Berkshire Healthcare NHS
NHS Foundation Trust

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

TRUST BOARD MEETING HELD IN PUBLIC

10:00am on Tuesday 10 April 2018
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 13 February 2018	Martin Earwicker, Chair	Enc.
5.2	Action Log and Matters Arising	Martin Earwicker, Chair	Enc.
	QUALITY		
6.1	Board Visit: Skimped Hill Health Visiting Service	Mark Day, Non-Executive Director	Enc.
6.2	Quality Assurance Committee a) Minutes of the meeting held on 20 February 2018 b) Learning from Deaths Quarterly Report c) Guardians of Safe Working Quarterly Report	Ruth Lysons, Chair of the Quality Assurance Committee Dr Minoo Irani, Medical Director	Enc.
	EXECUTIVE UPDATE		
7.1	Executive Report	Julian Emms, Chief Executive	Enc.
	PERFORMANCE		
8.1	Month 11 2017/18 Finance Report*	Alex Gild, Chief Financial Officer	Enc.
8.2	Month 11 2017/18 Performance Report*	Alex Gild, Chief Financial Officer	Enc.
8.3	Finance, Investment and Performance Committee Meetings on 27 February 2018 and 28 March 2018 **The Month 10 and 11 Finance and Performance Reports were reviewed by the FIP Committee*	Naomi Coxwell, Chair of the Finance, Investment and Performance Committee	Verbal
	STRATEGY		
	Corporate Governance		
9.1	Use of the Trust's Seal	Alex Gild, Chief Financial Officer	Enc.

No	Item	Presenter	Enc.
9.2	Council of Governors Update	Martin Earwicker, Chair	Verbal
Closing Business			
10.	Any Other Business	Martin Earwicker, Chair	Verbal
11.	Date of the Next Public Trust Board Meeting – 8 May 2018	Martin Earwicker, Chair	Verbal
12.	**CONFIDENTIAL ISSUES:** To consider a resolution to exclude press and public from the remainder of the meeting, as publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted.	Martin Earwicker, Chair	Verbal

Berkshire Healthcare NHS
NHS Foundation Trust

AGENDA ITEM 5.1

Unconfirmed minutes

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

Minutes of a Board Meeting held in Public on Tuesday 13 February 2018

Boardroom, Fitzwilliam House

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

18/001	**Welcome** (agenda item 1)
	Martin Earwicker, Chair welcomed everyone, including the observers: Nolan Victory, Equality Human Resources Manager, Rachel Cerfontyne, Insight Programme, Phil Kemp, Head of Professional Development, HFMA, Andy Mack, Norfolk and Suffolk, NHS Foundation Trust, John Adams, Liaison and Ed Leonardo, Liaison.
18/002	**Apologies** (agenda item 2)
	Apologies were received from: Mehmuda Mian, Non-Executive Director.
18/003	**Declaration of Any Other Business** (agenda item 3)
	There was no other business declared.
18/004	**Declarations of Interest** (agenda item 4)
	i. Amendments to Register – none
	ii. **Agenda Items** – none
18/005	**Minutes of the previous meeting – 12 December 2017** (agenda item 5.1)

	The Minutes of the Trust Board meeting held in public on Tuesday 12 December 2017 were approved as a correct record of the meeting.
18/006	**Action Log and Matters Arising** (agenda item 5.2)
	The schedule of actions had been circulated. **The Trust Board**: noted the schedule of actions.
18/007	**Patient Story Video (agenda item 6.1)**
	The Trust Board watched a video in which a father described the experience of his daughter who was an in-patient in the Campion Unit. It was noted that the patient was autistic and had learning disabilities and had been a resident in the Campion Unit for two years. The patient's father was complimentary about the care his daughter had received but also spoke of the challenges both for himself and for his daughter around leaving the home environment and moving to a residential setting. The Chair said that it would be helpful for the Trust Board to hear a variety of experiences, both positive and negative. The Trust Board: thanked the patient's father for sharing his experience.
18/008	**Patient Experience Report – Quarter Three (agenda item 6.2)**
	The Director of Nursing and Governance presented the paper and highlighted the following points: • The Trust had continued to sustain a complaint response rate of 100%. This continued to be an excellent achievement. • The average number of days to resolve a complaint was 18; • Just under 65% of complaints closed in Quarter three were upheld or partially upheld; • The Trust had received 53 complaints in Quarter 3 across a range of services. • Reading Community Mental Health Team (CMHT) remained an outlier in the number of complaints received. • Graph 1 on page 26 of the agenda pack showed a breakdown by locality of the number of complaints received by Community Mental Health Teams over the last three years. It was important to look at trends over time rather than compare performance against the last Quarter; • The Friends and Family Test results in respect of people with Learning Disabilities was included in the report. During Quarter 3, there was a response rate of 32% and 86.27% of people would recommend the service to friends and family. • The Friends and Family response rate for the rest of the Trust's services remained below the 15% threshold to be statistically valid. The Chair asked how the Trust had managed to achieve a response rate of 32% for people with Learning Disabilities. The Director of Nursing and Governance said that the response rate for physical health was always higher than for mental health. The Director of Nursing and Governance reported that the Trust had developed an easy read Friends and Family Test form for people with Learning Disabilities. Mark Day, Non-Executive Director said that it was disappointing that the Friends and Family Response Rate was still below 15% and asked what more could be done to reach

	the 15% threshold. The Director of Nursing and Governance said that the latest initiative was to include the form with the patient's discharge letter, but it was too early to judge whether this would improve the response rate. Ruth Lysons, Non-Executive Director referred to the acute mental health in-patient complaints and said that staff at Prospect Park Hospital had informed her that there were sometimes delays in the Care Quality Commission providing Doctors to provide a second opinion. The Director of Nursing and Governance said that this was the responsibility of the Care Quality Commission, but agreed to contact the Mental Health Act Office to find out whether there were any concerns raised about the non-availability of a Care Quality Commission appointed Doctor to provide a second opinion. **Action: Director of Nursing and Governance** Ruth Lysons, Non-Executive Director referred to table 10 (pages 32 and 33 of the agenda pack) and commented that the Crisis Resolution and Home Treatment Team service had the highest number of complaints which were not upheld and asked whether there was a process to review the outcome of complaints. The Director of Nursing and Governance reported that the Locality Clinical Directors reviewed all complaints and complaints were also discussed at the Locality Patient Safety and Quality meetings. The Chief Executive said that the Trust recorded telephone calls and in some cases, complaints about staff attitude were not upheld because it was clear when listening to the tape that the complainant had been rude and abusive to the member of staff. The Director of Nursing and Governance said that when a complaint was upheld, the tape would be used in a training session with staff. Chris Fisher, Non-Executive Director commented that the largest number of complaints related to care and treatment and asked whether there were any underlying themes. The Director of Nursing and Governance said that one of the key learning themes from complaints was that the Trust needed to communicate better with patients, their families and carers to ensure that they were clear about what services would be provided. David Buckle, Non-Executive Director referred to graph 8 of the report (page 37 of the agenda pack) and said that it was impressive that 5,950 compliments were recorded in 2016-7 and asked whether there was a system in place to record compliments. The Director of Nursing and Governance reported that compliments were recorded on the Trust's electronic DATIX system. It was noted that not all compliments were counted and that it tended to be written compliments which were recorded. David Buckle, Non-Executive Director referred to table 14 of the report (page 35 of the agenda pack) and asked whether there was any learning from the two Parliamentary and Health Service Ombudsman complaints which were partially upheld. The Director of Nursing and Governance said that the key learning was in relation to ensuring that a record of any meetings with a complainant was taken. The key learning in respect of the other complaint was around nutrition and hydration.

	The Chief Executive said that he signed off all complaint letters and confirmed that the Trust had a rigorous complaints process. Naomi Coxwell, Non-Executive Director referred to the section on “deep dives” (page 39 of the agenda pack) and asked whether the associated costs of implementing the recommendations from the “deep dive” into same sex accommodation had been taken account of in the budget. The Director of Nursing and Governance reported that the proposals were at the planning stage and would need to be costed. **The Trust Board:** noted the report.
18/009	**Executive Report** (agenda item 7.1)
	The Executive Report had been circulated. The following issues were discussed further: **a) Staff Flu Vaccination Programme** The Chief Executive said that he was pleased that the Trust had met NHS England’s 70% target for the uptake of the staff flu vaccination. It was noted that the Trust had vaccinated more staff than in the previous years, but changes to NHS England’s requirements for the CQUIN monies meant that staff who were vaccinated, but who subsequently left the Trust had to be discounted, meant that the Trust’s performance had deteriorated. David Buckle, Non-Executive Director asked whether the Trust would ensure that staff were offered the best available vaccine. The Director of Nursing and Governance reported that the Trust would be offering staff the quadrivalent flu vaccine in 2018-19. **b) National Shortages of Nurses** David Buckle, Non-Executive Director commented that in addition to the shortages of nurses, the average age of retirement for GPs was 57 years old and asked what the Trust was doing to retain Westcall GPs. It was noted that changes to the NHS Pension Scheme had resulted in an increase in the number of Doctors opting for early retirement. The Chief Operating Officer said that the Trust was working with different staff groups to find out what actions could be taken to try and reduce staff turnover by making the Trust a more attractive place to work. The Chair reported he and the Director of Nursing and Governance were meeting with local Universities to discuss how to encourage more nurse applicants and to identify whether there were any barriers which needed to be escalated at the national level. **c) 2018-19 Planning Guidance** Chris Fisher, Non-Executive Director referred to NHS Provider’s briefing paper on the 2018-19 Planning Guidance and asked what was meant by the eight shadow Accountable Care Systems (now called Integrated Care Systems) moving to a more “autonomous” regulatory relationship with NHS England and NHS Improvement. The Chief Executive explained that as a Segment 1 NHS Foundation Trust, the Trust had minimal contact with NHS Improvement. In contrast, NHS England had significant involvement in the work of the Clinical Commissioning Groups. Moving forward, it was

	envisaged that the Integrated Care System would have greater freedoms and autonomy. **d) Ban on the use of Agency Health Care Assistants** Ruth Lysons, Non-Executive Director asked whether the ban on the use of agency Health Care Assistants had impacted on other staff groups. The Director of Nursing and Governance said that if there were particular issues with shifts not being filled, a decision would be taken to temporarily close beds in order maintain safe staffing for patients. The Director of Nursing and Governance said that there was a process in place called the "platinum key" whereby the ban on the use of agency Health Care Assistants could be overturned in certain defined circumstances. It was noted that the platinum key process had recently been invoked, but the Agency was also unable to fill the shift. **The Trust Board**: noted the report.
18/010	**Month 9 2017-18 Finance Report** (agenda item 8.1)
	The Month 9 financial summary report had been circulated. The Chief Financial Officer reported that the Finance, Investment and Performance Committee meeting held on 31 January 2018 had reviewed the Month 9 Finance Report. The Chief Financial Officer presented the finance report and highlighted the following points: • The Quarter 3 financial position was largely in line with the financial plan for 2017-18. • The capitalisation of the Electronic Prescribing and Medicines Administration project costs, the on-going vacancy factor and reduced depreciation costs had offset the increased cost of Out of Area Placements and the non-delivery of some of the Cost Improvement Plans. • The Trust was on track to deliver its financial plan at year end and to achieve its control total. **The Trust Board noted:** the following summary of financial performance and results for Month 9 2017/18 (December 2017): **Year To Date (Use of Resource) metric:** • Overall rating 1 (plan 1) o Capital Service Cover 2.1 (rating 2) o Liquidity days 7.9 (rating 1) o Income and Expenditure Margin 1.0% (rating 2) o Income and Expenditure Variance 0.3% (rating 1) o Agency -30.7% (rating 1) **Year To Date Income and Expenditure** (including Sustainability and Transformation funding): • Plan: £1,329k net surplus • Actual: £1,834k net surplus • Variance: £505k favourable

	Month 9: £523k surplus (including Sustainability and Transformation funding), +£298k variance from plan: Key variances: • Non recurrent Electronic Prescribing and Medicines Administration (EPMA capitalisation of staff costs in line with the Global Digital Exemplar plan (+£220k). The Trust's External Auditors had been informed and had raised no objections; • Depreciation charge was lower than plan by +£120k; • Acute Overspill Out of Area Placement pressures (-£205k) **Forecast** The Trust's current forecast was to achieve its year end control total (£2.4m net surplus). The Trust Board noteed in particular, the vacancy factor and asset life review of IT which had reduced the depreciation charge and had offset acute overspill and independent hospitals (specialist) Out of Area Placement overspends, driving an adverse EBITDA (operating surplus) forecast variance of -£920k. **Cash:** Month 9: £19.9m (plan £19.7m) Largely offsetting variances to plan were: • Year to Date capital underspend due re-phasing of the Estates and IM&T expenditure +£2.9m • Aged debtors over 30 days total: -£3.0m; including the Royal Berkshire Hospital NHS Foundation Trust (£0.3m). The majority of the debt was 30-60 days old and was being actively worked on to reduce balances by year end. **Capital expenditure Year To Date:** Month 9 £4.5m (plan £6.2m. The variance to plan was primarily due to: • Estates – extended timescales regarding ward configuration at Prospect Park Hospital, the majority of the budget was likely to be spent in the next financial year (£1.5m) • IM&T, re-phasing of IT replacement programme (£2.4) • Externally funded: the Global Digital Exemplar funding was included in the total capital spend (£0.7m) and the Renal Unit donation (£1.5m) **The Trust Board**: noted the report.
18/011	**Month 9 2017-18 Performance Report** (agenda item 8.2)

	The Month 9 2017-18 Performance Summary Scorecard and detailed Trust Performance Report had been circulated. The Chair reported that the Finance, Investment and Performance Committee had scrutinised the Month 9 Performance Report at its meeting on 31 January 2018. The Chief Executive reported that the Finance, Performance and Risk Executive Committee had also reviewed the Month 9 performance report and had concluded that the Trust's Quality Improvement Programme was focused on the right performance issues. It was hoped that as the Quality Improvement Programme developed that there would be improvement in the key areas of: falls; self-harm, absent without leave/absconsions from Prospect Park Hospital and a reduction in the number of violence and aggression incidents towards staff. It was noted that the performance scorecard was rated amber for people and contractual performance. **The Trust Board**: noted the report.
18/012	**Finance, Investment and Performance Committee Meeting – 31 January 2018** (agenda item 8.3)
	Naomi Coxwell, Chair of the Finance, Investment and Performance Committee reported that the Finance, Investment and Performance Committee meeting in January 2018 had discussed the year end forecast position and had confirmed that the Trust was on track to meet its control total. The Committee had particularly noted the Trust's cash position and the phasing of the Capital Programme. The Committee had also discussed the draft financial plan for 2018-19. The Committee had not identified any issues of concern in respect of the performance indicators for month 9 as presented in the Performance Assurance Framework report. **The Trust Board:** thanked Naomi Coxwell, Chair of the Finance, Investment and Performance Committee for her update.
18/013	**Key Projects and Strategy Implementation Plan 2017-18 – Update Report** (agenda item 9.1)
	The Director of Corporate Affairs presented the report and highlighted the following points: • This was the first report which used a revised template for updating the Trust Board on the key Trust initiatives and other elements of the Strategy Implementation Plan. • The new approach was in line with the revised reporting arrangements for the Trust's Executive Committees. • The Trust Board was asked to particularly focus on any schemes RAG rated as Amber or Red. In particular, for January 2018 these included Out of Area Placements, Health and Wellbeing and Recruitment and Retention. **The Trust Board:** noted the report.
18/014	**Equality Strategy Six Monthly Update** (agenda item 9.2)
	The Director of Corporate Affairs presented the report and highlighted the following points: • There had been an improvement in the ethnic diversity of the workforce at Bands 7 and 8a; • There was greater equity in access to external learning and development opportunities by BAME staff across all bands with the exception of Bands 8C and

	8D; • There had been a downward trend in the number of bullying and harassment complaints. • The next update report would incorporate the results of the 2017 Staff Survey which would be published in March 2018. The Chair referred to current key performance indicators in relation to increased representation of BAME staff in agenda for change Bands 7-8D and said that it was disappointing that there was a negative change in relation to the representation of BAME staff at Band 8C. The Director of Corporate Affairs explained that there were relatively few staff at Bands 8C and 8D and the increase/decrease was likely to relate to one or two staff changes. The Director of Corporate Affairs said that progress in relation to staff at Band 7 was very encouraging because this represented a much greater number of staff. The Chief Executive said that it would be helpful to include the number of staff alongside the percentages in future reports. **Action: Director of Corporate Affairs** The Chair referred to the section on access to external Learning and Development opportunities and asked why there had not been the same increase in parity in respect of staff at Bands 8C and 8D. The Director of Corporate Affairs repeated that there were relatively small numbers of staff at Bands 8C and 8D and also staff at this level tended to access internal learning and development programmes rather than more generic external programmes. The Chief Executive introduced the Equality Human Resources Manager who was observing the Trust Board meeting and paid tribute to his work in developing the Trust's *Make it Right* programme for BAME staff. It was noted that there would be an external evaluation of the *Make it Right* programme, but initial feedback from the delegates on the pilot programme was very positive. Ruth Lysons, Non-Executive Director referred to the cover sheet and requested that the dates of the local Diversity Road Show events planned between April-September 2017 be circulated to members of the Trust Board so they could attend the event. **Action: Director of Corporate Affairs/Company Secretary** Naomi Coxwell, Non-Executive Director reported that she had recently attended the Staff Induction session and confirmed that there was a very good session on Equalities presented by the Equality Human Resources Manager. **The Trust Board:** noted the report.
18/015	**Annual Health and Safety Report** (agenda item 10.1)
	The Chief Operating Officer presented the paper and highlighted the following points: • Following the fire at Grenfell Tower in June 2017, a full review of all sites was undertaken. No buildings were confirmed to have the type of cladding at Grenfell Tower. • During 2017, the Royal Berkshire Fire and Rescue Service undertook two fire safety visits and several site specific risk assessment visits at Prospect Park Hospital and inspected all in-patient sites with cladding and conducted a joint

	training exercise with the Trust at Jasmine Ward, Prospect Park Hospital. • There were seven incidents reported under the RIDDOR regulations, down from 23 incidents in the previous year. • There was a decrease in the number of days lost through sickness (the full time equivalent rate for 2017 was 13.5 days compared with 14.9 days in 2016). The main reasons for absence were anxiety, stress, depression and other psychiatric illnesses. • Compliance with statutory fire safety training target of 90% had been met with the exception of October and November when the rate had dipped to 89%. Ruth Lysons, Non-Executive Director asked whether the Fire Service had raised any concerns about the cladding on the Trust's in-patient areas. The Chief Operating Officer reported that the Fire Service checks had resulted in some minor remedial works being undertaken at Upton Hospital and at Wokingham Community Hospital on Windsor and Ascot wards. The majority of the work was around the effectiveness of fire resisting doors. The Chief Executive said that it would be helpful if future annual reports included a section on the number of fires involving patients together with benchmarking data from similar Trusts. The Chief Executive pointed out that the Trust treated Arsonists and therefore the risk of a patient deliberately starting a fire was high. **Action: Chief Operating Officer** Ruth Lysons, Non-Executive Director referred to the section on personal safety and lone working (page 137 of the agenda pack) and asked for more information about the comment that around 23% of the 1,352 registered on the web portal as users of the lone worker personal safety devices had been activated within any one month. The Chief Operating Officer said that the 23% related to staff routinely activating the devices when they were making home visits and did not relate to the number of incidents. The Chief Operating Officer said that at the moment, staff were not required to activate the devices when they were making home visits, but this was something which was currently being reviewed. The Chief Executive pointed out that there were a range of activities, including conducting risk assessments of patients which were designed to make home visits safer for staff. Chris Fisher, Non-Executive Director congratulated the Trust on significantly reducing the number of RIDDOR incidents during 2017. The Chair referred to the section on the number of days lost through sickness (page 140 of the agenda pack) and said that it would be helpful for the Trust Board to understand the underlying reasons behind the most common reason for staff sickness which was anxiety, stress, depression or other psychiatric illness. David Buckle, Non-Executive Director said that it would also be helpful to see how the Trust compared with other similar Trusts. **Action: Director of Corporate Affairs** **The Trust Board:** noted the Annual Health and Safety Report.
18/016	**Use of the Trust Seal** (agenda item 10.2)
	The Trust Board: noted that the Trust's Seal had been affixed to the Newbury and Thatcham PFI Renal Dialysis Unit lease and licence for alternations to the building.

18/017	**Audit Committee Minutes – 31 January 2018** (agenda item 10.3)
	Chris Fisher, Chair of the Audit Committee reported that both the Trust's Internal and External Auditors had praised the Committee's approach to reviewing the Board Assurance Framework. Mr Fisher reminded the meeting that the Trust had changed its approach to the Board Assurance Framework back in October 2016. There was now a clear distinction between the strategic risks on the Board Assurance Framework and the Trust wide operational risks on the Corporate Risk Register. In addition to reviewing the Board Assurance Framework and the Corporate Risk Register at each of its meetings, the Audit Committee had also conducted "deep dives" into three of the risks, reviewed the gaps in controls and assurance and scrutinised the evidence to demonstrate that the mitigations put in place were effective in managing the risks. It was noted that the Internal Audit Plan 2018-19 (attached as an appendix to the Audit Committee minutes) was linked to the risks on Board Assurance Framework. Mr Fisher thanked the Company Secretary for the work she had done to develop the new approach to the Board Assurance Framework and Corporate Risk Register. Mr Fisher reported that there was a new standing item on Clinical Claims and Litigation on the Audit Committee agenda which also included a section on any learning. It was noted that the Audit Committee had also discussed the Annual Cyber Security Report and had received a report on the Implementation of the General Data Protection Regulations. The Chief Executive referred to the section on Internal Audit and commented that it was very reassuring that the Internal Auditors had concluded that there was significant assurance in respect of the Trust's Mortality Review systems and processes. The Chief Executive paid tribute to the work of the Medical Director for his work on developing a robust mortality review process. Mark Day, Non-Executive Director referred to the Annual Audit Plan for 2018 and asked how the audits would be prioritised. Mr Fisher explained that the Trust's contract with the Internal Auditors was for a fixed number of days per year and that over the course of the year, if other more urgent audits were identified there was scope to amend the plan and accommodate more urgent work. The Chair thanked Chris Fisher for his update on the Audit Committee. **The Trust Board:** noted the minutes of the Audit Committee held on 31 January 2018.
18/018	**Annual Declarations of Interest and Fit and Proper Person Test Assurance Report** (agenda item 10.4)
	The Company Secretary presented the paper and explained the Trust Board received an annual Declarations of Interest Report and that this year, the report had been expanded to include a section on the Fit and Proper Persons Test and the Trust Board Code of Conduct.

	The Chief Executive said that paper provided assurance that the Trust was taking appropriate steps to ensure that the requirements of the Fit and Proper Person Test were being met on an on-going basis. The Chief Executive proposed that there should be a standing item on Remuneration Committee's agenda on the Fit and Proper Persons Test as part of the report back on the outcome of the Chief Executive's and Executive Directors' appraisals. **Action: Company Secretary** The Trust Board: a) Noted the Register of Individual Executive and Non-Executive Directors' Interests; b) Noted the Assurance provided in the report that all Directors and Staff on Very Senior Manager contracts are and remain "Fit and Proper Persons" as defined in Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014) and do not meet the grounds of unfitness as specified in Part 1 of Schedule 4 of the Registered Activities Regulations. **The Trust Board**: noted the report.
18/019	**Constitutional Changes Report** (agenda item 10.5)
	The Company Secretary presented the paper and reported that the Trust's Constitution was last updated in 2015. A summary of the proposed changes was attached at appendix 1 of the paper. The Company Secretary explained that key changes included provision of the Chair to rule whether there would be a conflict of interest for a Non-Executive Director to serve on the Board of another NHS Body. The wording in respect of the Council of Governors voting to remove a Governor had also been made clearer. It was noted that the other proposed changes reflected changed in national guidance and legislation. Mark Day, Non-Executive Director queried whether references to "Monitor" in the Constitution should be replaced with "NHS Improvement". The Company Secretary explained that legally Monitor and the Trust Development Agency remained separate organisations. Ruth Lysons, Non-Executive Director queried whether references to "he" should be replaced with "he or she". The Company Secretary explained that the Trust followed the NHS Foundation Trust Model Constitution which used the convention of the masculine gender to include the feminine gender. It was agreed to amend the Constitution to include "he or she". **Action: Company Secretary** Ruth Lysons, Non-Executive Director referred to the summary of proposed changes (appendix 1 of the report) in relation to Annex 7 of the Constitution and suggested that the proposed changes should be made clearer when the report was submitted to the Council of Governors. **Action: Company Secretary** The Trust Board approved the proposed changes to the Trust's Constitution and noted that the proposed changes would also need approval by the Council of Governors and would be need to be ratified by the Members at the next Annual Members' Meeting in September 2018.
18/020	**Annual Trust Board Meeting Planner** (agenda item 10.6)

	The Annual Trust Board Meeting Planner 2018 had been circulated. Mark Lejman, Non-Executive Director said that for the Trust to receive an unqualified opinion from the External Auditors was a significant achievement. **The Trust Board:** noted the Annual Trust Board Meeting Planner.
18/021	**Council of Governors Update** (agenda item 10.7)
	The Chair reported that three new public governors, a new appointed governor and a new staff governor had recently joined the Council of Governors and had attended the Governor Induction session. The Chair reported that he was holding a series of coffee mornings with governors at locations around Berkshire to provide an opportunity for governors to have informal conversations with him. The Chair reported that the Trust would be hosting a Frimley Health and Care Integrated Care System event for the governors from the three Provider Trusts (Berkshire Healthcare, Frimley Health and Surrey and Borders). **The Trust Board:** noted the update.
18/022	**Any Other Business** (agenda item 11)
	There was no other business.
18/023	**Date of Next Meeting** (agenda item 12)
	Tuesday, 10 April 2018
18/024	**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 13 February 2018.

Signed…….Date 10 April 2018
(Martin Earwicker, Chair)

Berkshire Healthcare NHS
NHS Foundation Trust

AGENDA ITEM 5.2

BOARD OF DIRECTORS MEETING: 10/04/2018

Board Meeting Matters Arising Log – 2018 – 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
12.12.17	17/232	Workforce Strategy Update Report	The timescales for achieving the retention targets to be included in future update reports.	08.05.18	**BS**	Progress to be included in the next Workforce Strategy update
13.02.18	18/008	Patient Experience Report	The Director of Nursing and Governance to contact the Mental Health Act Office to find out whether any concerns had been raised about the availability of a Care Quality Commission appointed Second Opinion Doctor at Prospect Park Hospital	08.05.18	**HM**	The Director of Nursing and Governance plans to raise this issue at the next CQC engagement meeting towards the end of April 2018

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Status
13.02.18	18/014	Equality Strategy Six Monthly Update Report	Future update reports to include the number of staff alongside the percentages in relation to the number of BAME staff in Bands 7-8D and the numbers accessing training and development opportunities.	July 2018	**BS**	
13.02.18	18/014	Equality Strategy Six Monthly Update Report	Non-Executive Directors to be forwarded the dates of the local Diversity Road Show events.	10.04.18	**BS/JH**	Dates to be confirmed
13.02.18	18/015	Annual Health and Safety Report	Future reports to include a section on the number of fires involving patients together with benchmarking data from similar trusts.	April 2019	**DT**	
13.02.18	18/015	Annual Health and Safety Report	Further information to be provided on the underlying reasons behind the most common reason for staff sickness (anxiety, stress, depression and other psychiatric illness) and how the Trust benchmarked with other similar trusts.	08.05.18	**BS**	To be included in Workforce Strategy Update in May 2018
13.02.18	18/018	Annual Declarations of Interest and Fit and Proper Persons Test Assurance Report	A standing item on the Remuneration Committee's agenda on the Fit and Proper Persons Test as part of the report back on the outcome of the Chief Executive's and Executive Directors' appraisals.	10.04.18	**JH**	The Remuneration Committee's work programme has been updated.
13.02.18	18/019	Constitutional Changes	The Constitution to be amended to include	10.04.18	**JH**	Completed

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Status
			feminine as well as masculine pronouns.			
13.02.18	18/019	Constitutional Changes	The Constitution summary sheet in relation to the proposed changes to Annex 7 to make it clearer that the section number relate to the body of the Constitution document when the report was presented to the Council of Governors.	20.06.18	**JH**	A group of Governors have volunteered to meet with the Company Secretary to review the proposed Constitutional changes in more detail. The proposed changes will now be considered at the June 2018 Council meeting.

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	10 April 2018
Title	**Board Visit Report – Skimped Hill Health Visiting Service**
Purpose	To receive the report of the Board Visit undertaken by Mark Day, Non-Executive Director
Business Area	Corporate
Author	Company Secretary
Relevant Strategic Objectives	To provide good outcomes from 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
Equalities and Diversity Implications	N/A
SUMMARY	Board members conduct 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 Visit report is selected for inclusion on the agenda for discussion.
ACTION REQUIRED	To receive and note the report and discuss any matters raised.

Berkshire Healthcare NHS
NHS Foundation Trust

BERKSHIRE HEALTHCARE BOARD VISIT TO HEALTH VISITING SERVICE , SKIMPED HILL HEALTH CENTRE, BRACKNELL ON THURSDAY 25TH JANUARY 2018.

People participating

Mark Day - NED
Michelle Davison – Health Visitor
Jo Bishop
Eleanor Hyde
Jane Proctor

Introduction

My visit was conducted with Michelle Davison a health visitor based at Skimped Hill Health Centre. On arrival I was met by a member of the Health Visiting team as Michelle was away from the clinic conducting a visit with a patient. However, I was made to feel welcome by other members of staff and upon her arrival Michelle was apologetic for her late return to the Health Centre which was due to a number of late changes to her priorities for the day. As I was to learn during the course of my visit daily work schedules and demands upon the Team's work are continually changing and the ability to multi task and cope with conflicting demands is a regular occurrence and a critical skill required by the team members.

Michelle qualified around three years ago and has specialised in Health Visiting since that time. She appears to enjoy her work and spoke both professionally and passionately about the work she undertakes as part of the Health Visiting team based at Skimped Hill.

The Work

Within the Bracknell locality there are four teams and they provide a service covering Bracknell and extending out as far as Ascot, Crowthorne and Sandhurst. There are currently two health visiting teams based at Skimped Hill due to high sickness levels. The nature and range of the services provided has been changing over the past few years due both to the contracts negotiated by the commissioners and the reducing resource available within the health visiting teams.

The current emphasis is clearly focussed on new born children and child protection issues which requires an integrated service approach operating in a multi-agency environment. The issue of resources was raised with me by all of the people I met with and not in a negative manner but rather out of concern for the people being cared for as well as the pressures and demands being placed on the staff involved in providing the service.

Over the past couple of years the number of health visitors has reduced considerably and this has had a corresponding effect on the pressures being experienced by the remaining staff. Steps have been taken to re-align some of the work being performed such as the transfer of 6-8 week checks, 9 month and 24 month development reviews now being undertaken by the nursery nurse team to reduce the workload on the health visiting team.

Despite this and some other changes it still feels to the team that the expectations of them and the needs of their service users exceed the resources available. Whilst performance targets are being achieved it is not always clear from the reporting of key performance indicators the level of challenge being experienced to deliver these results.

Due to the nature of their work the health visitors work for a large part of their time independently and see themselves as remote workers. When talking about support networks and team working it was evident that the individuals do feel a real sense of camaraderie and spoke positively about the strong team ethos that exists across the team and the flexibility each of them provides to offer support to fellow team members. This is particularly the case during the weekly allocation meeting where the teams come together for resource sharing and distribution of the following weeks caseload.

During my time with Michelle we conducted a visit to a 7 month old baby in foster care. It was impressive to see the professionalism of Michelle as she conducted the assessment of the baby and handled the foster carer parents. Her knowledge extended well beyond simply the health assessment of the baby to discussions of the transitioning of the child over the coming weeks to his new adoptive parents.

The foster parents have been fostering for over nine years and had been caring for the current baby since he was two days old. They were complimentary about the support they have received from the health visiting team particularly in the past when their needs have been more challenging.

Michelle showed interest in the foster parents attitude and preparedness for the imminent transitioning period and the consequent effect on the baby. It felt a re-assuring visit with a positive check of the child and outlook for the future with the adoption plan.

Key Risks

It was apparent from all of the conversations that took place during my visit that resourcing is the subject uppermost in people's minds. However, this subject was not, in my opinion, approached from a negative perspective but from a genuine desire to be able to deliver a quality service with reduced levels of risk to patient safety and wellbeing of service users. Similarly there is a desire to see less pressure on staff and to improve the sickness levels that have been experienced in the past.

It was frequently mentioned that the team has been through a huge amount of change over the past couple of years and that a period of stability is needed to allow the team to deliver the service expected both by the commissioners and the people they care for. A few

references were made to the recent contractual changes in Slough and how this has caused a sense of concern amongst the team across the rest of the county.

Technology improvements appeared to have been made and were well received over the past few years but further improvements and refinements to the systems are needed by the team to allow a more efficient use of their time and avoid duplication of effort. Most commonly cited were enhancements to Rio and mobile phone connectivity to the system which would allow better use of time. Most of the team appeared to be using a paper diary system due to systems limitations.

Last but not least on issues facing the team is the subject of car parking. This matter was mentioned to me by all of the people I spoke to and it appears to have worsened following the opening of the new shopping centre next to the health centre. The situation was already chaotic for parking spaces but follwing the opening of the Lexicon Centre the matter has become a source of immense frustration. This is particularly the case for health visitors who by the very nature of their work will be leaving and returning to the health centre on a frequent basis.

To re-inforce the matter it was illustrated personally to me following the home visit that we conducted with patients unable to leave the car park due to some inappropriate parking that had blocked the exit and caused frustration for those trying to use the car park.

Conclusion

I enjoyed my visit to the health visiting team and found the team to be keen to share their pride in their work and the quality of services provided to their service users. Pressures do exist in terms of workload and resourcing and the strong team ethic that exists is a real strength in dealing with the challenges that the team face.

During my visit I gave the Board's thanks and appreciation for all of the professionalism and dedicated work undertaken by the team and in closing I would like to offer my sincere thanks to everyone that I spent time with and in particular Michelle for her time and patience during our discussions.

Mark Day

29th January 2018

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	10 April 2018
Title	**Quality Assurance Committee – 20 February 2018**
Purpose	To receive the unconfirmed minutes of the meeting of the Quality Assurance Committee of 20 February 2018
Business Area	Corporate
Author	Company Secretary for Ruth Lysons, Committee Chair
Relevant Strategic Objectives	Goal 3 – Good Patient Experience - To provide good outcomes from treatment and care.
CQC Registration/Patient Care Impacts	Supports ongoing registration
Resource Impacts	None
Legal Implications	Meeting requirements of terms of reference.
SUMMARY	The unconfirmed minutes of the Quality Assurance Committee meeting held on 20 February 2018 are provided for information. Attached to the minutes are the following reports which were discussed at the Quality Assurance Committee meeting and are presented to the Trust Board for information: • Guardians of Safe Working Hours Quarterly Report • Learning from Deaths Quarterly Report
ACTION REQUIRED	The Trust Board is requested to receive the minutes and the quarterly Guardians of Safe Working Hours and Learning from Deaths Reports and to seek any clarification on issues covered.

Berkshire Healthcare NHS
NHS Foundation Trust

Minutes of the Quality Assurance Committee Meeting held on Tuesday, 20 February 2018, Fitzwilliam House, Bracknell

Present:	Ruth Lysons, Non-Executive Director (Chair) Julian Emms, Chief Executive Dr Minoo Irani, Medical Director Dr Guy Northover, Lead Clinical Director Mehmuda Mian, Non-Executive Director Debbie Fulton, Deputy Director of Nursing Amanda Mollett, Head of Clinical Effectiveness and Audit
In attendance:	Julie Hill, Company Secretary Nav Sodhi, Inpatient Clinical Director *(via Skype for the item on Clinical Audit)*

1 Apologies for absence and welcome

The Chair welcomed everyone to the meeting and in particular welcomed Dr Guy Northover, Lead Clinical Director who was now a standing member of the Committee.

The Chair also reported that Dr Nav Sodhi, Inpatient Clinical Director would be joining the meeting via Skype for the Clinical Audit item. The Chair reported that it was now the Committee's standard procedure for the relevant clinician to be invited to participate in the discussion of the Clinical Audit item.

Apologies had been received from: David Buckle, Non-Executive Director, Helen Mackenzie, Director of Nursing and Governance and David Townsend, Chief Operating Officer.

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 21 November 2017

The minutes of the meeting held on 21 November 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:

a) Clinical Audit Report – Rapid Tranquilisation

The Medical Director reported that the action plan included improvements to recording of when patients had been offered oral tranquilisation.

b) Horizon Scanning

It was noted that a report on the use of falls assistive technology would be presented to the May 2018 meeting.

The Committee noted the schedule of actions.

5. Patient Safety and Experience

5.1 Quality Concerns Status Report

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

- The concern about Bluebell Ward had been downgraded from severe to high in response to the recent Care Quality Commission inspection where improvements were evidenced;
- Two further concerns had been added at the January 2018 meeting of the Quality Executive Committee:
    - Physical health monitoring at Prospect Park Hospital; and
    - Record keeping in mental health services, in particular, at Prospect Park Hospital.

The Chief Executive commented that the detail of the new quality concerns around physical health monitoring and record keeping at Prospect Park Hospital needed to be developed.

Action: Director of Nursing and Governance

The Chair asked whether trainee nurses received both physical and mental health training as part of their nursing degree.

The Deputy Director of Nursing explained that student nurses now specialised in either physical or mental health.

The Medical Director confirmed that junior doctors also started specialising at an early stage in their training.

Mehmuda Mian, Non-Executive Director referred to the concern in relation to the Campion Unit and asked when the new Ward Manager would be taking up their post.

The Deputy Director of Nursing reported that the new Campion Ward Manager had started with the Trust last week.

The Chair asked whether the Ward Manager being in post meant that the risk score would be reduced.

The Chief Executive said that Sorrell Ward which was the Trust's locked ward and the Campion Unit for people with learning disabilities would always be high risk because of the vulnerability of the patient cohort.

Mehmuda Mian, Non-Executive Director asked when the work on the new seclusion room would be completed. The Chief Executive said that the work was due to be completed by the end of March 2018.

Mehmuda Mian, Non-Executive Director referred to the quality concern about the interfaces between the Common Point of Entry, the Crisis Resolution Home Treatment Team and the Community Mental Health Team and asked what was meant by the relationships being described as “clunky”.

The Deputy Director of Nursing explained this comment related to the Trust’s internal referral process from the Common Point of Entry to the community mental health services which was sometimes not as efficient as it could be.

The Chief Executive said that it would be helpful if the quality concerns paper highlighted when progress had been made. This could include a reduction in the number of complaints and/or positive comments by the Internal Auditors etc.

Action: Director of Nursing and Governance

Mehmuda Mian, Non-Executive Director reported that in her role as a Mental Health Act Manager, she had met with the Mental Health Act Office staff and had discussed the challenges associated with the increase in the number of patients under section.

The Chair reported that Mental Health Act Office staff had raised a concern around the difficulty in finding a Care Quality Commission appointed Doctor to provide a second opinion. The Chief Executive said that this was a national issue which could only be resolved by the Care Quality Commission.

The Committee noted the report.

5.2 Serious Incidents Report – Quarterly Report

The Deputy Director of Nursing presented the report and said that in Quarter 3 there were initially 20 Serious Incidents but 2 were downgraded following further investigation.

The Deputy Director of Nursing reported that the key themes identified from the Serious Incidents this Quarter were:

- Improving awareness of correct and robust information governance processes;
- Management of falls risk in Mental Health In-patient wards; and
- Working with and involving carers and families.

The Chair said that the report provided a useful analysis of the Serious Incidents and learning and themes from those incidents.

The Chair commented that a number of Serious Incidents related to Information Governance breaches and requested that Non-Executive Directors and Mental Health Act Managers be reminded about the importance of Information Governance and not to use their personal or Berkshire email addresses to receive/send confidential information.

Action: Company Secretary

The Chair said that working with and involving carers and families had been identified as one of the Serious Incident themes this Quarter and asked what more could be done.
The Chief Executive said that carers and families were actively involved in the Trust’s Zero Suicide Project and in developing the new Personality Disorder

Pathway Quality Improvement Project. It was also noted that the Trust also had an active Carers Forum.

Mehmuda Mian, Non-Executive Director said that it would be helpful if an update on the Trust's Carers Strategy could be presented at one of the Trust Board Discursive meetings or if it was added to the Committee's work programme.

Action: Chief Operating Officer/Company Secretary

The Committee noted the report.

5.3 Thematic Review of Choking Deaths Action Plan

The Deputy Director of Nursing presented the report and said that following the death from choking of a patient at Prospect Park Hospital in July 2017, the Trust had commissioned a thematic review of all incidents of choking that had occurred at Prospect Park Hospital.

The Chair reminded the meeting that the February 2018 In Committee Trust Board meeting had discussed the findings of the Thematic Review and that it was agreed that the Quality Assurance Committee would be responsible for overseeing the implementation of the action plan.

The Committee noted the action plan.

5.4 Bluebell Ward Serious Incident Action Plan

The Deputy Director of Nursing presented the report and said that a number of the actions, for example, improving the effectiveness of ward handovers were now embedded as part of the Quality Management Information Systems (QMIS) Quality Improvement Programme work.

The Deputy Director of Nursing reported that the safer bedframes had now been ordered. It was noted that the new beds were not appropriate for some patients with physical disabilities.

The Committee noted that report.

5.5 Learning from Deaths Quarterly Report

The Chair reminded the meeting that the Committee was responsible for providing assurance to the Board that the Trust had robust mortality review systems and processes in place and that learning from deaths was identified and disseminated.

The Chair reported that the Trust's Internal Auditors had reviewed the Trust's mortality and learning from deaths systems and processes and had provided a rating of "significant assurance". On behalf of the Committee, the Chair thanked the Medical Director and his team for developing the mortality review methodology ahead of national guidance.

The Medical Director presented the paper and reported that the Royal College of Psychiatrists was expected to publish mortality review guidance in respect of deaths of people with Severe Mental Illness in September 2018.

The Medical Director reported that the key themes for Quarter 3 were similar to those identified in the last Quarter:

- Management of mental health patient's physical health;
- Communication with families
- Accessing reasonable adjustments
- Mental capacity.

The Chair welcomed the new format of the report which included a more detailed summary section.

Mehmuda Mian, Non-Executive Director commented that in respect of deaths investigated as Serious Incidents, only one family out of seven had taken up the opportunity to have a meeting with the Trust following the death of their relative.

The Deputy Director of Nursing said that it was unusual that the number was so low this Quarter, but explained that some families chose to meet with the Trust at a later date. It was noted that the Serious Incident Investigating Officer also made contact with the families as part of the Serious Incident Review process.

The Committee noted the report.

5.6 Care Quality Commission Compliance Actions Report

The Deputy Director of Nursing reported that the purpose of the paper was to provide an update on the progress made to complete the Care Quality Commission's "should do" and "must do" action plans following recent inspections.

The Deputy Director of Nursing reported that the estates work in relation to Bluebell Ward was due for completion by the end of March 2018.

The Committee noted the report.

5.7 Board Assurance Framework (Risks 1, 2 and 5)

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

The Chair referred to risk 2 and asked what the Trust was doing to meet the needs of rough sleepers and the homeless. The Chief Executive pointed out that the Trust was not commissioned to provide services for the homeless and that this was an issue for local authorities. The Chief Executive reported that a number of homeless people were former members of the armed forces and the Trust provided mental health services to veterans.

The Committee reviewed each risk and agreed that there was nothing further to add.

Mehmuda Mian, Non-Executive Director reported that the Audit Committee had reviewed the whole Board Assurance Framework at its meeting on 31 January 2018.

The Committee noted the report.

Clinical Effectiveness and Outcomes

6.1 Quality Accounts Report 2017-18 – Quarter 3

The Head of Clinical Effectiveness and Audit presented the report and advised that the updated information from the Quarter 2 report was highlighted in yellow. It was noted that the Quarter 3 report would be circulated to stakeholders for their comments.

The Head of Clinical Effectiveness and Audit reported that NHS Improvement was expected to publish the final Quality Accounts guidance later this week.

The Head of Clinical Effectiveness and Audit reported that the draft Quality Accounts report would be forwarded to members of the Committee electronically for their comments and that the final Quality Accounts report would be submitted to the May 2018 Trust Board meeting for final approval.

The Chair asked whether there were any concerns about meeting NHS Improvement's deadline for submission of the final Quality Accounts Report. The Head of Clinical Effectiveness and Audit said that the timescales were tight, but confirmed that the Trust was on track to submit the Quality Accounts Report on time.

The Committee noted the report.

6.2 Clinical Audit Report – Prescribing High Dose and Combined Antipsychotics on Adult Psychiatry Wards

The Chair welcomed Dr Nav Sodhi, Inpatient Clinical Director who joined the meeting via Skype. The Chair explained that she had introduced a new system for reviewing clinical audit reports which included inviting the relevant clinician to join the meeting. In addition, the covering report now included a more detailed summary of the audit findings. It was noted that the Chair and David Buckle, Non-Executive Director continued to be sent the full clinical audit reports in advance of the meeting.

The Medical Director reported that the audit had measured three practice standards, of which the Trust had a compliance rate higher than the national sample across all three standards and was measured very positively against other trusts.

It was noted that the main area requiring improvement (practice standard 3) was to ensure that where regular high-dose antipsychotics were prescribed, there should be a clear plan documented for regular clinical review, including safety monitoring.

Dr Sodhi commented that the audit demonstrated that the Trust had performed better than other trusts in its use of PRN (as and when required) medication and that this was a very positive result.

The Chair referred to the summary table on page 190 of the agenda pack which highlighted the Trust's performance in relation to the number of individuals who received one antipsychotic at a time and asked whether it was better for patients to receive combined doses of medication.

The Medical Director explained that there were clinical nuances and that there were circumstances when you had to give more than one antipsychotic at a time and that it was important to note that the Trust's performance for this practice standard too was higher than in the benchmarked group.

The Chair asked whether it would be possible in future to link the outcome of clinical audits to the Trust's Quality Concerns in the summary report.

The Medical Director pointed out that the Quality Concerns were at a very high level and that the clinical audits were in the main about specific aspects of clinical practice. The Chief Executive explained that the Quality Concerns were the result of the triangulation of data from a number of sources, including clinical audits and that if a clinical audit was relevant to a Quality Concern, this would feature in the Quality Concern summary.

The Chair thanked Dr Sodhi for joining the meeting.

The Committee noted the report.

Update Items for Information

7.1 Guardians of Safe Working Hours Quarterly Report

The Medical Director presented the paper which had been written by the Trust's Guardians of Safe Working Hours. The Medical Director said that it was reassuring that no unsafe working hours had been reported and that no other patient safety issues requiring escalation had been identified.

The Committee noted the report and in particular that no trainee doctor had breached the key mandated working limits of the new contract and that all rotas were currently compliant.

The Medical Director reported that one exception report was received in this Quarter from a core trainee who had worked 1.5 additional hours on a shift to support a timely review of a CAMHS case at Wexham Park Hospital.

The Chair referred to the section in the report about rota gaps (page 205 of the agenda pack) and asked whether the Trust used Bank staff to fill gaps in the trainee rota. The Medical Director confirmed that the Trust used Bank staff who were in the main Trust employees who were willing to work additional shifts.

The Committee thanked the Guardians of Safe Working Hours for their report.

7.2 Quality Executive Committee Minutes

Mehmuda Mian, Non-Executive Director asked whether the Trust had been impacted by flu and the norovirus. The Deputy Director of Nursing reported that a couple of the wards had patients with flu, but this was nothing out of the ordinary for this time of year.

The minutes of the Quality Executive Committee meetings held on: 13 November 2017, 11 December 2017 and 08 January 2018 were noted.

Closing Business

8. Standing Item – Horizon Scanning

The Chair reminded the meeting that as stated on the action log update report, the issue of demand outstripping capacity and meeting the health care needs of the local population would be discussed as part of the Trust Board's discussion on the Trust's three year Strategy at the March 2018 Discursive meeting.

The Chair reminded the meeting that a presentation on the use of falls assistive technology was on the forward plan for the May 2018 meeting.

The Chief Executive asked for an update on the Quality Improvement Programme's reducing harm work stream which included falls, self-harm, pressure ulcers and reducing assaults on staff to be included on the Committee's work programme for the year.

Action: Director of Nursing and Governance

As discussed earlier, Mehmuda Mian, Non-Executive Director said that it would be helpful to have an update on how the Trust involved carers at either this Committee or at a Trust Board Discursive meeting.

Action: Chief Operating Officer/Company Secretary

The Chair requested that a "deep dive" report on meeting the physical health needs of mental health patients also be added to the Committee's work programme.

Action: Director of Nursing and Governance

9. Any Other Business

There was no other business.

10. Date of the Next Meeting

15 May 2018 at 10.00

These minutes are an accurate record of the Quality Assurance Committee meeting held on 20 February 2017.

Signed:-_____

Date: - 15 May 2018_____

QAC	20th February 2018
Title	**Learning from Deaths Quarter 3 Report**
Purpose	To provide assurance to the Trust Board that the trust is appropriately reviewing and learning from deaths
Business Area	Clinical Trust Wide
Authors	Head of Clinical Effectiveness and Audit, Medical Director
Relevant Strategic Objectives	1 – To provide accessible, safe and clinically effective services that improve patient experience and outcomes of care
Resource Impacts	None in this quarter
Legal Implications	None
Equality Diversity Implications	A national requirement is that deaths of patients with a learning disability are reviewed to promote accessibility to equitable care. This report provides positive assurance of learning of this
SUMMARY	965 deaths were recorded on the clinical information system during Q3 where a patient had been in contact with a trust service in the year before they died. Of these 62 met the criteria to be reviewed further. All 62 were reviewed by the executive mortality review group and the outcomes were as follows: • 27 were closed with no further action • 7 were classed as Serious Incident Requiring Investigation • 27 required further review using an initial finding review (IFR) • 1 Internal Root Cause Analysis (RCA) During Q3 the mortality review group reviewed the findings of 25 IFR reports, 9 IFRs related to patients with a learning disability (these are cases reviewed in Q3 and will include cases reported in previous quarters). Each case is reviewed to identify if there has been a lapse in care prior to the patient's death, In Q3 it was identified that there was 1 death of a patient with sepsis (the patient had died in September 2017) where a lapse in care occurred. This death was investigated as a serious incident, learning was identified by the service and an action plan is in place to consolidate the learning. Several themes and areas of learning from a review of the deaths are being implemented and the Q3 learning builds and supports the learning identified in Q2. Key learning themes which continue are: • Management of patient's physical health whilst they are under our care for management of their mental health • Communication with Families • Accessing reasonable adjustments • Mental capacity **Internal Audit of the Mortality Review Process and Learning from Deaths.** An audit of the trust's mortality review and learning from deaths policy and process was undertaken by RSM as part of the approved internal audit plan for 2017/18. The audit reviewed the Trust's adherence to the National Guidance on Learning from Deaths and found that the Trust is effectively identifying, reporting, investigating, monitoring and learning from deaths of patients in their care. The internal audit opinion is that the Board can take substantial assurance that the controls upon which the organisation relies to manage the identified risk are suitably designed, consistently applied and operating effectively. The audit has identified 2 low priority issues requiring management actions which have an action plan for implementation.

ACTION REQUIRED	The Quality Assurance Committee is asked to seek any further clarification and approve the Q3 learning from deaths report which was reviewed by the QEG on the 12th February. The report will be received by the Trust Board in March.

Table of Contents

1.0 Purpose

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

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

2.0 Scope

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

3.0 Introduction

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

The first part of the report identifies the total numbers of patients who have died, in most cases these are expected deaths but where a specific trigger is noted (as identified in our policy) we then review these deaths further.

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

We review the care provided for all patients who had a learning disability and died.

For any deaths which are reviewed and there is believed to be a lapse in care which contributed to the death, this would be escalated as a Serious Incident (SI) and investigated using a Root Cause Analysis (RCA) approach.

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

4. Data

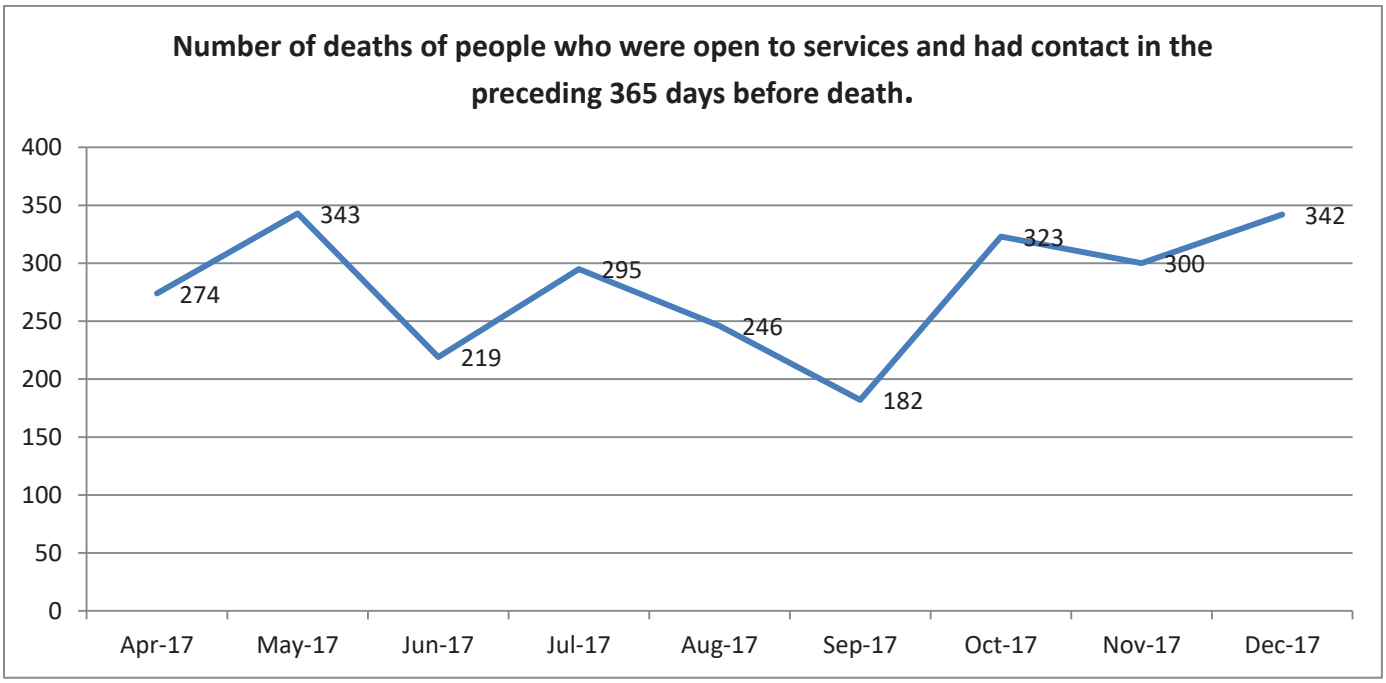
4.1 Total Number of deaths in Q3

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 with one or more of the trust services in the preceding 365 days before their death and was on an active caseload of the service at the time of death.

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

	Month of Death			
Specialty (last team seen before death)	**October 2017**	**November 2017**	**December 2017**	**Total**
Nursing episode	159	154	176	489
Dietetics	32	30	30	92
Old age psychiatry	33	23	32	88
Speech and language therapy	23	17	24	64
Community health services medical	13	20	25	58
Podiatry	17	16	19	52
Palliative medicine	14	14	17	45
Cardiology	7	4	3	14
Respiratory medicine	5	7	1	13
Rehabilitation	7	3	3	13
General medicine	5	2	5	12
Adult mental illness	3	5	3	11
Physiotherapy	1	1	2	4
Clinical psychology	1	1	1	3
Geriatric medicine		2		2
Genito-urinary medicine		1	1	2
Learning disability	2			2
Community paediatrics	1			1
Grand Total	323	300	342	965

Figure 2 shows the total numbers of deaths for 2017/18



*** Note Figures will be revised at the end of the fiscal year and will increase as notifications from the national spine are updated.**

In quarter 3 we reviewed the number of deaths by age range, this has allowed us to also ensure we are aware of all children's deaths which are reviewed in detail by the child death overview panel (CDOP) hosted by the Local Authority.

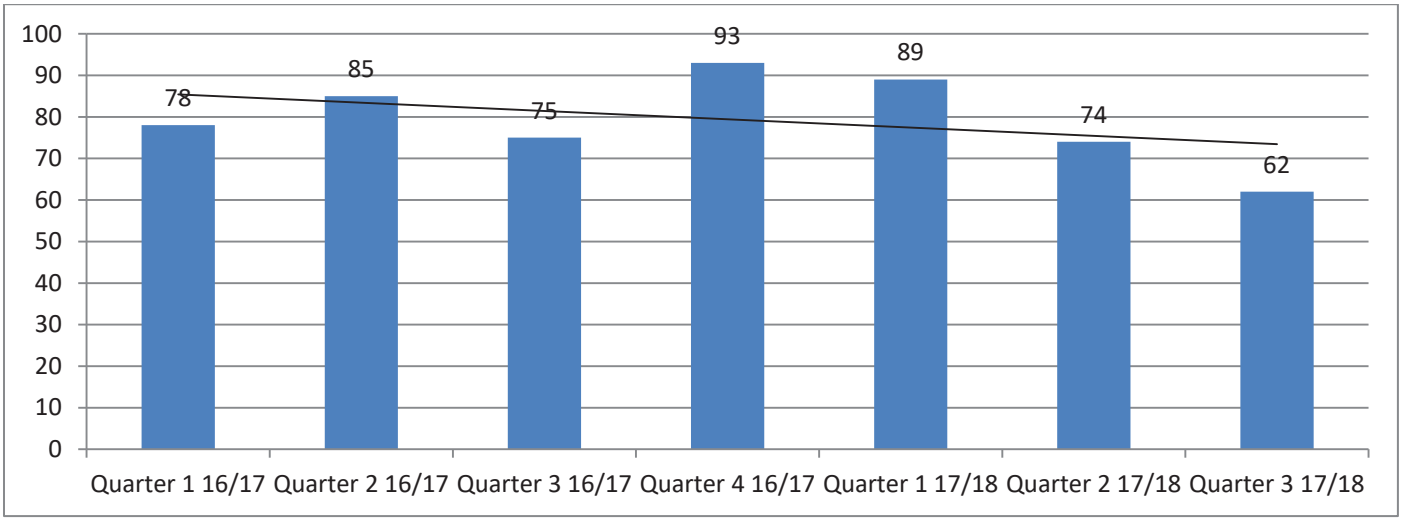
Figure 3	Age Range				
Last service accessed	0-17	18-65	66-75	Over 75	Total
Nursing episode	7	50	78	354	489
Dietetics	1	15	16	60	92
Old age psychiatry			5	83	88
Speech and language therapy	1	5	8	50	64
Community health services medical		6	3	49	58
Podiatry		4	15	33	52
Palliative medicine		17	11	17	45
Cardiology		1	3	10	14
Respiratory medicine		3	5	5	13
Rehabilitation		5	3	5	13
General medicine		3	1	8	12
Adult mental illness		10	1		11
Physiotherapy			1	3	4
Clinical psychology		1	1	1	3
Geriatric medicine				2	2
Genito-urinary medicine				2	2
Learning disability		2			2
Community paediatrics	1				1
Grand Total	10 (1%)	122 (13%)	151 (16%)	682 (70%)	965

*** Note Figures will be revised at the end of the fiscal year and will increase as notifications from the national spine are updated.**

4.2 Deaths reported for review

The learning from deaths policy identify a number of criteria which if met require the service to submit an incident form for review on the Trust incident management system (Datix) following the notification of a death. Figure 4 identifies those deaths which have been reported.

Figure 4 The Number of deaths reported per quarter on the Datix Incident System.



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

Figure 5 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 5 – Datix reported deaths by month reported and service which the patient had contact with.

Service	October	November	December	Total
Community Hospital Inpatient	10	6 (3T)	6 (1T)	**22**
Community Mental Health	2	1	5	**8**
Community team for people with learning disabilities	3	2	2	**7**
Crisis response and home treatment team	1		1	**2**
Children's and young people's services		2	3	**5**
District Nursing /Intermediate care		1		**1**
Community Mental Health Older Adults	1	2	1	**4**
Criminal liaison and justice	1		3	**4**
Common point of entry			1	**1**
Westcall out of hours GP	1	1		**2**
Mental Health inpatients		1	1	**2**
Tissue viability service	1			**1**
Rapid response and assessment service	1			**1**
Psychological medicines service	1		1	**2**
Total Datix	**22**	**16**	**24**	**62**

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) report

All deaths classified as SI will follow the existing SI investigation process using Root Cause Analysis methodology 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 6. Outcome following review at EMRG in Q3

	Number
Datix closed no further action required	27
Classified as a Serious Incident (SI)	7
Initial findings report (IFR) requested	27
Local RCA being undertaken	1
Total	62

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

Figure 7: Number of SI relating to a patient death in Q3

Service (Source Q3 Serious Incident Report)	Number
Mental Health Inpatients (patient on planned leave at the time)	1
Wokingham Community Mental Health	1
Reading Community Mental Health	1
Slough Community Mental health	1
Crisis Resolution and Home Treatment Team (CRHTT)	1
Westcall Out of Hours GP Services*	2
Total	**7**

*1 reported as a sub SI in Q2 and escalated to an SI in October 2017 (Q3)

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) makes contact with the family as soon as it is known that an incident causing death has occurred. At this time they offer a face to face meeting which will include:

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

Telephone contact was made with all 7 families in Q3 and this is followed up in writing. At this point all were offered the opportunity for a face to face meeting, 1 family accepted this opportunity and the meeting occurred in October, all other families declined to meet.

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 provides contact details and explains 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 makes 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 is provided to the family if they would like one. This meeting is also followed up in writing.

Of the SI's reported in Q3 only one investigation has been fully completed; the family involved in this case declined to have a meeting to discuss the investigation at this stage.

Of the SI's reported in Q2 two have been completed and the families both accepted a post investigation meeting, one is due to be completed and the family are reviewing the report before a meeting is confirmed.

5.2 For non SI deaths

The learning disability team make contact with the family following the reported death of a person with a learning disability. Telephone contact was made for each of the 7 individuals, for 6 of the 7 this was to offer condolences to the care home or supported living staff where the individuals lived. This action was completed by the local CTPLD team members who knew and had a relationship with the staff teams. 1 of the 7 individuals lived at home with their family and therefore the support call was made to their next of kin.

The Head of Learning Disability Services also sends a card of condolence to the family with information on how to contact the team if the family would like to discuss the person's care and treatment prior to death. This has recently been updated to include details regarding the LeDeR programme. Of the 7 individuals 1 had no known family

therefore only 6 cards and letters were sent to those identified as next of kin. Two families have made telephone contact thanking the Head of Service for his letter and to advise that they were raising concerns about the other organisation's care of the patient. Details of these issues were passed to the LeDeR review to follow up further with the individual families and providers.

6. Mortality Review Group

6.1 Reviews Conducted

The purpose of the local review of deaths is to determine if any potential problem or lapse in care may have contributed to the person's death, to identify learning and to utilise the learning to guide necessary changes in services in order to improve the quality of patient care. It is expected that, over a period of time, these improvements in response to learning from deaths will nationally contribute to reduction in premature deaths of people with learning disabilities and severe mental 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 Q3.

Figure 8: Reviews Conducted in Q3

	Total Number	Services
October	12 IFRs reviewed	Learning Disability – 4 cases Crisis Resolution and Home Treatment Team -1 case Court Liaison and Divert Services – 1 case Older peoples mental health services – 1 case Mental Health Inpatients – 1 case Westcall Out of Hours GP – 1 case Community Hospital transfer -2 cases Neurorehabiliation services – 1 case
November	7 IFRs reviewed	Learning Disability – 3 cases Community Hospital -1 case Home treatment team – 1 case Older Peoples Mental Health Services -1 case Westcall Out of Hours GP -1 case
December	6 IFRs reviewed	Learning Disabilities – 3 cases Community Hospital – 2 cases Common Point of Entry - 1 case

Note: these are cases reviewed in Q3 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 Q3.

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 Q3, 16 expected deaths (patients admitted for end of life care) were reported on our community health inpatient wards (compared to 20 in Q2). These were reviewed by the executive mortality review group where sufficient information had been provided to give assurance that appropriate and of life care had been given.

In addition 2 patients died unexpectedly whilst inpatients on our physical health wards and both of these had IFRs completed which were reviewed by the EMRG.

2 deaths were reported by community nursing services; both were reviewed by the executive mortality group. 1 death reported related to a patient receiving palliative care at the end of life, sufficient information had been provided to give assurance that appropriate care had been given and the case was closed with no further review required. The other case was reported as the police had raised safeguarding concerns about the care home in which the patient lived, our only contact was a referral by the GP for a tissue viability review and the case was being taken forward for further review by the trust safeguarding team.

6.3 Deaths of Children and Young People

From RiO 11 deaths were identified where the child or young person had been in contact with our services in the year before their death.

Of these 5 have been reported on Datix in Q3 (4 have been reported in January and 2 are in the process of being reported). 3 of the deaths were closed after Datix information was reviewed by the EMRG with no further action and for 2 deaths an IFR was requested and these are due for review by the mortality review group in February 2018.

The table below details the circumstances of the death, 4 of the 5 children whilst known to our services were receiving significant care and treatment from the acute hospital or consultants at the time of death

All child deaths below are discussed and reported through the Child death overview panel (CDOP) the Trust Clinical Director for Children Young People and Families will attend this panel from February 2018, where additional learning can then be shared back to the MRG.

Age	Description of circumstances
<1 month	Sudden unexpected infant death from natural causes
<1 year	Extreme Prematurity not discharged following birth
1 year	Child with complex health needs and learning disabilities admitted to acute hospital, condition deteriorated, end of life care implemented and discharged home where child died.
11 year	A child with complex health care and learning disabilities who following a period in intensive care was transferred to a children's hospice for end of life care
16 years	Child with complex health needs with learning difficulties, sudden death from epilepsy

6.4 Deaths of adults with a learning disability

In Q3 a total of 7 deaths of adults with learning disabilities who were known/open to the learning disability services in the 12 months prior to their death have been reported.

All 7 have undergone review by the clinical review group, and of those reviewed 6 individuals were known/open to the specialist learning disability services in the 12 months prior to their death. 1 individual was referred to the service one month prior to their death

There was no lapse in care provided by BHFT LD service identified in all 7 deaths, and these deaths were attributed to the following causes:

4 deaths associated with respiratory disorders
1 death due to acute leukaemia
1 death due to spontaneous intracerebral haemorrhage
1 death due to biliary sepsis

Demographics of adult patients with a learning disability

In Q3 we were notified of 7 people who died, 5 were male and 2 were female.

Age

The age at time of death ranged from 31 to 88 years of age (median age: 60 yrs.).

Severity of Learning disability

Mild	1
Moderate	3
Severe	2
Not known	1

Ethnicity:

All of the individuals who died in this period were from a 'White British' background.

National Learning Disability Mortality Review Process (LeDeR)

From the 1st September 2017 the Learning Disability Service has provided notification to LeDeR (national Learning Disability Mortality Review process) of all deaths of individuals with learning disabilities known to the Trust. Notifications have been made to LeDeR for each of these 7 adult deaths and also 4 deaths related to children who had learning disabilities (Section 6.3)

7. Additional Case Review

7.1 In addition to our standard criteria for reporting deaths we are required to identify an additional sample of cases to review which fall outside of this criteria. This is to provide assurance that at least a small proportion of deaths which fall outside our Datix reported criteria are reviewed for learning and for any lapse in care. In Q3 we reviewed an additional number of deaths where the patient had accessed community district nursing in the 3 months prior to their death.

We reviewed the cases retrospectively and selected a random sample across all 6 localities. The total sample (from Q2) was 270 deaths which were identified on the electronic patient system (RiO). A total of 18 records (6%) were reviewed with 3 from each locality. Service Managers reviewed the cases against a set of detailed questions with the assistance of the Head of Clinical Effectiveness and Audit. All 18 case reviews were then subjected to a second line review by the EMRG where no further investigation was required; no lapse in care or cause for concern were identified.

7.2 End of Life Care National audit

A new national audit of Care at the End of Life (NACEL) is being launched 2018 and will span 3 years. It will be auditing progress against the Five Priorities for Care, NICE Quality Standards and the CQC Domains. The scope of the audit will include the following elements:

- A case note review of inpatients in hospital in the last few days and hours of life (for those patients who die in April 2018)
- An organisational level audit covering service models, activity, workforce, finance quality and outcomes
- The development and administration of an innovative Carer Reported Experience Measure
- The development and administration of a Staff Reported Measure, and
- Topics for periodic, time-limited 'spotlight' audits

We will be registering for the audit in February 2018 and starting the initial scoping and planning with the relevant clinical teams.

8. Was a Lapse in care identified?

Of the 25 initial findings reports and serious incident investigations which have been concluded in Q3 one death in Q3 which was reported as a Serious Incident identified a lapse in care.

The lapse in care related to a patient with sepsis seen by the Westcall out of Hours GP service. It is not possible to conclude if the death could have been prevented had the patient been immediately transferred to the acute hospital.

The learning from this case will be reviewed by all services involved in the care of the patient and this will include south central ambulance service, NHS 111 and Westcall out of Hours GP service. Immediate actions taken included supervision discussions with the clinicians involved and training for GPs working within the Westcall Service to ensure they are aware of the sepsis pathway and immediate red flags and clinical signs which need to be considered and escalated appropriately.

9. Learning from Deaths

The aim of the policy and procedure is to ensure that we learn from deaths and improve care even when the death may not be due to an avoidable cause. The following section details updates on learning identified in Q2 and the new learning identified in Q3 .

9.1 Theme: Working with families and carers

Previous quarterly reports have highlighted the theme of the importance of involving families and carers during the care and treatment of mental health patients. This theme continues in Q3. There is a significant amount of work being undertaken to support staff in this including:

- Zero suicide resource with information on supporting carers
- Carers webpage includes information on supporting carers
- Emphasis on carers and guidance on how to tackle confidentiality and information sharing in our zero suicide guide currently being updated by a carer
- Using feedback from carers to inform scenarios for real play within the training
- A Film clip is being developed for staff on the importance of involving carers as well as services users in risk assessments and safety plan a service user has been recruited to help with this production and the first meeting was held on 1st January 2018.
- E- learning is available from the zero suicide alliance for all staff - a simple but effective training video that combines facts about suicide with stories of real people who have experienced the impact of it on their lives. It also provides advice on how to speak to someone with suicidal thoughts and real life scenarios to give the skills to be able to deal with difficult conversations with loved ones, friends or colleagues
- An infographic to help carers, staff and service users know how to work together on safety plans is now complete and a simialr resource has been developed on saftey planning.

9.2 Theme: monitoring and supporting the physical health of patients being managed for their mental health

Mental Health Inpatient Wards

A number of initiatives and training sessions are being provided to up skill the staff working within Prospect Park on Physical Healthcare this includes:

- Diabetes training sessions are being delivered. In addition to this 4 of the clinical Development Leads have attended the Diabetes foundation course with a further course identified for the remaining Leads to attend.
- Training on the deteriorating patient with the Clinical Development Leads been trained in competency assessment and support from Clinical Practice Educators in up skilling of ward staff.
- Wound care management- 3 courses in Oct and November
- SALT/ choking training- 6 sessions planned for November; to be delivered by SALT therapist
- Bowel management- planned for discussion at SPACE groups in October and at Physical health wellbeing clinic.
- Further training being planned around hydration/ nutrition/ Food and fluid monitoring

Community Mentall Health

Within Community mental health we also have a number of initiatives to suport patients physicall health, these

include:

- Kate Dale a physical health lead from Bradford has presented to teams hosted by Wokingham Community Mental Healt Team (CMHT). A further session is scheduled for 31st January at the Slough locality away day. The focus will be on sharing good practice in terms of physical health monitoring.
- We have also appointed a physical health lead role for a 12 week period to scope out what CMHTs require to assist them with screening and intervening in relation to physical health. This information will be shared across the localities and it will inform further developments.
- We have developed a physical health Job decription and are recruiting to this post. The job description was informed by learning from the mortality review. The primary purpose of this role is to coordinate a patient focussed programme of work to improve the physical health of people with a serious mental illness (SMI) under the care of East Berks CMHT. This will be achieved through:
    - Provision of improved physical health monitoring and review
    - providing information and signposting to support physical health
    - support to enable service users to access interventions
    - physical health promotion
    - facilitating learning sessions with the CPE to enable staff to learn from incidents

9.3 Theme Mental Capacity and Safeguradingin Older Adults Mental Health

Mental capcaity and safeguarding considerations for vulnerable people were key aspects of learning identifed in Q2, a learning event has been held in Reading to embed this learning and a cross county event is planned for janaury 2018 to further embed this across services.

Learning from deaths of patients with a learning disability

9.4 Theme accessing reasonable adjustments

Information continues to demonstrate that individuals with learning disabilities experience difficulties in accessing reasonable adjustments – particularly in relation to the provision of healthcare in acute settings. On-going opportunities for joint working and information sharing with the local acute providers continue to be progressed. This is also likely to be positively impacted by the implementation of the LeDeR programme across the Berkshire Clinical Commission Group (CCG). We have had confirmation that the CCG are currently in the process of developing a business case for the provision of a learning disability clinical liaison nurse role at the local acute hospital.

9.5 Theme Mental Capacity

Whilst examples of good practice in this area have been identified there is a continued need to ensure that when services are involved in the process whereby capacity decisions are being made, they are able to demonstrate adherence to the relevant legislation and guidance. We continue to provide regular updates and alerts provided to staff via the bi-monthly Learning Disability Service Patient Safety Quality and Governance Meeting, and provide Feedback to the local teams re: lessons learned following IFR.

9.6 Children's and young people services

There are no relevant areas of learning for the trust from the cases reviewed in Q3, but as a response to the Sudden Infant Deaths the CDOP have focused their Annual Study Day this year (attended by all agencies working in Berkshire) on Unexpected Child Deaths and a number of staff from BHFT will be attending.

9.7 Learning from Complaints where the patient died

3 complaints were received in Q3 where the patient had died and the family were unhappy, these related to district nursing services and our community hospitals. The MRG reviewed all 3 complaints. The main learning identified related to a breakdown in communication. A learning event is being organised with the staff and will be reported in Q4, none of the cases identified a lapse in care.

10. Internal Audit of the Mortality Review Process and Learning from Deaths.

An audit of the policy and process followed by BHFT for investigating unexpected deaths and learning from deaths was undertaken by RSM as part of the approved internal audit plan for 2017/18.

The audit reviewed the Trust's adherence to the National Guidance on Learning from Deaths and found that the Trust is effectively identifying, reporting, investigating, monitoring and learning from deaths of patients in their care.

The internal audit opinion is that the Board can take substantial assurance that the controls upon which the organisation relies to manage the identified risk are suitably designed, consistently applied and operating effectively.

The audit has identified 2 low priority issues requiring management actions which will be addressed as follows:

1. National guidance on specific methodology for review of deaths of mental health patients (which are not Serious Incidents) is awaited. Following publication of this guidance, training requirements will be considered by the trust and appropriate training will be offered to staff involved in the process of review of deaths'.
2. Quarterly reports to the Board will include reference to themes and learning identified in the previous quarter and an update whether progress with implementing learning has been made.

11. Conclusion

The Trust Board can be assured from this report that the learning from deaths process is robust. The Internal Audit conclusions provide additional support to this claim.

In Q3, of the 25 deaths concluded as through the mortality review group and serious incident process, one death was identified in which lapse in care occurred, this death was reported as a serious incident and the corresponding action plan will be implemented in line with the serious incident policy.

Several themes and areas of learning from a review of the deaths are being implemented and the Q3 learning builds and supports the learning identified in Q2.

Key learning themes which continue are:

- Management of patient's physical health whilst they are under our care for their mental health (Both SI and Non SI deaths).
- Communication with Families
- accessing reasonable adjustments
- Mental capacity

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

This report covers the period 1st November 2017 – 6th February 2018

Executive summary

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

This report focusses on the period 1st November 2017 – 6th February 2018. Since the last report to the Trust Board we have received 1 exception report.

We report on the successful continuation of Trainee forum. Further we can assure the Trust that the exception reporting policy is working, and we have discussed the process again at the MSC to ensure trainers are clear about the process.

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

Introduction

The current reporting period covers the second half of a six month CT and GPVTS rotation. Our primary concerns have not so much been the day-to-day issues of rota cover and exception reporting, although these have all been dealt with where they have occurred, rather we have been looking to the future, specifically the rotation in August 2018 and latterly to the new NHS Improvement requirements on rota notification.

High level data

Number of doctors in training (total):	31 (FY1 – ST6)

(The Trust has two locum training grade doctor in post as 'Locum Appointment for Service' who are not included in the above figures as they are not covered under the exception reporting of the 2016 TCS – they have, however, greatly helped in filling the large number of gaps we had on the OOH rota – see below for further information).

Number of doctors in training on 2016 TCS (total):	31
Amount of time available in job plan for guardian to do the role:	0.5 PAs Each (job share)
Admin support provided to the guardian (if any):	Medical Staffing
Amount of job-planned time for educational supervisors:	0.25 PAs per trainee

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

b)

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

Exception reports by grade				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
CT 1-3	0	0	0	0
ST 4-6	0	0	0	0
Total	0	0	0	0

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

Exception reports (response time)				
	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
CT1-3 / ST1-3	0	0	0	0
ST4-6	0	0	0	0
Total	0	0	0	0

In this period we have had one exception report. As West duty doctor on shift, the trainee went to Wexham Park Hospital in place of the East duty doctor who was otherwise busy. This involved the assessment of a minor. This work was completed at 10pm, and the return journey took a further 30minutes. The exception report was submitted on 12th November; the Guardians emailed the trainee and Trainer for urgent resolution on 9th January following no completion of the exception; and the Guardians closed the exception report with no action 23rd January due to no response to the exception report or email. This is in accordance with practice with the local network of guardians. The Guardians have since reminded trainers of the processes via the Medical Staffing Committee.

c) Work schedule reviews

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

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

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

d) **Locum bookings**
(All data provided below for locum bookings (bank/agency/trainees) covers the period 1st November 2017 – 6th February 2018).

i) Bank

Locum bookings (bank) by department					
Specialty	Number of shifts requested	Number of shifts worked	Number of shifts done by agency	Number of hours requested	Number of hours worked
Psychiatry	20*	16	0	184	152
Dentistry	0	0	0	0	0
Sexual Health	0	0	0	0	0
Total	20	16	0	184	152

Locum bookings (bank) by grade					
Grade	Number of shifts requested	Number of shifts worked	Number of shifts done by agency	Number of hours requested	Number of hours worked
CT1-3 level	20*	9	0	184	76
ST4-6	0	0	0	0	0
SAS	20	7	0	184	76
Total	20	16	0	184	152

*4 shifts covered by current trainees

Locum bookings (bank) by reason*					
Specialty	Number of shifts requested	Number of shifts worked	Number of shifts done by agency	Number of hours requested	Number of hours worked
Gaps	12	10	0	88	80
Sickness	8	6	0	96	72
Total	20	16	0	184	152

*4 shifts covered by current trainees

ii) Agency

Locum bookings (agency) by department				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Psychiatry	1	0	12	0
Total	1	0	12	0

Locum bookings (agency) by grade				
Grade	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Specialty doctor covered CT shift	1	0	12	0
ST4-6	0	0	0	0
Total	1	0	12	0

Locum bookings (agency) by reason**				
Psychiatry	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Maternity	0	0	0	0
Sickness	1	0	12	0
Total	1	0	12	0

e) Locum work carried out by trainees

Locum work by trainee						
Specialty	Grade	Number of shifts worked	Number of hours worked	Number of hours rostered per week	Actual hours worked per week	Opted out of WTR?
Psychiatry	CT	1	4	47	51	
Psychiatry	CT	1	4	47	51	
Psychiatry	CT	1	12	47	59	
Psychiatry	CT	1	12	47	59	
Total		4	32			

The period 1st November 2017 – 6th February 2018 sees the same situation regarding the number of trainee gaps on the OOH rota we had to fill and the methods we used to fill them as this forms the second half of the six month rotation from August 2017 to February 2018. For this second half we had no shifts uncovered.

Looking forward to the next rotation (February – August 18) we have one gap which we filled by recruitment and second which will be resultant from the doctor in question going off the rota as she is pregnant. This will gives us 41 shifts to cover of which we have so far covered 26. On top of these there will be the usual sickness that will need covering but which understandably cannot be quantified.

Looking even further ahead to the junior doctor's rotation in August 2018 we have started to put in place a number of strategies to mitigate the expected gaps caused by HEETV's system of allocating junior doctors. Psychiatry trainees within HEETV chose their placements and in order to make trainees new to the area consider BHFT above other trusts, the DME is working with the Clinical Supervisors to revise the existing trainee job descriptions in order to highlight all of things the trust can offer – from QI, to research, to teaching, to our modern inpatient facilities, to name but a few.

Alongside this, via the MTI (medical training initiative) and WAST (widening access to specialty training) schemes we are seeking to recruit a number of doctors trained outside the UK yet with the medical skills and experience suitable for the Trust. They would be in rotational posts, two years for MTI and six months for WAST. This should if successful increase the number of doctors on the OOH rota and reduce or remove the gaps on the OOH rota. We have also informed the GP School that from August 2018 we will have no "unbanded" GPVTS posts (previously we had one) and while this will not reduce the number of GP trainees we should receive, it will ensure that all go on the OOH rota.

All of these have been put in place and are being pursed to ensure we can run the OOH rota at, at least 1:9, as the trainees are concerned that the rota pattern is onerous and has a detrimental effect on training if not properly staffed and we are doing everything we can both to reassure them and to ensure that the rota is properly staffed and covered.

From December 2017 as part of the *'Next Step on the NHS Five Year Forward View'* document, published in March 2017 we are now required to report before each rotation that we have notified the trainees well in advance of their rota commitments. With trainees receiving their proposed rota a minimum of eight weeks before and final rota six weeks before they start their rotation.

In the Trust the rota is written by the trainees. This is by far and away the best system as the trainees then "own" the rota, and are happier with the finished result. Their engagement with it and their willingness to help out is higher than where a rota has been produced by a consultant or Medical Staffing and simply sent to them.

Going forward we are planning to work with the JDF and the junior doctor reps to ensure that we meet NHSI targets. With the hard deadlines ahead of the 1st August rotation being 6th June (8 weeks prior) and 20th June (6 weeks prior to rotation). On top of this HEETV are required to provide us with the names and details of the rotating doctors no later than 12 weeks before rotation, which this year means by the 9th May 2018. We will therefore be working with the DME to ensure that the various

schools (Psychiatry, GP & Foundation) provide us with the relevant information in a timely manner in order to allow our trainees to continue to write the rota.

f) Vacancies

Vacancies by month						
Specialty	Grade	Month 1	Month 2	Month 3	Total gaps (average)	Number of shifts uncovered
Psychiatry	0	0	0	0	0	0
Total	0	0	0	0	0	0

g) **Fines**

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

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

Fines (cumulative)			
Balance at end of last quarter	Fines this quarter	Disbursements this quarter	Balance at end of this quarter
£0	£0	£0	£0

Qualitative information

The Junior Doctors' Forum (JDF) continues under the oversight of the junior doctor leads, and has been well attended. No immediate patient safety concerns have been raised in this quarter.

Issues arising

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

Actions taken to resolve issues

The Guardians of Safe Working continue to communicate through the MSC to ensure that trainers have an understanding of the exception reporting process. There is on-line training which trainers have been reminded to complete in regard to the exception reporting process and we will continue

to encourage them to complete this. It has been noted that this could be enquired about at Consultant Appraisal.

Summary

All rotas are currently compliant.

No trainee has breached the key mandated working limits of the new contract.

The one exception report discussed above for this period relates to a predictable and unavoidable occurrence, and is not illustrative of any pattern of concern to the Guardians of Safe working. The trainee acted appropriately. The Guardians have reminded their consultant colleagues of the correct process for responding to exception reports and have encouraged timely resolution.

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

Questions for consideration

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

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

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

Appendix A: Glossary of frequently used terms and abbreviations

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

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

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

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

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

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

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

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	10 April 2018
Title	**Executive Report**
Purpose	This Executive Report updates the Board of Directors on significant events since it last met.
Business Area	Corporate
Author	Chief Executive
Relevant Strategic Objectives	N/A
CQC Registration/Patient Care Impacts	N/A
Resource Impacts	None
Legal Implications	None
Equality and Diversity Implications	N/A
SUMMARY	This Executive Report updates the Board of Directors on significant events since it last met.
ACTION REQUIRED	To note the report and seek any clarification.

Trust Board Meeting 10 April 2018

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. Frimley Health and Care Integrated Care System Governor Event

On the 27 March 2018, the Trust hosted a Governor event on behalf of the Frimley Health and Care Integrated Care System. The event was well attended and included representatives from:

- Governors from the three Providers (Berkshire Healthcare, Frimley Health and Surrey and Borders)
- Chairs and Non-Executive Directors from the three Providers
- Local Authority Elected Members
- Clinical Commissioning Group officers and Clinical Chairs

Chris Ham, Chief Executive of the Kings Fund gave a key note presentation on the development of Integrated Care across the United Kingdom as well as drawing upon International examples.

An update was then provided on the progress of the Frimley Integrated Care System. There was a good opportunity for Governors to ask questions and it certainly felt like a helpful way to engage important stakeholders.

Some of the key areas of feedback received included the need to have a better elevator pitch to convey more clearly what the Integrated Care System was seeking to achieve and also what progress had been made to date. A copy of the slides presented are attached at appendix 1 (slide 4 entitled plan on a page is perhaps the most useful to note).

Executive Lead: Julian Emms, Chief Executive

3. Public Satisfaction with the NHS 2017

The latest British Social Attitudes (BSA) survey found dissatisfaction with the NHS overall had reached its highest level for a decade. The findings, collected by the National Centre for Social Research and analysed by the King's Fund and the Nuffield Trust, showed voters are increasingly concerned about staff shortages in the NHS, long waits to receive care and the amount of money given to health services.

The majority (68%) of respondents said they were satisfied with the NHS's quality of care, 64% with the fact that care was free at the point of use and 44% with the attitude and behaviour of staff. Those saying they are very or quite satisfied with the NHS as a whole had fallen 6% since 2016 to 57%, the lowest level since 2011. Dissatisfaction, which the BSA measures separately, has risen to 29%, the highest level since 2007.

Executive Lead: Julian Emms, Chief Executive

4. NHS Pay

More than one million NHS staff, including Nurses, Porters and Paramedics, are being offered increases of at least 6.5% over three years - with some getting as much as 29%. The deal was formally agreed by Union Leaders and Ministers on Wednesday 21 March and will cost around 4.2bn.

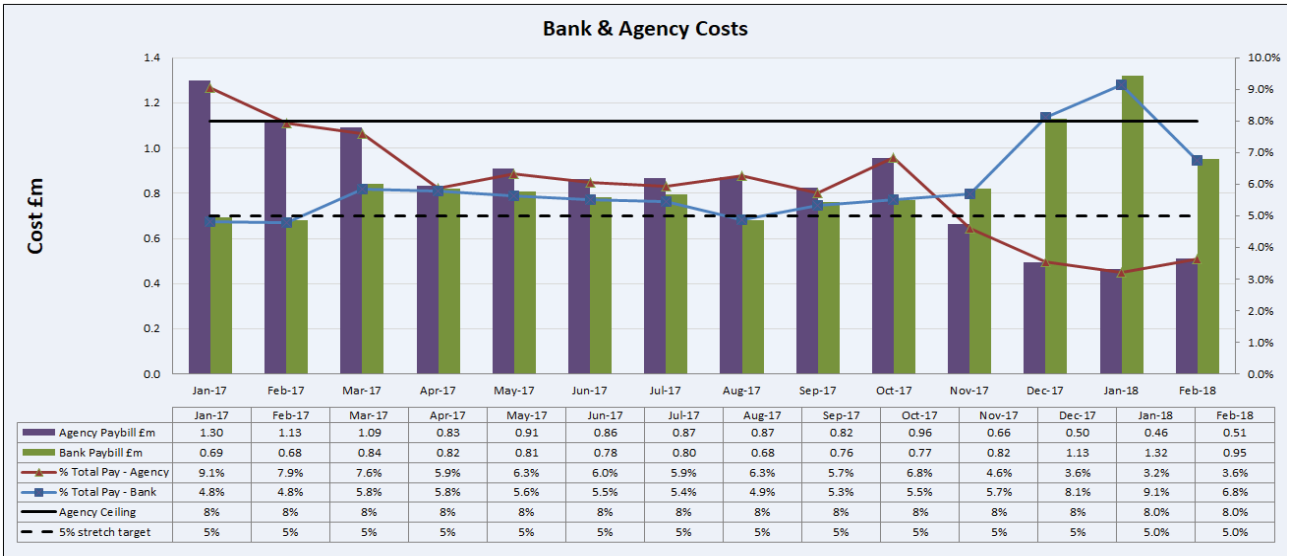
Staff will now be asked to vote on the deal, with rises backdated to April 2018 if they agree by the summer. The deal is tiered with the lowest-paid in each job receiving the biggest rise. The agreement covers all staff on the Agenda for Change contracts - about 1.3m across the UK - which is the entire workforce with the exception of Doctors, Dentists and Senior Leaders.

Executive Lead: Julian Emms, Chief Executive

5. Temporary Staffing Programme

Use of agency v NHSP bank staffing and associated issues

- As the Trust Board is aware, there is an NHS Improvement cap set for the Trust of a maximum of 8% of the total staff pay cost to be spent on Agency staff during 2017-18, and an internal Trust stretch Cost Improvement Progamme target of 5%. During February 2018, the percentage spent on Agency staff increased slightly to 3.6% (from 3.2% in January 2018). This was due to a financial technical adjustment that had been made in January 2018.
- The monthly spend on NHSP (bank) as a percentage of the total staff pay cost decreased to 6.8% in February 2018 (9.1% in January 2018).
- This meant that the monthly combined Agency and Bank usage percentages of the total staff pay cost so far in 2017-18 are:
    - April 2017 – 11.7%
    - May 2017 – 11.9%
    - June 2017 – 11.5%
    - July 2017 – 11.6%
    - August 2017 – 11.7%
    - September 2017 - 11%
    - October 207 – 12.3%
    - November 2017 – 10.3%
    - December 2017 - 11.7%
    - January 2018 - 12.3%
    - a total of 10.4% for February 2018.

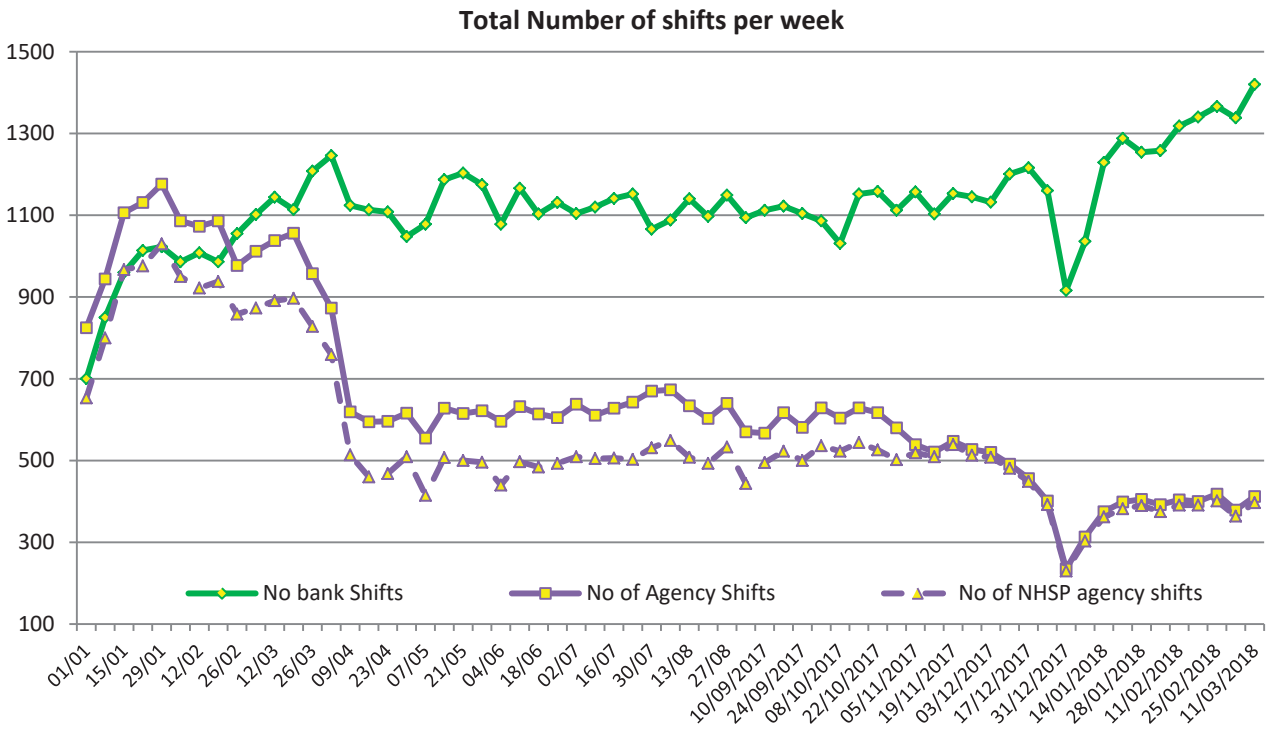


	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
Agency Paybill £m	1.30	1.13	1.09	0.83	0.91	0.86	0.87	0.87	0.82	0.96	0.66	0.50	0.46	0.51
Bank Paybill £m	0.69	0.68	0.84	0.82	0.81	0.78	0.80	0.68	0.76	0.77	0.82	1.13	1.32	0.95
% Total Pay - Agency	9.1%	7.9%	7.6%	5.9%	6.3%	6.0%	5.9%	6.3%	5.7%	6.8%	4.6%	3.6%	3.2%	3.6%
% Total Pay - Bank	4.8%	4.8%	5.8%	5.8%	5.6%	5.5%	5.4%	4.9%	5.3%	5.5%	5.7%	8.1%	9.1%	6.8%
Agency Ceiling	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8.0%	8.0%
5% stretch target	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5.0%	5.0%

- For the financial year to date (month 11), the Trust is reporting an agency spend of £8.296m which is £3.542m below the NHS Improvement ceiling of £11.838m.
- The Trust has been informed that the NHS Improvement ceiling on agency spend for the Trust in 2018-19 will be £10.6m, which has been reduced from the £13.868m set for 2017-18. At the moment, based on eleven months expenditure (£8.296m in 2017-18), and the agency reductions seen (due to the Trust no longer managing the Slough Walk In Centre service and the WestCall GP bank establishment) this appears achievable.
- An internal Agency usage stretch target for 2018-19 has not been set.

Agency and Bank Shift Usage

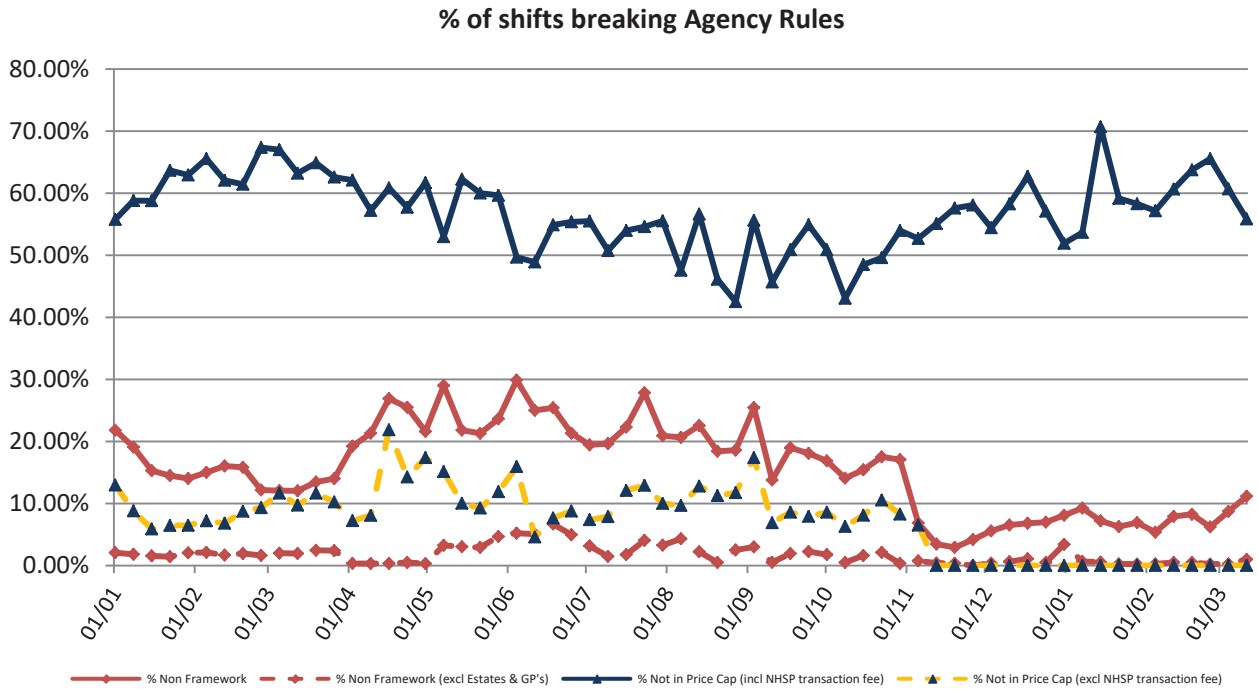
- The number of agency and bank shifts used weekly during the past year are shown in the table overleaf:



- It can be seen that since June 2017 onwards the number of bank shifts being used has been more stable.
- The difference between *the number of agency shifts* (which includes agency shifts not booked through NHSP, which included historically Westcall and Slough Walk In Centre GPs, Mental Health medical staff and a small number of Children Services staff and Nursery Nurses) and that of the *number of NHSP agency shifts* (agency shifts booked through NHSP only) has decreased as has the total since November 2017, following the establishment of the GP bank, which has also led to the corresponding increase in the total Bank shifts each week (except over Christmas and New Year).
- During February 2018, there has continued to be a rise in the number of bank shifts being worked each week, but a stable level of agency usage.

Framework and Price cap Issues

- 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 (overleaf) covers 2017 and 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 GPs) 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 would not 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.
- Data excludes the NHSP transaction fee since November 2017 due to report availability. The new contract will correct this as there will be no agency transactional charge applied.
- The increase in non-framework percentages from April 2017 was due to the decreased (framework) agency fill following the agency Health Care Assistants ban.
- Following the introduction of the internal GP Bank at the beginning of November 2017, there has been a drop in the total number of agency shifts being reported each month.
- This has led to an increase (based on lower numbers of shifts overall) in the percentage of shifts breaching the hourly price cap (including the NHSP hourly transaction fee), and in the percentage of non-framework agencies being used.
- Price cap breaches were historically often in Westcall, Sough Walk In Centre GPs and agency community nurses in a number of localities.

Temporary Staffing Contract

- The Trust Board will recall that the Trust was retendering the Temporary Staffing Contract in conjunction with the Royal Berkshire Hospital NHS Foundation Trust, where there will be the (financial) benefits of economies of scale from the Provider awarded the tender. This process has now been completed.
- The Temporary Staffing contract was awarded to NHSP by both Trusts, as a joint contract for an initial three years, with two one year extensions possible.
- There continues to be on-going discussion and dialogue between the Trust's Head of Procurement and Temporary staffing leads and with NHSP, which has delayed any signing of the contract. As a consequence, there has needed to be an extension to the existing contract to the end of April 2018, when it is anticipated that the outstanding issues will have been resolved.
- This position continues to delay formal communication with both Trust's staff about the awarding of the contract to NHSP.

Trust reporting on Agency and Bank Usage to NHS Improvement

- There are now since the beginning of February 2018, two different weekly returns needing to be compiled for NHS Improvement. As previously noted, NHS Improvement changed their original agency usage weekly reporting requirement to include bank staff shifts, and introduced a second weekly requirement, basically covering Medical and Allied Health Professional Agency staffed booked to be used (in the week of the Monday report return), which specifically requires information on the total the staff members grade and speciality, total agency charge, agency commission rate, speciality and the name of the agency.
- The aim of the second report is to identify information about whether the Trust is paying above capped hourly rates, paying a high rate of commission to the agency, and whether there are opportunities to use alternative agencies (who may charge a lower rate – but may not necessarily have the staff available locally).
- Reports are then provided to the Trust on a local basis, and periodically on a Sustainability and Transformation Partnership level, so that other Trusts usage and costs incurred (for example, agency commission rates) can be seen and reviewed.
- From the four weeks' worth of reports received back to date, the Trust compares favourably to other Sustainability and Transformation Partnership area Trusts in relation to the usage of Agency Medical staff (low level and within capped rates). For Allied Health Professionals the Trust has used more Agency Allied Health Professionals than other Trusts some weeks, and paid a higher charge for some of them, however this has been variable per week.

Executive Lead: Helen Mackenzie, Director of Nursing and Governance

6. Care Quality Commission (CQC) Inspection Process

In February 2018, the Trust received our Provider Information Request (PIR) which indicates that the CQC intend to inspect the trust within the next six months. The PIR was submitted to the CQC ahead of the deadline and following a series of queries on 28th March 2018, the Trust was informed that all queries were resolved.

The process of inspection is as follows:

- Focus groups with staff from core services will be held during April and May 2018
- Focus groups with patients and carers associated with core services will be held during the same time frame
- Unannounced visits to core services can be expected at any point
- The Trust will be given 12 weeks' notice of the timing of our well-led inspection

The Trust is already preparing for the inspection with staff anticipation growing as they are very proud of the services they provide.

Executive Lead: Helen Mackenzie, Director of Nursing and Governance

7. West Berkshire Urgent Treatment Centre

Further to a March 2018 Finance, Investment and Performance Committee request, a summary paper is appended from the Berkshire West Accident and Emergency Delivery Board outlining for all Trust Board members, information in relation to the development of an Urgent Treatment Centre at West Berkshire Community Hospital, incorporating the Trust's Minor Injury Unit.

Executive Lead: Alex Gild, Chief Executive

8. Primary Care Streaming Service at the Royal Berkshire NHS Foundation Trust

The Urgent and Emergency Care Delivery Plan (NHS England April 2017) required hospitals to implement core best practice on streaming and ambulatory care pathways by winter of 2017-18.

In addition, the Memorandum of Understanding between NHS England and Berkshire West Commissioners that was established as a pre-condition for development of the Accountable Care System identified the requirement to implement front-door streaming at the Royal Berkshire NHS Foundation Trust by October 2017.

NHS England requirements set out in "Primary care streaming: Roll out to September 2017" were:

- *Service operational from 8am to 11pm (365 days per year)*
- *Emergency Department streaming – 1x band 7 nurse*
- *GP clinic with 2 GPs available (for quiet periods this can be 1 GP, and flexed up if required)*

- *1 clinical nurse and 1 Health Care Assistant*
- *2 consulting rooms and a clinic room (which can also be used as a third consulting room)*
- *Small waiting area*
- *No diagnostics*

The GPs working within the service should not be 'embedded' within the Emergency Department, nor should it have its own front door facility for patients to choose to walk-in there. The streaming nurse should have no 'hand on' contact with the patient. Payment for the service is the GP tariff.

Berkshire West Commissioners, Royal Berkshire NHS Foundation Trust and Berkshire Healthcare NHS Foundation Trust launched a pilot of Primary Care streaming at the front of the Emergency Department in October 2017, operating daily between 0800 and 2300. The operating model was based on the Luton and Dunstable model mandated by NHS England. The decision was made to deliver the service through a contract variation with the Trust as they were already providing a primary care service on-site on a pilot basis.

The launch of the service saw good collaboration between the Royal Berkshire NHS Foundation Trust Emergency Department and Westcall staff at managerial levels and while locum GPs were employed to support launch, salaried GPs are now in place.

The anticipated benefits were as follows:

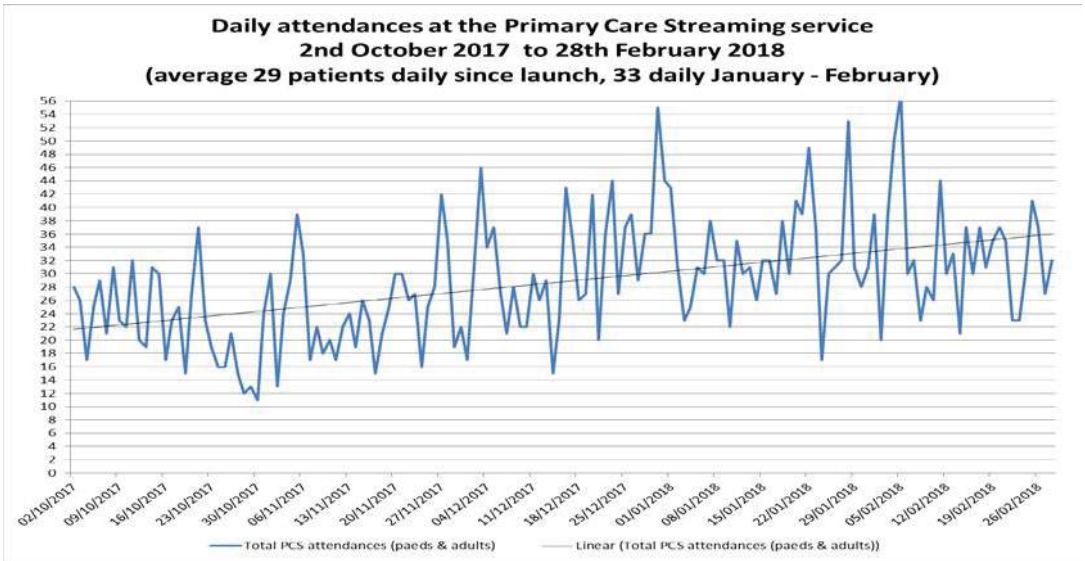
- This streaming model will help ensure ambulatory care patients receive the highest quality care from the most appropriate clinician in the right setting.
- Front door streaming will speed up clinical decision making ensuring that patients with non-life threatening illness can be immediately directed to a service that better meets their needs.
- The primary care stream will be co-located with the Emergency Department and Pharmacy and will be integrated with the existing front door ambulatory care pathways. It will sit alongside a nurse led Minor Injuries stream and enhanced ambulatory care area. The new design will ensure that the ambulatory care area is protected at times of escalation as it will be provided from an outpatient rather than an inpatient setting.
- Emergency Department staff will be freed up to concentrate on life threatening and complex conditions.
- The model includes the opportunity to co-locate an integrated discharge hub (health and social care) adjacent to the primary and ambulatory care area. This will support admission avoidance and improved patient flow through the hospital further improving the experience of patients.
- The final benefit of the model will be creation of additional space to support the assessment of the frail elderly.

From the launch on 2nd October 2017 to 28th February 2018, a total of 4,323 patients were assessed by the Primary Care Streaming service, an average of 29 daily (range 11 to 57), or 1.92 per hour.

In January and February 2018, following formal acceptance of Paediatrics, the service saw an average of **33** patients daily, or 2.2 patients per hour.

The number of patients managed by day and per hour while in full operation is lower than in more developed services, suggesting potential for growth and this is reflected in March 2018 data to date (1st to 18th), where 37 patients were seen daily on average.

For comparison, an average of 301 patients attended the Type 1 Emergency Department daily from October to February 2018 (range 237 to 383) and an average of 66 patients attended the Thatcham Minor Injuries Unit daily (range 10 to 129). Primary Care Service attendances account for 10% of Emergency Department attendances over the period.



A review, following six months of operation of the service, highlighted the following:

- Numbers streamed are significantly less than anticipated. Since formal acceptance of Paediatric cases in January 2018, Primary Care Service manages an average of 33 patients per day, or 2.2 per hour of opening
- The service requires 15 hours of GP input daily at a time when GP resources are scarce and highly challenged across a range of Urgent and Emergency Care services
- Cost of current model per patient is £82.69 based on February costs and activity, this is higher than comparable on-the-day services at the Minor Injuries Unit, Walk in Centre or the Emergency Department itself
- Limited evidence of contribution to any improvement of delivery for the Accident and Emergency 4 hour standard
- Emergency Department staff positive about the impact of the service in streaming away appropriate patients.

Partnership working between the Trust's Urgent Care and the Royal Berkshire NHS Foundation Trust Emergency Department has been positive although there has been some lack of clarity on the suitability of patients. The NHS England service vision suggested that the Primary Care Service would only manage minor ailment presentations that did not require investigation, but in actual fact, the service has been managing high acuity patients requiring admission in addition to those that were initially expected.

To date,the service has achieved 100% performance against the 4 hour Emergency Department target but it has had minimal impact on the overall performance for the Royal Berkshire NHS Foundation Trust (they do not allow for the assumption that had these 33 cases been seen in the Emergency Department then a large percentage would have breached given that they are currently focussing on very high acuity patients in big numbers).

The evaluation of this service cannot be done in isolation from other factors which influence the way in which urgent on the day demand is managed outside of an acute setting, or planned to be managed in future. The landscape of Urgent Emergency Care provision is changing and will offer increased opportunity to divert patients away from the Emergency Department. The key initiatives are listed below –

Integrated Urgent Care
The national Integrated Urgent Care specification (August 2017) improves previous provision of the NHS 111 telephone service, with an implementation deadline of March 2019.

Urgent Treatment Centres
Berkshire West intends to designate the Newbury Minor Injury Unit as an Urgent Treatment Centre which fully meets the required NHS England standards by December 2019.

GP Enhanced Access
The NHS England Planning Guidance for 2017 required that 100% of patients have access to bookable and on-the-day appointments between 6.30-8pm (in addition to core hours provision 8am-6.30pm) and on Saturdays, Sundays and Bank Holidays from 1st October 2018.

Ambulatory Care Unit
The Royal Berkshire NHS Foundation Trust provides an Ambulatory Care Unit staffed by Advanced Nurse Practitioners along with a Consultant medic. There is opportunity for greater integration between Primary Care Service staff, Emergency Department and the Ambulatory Care Unit to gain maximum benefit from improved flow management across the three services.

The Operating Plan for 2018-19 contains no new policy statements in relation to Primary Care Service so it is unclear whether retaining the service is a formal policy requirement or not.

A paper on the evaluation of the Primary Care Streaming Service was reviewed by the Berkshire West Emergency Care Board in March 2018. This stated any decision on the future of PCS needs to deliver maximum value for money for the Integrated Care System which has an underlying financial gap for 18/19 and beyond.

A number of options for the service were considered:

- Cease the service from an agreed date, (taking into account that any decision to cease the service will need to incorporate potential costs and logistics of re-providing any alternative)
- Extending the pilot for a further six months to see if anticipated benefits can be realised

- Extend the pilot with existing Provider but change the model of delivery to increase throughput, reduce cost and deliver better value for money to the Integrated Care System
- Procure a new service model of delivery to be determined (taking into account the other changes to management of urgent on the day demand as described above)
- Option 3 was the recommended option and this was agreed and will now be presented to the next Integrated Care System meeting for approval. Providing the Integrated Care System agrees and are happy to proceed with option 3, a task and finish group will be set up to produce and agree a new delivery model.

Executive Lead: David Townsend, Chief Operating Officer

Presented by: Julian Emms
Chief Executive
April 2018

Appendix 1

System Transformation Partnership and Integrated Care System update

Councils of Governors
27 March 2018

Frimley Health and Care ICS

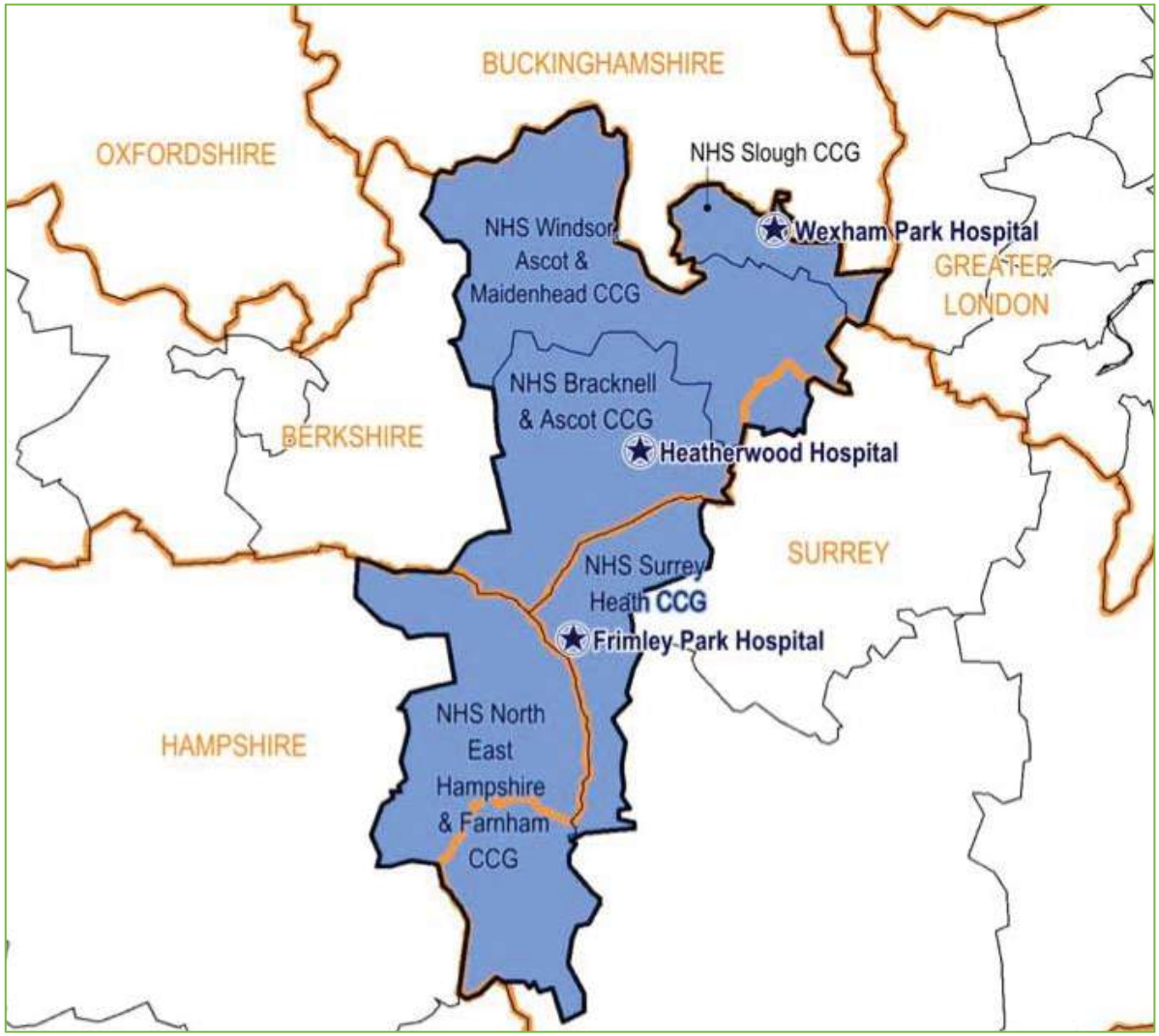
Health and Wellbeing

Care and Quality

Finance and Efficiency

Effective Workforce

Our geography and context



Frimley Health and Care ICS:

- Population of **800,000** people in east Berkshire, Hampshire and Surrey.
- Involves **30 statutory bodies**.
- Includes Local Authorities, CCGs, provider Foundation Trusts and others across 5 localities

Our System Ambition

Our collective ambition is that the people living in the Frimley system have the best possible health and wellbeing, keeping them healthy and in their homes for longer.

The changes required across our health and care system cannot be addressed by individual organisations; they are a collective challenge and require a collective response. Our success will be judged by the strength of our system, not the individual organisations.

Our system is inclusive and brings together the providers and commissioners of all health services, social care, public health and the voluntary sector.

Primary Care constitutes one of our key partners in successful transformational change. We are working with GP leaders to ensure resilience and increased capacity to support our local residents.

STP to ICS

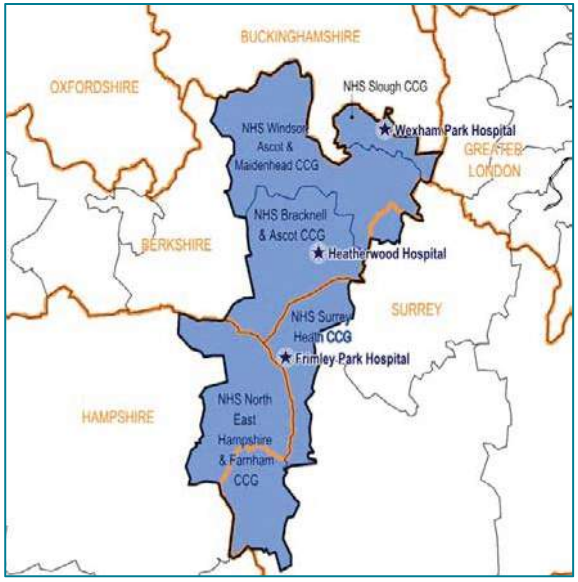
One System

One Budget

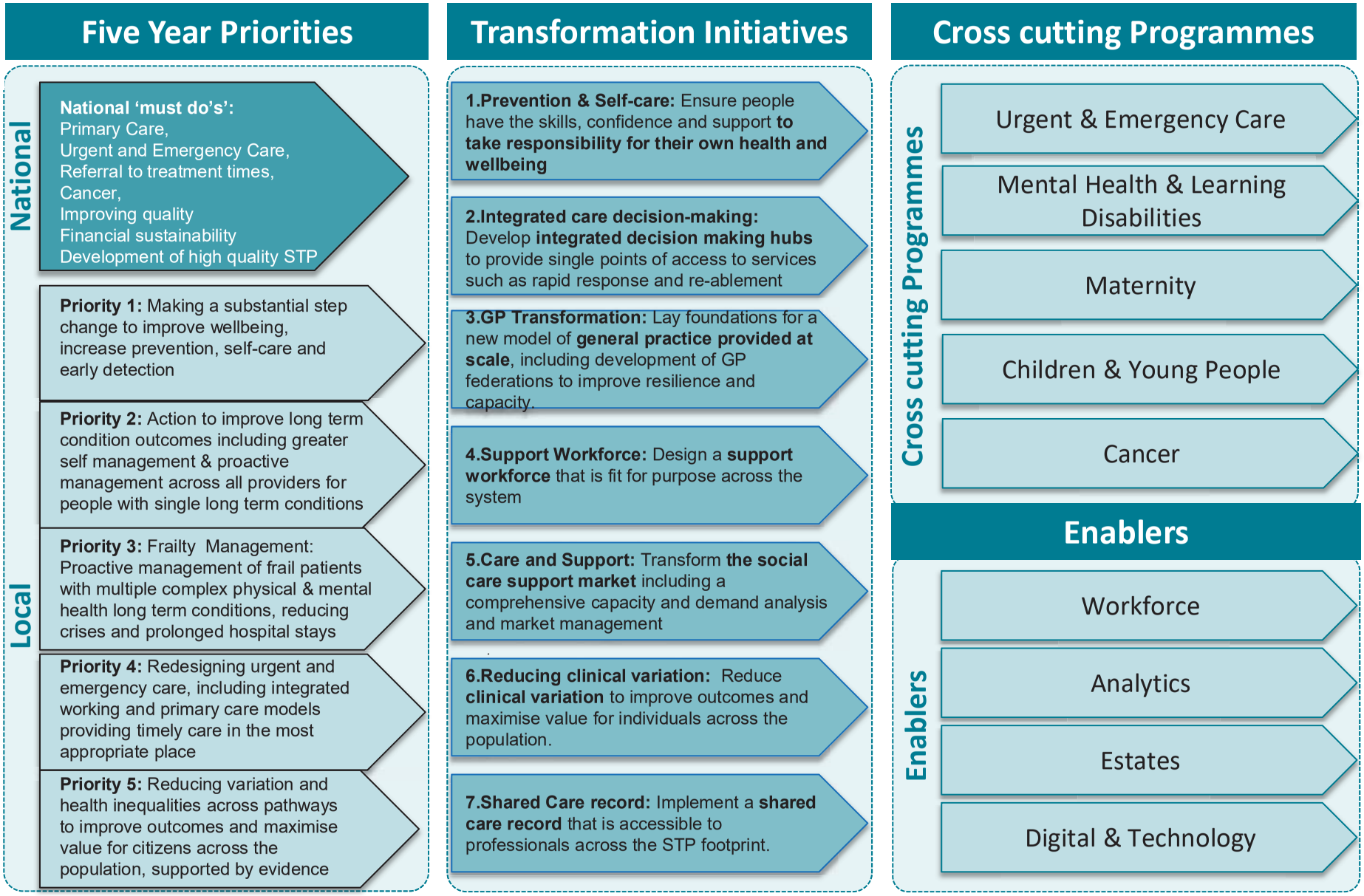
One Vision

Frimley Health and Care ICS

- Aligned across all partners
- Shared vision and priorities
- System operating plan for 18/19
- System control total across health
- Communities, patients and professionals at the centre



2018/19 System Plan On A Page



Driving quality and measuring success

- We are developing a view and vision for system wide quality
- We will be measuring our success across all improvements through system-wide dashboards
- We will monitor, measure and evaluate how effective our changes are in driving health and well-being, care and quality and finance and efficiency goals across the system
- We think that how we use ‘residents time’ is a good measure of improving experience and efficiency

Building on success

STP priorities and initiatives built on success and delivering now

Evidence of transformation

Spread and scale in progress

Common framework but locally shaped

Co-designed with communities and clinicians and professionals

Supporting all our workforce

Engaging local people and professionals

- Ensuring people's views are integral to service development and our communities shape our engagement activity
- Clinical and professional leads and our workforce co-design all service changes and developments
- Working together with a wide range of stakeholders including residents, carers and our local voluntary sector colleagues

How are we delivering a new model of care?

Creating a system where fewer services are delivered in an acute provider setting…

..and more are delivered at….

Home

GP surgery

Community-based services

It's starting to work

	SH	NEHF	WAM	B&A	Slo
A&E attendances	↓1%	↑1%	↓4%	↑1%	↓3%
Non-E admissions	↓3%	↓2%	↓1%	↓3%	↑2%
GP referrals	↓10%	↓3%	↑1%	↓2%	↑5%

- Sharing models and successes
- Evaluation to test outcomes and value for money
- Working with national teams and other areas
- All priority areas under review for impact over time
- Expectation using evidence that demand can continue to be controlled in 2018/19
- Planning underway for capital investments in out of hospital care

Key Points

- Whole person, whole place
- Co-designed with population and front line staff
- Model *(not a service)* that is scalable
- Health & Care, Physical & Mental, Statutory & Voluntary
- Moving from reactive to proactive to prevention
- New roles, helping with retention and recruitment
- Transformation is happening now, and spreading across the system

Our ambition – our whole population has access to the same high quality care – and they are part of achieving it

Appendix 2

Paper Number: AE1712-08

A&E Delivery Board:
Project Update – West Berkshire Community Hospital Minor Injury Unit conversion to an Urgent Treatment Centre

Sponsoring Lead:	Dr Heike Veldtman (GP Lead Newbury & District CCG)
Author:	Tim Cooling (Newbury & District CCG)
Purpose:	To inform the Board that a project group has been established, and outline the recent progress made by the group in identifying specific areas of focus
Previously considered by:	N/A
Links to A&E Delivery Board Mandates:	All
Links to the Seven UEC Priorities:	All
Links to Eight High Impact Changes for Managing Transfers of Care:	N/A

Summary

Since the release of the NHS England guidance on Urgent Treatment Centres a local Task & Finish group has been established to review the current service provision at the existing Minor Injuries Unit operating out of West Berkshire Community Hospital and the steps that are required to meet the standards expected of a UTC going forward.

Although the existing service meets many of the conditions of a UTC, considerations will have to be made to upskilling the workforce in minor illness, (including employing additional Advanced Nurse Practitioners), establishing additional premises requirements, interoperability and introducing an appointment booking system. Additionally the extent of GP presence at the UTC is yet to be determined, but the CCG is working with member practices to determine an agreeable model going forward.

The group feels confident that the WBCH MIU it will be able to meet the standards required by the deadline of December 2019 and will work towards earlier implementation if possible.

Recommendation:

That the Board: Note the update on progress made

What change is required?

The *"Next Steps on the NHS Five Year Forward View (5YFV)"* was published on 31 March 2017. This plan explains how the 5YFV's goals will be implemented over the next two years. One element of the UEC section of the FYFV is *"Roll-out of standardised new 'Urgent Treatment Centres'". To* end the confusing national mix of walk-in centres, minor injuries units and urgent care centres, NHS England have set out a core set of standards for urgent treatment centres (UTC) to establish as much commonality as possible.

By December 2019 patients and the public will:

a. Be able to access urgent treatment centres that are open at least 12 hours a day, GP-led, staffed by GPs, nurses and other clinicians, with access to simple diagnostics, e.g. urinalysis, ECG and in some cases X-ray.
b. Have a consistent route to access urgent appointments offered within 4hrs and booked through NHS 111, ambulance services and general practice. A walk-in access option will also be retained.
c. Increasingly be able to access routine and same-day appointments, and out-of-hours general practice, for both urgent and routine appointments, at the same facility, where geographically appropriate.
d. Know that the urgent treatment centre is part of locally integrated urgent and emergency care services working in conjunction with the ambulance service, NHS111, local GPs, hospital A&E services and other local providers.

Attendances at urgent treatment centres will count towards the four hour access and waiting times standard and we expect reduced attendance at, and conveyance to, A&E as a result of this standardisation and simplified access, as well as improved patient convenience as patients will no longer feel the need to travel and queue at A&E.

National Standards for UTCs

Urgent treatment centres must conform to the 27 separate standards stipulated in the national Guidance. There are but STPs and commissioners may also choose to build upon or add to these, according to their requirements.

The CCG should review current provision against the standards and make a plan for each existing facility, alongside current provision and plans for extended GP access, subject to local consultation and following proper procurement process where appropriate.

Alignment with primary care and other urgent care services

The view of the CCG is that the UTC should be 'a *Community and Primary Care facility that provides access and urgent care to its local population'.*

There is an opportunity for commissioning of a genuine integrated urgent care service, aligning NHS 111, the urgent treatment centre, GP out-of-hours and routine and urgent GP appointments

with face to face urgent care. GPs should have a clinical leadership role within the UTC, but it is understood that it will not always be desirable or practical to have a GP on site at all times. As commissioners we will want to consider local demand, be realistic about local supply of workforce, and ensure there is sufficient capacity to meet patient requirements, including bookable appointments with GPs and other clinicians.

The CCG and GP Provider Alliances are starting to align their thinking for urgent treatment centres with the core requirements for extended access, as well as opportunities with the clinical assessment service that supports NHS 111.

How will patients get an appointment?

Patients should be encouraged to contact the Integrated Urgent Care service via NHS 111 to access urgent treatment services. A range of clinical professionals such as paramedics, nurses with specialist experience, mental health professionals, pharmacists, dental professionals and doctors will be available to speak to callers who require it, and when a patient needs to see a GP, or needs an appointment at a UTC, a mental health crisis service or other service, this should be booked directly for them (where locally commissioned). UTCs are expected to offer directly booked appointments, direct from NHS 111, from the ambulance service or from their GP practice.

Equally, patients should be able to walk in and get to see a clinician. Access time standards for booked appointments and walk-in patients are given and will all contribute to the local waiting times standard.

Local progress to date

An initial walk round the existing MIU facility by commissioners and the existing provider Berkshire Health Foundation Trust (BHFT) in November has helped to outline some of the potential challenges around premises and workforce.

Subsequently the CCG has started to meet regularly every two weeks with BHFT and the Commissioning Support Unit as part of a Task & Finish Group to start the process of mapping what we will need to do to convert the existing Minor Injury Unit (MIU) operating out of West Berkshire Community Hospital into a UTC.

The group has reviewed the national standards and RAG rated them according to whether the standard is in place or easy to implement quickly (green), achievable with further co-ordinated work (amber), or a significant risk (red). Against the 27 standards 16 are RAG rated green, 10 are amber and 1 is red.

Broadly speaking the Amber standards relate to implementing a booking system within the MIU and upskilling the staff to be competent in dealing with minor illness on top of minor injury. All these standards have been judged as ultimately achievable with time.

The red standard relates to the composition of the new multidisciplinary workforce to include GPs. The commissioners will need to decide the scope of this standard to enable meaningful discussions to take place about premises and governance requirements. As mentioned earlier, the CCG and GP Provider Alliances are working to see if the UTC can help meet the core

requirements for extended access going forward and is currently the focus of a number of Organisational Development Sessions being hosted by the CCG for its member practices and GP Alliance leads. It is anticipated that a model will be agreed on early in the New Year.

Rag Rating	Number of Standards	Theme
RED	1	1. What GP provision should be put within the UTC? 2. How many appointments? What mix of physical and remote cover?
AMBER	10	1. Creating the additional booked appointment facility and establishing systems to manage walk in activity alongside. 2. Workforce upskilling to accommodate minor illness 3. ICT
GREEN	16	1. Existing protocols and data sharing arrangements 2. Opening hours

As part of developing the project other risks that have been flagged concern the limited expansion opportunities of the building and the potential increase in activity levels going forward as the unit moves towards treating patient with minor illness on top of minor injury.

BHFT are working on possible solutions to these issues and there is a specific piece of work being done to map the presenting conditions to help set future parameters for what conditions should be seen at the UTC going forward.

There is general consensus that the standards can be met by December 2019, and it is hoped that once some of the fundamental issues around the model of clinical provision are clarified we will look to make significant progress at the beginning of 2018.

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	10 April 2018
Title	Financial Summary Report – Month 11 2017/18
Purpose	To provide the Month 11 2017/18 financial position to the Trust Board
Business Area	Finance
Author	Chief Financial Officer
Relevant Strategic Objectives	4. - Strategic Goal: To deliver services that are efficient and financially sustainable
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 11 2017/18 (February 2018) financial position.
ACTION REQUIRED	The Board is invited to note the following summary of financial performance and results for Month 11 2017/18 (February 2018): 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 2.1 (rating 2) o Liquidity days 9.8 (rating 1) o I&E Margin 1.1% (rating 1) o I&E Variance 0.2% (rating 1) o Agency -35.4% (rating 1) **YTD income & expenditure (including S&T funding):**

	• Plan: £2,060k net surplus • Actual: £2,580k net surplus • Variance: £519k favourable **Month 11: £478k surplus (including S&T funding), +£73k variance from plan:** Key variances: • Additional Income NCA (£84k) & COIN (£78k). • Acute Overspill pressures (-£169k). • Pay Underspend; vacancies (£297k) **Forecast** The trust is forecasting exceeding control total. (£2.8m surplus). **Cash:** Month 11: £21.2m (plan £19m) Variances to plan are: • YTD capital underspend due to re-phasing of Estates and IM&T expenditure +£3.2m • Aged debtors over 30 days totals -£1.8m • STF bonus not in plan (16/17) +£0.8m **Capital expenditure YTD:** Month 11: £6.5m (plan £7.5m) 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. (lower by £1.7m) • IM&T, re-phasing of IT replacement programme; focus on GDE instead. (lower by £2.6m) • Funded externally; included in total capital spend is GDE (£1.8m) and Renal Unit (£1.6m).

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

Finance Report

Financial Year 2017/18

Month 11 (February 2018)

Purpose

This document provides the Board and Executive with information giving the financial performance as at 28th February 2018 (Month 11).

Document Control

Version	Date	Author	Comments
1.0	13.03.18	Bharti Bhoja	Draft
2.0	13.03.18	Tom Stacey	Review & 2nd Draft
3.0	14.03.18	Paul Gray	Review & 3rd Draft
4.0	15.03.18	Tom Stacey	Final
5.0	27.03.18	Tom Stacey	Final for Board

Distribution:

All Directors

All staff needing to see this report.

Contents

1.0 Overview

The trust has posted a surplus of **£478k** in month 11 against budgeted surplus of **£405k, £73k** better than planned.

This brings the YTD surplus to **£2.58m, £519k** higher than the planned surplus of **£2.06m.**

The Trust had £21.2m cash at month 11. This is higher than plan of £19.0m by £2.2m, and is largely due to slippage against the capital programme of £3.2m.

The overarching NHSi Use of Resources rating is maintained as a "1".

Key messages this month:

Month 11

- **Acute Overspill & PICU** OAPs costs are still high, with costs £169k higher than planned, with number of patients remaining high at av. 6 acute overspill and av. 2 PICU. It is likely that these costs increase further in March with average patients needing placements for acute overspill increasing by 8 (to an average of 14 patients) in the last week of February/early March.

- **Additional Income** recognised for a patient with a 5 month stay (NHS Durham Dales), £84k, and COIN central funding not previously anticipated, £78k.

- **Cash** receipts from disposal of WBCH land (£1m) and Little House (£0.8m) are unlikely to complete before the end of the financial year and the cash is now expected in early 2018/19.

Forecast Outturn

- Indications are that the Trust will deliver its NHSI financial commitment, with a forecast YE surplus in the region of £2.8m, incl. core S&T Funding of £1.7m and before donations. This forecast would result in us surpassing this year's £2.5m Control Total by £0.3m, and as a consequence, we will attract at least £ for £ matching additional STF. The statutory reportable forecast, after accounting for donations is likely to be £4.37m.

2.0 Income & Expenditure Summary

Description	Current Month			Year to Date			Forecast Outturn		
	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Actual	Variance
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Main Operating Income	**18,639**	**18,839**	**200**	**206,851**	**208,622**	**1,771**	**225,437**	**227,008**	**1,571**
Other Operating Income	**1,798**	**1,891**	**93**	**18,994**	**18,483**	**(511)**	**20,794**	**20,393**	**(401)**
Operating Expenditure									
Pay - SIP	(14,117)	(12,582)	1,535	(157,652)	(138,342)	19,311	(171,823)	(150,779)	21,044
Pay - Bank	(199)	(950)	(750)	(1,867)	(9,857)	(7,990)	(2,066)	(10,885)	(8,819)
Pay - Agency	(23)	(511)	(487)	(386)	(8,257)	(7,871)	(409)	(8,846)	(8,437)
Non Pay - Acute Overspill	(43)	(213)	(169)	(477)	(2,738)	(2,261)	(521)	(2,924)	(2,403)
Non Pay - Specialist Placements	(667)	(747)	(79)	(7,343)	(8,506)	(1,163)	(8,011)	(9,292)	(1,281)
Non Pay - Drugs & Clinical Supplies	(743)	(736)	7	(8,228)	(8,239)	(11)	(8,977)	(8,975)	2
Non Pay - Premises	(985)	(1,082)	(97)	(10,695)	(11,365)	(670)	(11,682)	(12,447)	(764)
Non Pay - All Other	(2,348)	(2,542)	(195)	(27,147)	(28,116)	(969)	(29,373)	(30,522)	(1,148)
Total Operating Expenditure	**(19,126)**	**(19,363)**	**(236)**	**(213,796)**	**(215,419)**	**(1,623)**	**(232,863)**	**(234,669)**	**(1,806)**
EBITDA	**1,310**	**1,367**	**57**	**12,049**	**11,686**	**(363)**	**13,368**	**12,732**	**(636)**
Non Operating Income/Expenditure									
Interest Receivable	3	7	4	37	44	7	40	52	12
Interest Payable	(299)	(299)	(0)	(3,291)	(3,291)	(0)	(3,590)	(3,710)	(120)
Impairment	0	0	0	0	(95)	(95)	0	(95)	(95)
Depreciation & Amortisation	(508)	(477)	31	(5,619)	(4,446)	1,173	(6,127)	(4,800)	1,327
PDC Dividend	(101)	(120)	(18)	(1,115)	(1,317)	(203)	(1,216)	(1,423)	(207)
Total non operating income/expenditure	**(905)**	**(889)**	**16**	**(9,988)**	**(9,106)**	**882**	**(10,893)**	**(9,976)**	**918**
Net Surplus/(Deficit) - For Control Total	**405**	**478**	**73**	**2,060**	**2,580**	**519**	**2,475**	**2,756**	**281**
Charitable Donations									
Donations credited to SoCI	0	14	14	0	1,638	1,638	0	1,638	1,638
Depreciation of Donated Assets	(8)	(2)	6	(67)	(17)	50	(74)	(20)	54
Total Charitable Donations	**(8)**	**12**	**20**	**(67)**	**1,621**	**1,687**	**(74)**	**1,617**	**1,692**
Net Surplus/(Deficit) - Statutory	**397**	**490**	**93**	**1,994**	**4,201**	**2,207**	**2,400**	**4,373**	**1,973**
Note to SoCI table above:-									
S&T Funding within Operating Income	202	202	0	1,528	1,528	0	1,730	1,730	0
Net Surplus/(Deficit) ex. S&T & Renal	**203**	**276**	**73**	**532**	**1,052**	**519**	**745**	**1,026**	**281**
RCI Note:-									
RCIs Achievement	**392**	**129**	**(263)**	**4,308**	**1,328**	**(2,980)**	**4,708**	**1,874**	**(2,834)**

In Month

The Trust reported a £478k surplus, £73k higher than the budgeted surplus of £405k.

Excluding S&T funding of £202k, the Trust generated an underlying surplus of £276k.

Income over-achieved by £293k, with the main reasons being:

- £84k NCA billing for 5 months to NHS Durham Dales and Community.
- £78k COIN Income received.
- £48k Silvercloud income.

The Pay trend continues, with the Trust continuing to operate with a substantial number of vacancies, which even after accounting for the use of non-permanent staffing, has given rise to a £297k underspend in February. The main areas of underspend include:

- £137k District Nursing – High vacancy levels.
- £52k Intermediate Care-Vacancies.
- £44k IAPT – Mainly vacancies inclusive of slippage in investment.
- £39k Liaison and Diversion – Vacancies and slippage in investment
- £37k CMHT's – Vacancies.
- £35k OPMH - Vacancies
- £26k CAMHs - Vacancies

Despite many areas operating below establishment, there are isolated pockets where staffing costs were ahead of plan, including:

- -£28k Medical Staffing due to locum and CRHTT cover.
- -£13k CRHTT mainly due to additional bank staff usage, although has reduced from previous months, partly due to shorter month to cover shifts.

The current pay position continues to offset this years unallocated / unachieved CIPs.

Non Pay is overspent by £534k with the main reasons being:

- £169k Acute overspill & PICU OAPs costs with numbers of patients remaining high.
- £71k Independent Hospital (specialist) placements.
- £72k Estates costs with high level of replacement and improvement to buildings over recent months.
- £18k FP10 costs are high. (Excludes recharged Westcall FP10s).

Non-operating Income & Expenditure is underspent by £16k mainly due to lower depreciation (£31k).

Year to date

Income is over achieved by £1.26m with the main reasons being:

- £233k MSK East contract renegotiation upwards as well as moving from variable to block contract.
- £158k Additional in-year and prior year income recovery in CAMHs.
- £150k Westcall and Sexual Health
- £122k Connected Care income released.
- £77k Slough Walk-In Centre - prior year over delivery on activity funding and tariff uplift.
- £88k Silvercloud income.
- £141k COIN Income received.
- £97k Community non-contract activity charged out.

YTD Pay spend is £3.45m below plan, with £19.3m of substantive vacancies. We are continuing, through the planning process, to identify unfilled establishment which can safely be released. The main areas of underspend are:

- £1.63m District Nursing - Mainly due to vacancies
- £756k Talking Therapies – Due to vacancies
- £581k Liaison & Diversion - Vacancies and slippage on investment
- £545k Intermediate Care - Vacancies
- £413k CMHT's - Mainly due to vacancies
- £370k Health Visiting - Mainly due to vacancies
- £357k OPMH – Mainly due to vacancies
- £340k CAMHs – Mainly due to vacancies
- £251k Learning Disabilities - Mainly due to closed ward whilst community service is implemented.
- £207k CTPLD – Mainly due to Vacancies.

The overall underspend is after the following overspends having been absorbed:

- £458k Westcall - Including high cost cover during holiday periods.
- £376k CRHTT - Including over establishment costs, sickness, maternity and vacancies. Although to note, this includes favourable variance within East Liaison team as until December staff cross-covered between East CRHTT and East Liaison.
- £376k Medical Staffing – driven by various locum covers and recently additional cover in CRHTT.

The current pay position continues to offset this years unallocated / unachieved CIPs.

Non Pay is overspent by £5.07m and is the major risk within the financial position. The key areas of overspend are:

- £2.26m Acute Overspill / PICU OAPs
- £1.10m Independent Hospital (specialist) Placements, with placements 8 higher than at the start of the financial year, and 9 patients over budget overall.
- £536k Estates and Property costs including redecorating, floor works, boiler works and automatic door repairs predominantly on the East hospital sites. We are continuing to review these costs to ensure appropriate capitalisations and recharging to Property Co.
- £226k FP10 costs are high, (Excludes recharged Westcall FP10s).
- £122k MH Assessment Fees are high.

Non-operating Income & Expenditure is underspent by £882k with lower depreciation of £1.17m being offset by increased PDC Dividend £203k and impairment costs of £95k.

Recurrent Cost Improvements (RCIs)

Scheme	Plan Month £000	Month Actual £000	Var month £000	Plan YTD £000	YTD £000	Var YTD £000	Plan Full Year £000	FYE £000	Var Full Year £000
Operational Vacancy	96	55	-40	1,054	608	-446	1,156	664	-492
Corporate Back Office	83	39	-44	917	418	-499	1,002	470	-532
Operational Mngmnt & Spprt	50	6	-44	550	37	-513	600	166	-434
Procurement	25	13	-12	275	103	-172	300	398	98
Discretionary Spend	8		-8	92		-92	100		-100
Estates Strategy	17		-17	183		-183	200		-200
OAPs	42		-42	458		-458	500		-500
Unallocated / Possible STP	71	15	-56	779	162	-617	850	177	-673
Total	**392**	**129**	**-263**	**4,308**	**1,328**	**-2,980**	**4,708**	**1,874**	**-2,834**

We have delivered £129k of recurrent savings in month, taking YTD reductions to £1,328k. The Trust is offsetting its remaining unachieved savings with underlying vacancy factor.

FYE delivery for the year is expected to be £1.9m, with the majority of savings identified and with full-year effect benefitting the 18/19 plan. This represents a shortfall of £2.8m against our CIP plan and delivery of only 40%. This level of performance will need to improve if next year's Control Total is to be delivered.

3.0 Forecast & Risks

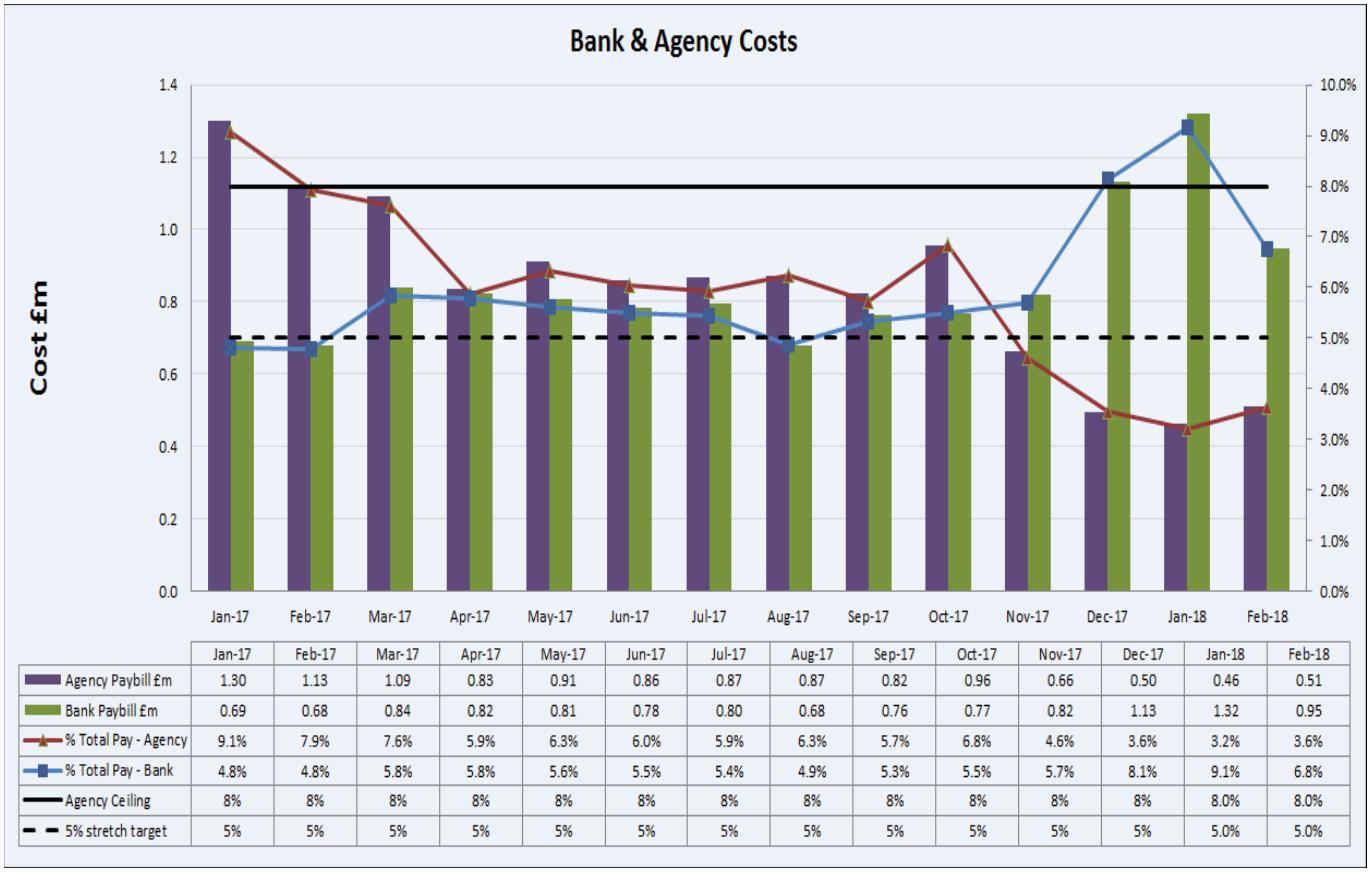
The mid-range YE forecast has been revised upwards to £2.76m due to a better than forecast February surplus, resulting from a reduction in cost in most pressure areas (OAPs, CRHTT, Westcall). This forecast will exceed our Control Total by £0.3m, and we will attract at least £ for £ additional STF funding. After factoring in S&T Funding and Donations, we anticipate a statutory reportable forecast surplus of £4.37m, excluding any S&T bonus payments.

4.0 Use of Resources Metric and Summary

Use of Resource Metric	YTD Plan		YTD Actual		Annual Plan		Forecast	
Metric	**Metrics**	**Rating**	**Metrics**	**Rating**	**Metrics**	**Rating**	**Metrics**	**Rating**
Capital Service Cover (times)	2.2	2	2.1	2	2.3	2	2.2	2
Liquidity (days)	2.0	1	9.8	1	1.6	1	6.2	1
I&E Margin (%)	0.9%	2	1.1%	1	1.0%	1	1.2%	1
I&E Variance From Plan (%)	-	-	0.2%	1	-	-	0.2%	1
Agency (% above / below target)	0.0%	1	-35.4%	1	0.0%	1	-35.0%	1
Use Of Resources Rating		1		1		1		1

Our current and forecast performance is ensuring we maintain our Use of Resources rating of '1'.

Agency Spend vs Cap



	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
Agency Paybill £m	1.30	1.13	1.09	0.83	0.91	0.86	0.87	0.87	0.82	0.96	0.66	0.50	0.46	0.51
Bank Paybill £m	0.69	0.68	0.84	0.82	0.81	0.78	0.80	0.68	0.76	0.77	0.82	1.13	1.32	0.95
% Total Pay - Agency	9.1%	7.9%	7.6%	5.9%	6.3%	6.0%	5.9%	6.3%	5.7%	6.8%	4.6%	3.6%	3.2%	3.6%
% Total Pay - Bank	4.8%	4.8%	5.8%	5.8%	5.6%	5.5%	5.4%	4.9%	5.3%	5.5%	5.7%	8.1%	9.1%	6.8%
Agency Ceiling	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8.0%	8.0%
5% stretch target	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5.0%	5.0%

Agency costs were £511k in month and £8,257k YTD. We are continuing to operate well below our NHSi ceiling of 8% or £11,393k YTD.

Agency costs remain substantially below levels seen earlier in the year, costs rose by £17k this month.

Bank costs have reduced by £369k due in part to reduced cover requirements due to working days, and no bank holidays enhancements. This was particularly noted within WestCall where costs fell £159k.

5.0 Balance Sheet Summary

Statement of Financial Position

A current and forecast Statement of Financial Position (Balance Sheet) is provided below. This reflects the increase in PPE and Intangibles arising from the capital expenditure programme; an increase in cash and the increase in Public Dividend Capital as a result of the GDE funding from the DoH for IM&T investment and developments.

Statement of Financial Position	31st March 2018 (Plan) £'000s	28th Feb 2018 (Actual) £'000s	31st March 2017 (Final - unaudited) £'000s
Non Current Assets (Intangible, Propery Plant and Equipment)	92,843	90,436	88,483
Inventory	109	122	113
Current Receivables (Trade and Other Debtors)	10,111	13,415	11,977
Cash	22,241	21,226	20,698
Current Payables (Trade and Other Creditors)	(25,569)	(24,471)	(26,049)
Other Liabilities (Deferred Income)	(1,469)	(2,510)	(2,012)
Provisions (Current & Non Current)	(1,612)	(2,001)	(2,098)
PFI Finance Lease Creditor (Current & Non Current)	(30,753)	(30,831)	(31,704)
Total Net Assets / (Liabilities)	**65,901**	**65,386**	**59,408**
Financed by:			
Public Dividend Capital	15,985	15,985	14,210
Revaluation Reserve	31,243	31,243	31,243
Income and Expenditure Reserve	18,673	18,158	13,955
Total Reserves	**65,901**	**65,386**	**59,408**

Cash

The closing cash balance for February was £21.2m, against a plan of £19m.

The main factors contributing to the cash balance variance were:-

- Slippage against capital expenditure of £3.2m, expect to increase to £4.3m by YE.
- STF bonus funds from 2016/17 received in 2017/18 that were not in the plan £0.8m;
- Offset by aged debtors over 30 days totalled £1.8m of which NHSPS is the largest at £0.8m. To note RBH is reduced to £0.1m

Actions have been taken to resolve the aged debtors with the respective organisations before the year end including NHSPS (£0.8m) and RBH (£0.1m). Any risk with NHSPS balance is fully offset by the payable balances due to this organisation (£1.8m).

Funding from the Department of Health for Global Digital Exemplar, to fund IM&T investments and developments of £5m over 3 years has been approved. The first drawdown of £1.8m has now been received, and the funding has now been fully spent.

Cash Forecast

We anticipate our cash balance to increase by YE to £22.2m, which will be £2.7m higher than the plan of £19.5m. This favourable outcome is being driven by capital expenditure slippage. Risks against achieving this outturn for cash include inability to recover against aged debtors.

The overall cash forecast has decreased by £1m from that reported last month, with anticipated cash receipts from disposal of WBCH land, £1m and Little House, £0.8m unlikely to complete before the end of the financial year, being offset by an increase in forecast capital slippage.

Trade Receivables

The overall receivables balance was £5.7m, which is an increase of £2.2m from January. The above increase has been driven mainly by an increase in current receivables of £2.7m. There is also an increase in 60-90 days receivables of £0.6m, mainly relating to NHSPS debts of £0.7m.

Trade Payables

Trade Payables at the end of February were £7.3m, which is an increase of £0.8m from January. The main driver for the movement was an increase in 31-60 days payables by of £1.8m, mainly due to £1.6m of NHSPS invoices.

6.0 Capital Programme

Capital Expenditure February 2018

Capital Expenditure	Current Month			Year to Date			Forecast Outturn		
	Budget (£'000s)	Actual (£'000s)	Variance (£'000s)	Budget (£'000s)	Actual (£'000s)	Variance (£'000s)	Budget (£'000s)	Forecast (£000)	Variance (£'000s)
Estates Maintenance & Replacement Expenditure									
- Trust Owned Properties	3	5	(2)	118	25	93	120	59	61
- Leased Non Commercial (NHSPS)	8	18	(10)	296	99	196	540	218	322
- Leased Commercial	1	0	1	75	10	65	82	14	68
- Statutory Compliance	0	10	(10)	565	121	444	640	161	479
- Locality Consolidations	56	3	52	655	1,160	(505)	820	1,200	(380)
- PFI	2	43	(41)	2,190	734	1,456	2,223	938	1,285
Subtotal Estates Maintenance & Replacement	**69**	**78**	**(10)**	**3,898**	**2,149**	**1,749**	**4,425**	**2,591**	**1,834**
Development Expenditure									
- IM&T Refresh & Replacement	261	(315)	576	1,630	618	1,012	2,076	1,174	902
- IM&T Business Intelligence and Reporting	0	0	(0)	378	60	318	378	205	173
- IM&T System & Network Developments	0	6	(6)	795	26	769	795	54	741
- IM&T RiO	0	0	0	447	8	439	447	8	439
- IM&T Other	0	0	0	131	102	29	151	106	45
- IM&T Locality Schemes	16	23	(7)	182	105	77	200	105	95
Subtotal Development Expenditure	**277**	**(286)**	**563**	**3,563**	**919**	**2,644**	**4,047**	**1,652**	**2,395**
Other Locality Schemes									
- Other Locality Schemes	0	4	(4)	0	24	(24)	100	50	50
Subtotal Other Locality Schemes	**0**	**4**	**(4)**	**0**	**24**	**(24)**	**100**	**50**	**50**
Subtotal Capital Expenditure	**346**	**(203)**	**549**	**7,461**	**3,093**	**4,368**	**8,572**	**4,293**	**4,279**
Capital expenditure additional funding									
GDE capital cost funded by NHS Digital	0	371	(371)	0	1,775	(1,775)	1,775	1,775	(0)
Renal Unit at WBCH funded by donation	0	12	(12)	0	1,628	(1,628)	2,400	1,628	772
Grand Total Capital Expenditure	**346**	**180**	**165**	**7,461**	**6,496**	**965**	**12,747**	**7,696**	**5,050**

Month

Total capital spend was £0.2m, excluding GDE and Renal Unit, an underspend of £0.2m. In addition £0.4m of IM&T Refresh & Replacement spend was reclassifying against GDE Second Generation Mobile Workforce project.

YTD

Our YTD spend continues well behind our plan, with an under spend of £4.4m.This is due to:

- Estates underspent by £1.7m:
    - Slippage of the LD to Jasmine Project, £1.3m, which has now been re-profiled to commence in 2018/19
    - A number of smaller estates projects underspent by £1.1m.
    - New in year schemes, offsetting the underspend including, University of Reading £0.5m and Reconfiguration of Southcote & Tilehurst Clinic £0.2m.
- IM&T underspent by £2.6m:
    - Due to elements of expenditure being reclassified to the Global Digital Exemplar programme, specifically Refresh and Replacement, £0.6m, ePMA ,£0.5m, and Clinical Correspondence, £0.3m.

The Trust has now received £1.8m of GDE funding for year one of this 3.5 year programme. This has been spent on IAPT online therapies, £0.2m, Digital Appointment Correspondence, £0.1m, Second Generation mobile workforce, £0.6m, Pharmacy Automation (ePMA), £0.7m, and EOBS £0.2m.

In addition to Trust funded schemes, the charitable funded Renal Unit is expected to have £1.6m spent relating to shell & core work, which is matched with a receipt of donations from Newbury & Thatcham Hospital Building

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	10th April 2018
Title	**Summary Board Performance Report M11 2017/18**
Purpose	To provide the Board with a performance summary dashboard, including narrative and KPI exception highlights.
Business Area	Trust-wide Performance
Author	Chief Financial Officer
Relevant Strategic Objectives	2 - To provide safe, clinically effective services that meet the assessed needs of patients, improve their experience and outcome of care and consistently meet or exceed the standards of CQC and other stakeholders.
CQC Registration/Patient Care Impacts	All relevant essential standards of care.
Resource Impacts	None.
Legal Implications	None.
Equality and Diversity Implications	None.
SUMMARY	The enclosed summary performance report provides information against the Trust's performance dashboard for February 2018. **Month 11** **2017/18 <u>EXCEPTIONS</u>:** **The following Trust Performance Scorecard Summary indicator groupings are Red rated:** The "red" indicator grouping has been rated on an override basis, related to 1 specific indicator; • Service Efficiency and Effectiveness – RED **The following Trust Performance Scorecard Summary indicator groupings are Amber rated:** • People • Contractual Performance Further detail on the AMBER dashboard ratings is narrated within the section commentaries of the

	summary performance report. **The following individual performance indicators are highlighted by exception as RED with their link to the Trust Performance Dashboard Summary identified in brackets:** • **US-05 -** Self-harm incidents: Number **(User Safety)** • **US-18** – Prevention and Management of Violence and Aggression (PMVA) **(User Safety)** • **PM-01** - Staff Turnover **(People)** • **PM-02** – Gross Vacancies (% WTE) **(People)** • **PM-03** – Sickness **(People)** • **SE-03** - Mental Health: Acute Average LoS (bed days) **(Service Efficiency & Effectiveness)** • **SE-03a** - Mental Health: Acute Average LOS Snapshot **(Service Efficiency & Effectiveness)** • **SE-06a** - Mental Health: Acute Occupancy rate (Ex HL) **(Service Efficiency & Effectiveness)** • **SE-06b -** Mental Health: Acute Occupancy rate by Locality (Ex HL) **(Service Efficiency & Effectiveness)** • **SE-07 -** MH Non-Acute Occupancy Rate (**Service Efficiency & Effectiveness)** • **SE-08** – New Birth Visits Within 14 days (**Service Efficiency & Effectiveness)** • **SE-10** - Mental Health Clustering within target **(Service Efficiency & Effectiveness)** Further RED KPI performance detail and trend analysis is provided in the summary performance report.
ACTION	The Board is asked to note the above.

Board Summary Performance Report

M11: 2017/18 February 2018

Performance Scorecard Summary: Month 11: 2017/18

Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

Board Summary

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

Key :

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

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

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

MA-01, 04, 06, 09, 10, 11, MA-15, 17, 18 & 19
MA 21-23

% 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; M11: February 2018:

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

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

Subjective

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

Exception report

Summary of Red Exceptions M11: 2017/18			
Indicator	**Indicator No**	**Comments**	**Section**
Self-Harm incidents	US 05	Increased from 242 to 291	User Safety
Prevention and Management of Violence and Aggression	US 18	Decreased from 61 to 52	User Safety
Staff Turnover	PM 01	Increased from 16.3% to 16.4%	People Management
Gross Vacancies	PM 02	Decreased from 12.7% to 12.5%	People Management
Sickness	PM 03	Increased from 3.99% to 4.46%	People Management
MH Acute Length of Stay	SE 03	Decreased from 42 days to 36 days	Service Efficiency
MH Average Length of Stay Snapshot	SE 03a	Increased from 50 to 52 days	Service Efficiency
MH Acute Occupancy Rate by Locality and Ward	SE 06 a & b	Increased from 96% to 98%	Service Efficiency
MH Non-Acute Occupancy Rate	SE 07	Increased from 72% to 81%	Service Efficiency
New Birth Visits	SE 08	Decreased from 94% to 91.6%	Service Efficiency
Clustering	SE 10	Decreased from 88.0% to 88.2%	Service Efficiency

User Safety Commentary

There were 2 serious incidents in February 2018. These were; 1 unexpected death of a WAM CMHT client and 1 suspected suicide of a Wokingham CMHT client.

The number of assaults on staff increased to 68 in the rolling quarter to February 2018 and remains amber rated. In the rolling quarter, Mental Health Inpatients reported 41 incidents (46 last month), 5 incidents were reported on Sorrel ward (same as last month), 2 on Daisy ward (same as last month), 5 incidents on Bluebell ward (8 last month), 20 on Snowdrop ward (17 last month), 3 on Rowan ward (same as last month), 2 incidents were reported on Rose ward (same as last month) and 4 on Orchid ward (7 last month). In addition, 4 incidents took place at the Place of Safety and 2 at an unreported location at Prospect Park Hospital. In the rolling quarter, 19 incidents were reported at Willow House, CAMHS. In the community there was 1 incident each reported by CAMHS and talking Therapies. All incidents in February 2018 were rated as low or minor risk. This shows an increasing trend.

For Learning Disabilities there was an increase in the number of assaults on staff from 40 in the rolling quarter to January 2018 to 47 in the rolling quarter to February 2018. All incidents in February 2018 were rated as low or minor risk. This shows a decreasing trend.

Patient to Patient Assaults - In Mental Health Inpatient services this has increased to 29 in the rolling quarter to February 2018 and remains rated as green against a local target. In the rolling quarter these occurred as follows; 6 incidents took place on Sorrel ward (5 last month), 1 on Rowan ward (same as last month), 6 on Daisy ward (5 last month), 4 on Rose ward (3 last month), 1 on Bluebell ward (same as last month), 6 on Snowdrop ward (7 last month). 2 incidents were reported at Willow House in the rolling quarter. 1 incident has been reported in the community by Talking Therapies. All incidents in February were reported as low or minor risk. At the time of reporting a total of 19 clients carried out assaults on other patients. This shows an increasing trend.

Learning Disability - Patient to Patient Assaults increased to 16 (previously 13) in the rolling quarter to February 2018. All incidents were rated as low or minor risk and the assaults were carried out by 5 clients including 1 client responsible for 8 incidents. This shows a decreasing trend.

Slips Trips and falls – Orchid ward (7 falls) and Highclere ward (5 falls) are above target. Orchid ward has chosen falls as their breakthrough objective as part of their Quality Improvement Programme. In addition, as part of the fall safe project, the ward implemented the falls and fear of falling assessment as part of the first phase of work. Highclere ward were part of Wave 1 of the Quality Improvement programme and have also trialled fall sensors. In February 2018 the ward had some challenging patients (such as those with advanced dementia).

Self-Harm incidents have increased to 291 in the rolling quarter to February 2018, and remains rated as red. In the rolling quarter, 132 incidents (114 last month) have been reported by Willow House. At the time of reporting these were for 10 clients; including 46 for 1 client and 44 incidents for another. At the time of reporting 1 incident in February 2018 was rated as moderate risk; all other incidents reported at the Willow House were rated as low or minor risk. There were a total of 139 incidents reported in the rolling quarter to February 2018 by Mental Health Inpatients; which is an increase from 89 in the rolling quarter to January 2018. Of these, 41 incidents were reported on Rose ward (31 last month), 42 incidents on Bluebell ward (33 last month) and 12 on Snowdrop ward (increased from 9) and 28 on Daisy ward (13 last month) and 1 each on Sorrel ward and Rowan ward. There were also incidents reported as follows; 2 at Prospect Park, 6 at patient home and 4 public place or street. At the time of reporting, 27 inpatients self-harmed during the rolling quarter with one client responsible for 31 incidents, another client responsible for 14

incidents. Three incidents in Mental Health Inpatients in February 2018 were rated as moderate; including two incidents where the patient was on leave at the time. All other incidents in Mental Health Inpatients in February 2018 were rated as low or minor risk. In the community in the rolling quarter the following incidents were reported; 7 for IAPT, 4 for CMHT (1 each for Bracknell, Wokingham, Reading, and Slough), 4 for the Crisis Resolution team, 2 for IMPACTT and 1 each for Criminal Justice Liaison and Diversion service, Traumatic stress service and Psychological Medicines Service. This shows an increasing trend. For Mental Health inpatients including Willow House, this is a Quality Improvement programme breakthrough objective.

Learning Disability Self Harm – decreased to 4 in the rolling quarter to February 2018. No incidents were reported in February 2018. This shows a decreasing 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 (20 to 19) and Absconsions decreased (13 to 12) in the rolling quarter to February 2018. In February 2018, there were a total of 5 AWOLs reported; 1 each from Rose ward, Bluebell ward and Snowdrop ward and 2 from Daisy ward. All incidents in February 2018 were rated as low risk. In February 2018, there were 5 absconsions; 1 each from corridor at Prospect Park Hospital, the Therapy Centre, and Bluebell ward and 2 from the gym at Prospect Park. Both AWOLs and Absconsions show increasing trends.

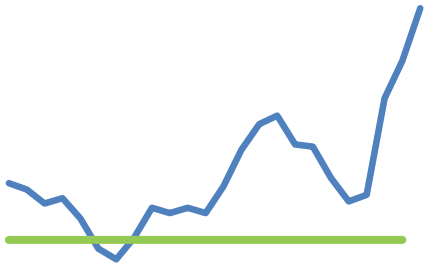
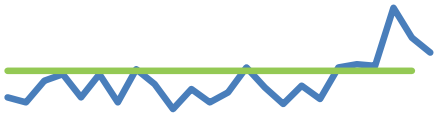
PMVA (Control and Restraint of Mental Health patients) – At the time of reporting in February 2018, there were 52 uses on 14 clients with 13 uses on 1 client. There were 16 uses at Willow House, 4 uses on Sorrel ward, 7 uses on Bluebell ward, 2 on Rose ward, 2 uses on Snowdrop ward, and 11 on Daisy ward, 1 each place of safety and Gym at Prospect Park Hospital, 2 in corridor, 2 other or unknown location, 1 Prospect Park Hospital, 1 Royal Berkshire hospital.

There were 5 incidents of prone restraint in February 2018, these occurred on the wards as follows; 3 on Sorrel ward, 1 each in a corridor and 1 other or unknown location. The trend for use of prone restraint is downwards, when measured over a 3-year period. A programme of work is in place to reduce the use of prone restraint on the wards by 90% by the end of 2018/19.

There were 9 uses of Strategy for Crisis Intervention and Prevention on 2 Learning Disability clients, with one client with 8 uses.

Seclusion in February 2018 for Mental Health Inpatients, there were 12 uses of seclusion for 6 patients. The longest episode of seclusion was for 16 hours due to violence and aggression shown by the patient. There were 5 uses in Learning Disability Services for one client; the longest episode of seclusion was for 8 hours and 20 minutes.

User Safety Exception Report Month 11: 2017/18

KPI	Target	Feb-18	Trend	Context/Reasons	Commentary of Trend
Self-Harm incidents	<75	291		Self-harm incidents increased in Adult Mental Health Inpatients and CAMHS Inpatients, with 3 individuals driving the increase.	
Preventing and Managing Violence and Aggression (PMVA)	<41	52		This is the number of physical restraints of patients on our Mental Health Inpatient wards. This includes an increase in use in our CAMHS ward.	In the 2016/17 NHS Benchmarking exercise, the Trust was amongst the lowest users of restraint but amongst the highest users of prone restraint when compared to other Mental Health Trusts.

Other Key Performance Highlights for this Section

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

- Mental Health Physical Assaults on staff worsened from 66 in the rolling quarter to January 2018 to 68 in the rolling quarter to February 2018.
- Mental Health Patient to Patient Assaults worsened from 26 in the rolling quarter to January 2018 to 29 in the rolling quarter to January 2018.
- Learning Disability Physical Assaults on staff worsened from 40 in the rolling quarter to January 2018 to 47 in February 2018.
- Learning Disability Patient to Patient Assaults worsened from 13 in the rolling quarter to January 2018 to 16 in the rolling quarter to February 2018.
- SCIP (Strategy for Crisis Intervention and Prevention) has worsened from 7 uses in January 2018 to 9 uses in February 2018.

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

- Mental Health use of prone restraint reduced from 13 uses in January 2018 to 5 uses in February 2018.
- Mental Health AWOLS improved from 19 in the rolling quarter to January 2018 to 19 in the rolling quarter to February 2018.

People Commentary

Performance in this category drives an "amber" rating on the performance scorecard summary on a subjective basis. Sickness, turnover, and gross vacancies are stretch targets internally and PDP is a local target. Of the 8 indicators, 2 are red (Staff turnover and Gross Vacancies), 2 are amber (Fire and Information Governance), 2 are green (Statutory training - Health and Safety and Manual Handling). The provisional sickness figure is no longer reported and the PDP target for June 2017 was achieved.

Sickness Absence

• The confirmed Trust-wide monthly sickness rate for January was 4.46%, an increase from 3.99% in December. This increase is attributed to a significant increase in absences due to cold/cough/flu. The total sickness rate attributed to cold/cough/flu absences in January was 1.07% (an increase from 0.69% in December) with increases evident in both the short-term and medium-term sickness rates for this reason. Cold/cough/flu was the most common reason for sickness absence in January and accounted for 23.5% of all absences in the month. These rates are higher than the same period last year.

• There was a decrease in the long-term sickness rate in January to 1.82%, from 2.04% in December. This rate is now at its lowest level in the last 12 months, with decreases evident in absences due to both anxiety/stress/depression and musculoskeletal/back problems. This follows focused work in the localities to ensure that long-term sickness cases are being effectively managed, and the focus now will be on sustaining these improvements. There were also decreases in January in the long-term sickness rates due to injury/fracture and tumours/cancers, with absences for these reasons at below average levels.

• There has been a significant increase in the number of new referrals to the early intervention physiotherapy service, with 49 new referrals in January (an increase from 16 in December). This follows Trust-wide publicity for the service through screensaver messages.

• There has been a further increase in the short-term absence attributed to gastrointestinal problems, to 0.31% (from 0.23% in December) compared to an average of 0.09% for the six months prior to the recent increase. Analysis of the data indicates that these cases are predominantly within specific community and nursing teams, suggesting that they are attributed to outbreaks of seasonal illness. The data will be kept under review to ensure that any further trends are identified.

• Following the decline in the timeliness of management referrals to Occupational Health for those absent from work as reported last month, some localities are working with the Occupational Health on refresher training for managers on writing a good referrals/asking the right questions. Any learning will be shared across localities by the HR Managers.

Recruitment

• Trust attendance at job fairs continues to yield candidates for community nursing and mental health vacancies, with 11 accepted offers of employment to date, all of which are for community nursing vacancies. Job fair attendance also continues to increase the numbers of student nurses registered to the Talent Pool database.

• Since the pilot commenced in January, the four rounds of community nursing recruitment hubs have now resulted in 33 applications for vacancies in bands 4-6 and

twelve accepted offers of employment.

Turnover

• The Trust-wide turnover rate in February has decreased further to 16.28% and remains the lowest rate in over 12 months. The turnover rate in Oxford Health for December 2017 was 18.55%.

• Focused work to reduce turnover, linked to the NHSI Retention Support Programme, has resulted in an action plan for Mental Health Urgent Care services which aims to reduce the turnover of qualified staff by 3% by September 2018, and a further 2% by March 2019. The next phase of the programme will focus on turnover in District Nursing. In East Berkshire, the work will initially focus on the Bracknell team identifying the issues and action planning to target a measurable reduction in the turnover rate. This work will then be extended to include the other District Nursing teams in the East. In West Berkshire, the next step will be to undertake some further analysis of the data to identify the priority areas/teams.

Statutory and Mandatory Training

Statutory Training – Fire Training reduced to 92% with only Mental Health Inpatients above target. Services had been asked to ensure compliance by end of December 2017. Weekly reports are being sent to Locality Directors and for Corporate staff reports on non-compliance have been sent to the relevant Heads of Service/Directors. The Head of Training and Organisational Development has also been sending emails to staff that are non-compliant. Largest area of non-compliance is Estates and Facilities who are being offered training with a paper-based test.

Mandatory Training - Information Governance has reduced to 94% and remains below target for compliance. Services need to ensure staff compliance by 31st March 2018. For Information Governance, the reporting has changed to reflect the requirement for annual "refresher" training for all staff. 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. Estates and Facilities staff and Medics are amongst have the highest number of non-compliant staff. 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 94%.

PDP - Target for June 2017 was achieved.

People Exception Report Month 11 2017/18

KPI	Target	Feb-18	Trend	Context/Reasons	Commentary of Trend
Staff Turnover (% YTD): Percent	<15.2%	16.40%		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%	12.50%		This figure includes areas where there has been difficulty recruiting such as CHS inpatients and nursing, LD and MH inpatients, Community Mental Health teams, Children's' and Young Persons Integrated Therapies and Crisis Services.	Recruitment and Retention group established to look at priority areas.

KPI	Target	Feb 18	Trend	Context / Reason	Commentary of Trend
Sickness	<3.5%	4.99%		The short-term sickness has increased to 1.20%, and the long-term sickness to 1.82%	The increase is in line with historic trends at this time of year.

Other Key Performance Highlights for this Section

- Staff Turnover has worsened from 16.3% in January 2018 to 16.4% in February 2018.
- Information Governance training has improved from 93% in January 2018 to 94% in February 2018.

NHS Improvement Non-Financial and Financial Commentary

The Single Oversight Framework for 2017/18 now includes the following metrics:

• Introduction of the Data Quality Maturity Index (MHSDS dataset score); this will cover submissions of the following fields and published scores for Quarter 2 2017/18 are below:

- Ethnic Category (100%)
- GMC practice code (patient registration) (100%)
- NHS Number (100%)
- Organisation code (code of commissioner) (88%)
- Person stated gender code (100%)
- Postcode of usual address (99%)

The Trust was given an overall data set score of 97.8% but a DQMI Score of 97.9% for the MHSDS, against a target of 95%, according to Quarter 2 2016/17 data which was published by NHS Digital on 16th February 2018 for the MHSDS. This was higher than the Oxford Health at 95.8%, Surrey Borders 96.1% and Southern Health at 97.8% for the MHSDS.

• Inappropriate out of area placements - 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 this 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). Each STP area must produce a trajectory to eliminate the number of Out of Area placements by 2020/21 for submission by 17th November 2017. The latest published data on NHS Digital website 16th February 2018, shows that for December 2017, the Trust had 5 inappropriate OAPs and 995 beds days were used by patients sent out of area. For the calendar year 2017, the Trust had a total of 125 OAPS, and 5,595 bed days were used by patients sent out of area. The OAPS Board will ensure there is a robust process and sign off for return from April 2018. The next publication is due on 20th March 2018.

• Proportion of people completing treatment who move to recovery (from IAPT minimum dataset). For February 2018 all CCGs were above the 50% recovery threshold target.

In addition, Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI) will be included. Work in partnership with acute trusts/CCGs is on-going with organisations within Berkshire seeking to ensure a consistent approach to surveillance. A joint action plan was produced in September 2017; however, no health economy target has been set. Methicillin-sensitive Staphylococcus aureus (MSSA) has also been added and the Head of Infection Control has contacted

commissioners to ascertain whether there are targets for the Trust, but there currently is not. Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate and follows a national reporting process and there was one incident reported by Oakwood unit in February 2018.

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 the targets published in the Single Oversight Framework, for 2017/18 Royal College of Psychiatrists audit data has been submitted and results are due in June 2018:

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

Service Efficiency and Effectiveness Commentary

There are 13 indicators within this category, 5 are rated as "Green" including DNA rates, CHS Length of stay and CHS Occupancy, Crisis plans, and Mental Health Readmissions. None are rated as "Amber", 7 are rated "Red", MH Average and Snapshot Length of Stay, Mental Health Acute occupancy by ward and by locality (same graph below), MH Non-Acute Occupancy, Clustering and Health Visiting, and 1 of which does not have a target (place of safety). As more than 50% of indicators are red, this whole section is red.

The DNA rate increased from 4.80% in January 2018 to 4.96% in February 2018 and remains green. Slough East Mental Health (7.42%) and Reading (West Mental Health) at 6.69% are rated as red. This indicator shows a decreasing trend.

In CPE, the DNA rate reduced from to 9.66% in January 2018 to 9.65% (83/860) in February 2018.

In Children and Families, Community Paediatrics at 11.37%, Health Visiting 8.35%, School Nursing 5.33%, CAMHS 7.61% are above 6% target. Looked After Children has a DNA rate of 16.13% but it has been identified that the Local Authority may not pass on details to carers to ensure that appointments are attended and also a child may choose not to attend appointment but not contact the service.

For Mental Health, there were improvements in the following areas; West Berkshire 5.70% (last month 5.26%). Reading 7.67% (7.62% last month), WAM 4.32% (last month 3.31%) and Wokingham 4.80% (last month 2.60%) all improved. Slough 6.65% (last month 8.63%) worsened. SMS text messaging can be used for reminders for appointments which take place in clinics provided that a mobile number is collected and entered onto RiO in the correct format. In February 2018, 13,920 text messages were sent.

CHS Inpatient Average Length of Stay decreased to 27 days and is within target, with only Wokingham (37 days) and West Berkshire remaining above target but having an average length of stay of 33 days (35 days last month). Delayed transfers have an adverse impact on length of stay. There have been some improvements in the East, WAM 3.58% (last month 6.08%), Slough 3.11% (last month 9.52%) and in the West, with Wokingham 6.28% (last month 10.47%) but Reading 23.49% (last month 14.64%), and West Berkshire 12.28% (last month 9.25%) worsened. A total of 50 patients' discharges were delayed in February 2018, 12 of these are the responsibility of the NHS, and 13 are the responsibility of social care and 25 are joint health and social care responsibility. The most common reason for a delay was awaiting care package in own home (total 23, 5 social care, 2 NHS responsibility, 17 joint responsibility health and social care). 11 are awaiting either Care home or nursing home placement (1 is the responsibility of the NHS, 5 Social Care and 1 is joint responsibility).

Mental Health Acute Occupancy excluding home leave increased to 98% in February 2018.

The Average Length of Stay for Mental Health reduced to 36 days in February 2018 and the acute snapshot length of stay increased to 52 days in February 2018 and continues to remain above target. Of the 196 clients discharged during December 2017 to February 2018, 58% (114) had lengths of stay below 30 days. 15 clients who were discharged in the period had lengths of stay above 90 days, including 14 above 100 days and 1 at 275 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. At 14th March 2018 there were a total of 13 acute clients

who were agreed as delayed transfers of care (an increase from 8 on last month), with a further 2 potential delays. Including potential delays by locality, there are 3 delays each for West Berkshire and Slough, 4 for Windsor and Maidenhead, and 2 for Wokingham. By ward on 14th February 2018, there were 3 delays on Bluebell ward, 4 each on Rose ward and Snowdrop ward. Additionally, there are 2 delays on Sorrel ward.

There are 3 clients delayed on Campion Unit, all detained under the Mental Health Act, by locality there are 2 for Reading, and 1 for an out of area client (Durham).

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, Slough and Wokingham are above target.

At the 15th March 2018 there were 8 Out of Area Placements; 7 Acute Adult Mental Health and 1 PICU clients. The national return for February 2018 showed that 16 Acute overspill patients and 1 PICU client was sent out of area.

Older Adults Mental Health wards length of stay is 83 days for Rowan ward and 77 days for Orchid ward for clients discharged.

CHS Occupancy – This decreased to 83%. The CCGs have asked that 10 beds on Highclere ward be repurposed. Windsor ward in Wokingham was placed on restricted admission and transfer activity from 10th February 2018 and fully reopened on 19th February 2018.

MH Readmission rates reduced to 7.1% in February 2018, however Slough and Wokingham were above target.

Learning Disability – 2016/17 NHS Benchmarking submission was made on 17th November 2017, reports will be published in March 2018.

Community Services benchmarking – NHS Benchmarking were published at the end of December 2017, following a period of final validation. These reports were distributed to Locality Directors. A fuller analysis has been given to Locality Directors to distribute to Service Heads and staff for comment.

Mental Health Benchmarking –The 2017/18 data collection will be discussed by the reference group on 23rd March 2018.

A supplementary audit of a Mental Health services workforce skills mix was launched on 11th October 2017. The Trust including Local Authorities made submissions to the deadline; we are still awaiting final outputs.

CAMHS Benchmarking – there is a separate paper included this month.

Clustering – remains at 88% compliance but remains below the 95% target. With the exception of Slough OPMH (97.8%) all services are below target. Common Point of Entry 67.1% (109 out of 157 clients clustered) and Eating Disorders at 78.9% (186 out of 233 clients clustered in date), 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 93% of those clustered. Early Intervention in Psychosis clients must remain in Cluster 10.

Place of Safety – This reduced to 30 uses in February 2018, with no uses for minors. Of these 30 uses of the place of safety, 20 were admitted following assessment including 13 under Section 2 and 1 under Section 3 of the Mental Health Act. 6 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. 29 out of the 30 assessments were carried out by Berkshire Healthcare NHS Foundation Trust Section 12 Doctors. The most common time in February 2018 to be brought to the place of safety was between was midnight to 3am and then 12 pm. The most common days for detention in February 2018, was Tuesday and Wednesday with 7 detentions each followed by Saturday with 5 uses each.

Crisis plans – This improved to 94% overall with Slough below target.

Health visiting – The Trust attained 91.56% in February 2018 with all areas below target, however the service does not believe this is accurate and are reviewing with Business Analytics. Reasons for non-compliance include; parental choice, delayed discharge from midwifery, and baby in special care baby unit.

System Resilience – Frimley Health NHS Foundation Trust achieved 85% for Type 1 A&E attendances in February 2018.

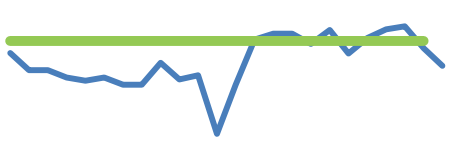
In the West – the A&E waiting times national return for February 2018 show the Royal Berkshire Hospital achieved 73.4% for Type 1 A&E services and 79.2% compliance for all Tier 1 to 3 attendances. Nationally only 76.9% of patients waiting at a Tier 1 A&E services met the target for the discharged, admitted transferred within 4 hours of arrival, and a national average 85.0% for all Tier 1-3 attendances during January 2018. The Trust's Minor Injury Unit achieved 100% for discharged, admitted transferred within 4 hours of arrival.

The system wide report showed West Berkshire, Reading and Wokingham Rapid Access teams had capacity on 14th March 2018. In terms of inpatients on 14th March 2018, there were a total of 8 community beds available across Oakwood, Donnington and Highclere, however both Ascot and Windsor wards had no capacity.

Service Efficiency And Effectiveness Exception Report Month 11: 2017/18

KPI	Target	Feb-18	Trend	Context/Reasons	Commentary of Trend
Mental Health: Acute Average LoS: Number	<30 Days	36		Bed optimisation project underway to look at alternatives to admission, productive stay and productive discharge. This is the lowest average length of stay since July 2016.	Delayed transfers and lack of onward accommodation have impacted on this metric. In the 2016/17 NHS Benchmarking Exercise the Trust was above the national mean with an average length of stay of 30.8 days at 38 days.
MH Acute Length of Stay Snapshot	<30 Days	52		This is an increase on the preceding month and reflects the acuity of clients and number of delayed transfers of care.	

KPI	Target	Feb-18	Trend	Context/Reasons	Commentary of Trend
MH Acute Occupancy rate (exc. HL - by Ward/ Locality)	< 90%	98%		Reading, Slough and Wokingham are 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. New bed management process including gatekeeping of clients is in progress.	Increase in the number of patients detained under the Mental Health Act. For 2016/17 there was 41% increase in detained patients in comparison with 2015/16. Quarter 3 shows an increase in the number of formal admissions; it is predicted that 2017/18 will show a 21% increase on 2016/17.
Mental Health: Non-Acute Occupancy rate (exc. HL): Percent (by Locality and Ward - 2 indicators)	< 80%	81%		This has been driven by increases in occupancy in Orchid (94%) and Daisy Detox beds (96%).	3 Orchid ward clients were delayed transfers of care.

KPI	Target	Feb-18	Trend	Context/Reasons	Commentary of Trend
Health Visiting: New Birth Visits Within 14 days	95%	91.6%		High vacancies, long-term sickness and babies being placed in Special Care Baby Units are the main reasons for under performance.	The Trust is above the 86.4% England average in Quarter 1 2017/18, which is the latest data available on the Public Health England 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 worsened from 4.80% in January 2018 to 4.93% in February 2018.
- CHS Length of Stay improved from 28 days in January 2018 to 27 days in February 2018.
- CHS Occupancy improved from 85% in January 2018 to 83% in February 2018.
- Mental Health Readmission rates improved from 7.6% in January 2018 to 7.1% in February 2018.
- Mental Health Crisis plans for clients on CPA improved from 93% in January 2018 to 94% in February 2018.
- Prospect Park Place of Safety improved from 52 uses in January 2018 to 30 uses in February 2018.

Contractual Performance Commentary

Updates are as follows:

17/18 CQUIN performance reviewed with appropriate provision for revenue risk made in light of final review with commissioners, due in first part of 18/19.

CCG and NHSE financial heads of contract agreed as a variation for 18/19, by the deadline of 23rd March. Year two of the contact secures planned block growth, IAPT LTC investment and confirms expected revenue values for known commissioning service changes.

NHSE has confirmed contracting and commissioning intentions, securing on-going operation of Willow House Tier 4 CAMHs service and review of development at Prospect Park Hospital.

CPE transformation funding agreed for next two years. Service will support transition to new wellbeing service, overseen by a joint programme board with commissioners.

ICS discussions continue in relation to closing system financial gaps for 18/19, and we await news of a revised proposal on system control totals. Clarity expected for final plan submissions on 30th April.

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	10 April 2018
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
Equalities and Diversity Implications	N/A
SUMMARY	The Trust's Seal was affixed to the following documents: • Land Registry Transfer of Title document pertaining to Little House, Bracknell.
ACTION	To note the update.