish assistance to obtain the best care package for their sister.	Investigation currently underway		Communication
Slough	Crisis Resolution & Home Treatment Team (CRHTT)	Reading	25/04/2017	Moderate	Crisis team did not turn up to any of the numerously arranged meetings and put a card through the letter box when pt was in, she did not hear them knock and they did not phone. She has lost confidence in CRHTT but want an explanation as to why all the planned visits for help never materialised	Upheld	There was a breakdown in communication and a number of learning outcomes have been identified in the IO report.	Care and Treatment
Windsor, Ascot and Maidenhead	Crisis Resolution & Home Treatment Team (CRHTT)	Reading	19/04/2017	Low	Mother unhappy with contact with CRHTT, following which her daughter was detained on section. Mother also feels as a carer she was unsupported by staff.	Partially Upheld	There were no clinical care failings for the patient but mother did feel unsupported and we have acknowledged and apologised for that. Staff member has reflected and apologised.	Communication
Windsor, Ascot and Maidenhead	CMHT/Care Pathways	Slough	15/06/2017	Moderate	Pt says the medicine Aripiprazole gives him side effects. He has a cornea graft and extremely high blood pressure and he says this medication has contraindications to his other medication. He has been told if he does not have this injection he will be sectioned. SEAP have advised him there must be documentation in order to make him comply to having this medication.	Investigation currently underway		Medication
Slough	Health Visiting	Windsor, Ascot and Maidenhead	27/06/2017	Moderate	HV provided assistance for complainants partner and 2 children to depart the house without notice bound for a women's refuge. Father of the children believes the HV has put his children at risk as he states his partner was in fact the perpetrator of domestic abuse towards him.	Investigation currently underway		Attitude of Staff
Slough	CMHT/Care Pathways	Slough	07/04/2017	Moderate	Complaint that there has been a catalogue of failures by Slough CMHT. Family say they have been crying out for help but these have been ignored and patient has now damaged neighbour's property leading to him being arrested and sectioned.	Upheld	The investigation has shown a lack of documented support and evidenced conversation with family members. The primary carer of the patient was not identified as such and was not offered any support. The revised risk planning processes will improve this area of care and support. The clinical care offered to the patient was clinically appropriate.	Care and Treatment

Geographical Locality	Service	Reporting Locality	First received	Complaint Severity	Description	Outcome code	Outcome	Subjects
Wokingham	CAMHS - Child and Adolescent Mental Health Services	Windsor, Ascot and Maidenhead	23/05/2017	Moderate	Meeting June/July 2016, family advised they would get a report which they have yet to receive, they were also told there would be another meeting in 6 months which also has not happened. Mother has made many calls leaving messages which have not been returned	Local Resolution		Care and Treatment
Slough	LDS Community Patients	Reading	12/04/2017	Minor	Mother wants to know why her daughters epilepsy medication was increased when she had not had a fit for 10 years and why it took from diagnosis of Epilepsy in 2013 until Feb 2017 to be advised of this diagnosis.	Upheld	The root of the complaint is about communication with the named doctor. This person has left the Trust and record keeping in not clear that he communicated decisions with the family. Therefore complaint is upheld.	Care and Treatment
Reading	CMHT/Care Pathways	Reading	30/05/2017	Minor	Pt discharged from services but says she did not receive any notification of this. States she is struggling with her MH and needs help which she says is not on offer. She wants to 1.see a community Psychiatrist 2.be referred for specialist help, Trauma Service 3. Have a CPN if necessary 4. Meaningful liaison between MH and GP 5. recognition of sleep deprivation 6. recognition that 'inappropriate behaviour' is due to her condition. 7. recognition that she needs support not a judgmental approach 8. that she is recognised as a person not a condition	Partially Upheld	The patient did not engage with care co-ordinators after initial allocated one left. It is recognised that the initial relationship did not have the boundaries that were expected which would have impacted managing the expectation of future relationships with the team. Further appointments with the team have been offered.	Care and Treatment
Bracknell	Crisis Resolution & Home Treatment Team (CRHTT)	Reading	25/05/2017	Low	Pt referred to CRHTT in May 2015 following a visit to A&E. In Jan 2017 pt became distress contacted CRHTT who agreed to come out but did not causing further distress. Since that time pt says there have been many other occasions where CRHTT have said they will attend and have not.	Investigation currently underway		Care and Treatment
West Berks	District Nursing	West Berks	12/06/2017	Moderate	Mother wishes to know how and why her son's pressure ulcer ended up as it did?	Partially Upheld	Although no failings in nursing care and nurses acted appropriately, the investigation has identified a number of learning outcomes to improve the service going forward.	Care and Treatment

Geographical Locality	Service	Reporting Locality	First received	Complaint Severity	Description	Outcome code	Outcome	Subjects
Reading	Intergrated Pain and Spinal Service	West Berks	15/06/2017	Low	Pt unhappy about the letter summarising his assessment. He says it is full of half truths and conjecture and he wants it reviewed. He also states that throughout the meeting the clinician were dismissive of the pts expectations of recovery through the NHS.	Partially Upheld	A clear explanation has been given regarding the wording in the letter with an apology for the wording towards the end of the letter that stated patient was 'happy' to continue. Clinician has also apologised that he was perceived as condescending and mocking.	Attitude of Staff
Reading	CMHT/Care Pathways	Reading	30/03/2017	Low	Secondary complaint - Pt has received correspondence from NHS England saying they have not received an application from BHFT so patient wishes to know what is happening. He has responded to several of the points raised in our letter which need addressing ORIGINAL COMPLAINT Patient feels there has been a lack of provision of adequate and appropriate treatment for his MH and psychological condition from 2014 to the present day. Pt wishes to receive adequate and relevant treatment at Castle Craig Hospital and redress for damage to health and life and expense of alternative support.	Not Upheld		Care and Treatment
Bracknell	Common Point of Entry	Wokingham	06/03/2017	Low	Pt diagnosed with Asperger's wants to know why therapy has been refused by CMHT as this goes against the Autism Act and is not making reasonable adjustments under the Equality Act. Why does the Trust not provide ASD Pathway on a diagnosis service? Why can't services communicate with each other when using different systems?	Partially Upheld	No clinical failings identified. Care has been appropriate but patient cannot have the therapy she wants. However, PALS have apologised for the lack of responsiveness so this element upheld.	Care and Treatment
Wokingham	CMHT/Care Pathways	Wokingham	16/01/2017	Minor	Mother feels her son's Consultant Psychiatrist has neglected her son's wellbeing and has failed to give him the correct care and medication that he had required. She feels the cocktail of drugs he was on led to his nervous breakdown and she feels she questioned the pt in an inappropriate manner.	Partially Upheld	1.Dr will discuss with colleagues recently involved in care about the issues raised in the complaint and will reflect on any learning points. 2. Dr will continue having reflective notes and case based discussions as part of her annual appraisal. 3.The importance of involving and working together with patients families and carers will be shared with all team managers in the monthly patient safety and quality meetings at Wokingham locality meeting and discussed in the wider trust clinical governance meeting.	Care and Treatment

Geographical Locality	Service	Reporting Locality	First received	Complaint Severity	Description	Outcome code	Outcome	Subjects
Reading	Adult Acute Admissions	Mental Health Inpatients	06/03/2017	Moderate	Pt previously on a section now voluntary has been going out of the ward buying tablets / knives and bleech from Boots and Asda. Father believes pt is at high risk of self harm and suicide. Father does not understand why PPH are talking about discharge and feels we are neglecting our duty of care.	Partially Upheld	The main issue for this complaint is that the patient was allowed off the ward when she purchased items such as bleach, tablets and knives. Investigation showed that our record keeping was lacking and we are unable to say that the risk assessment was fully carried out. However, assessing risk briefly at the time of leave is considered to be part of a more overarching risk assessment.	Care and Treatment

Berkshire Healthcare NHS
NHS Foundation Trust

2017/18 Strategy Implementation Plan Exception Report to end of July 2017

INITIATIVE	Apr/May	June/Jul	Aug/Sep	Oct/Nov	Dec/Jan	Feb/Mar
Strategic Goal 1: To provide safe services, good outcomes and good experience fo treatment and care.						
QUALITY IMPROVEMENT PROGRAMME						
Strategy Deployment						
Quality Management Improvement System (QMIS)						
Improvement Projects						
Quality Improvement Office						
Benefits Realisation						
Comments:						
OPTIMISING ESTATES						
Options for Trust Headquarters						
Development of University of Reading as a primary Trust site						
Sale of Craven Road						
Comments:						
Development of UoR as primary Trust site - work has started on site for Phase 1, with relocation of children's services expected in January 2018. Relocation of services in Phase 2 now expected to be in December 2018.						
MENTAL HEALTH SERVICE DEVELOPMENT						
Mental Health Strategy Implementation (initiatives not covered elsewhere)						
Prospect Park Hospital Development Programme						
Out of Area Placements - non-acute						
Mental Health Pathways						
Comments :						
Centre of Excellence: new exclusion suite and staff office delays while agreements with funders concluded. Seclusion suite completion date Dec 2017, office accommodation February 2018						
MH Pathways - a delay on the implementation of new Cluster 8 Pathway, dependent on approval of investment case due for submission for approval at end of August.						
ZERO SUICIDE INITIATIVE						
Comments:						
ELECTRONIC PRESCRIBING AND MEDICINES ADMINISTRATION (EPMA)						
Comments: All workstreams delayed for 2-3 months to resolve issues.						
CHILDREN YOUNG PEOPLE AND FAMILIES (CYPF) SERVICE INTEGRATION:						
Comments: Health & Wellbeing on toolkit delayed due to scale of project. Additional resource deployed. Management restructure delayed during round of 0-19 service tenders, to reflect their outcome and ensure delivery of efficiencies.						
CAMHs DEVELOPMENT						
Future in Mind						
Tier 4 proposed move from Wokingham Hospital to Prospect Park Hospital						
Comments : *Both projects awaiting national developments and commissioner intentions.*						
AGENCY AND BANK PROJECT						
Comments:						
Strategic Goal 2: To strengthen our highlight skilled and engaged workforce.						
WORKFORCE STRATEGY						
Staff recruitment and retention						
Comments:						
BUILDING OUR STRATEGIC WORKFORCE CAPABILITY						
Comments:						
EMBRACING DIVERSITY - Delivering our Equality and Inclusions Strategy 2016-20						
Mandatory & Statutory Reporting						
Other priorities						
Comments:						
Other priorities: Disability Steering Group action plan delayed for further consultation and development.						
Strategic Goal 3: To deliver services which are efficient and financially sustainable.						

INITIATIVE	Apr/May	June/Jul	Aug/Sep	Oct/Nov	Dec/Jan	Feb/Mar
COST IMPROVEMENT PLANS						
Comments: Overall on target however slippage on specific projects.						
INFORMATION TECHNOLOGY ROADMAP						
Information Technology Architecture Strategy						
Comments:						
Strategic Goal 4: Understanding and responding to local needs as part of an integrated system.						
GLOBAL DIGITAL EXEMPLAR						
Direct patient access and communications						
Digital wards and services						
Digital workforce						
Research and quality improvement						
Comments: *Specific programmes will be reported when fully underway*						
CONNECTED CARE (Interoperability)						
Comments:						
LEARNING DISABILITY (LD) STRATEGY						
LD Service Optimisation and Redesign						
Comments:						
SUSTAINABILITY AND TRANSFORMATION PLANS						
Frimley Health and Social Care						
Buckinghamshire, Oxfordshire and Berkshire - *to be updated when details known*						
Bekshire West Accountable Care System						
Comments:						
INTEGRATED IAPT						
Comments:						
HEALTH AND SOCIAL CARE INTEGRATION (by 2020/21)						
Details to be added when known.						
ONE PUBLIC ESTATE						
Berkshire East (Frimley Health and Social Care)						
Berkshire West (ACS Programme)						
Comments: Some elements of the Berkshire West plans are being revisited to consider the efficacy of delivery.						
DEVELOPMENT OF THE HEALTH HUB						
NHS 111/Urgent Care Clinical Coordination Hub - Alliance with SCAS						
Comments: Some delays in signing the subcontract with SCAS; heads of terms agreed. (*Postscript: contracts signed and mobilisation on track for 5 September 2017)*						

Trust Board Meeting Dates 2018

Meeting	January	February	March	April	May	June	July	August	September	October	November	December
Discursive Trust Board	9		13			12				9		
Trust Board		13		10	8		10	14 *(If needed)*	11		13	11
Audit Committee	31			25	23		25			31		
Finance, Information and Performance (FIP)	31 *(If needed)*	27	28	25	30 *(If needed)*	27	25	29 *(If needed)*	26	31	28	26 *(If needed)*
Quality Assurance Committee (QAC)		20			15			21			20	

Council of Governors Dates 2018

Meeting	January	February	March	April	May	June	July	August	September	October	November	December
Formal Council Meeting			21			20			19 (+AGM)			12
Trust Board / Council Meeting		21 (NED)			16 (Board)		18 (NED)				21 (Board)	