Berkshire Healthcare NHS
NHS Foundation Trust

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

TRUST BOARD MEETING HELD IN PUBLIC

10:00am on Tuesday 08 May 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 10 April 2018	Martin Earwicker, Chair	Enc.
5.2	Action Log and Matters Arising	Martin Earwicker, Chair	Enc.
QUALITY			
6.1	Patient Story	Helen Mackenzie, Director of Nursing and Governance	Enc.
6.2	Patient Experience Quarter 4 Report	Helen Mackenzie, Director of Nursing and Governance	Enc.
6.3	BHFT Quality Account 2017/18	Minoo Irani, Medical Director	Enc.
6.4	Six Monthly Safe Staffing Report*	Helen Mackenzie, Director of Nursing and Governance	Enc.
EXECUTIVE UPDATE			
7.1	Executive Report	Julian Emms, Chief Executive	Enc.
7.2	Staff Survey Results 2017 Report	Bev Searle, Director of Corporate Affairs	Enc.
7.3	Gender Equality Pay Report	Bev Searle, Director of Corporate Affairs	Enc.
PERFORMANCE			
8.1	Month 12 2017/18 Finance Report*	Alex Gild, Chief Financial Officer	Enc.
8.2	Month 12 2017/18 Performance Report*	Alex Gild, Chief Financial Officer	Enc.
8.3	Financial Plan 2018-19*	Alex Gild, Chief Financial Officer	Enc.
8.3	Finance, Investment & Performance Committee – 25 April 2018 **The Month 12 Finance Report, Financial Plan, and Performance Report were*	Naomi Coxwell, Chair of the Finance, Investment and Performance Committee	Verbal

No	Item	Presenter	Enc.
	reviewed by the April 2018 FIP Committee		
STRATEGY			
9.1	Strategy Implementation Plan 2017-18 Update Report	Bev Searle, Director of Corporate Affairs	Enc.
CORPORATE GOVERNANCE			
10.1	Annual Report 2017-18 **	Excluded – See Note below	N/A
10.2	NHS Improvement Board Declarations	Alex Gild, Chief Financial Officer	Enc.
10.3	NHS improvement Data Security Protection Requirements Compliance	Alex Gild, Chief Financial Officer	Enc.
10.4	Audit Committee – Minutes of the Meeting held on 25 April 2018	Chris Fisher, Chair of the Audit Committee	Enc.
10.5	Council of Governors Update	Martin Earwicker, Chair	Verbal
Closing Business			
11.	Any Other Business	Martin Earwicker, Chair	Verbal
12.	Date of the Next Public Trust Board Meeting – 10 July 2018	Martin Earwicker, Chair	Verbal
13.	**CONFIDENTIAL ISSUES:** To consider a resolution to exclude press and public from the remainder of the meeting, as publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted.	Martin Earwicker, Chair	Verbal

** *It is a legal requirement that an NHS Foundation Trust's Annual Report is not published until the Report has been laid before Parliament in July. The draft Annual Report is therefore excluded from the Public Trust Board papers on the Trust's website.*

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 10 April 2018

Boardroom, Fitzwilliam House

Present:	Martin Earwicker	Chair
	Naomi Coxwell	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
	Mehmuda Mian	Non-Executive Director
	Bev Searle	Director of Corporate Affairs
	David Townsend	Chief Operating Officer
In attendance:	Julie Hill	Company Secretary

18/044	**Welcome** (agenda item 1)
	Martin Earwicker, Chair welcomed everyone, including the observers: Krupa Patel, Public Governor and Andrew Horne, Public Governor.
18/045	**Apologies** (agenda item 2)
	Apologies were received from: David Buckle, Non-Executive Director and Mark Day, Non-Executive Director
18/046	**Declaration of Any Other Business** (agenda item 3)
	There was no other business declared.
18/047	**Declarations of Interest** (agenda item 4)
	i. Amendments to Register – none
	ii. **Agenda Items** – none
18/048	**Minutes of the previous meeting – 13 February 2018** (agenda item 5.1)
	The Minutes of the Trust Board meeting held in public on Tuesday 13 February 2018 were approved as a correct record of the meeting.

18/049	**Action Log and Matters Arising** (agenda item 5.2)
	The schedule of actions had been circulated. **a) Annual Health and Safety Report** The Chair noted that future Annual Health and Safety Reports would include a section on the number of fires involving patients together with benchmarking data from similar trusts and asked whether it would be possible for the Trust Board to receive this information sooner. The Chief Operating Officer reported that benchmarking data was not yet available but work was in hand to source the information in time for the next Annual Health and Safety report. **b) Mental Health Act Office – Care Quality Commission Appointed Second Opinion Doctors** The Director of Nursing and Governance reported that she would raise the issue of the shortage of Care Quality Commission appointed Second Opinion Doctors at the Trust's next Care Quality Commission Engagement meeting on 27 April 2018 and would inform the Trust Board of the Care Quality Commission's response. **c) Local Diversity Road Show Dates** The Director of Corporate Affairs agreed to email round the dates of the Local Diversity Road Show events. **The Trust Board**: noted the schedule of actions.
18/050	**Board Visit: Skimped Hill Health Visiting Services (agenda item 6.1)**
	The Chair reported that unfortunately Mark Day, Non-Executive Director was unable to attend the meeting and present the report of his Board visit to Skimped Hill Health Visiting Services in Bracknell. The Chief Executive said that it was a very clear and helpful report and said that Executive Director colleagues would be happy to give an update on any of the issues raised in Mr Day's report. The Chair commented that the environment, car parking, the uncertainty created by the tendering process for Health Visiting Services in Slough, together with problems with IT connectivity seemed to be the key issues for staff. Chris Fisher, Non-Executive Director referred to page 20 of the agenda pack and commented that staff had mentioned that the reduction in the number of Health Visitors over recent years had been considerable. The Chief Executive explained that David Cameron when he was Prime Minister had given a commitment and set targets for increasing the number of Health Visitors (which the Trust had met), but when responsibility for commissioning Health Visiting Services transferred to local authorities, each local authority had been able to develop its own service specification and there were now no centrally mandated targets in terms of the number of Health Visitors. The Chief Operating Officer reported that Bracknell was the first of the Trust's Health Visiting Services to go through the tendering process. It was noted that the Trust's tender

	was successful, but the contract value was less and this required the service to change its skills mix. In addition, there was considerable uncertainty about whether the service would be re-tendered again within a year. The Chief Executive said that the Trust had submitted a tender for Bracknell Health Visiting Services because staff were confident that they would be able to deliver the service safely within the contract value. In contrast, the Trust did not consider that they could deliver a safe Health Visiting Service in Slough within the contract value. The Chief Operating Officer said that the Skimped Hill accommodation was owned by NHS Property Services and it was earmarked for demolition as part of the re-development of Bracknell Town Centre. It was noted that the Health Visiting Service was one of a number of different services operating out of the same building. The Chief Operating Officer said that in addition, the individual services were commissioned by a mix of NHS England, the Clinical Commissioning Group and the Local Authority. The Chief Operating Officer reported that the Trust was working with the various partner organisations to find suitable alternative clinical accommodation for the different services. The Chief Operating Officer said that the re-development of the Bracknell Town Centre had increased the number of people using the Skimped Hill Car Park and the Trust was working with NHS Property Services (who owned the site) to reduce unauthorised car parking. The Director of Nursing and Governance said that Ofsted and Care Quality Commission inspections of the Bracknell Health Visiting Service had been very positive. The Chief Executive said that it was clear that staff were delivering a good service, but workforce shortages and working out of unsuitable premises were placing additional strain on staff. The Chair asked how the Trust went about deciding whether or not to bid for contracts. Chris Fisher, Non-Executive Director said that in respect of the Health Visiting Service contracts, the detailed discussions took place at the Finance, Investment and Performance Committee meetings with the final decision taken by the Trust Board. The Chair asked about the issues around mobile phone connectivity to the system which were raised by staff. The Chief Operating Officer reported that 50 Community Nurses were currently testing out two different mobile systems. The Chief Financial Officer reported that the Trust was undertaking a major review of mobile working and technical support and agreed to find out why staff were continuing to opt for paper diaries. **Action: Chief Financial Officer** On behalf of the Trust Board, the Chair thanked Mark Day, Non-Executive Director for his report. **The Trust Board:** noted the report.
18/051	**Quality Assurance Committee Meeting held on 20 February 2018 (agenda item 6.2)**
	a) Minutes of the meeting held on 20 February 2018 Ruth Lysons, Non-Executive Director reported that the Committee attendees had been extended to include the Lead Clinical Director and the relevant Lead Clinician for the Clinical Audit(s) under discussion at the meeting. Ms Lysons reported that two new concerns had been added to the Quality Concerns

	Report: physical health monitoring at Prospect Park Hospital and Record Keeping within Mental Health Services. It was noted that the Quality Concerns paper was on the agenda for the In Committee meeting to ensure that all Board members were sighted on the Trust's key Quality Concerns and the actions being taken to mitigate the risks. Ms Lysons reported that the Committee had reviewed the Serious Incidents for the quarter and had noted that one of the key themes identified was around working with and involving carers and families and reported that the Committee had requested an update on the Trust's Carers' Strategy at a future meeting. Ms Lysons reported that the Committee was responsible for overseeing the development of the Annual Quality Accounts Report and would be reviewing the final version via email prior to its submission to the Trust Board meeting in May 2018. Ms Lysons said that it was pleasing that the Trust had good compliance in respect of the national clinical audit on prescribing anti-psychotics. Chris Fisher, Non-Executive Director asked Mehmuda Mian, Non-Executive Director who sat on both the Audit Committee and the Quality Assurance Committee whether from her perspective there were any overlaps or inconsistencies in relation to the operation of the two committees. Ms Mian agreed to reflect and share any observations with Mr Fisher. **Action: Mehmuda Mian, Non-Executive Director** Chris Fisher, Non-Executive Director referred to section 5.7 of the minutes and said that it was concerning that local authorities were not meeting the needs of rough sleepers and the homeless. Mr Fisher also noted that the Trust was not commissioned to provide services for the homeless and rough sleepers and asked whether the Trust could do more to raise the issue with the relevant organisations. The Chief Executive said that local authority funding had been significantly reduced over recent years and that local authorities were reducing the services they were providing in order to focus on meeting their statutory obligations. The Director of Nursing and Governance reported that the Trust did not discharge rough sleepers or the homeless to the streets. Chris Fisher, Non-Executive Director said that the Trust's strategic bed modelling work needed to plan for the increase in rough sleepers and the homeless. **Action: Chief Financial Officer** Ruth Lysons, Non-Executive Director asked whether the Trust should be lobbying for increased support to be provided for rough sleepers and the homeless. The Chief Executive said that organisations such as Shelter were raising the issue both nationally and locally, but to no avail. The Chief Executive suggested including a discussion on where the Trust should focus its lobbying work on the agenda of the Trust Board's annual Strategic Planning Away Day in October. **Action: Company Secretary** **b) Guardians of Safe Working Hours Quarterly Report** The Medical Director said that it was reassuring that the junior doctors had submitted no exception reports in the quarter; the Guardians of Safe Working Hours closely monitor this and continue to encourage the junior doctors to report. The Medical Director highlighted that the biggest challenge had been in relation to rota gaps as the supply of junior doctors from the Deanery was insufficient to fill all the out of hours rotas.

	c) Learning from Deaths Quarterly Report The Medical Director said that the purpose of the quarterly reporting was to provide assurance to the Board that the Trust was appropriately reviewing and learning from deaths. The Medical Director reported that in Quarter 3, one death had been identified as a lapse in care prior to the patient's death. This death was investigated as a serious incident, learning was identified by the service and an action plan was put in place to consolidate the learning. The Medical Director reported that the Internal Auditors had reviewed the Trust's Mortality Review and Learning from Deaths systems and processes and had given a rating of "substantial assurance". Naomi Coxwell, Non-Executive Director asked how a "lapse in care" was viewed externally. The Chief Executive said that the Trust had developed a positive working relationship with both the Coroner and with the Care Quality Commission who valued the Trust's open and transparent approach. The Director of Nursing and Governance explained that the Coroner would only issue a Regulation 28 Notice (action to prevent future deaths) in cases where a gap had been identified which the Trust had not identified and addressed. The Chief Executive reported that both the Medical Director and the Director of Nursing and Governance had worked hard to develop a culture of openness which encouraged staff to report incidents so that learning could be disseminated. Mehmuda Mian, Non-Executive Director referred to page 39 of the agenda pack and asked whether those families who had declined an opportunity to have a face to face meeting with the Trust were offered another opportunity later on. The Director of Nursing and Governance said that in respect of deaths which met the criteria for serious incidents, the Trust had a statutory duty of candour to be open and honest with families. It was noted that Serious Incident Investigating Officers always encouraged families to meet with them as part of the investigation process. The Medical Director confirmed that the role of families was central to the Learning from Deaths and Serious Incident investigation processes. The Medical Director said that the Trust needed to be mindful that some family members did not want to meet to discuss the death of their loved one. The Medical Director said that people with learning disabilities often died in an acute hospital or in a care setting and that in these circumstances, the Trust would not be leading the mortality review process, but would be supporting families to understand the medical background to their loved one's death. Mehmuda Mian, Non-Executive Director referred to the Learning from Deaths in quarter 3 (page 44) of the agenda pack and asked what was meant by a "breakdown in communication." The Medical Director explained that this related to three complaints separately involving District Nursing Services and community rehab ward. It was noted that when the complaints were investigated, there was no evidence of any negligence or any lapses in care, but it was apparent that clinical staff could have communicated better with the families.

	Mehmuda Mian, Non-Executive Director asked whether staff had received training about how to engage with bereaved families. The Director of Nursing and Governance confirmed that this was the case. **The Trust Board:** noted the: a) Minutes of the Quality Assurance Committee held on 20 February 2018 b) Report from the Guardians of Safe Working Quarterly Report c) Learning from Deaths Quarterly Report.
18/052	**Executive Report** (agenda item 7.1)
	The Executive Report had been circulated. The following issues were discussed further: **a) NHS Pay Award** The Chief Executive reported that the Treasury had confirmed that the cost of the NHS Pay Award, if approved by Union Members, would be met centrally. It was noted that central government would also meet the additional cost of the Pay Award in respect of health service staff working on local authority contracts. The Chief Executive said that dissatisfaction with pay had been highlighted as a key issue for staff in successive national NHS Staff Surveys. **b) Public Satisfaction with the NHS 2017** Ruth Lysons, Non-Executive Director asked whether the Department of Health had responded to the decreasing level of public satisfaction with the NHS. The Chief Executive said that the Department of Health had not formally responded butTheresa May had announced that the Government was reviewing the NHS financial planning assumptions and the government was investing more in mental health services. **c) West Berkshire Urgent Treatment Centre** Ruth Lysons, Non-Executive Director asked which organisation would be running the West Berkshire Urgent Treatment Centre and was informed that it was the responsibility of the Trust. Ms Lysons commented that it was an example of integrated care which would provide a more convenient service to local people. The Chief Executive said that the service would need to demonstrate the return on investment. **d) Temporary Staffing and Agency** Chris Fisher, Non-Executive Director congratulated the Director of Nursing and Governance for her leadership in achieving a significant reduction in the cost of agency staff. The Director of Nursing and Governance explained that the drop in the use of agency staff this month reflected the establishment of the WestCall bank. **e) Frimley Integrated Care System Event** The Chair reported that the Frimley Integrated Care System event held on 27 March 2018 had been well attended by Governors, Non-Executive Directors, Local Authority Leaders and Commissioners. The Chair said that it had been a useful engagement event, but that further work was needed to articulate the benefits to patients and demonstrate how the

	Integrated Care System model would make a difference. **f) Primary Care Streaming Service at the Royal Berkshire NHS Foundation Trust** The Chair noted that the Primary Care Streaming Service at the Royal Berkshire NHS Foundation Trust's Emergency Department had not been a great success with the numbers streamed being significantly less than anticipated. It was noted that the Berkshire West Emergency Care Board had agreed to extend the pilot but to change the model of delivery in order to increase throughput, reduce costs and deliver better value for money. **The Trust Board**: noted the report.
18/053	**Month 11 2017-18 Finance Report** (agenda item 8.1)
	The Month 11 financial summary report had been circulated. The Chief Financial Officer reported that the Finance, Investment and Performance Committee meetings held on 27 February 2018 and 28 March 2018 had reviewed the Month 10 and 11 Finance Reports. The Chief Financial Officer presented the finance report and highlighted the following points: • The year-end position was in line with the forecast. • The sale of grazing land at West Berkshire Community Hospital was not proceeding at the current time. The sale of Little House had been completed and the proceeds from the sale would be retained in the 2018-19 financial plan. The Chair congratulated the Trust on delivering the financial plan for 2017-18 but commented that the financial plan for 2018-19 included an ambitious Cost Improvement Programme target. The Chief Financial Officer said that the Cost Improvement Programme for 2018-19 had a particular focus on reducing the number of Out of Area Placements. **The Trust Board noted:** the following summary of financial performance and results for Month 11 2017/18 (February 2018): **Year To Date (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 Income and Expenditure Margin 1.1% (rating 1) o Income and Expenditure Variance 0.2% (rating 1) o Agency -35.4% (rating 1) **Year To Date Income and Expenditure** (including Sustainability and Transformation funding): • Plan: £2,060k net surplus • Actual: £2,580k net surplus • Variance: £519k favourable

	Month 11: £478k surplus (including Sustainability and Transformation funding), +£73k variance from plan: Key variances: • Acute Overspill and Psychiatric Intensive Care Unit Out of Area Placements costs were still high. It was likely that these costs would increase further in March 2018. • Additional Income Non-Contract Activity (£84k) and the Community of Interest Network central funding not previously anticipated (£78m) • Acute Overspill Out of Area Placement pressures (-£169k) **Forecast Outturn** Indications were that the Trust would deliver its NHS Improvement financial commitment with a forecast year end surplus in the region of £2.8m, including core Sustainability and Transformation funding of £1.7m (before donations). This forecast would result in the Trust surpassing this year's £2.5m Control Total by £0.3m and as a consequence, the Trust would attract at least pound for pound matching additional Sustainability and Transformation funding. The statutory reportable forecast, after accounting for donations was likely to be £4.37m. **Cash:** Month 11: £21.2m (plan £19.m) Variances to plan were: • Year to Date capital underspend due re-phasing of the Estates and IM&T expenditure +£3.2m • Aged debtors over 30 days total: -£1.8m; • Sustainability and Transformation funding bonus not in the plan +£0.8m **Capital expenditure Year To Date:** Month 11 £6.5m (plan £7.5m). 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 (£1.7m) • IM&T, re-phasing of IT replacement programme – focus on the Global Digital Exemplar work (£2.6m) • Externally funded: the Global Digital Exemplar funding was included in the total capital spend (£1.8m) and the Renal Unit (£1.6m) **The Trust Board**: noted the report.
18/054	**Month 11 2017-18 Performance Report** (agenda item 8.2)

	The Month 11 2017-18 Performance Summary Scorecard and detailed Trust Performance Report had been circulated. It was noted that People and Contractual Performance were RAG rated amber for February 2018 and Service Efficiency and Effectiveness was RAG rated red. The Chief Executive reported that the Trust was developing a set of "business rules" which would be approved by the Finance, Investment and Performance Committee in respect of the Performance Management Framework to make it easier to identify performance trends in respect of the individual indicators. Moving forward, this would mean that if a negative performance trend was identified, the Finance, Investment and Performance Committee would receive a briefing on the actions that were being taken to get performance back on track. Naomi Coxwell, Non-Executive Director said that the Finance, Investment and Performance Committee received a monthly Safe Staffing report and said that it was important that recruitment and retention and financial performance was viewed in the context of Safe Staffing. The Director of Nursing and Governance said that the Trust achieved Safe Staffing by using temporary and agency staff, but acknowledged that this was not an optimal position. The Chair referred to the User Safety section and asked whether it was a realistic target to reduce the use of prone restraint on the wards by 90% by the end of 2018-19. The Director of Nursing and Governance confirmed that she thought this was a realistic target. Ruth Lysons, Non-Executive Director and Chair of the Quality Assurance Committee requested that a paper be presented to the next meeting of the Quality Assurance Committee setting out the Trust's plan to reduce to use of prone restraint. **Action: Director of Nursing and Governance/Company Secretary** Mehmuda Mian, Non-Executive Director noted that there had been an increase in the number of patient assaults on staff and patient to patient assaults and asked whether there was any particular reason for the increase. The Chief Executive reminded the meeting that reducing assaults was one of the Quality Improvement Programme "True North" indicators and that work had begun to understand the underlying causes and to develop counter measures. **The Trust Board**: noted the report.
18/055	**Finance, Investment and Performance Committee Meetings – 27 February 2018 and 28 March 2018** (agenda item 8.3)
	Naomi Coxwell, Chair of the Finance, Investment and Performance Committee reported that the Finance, Investment and Performance Committee meeting had paid tribute to the work of the Chief Financial Officer and his team for their careful financial management and robust planning which had resulted in the Trust exceeding its Control Total. Ms Coxwell reported that the Committee had discussed the importance of focusing on the recruitment of staff which in turn would reduce the use of bank and agency staff. **The Trust Board:** thanked Naomi Coxwell, Chair of the Finance, Investment and Performance Committee for her update.

18/056	**Use of the Trust Seal** (agenda item 9.1)
	The Chief Financial Officer reported that the Trust's seal had been affixed to documents pertaining to the sale of Little House. The Trust Board: noted the report.
18/057	**Council of Governors Update** (agenda item 9.2)
	The Chair reported that the Frimley Health Integrated Care System event held on 27 March 2018 had been well attended by BHFT Governors. The Chief Executive said that he thought the event was a good way of engaging with Governors and Senior Leaders at a system level. The Chief Executive said that attendance at the formal Council of Governors meetings had dipped recently and suggested providing an opportunity at the next formal meeting of the Council to discuss with Governors their ideas for refreshing the format of meetings. **Action: Company Secretary** Ruth Lysons, Non-Executive Director reported that she had attended the Frimley event and said that it had been an informative event with good questions from the Governors. The Chair reported that he was continuing to hold coffee mornings with Governors but only two or three Governors joined him at these events. The Chair reported that he was in discussions with the Lead Governor and the Chair of the Membership and Public Engagement Governor Group about the venue and timing for the Annual Members Meeting. It was noted that the Communications Team had reviewed the options and had recommended not changing the time or venue on the basis of convenience and cost. The Chief Executive said that the Trust had held evening events for Governors and Members in the past, but this had proved to be divisive because evening meetings were not convenient for a number of people. **The Trust Board:** noted the update.
18/058	**Any Other Business** (agenda item 10)
	There was no other business.
18/059	**Date of Next Meeting** (agenda item 11)
	Tuesday, 8 May 2018
18/060	**CONFIDENTIAL ISSUES:** (agenda item 12)
	The Board resolved to exclude press and public from the remainder of the meeting on the basis that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted.

I certify that this is a true, accurate and complete set of the Minutes of the business conducted at the Trust Board meeting held on 10 April 2018.

Signed…….Date 8 May 2018
(Martin Earwicker, Chair)

Berkshire Healthcare NHS
NHS Foundation Trust

AGENDA ITEM 5.2

BOARD OF DIRECTORS MEETING: 08/05/2018

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 included in the Workforce Strategy update report on the agenda for the In Committee meeting.
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**	I raised the concern with the MHA manager in attendance in the meeting on Friday who is going to take it back to the central

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Status
						office. The trust has also received a letter from the CQC proposing a new way of SOAD appointments in the community through centralisation. We are currently reviewing this proposal for its practicality before responding.
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**	We will send them once they are 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**	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Status
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**	Included in the Workforce Strategy update report on the agenda for the In Committee meeting.
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.
10.04.18	18/050	Board Visit – Skimped Hill Health Visiting Service	The Chief Financial Officer to find out why staff were opting to use paper rather than electronic diaries systems.	08.05.18	**AG**	Digital transformation team to review the issue with the service to determine the process or find a system fix.

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Status
10.04.18	18/051	Quality Assurance Committee minutes	Mehmuda Mian, Non-Executive Director to reflect on whether there were any overlaps or gaps in the operation of the Quality Assurance Committee and the Audit Committee and to share any observations with Chris Fisher, Chair of the Audit Committee.	08.05.18	**MM/CF**	Completed
10.04.18	18/051	Quality Assurance Committee minutes	The Trust's bed modelling work to reflect the increase in the number of rough sleepers and the homeless.	08.05.18	**AG**	This issue will not be picked up specifically in terms of bed modelling methodology agreed, but the impact of local authority/ voluntary and 3rd sector service availability is being considered as a factor more generally in bed modelling scenarios and solutions design against a baseline population and housing driven Mental Health bed

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Status
						need projection over the next 10 years. The Final report is due in June 2018.
10.04.18	18/051	Quality Assurance Committee minutes	The Trust's lobbying priorities to be added to the agenda for the Trust Board Strategic Planning Away Day in October.	09.10.18	**JH**	
10.04.18	18/054	Performance Report	A paper setting out the Trust's plan to reduce the use of prone restraint by 90% to be presented to the May 2018 Quality Assurance Committee.	15.05.18	**HM/JH**	An update on the Trust's Prone Restraint work in on the agenda of the May 2018 meeting of QAC.
10.04.18	18/057	Council of Governors Update	The Company Secretary to feedback from the Governors on refreshing the format of formal Council meetings.	20.06.18	**JH/ME**	There will be an item on the agenda of the next formal Council meeting on 20 June 2018.

Berkshire Healthcare NHS
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Trust Board Paper

Board Meeting Date	8th May 2018
Title	Patient Experience Quarter 4 report
Purpose	The purpose of this report is to provide the Board with information on patient experience within the trust
Business Area	Nursing & Governance
Author	Liz Daly, Head of Engagement and Service User Experience Nathalie Zacharias, Professional Lead for Allied Health Professionals Helen Mackenzie, Director of Nursing and Governance
Relevant Strategic Objectives	1 – To provide accessible, safe and clinically effective services that improve patient experience and outcomes of care
CQC Registration/Patient Care Impacts	Supports maintenance of CQC registration and supports maintaining good patient experience
Resource Impacts	N/A
Legal Implications	N/A
Equality and Diversity Implications	Patient experience has equality and diversity implications and this information is used to consider and address these.
SUMMARY	Boards are required to review patient feedback in detail. The Director of Nursing and Governance has provided an overview at the beginning of the paper. In quarter three, the Trust received 55 formal complaints. The top reasons for complaints being made during quarter four continue to be: • care and treatment • attitude of staff • communication The formal complaint response rate, including those within a timescale re-negotiated with complainants was 100% for the quarter which continues to be exceptional performance. **Patient and Public Involvement** 94% of patients rated our services as good or better in the trust's internal patient survey.

ACTION	The Board is asked to: Consider the report and reflect on the patient feedback received

Overview

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

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

During quarter four, the trust continued to sustain a complaint response rate of 100%, having achieved this for over two years now. The average number of days taken to resolve a complaint was 18. Just under of 65% complaints closed in 2017/18 were upheld or partially upheld.

In quarter four the trust received 55 complaints across a range of services. The number received over the year has been the same as in 2016/17, although fluctuating between quarters. The services which were identified for close monitoring by the board all received complaints. When considering which services to monitor other quality indicators are also examined:

- Community Mental Health Teams (CMHTs) have received 22% of the complaints received over the year. As previously reported Reading CMHT remains an outlier in the receipt of complaints and they remain on our quality concerns list, predominantly because of the changes planned by Reading Borough Council to reduce the number of social workers in the team and to no longer have shared posts. The patient experience team have commissioned a deep dive into the service so that we are able to understand the experience of all patients not just those that choose to complain and agree appropriate actions. All CMHTs are under pressure however work is continuing to review caseloads and discharge processes to try and create capacity.

- Crisis Resolution Home Treatment Team (CRHTT) West hub has received a similar number of complaints compared to 2016/17. Although care and treatment, communication and attutude of staff are the main themes of complaints, they are predominantly around the telephone response patients receive. The East hub has established a triage system for call handling which has been well received by patients and the management team are exploring options to extend this to the west. The team have also received customer care training.

- Child and Adolescent Mental Health Services have seen a rise in complaints compared to last year. The main themes of the complaints are around communication, attitude and care and treatment however in quarter four waiting times was again raised. The increases in caseload, activity and wait times are being driven by the increased number and complexity of referrals. The impacts of this are being partly mitigated by the improved productivity and service improvements. A significant amount of time is invested in supporting families whilst waiting for appointments.

- Acute Mental Health Inpatients received 6 complaints in quarter 4, so 23 in total for 2017/18 which is 11% of all complaints received. The complaints are predominantly around care and treatment. A spring to green programme commenced on 23rd April aiming to reduce bed occupancy to 85% which will improve patient experience. The hospital continues to have band 5 qualified nursing staff vacancies continues to result in higher levels of temporary staff on the wards which is not optimal. The service has held a number of learning events where carer points of view have been discussed.

These services will continue to be monitored closely in 2018/19, as will the trends of overall complaints.

The top reasons for complaints being made over this year and the previous two years continues to be:

- Care and treatment
- Attitude of staff
- Communication

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

There have been two referrals to the Parliamentary and Health Service Ombudsman, one of which has progressed to investigation at this point, involving older people's mental health services.

The deep dive into understanding the views of patients, carers and staff of same sex accommodation in our mental health wards was completed in quarter three and the action plan developed in response has been included.

The trust is participating in the national 'Always Events' programme during 2018/19 which works by actively seeking understanding and feedback from patients and carers to identify and implement behaviours and experiences that should always happen.

There were 48,572 patients eligible to complete the FFT during quarter four, and we received 5463 returns, this resulted in a response rate of 11% overall, which is the highest ever. This level of response rate means the results are not valid though. Where responses are received patients are generally positive about the care they receive. Individually our community health services had a response rate of 9% with a recommendation rate of 97% and mental health services a response rate of 8% with a recommendation rate of 88%. Actions continue to try and increase our response rate

The board specifically requested to understand the FFT results for patient with a learning disability. The response rate was 29% with 85% of respondents recommending the service they received.

The patient and public involvement information collection is our long standing internal patient survey which asks patients how they rate their experience, 94% reported the service they received as good or better.

Conclusion

Patient experience is an important indicator of quality and this report provides good intelligence when considering quality concerns. In terms of volume, the level of positive feedback received by services far outweighs the negative feedback received. Over the year there are no new emerging trends with care and treatment and fundamentally communication being the underlying issues in most complaints. I do not take these lapses in care lightly and it is important services recognise and take steps to prevent similar incidents and that this is shared across the organisation. This continues to be work in progress.

Helen Mackenzie, Director of Nursing and Governance

Patient Experience Report Quarter Four 2017/18

Complaints

Formal complaints received

55 complaints were received across a number of services during quarter four of 2017/18. Details of complaints received can be found in appendix one.

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

	2017/18						2016/17					
Service	Q4	Q3	Q2	Q1	Total	% of received	Q4	Q3	Q2	Q1	Total	% of received
CMHT/Care Pathways	10	12	11	11	44	22.08	8	7	8	9	32	15.31
CAMHS - Child and Adolescent Mental Health Services	4	6	9	7	26	14.29	5	2	5	6	18	8.61
Crisis Resolution & Home Treatment Team (CRHTT)	6	4	6	4	20	9.09	4	3	4	10	21	10.05
Adult Acute Mental Health Admissions	6	4	9	4	23	11.04	4	4	7	5	20	9.57
Community Nursing	3	1	4	4	12	5.84	1	3	2	3	9	4.31
Community Hospital Inpatient	6	1	1	3	11	3.25	4	3	3	7	17	8.13
Common Point of Entry	2	1	-	2	5	1.95	4	0	1	0	5	2.39
Out of Hours GP Services	2	3	2	2	9	4.55	1	1	3	4	9	4.31
Walk in Centre	-	-	-	-	0	-	4	0	0	2	6	2.87
GP - General Practice	-	-	-	-	0	-	-	1	4	4	9	4.31
PICU - Psychiatric Intensive Care Unit	-	-	-	-	0	-	-	1	3	1	5	2.39
Minor Injuries Unit (MIU)	2	1	2	-	5	1.95	-	0	1	2	3	1.44
Older Adults Community Mental Health Team	3	1	1	0	5	2.39	1	1	0	0	2	0.96
7 other services in Q4– no trends identified	11	19	14	5	49		15	10	15	13	53	
Grand Total	55	53	59	42	209		51	36	56	66	209	

CMHT/Care Pathways received the highest number of formal complaints at 22 % of the total complaints received. CAMHS and CMHT/ Care Pathways have seen the greatest increase in complaints compared to 2016/ 2017. Care and treatment, communication and attitude of staff are the main themes of complaints for these services. There has been a 12 % increase in complaints regarding care and treatment in 2017/2018 compared to 2016/2017.

Table Two: *Top four services and theme of complaints during quarter four*

	Service				
Theme	CMHT/Care Pathways	Adult Acute Admissions	Crisis Resolution & Home Treatment Team (CRHTT)	Community Hospital Inpatient	Grand Total
Care and Treatment	5	3	2	4	14
Attitude of Staff		1	2	2	5
Communication	2				2
Discharge Arrangements		1	1		2
Admission		1			1
Confidentiality	1				1
Access to Services	1				1
Discrimination, Cultural Issues			1		1
Medication	1				1
Grand Total	10	6	6	6	28

In quarter four, half the complaints about CMHTs were about care and treatment, with the remaining complaints including communication, access to services, confidentiality and medication.

CAMHS were not in the four services with the highest number of formal complaints for the first time during 2017/18.

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

In addition to the complaints detailed in this section of the report, the Trust monitors the number of multi-agency complaints they contribute to, but are not the lead organisation (such as NHS England and Acute Trusts). There were two new complaints received during quarter four, 1 of which is currently being investigated.

A local Acute Trust led a complaint about care from 2014 involving our High Tech Care service. This was found to be not upheld. NHS England is leading a complaint investigation which incorporates our Sexual Health Service. The investigation is on-going as at the end of quarter four.

CMHT/Care Pathways

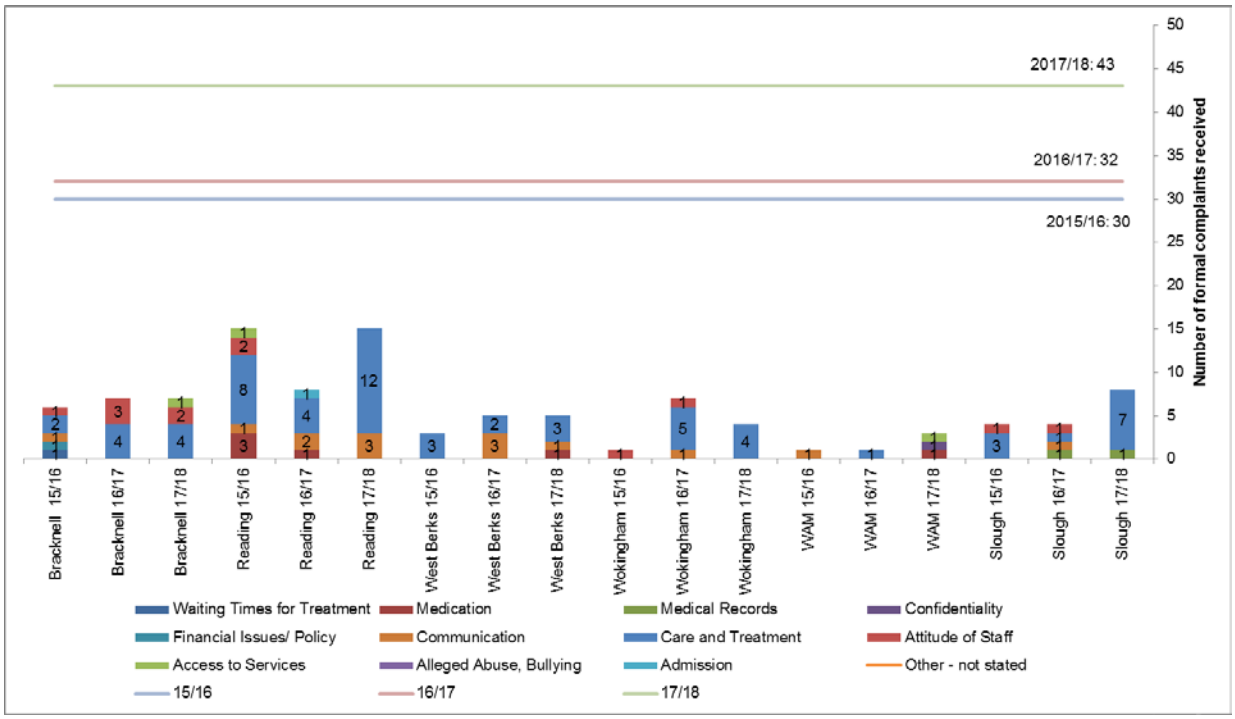
CMHTs saw an increase in complaints, receiving an additional 12 formal complaints compared to 2016/2017. During 2017/18 there have been 44 complaints for the CMHT's, compared to 32 total complaints in 2016/17 and 30 in 2015/16, which demonstrates an increasing trend in complaints for CMHTs. Care and treatment still remains the main theme of complaints across the CMHTs, accounting for half the complaints.

Table Three: *Theme of complaints received in quarter four by CMHTs by locality of service*

	Theme					
Locality of Service	Care and Treatment	Communication	Confidentiality	Medication	Access to Services	Grand Total
Bracknell	1				1	2

Reading	3	1				4
Slough	1					1
West Berks		1		1		2
Windsor, Ascot and Maidenhead			1			1
Grand Total	5	2	1	1	1	10
Percentage of Total	50%	20%	10%	10%	10%	

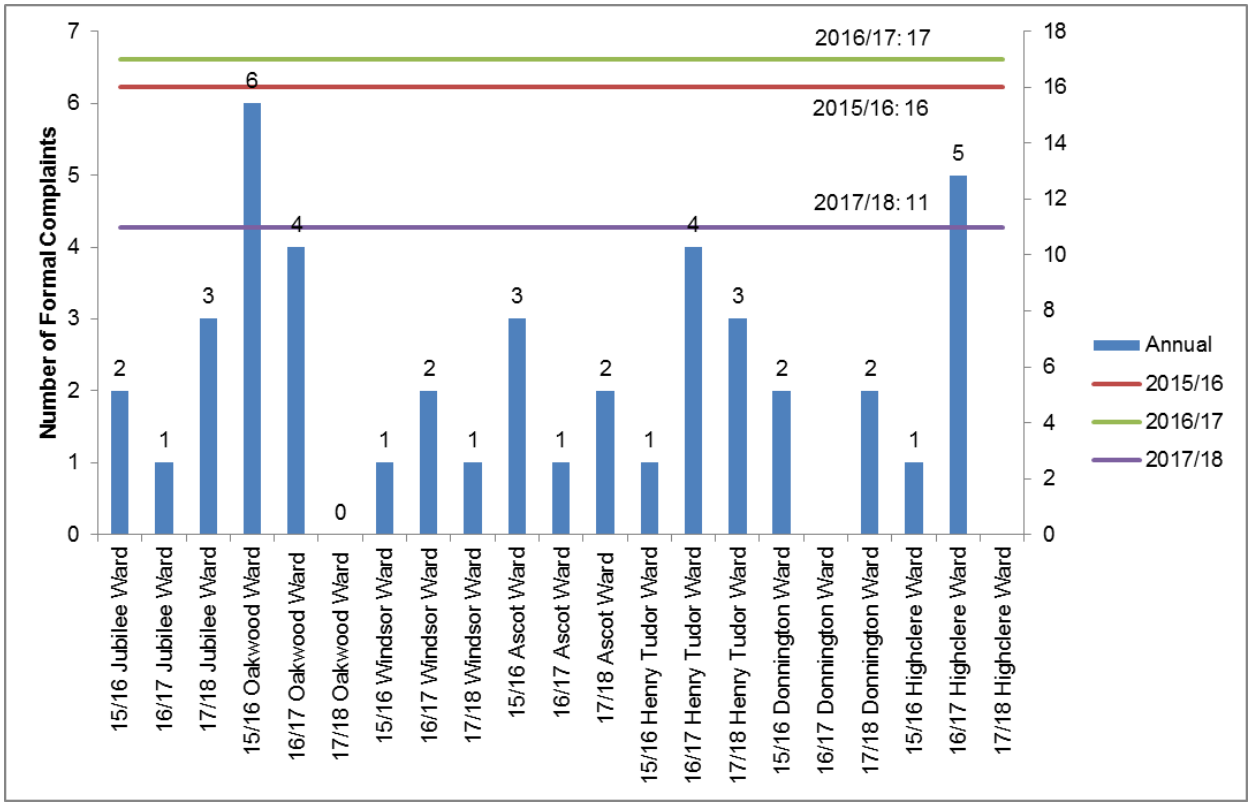
Graph One: *Number of formal complaints received for CMHT/Care Pathways by location of the service*



Community Hospital Inpatient Wards

The community wards have seen a reduction of formal complaints from 17 in 2016/2017 to 11 in 2017/2018. 6 of the 11 complaints were made in quarter four, two each for Ascot Ward and Jubilee Ward. The majority of the complaints were about care treatment (4), with the remaining complaints about attitude of staff.

Graph Two: *Number of formal complaints received for Community Hospital Inpatient wards*



Care and treatment is the main cause of complaints as illustrated below.

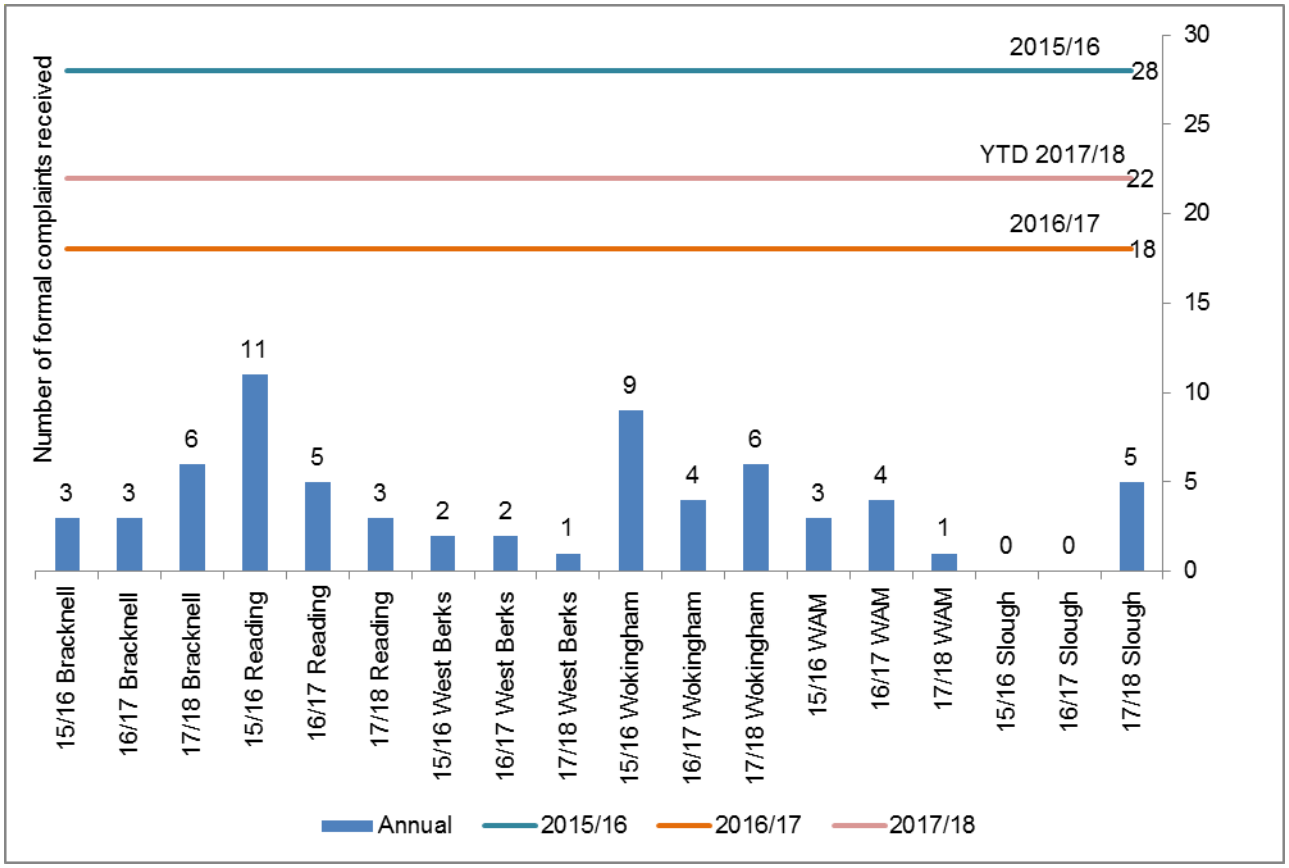
Table Four: *Theme of complaints received by Community Inpatient wards during 2017/18*

	Theme								
Ward	Attitude of Staff	Care and Treatment	Communication	Discrimination, Cultural Issues	Failure /incorrect diagnosis	Discharge Arrangements	Patients Property	Total	%
Henry Tudor Ward	1	1	1	0	0	0	0	3	27.27
Donnington Ward	1	1	0	0	0	0	0	2	18.18
Jubilee Ward	1	1	0	0	1	0	0	3	27.27
Ascot Ward	0	2	0	0	0	0	0	2	18.18
Windsor Ward	0	1	0	0	0	0	0	1	9.09
Total	3	6	1	0	1	0	0	11	

CAMHS - Child and Adolescent Mental Health Services

CAMHS has seen an increase in formal complaints from 18 in 2016/2017 to 26 in 2017/2018. The majority of the complaints received relate to care and treatment. The number of complaints received remains lower than those received during quarters one and two in 2015/16, where there were a higher number of complaints about waiting times. Three of the twenty six complaints received in 2017/2018 involved waiting times demonstrating the work that has been undertaken in the system.

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



For the first time during 2017/18, waiting times for treatment was the main theme of complaints, with a complaint across the Reading, Slough and Wokingham localities. The service based in Wokingham also received a complaint about care and treatment.

Table Five: *Theme of complaints received by CAMHS during 2017/18*

	Theme								
Locality	Alleged Abuse, Bullying	Attitude of Staff	Care and Treatment	Confidentiality	Communication	Medication	Waiting times for treatment	Total	%
Bracknell	0	2	1	0	3	0	0	6	23.08
Reading	1	0	2	0	0	0	1	4	15.38
West Berks	0	0	0	0	1	0	0	1	3.85
Wokingham	0	0	6	0	0	0	1	7	26.92
WAM	0	1	1	0	0	0	0	2	7.69
Slough	0	2	1	1	0	1	1	6	23.08
Total	1	5	11	1	4	1	3	26	

Crisis Resolution/Home Treatment Team (CRHTT)

CRHTT received 20 complaints in 2017/2018, one less than the previous year. The majority of the complaints received were for CRHTT West. Care and treatment, communication and attutude of

staff are the main themes of complaints received so far this year, which aligns to the main themes for all complaints received

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

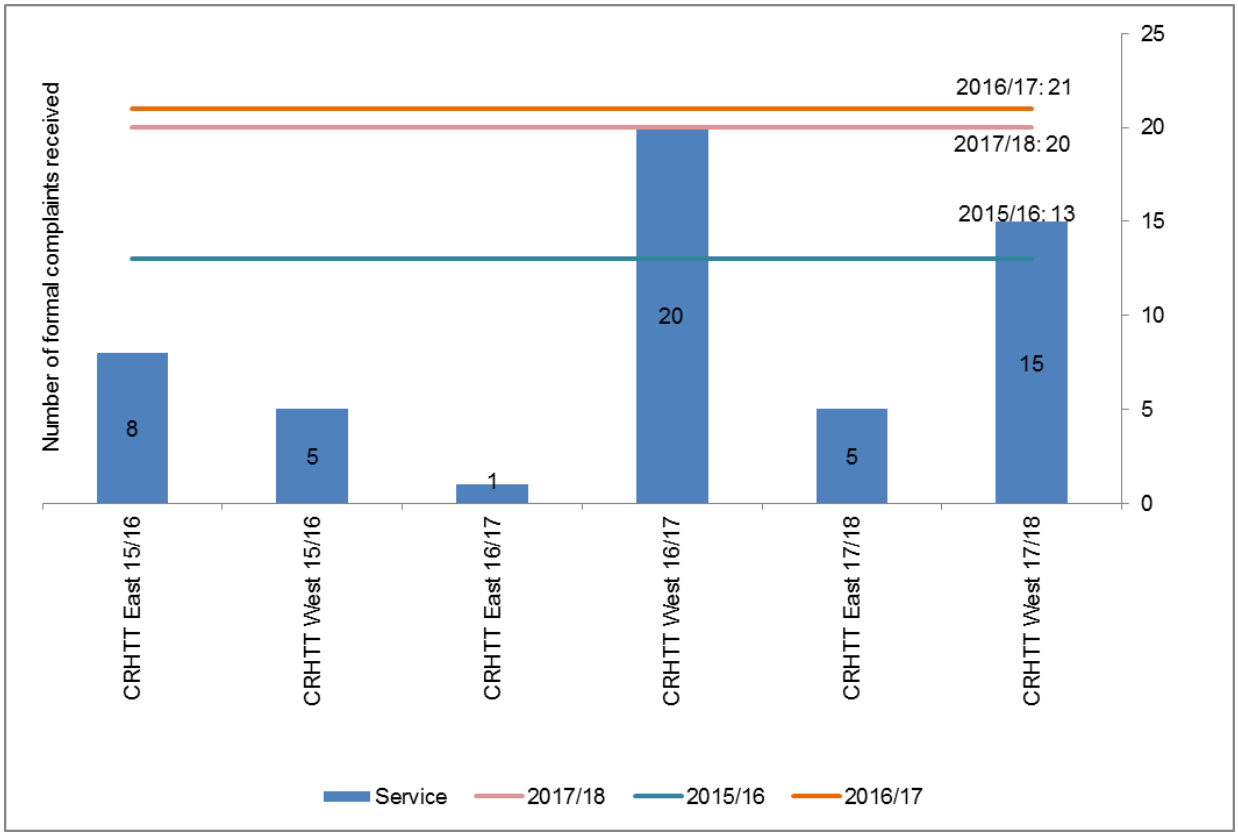


Table Six: *Theme of complaints received by CRHTT during 2017/18*

Service	Admission	Attitude of Staff	Care and Treatment	Communication	Discharge Arrangements	Discrimination, Cultural Issues	Total
CRHTT East		2	2	1			5
CRHTT West	1	3	7	2	1	1	15
Total	1	5	9	3	1	1	20

Mental Health Inpatients

All of our mental health inpatient wards are based at Prospect Park Hospital in Reading; there were seven complaints about wards, and two about the Tribunal process.

Table Seven: *Number of formal complaints received for mental health inpatient wards during 2017/18*

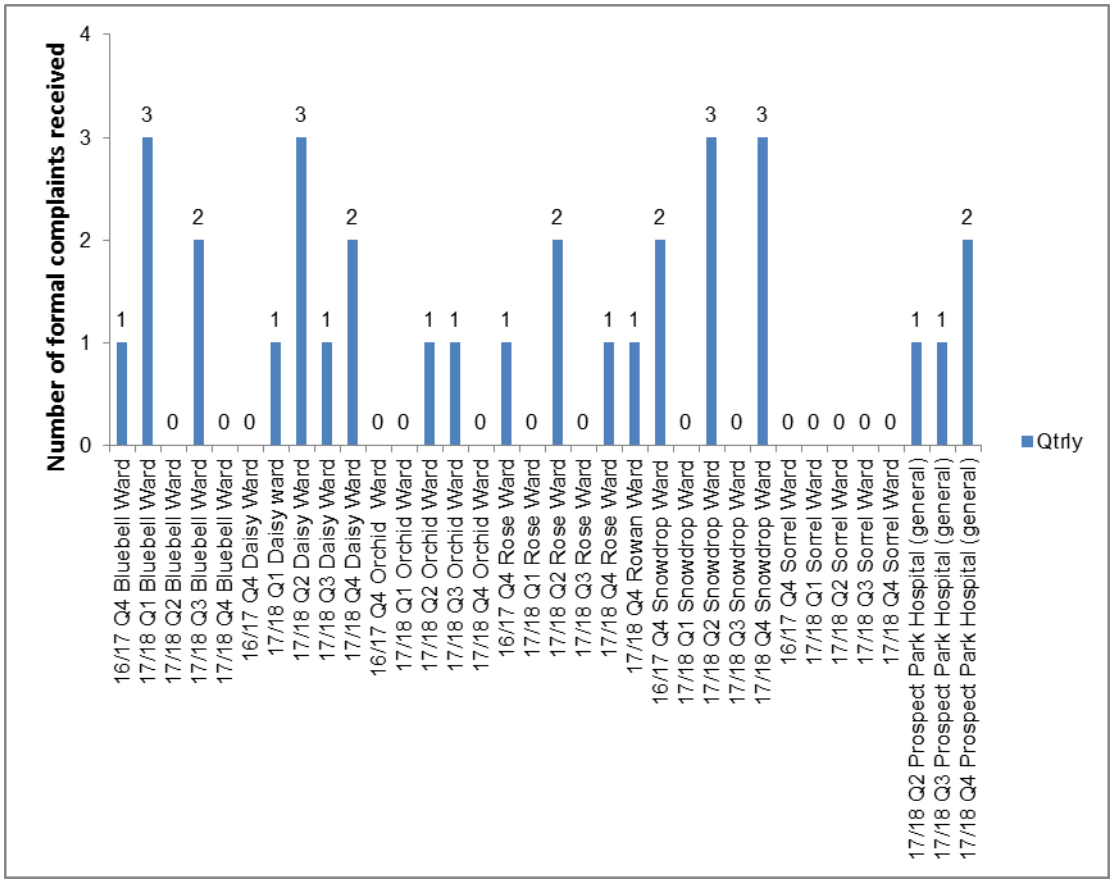
Ward	Admission	Alleged Abuse, Bullying	Attitude of Staff	Care and Treatment	Communication	Discharge arrangement	Medication	Patients Property	Total
Bluebell Ward				4			1		5

Daisy Ward	2			4		1			7
General				2					2
Orchid Ward				1					1
Rowan Ward				1					1
Rose Ward				2	1				3
Snowdrop Ward			1	3		1		1	6
Total	2	0	1	17	1	2	1	1	25

During 2017/18 care and treatment was the main theme of the complaints received, making up 68% of total complaints. There are no other emerging themes. There were fewer complaints about our older person's inpatient wards, Orchid Ward (2) and Rowan Ward (1).

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

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



There were no formal complaints received about community or inpatient Learning Disability Services in quarters three and four 2017/18

Table Eight: *Themes of all formal complaints received*

	2017/18						2016/17					
Theme	Q4	Q3	Q2	Q1	Total	% received	Q4	Q3	Q2	Q1	Total	% received
Care and Treatment	27	32	34	26	119	56.94	26	19	22	26	93	44.50

Attitude of Staff	8	7	11	9	35	16.75	8	7	12	14	41	19.62
Communication	7	5	8	4	24	11.48	7	7	4	8	26	12.44
Admission	1	1	0	0	2	0.96	0	0	1	0	1	0.48
Alleged Abuse, Bullying	0	1	0	0	1	0.48	2	2	3	4	11	5.26
Access to Services	2	0	1	0	3	1.44	3	0	0	4	7	3.35
Medical Records	1	1	0	0	2	0.96	3	0	0	4	7	3.35
Medication	1	1	1	1	4	1.91	0	0	2	2	4	1.91
Confidentiality	2	2	2	0	6	2.87	0	0	3	1	4	1.91
Discharge Arrangements	2	0	0	1	3	1.44	0	0	3	1	4	1.91
Waiting Times for Treatment	3	0	0	0	3	1.44	1	0	3	1	5	2.39
Support Needs (Including Equipment, Benefits, Social Care)	0	1	0	0	1	0.48	0	1	1	0	2	0.96
Management and Administration	0	0	0	0	0	0.00	1	0	1	0	2	0.96
Other/not stated	1	2	2	1	6	2.87	0	0	1	1	2	0.96
Total	55	53	59	42	209		51	36	56	66	209	

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

- Care and treatment
- Attitude of staff
- Communication

Formal complaints closed and action taken

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

Table Nine: *Outcome of formal complaints closed*

	2017/18						2016/17					
Outcome	Q4	Q3	Q2	Q1	Total	% 17/18	Q4	Q3	Q2	Q1	Total	% 16/17
Case not pursued by complainant	1	1	1	1	4	1.95	1	5	1	4	11	5.19
Consent not granted	4	0	1	0	5	2.44	3	4	1	1	9	4.25
Local Resolution	2	6	3	3	14	6.83	4	0	1	4	9	4.25
Managed through SI process	4	Reported from Q4			4	1.95	Not reported					
Referred to other organisation	1	0	1	0	2	0.98	0	0	0	0	0	0
No further action	1	2	0	0	3	1.46	0	0	0	0	0	0
Not Upheld	7	7	20	6	40	19.51	9	7	16	14	46	21.7
Partially Upheld	28	22	19	18	87	42.44	14	18	24	22	78	36.8
Upheld	10	10	18	8	46	22.44	14	7	18	20	59	27.8

Grand Total	58	48	63	36	205		45	41	61	65	212

The percentage of complaints upheld has decreased from 27.8% in 2016/17 to 22.44%. Complaints found to be not upheld have also decreased from 21.7% to 19.51% partially upheld complaints have increased to 42.44% from 36.8%.

Table Ten shows the services with upheld or partially upheld complaints during quarter four.

Table Ten: *Upheld and Partially upheld formal complaints during quarter four, out of a total of 58 closed complaints*

	Outcome		
Service	Partially Upheld	Upheld	Grand Total
CAMHS - Child and Adolescent Mental Health Services	2	4	6
Adult Acute Admissions	5	0	5
Community Hospital Inpatient	3	0	3
Crisis Resolution & Home Treatment Team (CRHTT)	2	1	3
CMHT/Care Pathways	2	0	2
Integrated Pain and Spinal Service	2	0	2
Other	0	2	2
Out of Hours GP Services	1	1	2
Physiotherapy Musculoskeletal	1	1	2
Psychological Medicine Service	2	0	2
Children's Speech & Language Therapy - CYPIT	0	1	1
Common Point of Entry	1	0	1
District Nursing	1	0	1
Eating Disorders Service	1	0	1
Health Visiting	1	0	1
Hearing and Balance Services	1	0	1
Older Peoples Mental Health (Ward Based)	1	0	1
Sexual Health	1	0	1
Traumatic Stress Service	1	0	1
Grand Total	28	10	38

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

- Care and treatment (47%) – an increase compared with 44% during quarter three and a reduction compared with quarter two (54).
- Attitude of staff (18%) - an increase from 16% during quarter three and consistence decrease from 22% in quarter two, 27% in quarter one.
- Communications (18%) – a decrease from the peak of 31% in quarter three and sustained increase from 11% in quarter two and 8% in quarter one.

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

Table Eleven: *Outcome of formal complaints by service*

	Outcome							
Service	Consent Not Granted	Local Resolution	Not Upheld	Partially Upheld	Referred to other organisation	Managed through SI process	Upheld	Grand Total
Adult Acute Admissions	1	2	1	5		1		10
CAMHS - Child and Adolescent Mental Health Services		1		2			4	7
CMHT/Care Pathways	1		3	2	1	1		8
Crisis Resolution & Home Treatment Team (CRHTT)				2			1	3
Grand Total	2	3	4	11	1	2	5	27

The Crisis Response and Treatment Teams have undertaken considerable amounts of work to reduce complaints, particular those around staff attitude which account for a quarter of their complaints in 2017/2018.

There were no formal complaints closed about community or inpatient Learning Disability Services in quarters three and four 2017/18.

All services review the findings from complaint investigations and these are discussed in the locality patient safety and quality meetings with actions identified and monitored to affect positive change. This information is also available via real time dashboards accessible to both the Locality and Clinical Directors.

Action planning within Datix continues to evolve and will give more assurance that actions identified as part of complaint investigations are being followed up and completed effectively and within timescale.

Learning from complaints

Examples of learning from complaints include:

They said: A carer feeling that they were not involved in risk/care plan

We did: A forum is needed for carers to be able to discuss risk and care planning. The Terms of Reference for our risk panel was reviewed in March 2018 to include time for carers to feedback. 2 carers have already taken up the offer to attend and be involved in the panel

They said: The daughter of a patient felt that communication and expectation about the community nursing service were not managed well. Also that there is a lack of peer support for carers

We did: The carer is co-creating and facilitating ‘getting to know your community nursing team’ sessions for carers, with an opportunity for a breakaway group for on-going peer support and potentially education. This is in the planning stage at the moment

They said: Links to information have been sent out, but cannot be accessed

We did: We confirmed that staff had been sending links to documents held on our intranet. An update on who can access our intranet and what to do if someone asks for information has been included in our weekly Trust wide staff email

They said: It is important to understand how long it will be before an appointment with the Berkshire Traumatic Stress Service

We did: Adapted the opt in letter to make all clients referred aware of the current waiting times for assessment, so they are able to make an informed decision about whether they do wish to opt in to the service for an assessment. The service have also informed referrers of waiting times for assessments, and a member of the team joined CPE for their weekly referral meetings to discuss potential referrals from January 2018.

Response rate for formal complaints

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

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

This is reflected sustained 100% response rate achieved since 2016/17.

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

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

The average number of days taken to resolve formal complaints during quarter four was 24 and increase from 18 in quarter three, and decrease from 25 in quarter two, and 27 in quarter one

There were 4 complaints closed that took longer than 40 working days, a decrease from 6 in quarter three, 5 in quarter two and increase from three in quarter one.

Whilst all of the complaints were closed within a timescale agreed with the complainant, there has been a notable increase in those which are closed closer to the deadline. Some of the reasons for this are around the timeliness of responses and investigating officers reports being received into the complaints office, and the subsequent sign off and quality checking by some locality Clinical Directors.

MP Enquiries

In addition to raising formal complaints on behalf of their constituents, Members of Parliament (MPs) can also raise service and case specific queries with the Trust. A review of the activity has been included in this report. We received 33 enquiries in 2017/2018, compared to 42 received in 2016/2017. The majority of the enquiries were about mental health services, possibly indicative of the increased focus on mental health at both a local and National level.

Table Thirteen: *Subject of MP enquiries received during quarter four*

	Theme				
Service	Access to Services	Attitude of Staff	Care and Treatment	Patients Property and Valuables	Grand Total
Adult Acute Admissions				1	1
CAMHS - Child and Adolescent Mental Health Services	1		3		4
CMHT/Care Pathways	1		1		2
Community Hospital Inpatient			1		1
Crisis Resolution & Home Treatment Team (CRHTT)		1			1
Eating Disorders Service	1				1
Minor Injuries Unit			1		1
Grand Total	3	1	6	1	11

Parliamentary and Health Service Ombudsman (PHSO)

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

Table Fourteen: *PHSO Activity*

Month open	Service	Month closed	Current Stage
Sep-16	CAMHS	Sep-17	Not Upheld
Oct-16	District Nursing	Jun-17	Not Upheld
Oct-16	Community Inpatient ward	Jun-17	Partially Upheld
Jan-17	District Nursing	Oct-17	Partially Upheld
Feb-17	Psychological Medicine Service	Apr-17	Not Upheld
May-17	CMHT/Older Adults	May-17	Not a BHFT complaint - records requested to inform investigation about Social Care - case closed after the notes were sent
Jun-17	CMHT	Sep-17	Not Upheld
Aug-17	Talking Therapies	n/a	Investigation Underway
Oct-17	District Nursing	Nov-17	Agreed local resolution - investigation not taken forward by PHSO
Nov-17	CMHT/Care Pathways	n/a	PHSO requesting information to assist with decision on whether to investigate or not
Mar-18	Older Adults Community Mental Health Team	n/a	Investigation Underway
Mar-18	Admin teams & office based staff	n/a	Enquiry at this stage

The Patient Experience and Engagement Group (which has now been combined with the quarterly Healthwatch meeting) monitor the action plans that arise from PHSO investigations on a quarterly basis. This provides a forum to share practice and learning across the different specialities and geographical localities. A template has been devised and is circulated for use from the first meeting in 2018/19 as an efficient way of sharing updates both within the meeting and with the wider Trust.

Informal Complaints/Local Resolution

The complaints office will discuss the options for complaint management when people contact the service. This gives them the opportunity to make an informed decision as to whether they are

looking to make a formal complaint or would prefer to work with the service to resolve the complaint informally. 6 informal complaints were received during quarter four.

The complaints office has been working with services to devise ways of resolving complaints in a way that meets the expectation of patients and their families, whilst capturing the information for staff to use in a friendly and manageable way. It is recognised that services are managing concerns effectively on a daily basis and an online form has been created as a mechanism for capturing these concerns and any actions, so that there can be learning across. This information is captured in real time on a dashboard that is accessible to the Locality and Clinical Directors.

The number of local resolution complaints that the Patient Experience team have been notified about has remained consistent with 205 received in 2017/2018, compared to 210 received in 2016/2017

NHS Choices, Compliments and PALS

NHS Choices

The internal monitoring of NHS Choices postings is an additional way of gathering feedback about our services. Similar to complaints, for an individual to take the time to post on our website about their experience, is an illustration of how strongly they feel. The Trust takes these comments seriously and responds accordingly.

15 negative comments were received in quarter four. There were no themes across the experiences that were shared: examples can be found below:

- CRHTT in East and West: Delay and failure to visit and the approach to an autistic patient and poor communication /empathy.
- The Garden Clinic: access to the service.
- CMHTs in Reading and Newbury: discharge arrangements.
- Reading CAMHS and CPE: Failure/delay in specialist referral and access to service.
- Physiotherapy in Wokingham: Discharge and attitude of staff.
- Prospect Park Hospital: Cleanliness of environment.
- Podiatry at St Marks Hospital: Could not contact the service.
- Hearing and Balance Service KEV11: Unable to obtain batteries from Reception.
- St Marks Hospital: Unable to contact Reception.
- Mobility and Falls service St Marks Hospital: Provision of unsuitable equipment.

There were 3 positive postings. These related to Hearing and Balance at KEV11 Hospital, COAMHS in WAM and the Traumatic Stress Service.

Compliments

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

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

The number of compliments received on an annual basis is:

2013/14: 3050
2014/15: 4359
2015/16: 4620
2016/17: 5950
2017/18: 4784

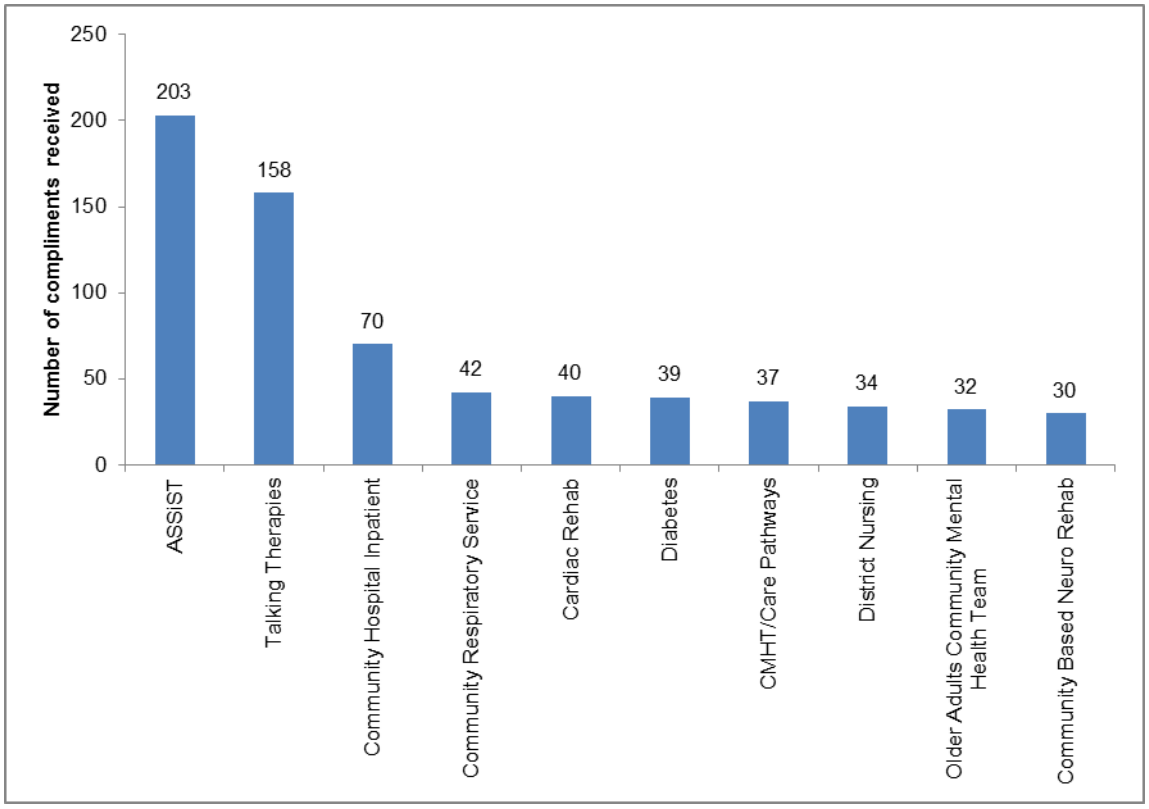
Table Fifteen: *Compliments, comparison by quarter.*

	2017/18				2016/17					
	Q4	Q3	Q2	Q1	Q4	Q3	Q2	Q1	17/18	16/17
Total Compliments	968	1163	1165	1488	1534	1993	1602	821	4784	5950

Compliment reporting continues to be encouraged and promoted with services and at locality meetings and staff can access comments which are available through our intranet.

The online compliment form enables people to add information such as staff group the compliment was received for and the theme.

Graph Eight: *Top services to report compliments in quarter four*



In addition, there were 124 compliments logged that were from sources other than patients, carers and the public. These include students on placements, other organisations and services.

PALS

During quarter four there were 430 contacts into PALS relating to Berkshire Healthcare and the services provided; this is comparable with quarters one, two and three. Not all of the calls to PALS are related to our services, this quarter the PALS service also received 72 enquires that were related to other providers and were supported / signposted to the relevant place.

Top reasons for contacting PALS during Quarter 4:

1. Communication – (Verbal to patients, written to patients and with other organisations)
2. Information requests
3. Access to services
4. Care and treatment

Themes relating to communication are facilitating communication between patients and clinicians, communication with other organisations and people confirming or cancelling appointments.
Themes relating to information requests were general information requests, finding a local service and people requesting clinical information.
Themes relating to access to services were people requesting choice as to where and when they have access, people unsure how to access the service and people unable to access the service due to lack of understanding of the eligibility criteria and problems with direct communication.
Themes relating to Care and treatment were delays in referrals to specialists and delays and failure to visit.

Patient and Public Involvement

Deep Dives

We commission two Deep Dives per year to take a more in-depth look at the experience of patients and carers either in a specific service or their journey on a pathway of care. Actions identified as a result of Deep Dives are monitored through the quarterly Patient Experience and Engagement Group:

Delivering Same Sex Accommodation:

Understanding the views of patients, carers and staff of same sex accommodation in our mental health wards. This was previously explored in 2011, when all wards moved onto the Prospect Park Hospital and all became mixed sex.

The aim of this deep dive was to revisit patient and carer views around same sex wards at Prospect Park Hospital, whilst also drawing together internal and external contextual insight e.g. bed availability vs. service demand, patient profiles and pathways, operational impacts, including staff attitudes.

The action plan in response to the deep dive is attached as Appendix Two.

15 Steps

Eight positive visits have taken place during quarter four.

Appendix Three contains the full quarterly report showing the feedback and themes from these visits.

The Friends and Family Test

The NHS Friends and Family Test (FFT) gives an opportunity for patients and their carers to share their views in a consistent way across the Health Service. Berkshire Healthcare has aligned its Strategic Objectives to support a 15% response rate for the FFT in both physical and mental health services. Nationally, NHS England has announced a review of the Friends and Family Test in 2018/19.

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

With the support of the Patient Experience Team and the commitment of the PPI Champions, CAMHS received 70 FFT returns in March – the highest number to date.

Based on the number of discharges from our services, there were 48572 patients eligible to complete the FFT during quarter four, and we received 5463 returns, giving our highest response rate to date.

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

		Number of responses	Response Rate
2017/18	Q4	5463	11.24%
	Q3	4105	6.81%
	Q2	4987	9.63%
	Q1	4238	7.04%
2016/17	Q4	3696	5.10%
	Q3	4024	5.10%
	Q2	5357	2.20%
	Q1	6697	2.70%
2015/16	Q4	4793	2.10%
	Q3	5844	4.20%
	Q2	6130	4.50%
	Q1	7441	6.60%

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

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

		2017/18				2016/17				2015/16		
Ward	Ward type	Q4%	Q3%	Q2%	Q1 %	Q4%	Q3 %	Q2%	Q1%	Q4%	Q3%	Q2%
Oakwood Ward	Community Inpatient Ward	100	72.97	93.75	100	100	-	85.7	89.47	95.16	94.55	88.71
Highclere Ward		94.64	96.7	100	100	96.6*	90	100	96.3	96.88	81.48	85.19
Donnington Ward							75.7	100	90.91	89.47	95.83	94.87
Henry Tudor Ward		97.59	42.86	98.86	93.5	97.1	89.3	95.7	95.92	87.27	95.71	100
Windsor Ward		95.24	94.44	100	100	100	92	94.7	93.94	100	96.61	98.08
Ascot Ward		100	100	100	100	100	80	100	88.89	90	93.55	97.14

		2017/18				2016/17				2015/16		
Ward	Ward type	Q4%	Q3%	Q2%	Q1 %	Q4%	Q3 %	Q2%	Q1%	Q4%	Q3%	Q2%
Jubilee Ward		97.83	100	100	100	100	90	100	97.78	97.44	95	97.22
Bluebell Ward	Mental Health Inpatient Ward	-	-	100	40	80	60	100	78.79	80	75	0**
Daisy Ward		33.33	-	66.67	50	50	-	66.7	85.71	68.42	75	71.43
Snowdrop Ward		100	85.71	76.19	60	78.6	66.7	50	66.67	85.71	0**	100
Orchid Ward		-	-	100	0**	-	0**	100	-	100	0**	100
Rose Ward		33.33	100	50	100	66.7	0**	80	33.33	54.55	58.82	100
Rowan Ward		-	-	-	100	-	0	-	72.73	100	-	-

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

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

An allocated member of the Patient Experience Team will be working with Prospect Park Hospital as part of their internal service user strategy and to help promote and support feedback from April 2018/19.

Learning Disabilities services

The Friends and Family Test is available as part of the wider patient survey that is used across Learning Disabilities services, in a more accessible version. A feedback device has been set up for our inpatient ward, the Campion Unit, to support collecting feedback.

During quarter four, there was a response rate of 29% and 85% of people would recommend the service to friends or family. There were three responses where people said that they would be either unlikely or extremely unlikely to recommend the service, and 6 said responded with don't know or neither. The survey has been revised and is available via an online link.

Table Nineteen: *Annual Friends and Family Test activity*

Walk in Service	Year	%
West Berks MIU	2017/18	98
Annual	2017/18	98
	2016/17	95
	2015/16	91

	Year	%
Community Hospital Inpatients	2017/18	97
	2016/17	95
	2015/16	94
Mental Health Inpatients	2017/18	67
	2016/17	74
	2015/16	70
Community mental health and physical health combined	2017/18	96
	2016/17	97
	2015/16	95

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

Number of responses					
2017/18		2016/17		2015/16	
Q4	86	Q4	74	Q4	15
Q3	39	Q3	57	Q3	15
Q2	32	Q2	54	Q2	73
Q1	111	Q1	22	Q1	29

The responses received are generally positive; however response rates are low and there is an aim to achieve for 100 per locality per quarter. Work is on-going to increase the awareness of Carer FFT cards within the trust and potential impact of the FFT on other carer feedback e.g. memory clinic accreditation.

FFT national benchmarking

Each month health services (both NHS and independent providing NHS services) submit a report to the Department of Health on their FFT results and activity. As each organisation differs in the services that they provide, and the guidance for calculating the response rate differs substantially. The table below shows the most up to date comparison information available from NHS England.

Table Twenty one: *Number of Friends and Family Test responses*
Community health services FFT data inc. February 2018

	Feb-18		Nov-17		Aug-17		May-17		Feb-17	
Trust Name	Response Rate	% RR	Response Rate	% RR	Response Rate	% RR	Response Rate	% RR	Response Rate	% RR
Berkshire Healthcare	9%	97%	6%	99%	9%	98%	6%	97%	4%	98%
Solent NHS Trust	5%	96%	4%	97%	4%	96%	3%	96%	2%	97%
Southern Health NHS FT	12%	94%	7%	97%	5%	98%	8%	94%	8%	95%
Oxford Health NHS FT	5%	97%	4%	97%	3%	97%	3%	97%	1%	96%

%RR – Recommendation rate

Table Twenty two: *Number of Friends and Family Test responses*
Mental health services FFT data inc. February 2018

	Feb-18		Nov-17		Aug-17		May-17		Feb-17	
Trust Name	Response Rate	% RR	Response Rate	% RR	Response Rate	% RR	Response Rate	% RR	Response Rate	% RR
Berkshire Healthcare	8%	88%	6%	87%	4%	88%	7%	92%	2%	88%
Solent NHS Trust	8%	93%	12%	93%	11%	93%	6%	92%	6%	92%
Southern Health NHS FT	2%	91%	3%	89%	3%	86%	3%	89%	3%	91%
Avon and Wiltshire MH Partnership	14%	89%	13%	88%	11%	86%	13%	89%	15%	89%
Oxford Health NHS FT	10%	91%	9%	92%	9%	92%	2%	79%	1%	79%

%RR – Recommendation rate

The available information demonstrates that the collection methodology with the highest response continues to be paper/postcard at point of discharge. To support existing methods of collecting the Friends and Family Test, the Patient Experience Team are distributing hard copy cards and freepost envelopes which services are to include with the discharge letters that are send to patients. The Patient Experience Team has developed adapted versions for children and young people. The use of SMS has been put on hold and is being restarted in 2018/19; this is a much more time effective way of collecting and reporting the FFT.

PPI strategy

Appendix Four is the Patient Participation Strategy work programme as at the end of 2017/18, Getting from good to outstanding. From August 2017 the Patient Experience and Engagement Group (PEEG) and quarterly Healthwatch meetings merged, providing a greater opportunity to share the learning and best practice from participation across services and geographical localities.

Over the past 12 months, the Patient Experience team has co-developed a PPI Champion role within the Children, Young People and Families locality. Participation representatives from the services act as champions for service user feedback and participation. The champion role provides opportunities for passionate and enthusiastic staff, at all levels, to play an active role in generating a positive focus towards the progression of service user feedback and participation, with direct support from both their peers and corporate services. The Patient Experience Team will further roll out the opportunity for PPI Champions across other localities during 2018/19.

We have signed up to be part of the NHS England 'Always Events' programme, which works by actively seeking understanding and feedback from patients and carers to identify and implement behaviours and experiences that should always happen.

Patient Leaders/Volunteers

We continue to promote Patient Leaders within the Trust. Our current Patient Leaders are engaging with the Quality Improvement team and are engaged in work around improving access to activities in the community for carers in Bracknell. One Patient Leader has unfortunately contacted the Trust following completion of training to say that they could no longer be involved due to other commitments. We are pro-actively co-facilitating the Patient Leadership Programme with the Royal Berkshire Hospital who have led the training, and as such, are moving towards sharing opportunities to be involved in projects across both Trusts more openly across both organisations.

There is a dedicated Patient Experience Volunteer based at St Marks Hospital, who received further training to be able to support activities and patients on the ward and in services, in addition to collecting feedback. The Voluntary Services Team continues to support recruitment with volunteers across other sites.

Good or Better results

Total feedback relevant to the good or better rating has been received from 2720 patients and carers, of those that provided feedback 94% reported the service they received as good or better. 17 of the services carrying out the internal patient survey were rated 100% for good and better with a further 19 services rating 85% or above.

Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

Formal Complaints received during quarter four 2017/18

Geographical Locality	Service	Revised BG	First received	Complaint Severity	Description	Outcome code	Outcome	Subjects	Sub-subject
Reading	CAMHS - Child and Adolescent Mental Health Services	Children, Young People and Families	02/01/2018	Low	Parents feel daughter is being denied support due to her age, approaching 18 in June. family want an assessment for their daughter by 31st Jan and to receive a referral if appropriate to help with A levels	Partially Upheld		Waiting Times for Treatment	Long Wait for an appointment
Reading	Psychological Medicine Service	Mental Health West	04/01/2018	Low	Patient unhappy with the person they who assessed them at the RBH	Partially Upheld	questions by clinician were appropriate but style of communication upset patient and clinician did not recognise this. Clinician will reflect and have supervision as appropriate.	Attitude of Staff	Healthcare Professional
West Berks	Minor Injuries Unit	Community Health West	04/01/2018	High	pt presented to MIU, was examined and told to go home and have a hot bath, they suggested he had over done it in the gym. 4 hours later following a visit to his GP he was blue lighted to ICU in hospital where he spent 3 weeks with Meningitis	Serious Untoward Incident Investigation	Being pursued as an SI	Care and Treatment	Failure to examine/examination cursory
Windsor, Ascot and Maidenhead	Hearing and Balance Services	Community Health East	04/01/2018	Low	Pt was the last patient of the day but did not have her hearing aid with her, she asked to go out to the car to have a look for it and the audiologist said no as they were the last patient they would have to make another appt. Pt unhappy with this	Partially Upheld	Points 3 and 5 upheld. Other points not upheld as it was patient's perception.	Communication	Verbal to Patients
Reading	Adult Acute Admissions	Mental Health Inpatients	05/01/2018	Low	Family wish to raise a complaint about the way their son is treated by certain members of snowdrop nursing team.	Partially Upheld	Upheld - It is acknowledged that staff did not act quickly enough when patient was missing from ward and documentation was not to required standard. Not documented if patient objected to female search. Not upheld - There was a male member of staff on the ward when patient returned, fulfilling other duties and female staff can undertake search. Ward may not have been the best place for patient but funding for suitable placement for someone with Asperger's can be lengthy. Staff and CPN offered support for patient's care.	Attitude of Staff	Healthcare Professional
Bracknell	Crisis Resolution & Home Treatment Team (CRHTT)	Mental Health West	09/01/2018	Low	Pt believe MH professional lied to him and was aggressive in her attitude to him. Pt also wishes to complaint that when he calls CRHTT they won't listen to him, he wants someone to listen to the recordings of his calls from his mobile number as he disputes always angry	Underway		Attitude of Staff	Healthcare Professional

Geographical Locality	Service	Revised BG	First received	Complaint Severity	Description	Outcome code	Outcome	Subjects	Sub-subject
West Berks	CMHT/Care Pathways	Mental Health West	10/01/2018	High	Misguided information from CMHT re medication resulting in pt taking the wrong dosage of anti depressants and mood stabilizers. Family believe this is why he needed to be admitted to PPH where their phone calls are not returned and there is no forward planning. Family feel the staff have no compassion or understanding of MH. Patient has also suffered a spinal fracture from having ECT treatment at PPH and the family feel this was brushed under the carpet.	Serious Untoward Incident Investigation		Medication	Wrong medication dispensed/wrong dose/Wrong Quantity
Windsor, Ascot and Maidenhead	District Nursing	Community Health East	11/01/2018	Low	Paralysed pt seen by DN's since 2013 needs to be seen for occasional pressure sores. DN usually attend 2 x aday. Different DN attended and advised they would not visit again as pt could make his own way to the surgery, she took the Home visit notes. Sister-in-law extremely upset by this and wish the decision to be reversed	Underway		Care and Treatment	Clinical Care Received
Wokingham	Crisis Resolution & Home Treatment Team (CRHTT)	Mental Health West	12/01/2018	Moderate	Deaf pt has not been provided with a lip speaker who is cognisent in Mental Health. Our door entry systems are not Deaf person friendly. Advocate wishes to know what training our staff receive in deaf awareness.	Underway		Discrimination, Cultural Issues	Needs interpreter, translator, sign language
Reading	Adult Acute Admissions	Mental Health Inpatients	15/01/2018	Moderate	Pt with long standing MH illness discharged from PPH without having access to her accommodation which resulting in her having no where to stay. Son is extremely surpirsied at the poor standard of care his mother had received, he feel there was bad treatment, lack of communication and poor information between services. He wishes the short comings between PPH and RCMHT to be dealt with as his mother is likely to be requiring our services again.	Consent Not Granted	Pt refused consent saying that she is now over it.	Discharge Arrangements	Discharge Planning
Slough	Crisis Resolution & Home Treatment Team (CRHTT)	Mental Health West	17/01/2018	Minor	Psychiatrist took husband into the public waiting room & discussed his wife's condition saying 'she was a maniac'. Husband upset about her right to privacy and the way the Dr went about this.	Underway		Attitude of Staff	Healthcare Professional
Reading	Intergrated Pain and Spinal Service	Community Health West	18/01/2018	Low	Pt disagrees with BHFT approach to her diagnosis of CFS/ME she feels we treat it as a MH issue not physical health. Pt strongly disagrees with a report written by a member staff and wishes for it to be accurately amended by an independent party using her full medical history to and her up to date circumstances.	Underway		Care and Treatment	Clinical Care Received
Wokingham	CAMHS - Child and Adolescent Mental Health Services	Children, Young People and Families	18/01/2018	Low	Referral did not get processed and the mother says she was advised to go private by a doctor due to the waiting lists as it would be quicker for her son to be seen. Mother was not given clear guidance on complaints process.	Underway		Care and Treatment	Clinical Care Received
Slough	District Nursing	Community Health East	19/01/2018	Moderate	Pt did not receive a visit to administer his insulin, complainant would like to know how this was missed and wants reassurance it will not happen again.	Consent Not Granted		Care and Treatment	Delay or failure to visit
Slough	CAMHS - Child and Adolescent Mental Health Services	Children, Young People and Families	19/01/2018	Minor	Mother unhappy with the wait times within CAMHS, the lack of communication. Mother does not understand why her son is not a priority when they have had to look for a new school as his current school can not cope with his behaviour. Family say the local authority think it is a safeguarding issue	Underway		Waiting Times for Treatment	Long Wait for an appointment
Windsor, Ascot and Maidenhead	Children's Speech & Language Therapy - CYPIT	Children, Young People and Families	23/01/2018	Low	Parents unhappy at the time it took for the clinic letter to be received and thus the delay in SALT. Also have not received information around a blood test	Underway		Communication	Written to Patients

Geographical Locality	Service	Revised BG	First received	Complaint Severity	Description	Outcome code	Outcome	Subjects	Sub-subject
Reading	CMHT/Care Pathways	Mental Health West	24/01/2018	Moderate	Family feel there was no discharge plan when pt left PPH and there seemed to be a complete change of medication. Family are struggling to keep the pt safe and they want her to have a care plan that all MH professional are aware of. Call to CRHTT on the 20th Jan made the pt feel worse.	Underway		Care and Treatment	Clinical Care Received
West Berks	CMHT/Care Pathways	Mental Health West	24/01/2018	Low	Pt wants to know why he did not receive a call back from services in August 2017 and December 2017 and why a psychiatrist said he was insensitive to drugs, he would like to know what that means.	Underway		Communication	Verbal to Patients
Reading	Other	Mental Health Inpatients	25/01/2018	Low	Delay in Section 2 Tribunal Application Submission	Underway		Communication	Written to Patients
Reading	Adult Acute Admissions	Mental Health Inpatients	25/01/2018	Low	Complainant stated poor communication between staff and to relatives with misinformation over the phone sometimes relating to different patients. Staff are unaware of patient where abouts, on one occasion pt was awol turning up at home which required the family to call the hospital	Underway		Care and Treatment	Clinical Care Received
Wokingham	Community Hospital Inpatient	Community Health West	26/01/2018	Moderate	Sister would like some answers to why her brother died of septicaemia caused by a urine infection that allegedly was not detected whilst the pt was on Ascot ward, Wokingham Hospital	Serious Untoward Incident Investigation	Being dealt with as SI	Care and Treatment	Clinical Care Received
Reading	Adult Acute Admissions	Mental Health Inpatients	29/01/2018	Low	Pt was transferred to Rose ward from RBH but their notes were either lost or ignored. Pt believes she was given drugs that caused her to collapse due to her low blood pressure.	Underway		Care and Treatment	Clinical Care Received
Slough	Community Hospital Inpatient	Community Health East	31/01/2018	Minor	Complainant feels the staff on the ward were extremely rude to her, so much so she feels she was made to cry. Complainant feels the staff were unprofessional and lacking in empathy	Underway		Attitude of Staff	Healthcare Professional
Slough	Community Hospital Inpatient	Community Health East	01/02/2018	High	Family feel the nurse did not take sufficient action to the patients deterioration. Family wish an apology from the Director on Call with an explanation as to why they took an hour to answer the call. Family also concerned of the treatment their mother may receive if she is re-admitted to Jubilee Ward	Underway		Care and Treatment	Clinical Care Received
Slough	Sexual Health	Community Health East	02/02/2018	Moderate	Patient went to have sub-dermal contraceptive implant and was told pregnancy test was negative, but she was in fact 13 weeks pregnant. Complaint says the Dr had a positive result but mis-read it. Patient had pregnancy confirmed at 19 weeks but due to abnormalities had a termination which resulted in a live birth but baby died shortly after.	Partially Upheld	Dr did give incorrect result informing patient she was not pregnant when she was. Clinic to review processes. Patient has not been seen by same Dr since and verbal apologies were offered at the time	Care and Treatment	
Windsor, Ascot and Maidenhead	CMHT/Care Pathways	Mental Health East	02/02/2018	Low	Pt unhappy that mental health services spoke to her boss (Who is a GP) about her mental health which she says has resulted in her loosing her job.	Underway		Confidentiality	Breach of Patient Confidentiality
West Berks	Community Hospital Inpatient	Community Health West	06/02/2018	Low	Complainant states he has been unable to obtain any information about the patient and says the whole family have been kept in the dark	Consent Not Granted	Pt will not consent to complainant having healthcare information about them	Care and Treatment	Clinical Care Received

Geographical Locality	Service	Revised BG	First received	Complaint Severity	Description	Outcome code	Outcome	Subjects	Sub-subject
Reading	Older Peoples Mental Health (Ward Based)	Mental Health Inpatients	08/02/2018	Moderate	Pt under section 2 fell on the ward, wife contacted 6 hours later. Pt taken off blood pressure meds at the RBH and placed on Aririprazole due to MH presentation. Pt lost weight, wife thought Rowan would be following the MUST guide line. Pt taken off MH meds and their physical condition improved. Pt had another fall which the wife struggled to get any information about. Wife concerned what would have happened if the pt had remained on Meds and says how difficult she found it to get info out of staff, she also wants to know PPH do not use sensors on the beds when a pt is at high risk of falls	Underway		Care and Treatment	Clinical Care Received
Reading	Psychological Medicine Service	Mental Health West	12/02/2018	Moderate	Pt attended RBH A&E walk-in centre to obtain a prescription under the instruction from 111. Complainant feels the process they went through was disorganised and they were misinformed. Complainant felt the MH service worker was callous and unprofessional, she could not find the pt details on the system. She feels the member of staff was negligent leaving the patient feeling worse and needing to call samaritans	Underway		Attitude of Staff	Healthcare Professional
Reading	Intergrated Pain and Spinal Service	Community Health West	13/02/2018	Minor	Pt unhappy that the service wrote to the RBH sharing information about her MH which she considers to be inaccurate. Pt feels this is unacceptable, humiliating and very degrading and a breach of her Data protection. She wishes an apology for sharing inaccurate info, an investigation into who wrote the letter as it has caused distress to her and a letter sent to the RBH to say the information was inaccurate.	Underway		Confidentiality	Breach of Patient Confidentiality
Reading	Adult Acute Admissions	Mental Health Inpatients	15/02/2018	Moderate	Adolescent patient admitted to PPH, pt wishes to know why they were placed in PPH as they feel staff were very ill prepared to support a young person. An apology is required for poor administration of the admission and alleged bad communication between teams. Apology for attitude of staff questioning as well as not being able to see a Dr. Assurance that improvement to services will occur as a result of this complaint.	Underway		Care and Treatment	Clinical Care Received
Reading	Out of Hours GP Services	Community Health West	16/02/2018	Low	Mother phoned 111 at 21:45 and was advised she would be called by the Dr in 2 hours. Received a call until 06:10 the following morning where the Dr left a message apologising and advising to take Nurofen and Piriton.	Underway		Care and Treatment	Delay or failure to visit
Reading	CMHT/Care Pathways	Mental Health West	20/02/2018	Minor	Complainant wishes to raise a complaint against the care is wife is receiving from her CPN. He feels the information written in a report submitted to her tribunal was inaccurate along with subsequent information to solicitors.	Refered to other organisation		Communication	Communication with Other Organisations
Wokingham	Common Point of Entry	Mental Health West	22/02/2018	Minor	Patient is complaining about the way she has been treated by CPE. She says they have caused a number of issues and she is still awaiting treatment.	Underway		Care and Treatment	
Reading	CMHTOA/COAMHS - Older Adults Community Mental Health Team	Mental Health West	23/02/2018	Minor	Daughter has escalated concerns about accuracy of the assessment report of the CPN and Psychiatrist, which she was not cc into. Correspondence shows that the service have been trying to resolve locally.	Underway		Medical Records	Inaccurate Records
Reading	CMHT/Care Pathways	Mental Health West	23/02/2018	Moderate	Advocacy organisation complaining about what they perceive to be lack of action by CMHT to get patient suitable treatment.	Underway		Care and Treatment	

Geographical Locality	Service	Revised BG	First received	Complaint Severity	Description	Outcome code	Outcome	Subjects	Sub-subject
Slough	CMHT/Care Pathways	Mental Health East	26/02/2018	Low	Patient says he was misdiagnosed with schizophrenia in 2004 and this has impacted on his life. He wants the diagnosis removed, an explanation and apology.	Underway		Care and Treatment	Failure/incorrect diagnosis
Reading	Other	Mental Health Inpatients	26/02/2018	Minor	Solicitors complaining on behalf of patient that Trust failed to process the tribunal application in a timely manner.	Underway		Communication	Written to Patients
Slough	Sexual Health	Community Health East	01/03/2018	Low	Patient unhappy with being asked if his partner was male and that they asked for the nationality of his partner.	Underway		Attitude of Staff	Healthcare Professional
Reading	Crisis Resolution & Home Treatment Team (CRHTT)	Mental Health West	05/03/2018	Moderate	Husband of patient would like to know why his wife had to travel 2 hours for a bed. There were concerns about lack of communication with the family and support on discharge.	Consent Not Granted		Discharge Arrangements	Discharge Planning
Reading	Out of Hours GP Services	Community Health West	05/03/2018	Low	On the 3rd March 2018, her mum who had shooting pain from her head to her neck called NHS 111, who referred the patient to Westcall. The OOH GP called the patient, did an assessment over the phone and arranged for her to be seen at 3.40pm, however she was only seen at 05.05pm where the doctor told the patient to take Paracetamol or Ibrufen tablets with little or no examination. The daughter was not happy with this and felt it was not sufficient treatment. On the 4th March 2018, the daughter called NHS 111 again as the patient was not still not any better. NHS 111 referred the patient again to Westcall and would receive a call back within 2 hours after 7.20pm, however the complainant was called on her mobile at 3.30am waking her whole family and in addition the patient was not at the complainants house to which annoyed the complainant. The OOH GP then called the patient at 3.45am only to tell the patient to contact her GP in the morning. Again the complainant was not satisfied with the response.	Underway		Communication	Verbal to Patients
Wokingham	CAMHS - Child and Adolescent Mental Health Services	Children, Young People and Families	07/03/2018	Low	Complaint about delay in ADHD service and attitude of clinician.	Underway		Waiting Times for Treatment	Long Wait for an appointment
Wokingham	Community Hospital Inpatient	Community Health West	08/03/2018	Minor	DECEASED PT: LRM has been requested as the wife would like to to discuss the dietary needs her husband had when he was transferred to Wokingham hospital from the RBH	Underway		Care and Treatment	Clinical Care Received
Reading	CMHT/Care Pathways	Mental Health West	08/03/2018	Low	Father wants to know why his daughter does not have a CPA or a care coordinator since the previous one left	Underway		Care and Treatment	Clinical Care Received
Bracknell	CMHT/Care Pathways	Mental Health East	15/03/2018	Minor	Pt who says she feels suicidal everyday, wants an explanation as to why she was refused PA despite it being suggested by her care coordinator. Pt does not feel able to call Crisis when feeling suicidal due to bad experiences with them, says they are rude, disrespectful and have lectured her in the past.	Underway		Care and Treatment	Failure/Delay in specialist Referal
Windsor, Ascot and Maidenhead	District Nursing	Community Health East	19/03/2018	Low	Unhappy that DN's came out to do BP and take blood samples on the day her husband died, also wishes to know why there was a delay in the provision of a call button watch as she feels she was left 'unprotected over Christmas'. Pt wishes to know why the pain clinic have not addressed her on-going issues with her knees. Pt wishes to know why the podiatrist did not attend her appointment	Underway		Care and Treatment	Clinical Care Received
Windsor, Ascot and Maidenhead	CMHTOA/COAMHS - Older Adults Community Mental Health Team	Mental Health East	19/03/2018	Minor	DECEASED PT:- Wife feels the psychiatrist denied her and her husband his final wish of being together at the end.	Underway		Care and Treatment	Clinical Care Received

Geographical Locality	Service	Revised BG	First received	Complaint Severity	Description	Outcome code	Outcome	Subjects	Sub-subject
Bracknell	CMHT/Care Pathways	Mental Health East	19/03/2018	Low	Pt wants to know why she has been turned down by the psychology depart and why she is still waiting for a care coordinator	Underway		Access to Services	
Reading	Common Point of Entry	Mental Health West	20/03/2018	Minor	Pt who has been under MH services since he was 5 has been told there is no commissioned service to support him in	Underway		Access to Services	Commisioning
Reading	Crisis Resolution & Home Treatment Team (CRHTT)	Mental Health West	20/03/2018	Low	Pt with Huntington's disease, suffering from severe MH issues over a period of time. Following an incident in dec 2017 the pt was admitted to Yew tree lodge, subsequently discharged and then discharged by CRHTT having been given medication despite his recent overdoses. The GP confirmed he had no discharge plan. The advocate has been advised the pt is open to his psychiatrist but they are not aware who that is and no one has come back to them.	Underway		Care and Treatment	Clinical Care Received
Bracknell	CMHTOA/COAMHS - Older Adults Community Mental Health Team	Mental Health East	22/03/2018	Low	Son of pt feels the social worker working with the patient lied in documentation and wants all records relating to this deleted. He also wants names of staff who raised a S42	Underway		Care and Treatment	Clinical Care Received
West Berks	Minor Injuries Unit	Community Health West	23/03/2018	Moderate	Pt presented as unable to walk with severe pain. Nurse suggested taking pain killers and doing exercises, did not check for contra-indication re ibuprofen. 2 weeks later had MRI scan which confirmed a stress fracture in the femoral head. Pt wants to make sure this does not happen to anyone else.	Underway		Care and Treatment	Failure/incorrect diagnosis
Reading	Adult Acute Admissions	Mental Health Inpatients	26/03/2018	Moderate	Pt arrived for alcohol detox at 10am and had to wait till 1pm to be allocated a room and then not reviewed by a doctor until 5pm by which stage the pt says he was in severe alcohol withdrawal, he did not receive any withdrawal medication till 7-8pm. IRIS also have concerns - 1. lack of staff knowledge and understanding of alcohol withdrawal syndrom 2. medics availability on admission day 3. communication between ward staff 4. Unprofessional treatment given to IRIS staff when raising concerns about a patient	Underway		Admission	Delayed admission
Windsor, Ascot and Maidenhead	Community Hospital Inpatient	Community Health East	26/03/2018	Minor	Distraught patient wants an investigation into the attitude of the staff on Henry Tudor ward. When on the ward the pt said she was continuously shouted at, would get up to go to the toilet and no one would help her, on one occasion she was told she could not go to the toilet.	Underway		Attitude of Staff	Healthcare Professional
Slough	Crisis Resolution & Home Treatment Team (CRHTT)	Mental Health East	26/03/2018	Minor	Pt feels extremely let down by the service. CRHTT and were extremely rude to the pt and her husband. Then the pt waited for the first of her promised visits which did not happen, she was not called to advise this would not happen and had to keep chasing which was very stressful. Pt discharged herself from Crisis as she feels they are causing the problem but says she is still in crisis.	Underway		Care and Treatment	Delay or failure to visit

Berkshire Healthcare NHS
NHS Foundation Trust

Delivering Same Sex Accommodation (DSSA) at Prospect Park Hospital
Deep Dive 2017-18 Action Plan

The findings of the DSSA Deep Dive showed that patients, carers and staff all wanted mixed gender wards to remain at the hospital. A father who was interviewed as part of this Deep Dive said 'mixed wards aren't an issue. Fast access to treatment is the priority. Mixed wards reflect life in general and it gives people the option to do what they want.'

Recommendation	Action	By whom	Completion date
Vulnerable ward(s) for women and a staged ward process staring with SSA	Whilst this wasn't a strong message in the report, it has been given consideration. PPH does not have the estates or capacity to offer SSA wards on admission for assessment.	N/A	**N/A**
Fewer beds on the wards, with single occupancy rooms only	The number of bed on Bluebell Ward has reduced by 5 (including all twin rooms). Evidence shows that 22 beds (our PPH ward average) is still high. There are no plans to reduce the number of beds at PPH however there is a project looking at improving bed capacity and reducing the number of people placed out of area. The Trust has commissioned an independent organisation to do a review of MH bed modelling for Berkshire for the next 10 years. The outcome of this will feed into the future planning.	Chief Operating Officer	**5 year programme** **July 2018**
Review staff numbers and teams based on ward mix	DDON undertook a review of the acuity of patients against staff numbers at the end of 2017. Recommendations were made which are currently being considered within budget setting.	Locality Director In-patient Mental Health/ PPH Development Programme Manager /Finance	**End March 2018**

Recommendation	Action	By whom	Completion date
Amalgamate data on staff preferences to assist ward scheduling	Designated Senior Nurse looks at gender balance on every shift on the wards to create an equal division. Changes to the staffing is documented the DSN book.	Designated Senior Nurse/ Locality Director In-patient Mental Health	**On-going**
Restricted access at night time for male staff in female areas	Part of local procedures	Locality Director In-patient Mental Health/ Service Manager	**On-going**
Analysis of patient clusters to balance mixes of illness	Due to capacity pressures patients can be placed where there is a bed, the bed state means that there is limited scope for flexibility. The Service Manager and Senior Nurses review patient clusters and patients are moved to other wards to improve the ward environment – as and when needed.	Service Manager/ Senior Nursing Team	**On-going**
Reinforce rules with improved security and signage/visual cues to rooms	Guidance has been provided to the Service Manager about patients admitted to the ward who are going through gender transition on how they can be cared for sensitively. New signage will take into consideration language and accessibility needs (such as visually impairments i.e. braille and colour) and be flexible to meet the needs of the ward environment and patients at that time. - male and female areas on wards, multi linguistic - flexible signage on entrance to wings – from communal areas This has developed further into signage around the hospital site to identify and find areas and wards more easily e.g. coloured lines with corresponding	Further support and guidance available from Corporate staff as required ISS/Senior Nursing Team/Activities Coordinator	**On-going** **End March 2019**

Recommendation	Action	By whom	Completion date
	building/ward colours from reception. This is being included within the wider PPH reception refurbishment.		
CCTV to protect staff, control ward corridor access, support searches (and to aid with the Trust with any allegations)	CCTV - looking to be installed over the next 12 months – in ward communal areas, ward corridors, MDT rooms, lounges, by the Mental Health Act office. Appropriate signage will be in place as will be notifying patients prior to admission. Body worn cameras are not appropriate due to both the psychiatric care and physical care needs of our patients. Searches – a scanning device which can be used by staff to assist with the location of prohibited items on the ward is being reviewed and costed. Hand held scanning devices/ wands used currently do not show all hidden items. Airlocks – additional door upon the entry of wards has been highlighted as an option due to the risk of patients absconding or, with patients who may be confused and blocking the entry or exit to a ward. Particularly with the acuity of patients increasing this is an important safety and security aspect for vulnerable people in our care. QI workshop on ward security held on 7 Feb. Access to outside spaces – we recognise the impact that this has to the wellbeing of our patients. On our PICU, access to the garden has been available in three one hour slots as this requires the capacity for level 2 observations. This is to be reviewed with a view to increasing this as soon as possible. Previous restrictions to the gardens on our acute wards were in place during the time of the Deep Dive due to fences being replaced	ISS Ward Manager – Rose Ward Locality Director In-patient mental health Locality Director/ senior ward staff in review Ward Manager – Sorrell Ward	**End March 2019= out to tender.** **End April 2019** **On-going** **End July 2018**

Recommendation	Action	By whom	Completion date
	(now complete). May need further environmental adjustments to enable this to happen i.e. higher fence review.		
Staff always accompanied by another member of staff	This is an aspiration and is not always possible. The needs of patients and the ward will take precedent.	N/A	**N/A**
Staff time for reflection and recovery	How time is used for reflection and recovery is individual decision. Every ward has a weekly SPACE group – facilitated by a member of the Senior Leadership Team. The Sanctuary is open 24/7 and each ward has a ward based staff room. Consider access to PALS for ward staff out of hours	Senior leadership team PPH facilitates these Head of Service Engagement and Experience	**End March 2018**
Creating a more homely environment on the wards	We are mindful that that as a hospital, it is important to maintaining clinical safety and adhere to infection prevention and control guidance. However, by involving patients and carers on the wards we can adapt the environment to make it more welcoming. This can involve the placement of furniture, wall colouring and art work. On Rowan Ward, stickers for bedrooms emulating 'front doors' are to be trialled. Current pamper sessions on the wards are predominantly attended by women. Activities for men are also being explored and many of the ward based activities are not gender defined or specific e.g. pool. There are discussions between Occupational Therapists	Ward Managers	**End March 2019**

Recommendation	Action	By whom	Completion date
	and Psychologists about setting up women only groups.		
Continue to survey patients and carers to make insight more robust	Strengthen the existing feedback processes through the Community meetings on the wards.	Therapy Manager	**End March 2019**

Healthcare from the heart of your community

Berkshire Healthcare NHS

NHS Foundation Trust

15 Steps Challenge

Quarter 4 2017/18

There have been 8 visits during quarter 4 making a total of 24 visits during 2017/18. The toolkits have been adapted to be bespoke to services in Berkshire Healthcare, which has coincided with a re-launch of the national toolkits.

Staff have fully engaged with the 15 steps programme and have received the feedback in a positive manner. Our pool of volunteers has grown and they have been able to support the majority of these visits.

Themes in quarter 4

- Every effort made by staff to ensure patients are happy and well cared for.
- Professionalism shown by all staff encountered during the visits.
- Limited space in outpatient areas to store equipment.
- Parking issues increasing at all sites.

Snowdrop Ward – Revisit

A pleasant visit, in which staff engaged fully with the team. The ward felt calm although minimal interaction between staff and patients was observed during the visit. The atmosphere of therapeutic care was better than the previous visit although the team felt this could still be improved further.

Henry Tudor

The friendly atmosphere on this ward was very noticeable and the interaction seen between staff and patients was caring, open and sociable. The team were especially impressed with the community feel of the patients and staff together in the dining room with the opportunity used to deep clean the bedrooms.

Podiatry – Wokingham

The team were impressed by the running of the unit in less than ideal settings. All the staff seen on the day were cheerful and welcoming and displayed a professional and caring attitude to their patients.

Windsor Ward

The team were impressed with the professional attitude of the staff and the obvious care they gave to their patients.

Physio – Wokingham

This is a small unit with limited resources which the staff cope with very well. Although small the service does have access to private rooms for examination should it be necessary.

A good, professional team who showed a rapport with and commitment to their patients.

Willow House

An impressive unit in which the welfare of the young people was paramount. A good cohesive team who worked well together. The unit was justifiably proud of their achievements and the care and support given to young people and their families.

Campion Unit
The team were impressed by the bright, well organised unit and with the dedicated, friendly and caring staff. There was a friendly atmosphere and the patients appeared happy and well looked after with good quality care provided in a considerate and thoughtful way.

Bluebell Ward
There was a feeling of safety on the ward and the team felt that the atmosphere gave a sense of calm. The staff appeared to be professional and provided therapeutic care to the patients. All the staff encountered by the team were friendly and reassuring.

Pam Mohomed-Hossen & Kate Mellor
Professional Development Nurses
March 2018

Patient Participation Strategy work programme for 2017/18

Getting from good to outstanding

	What we will do	How we will do this	Our timescale	Progress – Quarter 4
1.	Review the structure of the team as opportunities arise. Also look to rename the team to reflect the move from participation to co-creation/co-design.	As vacancies arise we will look at what is needed rather than replacing like for like.	Completed	A new Patient Experience Facilitator and Patient Experience Apprentice are in post.
		Work with STP to realise any potential synergies and opportunities for more unified ways of working.	Deferred to 18/19: CCG led	Meeting re ACS Comms and Engagement was repeatedly cancelled. Director of Nursing in the West CCG is looking to hold system wide Patient Experience Team workshops to explore opportunities for joint working.
	Ensure any changes are communicated across the organisation	Work with Marcomms to ensure there is effective communication of change within the team	Completed	Updates sent to MarComms for inclusion in Team Brief/Newsline
2.	Achieve 15% in FFT.	Re-look at process. Ensuring Denominator & numerator are well understood.	Completed	Teamnet Information updated
		Introduce cards to be sent out with discharge letters.	On-going	The Patient Experience Team is sending cards and envelopes out to services. Services are also being reminded of this when in contact with the team about their surveys.
		Recruit volunteers to gather FFT feedback on Community inpatient sites.	On-going	Volunteer advertisements are across sites. Volunteer collecting feedback at St Marks Hospital whose role has developed further to

	What we will do	How we will do this	Our timescale	Progress – Quarter 4
				support patients with activities and meal times on the ward.
		Continually learn from other organisations.	On-going	Focus on inpatient areas to increase response rates – Patient Experience Facilitator in post from January and is designated lead for PPH and will be the link to the Service User Strategy facilitated through the OTs and ward meetings.
		Review on a month by month basis to determine success of new approaches.	On-going	Quarterly comparison to other Trusts included in patient experience report. Tops and Pants (feedback mechanism targeted at children) developed by the Patient Experience Team and being tested within CAMHS through the PPI Champions group.
		SMS being implemented as more readily available option for services	Q4	Operational in some areas, further work required across Patient Experience Team and Clinical Transformation Team to fully embed. Feedback through an App on staff phones, as requested by teams, has been explored and is being referred through IT due to on-going projects around functionality and accessibility of devices.
3.	We will continue to look at	Identify with teams the key	Completed	CYPF PP review project underway – strategy

	What we will do	How we will do this	Our timescale	Progress – Quarter 4
	opportunities for co-creation/co-design and assist teams to achieve.	strategic change areas.		document 2017-2020. PPI Champions established across services.
		Recruit and align patient leaders.	On-going	PPH and CRHTT – no patient leaders currently in place to support the programme. However PPH deep dive may encourage some recruitment. Second cohort to commence training at the end of March. Patient Leaders have been recruited and completed training. Areas of work are: PPH nutrition and wellbeing project, Carer feedback project and NHSE Always Events – linking to QI.
		Evaluate co-creation/co-design input	On-going	Review of perinatal SHaRON – Head of Service Engagement and Experience is a moderator to build a rapport with users with a view to adapting the existing survey on user log in to the system. Linking to GDE as evidence of effectiveness and engagement. PPI reporting form has been adapted to capture impact of co-production. Part of NHSE Wave 8 Always Events programme.
4.	We will review the ToR and membership of Patient Experience and Engagement	Review PEEG ToR and membership.	Completed	First joint meeting took place on 15.08.17 with good attendance from both localities and Healthwatch. Directors contacted to request

	What we will do	How we will do this	Our timescale	Progress – Quarter 4
	Group (PEEG) to ensure captures the work of the organisation and focuses the input from the Patient Participation Team as a mechanism for sharing learning.			further support with consistent attendance
		We will revise the existing staff patient and public involvement online reporting form so that it is easier for our staff to use and gives information relevant for our services to make change.	Completed	Revised PPI reporting form live from September 2017. Being promoted through PSQs and Clinical Directors
		Set a PEEG work-plan for the year.	Q1-Q2	Not carried out during PEEG as planned on 31.10.17 due to priorities within the meeting. To be developed for 18/19 in April meeting.
		Use PEEG as a vehicle to gain insight into strategic programmes requiring support for co-design.	On-going	
		Communicating out to the organisation what is working well in terms of co-design/co-creation and any lessons learnt.	Completed	A4 template for service/locality feedback has been created based on the good practice example from the Reading Locality. To be used from April PEEG at service level with a summary to MarComms.
5.	Review recruitment of patient leaders to ensure more leaders recruited over 2017/18.	Review recruitment process to ensure it is not too onerous.	Completed	Completed – three patient recruited
	Continue to work with RBH and look to have better synergies between the 2 organisations around strategic programme involvement.	Work with RBH to see if there patient leaders can support some of our programmes whilst we are recruiting.	Q1	An existing patient leader has agreed to act as a pilot to work across both Trusts.

	What we will do	How we will do this	Our timescale	Progress – Quarter 4
		Learn from others on effective recruitment.	Completed	Advertising through the volunteer route has been more effective and there has been positive feedback about the process (it is less time consuming and with less paperwork than NHS Jobs). Single point of contact works well
		Reset the leadership of the patient leader work to ensure it is given greater focus.	On-going	Head of Service Engagement and Experience has shadowed the Patient Leader training. More collaboration and shared information to be built into future training so it includes more Berkshire Healthcare information
6.	Use the Healthwatch forum to gain better understanding of local priorities and look at how we better share the work of this forum throughout the organisation.	Ask Locality Directors the best way of keeping localities informed.	Completed	First joint meeting with PEEG took place on 15.08.17
		Communicate as/agreed process from Q1.	Completed	Clinical Directors contacted to request further support with consistent attendance
		Review, with Healthwatch, ToR and scope and remit of the meeting.	Completed	Completed
7.	2 Service Deep Dives to be completed in the year. • Exploring patient & carer Opinion of mixed sex accommodation at PPH.	Discussion with LD & Consultant Nurse PPH.	Completed	DSSA Deep Dive – Completed. Findings presented to QEG in March 2018.
		Feedback from Audit	Completed	
	• Exploring the reasons for		Underway – to	Scope confirmed as: To investigate views

	What we will do	How we will do this	Our timescale	Progress – Quarter 4
	experiences of delayed discharges from Campion Unit on patients and their carers		be reported in Q1	around discharge, to identify the factors contributing to delayed transfers and those which create successful ones. It will help us to take action to prevent delayed transfers and improve the experience for patients and their carers.

Trust Board Paper

Board Meeting Date	8th May 2018
Title	Quality Account 2017/18
Purpose	NHS Foundation Trusts must publish a quality account each year, as required by the NHS Act 2009, and in the terms set out in the NHS (Quality Accounts) Regulations 2010 as amended by the NHS (Quality Accounts) Amendments Regulations 2011 and the NHS (Quality Accounts) Amendments Regulations 2012 (collectively "the Quality Accounts Regulations"). For the Trust this provides an opportunity to present a balanced account of its quality priorities and performance against these. The report includes some mandated content which can be complex, but should, in general, be accessible for members of the public.
Business Area	Trust Wide
Executive Lead	Medical Director
Authors	Head of Clinical Effectiveness and Clinical Effectiveness Facilitator.
Relevant Strategic Objectives	Goal 1- Improving patient safety and experience: To provide safe services, good outcomes and good experience of treatment and care
CQC Registration/Patient Care Impacts	Does not negatively impact registration or patient care.
Resource Impacts	None
Legal Implications	The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. The NHS Improvement annual reporting guidance for the quality report incorporates the requirements set out in the Department of Health's Quality Accounts Regulations and additional reporting requirements set by NHS Improvement.
Equality and Diversity Implications	None
SUMMARY	The Quality Account for 2017/18 consists of three main sections in line with Department of Health and NHS Improvement requirements. Part 1 is the Chief Executive's Statement. Part 2 is a report on the priorities for improvement and statements of assurance from the Board. This section must also cover specified areas in relation to clinical audit, research, CQUINs, CQC, data quality, information governance and a newly mandated section on learning from deaths. Part 3 is a review of quality performance in 2017/18 and must include at least 3 measures in each of the areas of quality - patient safety, clinical effectiveness and patient experience. The Quality Assurance Committee have reviewed the draft account in Q1, Q2 and Q3, all required actions identified by the QAC were incorporated within the final Q4 version being presented today, due to timescales of meetings the QAC members received the Q4 version electronically outside of the formal meeting. Pages 4 and 5 of the Quality Account detail a summary of the Trust achievement against the 2017/18 priorities. The priorities for 2018/19 are directly linked to the true north annual plan. Clinicians, Trust Governors and other stakeholders have been consulted through various mechanisms to help agree the priorities. The draft Quarter 3 Quality Account was shared with the required stakeholders including the Clinical Commissioning Groups, Health Overview and Scrutiny Committees, Council of Governors and Health and Wellbeing Boards. Comments

	received are predominantly positive with some areas of clarification identified which we have responded to, all support the consistency of the QA with data and information they are aware of. Our external auditors, Deloittes, are currently auditing the content of the Quality Account to ensure that it meets the requirements set out in 'The detailed requirements for Quality Accounts 2017/18' NHS Improvement (2018). They will then provide an independent assurance report to the Council of Governors as well as a report to the Trust Audit Committee in May 2018. The final Quality Account will be submitted to NHS Improvement in May 2018 as part of the annual accounts and published on NHS Choices in June 2018. Board members are asked to note that this version of the Quality Account does not contain details of the CQUIN achievement for 2017/18 as the results of some are yet to be published nationally. Confirmation of this is due at the beginning of May 2018 and will be included in the version of the Quality Account that is submitted to NHS Improvement at the end of May 2018.
ACTION REQUIRED	The Board is required to seek any clarification required and approve the 2017/18 Quality Account. Directors are asked to consider the Statement of Directors' Responsibilities in Respect of the Quality Account (page 58), and ensure they are satisfied with the quality account in relation to the requirements detailed in this statement. Directors must confirm to the best of their knowledge and belief they have complied with the requirements detailed on page 58 in preparing the Quality Report, and the statement must then be signed by the Chair and Chief Executive by order of the Board to confirm this.

Healthcare from the heart of your community

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Berkshire Healthcare NHS Foundation Trust

Quality Account 2017/18

caring for and about you is our top priority

committed to providing good quality, safe services

working together with you to develop innovative solutions

"Our vision is to be recognised as the leading community and mental health service provider by our staff, patients and partners"

What is a Quality Account?

A Quality Account is an annual report about the quality of services provided by an NHS healthcare organisation. Quality Accounts aim to increase public accountability and drive quality improvements in the NHS. Our Quality Account looks back on how well we have done in the past year at achieving our goals. It also looks forward to the year ahead and defines what our priorities for quality improvements will be and how we expect to achieve and monitor them.

About the Trust

We are a community and mental health Trust, providing a wide range of services to people of all ages living in Berkshire. To do this, we employ over 4,500 staff who operate from our many sites as well as out in people's homes and in various community settings.

Having been rated as 'Good' by the Care Quality Commission– our ambition is to now reach 'Outstanding'.

We are also a digital pioneer, having been named by NHS England as a 'Global Digital Exemplar'– one of only seven mental health Trusts in the country to gain this status. This will allow us to transform patient care through new technologies.

We deliver joined up physical and mental health services, helping people to remain independent at home for as long as possible and providing the care and support that best meets the needs of our patients, in the most suitable location. From early years to end of life, we offer a wide range of services to keep you and your family well. We run a number of specialist clinics and services aimed at young people, adults and older people to support and treat mental health, physical health and sexual health conditions.

We work in partnership with Berkshire's two acute hospital Trusts, Royal Berkshire Hospital NHS Foundation Trust and Frimley Health NHS Foundation Trust. We also work closely with Berkshire's six local authorities and a diverse range of community and charitable organisations.

As a foundation Trust we are accountable to the community we support. NHS Improvement regulate our financial stability, and have given us a financial sustainability risk rating of 4, which is the best rating we could have (they rate from 1 to 4, with 1 being at most risk and 4 being the least risk). The Care Quality Commission oversee patient quality and safety – and they rate us as 'Good'

Table of Contents for Quality Account 2017/18

Quality Account Positive Highlights and Overall Summary 2017/18

Patient Experience

- The Trust is implementing a project to improve transition to adult mental health services for young people in our Child and Adolescent Mental Health Services (CAMHS)
- The Trust continues to prioritise and report on patient satisfaction to inform improvement and to involve people who use our services in the development and implementation of our plans and strategies

Patient Safety

- The Trust has launched a Quality Improvement (QI) programme and this has continued throughout the year
- The Trust has continued implementing its zero suicide programme
- Targets have been met relating to the development of cat. 2 pressure ulcers following a lapse in care by Trust staff. Community health wards continue to meet falls targets
- An IAPT (Talking Therapies)- long term conditions pilot has been implemented

Clinical Effectiveness

- Trust services have been assessed against NICE Guidelines relating to falls, pressure ulcers and patient experience of adult mental health services
- An internal audit of the Trust's adherence to National Guidance on Learning from Deaths resulted in substantial assurance being awarded to the Trust

Organisational Culture

- The Trust achieved positive results in the 2017 national staff survey
- The Trust continues delivering the Excellent Manager programme as well as values based recruitment and appraisal
- The Trust continues delivering its 'freedom to speak up programme', ensuring that staff are able to raise concerns in a variety of ways

Care Quality Commission (CQC) Rating

The Trust continues to be rated as 'Good' by the CQC and is committed to maintaining and improving on this rating

The Trust has set quality priorities for 2018/19 in the following areas:

Patient Safety Priorities

- To drive improvement through the Trust Quality Improvement (QI) Programme
- To deliver 'Harm Free' objectives relating to falls, self-harm and suicide
- To achieve reductions in urgent admissions, and delayed transfers of care for inpatients

Clinical Effectiveness Priorities

- To demonstrate evidence-based services by reviewing them against NICE guidance
- To continue reviewing, reporting and learning from patient deaths

Patient Experience Priorities

- To achieve a 95% satisfaction rate in our Friends and Family Test, and 60% of staff reporting use of service user feedback to inform decisions in their department
- To reduce our use of prone restraint by 90% by the end of 2018/19
- To focus on understanding and supporting outcomes of care that are important to patients
- To contribute to Integrated Care System work streams to improve outcomes

Organisational Culture Priorities

- To achieve improvements in staff feeling empowered to make improvements at work, staff recommending the Trust as a place to receive treatment and a reduction in assaults on staff
- To reduce vacancies by 10%
- To train an additional 24 services in our Quality Management Improvement System
- To achieve the objectives set out in the Equality Plans for each area

Figure 1- Summary of Trust achievement against 2017/18 Quality Account Priorities

Priority and Indicator		Results 2016/17	Results 2017/18	Comment & Change from 16/17- 17/18
Patient Experience				
Initiate project to improve transition from Child and Adolescent Mental Health Services (CAMHS) to Adult Mental Health services		N/A	**Met**	**Target Met**
Friends and Family Test- Achieve a response rate of at least 15%		N/A	**11.25% (Q4)**	**Target Not Met**
Friends and Family Test- % of patients likely or extremely likely to recommend the service to a friend or family member	Community Services (Mental health and physical health combined)*	95%	**96%**	**Change: +1%**
	Mental Health Inpatients*	74%	**67%**	**Change: -7%**
	Community Hospital Inpatients*	95%	**97%**	**Change: +2%**
	Minor Injury Units and Walk-in Centre*	95%	**98%**	**Change: +3%**
Trust Patient Satisfaction Survey- % of Patients rating the service they received as good or very good	Community Mental Health	85%	**82%**	**Change: -3%**
	Community Physical Health	93%	**95%**	**Change: +2%**
	Mental Health Inpatients	72%	**67%**	**Change: -5%**
	Patients in Community Hospitals	97%	**99%**	**Change: +2%**
Carer Friends and Family Test- % of carers likely or extremely likely to recommend the service to a friend or family member		96%	**97%**	**Change: +2%**
Continue Patient Leadership Programme		Met	**Met**	**Target Met**
National Community Mental Health Survey- Overall result (score out of 10)		7.2	**7.3**	**Change +0.1**
Patient Safety				
Initiate Trust Quality Improvement Programme		N/A	**Met**	**Target Met**
Continue Zero Suicide Programme		Met	**Met**	**Target Met**
Number of Pressure Ulcers developed following a lapse in care by Trust staff	Community Patient or Inpatient Category 2 pressure ulcers (Target- Less than or equal to 19)	N/A	**14**	**Target Met**
	Community or Inpatient Category 3 and 4 pressure ulcers (Target- Less than or equal to 9)	N/A	**15**	**Target Not Met**
Rate of inpatient falls per 1000 bed days on wards for older people	Older Peoples Mental Health Wards (Target- less than or equal to 8 per 1000 bed days)	6.62	**9.66**	**Target Not Met**
	Community Health Wards (Target- less than or equal to 8 per 1000 bed days)	4.95	**4.65**	**Target Met**
Smoking cessation for mental health inpatients- Meet CQUIN and Quality Schedule targets		N/A	**Met**	**CQUIN Target Met**
Initiate an Improving Access to Psychological Therapies (IAPT)- Long Term Conditions (LTC) expansion across Berkshire		N/A	**Met**	**Target Met**
Clinical Effectiveness				
Compliance with Trust NICE guidance implementation targets	Compliance with NICE Guideline on Pressure Ulcers	N/A	**94%**	**Target Met**
	Compliance with NICE Guideline on Falls	N/A	**95%**	**Target Met**
	Compliance with NICE Guideline on Patient Experience in Adult Mental Health	N/A	**91%**	**Target Met**
Gain internal audit assurance on the Trust's adherence to the National Guidance on Learning from Deaths (March 2017)		N/A	**Substantial Assurance from internal audit**	
Organisational Culture				
National NHS staff survey results- Percentage of staff agree or strongly agree they would recommend our Trust as a place to receive treatment (target 77%)		75%	**75%**	**Target not met**
Continue delivering the Excellent Manager Programme, Values Based Appraisal and Values Based Recruitment to ensure that we promote a culture of shared values and related behaviours across the entire organisation.		N/A	**Met**	**Target Met**
Continue the Trust 'freedom to speak up programme', ensuring that staff are able to raise concerns in a variety of ways.		N/A	**Met**	**Target Met**

***Specific Friends and Family Test targets have been set for 2018/19.**

Part 1. Statement on Quality by the Chief Executive of Berkshire Healthcare NHS Foundation Trust

Berkshire Healthcare NHS Foundation Trust has continued to deliver effective, safe and efficient care for its patients through 2017/18. We have a Trust-wide vision to be recognised as the leading community and mental health provider by our patients, staff and partners.

The Trust continues to be rated as 'Good' by the Care Quality Commission (CQC) and we are committed to achieving an 'Outstanding' rating in 2018.

We have successfully introduced an organisational Quality Improvement (QI) programme which will enable us to apply a consistent approach to continuous improvement by developing the ability of each and every staff member to make improvements to the way we deliver care for our patients. This programme has supported the development of our priorities for 2018/19 detailed within this account.

We are committed to ensuring that patients have a positive experience of the care we provide and we continue to prioritise learning from patient experience surveys, complaints and compliments. Overall, feedback from these results is positive, and we aim to maintain and improve on this during 2018/19.

Patient safety remains of paramount importance to us, and our Trust board monitors performance in this area through scrutiny of a variety of patient safety metrics, several of which are shared in this report. We maintain robust governance, patient safety, incident and mortality reporting systems which are able to highlight areas for improvement in a timely manner allowing for learning.

Our clinical effectiveness agenda helps to ensure that we are providing the right care to the right patient at the right time and in the right place. Our clinical audit and NICE programme allows us to measure our care against current best practice leading to improvement. This report details the work undertaken in this area.
The National Quality Board launched its Learning from Deaths policy in March 2017 in response to the CQC's report 'Learning, Candour and Accountability'. It 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 opportunities for learning from deaths and learning from the review of the care provided and the experience in the period prior to the person's death are not missed, and this is scrutinised by our Board and reported publicly.

Berkshire Healthcare is committed to the principles of system working and is actively involved with the Berkshire West and Frimley Integrated Care Systems in finding sustainable population based solutions for meeting the physical and mental health needs of our patients and service users.

This report demonstrates the breadth of improvement work that is being undertaken, as well as the commitment of Trust staff to improve services for patients across the county.

The information provided in this report is, to the best of my knowledge, accurate and gives a fair representation of the current services provided

Julian Emms CEO

"I would rate them positively in every way, both in their care towards my mother & their interaction and involvement with me in her care program… CMHT work with my mum has been invaluable. If I was allowed to give specific praise & name individuals in this review I would! All I can say is the nursing staff in the elderly mental health team have been excellent. Personally I have attended the 6 week course they run on understanding Alzheimer's; whilst much of the content I already knew I would still strongly suggest this course to others, as the 1 or 2 'nuggets' of information each week were invaluable. Keep up the good work!"

From a relative of a patient- Community Older Adult Mental Health Service- Maidenhead

Part 2. Priorities for Improvement and Statements of Assurance from the Board

2.1. Achievement of Priorities for Improvement for 2017/18

ⓘ This section details the Trust's achievements against its quality account priorities for 2017/18. These priorities were initially identified, agreed and published as part of the Trusts's 2016/17 quality account. Specific priorities have been set in the areas of patient experience, patient safety, clinical effectiveness and organisational culture

These quality account priorities support the Trust's quality strategy for 2016-20 (see Appendix A) to provide accessible, safe, and clinically effective community and mental health services that improve patient experience and outcomes of care through the following six elements:

- Patient experience and involvement – for patients to have a positive experience of our services and receive respectful, responsive personal care
- Safety – to avoid harm from care that is intended to help
- Clinical Effectiveness – providing services based on best practice
- Organisation culture –patients to be satisfied and staff to be motivated
- Efficiency – to provide care at the right time, way and place
- Equity – to provide equal care regardless of personal characteristics, gender, ethnicity, location and socio-economic status.

2.1.1 Patient Experience and Involvement

ⓘ One of the Trust's priorities is ensuring that patients have a positive experience of our services and receive respective, responsive personal care. This sub-section details our performance against our patient experience priorities for 2017/18.

Our 2017/18 Patient Experience Priorities:

1. To improve transition to adult mental health services for young people in our Child and Adolescent Mental Health Services (CAMHS)

2. To increase response rates for the Friends and Family Test (FFT) to at least 15% in each service and to continue to prioritise and report on patient satisfaction leading to improvements.

3. To involve people who use our services in the development and implementation of our plans and strategies

Transition from Child and Adolescent Mental Health Services (CAMHS) to Adult Mental Health Services

ⓘ The Trust has established strong arrangements for service user and family engagement in our CAMHS and this has helped to inform actions required to improve transition into adult services. We recognise how important this is, given that 50% of young people receiving CAMHS transfer into adult services.

Transition from CAMHS to Adult Mental Health Services has been addressed as part of a Commissioning for Quality and Innovation (CQUIN) project in 2017/18. This CQUIN aims to incentivise improvements to the experience and outcomes for young people as they transition out of CAMHS into Adult Mental Health Services.

Actions taken to meet the aim included the following:

- A transition policy was been agreed and distributed across the organisation
- Tools were developed to aid the process, including a transition care plan
- Joint agency planning for transition was rolled out across the localities
- Training and presentations took place across children's services to increase understanding of transition requirements and to embed the processes outlined in the transition policy and Standard Operating Procedure
- Engagement with clinical directors was undertaken to ensure that the transition process was embedded across services
- Engagement with Community Mental Health Team (CMHT) leads was undertaken to outline requirements, in accordance with the plan
- Ownership and expectations of the project were embedded in the CAHMS leadership team

In order to demonstrate that the requirements of the CQUIN were met, the following was undertaken:

1. A case note audit in order to assess the extent of Joint-Agency Transition Planning; and
2. A survey of young people's transition experience ahead of point of transition (Pre-transition / Discharge readiness); and
3. A survey of young people's transition experience after the point of transition (Post- Transition Experience)

The results from these three exercises demonstrated the consistent effort within the Trust over the last three years to set up a transition process in order to improve the experience of young people and their families and prevent vulnerable young people from falling between gaps in the service. In particular, the study found that:

- 88.9% of young people audited had evidence of joint agency transition planning and 11.1% had the requirements partially met.
- 88.6% of the young people audited had evidence of discharge planning completed.

- 80% of young people responding to the survey who had completed a transition into Adult Mental Health Services were satisfied with their pre-transition experience and 60% agreed that their plan had helped achieve their transition goals.

However, there was a gap identified in services for young people with neurodevelopmental disorders, particularly Attention Deficit Hyperactivity Disorder (ADHD) and Autistic Spectrum Disorder (ASD), and the varying prescribing practices between health providers appear to contribute to concerns around this. Families did not feel supported when discharged from CAMHS to their GP for medical monitoring while awaiting an appointment within the Adult ADHD service. The young people also indicated their preference for more frequent contact from the Adult Mental Health Services. In addition, some families believed that the transition process had been rushed and should have been discussed earlier on in treatment. It would have also been beneficial to meet a clinician from the adult service more than once to feel more at ease about transferring into to the care of another clinician, as some young people found the change difficult to adjust too.

The transition report will be disseminated and shared with the CAMHS and Adult Mental Health Services to inform further planning and development of our transition process.

Patient Friends and Family Test (FFT)

ⓘ The Friends and Family Test (FFT) is used by most NHS funded services in England. It is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. The FFT asks people if they would recommend the services they have used, and can be completed by text messaging after discharge, by card or on the internal Trust patient survey.

The Trust aim for 2017/18 was to achieve a response rate of at least 15% in each service for the Friends and Family Test. Figure 2 details achievement against this target and shows that the response rate stayed below the target during the year, but was at its highest in Quarter 4. It is believed that the low response rate during the year has been impacted on by staff capacity to support the FFT programme and resource has been identified to address this.

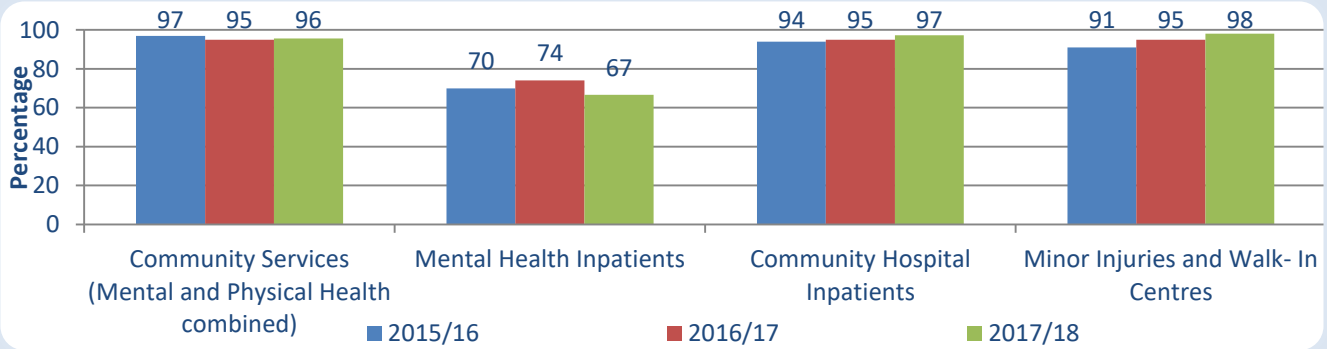
Figure 2: Response Rate for Patient FFT

Timeframe	Q1	Q2	Q3	Q4
% Response Rate	7.04	9.6	6.8	11.25

Source: Trust Patient Experience Reports

Figures 3 and 4 below demonstrate the Trust's achievement in relation to recommendation rate in the patient FFT. The figures demonstrate an increase in the percentage of patients that were either likely or very likely to recommend community services, community hospital inpatient and minor injuries and walk-in centres in 2017-18 compared with 2016-17. The figures also show that 67% of mental health inpatients would recommend the service in 2017/18, compared with 74% in 2016-17. However, these figures should be interpreted with caution due to the low number of responses by mental health inpatients.

Figure 3- Patient Friends and Family Test (FFT): Percentage of patients very likely or likely to recommend the service to a friend or family member.



Source: Trust Patient Experience Reports. Please note that the management of the Slough Walk-In Centre transferred to another organisation on 1st September 2017.

Figure 4- Patient Friends and Family Test- total number of responses

Survey and Service	2016/17			2017/18		
	Total no. of respondents	Respondents likely or extremely likely to recommend service		Total no. of respondents	Respondents likely or extremely likely to recommend service	
		No.	%		No.	%
Community Services- Mental Health & Physical Health Combined	11339	10815	95	15399	14718	96
Mental Health Inpatients	141	104	74	87	58	67
Community Hospital Inpatients	887	845	95	1057	1028	97
Minor Injuries Unit and Walk in Centre	5869	5577	95	3094	3035	98

Source: Trust Patient Experience Reports. Please note that the management of the Slough Walk-In Centre transferred to another organisation on 1st September 2017.

Carer Friends and Family Test (FFT)

ⓘ A Friends and Family Test for carers has also been created which asks if carers would recommend Trust services. Whilst this is not mandated nationally, the Trust recognises the crucial role that carers have and the value of their feedback.

Figures 5 and 6 below demonstrate the Trust's achievement in relation to the Carer Friends and Family Test. The figure shows that 97% of respondent carers in 2017/18 were likely or very likely to recommend Trust services to a friend or family member. This is 1% above the 2016/17 figure.

Figure 5- Carer Friends and Family Test: Percentage of carers extremely likely or likely to recommend the service to a friend or family member

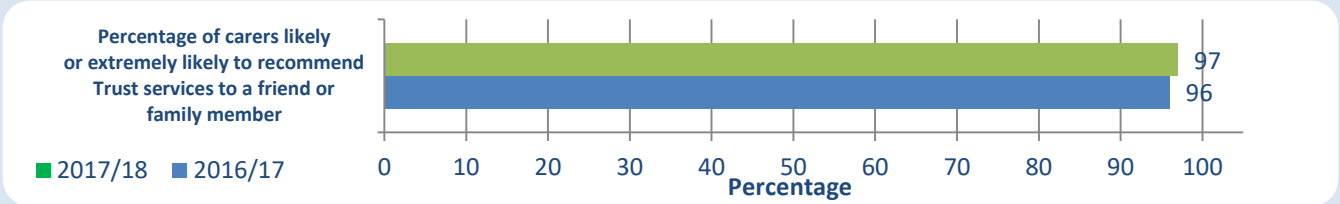


Figure 6- Carer Friends and Family Test- total number of responses

Survey and Service	2016/17			2017/18		
	Total no. of respondents	Respondents likely or extremely likely to recommend service		Total no. of respondents	Respondents likely or extremely likely to recommend service	
		No.	%		No.	%
All carers	207	198	96	269	261	97

Source: Trust Patient Experience Reports Please note that the Trust does not have a response rate for this survey.

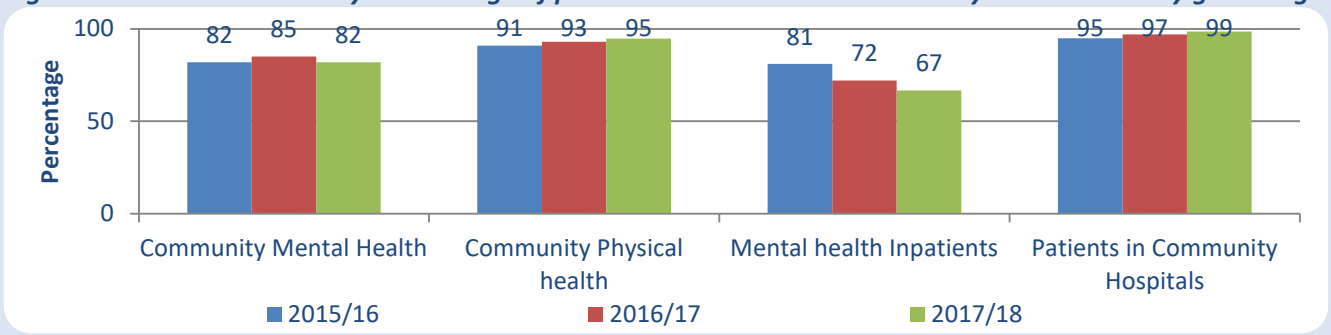
Trust Patient Satisfaction Survey

ⓘ The Trust also carries out its own patient satisfaction survey throughout the year to further ascertain and assure levels of patient satisfaction.

Figures 7 and 8 below demonstrate the Trust's performance in relation to this survey.

The figures show that in 2017/18, 82% or more respondents rated the service they received from Trust community mental health services, community physical health services and community hospitals as good or very good. 67% of mental health inpatients responding gave a rating of good or very good, but this figure is based on a small numbers of respondents (6).

Figure 7- Trust Patient Survey: Percentage of patients who rated the service they received as very good or good.



Source: Trust Patient Experience Report

Figure 8- Trust Patient Survey- total number of responses

Survey and Service	2016/17			2017/18		
	Total number of respondents	Total rating service as good or very good	% rating service as good or very good	Total number of respondents	Total rating service as good or very good	% rating service as good or very good
Community Mental Health	1254	1067	85	1203	985	82
Community Physical Health	9228	8544	93	12193	11559	95
Mental Health Inpatients	271	196	72	6	4	67
Patients in Comm. Hospitals	622	601	97	341	336	99

Source: Trust Patient Experience Reports

The Patient Leadership Programme

The Patient Leadership Programme aims to establish a group of people that have received training and support to work with us to design and improve patient services.

Patient Leaders are engaging with the Quality Improvement team and work around improving access to activities in the community for carers in Bracknell.

The Trust are proactively co-facilitating the Patient Leadership Programme with the Royal Berkshire Hospital who have led the training and are looking at opportunities for patient leaders to be involved in projects across both Trusts.

Learning from Complaints and Compliments

The Trust has continued to respond to and learn from complaints and compliments during the year.

Figures 9 and 10 below show the number of complaints and compliments received by the Trust. From these charts it is evident that there is a downward trend in complaints and compliments since April 2016. There were a total number of 209 formal complaints received in 2017/18 and this is the same as the number of complaints received in 2016/17.

Community Mental Health Teams (CMHTs)/Care Pathways received the highest number of formal complaints during 2017/18 (44 complaints in total) and these accounted for 22 % of the total complaints received by the Trust. In comparison CMHTs received 32 total complaints in 2016/17 and 30 in 2015/16. Care and treatment remains the main theme of complaints across the CMHTs, accounting for half the complaints received.

The community inpatient wards have seen a reduction in formal complaints from 17 in 2016/2017 to 11 in 2017/2018.

Child and Adolescent Mental Health Services (CAMHS) have seen an increase in formal complaints from 18 in 2016/2017 to 26 in 2017/2018. The majority of the complaints received relate to care and treatment. Three of the twenty six complaints received in 2017/2018 involved waiting times. There has been work undertaken in the system to address this issue and maintain a better position going forward, with more effective communication with young people and families about the wait times.

Crisis Resolution and Home Treatment Teams (CRHTT) received 20 complaints in 2017/2018, one fewer than the previous year. Care and treatment, communication and attitude of staff are the main themes of complaints received, and this aligns with the main themes for all complaints received.

All of our mental health inpatient wards are based at Prospect Park Hospital in Reading. During 2017/18, the mental health inpatient wards received 25 complaints. Care and treatment was the main theme of the complaints received, making up 68% of these complaints. There are no other emerging themes. There were fewer complaints about our older person's inpatient wards (Orchid Ward and Rowan Ward).

There were no formal complaints received about community or inpatient Learning Disability Services in quarters three and four of 2017/18.

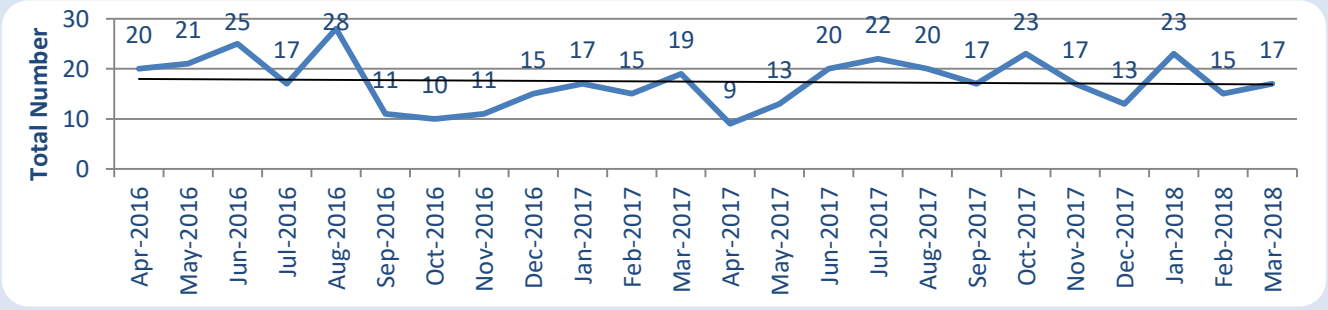
All services review the findings from complaint investigations and these are discussed in the locality patient safety and quality meetings with actions identified and monitored to affect positive change. This information is also available via real time dashboards accessible to both the Locality and Clinical Directors.

During 2017/18 the Trust achieved a complaints response rate of 100% within the timescale agreed with the complainant. In addition, 100% of new complaints were acknowledged within three working days.

The average number of days taken to resolve formal complaints during quarter four for 2017/18 was 24. This represents an increase from 18 in quarter three, and a decrease from 25 in quarter two and 27 in quarter one of 2017/18. This remains a significant decrease in comparison with 33 days in quarter three of 2016/17.

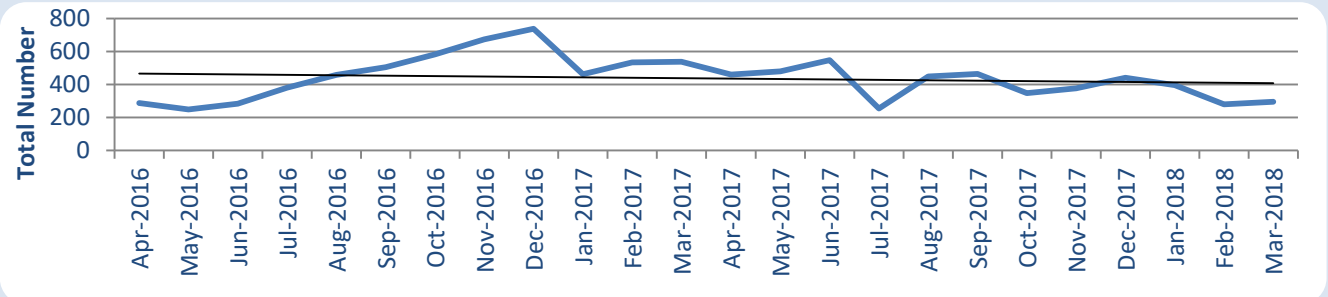
The Trust uses complaints to help inform service improvements, some of which are detailed later in this report. Please also note that the number of complaints, together with response and resolution times is included within section 3 of this report as they are indicators of quality.

Figure 9- Complaints received



Source: Trust Complaints Report

Figure 10- Compliments received



Source: Trust Compliments Report- this is based on compliments being submitted voluntarily by services

National NHS Community Mental Health Survey 2017

ⓘ The National Community Mental Health Survey is an annual exercise that aims to ascertain the experiences of people that receive specialist care or treatment for a mental health condition. Feedback from people about their experiences of our community mental health services is crucial in helping us highlight good care and to identify potential risks to the quality of services.

The results of the 2017 National Community Mental Health Survey were published in November 2017.

The Survey Sample. Patients were eligible to receive and respond to this survey if they had been seen by Community Mental Health Services between 1st September 2016 and 30th November 2016. Surveys were sent to 850 people meeting this inclusion criteria, with responses received from 241 of them (29%). This is an increase in the Trust response rate from 27% in the 2016 survey, and above the 2017 survey national rate of 26%.

About the Survey and how it is scored. The 2017 survey contained 36 questions organised across ten sections. Each question and section was scored out of a total mark of 10 and given a RAG rating (Red, Amber or Green) to indicate how the Trust had scored in relation to an expected range of scores. For example, an amber score indicated that the Trust score was not significantly different than average for that question, with a green score indicating that the Trust scored better and a red score worse.

Summary of Trust results. The Trust scored amber (about the same as other Trusts) across all sections of the 2017 survey- the same as in the 2016 survey. The Trust also scored amber across all questions in the 2017 survey, with the exception of two questions:

- Organising your care: Do you know how to contact this person (the person who is in charge of organising your care and services) if you have a concern about your care? Trust Score- Amber/ Green.
- Changes in who people see: What impact has this had on the care you receive?
  Trust Score- Green, the highest score of all Trusts for this question.

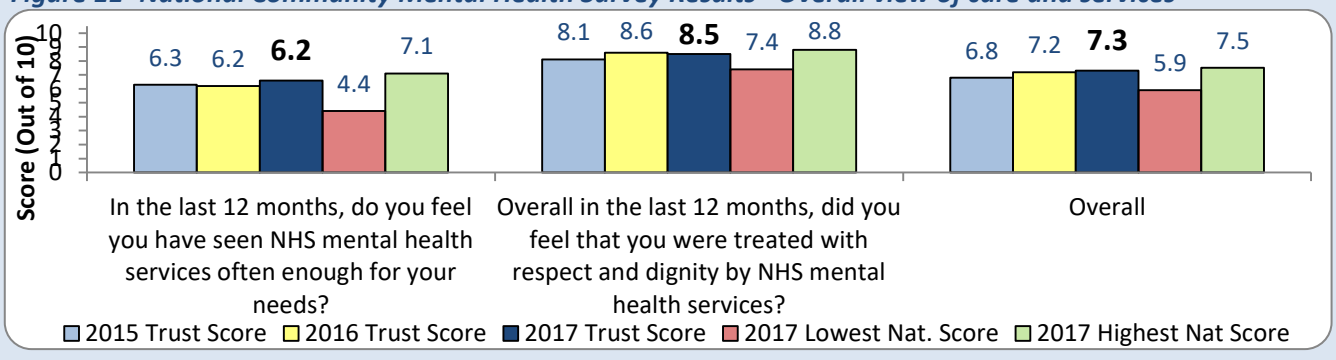
In addition, there has been an improvement in Trust scores relating to contacting the crisis team, where the Trust scored in the red range in the 2016 survey, but improved to the amber range in the 2017 survey.

Respondents' overall view of care and experience. Figure 11 below gives an overview of scores for the Trust in relation to respondents' overall views of the care and service they received and their overall experience. The 2017 Trust scores (shown by the dark blue bar in the middle of the chart) are compared with the highest and lowest scores achieved by other Trusts in 2017 (the red and green bars), and with the comparable Trust score in both 2015 and 2016 (the light blue and yellow bars).

These results are to be shared with the Community Mental Health Teams and the wider organisation. An analysis of the Trust reports and an associated action plan has been produced to be made available to our commissioners as part of our Quality Schedule.

The overall Community Mental health score for the Trust is also included within section 2.4 of this report as it is a core indicator.

Figure 11- National Community Mental Health Survey Results - Overall view of care and services



Source: National Community Mental Health Survey

2.1.2 Patient Safety

ⓘ The Trust aims to prevent errors in healthcare that can cause harm to patients. The errors that occur in healthcare are rarely the fault of individuals, but are usually the result of problems with the systems staff work in. Regardless, NHS patients should be treated in a safe environment and be protected from avoidable harm.

Our 2017/18 Patient Safety Priorities:

1. To drive quality improvement through the use of improvement methodology and supporting innovation
2. To continue implementing the Zero Suicide initiative, working to achieve a 10% reduction in numbers of people known to us taking their own lives by 2021
3. To provide 'Harm Free Care' in relation to two specific aspects of our community health services:
   - To continue to improve on the prevention and reduction of pressure ulcers developed due to a lapse in our care during the year, maintaining the level of performance against current indicators
   - To continue to achieve low numbers of falls on our older people's inpatient wards (less than eight per 1000 bed days)
4. Responding to people's needs for both physical and mental health care through prioritising support to stop people smoking in our inpatient mental health services and developing psychological support for people with long term physical health problems through our talking therapies service (IAPT)

Throughout the year, the Trust's aim has been to foster an environment where staff members can be confident to raise concerns about patient safety. Learning occurs with respect to errors, incidents, near misses and complaints across the organisation. Initiatives to achieve this have been implemented during 2017/18. The Trust has continued to engage with and contribute to cross organisational initiatives such as the patient safety collaborative.

The Trust has also signed up to the 'Sign up to Safety' pledges and through this has committed to put safety first, continually learn, be honest and transparent, collaborate in learning and support staff, to help them understand and improve on when things go wrong.

A list of Trust quality concerns and information relating to the Duty of Candour are also documented within this section. Further information on Trust patient safety thermometer metrics, including those relating to various types of harm, are included in Appendix D.

"I took my mother to the 'Falls Clinic' where the staff were not only efficient and diligent but kind and humorous. Her wonderful doctor and nursing team and physiotherapist did a complete range of tests on her and took their time to listen. We both felt she couldn't be in better hands and are very grateful. Thank you St Mark's.

From a relative of a patient- Mobility and Falls Service - St Marks Hospital, Maidenhead

The Trust Quality Improvement Programme

ⓘ The Trust introduced an organisational Quality Improvement (QI) Programme in 2017/18 as part of its commitment to achieve an 'Outstanding' rating by the CQC. This programme will enable a consistent approach to continuous improvement across the whole Trust and will be achieved by introducing new techniques, education, tools and training that focus on what patients value most.

The Trust Quality Improvement Programme was launched by the Chief Executive in April 2017 and has continued throughout the year.

As part of the programme, the Trust commissioned a partnership of KPMG, Thedacare (a world leader in healthcare improvement) and Western Sussex Hospitals to help develop new ways of working. This has been achieved in a variety of ways, including introducing new techniques, education, coaching tools and training. Staff have been trained in new Quality Improvement techniques, with many invited to take part in improvement events and workshops.

A Head of Quality Improvement, together with five Quality Improvement Practitioners have been appointed from inside the Trust to help drive and sustain the programme in the long term, and to build capacity and capability.

Ultimately, the Trust wants to provide all staff with the right support, knowledge and skills to give them the confidence to make changes and take away the frustrations that stop them focusing on the important parts of their job which really make a difference to patient care and experience. The Trust also wants to empower staff to solve problems rather than wait for the managers to do so.

Workstream Updates.

The work required to set in motion and sustain Quality Improvement throughout the Trust is set out in four workstreams. These are currently being progressed by the Quality Improvement Team, and a summary of progress against each of these at the end of 2017/18 is given below.

1. **Strategy Deployment**
   Identifying a small number of strategic priorities and cascading these through the organisation

The development of a mechanism for prioritising Trust projects continues. The aim of this is to ensure that all Trust projects are aligned to where the Trust wants to be (the "True North" direction of the Trust) and that they do not overburden the workforce

2. **Quality Management and Improvement System (QMIS)**
   A management system that aligns performance and daily improvement to the Trust's strategic goals.

QMIS training has been introduced to two cohorts of staff with a third cohort starting the training in Quarter 4 of 2017/18. Training for senior leaders also started from Quarter 4 of 2017/18.

3. **Improvement projects**
   Making improvements in areas that are too complex to be resolved through daily continuous improvement techniques

A project has been initiated to develop an end-to-end pathway for some of our most challenging mental health patients, including those with non-psychotic personality disorder. Detailed process maps for each part of the pathway have been produced that outline clinical detail and the process to follow. The design of the new clinical pathway has been co-produced with service users. Work has also been undertaken with the finance team looking at the resource required for the implementation of the future pathway.

4. **Quality Improvement office**
   Ensuring structured accountability, support and dedicated resources are in place for improvement activity. Developing capabilities for improvement across the Organisation

The QI Team have developed the training material provided by KPMG to make it more interactive and engaging, and are developing a Trust-wide training strategy. In addition, the QI team are working on the roll-out of QI over the next 2 years. The Head of Quality Improvement is also working closely with the Global Digital Exemplar programme team.

Suicide Prevention- Zero Suicide

ⓘ The Trust's vision is to develop a culture of zero suicide where patients, families and carers feel supported to manage illness when in crisis.

The Trust Zero Suicide programme was initiated in 2016. Four areas were prioritised to achieve the Trust vision, and these are based on the best available evidence, Trust values, data from Serious Incidents (SIs), staff feedback and resources:

- Leadership
- Optimising systems (RiO patient management system, use of data and audit)
- Training
- Support for service users, staff and families

The initial action plan focussed on the development of risk documentation that incorporated a risk summary, risk management plan and safety plan. The aim was to provide staff with the tools to assist them with their engagement and assessment. A programme of work and development of resources to assist with implementation was successful and this system is now fully operational. Monitoring was improved through the production of a suicide surveillance dashboard which also helped to inform learning and training.

Building upon the progress made in 2016/17, the Trust then focused on the following goals during 2017/18:

1. To achieve a 10% reduction from the 2015/16 baseline rate of suicides of people under Berkshire Healthcare NHS Foundation Trust mental healthcare by 2020/21.
2. To demonstrate an increase in positive staff attitude and a proactive approach to suicide prevention.
3. To develop an optimised RiO clinical record system for recording risk
4. To ensure families, carers and staff feel supported and know where they can get specific support after a suicide.

Progress made against each of these goals during the 2017/18 year is detailed below.

Goal 1: A 10% reduction from the 2015/16 baseline in suicides of people under Berkshire Healthcare NHS Foundation Trust mental healthcare by 2020/21.

Figure 12 below shows the yearly rate of suicides per 10,000 people under Trust mental healthcare. The 2015/16 rate was 9.2 per 10,000 people under Berkshire Healthcare NHS Foundation Trust mental healthcare, and whilst the Trust have met the 10% target reduction it is important to view this over a sustained period given the very small numbers and recognising the natural peaks and troughs in suicide rates.

Figure 12- Number of suicides per 10,000 people under Berkshire Healthcare NHS Foundation Trust Mental Healthcare

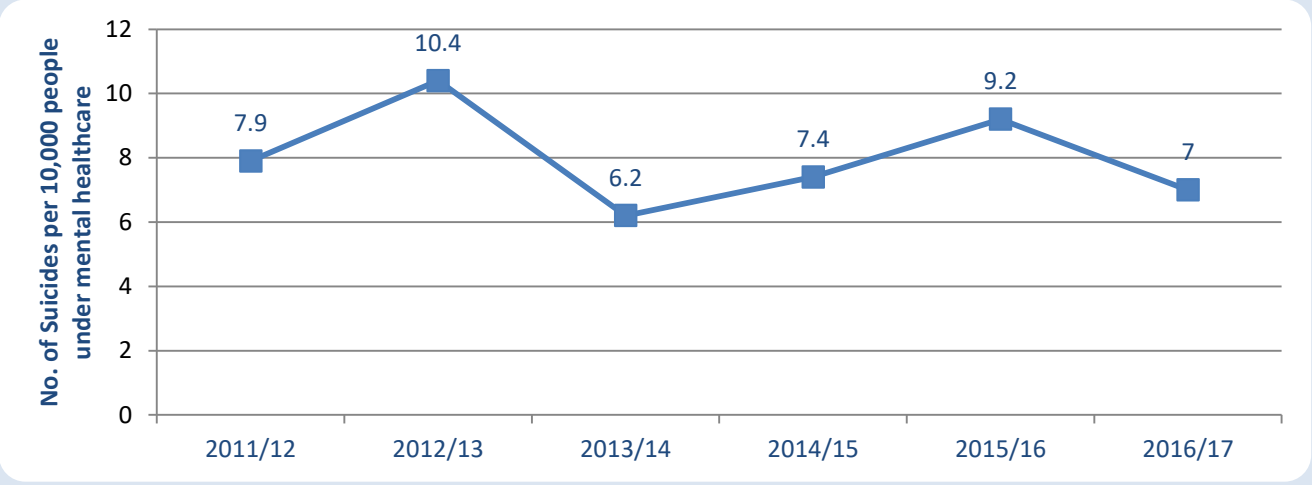
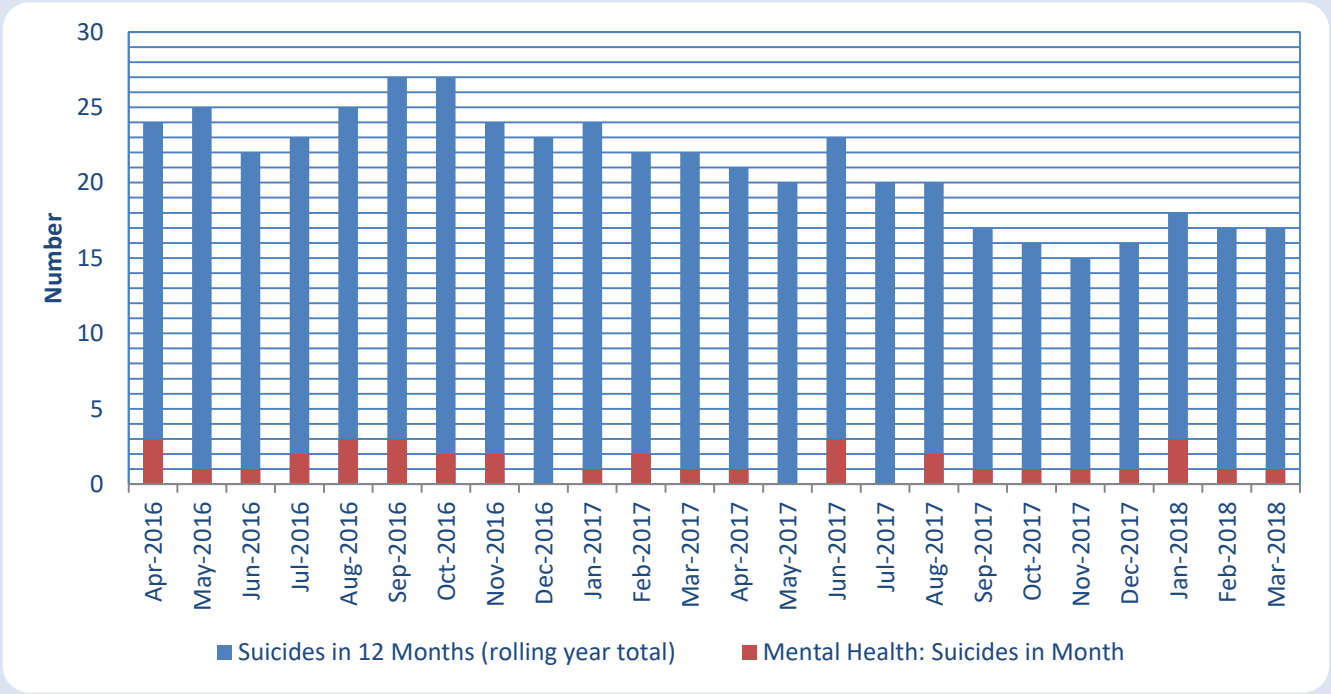


Figure 13 below shows the number of suicides of patients under Trust mental healthcare reported per month since April 2016. The rolling year total is also shown.

Figure 13- Suicides of patients under Berkshire Healthcare NHS Foundation Trust mental healthcare Number per month and rolling year total per month



Source: Trust Performance Assurance Framework

Goal 2: To demonstrate an increase in positive staff attitude and a proactive approach to suicide prevention

It is the aim of the Trust that staff will report an increase in confidence and competence in suicide prevention. This will be achieved through delivery of updated and improved suicide prevention and awareness training. Current training includes:

- Mandatory clinical risk one day induction training and mandatory monthly smart risk training. All materials for these courses have been updated based on evaluations, feedback and dashboard data
- A 3-day suicide awareness course
- Bespoke team training delivered in 1-2 hour workshops using incident data and near miss information from across the Trust and wider
- Specialist training modules
- Safety plan training sessions

The 3-day suicide awareness course continues to be well attended and evaluated. It has also been possible to see that those completing the training are more likely to achieve compliance with risk audit standards (detailed in Goal 3). New materials have been devised to focus on safety planning and learning from Serious Incidents, and the safety planning aspect will be the focus for improvement going forward

Figure 14 below shows the number of participants undertaking suicide prevention related training courses during 2017/18.

Figure 14- Suicide prevention training undertaken during 2017/18

Training description	Number of staff undertaking training during 2017/18
3-day suicide awareness training	139
Crisis intervention training	21
Bespoke crisis telephone training	17

The extent of the change in confidence and competence of staff in suicide prevention will be measured with reference to the results of the Trust Zero Suicide Workforce Survey, the first of which was undertaken in April 2017. Figure 15 below details some of the results of this survey. The Trust will not be undertaking this survey again until May 2018 due to the demand on the Zero Suicide Workforce Survey, which is an international database. Improvement will be measured once this survey has been undertaken again.

Figure 15- Trust Zero Suicide Workforce survey results relating to confidence of workforce- 2017

Respondent Group	Question	Total number responding to this question	Respondents that agreed or strongly agreed with statement	
			Number	%
All Respondents (Includes those working in clinical, managerial, support and admin roles, in both an inpatient and/or outpatient setting)	I have the knowledge and training needed to recognise when a patient may be at elevated risk for suicide	593	407	69%
	I am confident in my ability to respond when I suspect a patient may be at elevated risk of suicide	592	437	74%
Respondents that stated they are responsible for conducting screenings of suicide risk	I have the knowledge and skills needed to screen patients for suicide risk	263	246	94%
	I am confident in my ability to respond when I suspect a patient may be at elevated risk of suicide	263	234	89%
Respondents that stated that they are responsible for conducting suicide risk assessments for patients who screen positive for suicide risk	I have the knowledge and skills needed to conduct a suicide risk assessment.	246	221	90%
	I am confident in my ability to conduct a suicide risk assessment.	246	213	87%

Goal 3: To develop an optimised RiO clinical record system for recording risk

The Trust implemented a new risk summary at the beginning of January 2017. This summary consists of a simplified format that allows the practitioner to complete one form to cover risk assessment, risk management and crisis contingency/service user focussed safety plan. The summary was launched alongside a range of user guides, frequently asked questions and a new policy and standard operating procedures.

The implementation of this risk summary has been measured using a new qualitative audit system that looks for evidence that the risks and needs of the individual have been accurately captured through genuine engagement and that a collaborative plan is in place to manage any modifiable risks.

The risk audits continue to show a steady improvement and the focus will now be to ensure that that safety plans are in place and on the quality of the safety planning. The audit has been revised to capture this work.

Goal 4: Families, carers and staff will feel supported and know where they can get specific support after a suicide.

A support leaflet has been developed for families and carers, and 'Help is at Hand' material is provided to all families as part of the Trust's Duty of Candour. In addition, face-to face support is also provided and a support after suicide psycho-educational intervention has been developed and is being tested.

Carer training on suicide awareness, mental health first aid and also Zero Suicide has been made available, with six carers have undertaken Mental Health First Aid training. Zero Suicide online training has also been well received. The Trust has no way of knowing the exact number of Trust participants undertaking this online training, but as of April 2018 6453 people have completed the course overall. Each person completing the training will be provided with the skills they need to approach situations where they may encounter someone with suicidal thoughts. They will also be supported to better understand and be able to help anyone expressing suicidal thoughts or behaviours.

The Trust have secured the screening of the film 'Suicide- the ripple effect' in Camberley on 25th April 2018. In this film Kevin Hines shares his journey in relation to his suicide attempt. He is also filmed meeting with families and survivors all over the world.

As summarised under Goal 2 above, a range of support is available for staff, and a leaflet summarising this has been devised. This information is also included in the induction guide for staff. In addition, permission has been given to the Trust to utilise the resources of PAPYRUS, a national charity for the prevention of young suicide.

The extent to which staff feel that they are supported is being measured with reference to the results of the Trust Zero Suicide Workforce Survey, the first of which was undertaken in April 2017. Figure 17 below details some of the results of this survey. The Trust will be undertaking this survey again in May 2018, at which point improvement will be measured.

Figure 17- Trust Zero Suicide Workforce survey results relating to support to workforce- 2017

Respondent Group	Question	Total number responding to this question	Respondents that agreed or strongly agreed with statement	
			Number	%
All Respondents (Includes those working in clinical, managerial, support and admin roles, in both an inpatient and/or outpatient setting)	This organisation provides me access to ongoing support and resources to further my understanding of suicide prevention.	602	356	59%
Respondents Who Reported that they interacted with a patient who ended his/her life by suicide.	I felt supported by this organisation when a suicide occurred.	256	128	50%

In 2018/19, the programme of work will focus on the following:

- To continue supporting those in a leadership role in promoting the message that suicide is preventable, supporting their staff and teams to develop suicide awareness and ensuring we have a "no blame" culture that focuses on learning from incidents.

- To continue working on ensuring those who are under the care of secondary mental health services are offered a robust safety plan and that this is collaborative and shared with other stakeholders as appropriate. The Trust have recruited two peer volunteers to work on our inpatient wards to assist with this work.

- As well as providing support for service users and our staff, the Trust will keep a focus on involving and supporting carers.

Pressure Ulcer Prevention

ⓘ Pressure ulcers, sometimes known as 'bed sores' or 'pressure sores', are damage to the skin and underlying tissues caused by pressure or pressure and friction. They can range in severity from a red patch or blister to a complex open wound. Pressure ulcers are graded from 1 (superficial) to 4 (most severe).

The aim of the pressure ulcer prevention priority during 2017/18 was to provide the best care to patients through prompt and thorough risk assessment, education of patients and carers, and early intervention to ensure prevention of pressure damage in the first instance.

In pursuance of this aim, the Trust target was to demonstrate continuing improvement during the year, maintaining the level of performance against current indicators on pressure ulcers that have developed following a lapse in care by Trust staff.

Current interventions to ensure sustained best practice include completion of a pressure ulcer risk assessment. Waterlow and Malnutrition Universal Screening Tool (MUST) scores are completed on admission and, together with the patient's clinical condition, inform the development and implementation of an appropriate care plan, advice and education to minimise the risk. From April 2016, 'avoidable' pressure ulcers are referred to as Lapse in Care (LiC) and 'unavoidable' as Appropriate Care Given (ACG)

Progress against this priority has been monitored throughout 2017/18 using the following metrics, the results of which are detailed in the figures below:

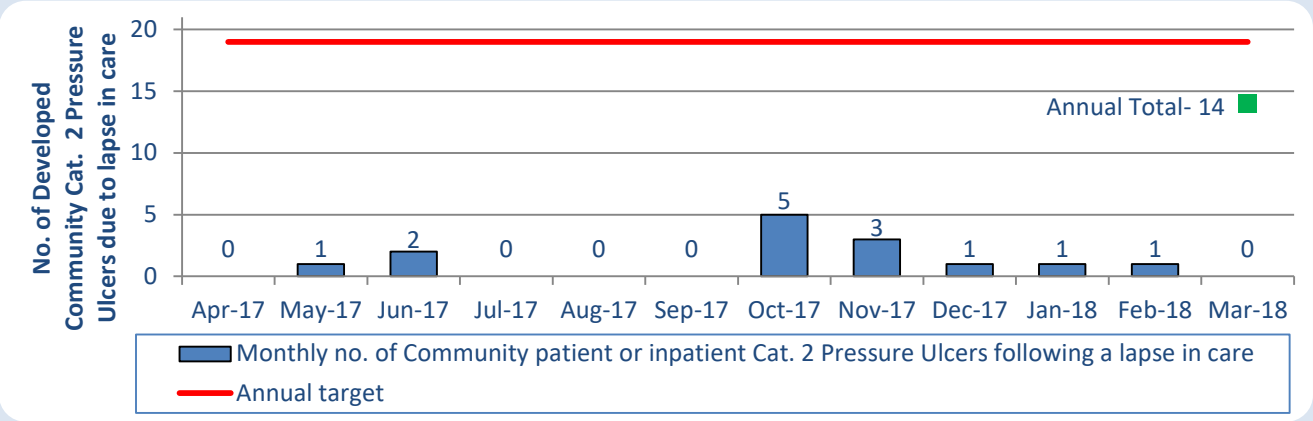
1. To achieve fewer than or equal to 19 community patients or inpatients annually developing Category 2 pressure ulcers which occurred following a lapse in care from Trust staff.
2. To achieve fewer than or equal to 9 community patients or inpatients annually developing Category 3 and 4 pressure ulcers which occurred following a lapse in care from Trust staff.
3. To monitor Trust point prevalence of new pressure ulcers as reported in the Classic Safety Thermometer

The charts below show that, during 2017/18, the Trust has kept below the target of 19 community patient or inpatient category 2 pressure ulcers following a lapse in care (LiC) by Trust staff. However, the Trust has exceeded the target of 9 category 3 and 4 pressure ulcers following a lapse in care by Trust staff (this does not necessarily mean that the pressure ulcer would have been prevented).

Focussed work as part of the Trust's wider quality improvement programme is being undertaken and learning events are continuing for every developed Category 3 and 4 pressure ulcer in the community with a potential lapse in care, and all pressure ulcers category 2 and above that have developed on our inpatient wards. These are positive events that are well attended by clinicians and supported by a senior manager and specialist Tissue Viability Nurse who are all engaged in looking for opportunities for improvement. There are processes in place to ensure local actions are undertaken and any learning is shared with wider teams. All teams have identified pressure ulcer champions who attend a quarterly forum. This provides support to their wider teams, however the workforce pressures on teams is considered to be attributing to the increase in developed pressure ulcers where there is an identified lapse in care.

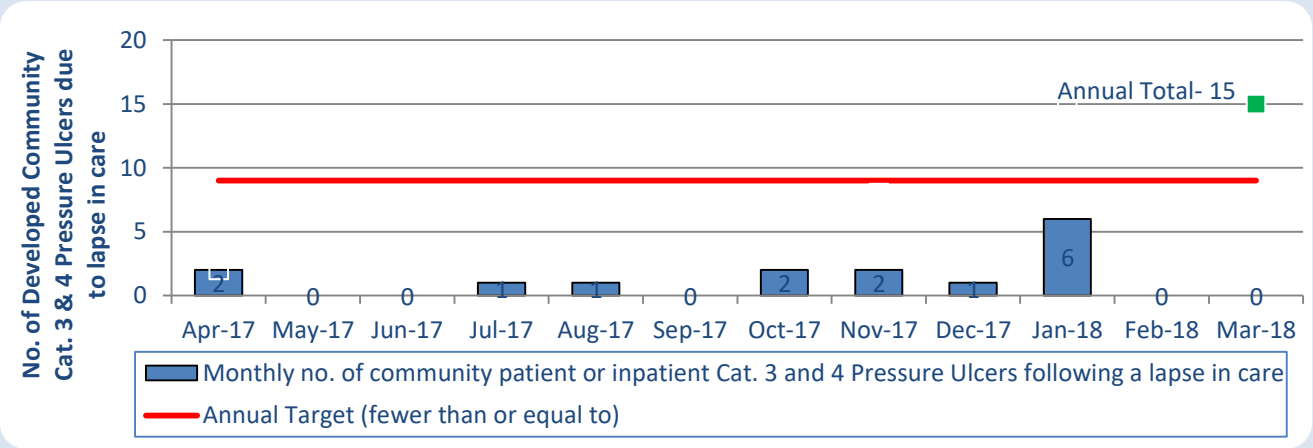
The numbers shown are subject to change as the investigation of some incidents is in progress and are subject to confirmation following the learning event.

Figure 18- Number of developed community patient or inpatient Cat. 2 pressure ulcers which occurred following a lapse of care from Trust staff. Target- Less than or equal to 19



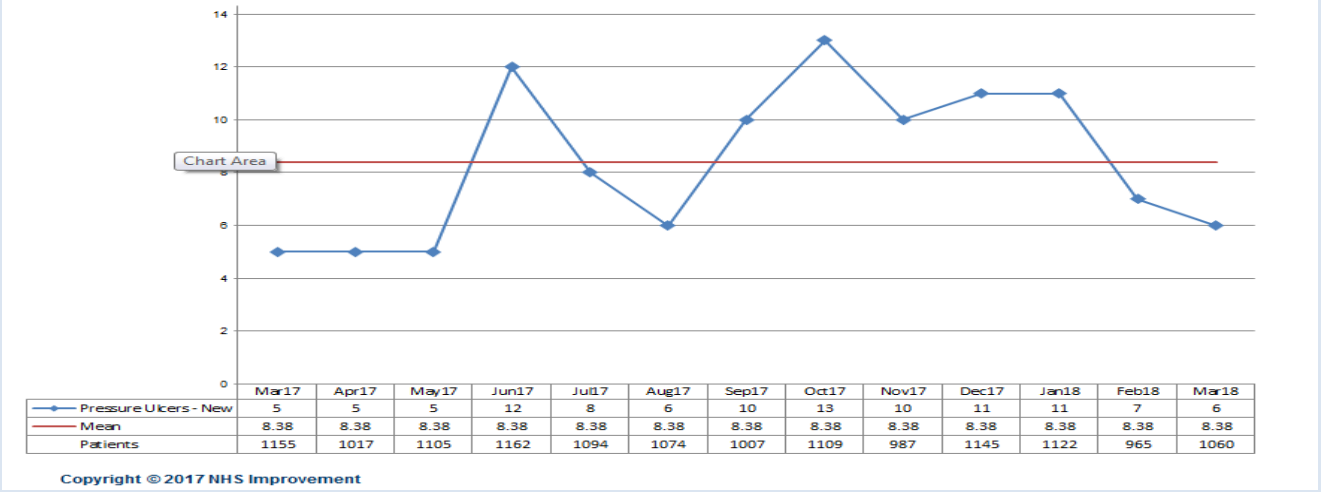
Source: Trust incident data (Datix) based on finally approved incident

Figure 19- Number of developed community patient or inpatient Cat. 3 and 4 pressure ulcers which occurred following a lapse of care from Trust staff. Target: Less than or equal to 9



Source: Trust incident data (Datix) based on finally approved incidents

Figure 20- Point prevalence of new pressure ulcers (all developed Pressure Ulcers for the Trust recorded at a specific point in time each month*)



	Mar17	Apr17	May17	Jun17	Jul17	Aug17	Sep17	Oct17	Nov17	Dec17	Jan18	Feb18	Mar18
Pressure Ulcers - New	5	5	5	12	8	6	10	13	10	11	11	7	6
Mean	8.38	8.38	8.38	8.38	8.38	8.38	8.38	8.38	8.38	8.38	8.38	8.38	8.38
Patients	1155	1017	1105	1162	1094	1074	1007	1109	987	1145	1122	965	1060

Source: Safety Thermometer

* **Please note** that the above Safety Thermometer chart does not show the total number of new pressure ulcers for the Trust, but only those that are recorded at a specific point in time each month.

Falls on older peoples inpatient wards

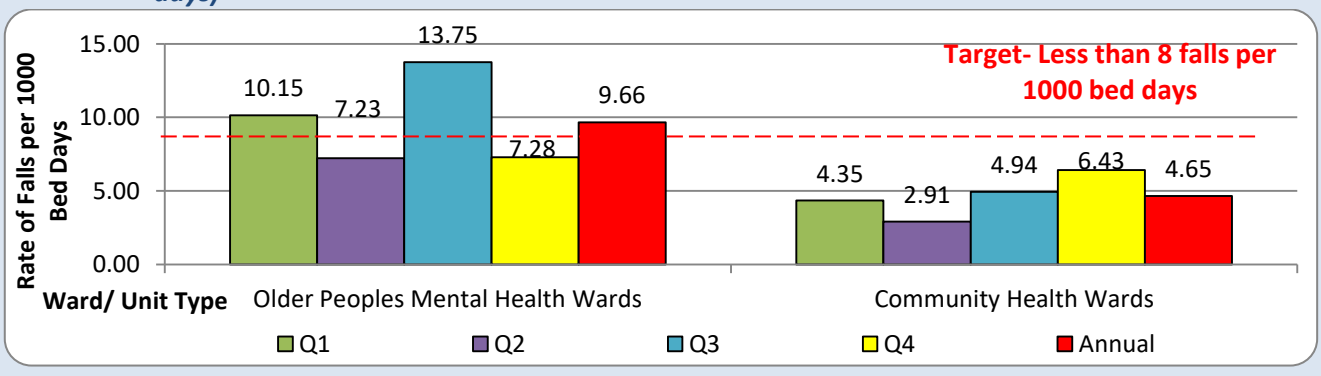
ⓘ The Trust considers prevention of falls a high priority. The Royal College of Physicians report that falls are the most commonly reported type of patient safety incident in healthcare. Although most people falling in hospital experience no or low physical harm (such as minor cuts and bruises), others suffer severe consequences, such as hip fracture, head injury or, on rarer occasions, a fall will be fatal (falls are the commonest cause of death from injury in the over 65s). The personal consequences of a fall for the individual can be significant and even 'minor' falls can be very debilitating.

During 2017/18, the Trust aimed to continue to achieve low numbers of falls experienced by inpatients on older people's inpatient wards (less than 8 per 1000 bed days). The Trust Falls Strategy was written and ratified in the autumn of 2015 in response to the recognition that its falls focus and assessments were not standardised across all its wards and that numbers were at times high, both on mental health and community wards, with no real understanding as to why that was. Many of the reasons people fall are out of the control of the Trust (e.g. co-morbidity) but equally the Trust can learn from many of the reasons people fall, and change practice.

During this year the Trust has worked closely with the Oxford Academic Health Science Network (OAHSN) across the Thames Valley to implement evidence-based ways of reducing falls in its services. This includes implementing the Royal College of Physicians FallSafe care bundles, which involves the analysis of falls data on each ward, completing a gap analysis and then identifying suitable care bundles to implement on each ward to reduce falls. Work is in progress to add the falls paperwork to the RiO risk summary on the patient record used on the Older People's Mental Health (OPMH) wards, and once that is done the Trust will resume the Fallsafe work on Rowan and Orchid Wards (older people's mental health wards at Prospect Park Hospital) with the Oxford AHSN.

Progress against this priority was monitored by analysing the number of inpatient falls against a target of no more than 8 per 1000 bed days. Figure 21 below shows the Trust's performance against this target, together with the total number of falls. The figure shows that the target rate has been met for Community Health Wards but not for Older Peoples Mental Health (OPMH) Wards. Both of the Trust's OPMH Wards are undertaking Quality Improvement Training (QMIS) and have selected falls as their driver metric. They will be using and analysing their falls data to understand the root cause of falls on the wards and will introduce a number of countermeasures over the coming months using Plan Do Study Act (PDSA) methodology. In addition to this Rowan Ward (an Older People's Mental Health Ward at Prospect Park Hospital) are trialling 2 different assistive technologies to help staff monitor patients at risk of falls.

Figure 21- Rate of falls per 1000 bed days- Split by Ward Type (Target- less than or equal to 8 per 1000 bed days)



Number of Falls in 2017/18	Q1	Q2	Q3	Q4	Total
Older Peoples Mental Health Wards	26	18	37	19	100
Community Health Wards	57	39	63	86	245

Please note- patients may fall more than once, and this table represents the total number of falls, not the total number of individual patients that have fallen

Responding to people's needs for both physical and mental health care

ⓘ As a provider of both community and mental health services, the Trust is in an ideal position to deliver holistic services to individuals which assess and respond to their physical and mental health needs. As a result of this, the Trust prioritised support to help people stop smoking in our mental health inpatient services, as well as developing our psychological support for people with long term physical health problems through Talking Therapies.

Targeted smoking cessation for mental health inpatients

The Trust is committed to enhancing the quality of life of its patients. To this end, targets were set as part of the Commissioning for Quality and Innovation (CQUIN) programme and Quality Schedule relating to targeted smoking cessation for mental health inpatients. CQUINs enable commissioners (such as the Clinical Commissioning Groups) to reward excellence, by linking a proportion of service providers' income to the achievement of national and local quality improvement goals.

For the CQUIN target, the sample included all unique adult mental health inpatients admitted during 2017/18 (i.e. if a patient was admitted in both Quarter 1 and Quarter 2 of 2017/18, then they were excluded from the Quarter 2 analysis).

For the quality schedule the sample included 25 patients, from which patients who smoke were identified and assessed against the audit criteria.

The table below details the Trust's performance against these targets. Actions have been put in place to address where criteria are not being met and include reminding ward staff to complete RiO documentation correctly and to follow and complete the admission protocol accurately. This will be supported by the ward managers. In addition, the Drug and Alcohol Lead will continue to support, educate and mentor staff to ensure patients are being asked throughout their admission whether they would like Nicotine Replacement Therapy (NRT) and/or referral to smoking cessation groups.

Figure 22- Trust performance in relation to targeted smoking cessation for mental health inpatient metrics

Quality Reference and Requirement	Target	Quarter	Qtr 1	Qtr 2	Qtr 3	Qtr 4
		Patients Audited	223	204	142	134
CQUIN 9a- Percentage of unique adult patients who are screened for smoking status AND whose results are recorded.	90%	% of patients meeting requirement	**100%**	**96%**	**94%**	**94%**
CQUIN 9B- Percentage of unique patients who smoke AND are given very brief advice	90%	% of patients meeting requirement	**92%**	**96%**	**93%**	**83%**
CQUIN 9C- Percentage of unique patients who are smokers AND are offered referral to stop smoking services AND offered stop smoking medication.	30%	% of patients meeting requirement	**92%**	**76%**	**73%**	**61%**
Quality Reference and Requirement	**Target**	**Patients Audited**	**25**	**25**	**25**	**25**
		Pts identified as smokers	**12**	**12**	**10**	**7**
Quality Schedule- Percentage of eligible patients who are identified smokers and are offered Nicotine Replacement Therapy (NRT) within 2 hours of admission	95%	Number and % of patients meeting requirement	**11/12 (92%)**	**7/12 (58%)**	**8/10 (80%)**	**7/8 (88%)**
Quality Schedule- Percentage of those patients who have consented to Nicotine Replacement Therapy (NRT), and where this therapy is commenced within 2 hours of admission	95%	Number and % of patients meeting requirement (of those consenting to NRT)	**6/7 (86%)**	**0/4 (0%)**	**2/5 (40%)**	**1/2 (50%)**

Source: Trust CQUIN and Quality Schedule Reports relating to Smoking Cessation for Mental Health Inpatients

Improving Access to Psychological Therapies (IAPT)- Long Term Conditions (LTC) expansion across Berkshire 2017/18

The Improving Access to Psychological Therapies (IAPT) service in Berkshire, known as 'Talking Therapies', is a nationally recognised highly performing service. This service was awarded an NHS England/Clinical Commissioning Group (CCG) grant to become an Early Implementer Integrated IAPT-LTC pilot site: two (one in East Berkshire and one in West Berkshire) of 22 nationally.

The initial tranche of funding has secured the staff resources to build up the new integrated service from the pre-existing IAPT service. The new service has focussed on chronic obstructive pulmonary disease (COPD), asthma, diabetes, cardiac conditions, and Medically Unexplained Symptoms (MUS). Ongoing funding is required from the CCG's in 2018/19 to secure staff resources to meet the Five Year Forward view to increase access to IAPT treatments for people with an anxiety and depression diagnosis alongside a physical health condition.

Initial service user satisfaction scores have been above 94% and treatments have yielded a 55% recovery rate (against a target of 50%). Reduced A&E attendance by IAPT-LTC service users has also been demonstrated.

In Berkshire, the new staff have completed specialist training and have started integrating within practice surgeries and running drop-in sessions for surgery patients. The focus is on treatment for patients with co-morbid presentations and those who are frequent attenders and high users of surgery resources. The limited results available to date are encouraging from both a patient quality and cost reduction perspective.

Work continues with specialist nurses to integrate the service into rehabilitation clinics and education sessions for patients with diabetes, Chronic Obstructive Pulmonary Disease (COPD) and heart failure. Members of the psychological therapies team are attached to more than 10 surgeries to date and are also integrated with specialist nurses.

Psychological training, known as PiPP care and 10 minute Cognitive Behavioural Therapy, has been delivered to over 100 health professionals to date and a mental resilience module has been developed and offered to practice staff at all levels.

The new IAPT-LTC service is collecting routine activity and outcome data and is also taking part in a national and Thames Valley wide health utilisation evaluation study due to report in September 2018 in conjunction with the Academic Health Science Network and Oxford University.

New and innovative service developments resulting from this funding have also included the Psychological Interventions in Nursing and Community services (PINC) project, developed out of a Royal Borough of Windsor and Maidenhead pilot, which offers a psychological programme to community nurses and patients to help improve management of selected patients' physical and mental health needs. This service has supported treatment of painful on-going conditions and patients with agoraphobia, for whom the treatment resulted in successful re-integration into healthy, independent life in the community.

Another initiative has seen the extension of HealthMakers from Bracknell into Slough and Windsor, Ascot and Maidenhead under the management of Talking Therapies within Berkshire Healthcare. HealthMakers are a group of volunteers with long term health conditions that provide peer support to others managing their long term health conditions. So far, HealthMakers have made a difference to the lives of people in Bracknell by acting as patient peers and facilitators who work closely with local health services to improve patient care and quality of life. The service also delivers structured, evidence-based training to help others become HealthMakers and has now established a programme of self-management courses to complement Talking Health.

These initiatives are not only having an impact at a healthcare level but are also enabling the residents of Berkshire to play a more active, safe and supported role in managing their own health conditions with confidence.

Overall the IAPT-LTC team are extending and continuing the work of the established Talking Health team and have demonstrated cost reductions, improvements in physical health markers (e.g. HbA1c) and benefits to the wider health system.

Quality Concerns

ⓘ The Quality Assurance Committee of the Trust Board identify and review the top quality concerns at each meeting to ensure that appropriate actions are in place to mitigate them. They are identified through some of the information sources provided in this account, together with intelligence received from performance reports, our staff and stakeholders.

The Trust is currently rated as 'good' overall by the Care Quality Commission (CQC).

Acute Adult Mental Health Inpatient Bed Occupancy
Bed occupancy continues to be consistently above 90%. Patients have high acuity, there is disruption for patients who are on leave with concerns about where they will go on their return and patients are being placed out of area (this increases suicide risk on their discharge). The Chief Operating Officer continues to lead a bed optimisation programme to try and alleviate this pressure. Delayed discharges have stabilised although Sorrel Ward at Prospect Park Hospital has its female beds closed as the ward is being refurbished. The new bed management system is working well and the number of out of area placements is reducing but the pressure remains on local beds.

Locked Wards
Our inpatient assessment and treatment unit for people with learning disabilities and psychiatric intensive care unit are both locked units managing very challenging and vulnerable patients, who frequently assault staff. Both of these units continue to experience leadership challenges, high turnover of staff and agency use and therefore potentially provide a poor patient experience. Regular supervision is in place along with recruitment plans. Professional leads are working closely with staff to ensure standards of practice are maintained. Both wards are monitored robustly by Executive Directors.

Shortage of permanent nursing and therapy staff
Mental and physical health inpatient and community services are now affected by shortages of permanent nursing and therapy staff. This has a potential impact on the quality of patient care and experience, and increases our costs. Community nursing services are experiencing significant staff shortages alongside increased demand for care. There are 10 inpatient beds closed in the West of Berkshire due to lack of staff. Prospect Park Hospital has recruited 60 staff since January 2017 which is alleviating the pressure there. A recruitment and retention programme is being developed for community nursing services.

Duty of Candour

ⓘ The Duty of Candour is a legal duty on hospital, community and mental health Trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. Duty of Candour aims to help patients receive accurate, truthful information from health providers.

Berkshire Healthcare NHS Foundation Trust has an 'Open Communication (Being Open) a Duty to be Candid' policy that supports our culture of openness when things go wrong. To promote and help embed this policy, face to face training has been provided and there is also a page on our intranet where staff can access information, flow charts and advice.

The Trust Patient Safety Team monitor incidents reported on our incident reporting system (Datix) to ensure that where incidents meet the requirement for formal Duty of Candour that this is undertaken.

The Trust process for formal Duty of Candour include meeting with patients and families, apologising for their experience, explaining the investigation process, inviting them to be involved in the investigation and then sharing the report and findings when the investigation is complete. We also ensure that support is offered to patients, family and carers as appropriate. The Duty of Candour supports the Trust learning from deaths programme detailed in Section 2.3.6. The table below details the total number of incidents requiring formal duty of candour during the year. The trust considers that the Duty of Candour was met in all cases.

Month	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
Incidents with formal DOC	8	8	15	4	6	10	8	14	7	22*	23*	30*

*Q4 increase relates to pressure ulcers detected at time of initiating duty of candour. However, at the time of writing, we do not know if these will be due to lapse in care as this is being investigated. However, most of them will not be due a lapse in care

2.1.3 Clinical Effectiveness

ⓘ Clinical effectiveness aims to ensure that each patient receives the right treatment in the right place at the right time. Achieving this requires the application of the best knowledge (derived from research, clinical experience and patient preferences) to achieve optimum processes and outcomes of care for patients.

Our 2017/18 Clinical Effectiveness Priorities are as follows:

1. To demonstrate our delivery of evidence-based services by reporting on the implementation of NICE guidance related to Trust priorities identified in this Quality Account
2. To review, report and learn from deaths in line with new national guidance as it is published. Information on learning from deaths is included is included within the 'Statements of assurance from the board' in Section 2.3.6 of this report

Implementing National Institute for Health and Care Excellence (NICE) Guidance related to Trust priorities identified in this Quality Account

ⓘ Since 1999, NICE have provided the NHS, and those who rely on it for their care, with an increasing range of advice on effective, good value healthcare. NICE guidelines, technology appraisals and quality standards provide valuable evidenced-based information on clinically effective and cost-effective services.

Falls in Older people: Assessing Risk and Prevention

To support the falls priority in the patient safety section of this Quality Account, a re-assessment of compliance against NICE Clinical Guideline 161 on Falls in Older People has been undertaken.

This assessment was completed with input from the Trust lead for falls and included a review of 31 NICE recommendations that were deemed to be applicable to the Trust. These recommendations covered the areas of risk identification and assessment, strength training and exercise, home hazard and safety intervention, psychotropic medications, falls prevention programmes and preventing falls during hospital stays.

The assessment found that the Trust was meeting 29 (94%) of the 31 recommendations.

Areas identified as not meeting recommendations included; the Trust not having a formal strength and balance training programme. However, a strength and balance programme was being piloted in one of the localities, and Trust physios are also available in the community and on wards to give advice.
In addition, NICE does not recommend using a falls prediction tool as a method of assessing patients' risk. However, Trust wards do use a traffic-light assessment tool, but only as the first stage of a more in depth assessment and care planning approach.

Pressure ulcers: Prevention and Management

To support the prevention of pressure ulcers priority in the patient safety section of this Quality Account a reassessment of compliance against NICE Clinical Guideline 179 on Pressure Ulcer Prevention and Management has been undertaken.

This assessment was completed with input from the Trust Tissue Viability Nurses (representing adult community services, adult community inpatient services and Older Peoples Mental Health Services), Children's Services (including Community Children's Nurses, Willow House Adolescent Unit, and Children's Respite Units), and Learning Disability Services.

The assessment included a review of 93 NICE recommendations that were deemed to be applicable to the Trust. These recommendations covered the areas of risk assessment, skin assessment, repositioning, nutritional supplements and hydration,

pressure redistribution devices, care planning, information and training

The assessment found that the Trust was meeting 88 (95%) of the 93 recommendations.

Areas identified as not meeting recommendations included; ensuring that screening and assessment of risk is undertaken on adult mental health inpatient wards. These wards are working with the Tissue Viability Nurses to implement a suitable system to ensure this. In addition, pressure ulcer training and information is being reviewed to ensure that recommendations are being met in these areas.

Service User Experience in Adult mental Health.
To support the patient experience priority in this Quality Account, an assessment of compliance against NICE Clinical Guideline 136 on Service User Experience in Adult Mental Health has been undertaken.

This assessment was completed with input from the Clinical Director and Clinical Lead for Zero Suicide, Inpatient Mental Health Services, Community Mental Health Services, the Common Point of Entry Team and the Crisis Resolution and Home Treatment Team.
The assessment included a review of 89 NICE recommendations that were deemed to be applicable to the Trust. These recommendations covered the areas of access to care, assessment, community care, crisis care, hospital care, discharge and transfer of care and treatment under the Mental Health Act.

The assessment found that the Trust was meeting 81 (91%) of the 89 recommendations.
Areas identified as not meeting recommendations included; waiting times for patients to see a mental health professional once referred (due to demand on services), content of appointment letters and the length of one-to-one time spent with inpatients. These have been highlighted to service leads with action being undertaken to address these findings

Other clinical effectiveness activity, including that relating to service improvements, clinical audit research and learning from deaths, are reported later in this report in Section 2.3- 'Statements of Assurance from the Board'.

2.1.4. Organisational Culture

ⓘ The Trust is committed to acting in line with our values, with a strong focus on delivering services which provide good outcomes for patients and their families. We will listen and respond to our staff and provide opportunities for training and development

Our 2017/18 Organisational Culture Priorities are as follows:

1. To improve on our National NHS staff survey results, with at least 77% of our staff saying they would recommend our Trust as a place to receive treatment
2. To continue delivering our Excellent Manager Programme, providing a strong foundation for all managers in our Trust
3. To continue Values Based Appraisal and Recruitment to ensure that we promote a culture of shared values and related behaviours across the entire organisation
4. To continue the Trust Intelligence Monitoring Group, thus enabling the review of a range of relevant indicators, including incidents, complaints and workforce data. Please see the 'Quality Concerns' paragraph in the patient safety section of this report for further information on this
5. To continue the Trust Freedom To Speak Up programme, ensuring that staff are able to raise concerns in a variety of ways

2017 National NHS Staff Survey

ⓘ The results from the National NHS Staff Survey are used by the Trust to inform local improvements in staff experience and wellbeing. This is important as a positive staff experience plays an important part not only in staff welfare, but also in helping to maintain and improve on patient safety and experience.

The Trust took part in the 2017 NHS National Staff Survey between September and November 2017.

The Survey Sample.

The survey was conducted online, resulting in it being open to over 4000 of the Trust's employees, 1,796 (44%) of whom responded. This is slightly lower than the Trust's 2016 response rate of 46% and the 2017 national response rate of 45% for similar Trusts (29 combined mental health, learning disability and community health services Trusts).

Summary of Trust Results.

The survey contained 32 Key Findings. The Trust results were benchmarked against the other 28 similar Trusts and showed:

- Better than average scores for 22 key findings (compared with 20 in 2016), with 6 equalling the best score
- Average scores for 6 key findings (compared with 7 in 2016)
- Worse than average scores for 4 key findings (compared with 5 in 2016)

The Key Findings (KF) where the Trust score equalled the best amongst similar trusts in 2017 were:

- KF4: Staff motivation at work: 4.04 out of 5
- KF7: Percentage of staff able to contribute to improvements at work: 76%
- KF8: Staff satisfaction with level of responsibility & involvement: 3.98 out of 5
- KF6: Percentage of staff reporting good communication between senior management and staff: 47%
- KF3: Percentage of staff agreeing that their role makes a difference to patients: 92%
- KF23: Percentage experiencing physical violence from other staff in the last 12 months: 1%

In addition, the Trust achieved a top 3 score amongst its peers in the following areas:

- Percentage of staff satisfied with the opportunities for flexible working patterns: 63%
- Staff recommendation of the organisation as a place to work or receive treatment: 3.88 out of 5
- Effective team working: 3.93 out of 5
- Recognition and value of staff by managers & the organisation: 3.65 out of 5

The Trust achieved a worse than average score amongst similar trust in 2017 in the following areas:

- Percentage of staff experiencing discrimination at work in last 12 months: 13%– peer avg. 11%
- Percentage of staff working extra hours: 77%- peer avg. 71%
- Percentage of staff/colleagues reporting most recent experience of violence: 83%– peer avg. 88%
- Percentage of staff reporting most recent experience of harassment, bullying or abuse: 53%– peer avg. 57%

The staff engagement score for the Trust in the 2017 survey was 3.93 out of 5, which was an improvement on the 2016 score of 3.91, and is important due to the link between staff engagement and the provision of good quality, safe services. In addition, one of the Trust targets for 2017/18 was for at least 77% of our staff saying they would recommend our Trust as a place to receive treatment. This target was just missed as the 2017 survey results show that 75% of respondents agreed or strongly agreed that they would be happy with the standard of care provided by the organisation if a friend or relative needed treatment. This is the same result as in 2016.

Please note that the overall National Staff Survey score for the Trust is also included within section 2.4 of this report as it is a core indicator.

The Workforce Race Equality Standard (WRES) requires organisations to demonstrate progress against a number of indicators of workforce equality, with some of these indicators based on the Trust's National Staff Survey results. Figure 23 below details these findings for the Trust, separated into scores for white and black and minority ethnic (BME) staff. The Trust has made positive progress in relation to three of the four survey results during 2017, whilst the score for KF25 (staff experiencing harassment or bullying from patients/ public) is the same as in the 2016 survey. The Trust continues making a consistent and sustained commitment over time to make progress in this area, and have in place a programme of work to achieve this.

Figure 23- Staff survey results relating to the Workforce Race Equality Standard

Description	Race	Trust Scores (%) 2014 (%)	2015 (%)	2016 (%)	2017 (%)	2017 Average (median) for combined MH/LD and community Trusts (29 Trusts)
KF25- Percentage of staff experiencing harassment or bullying from patients / public in the last 12 months	White	21	23	22	22	25
	BME	32	25	27	27	28
KF26- Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	White	19	19	18	18	20
	BME	23	27	26	21	23
KF21- Percentage of staff believing the Trust provides equal opportunities for career progression or promotion	White	88	91	90	89	88
	BME	76	74	68	74	76
Q17b- In the last 12 months have you personally experienced discrimination at work from manager/team leader or other colleagues	White	5	5	5	7	6
	BME	13	14	17	11	11

Source- 2017 National Staff Survey

Figure 24 below details further results from the 2017 staff survey and compares them with the Trust's results in prior years, and the median score for similar Trusts in 2017.

Figure 24- Annual comparison of Trust scores

Question and reference		Trust Score 2015 (%)	Trust Score 2016 (%)	Trust Score 2017 (%)	2017 Average (median) for combined MH/LD and community Trusts (29 Trusts)
Q2a	*I look forward to going to work (often or always)*	67	67	**65**	59
Q2b	*I am enthusiastic about my job (often or always)*	79	79	**78**	73
Q5f	*How satisfied am I that the organisation values my work (Satisfied or very satisfied)*	48	51	**55**	44
Q8c	*Senior managers try to involve staff in important decisions (agree or strongly agree)*	43	43	**47**	34
Q8d	*Senior managers act on staff feedback (agree or strongly agree)*	43	43	**46**	32
Q12a	*My organisation treats staff who are involved in an error, near miss or incident fairly (agree or strongly agree)*	56	60	**61**	53
Q12b	*My organisation encourages us to report errors, near misses or incidents(agree or strongly agree)*	92	91	**92**	89
Q12c	*When errors, near misses or incidents are reported my organisation takes action to ensure that they do not happen again (agree or strongly agree)*	78	78	**78**	68
Q12d	*We are given feedback about changes made in response to reported errors, near misses and incidents (agree/ strongly agree)*	65	67	**68**	60
Q13b	*I would feel secure raising concerns about unsafe clinical practice (agree or strongly agree)*	73	76	**77**	73
Q13c	*I am confident that my organisation would address my concern (agree or strongly agree)*	66	67	**67**	60
Q21a	*Care of patients / service users is my organisations top priority (agree or strongly agree)*	80	81	**82**	72
Q21b	*My organisation acts on concerns raised by patients and service users (agree or strongly agree)*	82	81	**81**	75
Q21c	*I would recommend my organisation as a place to work (agree or strongly agree)*	65	67	**66**	58
Q21d	*If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation (agree or strongly agree)*	74	75	**75**	67

Source: 2017 National Staff Survey

Excellent Manager Programme

ⓘ The Excellent Manager Programme was launched in 2013 and has proven successful in shifting culture, and engaging and motivating staff. The programme covers a range of managerial capabilities including vital conversations, maximising individual and team performance and leading service development and change.

All existing mangers have been trained and the programme will continue to be delivered to newly recruited or promoted managers and those seeking to progress within the Trust.

One measure of success has been seen in the annual staff survey which has demonstrated year-on-year increases in managers seeking views, manager support, staff feeling valued and engaged and improvement in general communication.

Values Based Recruitment

ⓘ Values based recruitment is a way of assessing candidates' strengths and development needs in relation to the values we are looking for to be successful in a role at Berkshire Healthcare NHS Foundation Trust. A number of assessment methods can be used to assess the candidates' performance against a pre-determined set of behavioural indicators.

Values-based recruitment went live in the Trust in early 2016 and was another important milestone in making real our commitment to our values and behaviours. Because of the involvement of colleagues, the Trust is confident that it has a first class approach that both recruiting managers and candidates will value.

Values Based Appraisal

ⓘ It is the policy of Berkshire Healthcare NHS Foundation Trust that every member of staff has an annual review, incorporating a review of performance against objectives, a review of behaviours against Trust values, setting of new objectives for the coming year and a personal development review and plan

The Trust values based appraisal process matches the values based recruitment process and ensures that Trust values run throughout the organisation and are reinforced. As such, the Trust values are embedded within the appraisal documentation.

In 2017, 96.5% of staff had a values-based appraisal conducted. This exceeded the Trust target of 94%. As a result, the target for 2018 will be increased to 97%.

Freedom to Speak Up

Following a review by Sir Robert Francis, a national 'Freedom to Speak up' policy was developed that contributes to a more open and supportive culture that encourages staff to raise any issues of patient care, quality or safety. It is expected that all NHS organisations in England adopt this policy as a minimum standard to help to normalise the raising of concerns

The Trust's Freedom to Speak Up Guardian role is now fully embedded and staff are aware of this additional resource or avenue to raise concerns.

In the period April 2017 to March 2018 there have been six concerns raised and investigated using the Trust's policy on raising concerns and whistleblowing. All of these cases are now closed, with an average completion time of 51 days against the target of an average 53 days.

The Trust will remind staff of the avenues open to them to raise any concerns they have, and that if preferred, concerns can be raised anonymously and via the Trust's dedicated whistleblowing helpline telephone number which is managed by an external Employee Assistance Programme provider.

Compassionate Leadership Programme

The Compassionate Leadership Programme has been developed to support the Trust in becoming a consistently compassionate organisation by 2020. Its aims are to develop motivation to care for ourselves, to inspire and motivate managers and teams to lead with compassion, to develop compassionate charters within teams to enhance team resilience and wellbeing and to enhance compassionate resilience within the workforce

The Compassionate Leadership Programme includes a two-day course on Compassionate Leadership and a one-day Introduction to Compassionate Resilience.

As at the end of 2017/18, 404 staff have attended the two day programme, with 483 staff attending the one-day course or a team event. Anecdotal feedback from individuals and teams has been extremely positive so far, and the programme is being evaluated for its impact.

Making it Right (MiR).

The Making it Right programme has been introduced in response to Trust Workforce Race Equality Standard (WRES) data. The programme has the overall aim of seeking to close the gap between the work experience of our white staff and our Black and Minority Ethnic (BAME) staff. It is part of the Trust's ongoing commitment to develop a high performing, diverse and inclusive workforce.

The Making it Right Programme pilot draws on best practice evidence aiming for; fair recruitment for all, career progression for all, zero tolerance of bullying and harassment, prioritising staff health and wellbeing and ensuring all individuals are valued and feel included. There has been wide consultation and input into the design and development of the programme.

The Programme is made up of three one day workshops aimed at developing participants' attitude, knowledge and skills, which in turn will enable them to communicate in a range of professional settings, compete effectively for jobs and feel empowered to

conduct themselves constructively when faced with discrimination or conflict at work. Participants are also assigned a mentor and paired together for the duration of the pilot.

The pilot was evaluated in February 2018 and showed encouraging signs that the training modules and mentoring programmes have been well constructed and have a good fit with the needs of BAME staff. The programme benefited by having been trialled before the roll-out of the formal pilot. It was also clear from participants' responses that the resulting training course was well designed, stimulating, content-rich and professionally delivered.

Nursing Associates

ⓘ In 2017 a number of new initiatives were being introduced to broaden opportunities for people to enter the nursing profession. There were no changes to the requirement that anyone joining the nursing profession must complete a degree in nursing. However, going forward, there are now opportunities in the Trust to combine working whilst studying to gain a nursing degree. As part of career development and progression the first major step on the work-based learning journey is the new profession of the Nursing Associate.

Trainees are recruited to the Band 3 role and will be appointed to a Band 4 Nursing Associate role once qualified. The qualified Nursing Associate supports the registered nurse. This highly trained support role helps the Registered Nurses deliver effective, safe and responsive care. Nursing Associates work independently, within defined parameters of practice, under the direction of registered nurses, to deliver care in line with an agreed plan of care.

The Trust is a lead employer in the Thames Valley pilot. Eight Trust employees started on this two-year programme in April 2017, attending university one day a week. For the remainder of the time they are working in the clinical settings with nine weeks a year in other placements. The Nursing and Midwifery Council (NMC) has agreed to register the new Nursing Associate workforce.

Some of the Nursing Associates are expected to move on to complete the degree programme and register as fully qualified nurses but most are likely to stay in their new role for a few years to consolidate the learning and to fill the skills gap. Nurse leaders in England have been clear that the intention is for nursing associates to support and not substitute nurses. Having a more highly educated and skilled support staff should enable better use of our graduate nurse resources.

There has been a great deal of interest and support for this role in the Trust. A new cohort of trainees is due to start in the spring of 2018 with the cohort size to double to at least 16.

"I have read a lot of generally negative comments on the internet about CAHMS in general but I would like to say the reception staff at Wokingham CAHMS are exceptional. I went there to complain however I was dealt with so professionally that I left there with a smile on face and the feeling that they were trying to do the best for us. Well done and Thanks."

Child and Adolescent Mental Health Services (CAMHS), Wokingham

2.1.5. Other Service Improvement Highlights in 2017/18

ⓘ In addition to improvements resulting from the priorities detailed above, services have undertaken additional initiatives to improve the quality, safety and experience of care provided to patients. Details of some of these improvements are detailed below in separate sections relating to the area of improvement

The Trust also participates in quality improvement programmes and accreditation schemes that are facilitated by the Royal College of Psychiatrists. These are a key part of the Trust annual plan. A table detailing the projects that the Trust is participating in, including the accreditation status of Trust services, is included in Appendix G

2.1.6. Improvements in Community Health Services for Adults

The New Vision of Care programme in East Berkshire enabled local stakeholders to deliver an ambitious new model of care that integrates care around each individual and supports them to maximise their independence. This is being taken forward by the Frimley Health and Care Integrated Care System (ICS) work streams.

The Frail Elderly Programme in Berkshire West has developed integrated ways of working in West Berkshire, Reading and Wokingham to develop joined up community services in partnership with GPs and Local Authorities as well as community and voluntary sector organisations.

Some of our Community Inpatient Wards have started implementing the Digital Inpatient Community Project, resulting in patients being admitted/discharged/transferred within an hour on the Trust electronic patient record system (RiO). Six Step Up beds were introduced in December 2017, receiving admissions directly from the patient's home serving as an alternative to an acute hospital admission.

Reading Community Matrons. Associate community matrons have been introduced into the service. Data shows that MDT meetings are continuing to reduce hospital admissions as well as GP/ out- of-hours contacts for patients that have been assessed by community matrons.

The Integrated Pain and Spinal Service (IPASS) moved into its 3rd year in operation and has continued to demonstrate a significant reduction in appointment wait times The integrated nature of the service has also led to a 1/3rd reduction in repeat secondary care attendances and has empowered patients to self-manage. The service has been commended by commissioners, who have put IPASS forward for a Health Service Journal award for which they were subsequently chosen as a finalist for the category Acute, Community and/or Primary Care Services Redesign.

The Musculoskeletal (MSK) Physiotherapy Service has demonstrated that 80% of service patients completing treatment experience statistically significant improvement following their physiotherapy intervention.

Reading Adult Acute Speech and Language Therapy team (SLT) work in the Royal Berkshire Hospital providing assessment, therapy, advice and support, as part of various medical MDTs, for all adults with swallowing (dysphagia) and communication difficulties. The team secured funding and have recruited into the Intensive Care Unit, thus improving safe tracheostomy weaning. The team also won a grant from UK Parkinson's Disease Excellence Network and were awarded funds to employ a highly specialist SLT to audit and improve SLT services. The specialist stroke team won the Royal Berkshire Hospital NHS Foundation Trust CEO's Transforming Services fund to provide endoscopic swallowing assessment for stroke patients. Alongside the catering team, the SLT team also reviewed the ward menus to ensure safe food texture options were available and provided training for the catering team in this. Through collaborative working, the team helped influence Royal Berkshire Hospital to change the kosher and Afro-Caribbean meals provider to comply with safe feeding recommendations.

The Nutrition & Dietetics Service. In order to reduce waiting times, the service are piloting monthly groups for parents with an infant with cow's milk allergy, enabling them to provide timely milk-free weaning

advice and reduce the number of appointments offered. As part of the Making Mealtimes Matter initiative, service staff assist ward-based staff at the Royal Berkshire Hospital at mealtimes, on a monthly basis, helping to increase their presence on the wards and building a good rapport with patients and nursing staff.

The Hearing and Balance Service continue to maintain their United Kingdom Accreditation Service (UKAS) accreditation status for Improving Quality in Physiological Services (IQIPS). Public awareness about hearing aids and hearing loss was also highlighted by the service at a combined charities fair attended by the Prime Minister at Maidenhead Town Hall.

The Sexual Health Service is participating in the National HIV pre-exposure prophylaxis clinical trial, a four and a half year clinical trial that will shape the future of the national HIV prevention strategy.

The Tissue Viability Team introduced a live line service In September 2017, offering advice and support to Trust clinicians in managing hard to heal and complex wounds.

The Diabetes Service Education for patients continues to be delivered through the Diabetes Education Through Adult Learning (DEAL), Carbohydrate and Insulin Calculation Education (CHOICE) and Xpert education programmes, and the service have received Quality Institute for Self-Management Education and Training (QISMET) accreditation.

2.1.7. Improvements in GP Out-of-hours Services and Urgent Care Services

WestCall is the out of hours (OOH), GP-led primary care service in West Berkshire. Following a comprehensive review of the position and challenges facing the WestCall service, new 'non-medical' practitioner posts were introduced into the service. This allows multidisciplinary working within the service to provide greater capacity to meet demand and allow the service to be more robust and will allow the team to spend more time focussing on the quality impact of our care delivery. Westcall has also been fully involved in the delivery of the TVIII Clinical Advisory Hub, and Emergency Department Streaming detailed further below.

The Thames Valley 111 (TV111) Clinical Advisory Hub. The TV111 Clinical Advisory Service hub, based at The Old Forge in Wokingham, provides an enhanced clinical assessment service and provides a GP to review calls through clinical streaming for particular patient groups; those over 85 years, under 5 years, complex frail elderly and Ambulance Green calls. Calls can be transferred directly from 111 to the GP or receive a call back within 10 minutes.

Emergency Department Streaming. Toward the end of 2017, the Trust was asked to provide primary care services at the front door of the Royal Berkshire Hospital (RBH) Emergency Department. This has a positive impact on the flow of patients through the Emergency Department. Whilst the service has only been operational for 4 months, it continues to grow steadily and now provides care to approximately 250 patients each week.

The Minor Injuries Unit (MIU) at West Berkshire Community Hospital, in liaison with the Royal Berkshire Hospital (RBH) have introduced a pathway to refer patients with acute soft tissue knee injuries into clinic at the RBH. This has reduced delay in assessment for patients who previously would have gone to their GP if their knee injury wasn't healing or would have taken up an appointment in fracture clinic before being referred on. Furthermore, the team have developed a new pathway with the physiotherapy team at West Berkshire Community Hospital that allows MIU to make direct referrals, thereby reducing the need for patient to see their own GP for a referral.

"The Audiology department bent over backwards to replace my mother's hearing aids after they were lost following a stroke. THANK YOU!"

From a relative of a patient- Hearing and Balance Service– King Edward VII Hospital Windsor

2.1.8. Improvements in Services for Children, Young People and Families (CYPF), including Child and Adolescent Mental Health Services (CAMHS)

Over the past year the Trust has undertaken a major project to continue transforming our Children, Young People and Families (CYPF) Services. Physical and mental health services have been brought together under one directorate. Initial Changes to our new, integrated CYPF Services went live on 2nd May 2017. A new CYPF online resource was launched for Children, Young People and Families, which has been designed and created alongside our service users, parents, carers and fellow professionals in education and healthcare. They have aimed to address the key questions that are asked by service users, providing them with the tools and information they require to self-manage in the community, alongside clear advice on when to seek further help and signposting to the best place to find it. You can access the online resource at: https://cypf.berkshirehealthcare.nhs.uk/.

The Health Visiting Service was re-accredited at level 3 of the UNICEF Baby Friendly Initiative (BFI) Accreditation. This high level of BFI accreditation allows the Trust to be nationally recognised.

The Community Child and Adolescent Mental Health Service (CAMHS). The new Community CAMHS Eating Disorders team is now well-established and meeting access and waiting time standards. A CAMHS Rapid Response service has now been funded following a successful pilot in East and West Berkshire in 2016/17. Service user engagement remains a core principle of the service with models of engagement and participation developed in CAMHS now informing the development of a strategy that has been rolled out more widely across CYPF services.

Work has been undertaken to improve prevention and early intervention services across the county. However, referrals to CAMHS have continued to increase in line with the national picture and this is starting to have an effect on waiting times, particularly in the Autism Assessment, ADHD and CAMHS Eating Disorder teams. These issues have been raised with our commissioners and we are engaged in work with our partners to review care pathways and improve joint working across the different providers involved in caring for these patients.

2.1.9. Improvements in Services for Adults with Learning Disabilities

During the past year, a new Intensive Support Team for people with learning disabilities has been established as part of the local response to "Transforming Care" for people with learning disabilities. This team has been developed to provide a specialist service to those adults with learning disabilities who are at risk of admission to inpatient services as a result of a significant change in their behaviour.

The specialist inpatient service (Campion Unit at Prospect Park Hospital) has been working towards achieving accreditation by the Royal College of Psychiatry through the Quality Network for Inpatient Learning Disability Services (QNLD). In December 2017, the service hosted an external peer review, when a team of reviewers visited the ward and spent the day with patients and staff. The service was accredited by the Royal College of psychiatrists in January 2018.

The service has also continued developing how they review and learn from the deaths of people with learning disabilities. The national Learning Disabilities Mortality Review (LeDeR) Programme has also been implemented locally during this year with service staff being trained to undertake these reviews.

2.1.10. Improvements in Mental Health Services for Adults, Including Talking Therapies and Older Peoples Mental Health Teams

Adult Mental Health Services

The 7 day working Quality Standard was introduced in 2016 as part of the Trust's commitment towards ensuring that there is senior medical input into care of inpatients at Prospect Park Hospital. Admission to hospital is a critical point in patient care. The 7 day Working Quality Standard requires the admitting junior doctors to discuss all out of hours admissions until 12 midnight with the consultant psychiatrist on call. This helps avoid unnecessary delays in commencement of treatment for patients admitted out of hours. Unless immediately necessary, admissions after 12 midnight are discussed with the teams the following morning.

Talking Therapies (IAPT). Talking Therapies were accredited by the Accreditation Programme for Psychological Therapies Services (APPTS) in October 2017. A key development in the service has seen the setting up of 'Our space' cafes in three localities to support service users after discharge from the service, to help prevent relapse following therapy and to sustain health benefits. The core Talking Therapies service has been developed to increase access to evidence based Psychological therapies across all CCG's. In addition, 39 therapists have received high intensity and psychological wellbeing practitioner training to support service growth. Working with the Common Point of Entry team (CPE) has been enhanced by a daily presence of an IAPT clinician or supervisor within the CPE hub to share decision making and support risk assessment across primary and secondary care service entry.

Community Mental Health Team (CMHT) accreditation. The Trust CMHTs are working towards the Royal College of Psychiatrists' Accreditation for Community Mental Health Services (ACOMHS). Bracknell CMHT has been the first to register. The process has required self-assessment against a rigorous set of standards, and has already driven up quality through initiatives such as standardising staff induction programs and providing reflective practice sessions facilitated by psychologists. This process has also encouraged the service to develop more standardised transfer pathways from Child and Adolescent Mental Health Services.

Windsor Ascot and Maidenhead (WAM) CMHT-Sectorisation. WAM CMHT identified the potential for improvement in multi-disciplinary and partnership working with primary care, and devised a process of 'sectorisation', whereby the team was sub-divided and aligned more closely with GP practices. This has resulted in shorter, more clinically relevant meetings. As the sectors are aligned to primary care surgeries, relationships with GPs have improved, and there has been excellent feedback from MDT staff.

West Berkshire CMHT has introduced a complex case forum which focuses on a single service user leading to the development of a plan for moving forward with the individual. This forum helps staff remain open to their patients, as well as sharing the problems with the team which increases the available information and team understanding.

The Circle of Friends (Mother and Baby Group) aims to provide a care pathway for mothers accessing mental health services, promoting a smooth transition to community based groups and the provision of ongoing support for mothers with severe and enduring and perinatal mental health conditions.

The Perinatal Mental Health service offers care to women and their families across Berkshire requiring intervention during pregnancy or in the first year post-partum. The provision of a perinatal Cognitive Behavioural Therapy (CBT) intervention, which is delivered in the woman's home, has been supplemented and complemented by perinatal nursery nurses delivering perinatal frame of mind support. The access that referrers and the team have to our perinatal psychiatrists and perinatal pharmacy has enhanced the advice that the women receive in respect of prescribing at this critical time.

The Lived Experience Group has grown in number and six of the members have talked about their experience to enhance the training we deliver. Alongside the ladies with lived experience, the perinatal team has contributed to regional awareness training delivered to nearly 200 individuals working with women during the perinatal period. The team have also delivered local training during the year to midwives and Health Visitors and have also supported

the training of nursery nurses to deliver the maternal well-being interventions at the post-natal check.

The Perinatal Trauma Pilot Project is now delivering specialist intervention to this cohort of women as part of national funding and. In addition to service development, the national funding is enabling an enhanced range of services and interventions for women who require them across Berkshire.

MOON is the name for the maternal wellbeing aspect of the Trust online support network, SHaRON. MOON has continued to grow during the past year and the numbers activating to use the resource is steady. The clinical moderating team is now supported by six women who have used MOON and who have completed recruitment to hold voluntary contracts with the Trust as peer moderators for MOON.

Assertive Intervention Stabilisation Team (ASSiST) is the service in east Berkshire which supports people with emotional instability, through psychological, social and practical interventions. The service aims to reduce the amount of time people spend as inpatients with mental health services, as hospital stay can be unhelpful for this patient group. This year, the ASSiST team have developed an inpatient group at Prospect Park Hospital (PPH) to help give confidence to the inpatients about community services waiting to support them upon discharge. The ASSiST team have also co-produced an innovative structure for Friends and Family sessions. ASSiST patients identified and scripted difficult social interactions, which were acted by ASSiST staff and filmed Lastly, ASSiST has worked with patients to co-produce a smoother discharge pathway to primary care. This includes using Safety plans and instructions on how their particular mental health difficulties can be best managed in the future, all co-developed with patients.

Hope House is a new recovery-focused supported living project, developed as a joint initiative between the Trust, Slough Borough Council and Lookahead Housing Association. Hope House is a 10 bedded unit with self-contained accommodation where residents stay for up to two years, with tailored support according to their needs. Several services are involved in providing flexible support to patients, including Slough CMHT, HOPE Recovery College, and ASSiST Team. Residents can then graduate to an independent block of six flats close by to Hope House, where they can stay for a further period to build confidence and progress their recovery.

Recovery colleges in East Berkshire. The Trust is commissioned to provide Recovery Colleges in two localities in East Berkshire. Hope College has now been running in Slough for 3 years, and Opportunity Recovery College has been running in Windsor Ascot and Maidenhead since October 2017. Key to the recovery college principles are adoption of education and training opportunities to promote mental health and recovery. The feedback from the clients has been positive.

Volunteer Peer Mentors. In November 2017**,** seven service users graduated from a ten-week volunteer ready induction programme run by Hope College, to become fully fledged volunteer peer mentors. Slough has now trained over 40 peer mentors who are actively supporting others with mental health problems in social and therapeutic activities and recovery college courses. Volunteers also assist on the CMHT reception, meeting and greeting clients and helping the reception team with anything they need.

Volunteers at Compass Recovery College have lived experience of their own Mental Health problems and feel they would like to give something back to the community. Their activities include running a games group, serve beverages and delicious cake at Caversham Court Kiosk, helping out with mother and baby groups and providing a social group. Some of the groups have been running for over 10 years and we are extremely lucky to have such dedicated volunteers.

Early Intervention in Psychosis Services (EIP). The Royal College of Psychiatrists EIP Network carried out a Developmental Review of the service during the year. The team are awaiting the full report, but verbal feedback from the visit has been very positive. In addition, a review was undertaken by the South West Early Intervention in Psychosis Peer Review pilot, with positive feedback.

The Oxford Academic Health Science Network awarded £5000 to the EIP service to implement a Personal Training Pilot during the year. The project involved a 12 week Personal Trainer pilot in Reading and Slough for 8 participants with a BMI of between 25 and 35 who were at the 'contemplation/ determination/ action' stages of change. In conclusion, the results indicated suitability of the intervention and the service are looking to expand in a more sustainable and inclusive way, targeting those whose physical health is deemed high-risk, as well as

clients new to the service to preserve their physical health.

Volunteers are also being recruited into the EIP service to support service users with improving their physical health and reducing social isolation. Art Therapy is also now provided within the EIP service. Finally, An EIP Young Person's group has been established in Slough for patients aged 25 and below.

The Crisis Resolution and Home Treatment Team (CRHTT). The last year has seen a substantial increase in the provision of psychology in CRHTT, with Assistant Psychologists (AP's) now playing an important role in each Home Treatment Team. Psychologists within CRHTT continue to support staff across the service offering regular clinical case reflection groups. Training in Solution Focused Therapy is being rolled out to all staff across CRHTT and to date has been well received.

Eye Movement Desensitization and Reprocessing Therapy (EMDR) continues to be delivered where possible within CRHTT and have demonstrated a clinically significant improvement, most notably a reduction in the desire for suicide post treatment. A recent audit of selected cases showed a 70% reduction in contacts with CRHTT and 79% reduction in admissions for those treated on the project.

The Intensive Management of Personality-disorders and Clinical Therapy Team (IMPACTT) has been rolling out evidence based therapy programmes across Berkshire for service users with Emotionally Unstable Personality disorder (EUPD) who present with current self-harm and chronic suicidal thinking and behaviours. All therapy programmes are being evaluated using valid outcome measures. In addition to the therapy work, the IMPACTT team have been rolling out a teaching programme for colleagues from other services within the organisation (such as inpatient wards, CRHTT and CMHT) to help them build confidence and skill with service users who present with self-harming/ chronic suicidal thinking and may meet criteria for an emotionally unstable personality disorder.

The Psychological Medicine Services (PMS)- Frequent attenders Pathway (FAP) has been looking at patients frequently attending the Emergency Department since January 2016. Multi-agency professional meetings are scheduled quarterly to discuss these clients and formulate individualised management care plans.

The Liaison and Diversion Service identify people who have mental health, learning disability, substance misuse or other vulnerabilities when they first come into contact with the criminal justice system as suspects, defendants or offenders, to help improve health and criminal justice outcomes. A single model of service has been established across Thames Valley. Services have been established within Reading Crown Court and there is an all age and all vulnerability service in Milton Keynes.

The Community Health Psychology Service (CHPS) have delivered training sessions with GPs around working with a psychological approach for patients with fibromyalgia, which received very positive feedback. Excellent feedback was also received for a training course delivered as part of the Oxford Clinical Psychology Doctorate on Working at the End of Life.

The Neuropsychology Service offers a service for adults in three main clinical areas: Acquired Brain Injury, adult diagnostic assessment for Autism/Asperger's Syndrome and adult diagnostic and medical treatment service for adults with ADHD. The team have recently set up long term support or self-help groups in all three clinical areas for those who have been through the system of initial diagnosis and pyscho-educational groups, and still have needs for continuing support.

Family Safeguarding Service. The Trust is part of the new Family Safeguarding Model being developed in Bracknell Forest Borough Council and West Berkshire District Council that builds upon new approaches in Children's Social care. The approach is described as a whole system change to child protection services, focusing on the children and families at the highest level of risk due to domestic abuse, mental health and substance misuse (known as the 'Toxic Trio'). Under the new service, the Trust has been commissioned to employ adult mental health workers and clinical psychologists, who are co-located with child protection social workers, domestic abuse and substance misuse workers, and work closely with police and probation services. The project is in its early stages of implementation with the expectation that the service will evolve over time. It is anticipated that addressing the mental health of parents will have a positive impact on outcomes for vulnerable children.

Older People's Mental Health Services (OPMH)

Memory Clinic Accreditation (ongoing cycle of quality improvement). All Trust Memory Clinics are accredited under the Royal College of Psychiatrists Memory Services National Accreditation Programme (MSNAP) and are preparing for their next MSNAP Peer Review.

Parity of provision for Younger People with Dementia (YPWD). Berkshire East Clinical Commissioning Groups (CCGs) approved funding to extend the YPWD Charity provision of workshops and weekday respite for YPWD and their carers to 5 days a week. This is equivalent to that provided in Berkshire West.

A Listening into Action (LiA) project has achieved its objective of defining a YPWD pathway which has been adopted across Berkshire. Teams are currently embedding the pathway in practice and monitoring the process for referrals to the YPWD charity and an Admiral Nurse to ensure it is robust. Each OPMH Service now has at least one YPWD Champion and have formed a network with members of the YPWD Charity.

The model of care for Young People with Dementia used in the Wokingham Memory Service is to be published as an example of positive practice by the Royal College of Psychiatrists.

The Dementia Care Advisor Pathway was funded by Thames Valley Strategic Clinical Network (TVSCN), with the aim of comparing Dementia Care Advisor provision across Berkshire. The resulting report proposed a best practice pathway that has been presented to Commissioners and various stakeholders. The Trust has been invited to present the paper at a TVSCN workshop in May 2018. Reading CCG have incorporated most of the report recommendations into a revised Dementia Care Advisor Service Specification.

Patient and Carer engagement. OPMH services hold forums and feedback sessions to seek feedback from patients and carers about their experience of pathways and processes and how they can be improved.

Dementia Pathway Reviews An Integrated Care System (ICS) outpatient workstream has been established in Berkshire West to review existing Memory Clinic pathways and identify opportunities to improve effectiveness and efficiency and maximise our ability to manage future demand and referral to diagnosis targets.

Training for Primary Care Practitioners. At the request of Berkshire West Clinical Commissioning Group, Wokingham OPMH is developing a training session to improve the skills and confidence of Practice Nurses and Healthcare Assistants in exploring patients/carers concerns about memory problems and obtaining the information required to request a Memory Clinic Assessment rather than asking the GP to make the referral.

Long term Conditions- Psychological Interventions in Nursing and Community (PINC) Services. Following a successful pilot in 2016 in WAM, PINC Services have been extended to the whole of East Berkshire in 2017 alongside IAPT and Healthmakers to provide therapy for people with long term conditions. PINC sees people who require a home visit and is an integrated service based with the community/district nurses. PINC was awarded innovative project of the year by the Trust in 2017, and a paper concerning PINC was presented at the national IAPT Connect 2017 conference at the British Library. A consultant has been shortlisted for a Winston Churchill Fellowship Award to visit similar services in the USA in 2018 and has had a paper "Integrating care in the UK" accepted by the American Psychological Association for their 2018 annual conference. In a further development, Health Education England (HEE) have awarded a grant for a pilot of a PINC type service with the Heart Failure and COPD services in East Berkshire in 2018.

2.1.11. Improvements in Pharmacy

The Trust is a Mental Health Global Digital Exemplar site. All mental health wards in PPH have now implemented Electronic Prescribing and Medicines Administration (ePMA). The system enables seamless linking between ePMA and the Trust patient record.

2.2. Setting Priorities for Improvement for 2018/19

ⓘ This section details Berkshire Healthcare NHS Foundation Trust's priorities for 2018/19. Specific priorities have been set in the areas of patient experience, patient safety, clinical effectiveness and organisational culture. They have been shared for comment with Trust governors, local Clinical Commissioning Groups (CCGs), Healthwatch Organisations and Health Overview and Scrutiny Committees. Responses to this consultation are included in Appendix H, together with the Trust response to each comment made by the stakeholders

2.2.1. Patient Safety Priorities

1. To drive quality improvement through the continued delivery of the Trust Quality Improvement Programme

2. To align our efforts and work to deliver the following harm-free objectives:
   - Reducing patient falls incidents by 50%
   - Reducing patient self-harm incidents by 30%
   - Reducing rates of suicide of people under our care by 10% by 2021

3. All our services will contribute to an Outstanding overall Care Quality Commission rating

4. At a system level, to achieve reductions in urgent admissions and delayed transfers of care across our inpatient services, working in collaboration with provider partners and commissioners.

2.2.2. Clinical Effectiveness Priorities

1. To demonstrate our delivery of evidence-based services by reporting on the implementation of NICE guidance related to Trust priorities identified in this Quality Account, specifically:
   - Depression in Adults (to support Zero Suicide)
   - Self Harm (to support Harm Free Care)
   - Psychosis and Schizophrenia in adults
   - Bipolar Disorder

2. To continue to review, report and learn from deaths in line with new national guidance as it is published

2.2.3. Patient Experience Priorities

1. To achieve a 95% satisfaction rate in our Friends and Family Test and 60% of staff reporting use of service user feedback to make informed decisions in their department

2. To reduce our use of prone restraint by 90% by the end of 2018/19

3. All our services will focus on understanding and supporting outcomes of care that are important to patients

4. At a system level , to contribute to Integrated Care System work streams to improve patient experience and outcomes.

2.2.4. Organisational Culture Priorities

1. To achieve improvements in the following key areas:
   - 66% of our staff feeling they can make improvements at work
   - 75% of our staff recommending our Trust as a place to receive treatment
   - A 20% reduction in assaults on staff

2. Our recruitment and retention plans will reduce vacancies by 10%

3. An additional 24 services will be trained in our Quality Improvement System

4. To achieve the objectives set out in the Equality Plans for each area

5. At a system level, to participate in Integrated Care System work streams, enhancing job satisfaction and career development opportunities.

2.2.5. Monitoring of Priorities for Improvement

All priorities detailed above will be monitored on a quarterly basis by the Trust Quality Assurance Committee as part of the Quality Report and the Board of Directors will be informed of performance against agreed targets. The Trust will report on our progress against these priorities in our Quality Account for 2019.

2.3. Statements of Assurance from the Board

During 2017/18 Berkshire Healthcare NHS Foundation Trust provided and/or sub-contracted 52 relevant health services.

Berkshire Healthcare NHS Foundation Trust has reviewed all the data available to them on the quality of care in all of these relevant health services.

The income generated by the relevant health services reviewed in 2017/18 represents 100% of the total income generated from the provision of relevant health services by Berkshire Healthcare NHS Foundation Trust for 2017/18.

The data reviewed aims to cover the three dimensions of quality – patient safety, clinical effectiveness and patient experience. Details of a selection of the measures monitored monthly by the Board which are considered to be most important for quality accounting purposes are included in Part 3. These incorporate more than three indicators in each to the key areas of quality.

2.3.1. Clinical Audit

ⓘ Clinical audit is undertaken to systematically review the care that the Trust provides to patients against best practice standards. Based upon audit findings, the Trust makes improvements to practice to improve patient care. Such audits are undertaken at both national and local level.

National Clinical Audits and Confidential Enquiries

During 2017/18, 15 national clinical audits and 6 national confidential enquiries covered relevant healthcare services which Berkshire Healthcare NHS Foundation Trust provides.

During that period Berkshire Healthcare NHS Foundation Trust participated in 100% (n=15/15) national clinical audits and 100% (n=6/6) national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Berkshire Healthcare NHS Foundation Trust was eligible to participate in during 2017/18 are shown in the first column of Figure 25 below.
This column also details the national clinical audits and national confidential enquiries that Berkshire Healthcare NHS Foundation Trust participated in during 2017/18.

The national clinical audits and national confidential enquiries that Berkshire Healthcare NHS Foundation Trust participated in and for which data collection was completed during 2017-18 are also listed below in Figure 25 alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry (detailed in the second column of fig 25).

Figure 25- National Clinical Audits and Confidential Enquiries Undertaken by the Trust

National Clinical Audits and Confidential Enquiries that the Trust was eligible to participate in and did participate in during 2017/18	Data collection status and number of cases submitted as a percentage of the number of registered cases required by the terms of the audit (where applicable)
1. National Clinical Audits (N=15)	
National Clinical Audit and Patient Outcomes Programme (NCAPOP)	
Falls and Fragility Fractures Audit programme (FFFAP) - Fracture Liaison Service Database	Data Collection: April 2017 to March 2018. 612 patients submitted, across 1 service (final figure not yet available). Report due: TBC. Please note that this service was taken over by the Royal Berkshire Hospital on 1/10/17.
Learning Disability Mortality Review Programme (LeDeR)	Data Collection: April 2017 to March 2018 26 (100%) patients submitted, across 1 service. Report due: TBC
National Audit of Anxiety and Depression	Registration: January 18 – March 18 Data Collection: June 18 – Sept 18. Report due: TBC 2019
National Audit of Psychosis	Data Collection: October 2017 to November 2017. 100 (100%) patients submitted, across 3 services. Report due: June 2018

National Clinical Audits and Confidential Enquiries that the Trust was eligible to participate in and did participate in during 2017/18	Data collection status and number of cases submitted as a percentage of the number of registered cases required by the terms of the audit (where applicable)
National COPD Audit - Pulmonary Rehabilitation (2017)	Data Collection: January 2017 to July 2017. 49 (100%) (West) plus 38 (97%) (East) patients submitted, across 2 services. Service level reports published: 25th January 2018. National report published: 12th April 2018
National Diabetes Audit - National Diabetes Foot Care Audit	Data Collection: Continuous. 76 (100%) patients submitted, across 1 service. Reported published: March 2018
National Diabetes Audit - National Diabetes Audit (Secondary Care)	Data Collection: April 2017 to March 2018. 1844 (100%) patients submitted, across 1 service. Report Published: 14th March 2018 Insulin Pump report due: April 2018
National End of Life Care Audit	Registration February 2018 – March 2018. Data Collection: June 2018 – October 18. Report due: May 2019
National Sentinel Stroke Audit	Data Collection: Continuous. 703 (97%) patients submitted for 2017/18, across 4 services (final figure not yet available). Annual report for 16/17 published: Dec 17
National Audit of Intermediate Care (NAIC)	Data Collection: May 2017 to August 2018. Data submitted across 11 services. Benchmarking Project. Reports published: December 2017
Non- NCAPOP Audits	
Prescribing Observatory for Mental Health (POMH-UK) - Prescribing high dose & combination antipsychotics on adult & PICU wards	Data Collection: February 2017. 75 (100%) patients submitted, across 5 services. Reported: October 2017
Prescribing Observatory for Mental Health (POMH-UK) - Use of depot/Long Acting antipsychotic injections for relapse prevention	Data Collection: May to June 2017. 139 (100%) patients submitted, across 5 services. Report published: January 2018
Prescribing Observatory for Mental Health (POMH-UK) - Prescribing for bipolar disorder (use of sodium valproate)	Data Collection: September to October 2017 181 (100%) patients submitted, across 7 services (final figure not yet available). Report due: May 2018
Prescribing Observatory for Mental Health (POMH-UK) – Rapid Tranquilisation re-audit	Data Collection: March 2018 – May 2018. TBC patients submitted, across TBC service (final figure not yet available). Report due: Sept 2018
UK Parkinson's Audit: (Elderly care)	Data Collection: May 2017 to October 2017. 20 (100%) patients submitted, across 1 service. Service level report published: March 2018. National report due: May 2018
National Confidential Enquiries (N=6)	
Child Health Clinical Outcome Review Programme - Young People's Mental Health	Data Collection: April 2017 to March 2018. TBC patients submitted, across TBC service (final figure not yet available). Report due: TBC
Mental Health Clinical Outcome Review Programme - a. Suicide by children and young people in England(CYP) b. Suicide, Homicide & Sudden Unexplained Death c. The management and risk of patients with personality disorder prior to suicide and homicide	a. Data Collection: April 2017 to March 2018. 1 Questionnaire sent out to the Trust, 1 submitted. Report due: May 2018 b. Data Collection: April 2017 to March 2018 31 Questionnaires sent out to the Trust, 24 submitted (final figure not yet available, to be confirmed at end of Q4). Report due: Oct 2018 c. Data Collection: April 2017 to March 2018. 0 Questionnaires sent out to the Trust, 0 submitted. Report due: June 2018
NCEPOD - a. Chronic Neurodisability study	a. Data Collection: April 2016 to March 2017 (extended). 0 patients submitted, across 1 service. The Trust completed the organisational survey and were not required to collect data as we do not admit these patients.1 patient was identified for the case note review for paediatric community care and the questionnaire was submitted. Report published: March 2018

National Clinical Audits and Confidential Enquiries that the Trust was eligible to participate in and did participate in during 2017/18	Data collection status and number of cases submitted as a percentage of the number of registered cases required by the terms of the audit (where applicable)
b. Mental Health Conditions in Young People	b. Data Collection: April 2016 to March 2017 (extended) 35 patients submitted, across 1 service and 9 patients (emergency attendances) for the retrospective data collection. The Trust submitted 8 questionnaires for 3 patients only. All service users were included in the data collection. (aged 11 – 25 years who present to hospital with anxiety, depression, an eating disorder or an episode of self-harm, during the study period).Report due: April 2018

Source: Trust Clinical Audit Team

The reports of 7 (100%) national clinical audits were reviewed by the Trust in 2017-18. This included 4 national audits for which data was collected in earlier years with the resultant report being published in 2017/18. Berkshire Healthcare NHS Foundation Trust intends to take actions to improve the quality of healthcare provided as detailed in Appendix B.

Local Clinical Audits

The reports of 63 local clinical audits were reviewed by the Trust in 2017/18 and Berkshire Healthcare NHS Foundation Trust intends to take actions to improve the quality of healthcare which are detailed in Appendix C.').

2.3.2. Research

ⓘ The Trust participates in research activity to help provide new knowledge that has the potential to be valuable in managing and treating patients. It is important that such research is open to critical examination and open to all that would benefit from it

The number of patients receiving relevant health services provided or sub-contracted by Berkshire Healthcare NHS Foundation Trust in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee was 1113 from 51 active studies.

2.3.3. CQUIN Framework

ⓘ The Commissioning for Quality and Innovation (CQUINs) payments framework was set up from 2009/2010 to encourage NHS providers to continually improve the quality of care provided to patients and to achieve transparency. CQUINs enable commissioners (such as the Clinical Commissioning Groups) to reward excellence, by linking a proportion of service providers' income to the achievement of national and local quality improvement goals.

A proportion of Berkshire Healthcare NHS Foundation Trust's income in 2017/18 was conditional upon achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2017/18 and for the following 12 month period can be found in Appendix E & F.

The income in 2017/18 conditional upon achieving quality improvement and innovation goals is £ FIGURE TBC. The associated payment received for 2016/17 was £3,949,099.

2.3.4. Care Quality Commission (CQC)

ⓘ The Care Quality Commission (CQC) is the independent regulator for health and social care in England. It ensures that services such as hospitals, care homes, dentists and GP surgeries provide people with safe, effective, compassionate and high-quality care, and encourages these services to improve. The CQC monitors and inspects these services, and then publishes its findings and ratings to help people make choices about their care.

Berkshire Healthcare NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is registered with no conditions attached to registration.

The Care Quality Commission has not taken enforcement action against Berkshire Healthcare NHS Foundation Trust during 2017/18.

Berkshire Healthcare NHS Foundation Trust is subject to periodic reviews by the Care Quality Commission.

The CQC visited the following wards during May 2017:

- Willow House, child and adolescent mental health ward, and found that there were some elements of safeguarding that needed improvement and therefore rated the unit as requires improvement for safety
- Bluebell Ward, Prospect Park Hospital finding that improvements were required in record keeping, ward environment and the process of governance involving audits.

The Trust remains overall rated as good across all five domains. The Trust expect a focused CQC inspection, including a well led assessment, to be undertaken by the CQC during 2018/19.

Berkshire Healthcare NHS Foundation Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2017/18:

- CQC Review of the Bracknell Forest Health and Social Care System.

Berkshire Healthcare NHS Foundation Trust intends to take the following action to address the conclusions or requirements reported by the CQC:

- The Trust have been working with Bracknell Local Authority to agree a new integrated service model. This will be a joint team, working 7 days a week, comprising health and social care staff to actively support and keep people at home and/or in a community setting, thereby preventing hospital admission. The team will also In-reach to Frimley Park to support timely and safe discharge back to a community setting.

Berkshire Healthcare NHS Foundation Trust has made the following progress by 31 March 2018 in taking such action:

- The resource required to support the new model has been approved and we are now awaiting final contractual sign off, to allow the recruitment process to begin.
- Further discussions are also on going in local workshops with Bracknell Local Authority and Primary Care to further develop the ICS Integrated Decision Making Hub model (IDMH)

By law, the Care Quality Commission (CQC) is also required to monitor the use of the Mental Health Act 1983 (MHA), to provide a safeguard for individual patients whose rights are restricted under the Act.

The CQC has carried out the following unannounced Mental Health Act (MHA) visits during the 2017/18 financial year.

- 22nd and 23rd May- Bluebell Ward, Prospect Park Hospital
- 23rd June 2017- Rose Ward, Prospect Park Hospital
- 17th October 2017- Bluebell Ward, Prospect Park Hospital
- 19th January 2018, Orchid Ward, Sorrell Ward, Snowdrop Ward and Daisy Ward, Prospect Park Hospital
- 21st February 2018- use of seclusion visit, Campion Ward, Bluebell Ward, Sorrel Ward, Daisy Ward, Snowdrop Ward and Rose Ward, Prospect Park Hospital

2.3.5. Data Quality and Information Governance

ⓘ It is important that data used by NHS services is of a high quality so that it can be best used to inform decisions on the management of patients. In addition, data must be of a high quality to help inform organisational decision-making and planning.

The Secondary Uses Service (SUS)

Berkshire Healthcare NHS Foundation Trust submitted records during 2017/18 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:

— which included the patient's valid NHS number was:
100% for admitted patient care
99.9% for outpatient care and
100% for accident and emergency care.

— which included the patient's valid General Medical Practice Code was:
100% for admitted patient care;
100% for outpatient care; and
100% for accident and emergency care.

Information Governance

ⓘ Information Governance requires the Trust to set a high standard for the handling of information. The aim is to demonstrate that it can be trusted to maintain the confidentiality and security of personal information, by helping individuals to practice good information governance

Berkshire Healthcare NHS Foundation Trust's Information Governance Assessment Report overall score for 2017/18 was 82% and was graded Green.

The Information Governance Group is responsible for maintaining and improving the Information Governance Toolkit scores, with the aim of being satisfactory across all aspects of the Information Governance toolkit.

Data Quality

Berkshire Healthcare NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2017/18 by the Audit Commission.

Berkshire Healthcare NHS Foundation Trust will be taking the following actions to improve data quality.
The Trust is using the latest Commissioning Data Set (CDS) version to send data. Data will continue to be monitored and improvements made where required.

The Trust continues to monitor the improvement of data quality. An overarching Information Assurance Framework (IAF) provides a consolidated summary of every performance information line and action plans.

Data Quality and Data Assurance audits are carried out throughout the year as part of the Information Assurance Framework (IAF) and where data issues are identified internal action plans are put in place. The data is monitored until assurance is gained that the

Trust can have a high confidence level in the data being reported. The assurance reports are included in the monthly Finance, Performance and Risk Executive committee alongside the Performance Assessment Framework (PAF) and reviewed in monthly and quarterly Locality meetings. External Data Quality reports published on the NHS Digital website are analysed to ensure consistency in reporting both internally and externally.

The clinical coding team continue to review and improve the Trust's diagnostic data. As part of our continuous improvement programme, a scheduled clinical coding audit took place in February 2018 and the primary diagnosis rate was 98%, and the secondary diagnosis rate was 91.3%. The coding team continues to work with consultants across the Trust to maintain accurate diagnosis data. Further audits are scheduled for August and December 2018.

The key measures selected for data quality scrutiny by external auditors, as mandated by the Foundation Trust regulator, NHS Improvement, and agreed by the Trust Governors are:

1. Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral (Mandated)
2. Inappropriate out-of-area placements for adult mental health services (Mandated)
3. Improving access to psychological therapies (IAPT): waiting time to begin treatment (from IAPT minimum dataset): within 6 weeks of referral (Governors' Choice).

2.3.6. Learning from Deaths

ⓘ For many people death under the care of the NHS is an inevitable outcome and they experience excellent care from the NHS in the months or years leading up to their death. However, some patients experience poor quality care resulting from multiple contributory factors. The purpose of mortality review is to identify whether problems in care might have contributed to the death and to learn in order to prevent recurrence.

In March 2017, the National Quality Board published Guidance on Learning from Deaths for all NHS Trusts to implement. The Trust has fully implemented this guidance, and a new Trust policy and procedures for learning from deaths was approved in August 2017.

An audit of this was undertaken by internal auditors 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. Substantial assurance was given that the controls upon which the organisation relies to manage the identified risk are suitably designed, consistently applied and operating effectively.

The Trust learning from deaths process includes all patients identified on our electronic patient records who have accessed one of our services in the year before death.

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 required will depend on whether certain criteria are met, and we review the care provided for all patients who had a learning disability and died.

During 2017/18 4381 of Berkshire Healthcare NHS Foundation Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 1194 in the first quarter;
- 1111 in the second quarter;
- 1112 in the third quarter;
- 964 in the fourth quarter.

By 31st March 2018, 307 case record reviews and 153 investigations have been carried out in relation to 4381 of the deaths included above.
In 153 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 38 in the first quarter;
- 39 in the second quarter;
- 35 in the third quarter;
- 41 in the fourth quarter.

In September 2017 in line with our policy we implemented the national quality board recommendations, as of quarter 3 we were required to make judgement on whether problems in care were associated with a death.

1 representing 0.02% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.
In relation to each quarter, this consisted of:

- N/A for the first quarter;
- N/A for the second quarter;
- 1 representing 3% for the third quarter;
- 0 representing 0% for the fourth quarter

These numbers have been estimated using either Initial Findings Report or Root Cause Analysis methodology.

In Quarter 3 of 2017/18, a lapse in care was identified relating 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. This death was investigated as a serious incident. Learning was identified by the service and an action plan is in place.

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.

The following paragraphs are mandated by NHS Improvement. However, they are N/A for this year as this is the first year of reporting.

[Number] case record reviews and [number] investigations completed after [date] which related to deaths which took place before the start of the reporting period.

[Number] representing [number as percentage of number in item 27.1 of the relevant document for the previous reporting period]% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the [name, and brief explanation of the methods used in the case record review or investigation]

[Number] representing [number as percentage of number in item 27.1 of the relevant document for the previous reporting period]% of the patient deaths during [the previous reporting period] are judged to be more likely than not to have been due to problems in the care provided to the patient.

"This is my second batch of treatment for PTSD (Brought on by recent active service in the Army) at this NHS run facility. The counter staff are welcoming, professional, attentive and a smiling face when you attend for your appointments which puts you at ease straight away, they should be commended for the work they do and the keen and courteous way they do it. The consulting staff are the most professional, knowledgeable and understanding people I have ever met, I have had other treatments for my condition but these people get to the heart of the matter and help you deal with it, the reason I am back for a second time is that the team gave me the tools to recognise when things were starting to go bad again and to seek help before it all got out of hand, this tool alone was worth the counselling sessions I attended, my appointments were arranged within weeks and a treatment plan discussed and implemented, so off I go again!! When it seems nobody has a good thing to say about the NHS look no further than the amazing team at Erleigh Road, thank you all so much for helping me and other veterans like me.

From a patient- Traumatic Stress service

2.4 Reporting against core indicators

ⓘ Since 2012/13, all NHS Foundation Trusts have been required to report performance against a core set of indicators. This section details the Trust's performance against these core indicators.

Where available, the national averages for each indicator, together with the highest and lowest scores nationally have also been included.

Figure 27	2015/16	2016/17	2017/18	National Average 2017/18	Highest and Lowest
The percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care during the reporting period	98.6%	97.8%	**97.7%** **(12M Average Percentage)**	Click for link	**Waiting for Nat. data**
Data relates to all patients discharged from psychiatric inpatient care on CPA					
Note: The acceptable exclusions for these indicators are as follows: (i) patient dies within 7 days of discharge, (ii) where legal precedence has forced the removal of the patient from the country (iii) patients discharged to another inpatient psychiatric ward (iv) CAMHs patients are not included.					
Berkshire Healthcare NHS Foundation Trust considers that this percentage is as described for the following reasons: In line with national policy to reduce risk and social exclusion and improve care pathways we aim to ensure that all patients discharged from mental health inpatient care are followed up (either face to face or by telephone) within 7 days of discharge. This is agreed and arranged with patients before discharge and this facilitates our high compliance level					
Berkshire Healthcare NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of services: The Trust meets the minimum requirement set by NHS Improvement of 95% follow up through the implementation of its Transfer and Discharge from Mental Health and Learning Disability Inpatient Care Policy.					

Source: Trust Performance Assurance Framework

Figure 28	2015/16	2016/17	2017/18	National Average 2017/18	Highest and Lowest
The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period	97.6%	99.1%	**99.2%** **(12M Average Percentage)**	Click for link	**Waiting for Nat. data**
Berkshire Healthcare NHS Foundation Trust considers that this percentage is as described for the following reasons: Crisis resolution and home treatment (CRHT) teams were introduced in England from 2000/01 with a view to providing intensive home-based care for individuals in crisis as an alternative to hospital treatment, acting as gatekeepers within the mental healthcare pathway, and allowing for a reduction in bed use and inappropriate in-patient admissions. An admission has been gate kept by the crisis resolution team if they have assessed the patient before admission and if the crisis resolution team was involved in the decision- making process					
Berkshire Healthcare NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of services, by: The Trust Admissions policy and procedures provides a clear framework to ensure that no admissions are accepted unless via the urgent care service					

Source: Trust Performance Assurance Framework

Figure 29	2015/16	2016/17	2017/18	National Average 2017/18	Highest and Lowest
The percentage of Mental Health patients aged— (i) 0 to 15; and (ii) 16 or over, readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period	7.7%	6.2%	**7.9%** **(12M Average Percentage)**	**Not Available** (National Indicator last updated 2013)	**Not Available** (National Indicator last updated 2013)
Berkshire Healthcare NHS Foundation Trust considers that this percentage is as described for the following reasons: The Trust focusses on managing patients at home wherever possible and has fewer mental health beds for the population than in most areas. Sometimes the judgement to send a patient home may be made prematurely or there may be deterioration in the patient's presentation at home due to unexpected events					
Berkshire Healthcare NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of services, by: Work being undertaken around gatekeeping for admission to the hospital should start to ensure all admissions are appropriate and/or have greater consideration of their benefits and risks. The Trust are introducing to all wards a 72 hour review for all patients following admission that will start to give greater clarity on what the purpose of the admission is, including what the presentation on discharge should look like. This is then more likely to be planned and coordinated in a shorter time with the appropriate community services.					

Source: Trust Performance Assurance Framework

Figure 30	2015/16	2016/17	2017/18	National Average 2017/18	Highest and Lowest
				For combined MH/LD and community Trusts	
The indicator score of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends	3.84	3.88	**3.88** KF1. Staff recommendation of the organisation as a place to work or receive treatment- Score out of 5	**3.68**	**3.40-3.90.**
	74%	75%	**75%** Q21d."If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	**67%**	**55%-76%.**
Berkshire Healthcare NHS Foundation Trust considers that this percentage is as described for the following reasons: The Trust's score is better than average and this is maintained. The Possible scores for KF1 above range from 1 to 5, with 1 indicating poor engagement of staff (with their work, their team and their Trust) and 5 indicating high engagement. The strength of recommendation as a place to work alongside staff involvement and staff motivation are strong indicators of the level of staff engagement with in the Trust.					
Berkshire Healthcare NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of services, by: Implementing a five year Organisational Development strategy which has at its heart the achievement of high levels of staff engagement and through that high quality care and service delivery. The specific objectives of the strategy, to be implemented in stages over five years are: To enable every member of staff to see how their job counts, to listen and involve staff in decisions that impact their areas of work, to provide support for their development, and to develop our clinical and managerial leaders. In this, Berkshire Healthcare Trust has signed up to the national Pioneer initiative – Listening into Action – aimed at engaging and empowering staff in achieving better outcomes for patient safety and care.					

Source- National Staff Survey

Figure 31	2015/16	2016/17	2017/18	National Figures 2017/18	Highest and Lowest
Patient experience of community mental health services indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period	6.8	7.2	**7.3**	**7.1 (Median Trust Result)**	**5.8-7.5**
Berkshire Healthcare NHS Foundation Trust considers that this percentage is as described for the following reasons: The Trusts score is in line with other similar Trusts					
Berkshire Healthcare NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of services, by: Being committed to improving the experience of all users of their services. Data is collected from a number of sources to show how our users feel about the service they have received. Actions are put in place through a number of initiatives to improve both an individual's experience and if required to change the service provision.					

Source: National Community Mental Health Survey

Figure 32	2015/16	2016/17	2017/18	National Figures 2017/18	Highest and Lowest
The number of patient safety incidents reported	**3513 ***	**3195 ***	**4824 ***	**167,477 ****	**N/A**
Rate of patient safety incidents reported within the Trust during the reporting period per 1000 bed days	**31.3 ***	**29.1 ***	**45.9 ***	**44.2 ** (Median)**	**16.00-126.47**
The number and percentage of such patient safety incidents that resulted in severe harm or death	**56 (1.6%) ***	**35 (1.1%) ***	**44 (0.9%) ***	**1744 (1%) ****	**1-172 ****
Berkshire Healthcare NHS Foundation Trust considers that this percentage is as described for the following reasons: The above data shows the reported incidents per 1,000 bed days based on Trust data. In the NRLS/ NHSI most recent organisational report published in March 2018, the median reporting rate for the Trust is given as 71.46 incidents per 1000 bed days (but please note this covers the 6-month period April 2017- September 2017. High levels of incident reporting are encouraged as learning from low level incidents is thought to reduce the likelihood of more serious incidents.					
Berkshire Healthcare NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of services, by: Bolstering the internal governance and scrutiny of serious incident reports, their recommendations and action plans. Implementation of strategies to address common findings in serious incident reports, including clinical record keeping and triangulation of patient risk information.					

Sources: * *Trust Figures*

** *NRLS/ NHSI Organisation Patient Safety Incident Report covering 6 months between April 2017- September 2017 relating to 55 Mental Health Organisations Only*

Part 3. Review of Quality Performance in 2017/18

ⓘ In addition to the key priorities detailed in Part 2 of this report, the Trust Board receives monthly Performance Assurance Framework reports related to key areas of quality. The metrics in these reports are closely monitored through the Trust Quality Governance systems including the Quality Executive Group, the Quality Assurance Committee and the Board Audit Committee. They provide assurance against the key national priorities from the Department of Health's Operating Framework and include performance against relevant indicators and performance thresholds set out in the Compliance Framework. Information relating to specific areas of Trust quality and safety performance in 2017/18 is detailed below.

Incidents and Serious incidents (SIs)

ⓘ An incident is any unintended or unexpected event which could have or did lead to harm for one or more people. Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response.

The Trust aims to maximise reporting of incidents whilst reducing their severity level through early intervention and organisational learning. Organisations that report more incidents usually have a better and more effective safety culture. The annual number of patient safety incidents reported by the Trust is detailed in Figure 29 above.

Never Events

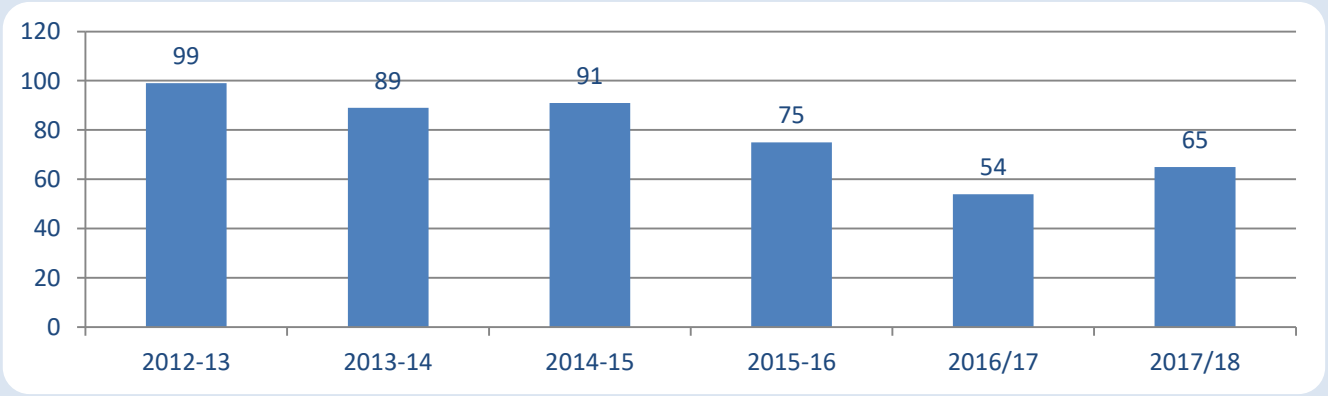
ⓘ Never events are a sub-set of Serious Incidents and are defined as 'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.

The Trust has reported 0 never events in 2017/18.

Figure 33 below shows the annual number of serious incidents reported by the Trust in comparison with the previous financial years.

It should be noted that from 2015/16 Admission of Minors was no longer reported as an SI.

Figure 33- Number of SIs- Year on Year Comparison (excluding pressure ulcers)



Source: Trust Serious Incident Report

Summary of findings from Quarter 4 2017/18 Serious Incident (SI) reporting

Suicide cases: In Q4 of 2017/18 there were 5 SI's reported as suicides/suspected suicides. This is an increase on all other quarters in 2017/18 where 3 were reported each quarter. The 5 incidents reported as a suicide/ suspected suicide during Q4 are from different localities.

Unexpected Deaths: There were 3 unexpected deaths reported as SI's in Q4 of 2017/18. Of these deaths, 1 was a person found dead in their house with cause of death unascertainable, 1 was a person whose cause of death has been confirmed by the coroner as alcohol toxicity and 1 was a patient found unresponsive during the night at Prospect Park Hospital, and at the time of writing this report the cause of this death has not been confirmed by the coroner.

Falls: In Q4, there was 1 SI reported for a patient fall resulting in serious harm. This incident occurred on Henry Tudor Ward at St Marks Hospital**,** Maidenhead.

Information Governance Breaches: There were 3 SI's reported as information governance breaches in Q4. 1 was related to the Diabetes Service, 1 related to Westcall and 1 related to Diabetic Eye Screening.

Alleged Assaults: There was 1 SI reported for alleged patient-on-patient sexual assault at Prospect Park Hospital**.**

Pressure Ulcers: Prior to April 2016, category 3 and 4 pressure ulcers were reported as SI's if they developed when the patient was in our care and were assessed as being avoidable. However, in agreement with the Commissioners, since April 2016 there is no longer a need to report developed pressure ulcers as SIs unless it is deemed that there was a significant lapse in care. However a learning event is undertaken for any incident where there was a potential lapse in care to explore learning with the teams involved. In Q4 there were no pressure ulcer incidents that were reported as an SI. In Q4 there were 11 learning events held for incidents of category 3 and 4 pressure damage where there was a potential lapse in care. Of these, 5 were agreed to be as a result of a lapse in care (these were in Wokingham intermediate care, 2 in Reading Community Nursing, and 1 each in Ascot and Oakwood wards). For 1 incident in each of WAM, Wokingham and Bracknell Community Nursing, although learning events revealed that the skin damage was not as a result of pressure there was learning for the teams.

AWOL/ Abscond: During Q4 there was 1 serious incident reported of a detained patient who failed to return from planned leave; whilst absent took an overdose and as a consequence was delayed in being able to return to Prospect Park Hospital.

Other SIs reported in Quarter 4: 1 incident of misdiagnosis in the Minor Injury Unit (MIU), this has subsequently been downgraded as detailed below, following investigation. 1 Road traffic accident of a patient who was on planned leave.

Downgrades: At the time of writing this report the incident of the misdiagnosis in Minor Injuries Unit (MIU), detailed above, has been downgraded following completion of the investigation and review by CCG.

Death of detained patients: There have been no deaths of a detained patient during this quarter.

Comparison to 2016/17: There has been 65 SIs reported this year compared to 54 reported in 2016/17 (excluding downgrades).This increase is in the main due to an increase in information Governance breaches with 18 reported during this year and 4 during 2016/17. Falls with harm has increased from 4 in 2016/17 to 7 in 2017/18, whilst SI for suspected suicides has decreased from 22 to 14.

Preventing Future Death reports (Reg 28): During 2017/18 Berkshire Healthcare has provided information and/ or attended 37 inquests, with 23 of these relating to incidents occurring in 2017/18. There have been no Regulation 28 reports issued to Berkshire Healthcare NHS Foundation Trust.

Key themes identified in SI investigation reports approved in Quarter 4 2017/18, together with actions taken to improve services:

The main themes identified from investigations completed and approved by commissioners in Q4 are:

Safety planning: A number of investigations have highlighted the importance of robust safety planning that is updated for the person's current circumstances, involves family and friends and is shared with the patient's family and friends.

Working with and involving carers and families: The importance of involving families and carers during the

care and treatment of mental health patients has been highlighted as a theme. This theme continues with the importance around hearing concerns and gaining information from family and friends to help inform risk assessments; treatment and safety plans.

Understanding choking risk in patients with swallowing problems: The importance of understanding and following specialist dietary advice provided

Record Keeping: A number of SIs closed in Q4 highlight the need for good record keeping including recording of all interventions, rationale and decision making around care and treatment

Developed Pressure Ulcers: During 2017/18 there have been 22 learning events held for developed pressure ulcers with a potential lapse in care. Both Wokingham Community Hospital and WAM Community Nursing Team have now identified pressure ulcers for their current quality improvement driver metric and will undertaking quality improvement work to reduce developed pressure ulcers within their care

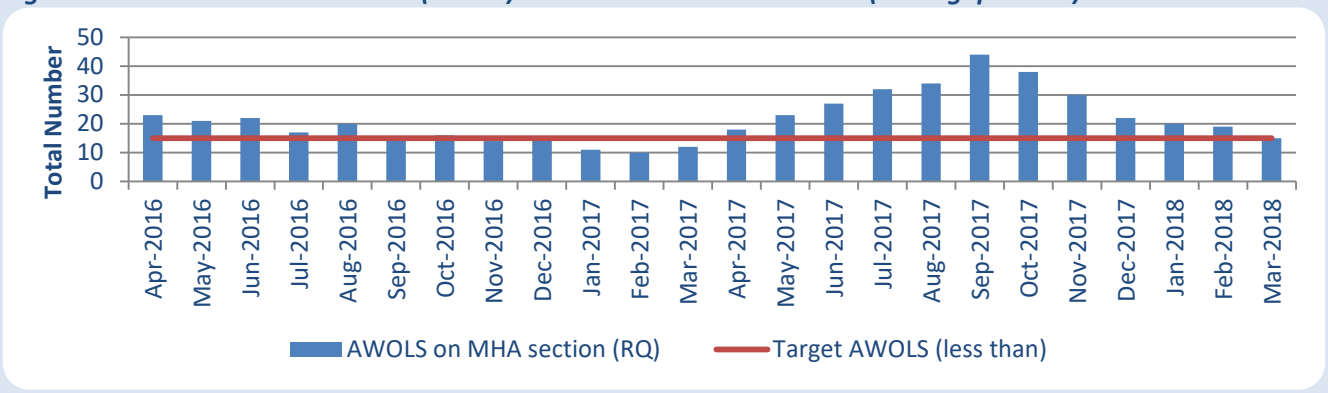
Actions are being undertaken to address these main themes.

Absent without leave (AWOL) and absconsions

ⓘ The definition of absconding used in the Trust is different than AWOL. Absconsion refers to patients who are usually within a ward environment and are able to leave the ward without permission.

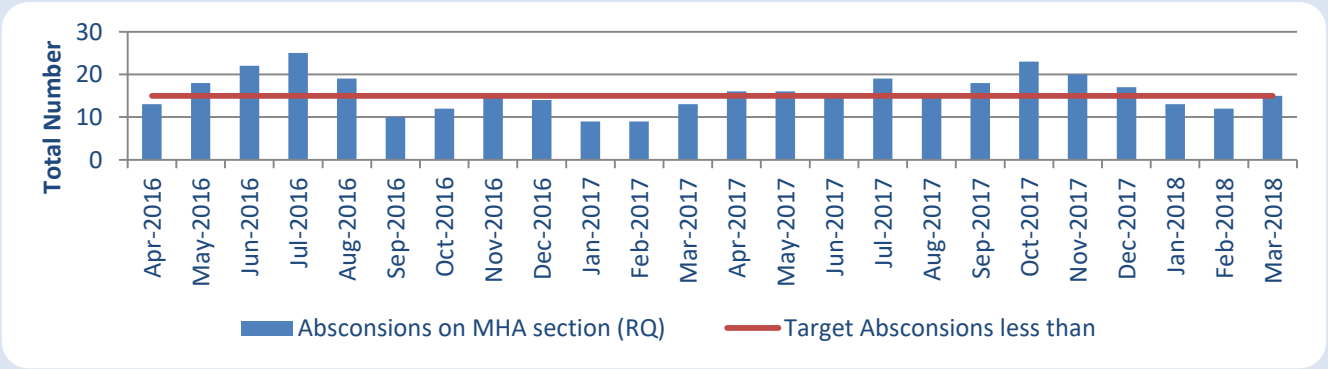
Figures 34 and 35 below detail the number of absconsions on a Mental Health Act Section and the number of patients absent without leave on a Mental Health section.

Figure 34- Absent without leave (AWOL) on a Mental Health Section- (Rolling quarters)



Source: Trust Performance Assurance Framework

Figure 35- Absconsions on a Mental Health Act (MHA) Section- (Rolling Quarters)



Source: Trust Performance Assurance Framework

Medication errors

ⓘ A medication error is any patient safety incident where there has been an error in the process of prescribing, preparing, dispensing, administering, monitoring or providing advice on medicines. Such patient safety incidents can be divided into two categories; errors of commission (e.g. wrong medicine or wrong dose of medicine) or errors of omission (e.g. omitting a dose or failing to monitor).

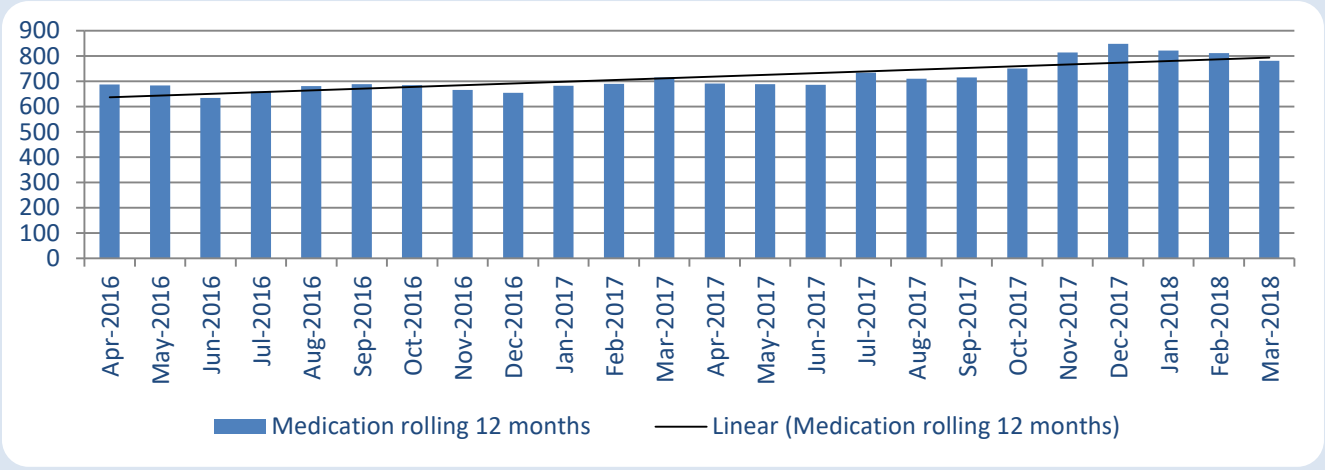
Figure 36 below details the total number of medication errors reported, based upon a rolling 12-month figure.

When interpreting this figure, it should be noted that a high and increasing rate of medication error reporting is a sign of a healthy learning culture in the organisation and that reporting of such errors is being encouraged as the first step in ensuring a robust safety culture exists.

All medication errors are considered by the Trust's Medication Safety Officer(s) and the Medication Safety Group (MSG) who consider trends and educational interventions appropriate to the errors. This group is a formal sub-group of the Trust Drug and Therapeutics Committee (DTC)

During quarter 4 of 2017/18 there were no moderate, major or severe medication errors.

Figure 36: Medication Errors (Rolling 12 Months)



Source: Trust Incident Database (Datix)

"I attend the centre for weekly therapy and DBT group therapy. I find the environment and atmosphere restful yet full of positive energy. It is clean and inviting. I am treated with respect ,dignity and concern. I am lucky to have a place on this well planned course".

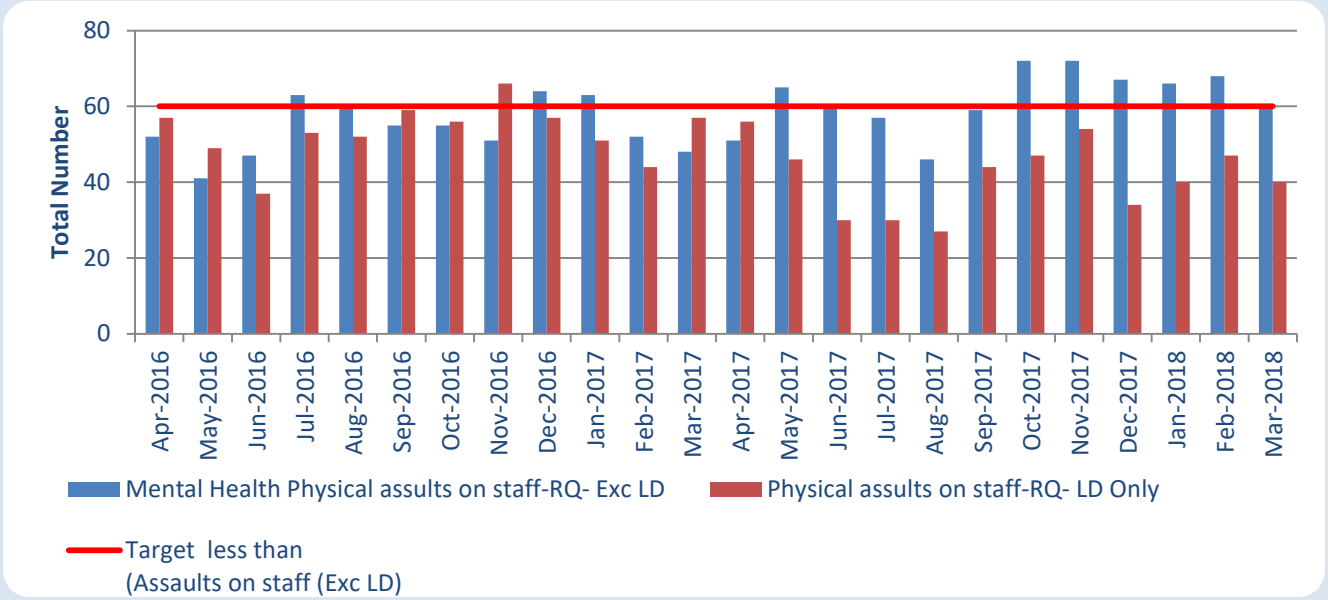
From a patient- Assertive Intervention Stabilisation Team (ASSIST)- Upton Hospital, Slough

Mental Health and Learning Disability Patient to Staff Physical Assaults

Figure 37 below details the number of patient to staff assaults. This data has been separated to show assaults by patients with and without learning disabilities (LD).

There have been fluctuations in the level of physical assaults on staff by patients. Often these changes reflect the presentation of a small number of individual inpatients.

Figure 37- Patient to staff assaults- Rolling Quarters (RQ)

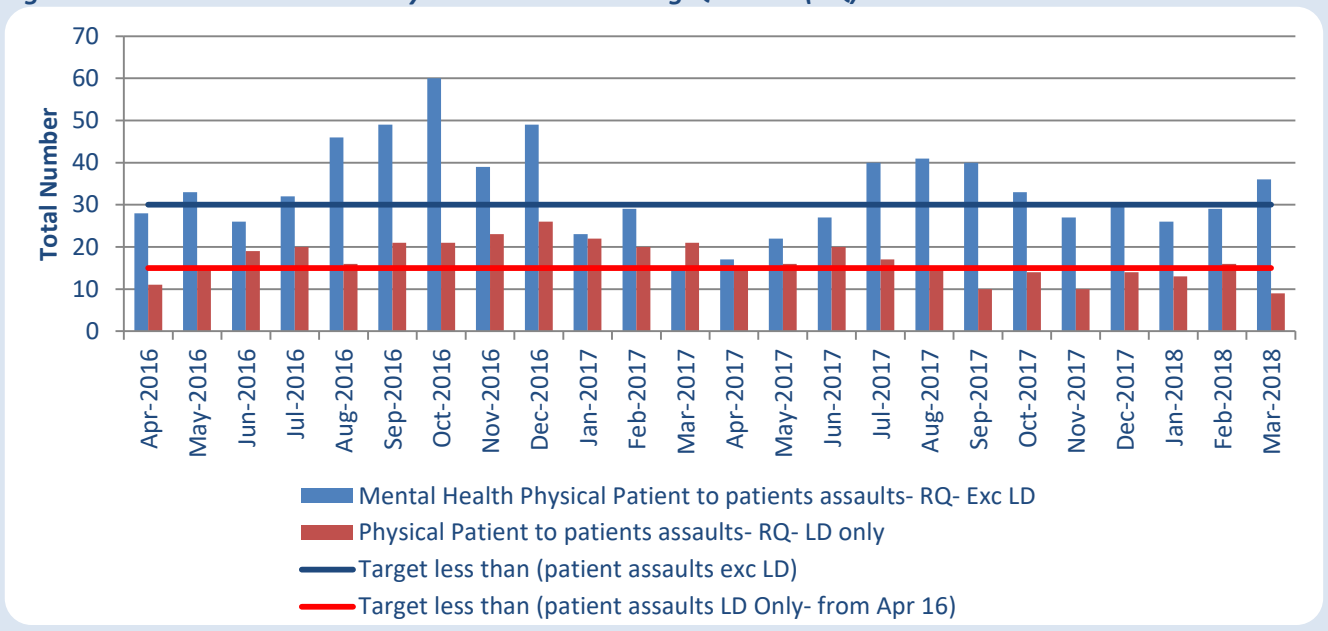


Source: Trust Performance Assurance Framework

Mental Health and Learning Disability Patient to Patient Physical Assaults

Figure 38 below details the number of patient to patient physical assaults. This data has been separated to show assaults by patients with and without learning disabilities (LD). As can be seen, the level of patient on patient assaults appears to fluctuate.

Figure 38- Patient to Patient Physical Assaults- Rolling Quarters (RQ)



Source: Trust Performance Assurance Framework

Other Quality Indicators

Figure 39	Target	2015/16	2016/17	2017/18	Commentary
Patient Safety					
CPA review within 12 months	95%	96.1%	95.3%	**94.2%**	12 month average %. For patients discharged on CPA in year last 12 months.
Never Events	0	0	0	**0**	Full year number of never events. *Source- Trust SI Report*
Infection Control- MRSA bacteraemia	0	0	0	**0**	Full year number of MRSA. *Source- Trust Infection Control Reports*
Infection Control- C. difficile due to lapses in care	<6 p/a	1	2	**3 (0.029 per 1000 bed days)**	Full year total number & rate per 1000 occupied bed days of C. Diff due to lapse in care by Trust. *Source- Trust Infection Control Reports*
Medication errors	Increased Report.	623	715	**781**	Full year total number of medication errors reported. *Source- Trust Datix incident management system*
Ensuring that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas: a) inpatient wards b) early intervention in psychosis services c) community mental health services (people on care programme approach)	a) 90% b) 90% c) 65%	N/A	N/A	**TBC- Data Due May 2017**	Percentage meeting requirement *Source- Trust CQUIN report*
Admissions to adult facilities of patients under 16 yrs old	TBC	N/A	N/A	**0**	Full year total number of <16yr old admissions *Source- Service Generated Data*
Inappropriate out-of-area placements for adult mental health services (Bed days)	TBC	N/A	N/A	**249**	Average monthly total bed days for Q4 17/18 *Source- Service Generated Data*
Clinical Effectiveness					
Mental Health minimising delayed transfers of care (Relates to Mental Health delays only-Health & Social Care).	<7.5%	1.7%	12.38%	**11.3%**	12 month average %. Calculation = number of days delayed in month divided by Occupied Bed Days in month.
Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral	50%	N/A	85.8%	**84.5%**	Total year %. Added from Q4 2015/16
Improving access to psychological therapies (IAPT): proportion of people completing treatment who move to recovery	50%	N/A	N/A	**58.8%**	Total year % *Source- Service Generated Data*

Figure 39	Target	2015/16	2016/17	2017/18	Commentary
Improving access to psychological therapies (IAPT):People with common mental health conditions referred to the IAPT programme will be treated within 6 weeks of referral	75%	N/A	98.4%	**98.9%**	12 month average %. Added from Q4 2015/16
Improving access to psychological therapies (IAPT): People with common mental health conditions referred to the IAPT programme will be treated within 18 weeks of referral	95%	N/A	99.9%	**100%**	12 month average %. Added from Q4 2015/16
A&E: maximum waiting time of four hours from arrival to admission/ transfer/ disch.	95%	99.4%	99.5%	**99.3%**	12 month average %.
Completeness of Mental Health Minimum Data Set	99.6% 50%	99.8% 99.2%	99.9% 98.7%	**99.9%** **99.1%**	12 month average %.
Completeness of Community service data 1) Referral to treatment info. 2) Referral info. 3) Treatment activity info.	 50% 50% 50%	 72.1% 61.8% 96.9%	 71.3% 62.5% 97.2%	 **72.9%** **62.6%** **97.9%**	12 month average %.
Patient Experience					
Referral to treatment (RTT) waiting times – non admitted –community.	95% <18 weeks	99.5%	99.3%	**100%**	12 month average %. Waits are for consultant led services in East CHS, Diabetes, and Paediatric services from referral to treatment (stop clock). Notification received from NHS England to exclude sexual health services.
RTT waiting times Community: Incomplete pathways	92% <18 weeks	99.7%	99.9%	**99.8%**	12 month average %.
Access to healthcare for people with a learning disability		Green	Green	**Green**	Score out of 24
Complaints received		218	209	**209**	Total number of complaints in year
1. Complaint acknowledged within 3 working days 2. Complaint resolved within timescale of complainant	100% 90%	96.3% 91.4%	100% 100%	**100%** **100%**	Total year %
Please note- there is no longer a requirement to report the number of new early Intervention in psychosis cases to NHS Improvement as part of their Single Oversight Framework. This indicator has therefore been removed.					

Source: Trust Performance Assurance Framework, except where indicated in commentary

Statement of directors' responsibilities in respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS Foundation Trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation Trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS foundation Trust annual reporting manual 2017/18 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2017 to May 2018
  - papers relating to quality reported to the board over the period April 2017 to March 2018
  - feedback from commissioners dated April 2018
  - feedback from governors dated April 2018
  - feedback from local Healthwatch organisations dated April 2018
  - feedback from Overview and Scrutiny Committee dated April 2018
  - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated April 2018
  - the 2017 national patient survey November 2017
  - the 2017 national staff survey March 2018
  - the Head of Internal Audit's annual opinion of the Trust's control environment dated May 2018
  - CQC inspection report dated May 2017
- the Quality Report presents a balanced picture of the NHS foundation Trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the board

DATE **Martin Earwicker** **Chairman**

DATE **Julian Emms** **Chief Executive**

Appendix A: Quality Strategy

Appendix B- National Clinical Audits- Actions to Improve Quality

National Clinical Audits Reported in 2017/18 and results received that were applicable to Berkshire Healthcare NHS Foundation Trust

	National Audits Reported in 2017/18	Recommendation (taken from national report)	Actions to be Taken
	NCAPOP Audits		
1	National Diabetes Audit - Foot care Audit 2016/17 (2779)	The National Diabetes Foot Care Audit (NDFA) is a measurement system of care structures, patient management and outcomes of care for people with active diabetic foot disease.	The Head of the Foot care Service is leading on an action plan to improve outcomes with regards to time from referral by any healthcare professional to assessment by the Multi-Disciplinary Foot-care Team (MDfT). Actions include employing a part time Foot Protection Lead role, this will support community podiatry wound care clinics along with increasing capacity in the weekly MDfT. Work on referral pathways is also underway and is being supported by the RBH Diabetes Clinical Governance meeting.
2	National Diabetes Audit 2015/16 – SWIC (3363)	The National Diabetes Audit (NDA) is a major national clinical audit, which measures the effectiveness of diabetes healthcare against NICE Clinical Guidelines and NICE Quality Standards, in England and Wales. The NDA collects and analyses data for use by a range of stakeholders to drive changes and improvements in the quality of services and health outcomes for people with diabetes.	Since the data collection for this audit, the service has undertaken an internal audit against the standards in the National Diabetes Audit, therefore the results and action plan for the local audit has superseded the results within this report. (due to the time lag in publication of national findings)
3	Falls and Fragility Fractures Audit Programme (FFFAP) - Fracture Liaison Service Database 2016/17 (3366)	The audit aimed to measure primarily against NICE technology assessments and guidance on osteoporosis and the National Osteoporosis Society (NOS) clinical standards for Fracture Liaison Services (FLS). This was the first national patient level audit of quality of FLS's.	An EPR nurse clinic now exists, meaning the Virtual Fracture Clinic (VFC) and specialist clinics can place an order for the service. Vertebral fractures identified incidentally by radiology can be booked into the Fracture Liaison Services (FLS) Virtual Clinic. The FLS has recently obtained software which provides staff access to patients via additional clinics, for example those being treated for hand injury. The contract for this FLS is being reviewed, which will transfer its provision to the local acute Trust.
4	National COPD Audit Programme. Pulmonary Rehabilitation Re-audit 2017. – 3373	The National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme comprises a number of ambitious programmes of work that aims to drive improvements in the quality of care and services provided for COPD patients in England and Wales. This programme looks at Quality Statements derived from the British Thoracic Society: Quality standards for Pulmonary Rehabilitation in Adults	Create protocol for completing outcome measure to ensure standardisation. Update Rio patient Assessment form to include new outcome measure to record data To begin to include 5 x sit to stand assessment test in Berkshire West Pulmonary initial and final assessments. Add outcome to patient's discharge letter and feedback to GP. Update Standard Operating Procedure. Berkshire east to add BMI pre & post to assessment paperwork

	National Audits Reported in 2017/18	Recommendation (taken from national report)	Actions to be Taken
	Non-NCAPOP audits		
5	POMH - Topic 16a - Rapid Tranquilisation (Sept 2016) (2885) – Part of the POMH National Audit programme	This is a national audit coordinated by the Prescribing Observatory for Mental Health (POMH) as part of their on-going programme of clinical audits. Acutely-disturbed behaviour is common in inpatient psychiatric settings, placing both the patient and others at risk. The importance of preventing and appropriately managing such behaviour is addressed by NICE in CG10: violence and aggression: short-term management in mental health, health and community settings (NICE, 2015).	Work on improvement in documenting by staff by on-going work to improve risk management plans, new emphasis within Trust on involving patients in their risk assessment, Pharmacy providing training to RT clinical staff, and on-going work in Trust to improve adherence to National Early Warning Score (NEWS) standards. Actions to improve datix reporting. To consider if more frequent RT training would be possible.
6	POMH - Topic 17a - Use of depot/LA antipsychotic injections for relapse prevention (May 2017) – 3475	This is a new topic within the POMH programme of national audits. The standards are derived from NICE Guideline CG178 'Psychosis and Schizophrenia in adults: prevention and management'. The audit aims to review practice against standards for use of depot/LA antipsychotic injections for relapse prevention.	Work being done around care/safety plans for patients without care co-ordinators as the patient is outpatient only or depot clinic. Also work on template/standard wording to be agreed around recording the patients relapse signatures and for clinicians to discuss and document these at patient's appointment.
7	Summary POMH Topic 1g & 3d: Prescribing high dose and combined antipsychotics on adult psychiatric wards (3474)	This was a re-audit of prescribing of high-dose and combination antipsychotics. . Though this is the 7th time that POMH has run this audit, and the 6th occasion that Berkshire Healthcare NHS Foundation Trust has taken part (2008 was missed), the last time this was audited as part of the POMH programme was back in 2012.	1. Trust high dose antipsychotic guidelines have been revised for review by the Trust Drugs and Therapeutics Committee. These guidelines will have more focus and clarity around roles of different staff groups. Revised concise guidelines to be circulated to inpatient medical, pharmacy and nursing staff through consultants meeting, Patient Safety and Quality meetings, pharmacy meetings, and nursing development programmes. 2. The high dose monitoring has been revised as part of the revision of the guidelines to improve layout and ease of use- this includes the physical health monitoring required when a patient is prescribed high dose antipsychotics. 3. To develop an e-form for monitoring on RiO with the RiO transformation team. The RiO transformation team has started building this e-form.

Appendix C- Local Clinical Audits- Actions to Improve Quality

	Audit Title	Conclusion/Actions
1	JD/QIP - Audit of VTE assessment and prophylaxis on Orchid and Rowan Wards (Prospect Park Hospital) (3519)	The purpose of this re-audit is to establish if all patients admitted to old age psychiatry wards had Venous Thromboembolism (VTE) risk assessment on admission in accordance with NICE venous thromboembolism quality standard and Berkshire Healthcare NHS Foundation Trust guidelines. Following review of this audit at a clinical effectiveness meeting, immediate measures were put in place to mitigate the risk associated with current practice and policy. The Trust policy has been changed to reflect current NICE recommendations and will be reviewed by the Drugs and Therapeutic group before final approval. Senior medical staff working on the wards have been made aware of the up-to-date good practice which is being followed.
2	Evaluation of the Behavioural Activation intervention work in CAMHS A&D pathway (2623)	The aim of this project is to conduct an audit on consecutive cases receiving Brief Behavioural Activation (BA) in the Trust CAMHS Anxiety & Depression Pathway, to assess feasibility and acceptability of this specific approach. If the findings from this audit are replicated in such studies as are recommended, brief BA should become a standard standalone treatment option offered to depressed adolescents within Trust CAMHS. This however is a long-term goal.
3	Treating comorbid anxiety and depression: A comparison of one vs. multiple interventions. (2717)	The main objective is to compare the impact of one vs. multiple simultaneous Cognitive Behavioural Therapy (CBT) interventions for patients with comorbid anxiety and depression. In patients with clinical levels of depression and anxiety of equal severity, there is no advantage of a broader treatment addressing both anxiety and depression compared to a treatment focused on depression
4	JD/QIP - Audit on implementation of Positive Cardiometabolic Health Resource in Prospect Park Hospital Acute Adult Inpatients (2924)	The overall aim of the audit is to assess compliance with the Lester Tool and associated Commissioning for Quality and Innovation (CQUIN) targets. Greater awareness of the Lester tool amongst staff, should lead to improved monitoring.
5	Delirium NICE Quality Improvement Re-audit (3246)	The aim of the delirium project is to improve the outcome and experience of patients at risk of or diagnosed with delirium by ensuring that best practice is followed in line with NICE Quality Standard 63- Delirium. The re-audit has shown that risk has reduced compared with the initial audit; however there is still scope to improve. Failure to identify and manage patients with delirium is associated with significant increased risks for the patient. People with delirium are likely to have longer and more complicated hospital stays (pressure sores, increased risk of falls etc.). They are also more likely to be admitted to long-term care when they leave hospital. There are also cost implications from failures to recognise delirium.
6	Audit of confidence in continuing use of techniques and managing relapse after Cognitive Behavioural Therapy (3252)	The aim of this is to improve client confidence in maintaining and continuing with progress after therapy. Therapy summaries have been recognised as helpful to both staff and clients.
7	JD/QIP – Multi- Disciplinary Team (MDT) documentation in Prospect Park Hospital acute wards (3290)	The objective of this audit is to assess the current practice of Multi-Disciplinary Team (MDT) documentation in order to analyse what improvements can be made. This audit has been useful in highlighting practice regarding use of MDT templates. Whilst a form is now available on RiO (the electronic patient record), staff will still need to be made aware of the importance of completing MDT forms with as many disciplines as possible attending and contributing to make the MDT meeting meaningful. A potential risk exists of poor patient management or significant events if the MDT meetings are not utilised effectively or documented accurately. Ward managers or consultants in charge need to take a lead in implementing a standardised MDT template as well as ensuring complete documentation

	Audit Title	Conclusion/Actions
8	JD/QIP - Establishing and monitoring the physical health needs of patients in Reading Short Term Team (3408)	This project aims to establish the physical health needs and prior diagnoses of patients referred to the Short Term Team at the time of referral and whether these have been identified or addressed appropriately by community mental health services during contact. As a result of this audit a prototype proforma for easily and intuitively requesting specific physical health monitoring tests from the GP has been designed.in addition, since this audit an electronic shared summary care record has been implemented within outpatient and inpatient psychiatric services at Prospect Park Hospital for easy access of historic and up to date patient information from GP to psychiatric services
9	Safe Handling and Disposal of Sharps Audit 2017 (3424)	The aim of the project is to identify whether sharps are handled safely to prevent the risk of needle stick injury, to assess practice and the correct use and management of sharps equipment, to assess staff knowledge relating to the management of an inoculation injury, and to ascertain the current level of compliance with Health and Safety Legislation across the Trust. A clear and well understood process for management of sharps will mean that any risk to staff and patients is minimised.
10	An audit on the management of nongonoccocal urethritis. (3444)	Nonspecific urethritis (NSU) is often a preliminary diagnosis in men who have lower urinary tract symptoms. Recently there has been a rise in treatment resistant NSU predominantly due to Mycoplasma genitalium and in the UK most centres do not test for this. A programme of education about the most up to date guidance is shared with staff to ensure best practice recognition and management.
11	Blood transfusion bed side audit (3460)	The aim of the audit is to ensure that the Trust's blood transfusion practice is in line with the required National Standards. A plan is being implemented to ensure all prescribers of transfusions are made aware of the criteria for NICE Clinical Guideline 24 and Quality Standard 138 when a referral is made for transfusion.
12	Audit of Routine Assessment for Home Treatment Team (3496)	The Royal College of Psychiatrists have set a series of standards for the Home Treatment Accreditation Scheme (HTAS) which have been accepted nationally. As part of this scheme there are recommendations for routine assessments when patients are referred to the team. The Royal College of Psychiatrists have developed standards for Home Treatment Teams and after thorough assessment if a service meets these standards provides accreditation. The Trust achieved accreditation from the Home Treatment Team Accreditation Scheme (HTAS) in September 2016.
13	Fluenz PGD Audit (3531)	This audit has been undertaken to review the consent forms of children who were administered the Fluenz Tetra nasal spray. Immunisation policy updated to add in additional measures around consenting very young children for nasal flu.
14	Management of anogenital warts in the sexual health service (3565)	The audit was undertaken to look at Garden Clinic standards of adherence to treatment algorithms, clearance rates and internal standards associated with diagnosis and management of anogenital warts. Obsolete clinic guidelines are being replaced with current national guidelines. Improvements to documentation and dynamic forms will support accurate recording.
15	Audit of compliance with sepsis early recognition tool community health inpatient units (3563)	This audit was undertaken to ascertain baseline compliance following the implementation of the sepsis early recognition tool. Within Berkshire Healthcare timely recognition and diagnosis of sepsis via identification and management of the deteriorating patient, including escalation, are key interventions in reducing mortality rates due to sepsis.
16	Re-audit of Antimicrobial Prescribing on all Trust Inpatient Wards 2016-17 (3494)	This audit monitors compliance with local standards for safe antimicrobial prescribing and practice, and national (Health and Social Care Act) requirements. This project supported the role-out of improving Antimicrobial Stewardship (AMS) awareness and face to face training sessions across all inpatient sites and sharing and spreading the Trust improvements across the other Trusts within the Thames Valley and Wessex region.

	Audit Title	Conclusion/Actions
17	An Audit on the Anticholinergic Cognitive Burden (ACB) in the Elderly population within Prospect park Older Peoples Mental Health (OPMH) wards (3045)	Anticholinergic cognitive burden (ACB) is the cumulative toxicity of anticholinergic medications leading to reversible mild cognitive impairment (MCI). The study successfully highlighted areas of patient care in need of improvement and recommended ways in which to reduce risk levels. High ACB was a prevalent problem across both groups. Poor compliance with the standards suggested limited awareness of ACB in practice, although there was some evidence of risk-mediation in the dementia population.
18	JD/QIP - Testing for blood borne virus infection in mental health inpatients (3479)	The aim of the project is to determine whether patients on the inpatient psychiatric ward are being offered testing for blood borne virus (BBV) infections. The project will raise awareness amongst psychiatry trainees and nurses about the prevalence of undiagnosed HIV in mental health inpatients, the risk factors for infection, the protocols/procedures involved in testing and what to do with a positive/negative result (information about local HIV services).
19	JD/QIP - Re-audit of assessment and management of pain in patients with dementia in a psychiatric inpatient ward (3561)	Pain is commonly experienced by older people and it is known that in patients with dementia it is under-recognised. Two recommendations by the Royal College of Anaesthetists suggest effective management of pain by regular assessment in all older patients. In comparison to the previous audit, this re-audit found similar results in terms of under recognition of pain management. There is still much potential for improvement as previous recommendations appear not to have been met in ensuring that pain assessments were included in routine observations.
20	Audit of arrangements for clear and accurate information exchange based on NICE Quality Standard 15, Statement 12 (3430)	The aim of the project is to ensure that there are local arrangements in place to support coordinated care through clear and accurate information exchange between relevant health and social care professionals. There are local arrangements in place to support coordinated care through clear and accurate information exchange between relevant health and social care professionals.
21	Cardio Metabolic CQUIN for Mental Health – Inpatients (IP), Community Mental Health Teams (CMHT) & Early Intervention in Psychosis (EIP) (2016/17) (3346)	This audit was as a National Commissioning for Quality and Innovation (CQUIN) project for 2016/17 and therefore a contractual requirement with an associated payment based on outcomes. The audit was conducted by the Royal College of Psychiatrists (RCP). It requires all patients to have a number of physical health screenings and interventions or referral for interventions when the screening meets a threshold (Identified by the national Lester Tool). More patients have received the full complement of recommended healthcare screening checks, across a range of EIP, IP and Community mental health services.
22	An evaluation of Paliperidone Palmitate within the Trust (1508)	An evaluation of the cost effectiveness using Health of the Nation Outcome Scales (HoNOS) and clustering and also a measure of whether patients are satisfied with the new treatment. Patients with schizophrenia prescribed Paliperidone Palmitate Long Acting Injectables (PPLAI) showed a significant improvement in mean Care Cluster scores when these are linked to payment (indicating lower costs of mental healthcare), a reduction in the Severe Disturbance factor, and a faster discharge from hospital at the point of initiation, as well as an increase in medication satisfaction.
23	Care Contact Time (2829)	As part of the national safer staffing expectations all Trusts are required to ensure that their wards undertake care contact time analysis on a regular basis. Wards have their data and are able to review how their time is spent with the initial aim of focusing on % of time was spent on non-patient facing non- patient related activity to ascertain if this could be converted into patient facing time.

	Audit Title	Conclusion/Actions
24	JD/QIP - Establishing and monitoring the physical health needs of patients in Reading Short Term Team (3408)	This project aims to establish the physical health needs and prior diagnoses of patients referred to the Short Term Team from Spring - Summer 2016 at the time of referral and whether these have been identified or addressed appropriately by community mental health services during contact. As a result of this audit a prototype proforma for easily and intuitively requesting specific physical health monitoring tests from the GP has been designed.in addition, since this audit an electronic shared summary care record has been implemented within outpatient and inpatient psychiatric services at Prospect Park Hospital for easy access of historic and up to date patient information from GP to psychiatric services, which should improve compliance to improving shared care via the GP summary on re-audit and ensure that important physical health problems are not missed.
25	Re- Audit of Patient Consent to Sharing Information based on NICE Quality Standard 15, Statement 13. (3428)	The aim of this re-audit project is to ensure that patients' preferences for sharing information with their partner, family members and/or carers are established, respected and reviewed throughout their care. Patients' preferences for sharing information with their partner, family members and/or carers are established, respected and reviewed throughout their care.
26	Assessment of compliance of healthcare workers practice with policy & best practice in patients requiring intravascular devices (3476)	The aim of this audit is to assess compliance of healthcare workers practice with policy and best practice when providing care for patients. This audit is part of the Berkshire Healthcare annual infection prevention and control audit programme 2016-17. The audit of the vascular access devices demonstrated excellent results achieving 100% compliance with all criteria of safe insertion, maintenance and removal of devices as per the Berkshire Healthcare policy and NICE guidance.
27	ASD/Anxiety Evaluation - Factor Structure and Measurement Invariance of the SCAS-P (1925)	The SCAS-P is used to assess anxiety in children with Autism Spectrum disorders (ASD) but its validity has not been established. The team compared the psychometric properties of the measure between young people with anxiety who were assessed at the Berkshire Child Anxiety Clinic and other young people with anxiety / ASD (recruited from outside the Trust) and to disseminate this further by publishing the findings in a peer-reviewed journal. Cross-group comparisons between ASD and anxious samples based on the SCAS-P scores may not always be appropriate.
28	Service evaluation of frequency pain flashbacks in patients at the Berkshire Traumatic Stress Service (2738)	The objective of this service evaluation is to analyse routinely collected data from patients assessed at the Berkshire Traumatic Stress Service to identify the prevalence of this experience in this population. The present study served two purposes: to determine the prevalence of pain flashbacks, and to begin the development of a measure. Clinicians could be encouraged to ask about pain and other somatosensory experiences, and to target these in therapy.
29	Promoting Dysphagia Awareness of Safety and Quality of Care in Patients with Swallowing Disorders (3295)	The aim of this project is to reduce numbers of incidences by 80% of non-compliance with dysphagia best practice recommendations by imparting dysphagia awareness training to housekeeping staff on the Acute Stroke Unit. The project highlighted areas of patient care requiring improvement and implemented actions to increase compliance and staff confidence. The project led to a significant increase in patients on modified dysphagia diets being offered drinks compliant with Speech and Language Therapist recommendations, thereby improving patient care.
30	Audit of Sharps use in Berkshire Eating Disorders Service (3425)	This audit is to review the safe handling and disposal of sharps within the Eating Disorders Service based at St Marks Hospital Ongoing audit is an important tool in the Quality Improvement process for managing sharps.
31	Compliance with HTM01-05 in the Dental Environment (Dental decontamination) - 2016/17 (3450)	The aim of the audit is to assess the salaried dental services' ability to comply with the essential quality requirements as set out in HTM 01-05 - Decontamination in Primary Dental Practices, in relation to the environment and their use of personal protective equipment. Good infection control and decontamination practices are essential in dental services in order to minimise the risk of infection to both patients and staff.

	Audit Title	Conclusion/Actions
32	EIPN Self-Assessment Tool (3452)	Monitoring of Early Intervention in Psychosis (EIP) services following the 2016 National audit (ID:2880) will be through participation in a quality assessment and improvement programme, organised and administered by the College Centre for Quality Improvement (CCQI). The EIP service monitors it's compliance levels closely, to ensure best practice is delivered, via a range of means.
33	JD/QIP Capacity and consent relating to Medication decision in the memory clinic (3533)	Documentation of the diagnosis and capacity to consent to medication prescribed in memory clinics is necessary in order to demonstrate that memory clinics are acting ethically and that they meet standards set by the Department of Health and Care Quality Commission (CQC) amongst others. The findings of this audit are being shared, and will feed into the accreditation process.
34	Do Not Resuscitate Forms (3638)	The aim of the audit is to review the "completeness" of the Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) paperwork used across the Trust, evidence discussion with patients re DNACPR , where possible, review involvement of "relevant other" e.g. Next of kin, family member in discussion re DNACPR, and address CQC findings as part of Good to Outstanding process. Although the audit has had its limitations it has been able to demonstrate improvements and clear areas that need further work which will assist in focusing action plans for both Community Nursing Teams and inpatient wards.
35	Evaluating HIV positive patients adherence to anti retro viral therapy (Slough 2016) (3371)	The topic is important to explore reasons and barriers for adherence/non adherence of anti-retro viral therapy. The aim is to explore what can/does help patients to be adherent. To project helped the service to gain up to date and local information from patients in the Slough area as there was no recent and local research available at present.
36	JD/QIP - Quality Improvement Project on Handover using Situation, Background, Assessment, and Recommendation (SBAR) between Nursing staff and Out of Hours (OOH) doctors (3394)	The aim of this project is to establish whether clinical staff (doctors and nurses) working out of hours (anything outside normal working hours of Monday to Friday 09:00-17:00 excluding bank-holidays) are aware of the SBAR handover system and, if so, whether they use it and are confident in doing so. This project highlighted that further work needs to be undertaken into improving current handover systems and practice.
37	JD/QIP - Radiology referrals (2015-2016) from Prospect Park Hospital to Royal Berkshire Hospital: audit of the referral process (3395)	This project aimed to review the Radiology referral process from inpatient wards at Prospect Park Hospital to the Royal Berkshire Hospital Radiology Department to improve the process of direct Radiology referrals, improve the quality of these referrals and to increase junior doctor awareness and improve completeness of referral forms, thereby improving quality of Radiology reports. Awareness of this audit and its dissemination to doctors provides potential for higher quality and more comprehensive referrals to Radiology, and in turn, higher quality reports received back from Radiology.
38	MPharm Student Project: Investigating shared care arrangements in mental health prescribing (3419)	The purpose of this study is to investigate issues around shared care arrangements in mental health prescribing. Stereotypes of mental illness allude to the ideologies reinforced by society. The study allowed for a range of media to be examined to understand the representation of drugs, mental health and pregnancy and the predominant themes relating to these concepts. Greater understanding of preconceptions can support adherence conversations.
39	An evaluation of multidisciplinary team meetings in a community mental health team (3446)	The aim of this project is to gather data to determine whether staff in the Community Mental Health Team feel that their Multi-disciplinary Team (MDT) meetings are effective, following structure change. Effective use of staff time in meetings allows patient face-to-face care to be increased.
40	JD/QIP - Psychotropic drug prescribing for people with intellectual disability (3501)	The aim of this audit is to determine the level of compliance with the current practice standards for psychotropic medication prescribing in intellectual disabilities as highlighted by the report of the Faculty of Psychiatry of Intellectual Disability, Royal College of Psychiatrists. The results from this audit demonstrated that overall, regular reviews of patients on psychotropic medication in the Reading and Newbury Community Teams for People with Learning Disabilities (CTPLD) are taking place.

	Audit Title	Conclusion/Actions
41	JD/QIP Evaluation of Use of Interpreters for Reading Common Point of Entry (CPE) Assessments (3560)	This audit evaluated Reading secondary service Community Mental Health Team's use of interpreters in accordance with principles set out by NHS England for high quality interpreting and translation services for primary care services. All patients included in the audit had documentation indicating that an interpreter had been booked for the CPE appointment.
42	Trust re-audit of POMH Prescribing for substance misuse: alcohol detoxification (3405) – Local re-audit of POMH topic	In August 2016 we reported on the POMH-UK alcohol and substance misuse audit to the Trust Quality Assurance Committee. There were certain areas where the Trust performed poorly, in comparison to other Trusts. As a result, the Quality Assurance Committee requested a local re-audit in 12 months' time to give assurance that improvement had been made. The 6 standards that were re-audited from the original POMH audit had all increased in compliance bar one ('documented assessments of the signs and symptoms of Wernicke's encephalopathy'). The lead Consultant raised this at the junior doctors' induction in Aug 17 and followed it up by emails to all trainees. Clinical Governance Nurse and psychiatric trainee will undertake monthly audits of 5 patients per ward on the use of the alcohol screening questionnaire and will attend the MDT on each ward to discuss expected compliance with Alcohol Detox
43	To Improve Compliance with Physical Health Monitoring for Service Users on Antipsychotic Medication in Slough Community Mental Health Team (CMHT) (3624)	The aim of the project is to improve compliance with regards to physical health monitoring for patients on antipsychotic medications. Attention to the physical health of patients is part of a holistic approach, and has been recognised as an increasingly important part of the work within mental health services (Rowlands, 2013). Work is on-going through CQUINS on Physical Health monitoring Trust wide
44	Evaluation of a treatment for childhood anxiety (the 'overcoming' programme).(3041)	This is an evaluation of treatment for childhood anxiety in which parents are taught the principles of cognitive behavioural therapy either in groups or individually (the 'overcoming' programme). Promising Results regarding children's outcomes following Group GPD-CBT. Group GPD-CBT was viewed by clinicians as acceptable and helpful. There is a need to develop and evaluate low-intensity treatments for childhood anxiety disorders in order to improve accessibility to psychological treatments.
45	Re-Audit- People whose Behaviour Challenges - Care Pathway (April 2017) (3535) – Local Audit	The publication of national guidance on working with people whose behaviour challenges the service prompted our service to agree a number of tasks designed to address the issues raised. The guidance stressed the importance of multidisciplinary and consistent approaches to the assessment and intervention of behaviour plans. The audit demonstrated areas of excellent practice with the vast majority of findings meeting standards 100% of the time a part from one 98%. The audit also demonstrated that our original Good Practice Standards and the more recent NICE Quality Statements are both being met to a very high degree.
46	JD/QIP Re-audit: Provision of Verbal and Written Drug Information on Adult Inpatient Psychiatric Wards (3659	The aim of this re-audit is to examine the provision of verbal and written information to adult inpatients prior to introducing a new psychotropic agent. This audit was undertaken as a part of audit cycle to assess whether recommendations from previous audits were followed and whether it has yielded any improvement in our practice. Encourage team to use the new template whenever changing/introducing new medication to avoid any possibility of under-recording of information. Create a separate form to fill in if it is felt that the capacity is not likely to change and repeated MCA forms are not required. This may be accessible in patient's care plan and improve record keeping practice. Make staff aware of existence of any leaflets available on the ward. This could be included in induction package. It has been shown that amount of information retained following verbal information alone is very limited. Therefore providing written information for patients to confer to and supplement their understanding is important.

	Audit Title	Conclusion/Actions
47	Berkshire Eating Disorder Unit Risk Assessment and Record Keeping Audit (3418)	This audit aims to investigate the service's compliance with standards relating to risk assessments and record keeping. Clinicians within Berkshire Eating Disorder Service (BEDS) should conduct their own risk assessment during assessment, reviews and discharge communicated with relevant other professionals. All staff made aware of policies and allocated dedicated admin time at the end of the day. Appropriate management support provided to improve confidence. Audit report and the action plan to be put on service shared drive and monitored. Findings and main actions to be presented at October 2017 Business meeting. Clinicians to identify sufficient administrative time in consultation with their clinical supervisors.
48	Management of cases of early infectious syphilis in the Service. (3520)	The main aim of the audit is to assess performance against auditable outcomes specified in the guidelines. All services should ensure that an appropriate contact action is agreed and pursued for every contact of individuals with early syphilis, including documenting where no action is taken because a contact is deemed to be uncontactable. Caution is needed in recording and interpreting PN outcomes, especially as regards contact attendance reported by the index patient Consideration should be given to early follow-up HIV testing of individuals with syphilis, as an opportunity to diagnose seroconversion. The service is reviewing whether any actions are required from these results at present. No concerns have been highlighted.
49	Re-audit following audit of personal practice for autism diagnosis in children in 2015 (3534)	The primary aim of the audit is to compare clinical practice with the best practice criteria listed in NICE Clinical Guideline 128—Autism Diagnosis in Children and Young People. In response to the findings, further analysis of CDC data has been requested and a meeting to explore ways of working which could reduce the delays in the assessment process. The service has also been made aware of the NICE recommendation—'Start the autism diagnostic assessment within 3 months of the referral to the autism team'. A meeting is arranged (health and social care partners involved in the ASD referral and assessment pathway) to agree upon measures to improve waiting times.
50	Audit of discharge summary from Berkshire Perinatal Mental Health Services (3800)	The aim of this audit is to evaluate the quality of discharge summaries compared with standards from the Perinatal Community Mental Health Services of the Royal College of Psychiatrist Quality Network for Community Mental Health Perinatal Teams. There was variation in the format and content of the discharge summaries. Whilst for Initial Perinatal Assessments the perinatal team uses a standardised assessment form that collects the same data for all patients, this is not in place for Discharge Summaries. Standardised the discharge summary to be used by perinatal clinicians.
51	Access and Waiting Time for Berkshire community Perinatal Mental Health services (3833)	This audit aims to compare waiting times with the standards introduced by NICE in 2016 and aims to compare the waiting time with the standards introduced by NICE, 'Implementing the Perinatal Mental Health Evidence Based treatment Pathway. The result of this audit is excellent. Therefore, no action recommended for the practice.
52	Audit of use of Dementia Assessment Integrated Care Pathway in Learning Disability Services (3875)	The aim of the audit is to ensure the new care pathway had been fully implemented into practice. Lower rate of completion of some of these items may reflect omissions in documentation, rather than omissions in clinical practice a new assessment tool being introduced for a group of staff; uncertainties about when to upload documentation onto RiO as completing the Care Pathway can be a lengthy process; and turnover of staff meaning that the Care Pathway may not be familiar to all Community Team for People with Learning Disability (CTPLD) staff. Audit findings to be fed back to staff, dementia planning meetings to be undertaken in all teams, training provision for staff will include how to use the Dementia Assessment care pathway.

	Audit Title	Conclusion/Actions
53	Service evaluation of effectiveness of specialist Multi-Disciplinary Team (MDT) tics clinics for neurodevelopmental and psychoeducation in East Berks CAMHS (3339)	This service evaluation was undertaken after the decision was made within East Berkshire to group referrals for tics so that they could be seen together and as part of a joint assessment. This model was based on the National Tourette Service at Great Ormond Street Hospital and was put in place due to the identification of patients with tics being poorly triaged and waiting a long time for assessment. During the project, staff realised that it was appropriate to discharge almost half the sample with just education (and no CAMHS input). These earlier discharges were achieved due to the introduction of an Assistant Psychologist phoning patients to provide advice, thereby reducing unnecessary appointments. Earlier discharges freed up appointments, thereby reducing waiting times and the need for medication. During feedback of these results to CAMHS clinicians, it was suggested that current practice could be audited in other business units for comparison data. Other further models of care have been suggested, in line with the Anxiety and Depression Pathway model. It is possible that this service may be eligible to participate in the National Audit of Anxiety and Depression.
54	Evaluation process for the MAP pressure monitoring system (Sidhill) (3357)	The M.A.P™ system is a continuous bedside pressure monitoring tool that enables nurses and carers to monitor bed-bound patient's optimal pressure distribution in order to reduce the risk of pressure ulcers. It uses a pressure sensing mat to identify high and low pressure areas between the patient and the support surface. The mat is linked to a monitor displaying a real time, high resolution image defining at-risk pressure points, giving accurate data to enable staff to reposition patients so that optimal pressure distribution is achieved. This tool proved to be useful as a teaching resource. It was decided that due to cost, the tool would not be purchased for the Trust, but would be hired as and when required.
55	Management of Anogenital Warts (C11A) at first presentation (3565): March 2017	Anogenital warts caused by the Human Papilloma virus (HPV) are the second most common sexually transmitted infection (STI) in the UK and most common STI of viral aetiology. The aim of the project was to measure clinical practice against auditable standards both from the British Association of Sexual Health and HIV (BASHH) as well as internal standards so that improvements can be made in areas of poor compliance. Actions include replacing the Garden Clinic guidelines with current BASHH guidelines; to add additional features to Lilie and provide training to staff; to update female dynamic forms; and to improve documentation of discussions with patients.
56	Is the transfer of physically ill patients from and to Prospect Park Hospital (PPH) in accordance to Trust Guidelines? (3880): October 2017	The burden of physical health problems increases with age and this is of particular concern in those patients with a co-existing mental health disorder. Berkshire Healthcare and PPH have created guidance to enable efficiency when transferring patients out of and back to PPH for acute medical problems, Procedure for the transfer of mental health inpatients to and back from physical treatment. Discussions with clinical colleagues and observation of concurrent guidance (Royal Pharmaceutical Society, 2011; DH, 2017) led to some key recommendations for action. These relate to providing a laminated checklist including handover, drug chart, s17 leave, informing relatives and informing doctors of review. Other actions include reminding staff to print EPMA drug charts when transferring patients out, and to complete handovers, which will be discussed at staff induction. At daily handovers, staff will now be reminded to attempt daily contacts with relatives/carers.
57	Evaluation of the Lower Limb Class (3898): November 2017	The purpose of this service evaluation is to evaluate the effectiveness of the Lower Limb Exercise Classes (LL class) run across Wokingham and Newbury outpatient physiotherapy sites. Actions relating to: obtaining more pre- and post- class PSFS scores; standardising the number of sessions across both localities; routinely enquiring about maintaining physical activity post discharge; and adapting the audit tool at re-audit are being implemented.

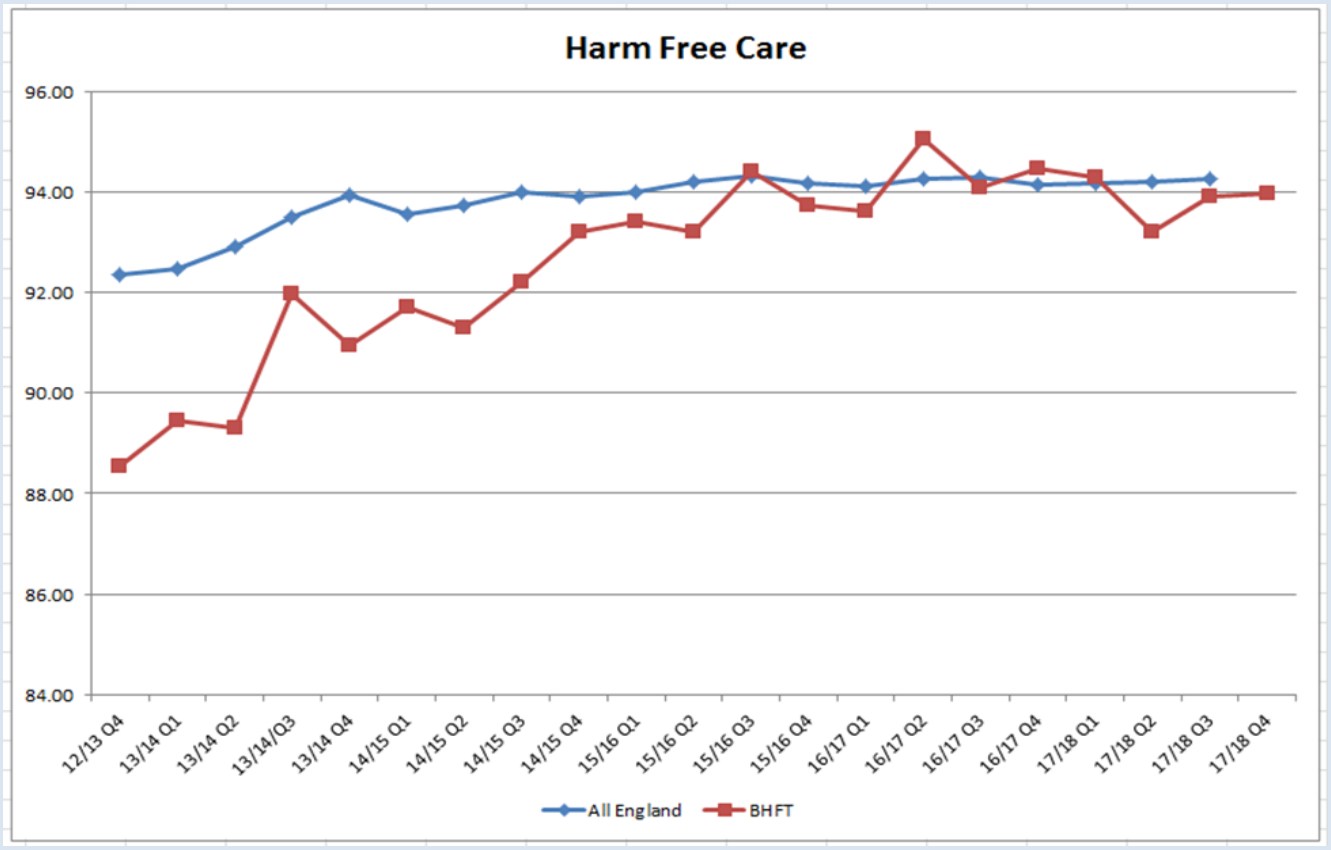
	Audit Title	Conclusion/Actions
58	Clinical Supervision Re-Audit -3943	The purpose of the re-audit of Clinical Supervision is to establish the level of compliance with the clinical supervision requirements outlined in policy CCR097 and to measure any changes in practice since the 2015/16 re-audit. Recommendations: Services across the Trust review their use of reflective diaries and actively encourage all clinical staff to complete them. Children's services review and formalise their protocols and arrangements for access to clinical supervision and provide clinical supervision training to supervisors and supervisees. Children's Services, East & West Physical Health Services and West Mental Health Services should make improvements with monitoring supervision attendance and non-attendances.
59	Re audit on the management of Gonorrhoea in the integrated sexual health service – 3279	The purpose of this re-audit is to measure current practice relating to management and treatment of gonorrhoea against standards developed from Public Health England's Gonococcal Resistance to Antimicrobials Surveillance Programme, BASHH Guidance for the Management of Gonorrhoea in Adults (2011) and Local Guidelines. Recommendations/actions: Development of an appointment system for TOC when given medications, fast track appointments and/or home tests. Improving documentation of information and health advice given during consultation –add a tick-box to the new IT system. Completing microscopy slides for all asymptomatic patients. To educate new staff as part of their induction.
60	Case Conference reports – 3562	The purpose of this audit is to re-audit the two standards which evidenced less than 90% compliance, and to also audit the quality of CAMHS Child Protection Case Conference Reports as recommended in the action plan. Actions: Named professionals for safeguarding children to discuss the findings with CAMHS practitioners at their management meetings and also to highlight the issue with the CAMHS management team. Main focus to be Trust safeguarding policy and procedure, the voice of the child, think family approach and the role of CAMHS in the safeguarding process. CAMHS to include safeguarding as part of induction. CAMHS staff to be reminded during supervision to use the Berkshire Healthcare template. Ensure child protection conference invites for CAMHS practitioners are being reviewed by CAMHS
61	Audit of Perinatal Mental Health Evidence (Amir Sam) Report-2017 – 3884	This audit aims to assess compliance with the standard outlined in Pathway 4: 75% of women with a perinatal mental health problem who are referred for psychological interventions, such as those provided by primary, secondary and tertiary care, start treatment within six weeks of referral. In relation to Pathway 4 which was the focus of the audit no actions were required as the standard was met in 100% of cases audited
62	JD/QIP - Clinical audit of the assessment of delirium at Wexham Park Hospital – 3927	This audit evaluated the proportion of medical admissions at Wexham Park Hospital, Slough, who were assessed for delirium. The tool mandates that the following group of patients must be assessed for delirium: age 75 and above or current confusion. Recommendations include: Increase of compliance of the 4AT tool through education. Creation of a standard question mandatory for all medical admissions, to capture patients at risk of delirium according to NICE but missed by hospital screening requirements. This may also prompt the user to complete the 4AT tool if 'yes' has been answered and can therefore increase compliance.
63	Qualitative Minor Injuries Unit notes audit 2017 – 3995	This audit was completed to ensure that certain criteria relating to note-taking were met. Standards were developed through discussions with staff to determine a consensus of opinion on minimum requirements for a set of clinical notes. The aim is to ensure that notes are high quality and that staff are able to easily understand notes written by other Practitioners. Member of staff incorrectly recording medical history on Adastra educated in correct procedure. Results and comments from audit disseminated to all staff through clinical governance newsletter. Continue audit on a bi-monthly rolling process. Involve other clinical staff in data collection as a way of sharing learning from practice by reviewing each other's notes.

Appendix D Safety Thermometer Charts

ⓘ Developed for the NHS by the NHS as a point of care survey instrument, the NHS Safety Thermometer provides a 'temperature check' on harm, that can be used alongside other measures of harm to measure local and system progress in providing a care environment free of harm for our patients. It allows teams to measure harm and the proportion of patients that are 'harm free'

When interpreting the charts below, it should be noted that this Safety Thermometer data does not show the total number of each type of harm for the Trust, but only those that are recorded at a specific point in time each month.

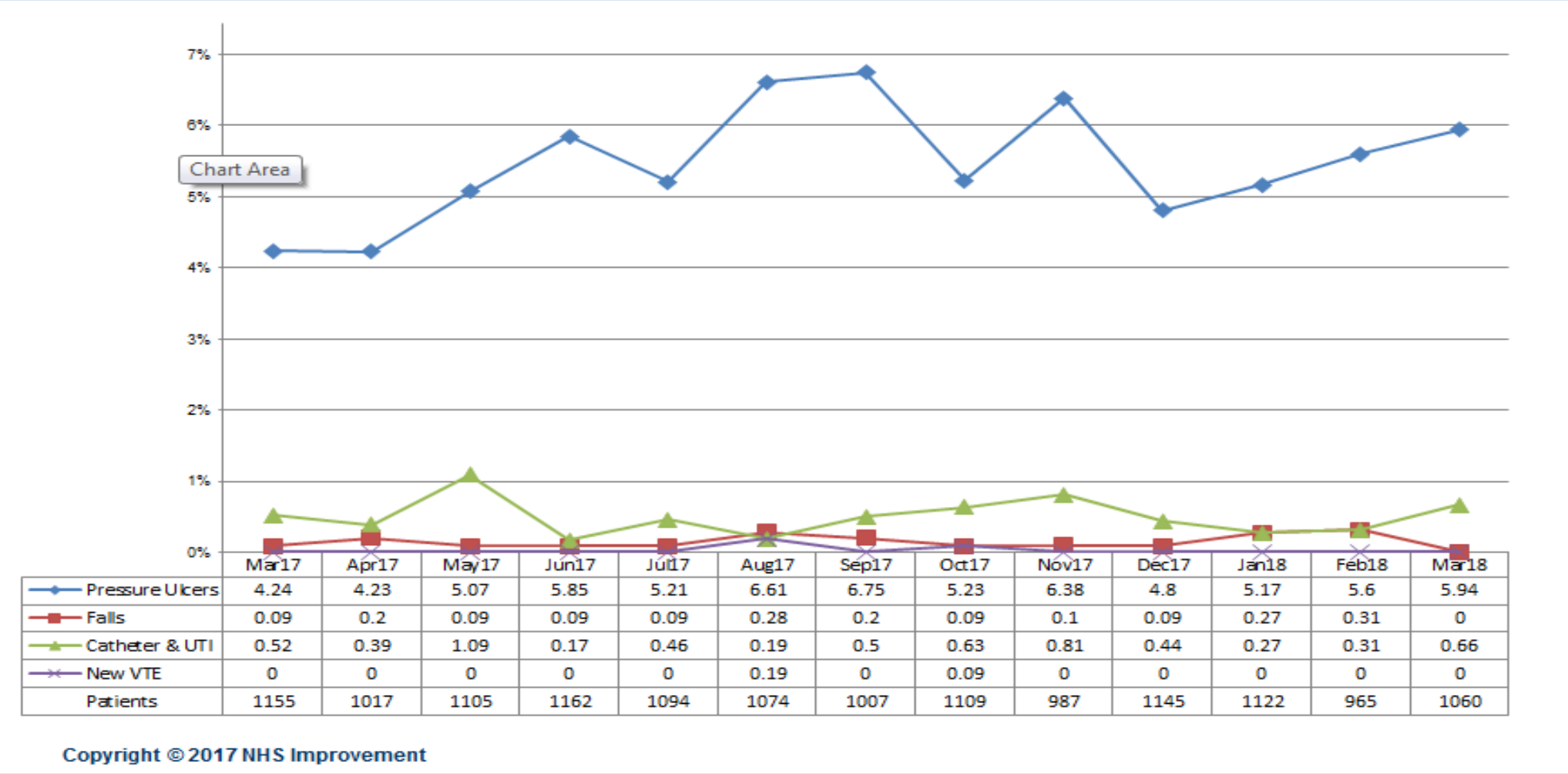
The figure below shows the percentage of harm-free care reported on the patient safety thermometer.
Harm Free care in Berkshire Healthcare has shown some improvement with 94% in Q4, 93.9% in Q3 and in Q2 it was 93.2%. These harms include those inherited to the Trust which are largely beyond our influence, such as old pressure ulcers and catheter and old urinary tract infections (UTI) which are almost three quarters of the harms we declare.



Source: Trust Safety Thermometer Reports

Types of harm

The chart below splits the types of harms across the whole organisation. Pressure ulcers remain the highest harm based on safety thermometer data.



	Mar17	Apr17	May17	Jun17	Jul17	Aug17	Sep17	Oct17	Nov17	Dec17	Jan18	Feb18	Mar18
Pressure Ulcers	4.24	4.23	5.07	5.85	5.21	6.61	6.75	5.23	6.38	4.8	5.17	5.6	5.94
Falls	0.09	0.2	0.09	0.09	0.09	0.28	0.2	0.09	0.1	0.09	0.27	0.31	0
Catheter & UTI	0.52	0.39	1.09	0.17	0.46	0.19	0.5	0.63	0.81	0.44	0.27	0.31	0.66
New VTE	0	0	0	0	0	0.19	0	0.09	0	0	0	0	0
Patients	1155	1017	1105	1162	1094	1074	1007	1109	987	1145	1122	965	1060

Source- Safety Thermometer

UTI= Urinary Tract Infection VTE = venous thromboembolism

Appendix E CQUIN Achievement 2017/18 (anticipated)- Awaiting confirmation in May 2018

CQUIN Number	CQUIN Indicator Name	Value
CQUIN 1a	Improvement of health and wellbeing of NHS staff	£427,006.40
CQUIN 1b	Healthy food for NHS staff, visitors and patients	
CQUIN 1c	Improving the uptake of flu vaccinations for front line staff within Providers	
CQUIN 3a	Improving physical healthcare to reduce premature mortality in people with Severe Mental Illness: Cardio metabolic assessment and treatment for patients with psychoses	£427,006.40
CQUIN 3b	Improving physical healthcare to reduce premature mortality in people with Severe Mental Illness: Collaborating with primary care clinicians	
CQUIN 4	Improving services for people with mental health needs who present to A&E.	£170, 802.56
CQUIN 5	Transitions out of Children and Young People's Mental Health Services (CYPMHS)	£170,802.56
CQUIN 8b	Supporting Proactive and Safe Discharge – Community Providers	£341,605.12
CQUIN 9a	Tobacco screening	£427,006.40
CQUIN 9b	Tobacco brief advice	
CQUIN 9c	Tobacco referral and medication offer	
CQUIN 9d	Alcohol screening	
CQUIN 9e	Alcohol brief advice or referral	
CQUIN 10	Improving the assessment of wounds	£256, 203.84
CQUIN 11	Personalised Care and Support Planning	£341,605.12

Appendix F- CQUIN 2017-2019-

Awaiting confirmation in May 2018

Appendix G- Trust Participation in Royal College of Psychiatrists Quality Improvement Programmes and Accreditation Schemes

Berkshire Healthcare NHS Foundation Trust			
Programmes	**Participating services in the Trust**	**Accreditation Status**	**Number of Services Participating Nationally**
ACOMHS: Accreditation for Community Mental Health Services	Bracknell Community Mental Health Team	Assessed – awaiting Accreditation Decision	8
	Wokingham Community Mental Health Team	Assessed – awaiting Accreditation Decision	8
AIMS-WA: AIMS-WA: Quality Network for Working-age Adult Wards	Bluebell Ward, Prospect Park Hospital	Accredited	145
	Snowdrop Ward, Prospect Park Hospital	Accredited	145
	Rose Ward, Prospect Park Hospital	Accredited	145
APPTS: Accreditation Programme for Psychological Therapies Services	Talking Therapies Berkshire	Accredited	32
C o C: Community of Communities	Slough Embrace	Participating but not yet undergoing accreditation	8
ECTAS: Electroconvulsive Therapy Accreditation Service	Prospect Park ECT Clinic	Participating in Accreditation renewal	83
EIPN: Early Intervention in Psychosis Network	Berkshire Early Intervention in Psychosis Service	Developmental Review	155
HTAS: Home Treatment Accreditation Scheme	Berkshire East Crisis Resolution Home Treatment Team	Accredited	54
MSNAP: Memory Services National Accreditation Programme	Bracknell Memory Clinic	Accredited	75
	Reading Memory Clinic	Accredited	75
	Wokingham Memory Clinic	Accredited	75
	OPMH Service Team (Beech Croft Newbury)	Accredited	75
	Slough Memory Clinic	Accredited until July 2018. Currently in review	75
	Windsor, Ascot & Maidenhead OPMH Memory Clinic	Accredited until October 2018. Currently in review	75

Berkshire Healthcare NHS Foundation Trust			
Programmes	**Participating services in the Trust**	**Accreditation Status**	**Number of Services Participating Nationally**
PLAN: Psychiatric Liaison Accreditation Network	Psychological Medicine Service (Royal Berkshire Hospital)	Accredited	81
QNIC: Quality Network for Inpatient CAMHS	Berkshire Adolescent Unit	Participating but not yet undergoing accreditation	130
QNLD: Quality Network for Inpatient Learning Disability Services	Campion Unit	Accredited	41
QNOAMHS: Quality Network for Older Adults Mental Health Services	Orchid Ward	Not accredited	86
	Rowan Ward	Not accredited	86

POMH-UK: Prescribing Observatory for Mental Health
Berkshire Healthcare NHS Foundation Trust – Topic 1g & 3d, Topic 17a and Topic 16a

Appendix H- Statements from Stakeholders

Berkshire Healthcare NHS Foundation Trust – Quality Account 2017/18
Response from the Council of Governors of the Trust

These comments are based on the Quality Account for the third quarter circulated to the 32 members of the Council of Governors for the Trust on the 6th March 2018. This summary is prepared by the Lead Governor, Paul Myerscough.

This report is a good account of the Trust, clearly expressed and with much of interest for all readers. The governors feel that the results shown in the report reflect the actual performance of the Trust.

There is general scepticism among governors about the nationally mandated measure known as the 'Friends and Family Test'. We would prefer that the effort expended on the collection and collating of this data is more focussed on areas of particular concern to patients and staff, where it could lead to a measurable improvement in the services delivered.

There some quality concerns mentioned which governors are aware of, and we appreciate regular updates from management. Several of these relate to staffing difficulties. This is an NHS-wide issue which puts pressure on management in most services.

Unfortunately the results from the staff survey was not available at the time this response was prepared. We would hope to see evidence of an improvement in staff well-being feeding through into the staff retention figures.

All governors were given the opportunity to comment. Much of the input was about format of information, with some requests for clarification of figures and, of course, concern expressed where it appears that performance is not getting better. All feedback is passed on to the team responsible for the report.

Berkshire Healthcare NHS Foundation Trust Response:

The Trust welcomes the feedback from Berkshire Healthcare NHS Foundation Council of Governors. We acknowledge that Members of the Council have contributed their views throughout the development of the account and we value this input.

The Friends and Family Test is a national measure that was originally introduced to support patient choice. We aim to achieve higher than a 15% response rate (this being the minimum for statistical relevance) and in some services, this is being exceeded. There are challenges in some services and the Patient Experience Team is working with the service and Clinical Transformation Team to look at different ways of collecting this feedback, such as via SMS text messaging.

The results of the most recent National Staff Survey have been included in the final version of the Quality Account, and the results have generally shown an improvement.

Responses to individual queries have been included in a separate document and this has been sent to the Chair of the Council of Governors.

Commissioners Response – BHFT QUALITY ACCOUNT 2017/18

Prepared on behalf of East Berkshire and Berkshire West CCG's

Statement

The Clinical Commissioning Groups (CCGs) are providing a response to the Quality Account for Quarter 3 2017/18 submitted by Berkshire Healthcare Foundation Trust (BHFT.)

The Quality Account provides information and a review of the performance of the Trust against quality improvement priorities set for the year 2017/18 and gives an overview of the quality of care provided by the Trust during this period. The priorities for 2017/18 were detailed in the report and these were;

- Patient Experience and involvement
- Patient Safety
- Clinical effectiveness
- Organisational culture

All the priorities if successful will have an impact on patient care and staff satisfaction.

The CCGs support the Trust's openness and transparency particularly in the area of the freedom to speak up programme. The CCGs are committed to working with the Trust to achieve further improvements and successes in the areas identified within the Quality Account. This will be carried out through a number of both proactive and reactive mechanisms and collaborative and integral working.

The Trust's Quality Priorities highlighted in the 2017/18 Quality Account were Patient Safety; Clinical Effectiveness; Patient Experience and Organisational Culture.

The Trust has implemented new processes which enable them to further learn from Complaints and Compliments, which is evidenced in the reduction of complaints in 2017/18.

The CCGs are very supportive of the Trusts project on zero suicides which was initiated in 2016. The programme focuses on challenging attitudes and behaviours and a new risk summary was implemented in 2017. There were a number of goals set for 2017/18 which included achieving a 10% reduction in the rate of suicides of people under BHFT care by 2020/21, demonstrating an increase in positive staff attitude and a having proactive approach to suicide prevention and ensuring families, carers and staff feel supported after a suicide.

The CCGs were pleased that the Trust has acknowledged the disappointing result of the 'Zero Suicide Workforce Survey' which showed that only 50% of the staff reported that they felt the organisation had supported them following their interaction with a patient that had committed suicide and the CCGs hope to see an improvement when the next survey is carried out.

The quality concerns that are raised within the quality account relate to acute adult mental health inpatient bed occupancy, locked wards and shortage of permanent nursing and therapy staff. The CCG echo the concerns that have been raised by the Trust and would like to see a more permanent workforce across all areas and therefore reducing the need to use agency staff and are pleased to see the efforts that are in place in order to achieve this.

It is important that the Trust participates with both National Clinical Audits and National Confidential Enquiries which they were eligible to take part in. This they have done and implemented actions to improve services.

The Trust continues to work on areas which have an impact on patient safety particularly around pressure ulcers and falls and the Trust has met its targets in quarter 3.

The Quality account also highlights other service improvements, which are all having a positive impact on patient care for example Family Safeguarding Service, and the Psychological Interventions in Nursing and Community (PINC) Services

Priorities for 2018/19

The Commissioners have reviewed the priorities that the Trust have set out for 2018/19 and support the Trust in achieving all aspects of the work streams in order for the Trust to be able to achieve an aspirational CQC rating of Outstanding. It is positive to see that the Trust have set some specific targets in order to measure against and acknowledge the hard work that will be undertaken in the following twelve months to achieve these targets. It is recognised that the zero suicide priority is a quality improvement initiative that will take a number of years to have an impact in the Trust as it is concerned with changing attitudes and behaviours.

The Commissioners would like to continue to be informed of any new quality concerns being identified during 2018/19 for the opportunity to support the Trust with these and working with BHFT with future Integrated Care system developments

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Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

Berkshire Healthcare NHS Foundation Trust Response:

The Trust welcomes this response to its 2017/18 Quality Account, prepared on behalf of East Berkshire and Berkshire West CCGs

The Trust welcomes the CCGs support of its 2018/19 priorities and is grateful for the comments made in relation to our achievement in 2017/18.

In relation to the Zero Suicide programme, we value the support of the CCGs and will be carrying out the Zero Suicide Workforce survey again in May 2018. At this point we will measure progress in this area and hope to see an improvement in findings.

We look forward to continuing to work with you to achieve further improvements and successes in the areas identified within the Quality Account, and keeping you informed of progress.

Together we speak louder

healthwatch Wokingham Borough

Healthwatch Wokingham Borough response to Berkshire Healthcare Foundation Trust Quality Account 2018

As the independent voice for patients, Healthwatch Wokingham is committed to ensuring local people are involved in the improvement and development of health and social care services.

Local Healthwatch across the country are asked to read, digest and comment on the Quality Accounts, which are produced by every NHS Provider (excluding primary care and Continuing Healthcare providers). The Quality Account is a lengthy and detailed document (70 pages) containing lots of data, Healthwatch would welcome a summary version that members of the public could access.

Healthwatch Wokingham is still hearing regularly the frustrations of parents waiting to get a CAMHS (Child & Adolescent Mental Health Services) assessment for their child. The main theme appears to be lack of information available to guide them through this process and help manage expectations. We are pleased to see that you are implementing a project specifically exploring the transition from CAMHS into adult services.

With regards your patient experience priorities – Healthwatch Wokingham does not feel that the family and friends is not the best tool to provide good feedback with regards customer satisfaction.
Healthwatch Wokingham is pleased to hear that you wish to involve service users in plans and developments, we would be happy to support this, as we are still hearing frustrations, especially from those accessing Crisis Care and the Community Mental Health Team.

Healthwatch Wokingham has received comments recently about poor communication that creates confusion – things such as contact details on your website being incorrect and professionals being unclear about signposting and pathways.

Our Enter and View project which entailed 11 visits over a period of a week in October 2017. Patients were complimentary about staff attitude, care and friendliness, however the report highlighted the lack of connection between your inpatient services and community mental health services.
We found it a bit contradictory the Quality Account talking about Zero Suicide initiative but then having a goal to better support families after they have been bereaved by a suicide and seeing a "*Help is at Hand*" leaflet as a solution to this.

Our recent visit to Rowan Ward to test out how Dementia Friendly the environment was provides the Trust with some suggestions about how to improve the older adult ward.

Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

Berkshire Healthcare NHS Foundation Trust Response:

The Trust welcomes the feedback from Healthwatch Wokingham.

In relation to the suggestion of a summary version of the report, we currently include a "Quality Account Highlights" section towards the beginning of the document. This shows highlighted trust achievements for the year, followed by a table detailing the Trust's achievements against each of its priorities. We will look into re-naming this section to highlight that it is a summary.

In relation to comments about Child and Adolescent Mental Health Services (CAMHS), the service are constantly reviewing how they can better support families & young people who are waiting, balancing this with the need to

protect as much clinical time as possible to provide care and treatment. They have worked closely with service users and their families to develop all of the information on our on-line resource, available at https://cypf.berkshirehealthcare.nhs.uk/our-services/mental-health-services-camhs/. This provides information about the range of CAMH services provided by BHFT, how each of the services works, what to expect when you attend for an appointment and how to refer.

Referrals to CAMHS continue to increase and, as a consequence of this, although waiting times for the service had been decreasing, they are now starting to increase again. All teams have protocols in place to support people while they are waiting for an appointment. The Autism Assessment team, which has the longest waiting times, work collaboratively with other local services to run an on-line support network that all families referred to the service are given access too. The Anxiety & Depression team have been piloting a programme of workshops designed to help families understand the difficulties they're facing, consider the types of support available and understand what the therapy they offer involves. We are looking to develop this type of support across other teams. All teams have duty workers available several times per week to respond to calls from families. All send information out to families once a referral has been accepted, providing information about the team, self-help information if appropriate, guidance on how to contact the team if they are concerned that things are getting worse and information on what to do in the event of a crisis. The teams also try to give realistic information about waiting times however it is difficult to be accurate as we have to prioritise young people on the basis of their level and immediacy of clinical risk so waiting times vary greatly.

In addition, CAMHs have been reviewing their induction programmes for new staff. This now includes information about all BHFT children's services in order to ensure that all of our staff are informed about all of the services we provide, not just the team in which they work.

In relation to patient experience, The Friends and Family Test (FFT) is a national measure that was originally introduced to support patient choice, by using a standard measure that people could relate to when they give their feedback, and people could understand when they look at the results for different services and organisations. Within the Patient Experience Report, we include a comparison to other local Trusts which shows that we perform well. We aim to achieve higher than 15% response rate (this being the minimum for statistical relevance) and in some services, this is being exceeded. There are challenges in some services, and the Patient Experience Team is working with the services to look at different ways of collecting this feedback, such as via SMS text messaging. There are challenges with some of the client groups and services that we provide, such as Prospect Park Hospital, where historically there is a low response rate and there can be difficulty in separating the quality of the experience to the reason for their admission to hospital. The results of the FFT are available to services on our intranet each month and, importantly, these include not only the recommendation rate and response rate, but the comments which are really powerful. The Trust also undertakes other activity to evaluate patient experience, such as the trust patient survey, learning from compliments and complaints, deep dives and learning from the National Community Mental Health Survey.

Regarding updated information on the Trust Website- the Trust has an automated system in place for services to review their content on our main website twice a year. However, changes do happen in between. Based on your feedback, we will now take this opportunity to review the content update process for our main website to see what additional changes can be made to streamline this further.

In relation to the interface between Trust inpatient and community mental health services, a programme of work to improve interfaces is underway. The first workshop will be held in May 2018.
Zero Suicide is a long-term programme that also benefits from having a goal to support bereaved families. The 'Help at Hand' leaflet is only one element of the support we provide to bereaved families affected by suicide, and we also include face to face support.

The trust appreciates the visit made to Rowan Ward by Healthwatch to test how Dementia Friendly the environment was, and we appreciate the suggestions made for improvements in this area. Our new Modern Matron role, implemented in April 2018 will focus on this feedback.

Appendix I

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST ON THE QUALITY REPORT

To be included once received

Glossary of acronyms used in this report

Acronym	Full Name
ADHD	Attention Deficit/ Hyperactivity Disorder
ACG	Appropriate Care Given
AMS	Anti-Microbial Stewardship
ASD	Autistic Spectrum Disorder
ASSIST	Assertive Intervention Stabilisation Team
AWOL	Absent Without Leave
BAU	Berkshire Adolescent Unit
BHFT	Berkshire Healthcare NHS Foundation Trust
BME	Black and Minority Ethnic (also BAME)
CAMHS	Child and Adolescent Mental Health Service
CCG	Clinical Commissioning Group
CDC	Centres for Disease Control and Prevention
CDS	Commissioning Data Set
CDiff	Clostridium Difficile
CEG	Clinical Effectiveness Group
CHS	Community Health Service
CMHT	Community Mental Health Team
CMHTOA	Community Mental Health Team for Older Adults
CNS	Clinical Nurse Specialist
CNT	Community Nursing Team(s)
COPD	Chronic Obstructive Pulmonary Disease
CPA	Care Programme Approach
CPE	Common Point of Entry
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CRHTT	Crisis Resolution and Home Treatment Team
CTO	Community Treatment Order
CTPLD	Community Team for People with Learning Disabilities
CYPF	Children, Young People and Families
CYPIT	Children and Young People's Integrated Therapy Service
CDS	Commissioning Data Set
DN	District Nursing
DNACPR	Do Not Attempt Cardiopulmonary Resuscitation
DQIP	Data Quality Improvement Plans
EIP	Early Intervention in Psychosis
EPMA	Electronic Prescribing and Medicines Administration
EPR	Electronic Patient Record
FFFAP	Falls and Fragility Fractures Audit Programme
FFT	Friends and Family Test
HEE	Health Education England
HoNOS	Health of the Nation Outcome Statistics

Acronym	Full Name
HOLT	Health Outreach Liaison Team
HTT	Home Treatment Teams
IAF	Information Assurance Framework
IAPT	Improving Access to Psychological Therapies
ICS	Integrated Care System
IFR	Initial Findings Review
IG	Information Governance
IMPACTT	Intensive Management of Personality Disorders and Clinical Therapies Team
IPS	Individual Placement and support (Employment Service)
IQIPS	Improving Quality in Psychological Services
KF	Key Finding
LD	Learning Disability
LeDeR	Learning Disability Mortality Review Programme
LIA	Listening Into Action
LIC	Lapse In Care
LSVT	Lee Silverman Voice Treatment
LTC	Long Term Conditions
MDT	Multi-Disciplinary Team
MDfT	Multi-Disciplinary Footcare Team
MH	Mental Health
MHA	Mental Health Act
MIU	Minor Injuries Unit
MRSA	Methicillin-Resistant Staphylococcus Aureus
MSK	Musculoskeletal
MSNAP	Memory Services National Accreditation Programme
MUS	Medically Unexplained Symptoms
MUST	Malnutrition Universal Screening Tool
NAAD	National Audit of Anxiety and Depression
NAIC	National Audit of Intermediate Care
NAP	National Audit of Psychosis
NCAPOP	National Clinical Audit and Patient Outcomes Programme
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NCISH	National Confidential Inquiry into Suicide and Homicide for people with Mental Illness
NDA	National Diabetes Audit
NDFA	National Diabetes Footcare Audit
NEOLCA	National End of Life Care Audit
NEWS	National Early Warning Score
NICE	The National Institute of Health and Care Excellence
NIHR	National Institute of Health Research
NSSA	National Sentinel Stroke Audit
OAHSN	Oxford Academic Health Science Network
OBD	Occupied Bed Days
OPMH	Older Peoples Mental Health
OT	Occupational Therapy
NRT	Nicotine Replacement Therapy

Acronym	Full Name
PAF	Performance Assurance Framework
PAPYRUS	Prevention of Young Suicide
PICU	Psychiatric Intensive Care Unit
PINC	Psychological interventions in nursing and community services
POMH	Prescribing Observatory for Mental Health
PPH	Prospect Park Hospital
PROMs	Patient Reported Outcome Measures
PU	Pressure Ulcer
QI	Quality Improvement
QMIS	Quality Management and Improvement System
QOF	Quality and Outcomes Framework
RBWM	Royal Borough of Windsor and Maidenhead
RiO	Not an acronym- the name of the Trust patient record system
RT	Rapid Tranquilisation
RTT	Referral to Treatment Time
RQ	Rolling Quarters
SALT	Speech and Language Therapy
SHARON	Support Hope & Recovery Online Network
SI	Serious Incident
SMI	Severe Mental Illness
SOP	Standard Operating Procedure
SSNAP	Sentinel Stroke National Audit Programme
SUS	Secondary Users Service
TVSCN	Thames Valley Strategic Clinical Network
UKAS	United Kingdom Accreditation Scheme
VTE	Venous Thromboembolism
WAM	Windsor Ascot and Maidenhead
WIC	Walk-In Centre
YPWD	Young People With Dementia

Trust Board Paper

Board Meeting Date	8th May 2018
Title	Six Monthly Safe Staffing Review
Purpose	The purpose of this report is to provide the Board with information on staffing levels within inpatient wards
Business Area	Nursing & Governance
Author	Debbie Fulton, Deputy Director of Nursing
Relevant Strategic Objectives	1 – To provide accessible, safe and clinically effective services that improve patient experience and outcomes of care
CQC Registration/Patient Care Impacts	Supports maintenance of CQC registration and supports maintaining good patient experience
Resource Impacts	N/A
Legal Implications	N/A
Equality and Diversity Implications	None associated with this paper
SUMMARY	This report considers staffing levels on inpatient wards over the last 6 months. Staffing levels are agreed using Keith Hurst tools and, from 1st April 2018, mental health acute inpatient services have had their staffing levels increased by one support worker in response to benchmarking and increasing patient acuity. For community and learning disability inpatient wards staffing levels remain appropriate. Band five qualified nursing vacancies continue across all services and therefore the use of temporary staff is high.
ACTION	The Board is asked to: Note the report

Six Monthly Safe Staffing Review
October 2017- March 2018

Executive Summary

In line with the National Quality Board requirement to review at least annually the staffing across inpatient wards, this board report details a review of the staffing for all of the inpatient wards within Berkshire Healthcare. This report does not cover community services which it is recognised are also challenged in terms of their workforce.

New resources were published on 30th January 2018 and are designed to support Trusts in agreeing their staffing establishments within community services, they recommend that staffing establishments for all services should be reviewed at least annually as well as when planning service changes. The published resources include Learning Disability, Mental Health and Community Nursing and these have been shared with relevant managers and workforce leads to support decision making around caseloads and skill-mix as part of current programmes of work around workforce.

During this reporting period the 10 beds at West Berkshire Community Hospital have remained closed due to inability to maintain safe staffing levels and the impact on quality and safety that this has. In December the Board approved the permanent closure of 5 beds on Bluebell ward. All other wards have remained the same in terms of bed capacity.

In February 2018 national reporting of Care Hours Per Patient Day (CHPPD) as part of the safer staffing data commenced.

The acute working age adult mental health wards and Orchid ward have an agreed safe staffing uplift of 1 additional member of staff per shift from April 2018 as a result of a review and recommendations presented in December 2017 and March 2018.

Prospect Park Hospital (PPH)

As demonstrated in this report PPH continues to experience challenges with high bed occupancy, patient dependencies and vacancy rates. Bed occupancy on the acute wards has been consistently above 90% (table 5) with an average of 94.3% over the reporting period.

The combination of current vacancy rate (table 6) which is at approximately 20% and additional staffing required to maintain safe staffing due to acuity and 1:1 observations means that a high number of temporary staff continue to be used.

Over this reporting period there has been a reduction in both turnover (19.2% in October 17 to 15.8% at end March 18) and vacancy (23% October 17 to 19.8% at end March 18) whilst this is very positive the majority of vacant posts are for registered nursing staff (29.6wte band 5 are currently vacant which equates to 38% of band 5 establishment) and the ability to maintain a position of 2 registered staff on each ward every shift remains a significant challenge with many registered nursing shifts being filled by temporary staff.

The number of temporary staff requested for PPH per month has varied between 1331 total shifts requested in February 2018 (lowest in reporting period) and 1792 total requested shifts October 17 (highest in reporting period), with unfilled rates ranging from 6.3% in Feb (lowest) to 13% in December (highest).

Bed occupancy on Rowan ward fluctuates more and is lower than the other mental health wards during this period with between 51% and 75% during this reporting period.

All of the mental health wards are experiencing an increasing number of patients with complex physical health conditions alongside their mental health diagnosis and work is ongoing to provide training and support around physical healthcare and a physical health lead for PPH commenced in March.

All of the mental health wards use a number of additional staff to support 1:1 observations, to mitigate the need for temporary staff to undertake this work some of the observation budget has been utilised to employ permanent support workers (12wte in total). These staff are rostered to Rowan and Sorrel wards, however can be allocated to any of the other wards at PPH if not required on these wards for a shift.

Ward teams have a number of junior and inexperienced staff and there has been changes in the senior nursing structure (4 wte) to support this with each senior nurse now having responsibility for 2-3 wards/ areas.

Staffing for the Place of Safety (POS) has changed with permanent staff now employed specifically for POS to cover late and night shifts. This supports the times when the unit is most used with ward staff covering the morning.

Other units

Willow House

The average bed occupancy during this period was 69.6% although continued high patient dependency has meant that additional temporary staffing has been required to meet patient need and 1:1 observations throughout this reporting period.

There has been an increase in number of temporary staffing requests from 124 in October 17 to 263 in March 18; this would appear to reflect the increased dependency of the young people admitted to the unit as the vacancy level has remained consistent at around 5wte. Sickness absence saw a peak in January at 11% with remaining months around 5-6% although this is an increase on previous six months where sickness absence was on or below the trust target of 3.5%

Willow House have the highest number of self-harm incidents of any ward within the trust and along with Snowdrop, Rose and Bluebell wards have this as a focus for their quality improvement work.

Campion

Campion have a new leadership team in place which is providing stability for the team, the units occupancy for the first 4 months of this reporting period were above 97% , however in the last 2 months this has reduced. Campion have one of the highest sickness absence rates across all of the inpatient wards peaking at 14.8% in January 18.

Campion has the highest reported patient on staff assaults and alongside Sorrel and Daisy wards have identified this as their main driver as part of the quality improvement programme.

Community Wards

Staffing establishment is assessed as being in line with patient need and dependency across the community wards although for all of the community wards (with the exception of Jubilee ward) securing temporary staffing (both registered and unregistered) is a challenge with up to 35% of requested shifts unfilled at times during this reporting period.

West Berkshire Community Hospital remains the most challenged of the community wards due to the registered nurse vacancy which currently is 20.8%. Wokingham also has a number of registered nursing vacancies.

The Advanced Practitioner role has been introduced across the West Community Wards and the East wards are planning to recruit a similar post to work across Jubilee and Henry Tudor

wards. Band 4 roles have also been introduced on the wards in the west to help filled the continued gaps of band 5 registered nurses.

Main Report

1. Background

In July 2016 the National Quality Board (NQB) published 'Supporting providers to deliver the right staff with the right skills in the right place at the right time: safe sustainable and Productive staffing', this was a refresh of the original document published in 2013 and was aimed at setting context and offering support to local decision making around an agreed workforce that is able to continue to provide high-quality and financially sustainable services

Detailed within the NQB report was a commitment to the development of additional resources to support NHS provider trusts with making staffing decisions that will deliver safe, effective, caring, responsive and well-led care. The improvement resources of relevance to Berkshire Healthcare are for learning Disability, Community Nursing, Adult Inpatients and mental Health. All of these resources were published on 30th January 2018.

These resource guides continue to advocate the use of the Keith Hurst tools (which were updated in October 17) for supporting safe staffing calculations on inpatient wards; this has always been the tool used within the trust to support safe staffing decisions and therefore alongside clinical judgement and benchmarking will continue to be the tool used. The work to address the registered nursing shortfall across our wards continues with a richer skill-mix of unregistered staff including band 4 being recruited to whilst maintaining the nationally recognised minimum of 2 registered staff on each shift remains. Support around recruitment and retention is also underway across Community Mental Health and Community nursing Teams who are also challenged in terms of recruiting to registered practitioner vacancies.

To agree planned staffing establishment for each ward a combination of the Keith Hurst modelling tools which include patient dependency toolkit, professional judgement and benchmarking across other similar wards is used. The updated toolkits from October 2017 have been used for the staffing establishments reviews discussed in this report.

Berkshire Healthcare continues to report their planned and actual staffing levels each month. This is published on NHS choices with a link to the BHFT website for further explanation on what the information means and reasons for differences between the planned and actual staffing numbers.

The national minimum staffing expectation of at least 2 registered staff on each ward every shift remains a requirement, however vacancy across all of the wards means that at times this has been challenging to maintain. The number of shifts where there is less than 2 registered staff on duty is monitored on a monthly basis at executive and board level meetings. The exception to this minimum is on Campion Unit where it was agreed that a skill-mix of 1 registered with 3 support workers was best able to meet with patient need at night, this position has not been altered.

2. Current Situation

Berkshire Healthcare Trust has a total of 14 wards:

- 1 learning disability unit
- 5 community hospital units
- 7 mental health wards.
- 1 Adolescent Unit

All of the wards have a staffing establishment that includes an allowance of 24% for planned and unplanned leave (training, annual leave, sickness absence). This report outlines in table 1 the actual staffing establishment and agreed staffing level on each shift and in table 2 the required establishment required for the dependency of the patients based on use of available tools.

Table1: Current Staffing establishment, bed numbers and shift patterns

Ward	Bed numbers	FTE Establishment in budget 17/18	Professional judgement FTE	Nurse: bed ratio FTE	Planned shift pattern (Early-late-night)
Donnington	30	74.13	39.9+ 1 ward manager + 0.2 matron = 41.01	38.2	9-6-6
Highclere	29 currently have 19 open		35.9+ 1 ward manger + 0.2 matron = 37.1	36.9	8-6-5 currently 6-5-4 due to closure of 10 beds
Oakwood	24	38.26	37.5 + 1ward manager =38.5	33.7	9-7-4
Wokingham	46	57.42	59+ 1 ward manager+ 0.8 senior nurse = 60.8	58.6	14-10-7
Henry Tudor	24	32.28	30.8+ 1 ward manager + 0.6 matron = 32.6	30.6	7-5-4
Jubilee	22	31.44	30.8+1 ward manager + 0.6 matron = 32.6	28	7-5-4
Campion	9	30.44	30.8 +1 ward manager= 31.8	24.2	6-6-4
Sorrel	12	30.00	27.3 + 1 ward manager +0.5 DSN= 28.8	29.5	5-5-4
Rose	22	30.00	27.3 + 1 ward manager +0.5 DSN= 28.8	29	5-5-4
Snowdrop	22	30.00	27.3 + 1 ward manager +0.5 DSN= 28.8	29	5-5-4
Rowan	20	33.50	29+ 1ward manager +0.5DSN = 30.5	27.3	6-5-4
Orchid	20	30.00	27.4 + 1 ward manager+ 0.5DSN = 28.9	26.5	5-5-4
Bluebell	22	36.00	33.3 +1 ward manager+0.5 DSN =34.8	34.4	6-6-5
Daisy	23	30.00	28.8 + 1 ward manager+ 0.5DSN =30.3	30.1	6-5-4
Willow House	9	22.58	24+1 ward Manager =25	23	Work shift pattern of long days with 4 on during day and 3 at night

***the above reflects the position up to end March and this reporting period and therefore does not reflect any increase in establishment agreed for the Mental Health Wards or the increase on Rowan and Sorrel ward to cover observations with permanent staffing.
**Highclere ward staffing establishment in table above reflects requirement for 29 beds

At times across a month, wards may require additional staff above what is planned within the establishment. This is to meet patient need and is because of the increased dependency of the patients. The staffing levels are reviewed daily and also monthly alongside a range of quality and workforce indicators to monitor the impact and experience for patients.

2.1 Assessment of current establishment

Dependency is measured by taking into account the level of nursing input (registered and care worker) required to meet the needs of the patient.

When workforce modelling is undertaken for the wards, the Keith Hurst dependency modelling tool is used to assist in the triangulation of data. However it is recognised that this modelling tool uses a snapshot of dependency of the patients on a given day. Dependency can fluctuate and therefore the collation of this data over a period of time is required in order to understand the average dependency for each ward. Where dependency is increased staff use clinical judgement in negotiation with their managers to agree additional staffing, which is assessed on a shift by shift basis.

Table 2 below shows the dependency scoring for each ward from October 2017 to March 2018. These scores are used to monitor patient workload on the wards and help identify when reviews are needed to maintain safe staffing levels across the Trust. The scores are a snapshot each month

The data in the table below is highlighted red where the dependency of the patients on the ward at the time is greater than what ward establishment is able to meet (all of the tools allow a 10% margin and therefore only the times when need is identified to be greater than 10% over the current establishment is highlighted). Additional temporary staff are used on the wards to help meet patient need and 1:1 observational requirements.

Table 2 - WTE requirements using the Keith Hurst dependency tool

Ward	Bed No	WTE establishment Planned shift pattern		Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018
Donnington Ward	30	74.13	9-6-6	39.7 (28)	33.9 (25)	33.7 (27)	41.1 (29)	36.3 (27)	36.7 (27)
Highclere Ward	29 19 open at present		8-6-5 currently 6-5-4 with 10 beds closed	19.6 (15)	21.6 (18)	21.5 (17)	24.3 (19)	21.1 (17)	23.4 (19)
Oakwood Ward	24	38.26	9-7-4	34.8 (22)	35.4 (22)	29.0 (22)	33.6 (22)	34.1 (22)	33.8 (20)
Wokingham Ward	46	57.42	14-10-7	48.2 (40)	36.2 (29)	49.0 (43)	45.5 (37)	46.1 (39)	46.8 (40)
Henry Tudor Ward	24	32.28	7-5-4		21.5 (17)	25.4 (21)	22.2 (18)		27.2 (19)
Jubilee Ward	22	31.44	7-5-4	24.1 (17)	26.9 (19)	23.7 (17)	31.4 (22)	28.2 (20)	29.2 (21)
Campion Unit	9	30.44	6-6-4	25.1 (9)	29.3 (8)	36.9 (9)	36.9 (9)	27.6 (7)	33.4 (8)
Sorrel (PICU)	12	30.00	5-5-4	41.5 (9)	22.7 (8)	24.0 (8)	22.7 (8)		26.7 (6)
Rose Ward	22	30.00	5-5-4	50.4 (22)	40.8 (22)	42.4 (22)	42.3 (20)		29.4 (21)
Snowdrop Ward	22	30.00	5-5-4	41.0 (22)	32.5 (22)	30.1 (21)	35.8 (19)		29.6 (19)
Rowan Ward	20	33.50	6-5-4	47.0 (15)	33.3 (12)	17.1 (10)	26.2 (10)		23.8 (10)

Orchid Ward	20	30.00	5-5-4	27.5 (16)	52.0 (18)	30.0 (15)	28.6 (18)		38.3 (17)
Bluebell Ward	27	36.00	6-6-5	47.5 (22)	52.3 (22)	37.1 (21)	34.4 (22)		40.9 (22)
Daisy Ward	23	30.00	6-5-4	27.3 (22)	28.3 (22)	33.4 (22)	29.2 (19)		36.0 (21)
Willow House	9	22.58	6-4	31.5 (7)	24.3. (7)	41 (7)	22.5 (6)	26.5 (9)	22.4 (8)

***** No dependencies were collected for PPH in February 2018, this was due to changes occurring in the leadership team at the time

2.2 Review of staffing establishment

There is an expectation set out within the NQB documents that all ward staffing levels are reviewed on an annual basis. The last six-monthly review covering Q1 and Q2 of 2017/18 (April –September) highlighted increased dependency and pressure on the acute adult wards at Prospect Park. This together with Prospect Park Hospitals clinical and management concerns that have been raised around staffing in terms of ability to safely manage the patients being admitted onto these wards led to a further review with findings presented to December Quality Executive Group. The review used a combination of national acuity tools, benchmarking against other similar trusts and clinical / professional judgement has been used to inform this paper**.** As a result of this review it was agreed that orchid, Rose, Daisy and Snowdrop wards would all receive a staffing uplift from April 2018 to achieve the new 6-6-5 staffing levels. Alongside this it was suggested that this increase was used to introduce activity coordinators into the skill mix and provide an increased therapeutic environment for patients.

As part of the on-going workforce programme within Prospect Park it was decided to use some of the observation budget to employ 12wte additional unregistered staff to increase consistency and proportion of permanent staff, the staff have been deployed into Rowan and Sorrel wards and means that their staffing levels have increased to 7-6-5 and 6-6-5 respectively, this will mean that they can manage 2 rather than 1 patient each requiring 1:1 nursing without bringing in additional staff. Were this additional resource is not required on these 2 wards it will be redeployed for the shift to a differing ward with need across Prospect Park hospital

During April a staffing review has been undertaken for all of the community health wards and Campion unit. This is undertaken using a combination of national tools (data captured daily for 14 days as oppose to snap shot as detailed in table 2 to provide increased confidence in average dependency for each ward) and benchmarking with other similar wards. The findings are detailed below in table 3 and table 4 demonstrating that the wards appear to be staffed in line with both dependency need and also benchmarking against other similar wards

Table 3: Establishment review undertaken April 2018 using dependency collation and Keith Hurst modelling tools

ward	Current establishment	Required establishment using modelling tools
West Berkshire Community Hospital	74 (for 59 beds)	52.8 + ward managers and matrons (based on 40 pts) + 5.8wte uplift (1 HCA per shift for neuro beds on Donnington)
Oakwood Ward	38.26	33 + ward manager & matron
Wokingham Ward	57.42	57.8 + ward manager and matron, not allowing for any 1:1 that were required on some nights during the data collation
Henry Tudor Ward	30.44	30wte +ward manager and matron, not allowing for any 1:1 that were required on some shifts during

		the data collation
Jubilee Ward	31.44	28.6 + ward manager and matron
Campion	30.44	27.8 + ward manager

Table 4: comparison with community wards in similar trusts

Organisation	Bed numbers	Staffing
Berkshire Healthcare Community wards	22-24 bed wards	7-5-4
North Hants	22 bed wards	6-5-4
Oxford health	21 bed wards	7-6-4
Somerset partnership	26 bed wards	8-7-5
Southern Health	20 bed wards	6-5-4 (29wte)

By way of benchmarking against other Learning Disability assessment and treatment wards for Campion (6-6-4 for 9 beds); Sussex Partnership has shared their staffing levels which are 6-6-4 for a 10 bed unit. In addition the latest benchmarking report demonstrates our inpatient learning disability inpatient units to be within the median range for cost per bed day.

2.3 Bed occupancy

Table 5 below details monthly bed occupancy over the reporting period, the data highlighted in red is where bed occupancy has exceeded 90%. The areas that have consistently experienced bed occupancy in excess of 90% are the Acute Adult Mental Health Wards; Campion unit has also exceeded 90% occupancy for the majority of the time.

Table 5: Bed Occupancy

	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Donnington	84.94%	80.89%	88.49%	87.63%	91.55%	86.88%
Highclere	87.53%	65.34%	58.40%	60.73%	61.7%	59.29%
Oakwood	80.00%	60.28%	72.04%	89.38%	96.28%	91.00%
Wokingham	71.65%	64.95%	85.86%	82.36%	82.87%	86.64%
Henry Tudor	79.70%	81.67%	84.95%	89.25%	82.89%	86.16%
Jubilee	75.81%	76.21%	80.94%	88.42%	88.8%	89.15%
Campion	96.77%	96.67%	99.28%	96.77%	76.19%	81.36%
Sorrel	73.39%	72.76%	80.00%	75.16%	73.21%	57.10%
Rose	95.01%	93.18%	92.38%	92.82%	98.86%	96.48%
Snowdrop	95.15%	93.48%	93.55%	92.96%	95.94%	94.72%
Rowan	75.65%	66.67%	52.10%	51.94%	71.07%	52.90%
Orchid	75.65%	81.50%	76.94%	82.97%	93.84%	90.88%
Bluebell	91.94%	95.30%	91.20%	93.99%	98.86%	95.89%
Daisy	95.54%	93.53%	95.43%	94.00%	97.96%	85.90%
Willow House	68.08%	67.41%	68.46%	59.50%	79.37%	74.91%

3. Workforce data

A number of factors have the potential to impact on the wards ability to achieve the agreed staffing levels on every shift; these include vacancy factor and sickness absence. The position

over the period October 2017 to March 2018 in relation to these two indicators is detailed below.

3.1 Vacancies

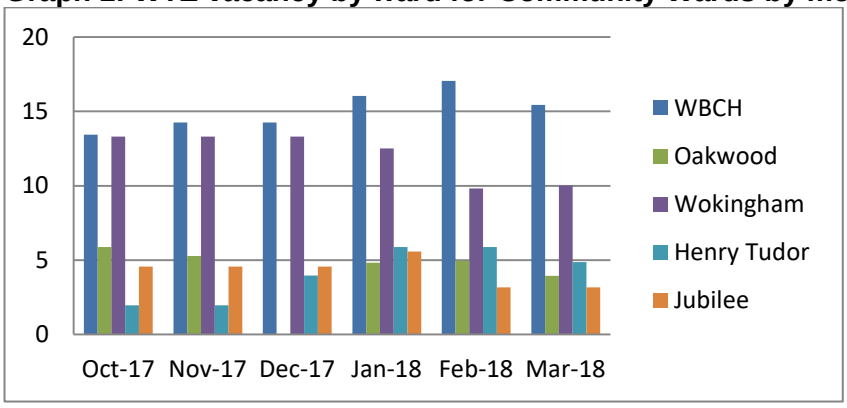
Table 6 below shows the combined WTE vacancy rate of registered nursing and care staff for each ward according to finance data over the last 6 months. All wards continue to struggle with recruitment, particularly RNs which as previously stated is a national problem. They continued to look at different models of care, with more focus on cross-professional working to address this shortfall in RNs.

Table 6 – Whole Time Equivalent (WTE) vacancy of registered nursing and care worker combined

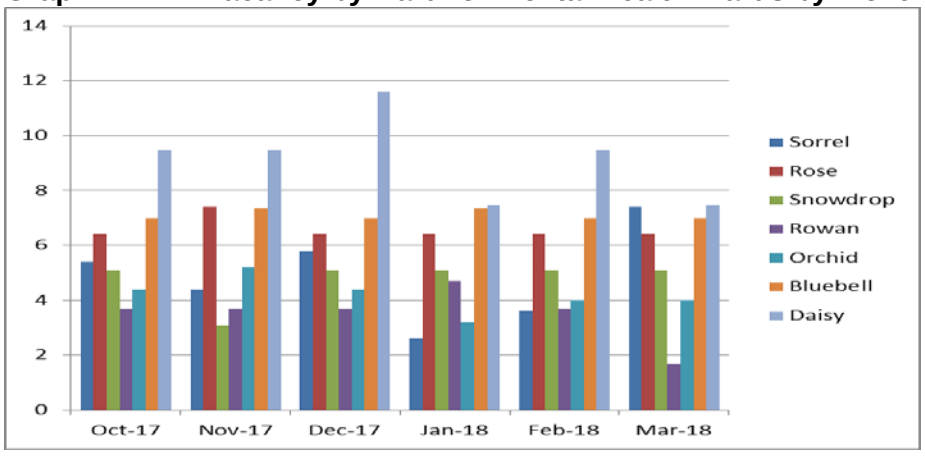
	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Current vacancy as approximate % total nursing staffing (registered and unregistered)
Prospect Park Hospital	41.46	40.62	43.99	36.82	33.30	44.7	18.9%
Community Health wards	39.17	39.37	36.08	44.82	40.86	37.46	14.5%
Campion	4.80	5.24	5.24	3.04	2.04	3.04	16%
Willow House	5.05	4.13	5.13	5.13	5.33	5.33	14.8%

Graphs 1 and 2 below detail the split of vacancy across the wards and demonstrate variation in level of vacancy that each ward is experiencing.

Graph 1: WTE vacancy by ward for Community Wards by month



Graph 2: WTE vacancy by ward for Mental Health Wards by month

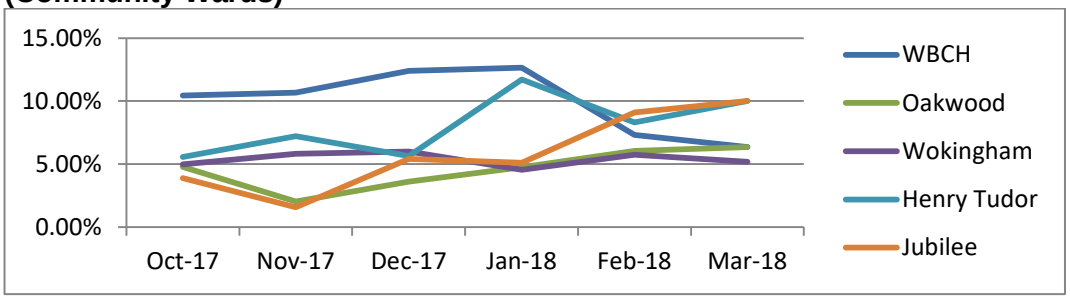


3.2 Sickness absence

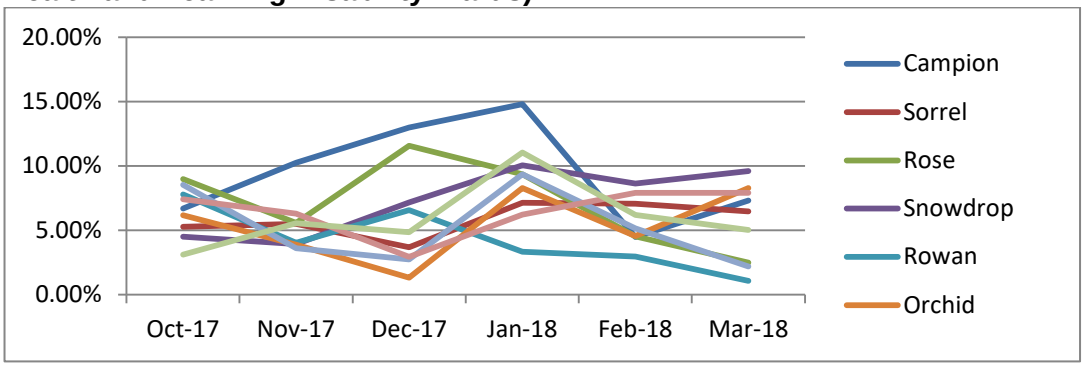
Graph 3 and 4 below details the sickness absence that is recorded on the trust's electronic staff record (ESR) sickness absence during each month as a % of the total registered nursing and care staff workforce for each ward. The sickness absence includes long and short term sickness.

The Trust sickness absence target is 3.5% therefore the wards are exceeding this target on most months. The Trust has a sickness absence policy which with support from the human resources department ensures that appropriate action is taken to support staff and their managers with sickness related absenteeism. There are a number of wards with a high sickness absence factor due to a combination of both long and short term sickness. These wards are working closely with Human Resources and our Occupational Health providers to ensure that appropriate actions are being taken.

Graph 3 - Sickness absence for wards as a percentage of total ward staffing (Community Wards)



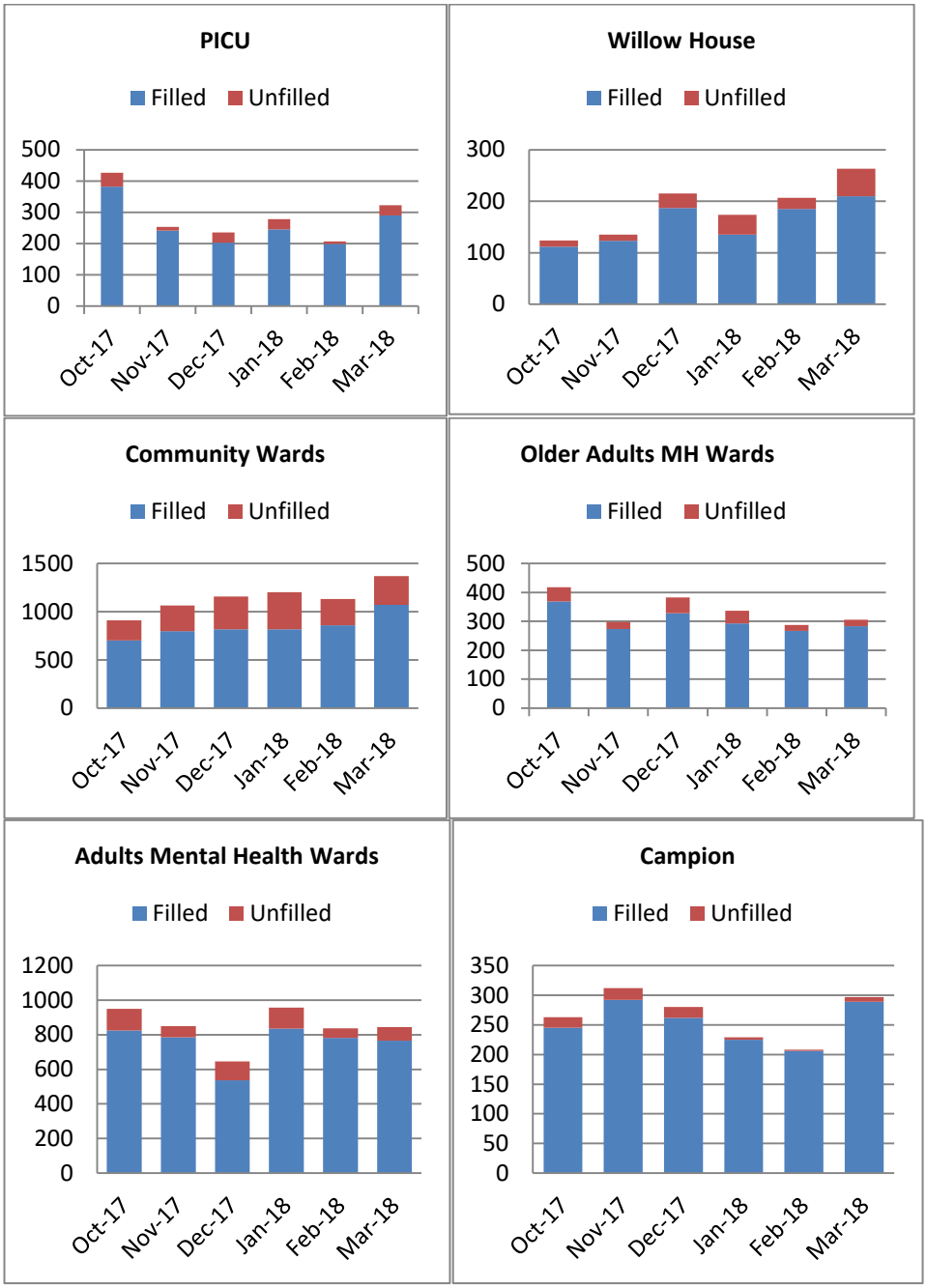
Graph 4 - Sickness absence for wards as a percentage of total ward staffing (Mental Health and Learning Disability Wards)



3.3 Temporary staffing

When the wards have vacancy/ sickness within their nursing staffing establishment they use temporary staffing (agency / bank or additional shifts by their own staff) to ensure that safe staffing levels are maintained. Temporary staffing is also used where patient need means that additional staff are required. It is recognised that increased numbers of temporary staffing has the potential to impact on quality and therefore the wards continue to work hard with the support of the recruitment team to fill vacancies and so reduce the reliance on temporary staffing.

The graphs below show the total number of shifts required to be filled for each area as well as number of these that were filled/ unfilled they demonstrate that the community wards have more of a challenge filling their required shifts than other ward areas across the Trust. Whilst Campion has the lowest unfill rate.



4. Displaying planned and actual registered and care staff on the wards

All of the wards within the trust have a display board which shows the number of staff that the ward had planned to have on the shift and the number of staff actually on the shift. This allows visitors to the ward to be clear about the number of registered nurses and care staff on the ward at the time. The boards also show who the nurse in charge is so that visitors know who to contact if they have a concern or would like to speak to the nurse in charge about anything. These boards are monitored by the Trust during visits to individual wards throughout the year.

5. Capability and safety on our wards

Having the right capacity of registered nurse and care staff on each ward allows for staff to have the best chance of achieving safe care. However it is just as important to have the appropriate staff capability to ensure that they can deliver a safe and quality service to all patients. This section of the report details how the Trust currently measures and monitors capability.

5.1 Quality indicators

To monitor safety of care delivered on the wards the Director of Nursing and Governance reviews a range of quality indicators on a monthly basis alongside the daily staffing levels. These indicators are:

Community wards

- Falls where the patient is found on the floor (an unobserved fall)
- Developed pressure sores
- Medication related incidents

Mental health wards

- AWOL (Absent without leave) and absconsion
- Falls where the patient is found on the floor (an unobserved fall)
- Patient on patient physical assaults
- Seclusion of patients
- Use of prone restraint on patients

Since November 2017 patient on staff assaults have been included in the quality data collection as part of the work wards are doing with the quality improvement programme.

Monthly teleconferences are held with senior staff from each of the ward areas to discuss the staffing data along with these indicators, any concerns are highlighted in the monthly safer staffing board report and are able to inform the safe staffing declaration provided by the Director of Nursing and Governance.

Table 7: Quality metric for mental health inpatient wards (October 2017 – March 2018)

Ward	AWOL	Falls	Patient on Patient Assaults	Patient on Staff Assaults	Prone Restraint	Seclusion	Self-harm
Bluebell	14	18	4	12	10	6	67
Campion	0	2	27	53	1	7	8
Daisy	13	2	8	4	5	1	66
Orchid	1	16	4	8	1	0	0
Rose	10	0	7	1	8	3	78
Rowan	0	11	8	5	0	0	1
Snowdrop	19	2	12	13	9	1	19
Sorrel	4	2	17	12	19	41	2
Willow House	5	0	8	20	19	2	206
Total	**66**	**53**	**95**	**128**	**72**	**61**	**447**

* Incident reporting data in above table is correct at time of writing the report (April 2018)

Table 8: Quality metric for community physical health inpatient wards (October 2017 to March 2018)

Ward	Medication related incidents	Falls	Patient on Staff Assaults	Pressure Ulcers
Donnington	23	15	4	4
Highclere	0	0	0	0
Oakwood	21	24	1	1
Wokingham	88	23	1	5
Henry Tudor	6	12	2	0
Jubilee	4	4	0	0
Total	**142**	**78**	**8**	**10**

* Incident reporting data in above table is correct at time of writing the report (April 2018); medication related incidents include those that are noted by our staff that are not our error for example medication charts not being sent with a patient or wrong medications being sent when a patient is admitted

The ability to achieve a position of at least 2 registered staff on duty is also perceived as a metric of quality, Nice Guidance on safe staffing in 2014 identified that a shift with less than 2 registered staff on duty should be perceived as a red flag (incident).

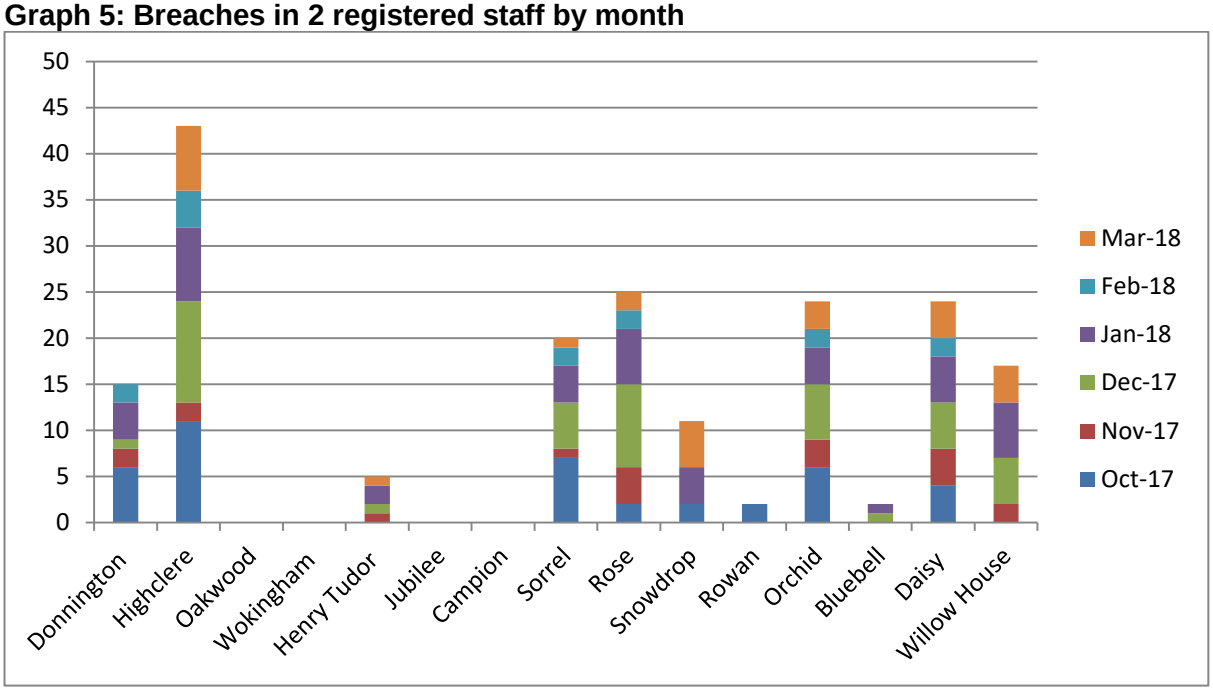
Table 9 below shows the number of occasions by ward and month where there were less than 2 registered staff on a shift (not including the night shift on Campion where it was agreed that patient need is best met with a skill-mix of 1 registered nurse and 3 support workers). The highlighted data in the table demonstrates the wards with the highest numbers of breaches each month. Highclere ward has the most breaches with 43 in total over the 6 months; Rose had the second highest number with 25 whilst Daisy and Orchid ward had 24 breaches within the 6 months.

For all of the wards where there are less than 2 registered staff, senior staff and ward managers (who are supernumerary to the safe staffing numbers) as well as other clinical staff such as Physiotherapy and Occupational Therapy support when available. For wards at Prospect Park Hospital the Duty Senior Nurse is also available and is able to take an overview of the wards and redeploy staff to areas of most need.

Table 9: wards and number of occasions where there was less than 2 registered staff on duty (excluding Ward Manager)

	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Total for ward
Donnington	6	2	1	4	2	0	15
Highclere	11	2	11	8	4	7	43
Oakwood	0	0	0	0	0	0	0
Wokingham	0	0	0	0	0	0	0
Henry Tudor	0	1	1	2	0	1	5
Jubilee	0	0	0	0	0	0	0
Campion	0	0	0	0	0	0	0
Sorrel	7	1	5	4	2	1	20
Rose	2	4	9	6	2	2	25
Snowdrop	2	0	0	4	0	5	11
Rowan	2	0	0	0	0	0	2
Orchid	6	3	6	4	2	3	24
Bluebell		0	1	1	0	0	2
Daisy	4	4	5	5	2	4	24
Willow House		2	5	6		4	17
Total for month	**40**	**19**	**44**	**44**	**14**	**27**	

Graph 5: Breaches in 2 registered staff by month



The 2 wards at Wokingham Community Hospital work as one unit although a few times during the 6 months there have been 3 instead of 4 staff across the unit, because of their close proximity on the same level they are able to support as required.

5.2 Safe staffing declaration

Each month the Director of Nursing and Governance is required to make a declaration regarding safe staffing based on the available information

As with the last six month report for the Acute Wards at Prospect Park Hospital, Sorrel ward and West Berkshire Hospital wards it has been declared consistently throughout the reporting period that the high number of temporary staff required each month does cause concern because of the challenge this provides in delivering consistent and good quality care.

For all months with the exception of February 2018, there has been no direct correlation between clinical incidents reviewed and staffing. In February a patient on Donnington Ward sustained a fall with injury (a late shift which had 4 staff instead of their usual 6 and at this time Highclere ward also had reduced staffing resulting in there being no flexibility to move staff between wards).

For Campion the declaration has altered over the 6 months with November and December detailing concerns around quality and safety due to high numbers of temporary staff and very high patient acuity. For the remaining months in this quarter because managers perceived these issues to have lessened with reduced bed occupancy it was possible to make a declaration that the wards were safely staffed with no quality and safety issues identified.

For Willow House a declaration of no identified impact on quality and safety of care provided as a result of staffing issues was declared for October and November, since December due to the increasingly complex young people on the unit requiring high levels of observations and high usage of temporary staff the declaration has indicated that maintaining consistently good quality care is challenging.

For all other wards current reporting is that there are no identified impact on quality and safety of care provided as a result of staffing issues was declared each month.

The overarching monthly declaration has been that the wards have had sufficient numbers of staff however this has required a high use of temporary staff over a significant period of time to achieve this position. The impact of this sustained high use of temporary staff is that there is increasing concern in relation to clinical risk and safety and as a result there is a limited ability to provide assurance that the care provided was good at all times.

5.3 Care Hour per Patient Day (CHPPD) Data Collection

The publication of Lord Carter's review, 'Operational productivity and performance in English acute hospitals: Unwarranted variations', in February 2016 highlighted the importance of the ensuring efficiency and quality across the whole NHS. One of the obstacles identified in eliminating unwarranted variation in clinical staff distribution within the NHS provider sector has been the absence of a single means of consistently recording, reporting and monitoring staff deployment.

In order to provide a consistent way of recording and reporting deployment of staff providing care on inpatient wards, the Care Hours per Patient Day (CHPPD) metric was developed and while it is recognised that the needs of patients using services are often quite different, the CHPPD measure provides a representation of the number of care hours available to patients and it is expected that this measure will enable wards of a similar size, speciality and patient group to be benchmarked in future. Collection of this data has only just commenced nationally so there is currently no benchmarking data available. CHPPD for all of the inpatient areas within Berkshire Healthcare is captured alongside the monthly fill rate and bed occupancy. Data capture and submission commenced in February 2018 and following a consistent period of data collection analysis and review will be completed within the next six-monthly report.

In September 2017 a CHPPD audit was undertaken to further understand the contribution of Allied Health Professionals (AHPs) in the care of patients on wards. A further one month audit will be completed during June to understand the AHP contribution in more detail.

6. Community Caseloads

Work from the review of community nurses caseloads and skill mix has resulted in a programme of work around recruitment and retention for community nursing and new recruitment hubs have been introduced.

7. Conclusion

The last six months have been very challenging for all wards as detailed in this report, particularly for West Berkshire Community Hospital; the acute wards at PPH and more recently Willow House. This is mainly due to challenges with the recruitment of registered nursing staff.

Additional resource has already been agreed with effect from April 2018 for the Acute Mental Health wards and Orchid ward, alongside this both Rowan and Sorrel wards have increased their staffing numbers to accommodate an additional patient on each ward on 1:1 observations with permanent staffing from the observation budget.

There is no evidence from the data collated within this report to indicate that the remaining wards are not staffed adequately in terms of their agreed establishments. The challenge will continue to be securing temporary staff to cover vacancy and sickness absence alongside increased observations.

CHPPD data collection has commenced as part of the monthly safer staffing data collection and analysis will be able to be presented in the next six-monthly report.

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	8 May 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 08 May 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. #EndPJparalysis

The trust is participating in the national campaign aiming to get older people back home to their loved ones living much happier and fuller lives.

The 70-day challenge is to see one million patient days across the country of people up, dressed and moving between Tuesday 17 April and Tuesday 26 June. The trust already practice this on community health inpatient wards, knowing that this improves our patients' wellbeing whilst in hospital and the challenge gives us an opportunity to show what we can do.

Executive Lead: Helen Mackenzie, Director of Nursing and Governance

3. Quality Impact Assessment 2017/18

The Ernst & Young external governance assessment in 2015 recommended that an evaluation of the Quality Impact Assessment (QIA) process be undertaken to check that there had been no impact on quality as a result of cost improvement plan.
In 2017/18 the QIA process was led by the Clinical Directors with the Senior Clinical Director, once satisfied about potential impact, recommended or not, to the Director of Nursing and Governance that the cost improvement plan (CIP) be approved.

Where the Director of Nursing and Governance believed that the CIP would have an impact it was agreed that at this point the Medical Director would become involved. This step was not required during 2017/18.

The three CIPs assessed for quality impact in 2017/18 were:

- Operational vacancy
- Corporate back office
- Operational management and support

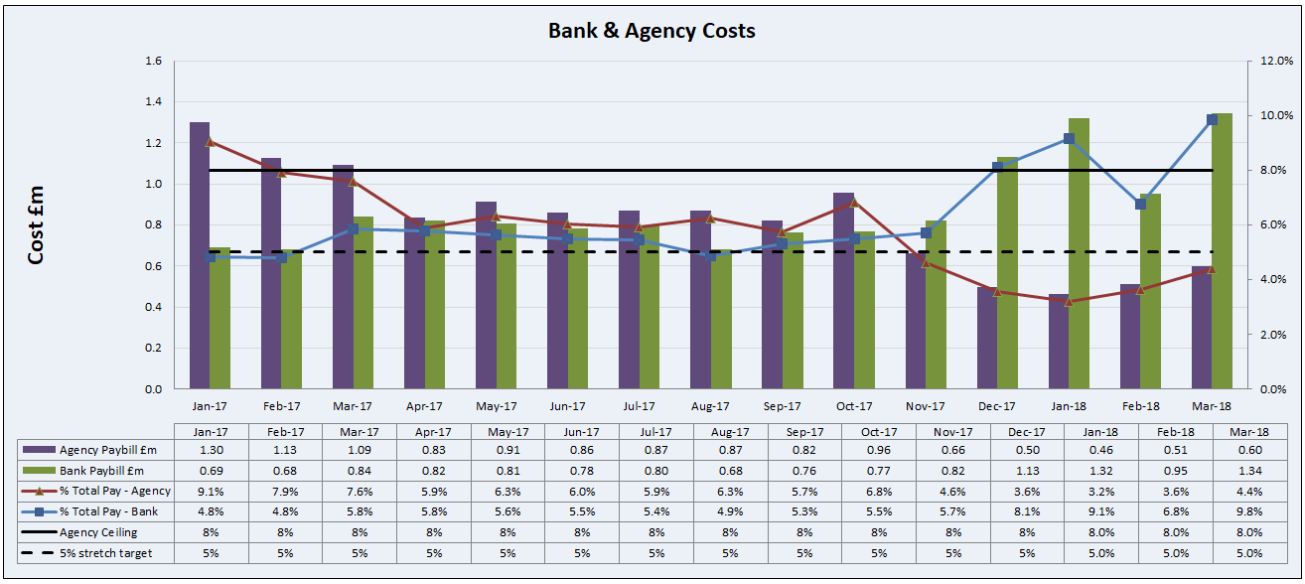
As part of these plans no significant service changes were proposed. The agency cost improvement plan continued to deliver successfully during 2017/18 and therefore was not re-evaluated.

The Clinical Directors have reviewed the CIP impact and have assured the Senior Clinical Director and Director of Nursing and Governance that no quality impact has occurred as a result the removal of vacant posts. The assurance provided included a review of incidents, complaints and staffing levels by the nursing and governance team during the year.

Executive Lead: Helen Mackenzie, Director of Nursing and Governance

4. Temporary Staffing Programme

- During March 18 the percentage of the total staff pay cost spent on agency staff increased to 4.4% [from 3.6% in February 18] and was partly due to an increase in leave being taken in the month and two days of the Easter bank holiday weekend.
- The monthly spend in March 18 on NHSP [bank] as a percentage of the total staff pay cost increased to 9.8% [6.8% in February 18] which was however largely in-line with usage in January 18. The reason attributed for the increase is the same as that for the agency staff increase.
- This meant that the monthly combined agency and bank usage percentages of the total staff pay cost in 2017_18 are: April 17 – 11.7% and May 17 – 11.9%, June 17 – 11.5%, July 17 – 11.6%, August 17 – 11.7%, September 17 - 11%, October 17 – 12.3%, November 17 – 10.3% December 17 - 11.7%, January 18 - 12.3%, 10.4% for February 18 and 14.2% in March 18.



	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	Mar-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	0.60
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	1.34
% 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%	4.4%
% 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%	9.8%
Agency Ceiling	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8.0%	8.0%	8.0%
5% stretch target	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5.0%	5.0%	5.0%

- As the Board is aware, there was an NHSi cap set for the Trust of a maximum of 8% [£13.9m] of the total staff pay cost to be spent on agency staff during 2017_18, and an internal Trust stretch CIP target of 5%.
- The end of year expenditure on agency staff in the Trust is reported as £8.86m, which is approximately 5.1% of the total spend on staff pay costs for the year, and well below the NHSi cap.
- The end of year expenditure on bank staff in the Trust came to a total of £12.5m, which is approximately 7.75% of the total spend of staff pay costs for the year.
- Approximately £21.36m or 12.85% of the total Trusts staff pay costs for the year were spent on agency and bank temporary staffing.

- The Trust has been informed that the NHSi ceiling on agency spend for the Trust in 2018_19 will be £10.6m [6.15% of the total planned staff pay costs of £171.75m].
- The internal agency usage stretch target for 2018_19 will remain at 5%.

As the spend has remained relatively stable over the last year, once confirmed by NHSi that full reporting to the board is no longer required, the agency metric will monitored through the financial reporting including performance against NHSi cap and current run rate trend.

Executive Lead: Helen Mackenzie, Director of Nursing and Governance

Presented by: Julian Emms
Chief Executive
May 2018

Trust Board Paper

Board Meeting Date	8 May 2018
Title	**National NHS Staff Survey**
Purpose	To outline the results of the 2017 survey, and set out action in progress following analysis to date.
Business Area	Corporate Affairs
Author	Bev Searle
Relevant Strategic Objectives	Relevant to all strategic objectives
CQC Registration/Patient Care Impacts	Well led
Resource Impacts	None anticipated
Legal Implications	None.
Equality and Diversity Implications	Our work towards achieving our equality and inclusion goals for our staff is addressed within our Equality and Inclusion strategy progress updates, our Workplace Race Equality Standard and Stonewall Workplace Equality Index reporting. We will use the results of our staff survey to inform further work, and

	note the encouraging signs of progress in the key findings used for the workplace race equality standard.
SUMMARY	The attached paper outlines the results of the 2017 staff survey and includes the following headline messages: • Our overall staff engagement score has improved for the sixth consecutive year • This year there were 22 key findings for which we had better than average scores, compared with 20 in 2016 • For 6 of the 22 better than average scores, our score equalled the best score, compared with 4 in 2016 • 6 key findings were average scores; compared with 7 in 2016 • 4 key findings were worse than average scores; compared with 5 in 2016 The paper provides a summary of our top 5, and bottom 5 scores, and how we compare with other similar Trusts. Information on staff experience, workplace race equality and health and wellbeing ratings are included, as well as a summary of action we are taking as a result of the survey.
ACTION	The Board is asked to note the progress represented by the results of the staff survey, areas of concern identified, future priorities and work in progress.

NHS National Staff Survey 2017

1.0 Introduction and headline messages

This paper provides a summary of the main findings of the 2017 NHS National Staff Survey. The staff survey engagement rating is one of our "vision metrics", and the results of the survey provide us with a rich source of information to test the extent to which we are living our values as an organisation.

In comparison with our results for 2016, and other combined mental health, learning disabilities & community health trusts our results showed:

- Our overall staff engagement score has improved for the sixth consecutive year
- This year there were 22 key findings for which we had better than average scores, compared with 20 in 2016
- For 6 of the 22 better than average scores, our score equalled the best score, compared with 4 in 2016
- 6 key findings were average scores; compared with 7 in 2016
- 4 key findings were worse than average scores; compared with 5 in 2016

There are notable improvements in key findings that are part of the Workplace Race Equality Standard, which are described in section 7 below, and evidence of insufficient improvement in the findings concerning staff health and wellbeing, outlined in section 8.

2.0 How the Staff Survey Results are presented

The staff survey results are presented as scores for 32 Key Findings (KF) and a staff engagement score. The Key Findings are based on one or more answers to the survey questions. As a general rule the percentages of staff are based on either:

1. The percentage of staff who picked one of two answers (e.g. yes or no); or
2. Where staff are asked to choose one answer from a scale of possible answers (e.g. choose from five possible answers ranging from strongly agree, agree, neither agree nor disagree, disagree or strongly disagree), the percentage would be a combination of the two top or the two bottom choices – i.e. excluding the 'neither agree nor disagree response as well as the two choices at the other end of the scale.

Some scores are numbers based on responses to a group of questions rather than percentages (e.g. the staff engagement scores). The survey indicates if high or low is best and what the best and average scores were, enabling the Trust to benchmark itself against other similar trusts as well as previous year's scores. Our benchmarking group includes the 28 community, mental health and learning disability trusts in England.

Berkshire Healthcare NHS Foundation Trust undertook the 2017 NHS National Staff Survey between October and December 2017, which was conducted on-line for the fourth consecutive year.

3.0 National staff survey response rate for 2017 compared with previous years

The table below shows that our response rate has increased since 2015/16, but has reduced by 2% since 2016/17, and is comparable to our benchmarking group.

Survey Response Rates in comparison to previous years					
Survey Year	**2015/16**	**2016/17**		**2017/18**	
Organisation vs benchmarking results	Berkshire Healthcare	Berkshire Healthcare	Benchmarking group	Berkshire Healthcare	Benchmarking group

Response rate	38%	46%	44.1%%	44%	45%

4.0 The top 5 ranking scores

- KF6. Percentage of staff reporting good communication between senior management and staff
- KF4. Staff motivation at work
- KF8. Staff satisfaction with level of responsibility and involvement
- KF3. Percentage of staff agreeing that their role makes a difference to patients / service users
- KF1. Staff recommendation of the organisation as a place to work or receive treatment

The table below shows how these scores compare with last year's performance and those of our benchmark group

Top 5 ranking scores				
2016/17		**2017/18**		**Trust improvement/ deterioration**
	BHFT	**BHFT**	***Benchmarking group average***	
Key finding 6	43%	47%	34%	Increase of 4% and equals best score
Key finding 4	4.05 score	4.04 score	3.93 score	Decrease of 0.01; and equals best score
Key finding 8	3.94 score	3.98 score	3.90 score	Increase of 0.04 and equals best score
Key finding 3	92%	92%	89%	No change and equals best score
Key finding 1	3.89 score	3.88 score	3.68 score	Decrease of 0.01 and equals best score

5.0 The bottom 5 ranking scores

The five key findings in which we achieved our lowest scores were:

KF16. Percentage of staff working extra hours

KF27. Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse

KF24. Percentage of staff / colleagues reporting most recent experience of violence

KF20. Percentage of staff experiencing discrimination at work in the last 12 months

KF21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion

The table below shows how these scores compared with last year's performance and those of our benchmarking group.

Bottom 5 ranking scores

	2016/17	2017/18		Trust improvement/ deterioration
	BHFT	**BHFT**	**Benchmarking group average**	
Key finding 16	75%	77%	71%	Increase – deterioration
Key finding 27	55%	53%	57%	Decrease – deterioration
Key finding 24	80%	83%	88%	Increase – Improvement
Key finding 20	12%	13%	11%	Increase - deterioration
Key finding 21	86%	86%	86%	No change

6.0 Staff experience - areas of improvement and deterioration from the prior year

The areas of statistically significant improvement or deterioration in staff experience were:

Key Findings	**2016/17**	**2017/18**	
KF10. Support from immediate managers	3.87	3.92	Improved
KF8. Staff satisfaction with level of responsibility and involvement	3.94	3.98	Improved
KF6. Percentage of staff reporting good communication between senior management and staff	43%	47%	Improved
KF17. Percentage of staff feeling unwell due to work related stress in the last 12 months	36%	39%	Deteriorated

7.0 Workforce Race Equality Standard 2017

The table below shows the answers from the National staff survey which will form part of our 2018 WRES submission and inform action plans. The progress made is very encouraging and reinforces our commitment to delivering our Equality Employment Programme.

WRES 2017 results		2017	Ave*.	2016
KF 25: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White BME	22% 27%	25% 28%	22% 27%
KF 26: Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White BME	18% 21%	20% 23%	18% 26%
KF 21: Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	White BME	89% 74%	88% 76%	90% 68%
Qu 17b: In the last 12 months have you personally experienced discrimination at work from manager/team leader or other	White BME	7% 11%	6% 11%	5% 17%

colleagues?				

**Average (median) for similar trusts*

8.0 Health and Wellbeing

With element 1a of the national Health and Wellbeing CQUIN requiring improvements in responses to questions 9a), 9b) and 9c) from the national staff survey, our 2017 versus 2015 scores to these questions have shown we have not achieved the targeted improvements. Our results have remained level or marginally improved as shown in the table below.

National Staff Survey(NSS) question measures of success	BHFT 2015 score	BHFT 2016 score	2017 target score	2017 actual score
1. **Question 9a**: Does your organisation take positive action on health and well-being? Providers will be expected to achieve an improvement of 5% points in the answer "yes, definitely" compared to baseline.	36% Yes	36% Yes	41% Yes	36.5%
2. **Question 9b:** In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities? Providers will be expected to achieve an improvement of 5% points in the answer "no" compared to baseline	76% No	77% No	81% No	76%
3. **Question 9c:** During the last 12 months have you felt unwell as a result of work related stress? Providers will be expected to achieve an improvement of 5% points in the answer "no" compared to baseline.	60% No	64% No	65% No	61.3%

None of the trusts similar to our own has achieved the required 5% improvement in two of any three questions. The average score showed a 1 per cent worsening for Qu9a; a 2 per cent worsening for Qu9b; and a 1 per cent worsening for Qu9c. Four trusts made a 5 to 10 percentage point improvement in Qu9a, and 3 of these 4 had below average scores in 2015; no trust achieved the 5% improvement for Qu9b or Qu9c.

9.0 Areas of concerns, future priorities and work in progress

The overall 2017 results are extremely positive, and are even better than the previous years - therefore the areas of concern need to be seen in that context.

The results have been reviewed by the Quality Executive Group and work is in progress to undertake further analysis by staff location and protected characteristics. We will be taking a focussed approach to improvement work, guided by this analysis.

Initial analysis indicates that there is a correlation between high levels of engagement and staff working extra hours – and we very much appreciate the level of discretionary effort that our staff make. However, we are committed to working with services and areas that are scoring lower levels of engagement, while also working additional hours, recognising the adverse impact this will have on morale and turnover.

The WRES results show that whilst there are still concerns to be addressed, the Equality Employment Programme is making progress. Funding to continue the programme has been approved in principle, enabling us to work to continue this improvement. This work will be overseen by the Diversity Steering

Group, working in partnership with the BAME Staff Network and informed by the analysis of survey responses from BAME staff.

Health and Wellbeing of staff is really important to us, and is a key contributor to the retention of staff. We support the objectives of the national CQUIN, however it is notable that no similar trusts to ours have achieved the targets. We will include a significant amount of supplementary information with our CQUIN submission to commissioners, demonstrating work undertaken to date. We have identified a number of actions to take forward regarding staff health and wellbeing:

- Surveying staff about the three specific survey questions, for their views and solutions. The survey has been completed and is being analysed by staff group and locality to inform targeted action.
- Identifying the additional resources that would be needed to accelerate development and implementation of initiatives in response to the suggestions from staff that the survey raises.
- Adopting the NHS Improvement methodology in terms of service specific retention plans will help identify the extent to which health and wellbeing is a root cause of turnover; and will engage staff in developing solutions.

The results of the 2017 survey have been shared with staff, through a direct communication from the Chief Executive. This included a message of thanks for participating, encouraged staff to review the results for themselves and confirmed our commitment to acting on the results. Progress towards implementing actions arising from the Staff Survey will be overseen by the Business and Strategy Executive.

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	8 May 2018
Title	**Gender Pay Gap Reporting**
Purpose	To outline the information reported and published in compliance with the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017. To provide some commentary from the Nuffield Trust on the national picture, as well as some comparison with other Trusts, and outline current actions being taken on gender pay.
Business Area	Human Resources
Author	Tracey Slegg and Bev Searle
Relevant Strategic Objectives	Supporting our staff; money matters
CQC Registration/Patient Care Impacts	Well led
Resource Impacts	None anticipated

Legal Implications	Compliance with legal obligations for gender pay reporting and publication of this information.
Equality and Diversity Implications	Although the Agenda for Change process is intended to address equal pay, the gender pay gap is a different issue and enables us to understand any differences in the average pay between men and women in the workforce and consider the average gross hourly rate and average bonus pay. Our Diversity Steering Group will oversee the actions outlined in the paper, which aim to deepen our understanding and ensure any specific issues are effectively addressed.
SUMMARY	The attached paper outlines the six calculations required for national reporting and publication, alongside narrative information supplied. The pay gap in the average hourly rate (20.76%) reflects the higher proportion of men in more senior grades within the Trust. The percentage of employees working across the four pay quartiles also shows that female staff are under-represented in the upper pay quartile (Quartile 4). Quartiles 1-3 are much more representative of the total workforce. A high percentage of our workforce is part-time (41.3% in March 2017), with the majority of these (92.6%) being female. Part-time, male staff accounted for just 3% of the total workforce. Comparison with neighbouring and similar Trust results is provided, along with some commentary from the Nuffield Trust based on their analysis of the national picture. A number of actions are highlighted, which summarise work being undertaken to deepen our understanding and inform our response.
ACTION	The Board is asked to note the information reported regarding our gender pay gap, and to provide advice on the actions being taken

Gender Pay Gap Report

1. Introduction

The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 came into force on 31 March 2017. They require that employers with 250 or more employees, including public sector employers report on gender pay and bonus gaps based on data taken from a snapshot date of 31 March each year. Employers have up to 12 months to publish their gender pay gap data

The figures must be uploaded to a dedicated Government website and in addition be published on the employer's website, and ours was published in time to meet this deadline.

The gender pay gap is different to equal pay: equal pay legislation requires that men and women who carry out the same work, similar work or work of equal value be paid the same. It is unlawful not to do so. Within the NHS, the Agenda for Change banding system is designed to reduce any such pay inequalities as it evaluates the responsibilities of the role across a number of factors.

The new gender pay gap reporting regulations are designed to identify any differences in the average pay between men and women in the workforce and consider the average gross hourly rate and average bonus pay.

2. Background and context

Data from 31 March 2017 shows that the gender breakdown by pay band within Berkshire Healthcare was as follows:

Pay Band	Female	Male	Female	Male	Total
Band 1	35	10	77.8%	22.2%	45
Band 2	271	76	78.1%	21.9%	347
Band 3	553	63	89.8%	10.2%	616
Band 4	472	56	89.4%	10.6%	528
Band 5	507	79	86.5%	13.5%	586
Band 6	824	141	85.4%	14.6%	965
Band 7	499	88	85.0%	15.0%	587
Band 8 - Range A	168	42	80.0%	20.0%	210
Band 8 - Range B	70	26	72.9%	27.1%	96
Band 8 - Range C	34	13	72.3%	27.7%	47
Band 8 - Range D	22	7	75.9%	24.1%	29
Band 9	3	2	60.0%	40.0%	5
Board Level Director	2	4	33.3%	66.7%	6
M&D	100	91	52.4%	47.6%	191
NED	2	4	33.3%	66.7%	6
Other	16	3	84.2%	15.8%	19
VSM	2	1	66.7%	33.3%	3
Total	**3580**	**706**	**83.5%**	**16.5%**	**4286**

The above table illustrates that:

- 16.5% of the total workforce on 31 March 2017 was male and 83.5% was female. The proportion of men is higher than this average from Band 8a upwards.

- 26.3% of men are in Band 8a or above (including Medical and Dental, VSM and Directors), compared with 11.2% of women.

3. Gender Pay Gap Reporting Requirements for the new regulations

The data required for the submission to the Government website is specific, and all employers must publish six calculations as follows:

1) the overall difference in the mean hourly rate of pay between male and female employees on the snapshot date of 31 March 2017;
2) the overall difference in the median hourly rate of pay between male and female employees on the snapshot date of 31 March 2017;
3) the difference in mean bonus pay made to male and female employees during the 12 months before 31 March 2017;
4) the difference in median bonus pay made to male and female employees during the 12 months before 31 March;
5) the proportions of male and female employees who received bonus pay in that 12 month period; and
6) the proportions of male and female employees working across quartile pay bands.

Berkshire Healthcare Gender Pay Gap Data for 31 March 2017 was reported as follows:

1) The overall difference in the mean hourly rate of pay between male and female employees on the snapshot date of 31 March 2017

Gender	Average Hourly Rate
Male	20.35
Female	16.13
Difference	4.22
Pay Gap %	20.76

2) The overall difference in the median hourly rate of pay between male and female employees on the snapshot date of 31 March 2017

Gender	Median Hourly Rate
Male	17.35
Female	14.97
Difference	2.38
Pay Gap %	13.72

3) The difference in mean bonus pay made to male and female employees during the 12 months before 31 March 2017

Gender	Average Pay
Male	8,131.02
Female	6,882.07
Difference	1,248.95
Pay Gap %	15.36

4) The difference in median bonus pay made to male and female employees during the 12 months before 31 March

Gender	Median Pay
Male	5,967.20
Female	4,773.70
Difference	1,193.50
Pay Gap %	20.00

5) The proportions of male and female employees who received bonus pay in that 12 month period

Gender	Employees Paid Bonus	Total Employees	%
Female	17	3590	0.47
Male	21	716	2.93

6) the proportions of male and female employees working across quartile pay bands

	Number of Employees		Percentage of Employees	
Quartile	Female	Male	Female	Male
1	873	138	86.35	13.65
2	845	133	86.4	13.6
3	888	155	85.14	14.86
4	754	261	74.29	25.71

Q1 = Low, Q4 = High

In addition to the information in the above tables, employers are afforded the opportunity of providing some narrative to accompany the data, and the following was included in our report:

- The pay gap in the average hourly rate (20.76%) reflects the higher proportion of men in more senior grades within the Trust. The percentage of employees working across the four pay quartiles also shows that female staff are under-represented in the upper pay quartile (Quartile 4). Quartiles 1-3 are much more representative of the total workforce.

- A high percentage of our workforce is part-time (41.3% in March 2017), with the majority of these (92.6%) being female. Part-time, male staff accounted for just 3% of the total workforce:

- The calculation of the hourly rate is based on the gross pay after any deductions for salary sacrifice. In March 2017, 347 members of staff sacrificed their salary, and of these, 83% were female. This will have a disproportionate impact on the hourly rate of female staff resulting in a lower average.

- Analysis of job applications in 2016/17 shows no evidence of bias against women. Female applicants were 1.2 times more likely than male applicants to be shortlisted for interview, and women were 1.1 times more likely to be appointed than men.

- The bonus pay data relates only to Clinical Excellence Awards (CEA) paid to medical staff. 47.6% of the medical workforce is male.

4. The national picture for the NHS and how we compare with others

The Nuffield Trust has published some useful analysis and commentary on gender pay differences in the NHS. This highlighted some important points for consideration:

- More than three-quarters of the NHS workforce is female.
- The NHS is seriously struggling to recruit and retain enough workers to deliver services. So if women working for the NHS are missing opportunities to progress and improve their skills because of the way that career breaks or part-time working are treated, or, for example, because shift patterns are difficult to reconcile with family life, then this is a major problem for the service as a whole. And if predominantly female professions tend to be undervalued, then this might do something to explain morale and retention problems - and even the remarkable lack of a coherent plan for dealing with these.
- While male consultants only receive slightly more in basic pay than their female counterparts: the gap really opens up when we also consider "additional pay" (including overtime, payments for specific initiatives and clinical excellence awards). We are taking this into account in our actions listed below.
- Of the 220 NHS organisations which have published gender pay gap information, 201 (91%) report a pay gap in favour of men.
- The proportion of women in the top pay quartile tends to be lower than in the bottom quartile for virtually all NHS organisations. And this under-representation of women in the top quartile is, to a degree, correlated with a pay gap favouring men.
- For the NHS, we know from staff surveys that employees believe that having equal opportunities for career progression or promotion within their trust has an effect on how

satisfied patients are with the care provided. Ensuring all staff are treated fairly in their pay and other factors, such as career progression, is likely therefore to not only be the right thing to do for staff, but for patients too.

For comparison purposes, the table below shows the mean and median figures for the hourly rate pay gap and the bonus payments pay gap for our neighbouring Trusts and for similar Trusts

	Hourly Rate Pay Gap		Bonus Pay Gap	
Organisation	**Mean**	**Median**	**Mean**	**Median**
Berkshire Healthcare	20.7%	13.7%	15.4%	20.0%
Frimley Heath	18.9%	2.8%	27.0%	33.3%
Royal Berkshire Hospital	24.9%	13.0%	39.4%	43.7%
Oxford Health	13.6%	-2.8%*	53.8%	65.1%
Buckinghamshire Healthcare	29.6%	12.1%	31.2%	0.1%
Southern Health	18.6%	10.7%	57.0%	42.9%

* minus (-) denotes that rate for women is higher than men

5. Actions

Completion of the gender pay gap reporting for compliance with the new regulations has highlighted some actions that we need to address in the coming year. These include

- Specific analysis of applications for posts at Band 8a and above to identify likelihood of shortlisting and appointment and therefore to understand any potential bias against women at any stage of the recruitment process for more senior management positions
- Building understanding of potential barriers to women being appointed to senior roles in our organisation:
    - Identify ways to encourage and accommodate flexible working opportunities for senior roles
    - Consider options to support career development of female staff, in particular those who have worked/are working part-time, for example career counselling, mentoring, shadowing, etc.
- Encouraging female consultants to apply for Clinical Excellence Awards and offer support (if required) to complete the application process. We will continue to monitor application and award value rates for men and women.
- Ensuring that our Awards Committee is gender-balanced.
- Build a consideration of gender balance into our workforce plans being developed for all our main service areas – ensuring that we develop an attractive employment offer for all prospective employees at all grades.

This work will be overseen by the Diversity Steering Group, chaired by the Director of Corporate Affairs, and including Non-Executive Director membership by Mehmuda Mian.

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	08 May 2018
Title	Financial Summary Report – Year End 2017/18
Purpose	To provide the Month 12 2017/18 financial position to the Trust Board
Business Area	Finance
Author	Chief Financial Officer
Relevant Strategic Objectives	To deliver financially sustainable services through efficient provision of clinical & non-clinical services
CQC Registration/Patient Care Impacts	N/A
Resource Impacts	None
Legal Implications	Meeting regulatory requirements
Equality and Diversity Implications	N/A
SUMMARY	The Financial Summary Report provides the Board with pre-audited summary of the YE 2017/18 financial position.
ACTION REQUIRED	The Board is invited to note the following summary of pre-audit financial performance and results for Month 12 2017/18 (March 2018): The Trust has delivered, and marginally exceeded its 17/18 surplus control total of £2.4m (1% margin). As a result a year end award was made by NHSi of incentive and bonus STF funding of £1.8m (£3.5m STF achieved in total). **YTD (Use of Resource) metric:** • Overall rating 1 (plan 1 – lowest risk rating) o Capital Service Cover 2.1 (rating 2) o Liquidity days 9.5 (rating 1) o I&E Margin 1.1% (rating 1)

	o I&E Variance 0.1% (rating 1) o Agency -35.0% (rating 1) **YTD Income Statement (for control total, including S&T Funding):** • Plan: £2.4m surplus • Actual: *£4.4m • Variance: £2.0m **(including £1.8m bonus & incentive payments)* **YE Cash** £22.3m vs Plan £19.5m Key Variances: • YTD capital underspend due to re-phasing of Estates and IM&T expenditure +£3.3m • Aged debtors over 30 days totals -£1.3m • STF bonus not in plan (16/17) +£0.8m **YTD Capital expenditure:** £7.7m vs Plan £12.8m Key Variances: • Estates, revised timings of ward configuration at PPH (PFI), to 18/19. (lower by £1.9m) • IM&T, re-phasing of IT replacement programme; focus on GDE. (lower by £2.5m)

Berkshire Healthcare NHS
NHS Foundation Trust

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

Finance Report

Financial Year YE 2017/18

Month 12 (March 2018)

Purpose

This document provides the Board and Executive with information giving the financial performance as at 31st March 2018 (Month 12).

Document Control

Version	Date	Author	Comments
1.0	12.04.18	Bharti Bhoja	Draft
2.0	13.04.18	Tom Stacey	2nd Draft
3.0	16.04.18	Paul Gray	Final
4.0	25.04.18	Bharti Bhoja	Inclusion of STF Bonus Payments
5.0	26.04.18	Paul Gray	Final

Distribution:

All Directors

All staff needing to see this report.

Contents

1.0 Overview

In the initial closure of the 17/18 accounts, the Trust exceeded Control Total by £0.2m. In doing so, the Trust has benefitted from £0.2m of STF £ for £ incentive, a general incentive payment of £0.556m, and an additional bonus payment of £1.056m.

The result is the Trust finishing the year with a surplus of £4.4m against its Control Total of £2.4m.

The Trust delivered a statuary surplus of £5.6m, after inclusion of donations and impairments. This was £3.2m ahead of our plan of £2.4m.

The Trust had £22.3m cash at the end of March. This is £2.8m higher than plan of £19.5m, and is largely due to slippage against the capital programme of £4.4m; offset partly by higher aged debt of £2.1m.

The Trust has maintained its NHSi Use of Resources rating of "1".

Key messages this month:

Month 12

- **Acute & PICU Mental Health placements** rose in March by £243k, increasing the adverse variance to £412k for the month. This has been driven by high number of patients during March (av. 10 acute and 3 PICU).

- **Additional Income** through additional STF funding (£207k) where £ for £ matching of surplus exceeding control total, general incentive of £556k and a bonus of £1.056m was gained. The control total delivery bonus was notified by NHSi on 20th April 2018.

- **Cash** receipt from disposal of Little House (£0.8m) was received in early April, although the actual sale was completed on the 29th March, and the profit on disposal recognised in March (£100k).

Statutory Item

- To note, within the statutory surplus; a £534k impairment on improvement works at the University of Reading site has been recognised. This does not affect Control Total performance, but does raise the issue of impairment risk against future works.

2.0 Income & Expenditure Summary

Description	Current Month			Year to Date		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Main Operating Income	**18,604**	**17,858**	**(746)**	**223,724**	**222,930**	**(794)**
Other Operating Income	**1,605**	**1,940**	**336**	**20,794**	**22,438**	**1,644**
S&T Funding	**195**	**2,014**	**1,819**	**1,730**	**3,549**	**1,819**
Operating Expenditure						
Pay - SIP	(14,190)	(11,692)	2,499	(171,843)	(150,033)	21,809
Pay - Bank	(199)	(1,342)	(1,143)	(2,066)	(11,199)	(9,132)
Pay - Agency	(23)	(600)	(576)	(409)	(8,857)	(8,447)
Non Pay - Acute Overspill	(43)	(456)	(412)	(521)	(3,194)	(2,673)
Non Pay - Specialist Placements	(667)	(794)	(127)	(8,011)	(9,300)	(1,290)
Non Pay - Drugs & Clinical Supplies	(749)	(620)	130	(8,977)	(8,858)	119
Non Pay - Premises	(987)	(1,221)	(234)	(11,682)	(12,586)	(903)
Non Pay - All Other	(2,224)	(2,543)	(319)	(29,371)	(30,659)	(1,288)
Total Operating Expenditure	**(19,084)**	**(19,267)**	**(182)**	**(232,880)**	**(234,686)**	**(1,806)**
EBITDA	**1,319**	**2,546**	**1,226**	**13,368**	**14,231**	**863**
Non Operating Income/Expenditure						
Interest Receivable	3	6	3	40	50	10
Interest Payable	(299)	(299)	(0)	(3,590)	(3,590)	(0)
Other Finance Costs	0	0	0	0	0	0
Impairment	0	2	2	0	(93)	(93)
Restructuring	0	0	0	0	0	0
Profit / (Loss) on Asset Disposal	0	100	100	0	100	100
Depreciation & Amortisation	(508)	(297)	211	(6,127)	(4,743)	1,384
PDC Dividend	(101)	(204)	(102)	(1,216)	(1,521)	(305)
Total non operating income/expenditure	**(905)**	**(692)**	**213**	**(10,893)**	**(9,798)**	**1,096**
Net Surplus/(Deficit) - vs Plan	**414**	**1,854**	**1,440**	**2,475**	**4,434**	**1,959**
Net Surplus/(Deficit) - vs Control Total				**2,408**	**4,434**	**2,026**
Impairment - below control total	**0**	**(534)**	**(534)**	**0**	**(534)**	**(534)**
Charitable Donations						
Donations credited to SoCI	0	77	77	0	1,714	1,714
Depreciation of Donated Assets	(8)	(2)	6	(74)	(19)	56
Total Charitable Donations	**(8)**	**75**	**83**	**(74)**	**1,696**	**1,770**
Net Surplus/(Deficit) - Statutory	**406**	**1,395**	**989**	**2,400**	**5,595**	**3,195**
Note to SoCI table above:-						
S&T Funding within Operating Income	195	2,014	1,819	1,730	3,549	1,819
Net Surplus/(Deficit) ex. S&T & Renal	**219**	**(160)**	**(379)**	**745**	**885**	**140**
RCI Note:-						
RCIs Achievement	**392**	**237**	**(155)**	**4,700**	**1,565**	**(3,135)**

In Month

The Trust reported a £1.9m surplus, £1.4m higher than the plan.

Excluding S&T funding of £2.0m, the Trust generated an underlying deficit of £160k.

Income under-achieved by £1,4m, and included a number of year-end adjustments. Aside from these the key contributors to the position were:

- £1,819k (F) STF income
- £200k (A) Deferral of IAPT West Expansion.
- £184k (F) release of Learning & Development deferred income.
- £129k (F) NHSPS costs recharged.

Pay trend continues, with the Trust continuing to operate with a substantial number of vacancies, which after accounting for the use of non-permanent staffing, has given rise to a £779k underspend in March. The main areas of underspend include:

- £168k (F) CTPLD –Vacancies & release of prior year accruals.
- £121k (F) Intermediate Care-Vacancies & release of prior year accruals.
- £98k (F) District Nursing – High vacancy levels.
- £98k (F) IAPT – Mainly vacancies inclusive of slippage in investment.

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

- £103k (A) Westcall due to Easter bank holiday cover and double running of Advanced Nurse Practitioners.
- £68k (A) CRHTT mainly due to additional bank staff and agency usage (to cover sickness, maternity and increased workloads).

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

Non Pay is overspent by £962k with the main reasons being:

- £412k (A) Acute & PICU MH placements adverse variance of £412k for the month. This is due mainly (£335k) to the high number of patients during March (av. 10 acute and 3 PICU) and (£77k) due to the increase in accruals rate to include increased usage of observations.
- £231k (A) Estates costs with high level of replacement and improvement to buildings over recent months*. Although to note, some offset within this month with received income from NHSPS.*
- £127k (A) Independent Hospital (specialist) MH placements.

Non-operating Income & Expenditure is underspent by £213k. Lower than expected depreciation (£211k) and profit on the disposal of Little House (£100k), offset a £102k increase in PDC costs arising from the upward year end revaluations of the estate.

Year to date

Income is over achieved by £2,669k with the main reasons being:

- £200k (A) Deferral of IAPT West Expansion.
- £312k (F) MSK East contract renegotiation upwards as well as moving from variable to block contract.
- £253k (F) Additional in-year CAMHs.
- £243k (F) Prior year income recovery in CAMHs.
- £1819k (F) STF matching and bonus additional income.
- £207k (F) COIN Income received.
- £184k (F) release of Learning & Development deferred income.
- £144k (F) CAMHS income released,
- £129k (F) NHSPS costs recharged.
- £122k (F) RiO income from CCG
- £99k (F) RBC income for prior years

- £80k (F) SWIC prior year activity income,
- £80k (F) Silvercloud development costs provision release,

YTD Pay spend is £4.230m below plan, with £21.8m of substantive vacancies. The current pay position continues to offset this years unallocated / unachieved CIPs. The plan for 18/19 assumes that £6m of these vacancies will continue as run rate, with significant difficulty in recruiting to specific service lines and qualified nurses. The main areas of underspend are:

- £1,727k (F) District Nursing - Mainly due to vacancies
- £855k (F) Talking Therapies – Due to vacancies
- £666k (F) Intermediate Care - Vacancies
- £594k (F) Liaison & Diversion - Vacancies and slippage on investment
- £403k (F) CMHT's - Mainly due to vacancies
- £390k (F) OPMH – Mainly due to vacancies
- £387k (F) Health Visiting - Mainly due to vacancies
- £374k (F) CTPLD – Mainly due to Vacancies
- £350k (F) CAMHs – Mainly due to vacancies
- £247k (F) Learning Disabilities - Mainly due to closed ward whilst community service is implemented.

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

- £561k (A) Westcall - Including high cost cover during holiday periods and double running for ANP.
- £445k (A) 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.
- £399k (A) Medical Staffing – driven by various locum covers and recently additional cover in CRHTT.

The elimination of overspends in WestCall and CRHTT is a key component of the 18/19 Cost Improvement programme.

Non Pay is overspent by £6.035m and has been the major risk within the financial position this year. The key areas of overspend were:

- £2,673k (A) Acute Overspill / PICU MH placements
- £1,290k (A) Independent Hospital (specialist) MH placements
- £564k (A) 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 recharging to NHS Property Services.
- £250k (A) FP10 costs are high, (Excludes recharged Westcall FP10s).
- £116k (A) MH Assessment Fees are high.

Non-operating Income & Expenditure is underspent by £1,096k with lower depreciation of £1,384k being offset by increased PDC Dividend £305k and impairment costs of £93k.

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	107	11	1,150	715	-435	1,150	715	-435
Corporate Back Office	83	119	36	1,000	537	-463	1,000	754	-246
Operational Mngmnt & Spprt	50	-17	-67	600	20	-580	600	37	-563
Procurement	25	13	-12	300	116	-184	300	155	-145
Discretionary Spend	8		-8	100		-100	100		-100
Estates Strategy	17		-17	200		-200	200		-200
OAPs	42		-42	500		-500	500		-500
Unallocated / Possible STP	71	15	-56	850	177	-673	850	177	-673
Total	**392**	**237**	**-155**	**4,700**	**1,565**	**-3,135**	**4,700**	**1,838**	**-2,862**

We have delivered £237k of recurrent savings in month, including final outstanding QIA CIPs. The in-year CIP benefit is a total of £1,565k; with those savings making a £1,838k on a full year basis.

This represents a shortfall of £2,862k against our CIP plan and delivery of only 39% of plan. This level of performance will need to improve if next year's Control Total is to be delivered.

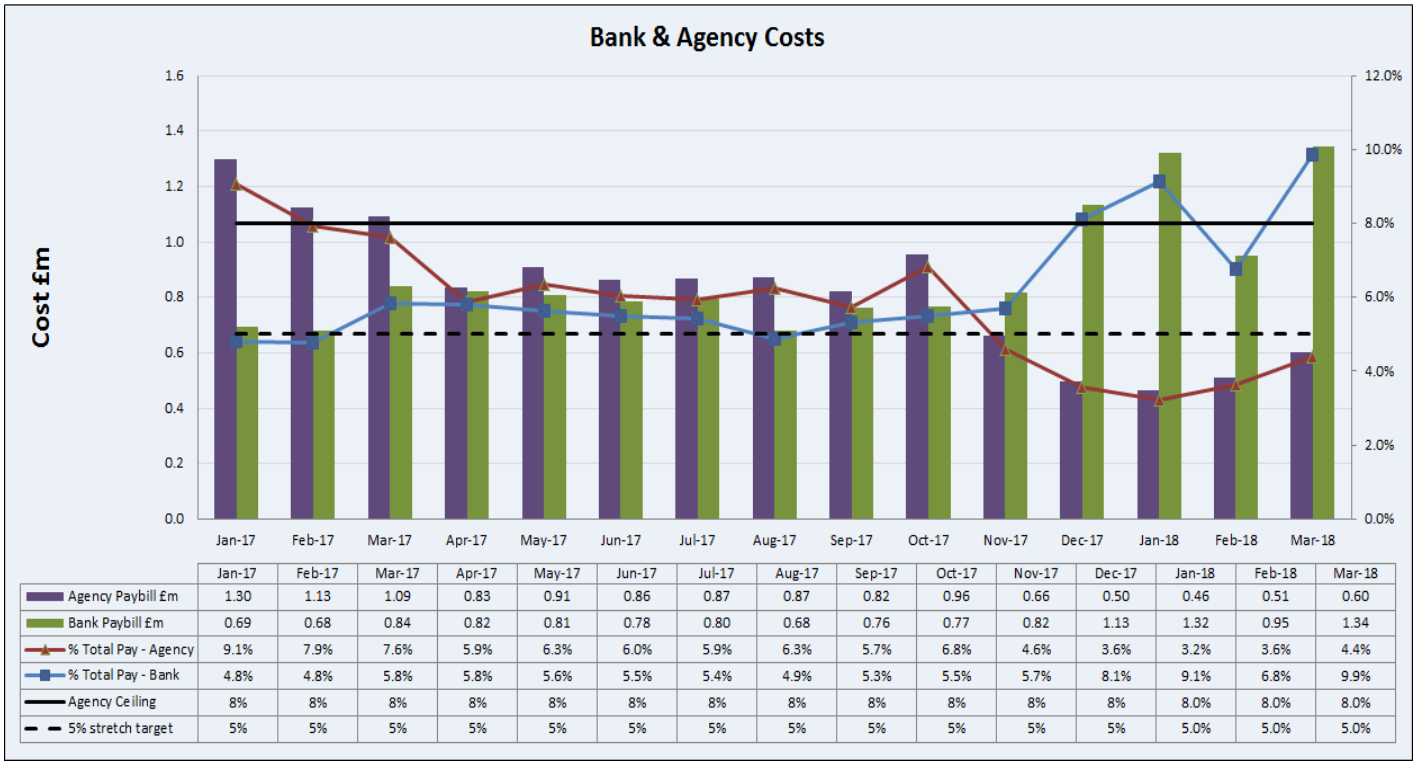
Alongside underlying vacancy benefit, significant mitigation to the CIP plan under performance is the maintenance of significantly reduced agency run rate costs during the year (well below NHSi cap).

3.0 Use of Resources Metric and Agency Summary

Use of Resource Metric	YTD Plan		YTD Actual	YTD Actual
Metric	**Metrics**	**Rating**	**Metrics**	**Rating**
Capital Service Cover (times)	2.3	2	2.1	2
Liquidity (days)	1.6	1	9.5	1
I&E Margin (%)	1.0%	2	1.1%	1
I&E Variance From Plan (%)	-	-	0.1%	1
Agency (% above / below target)	0%	1	-35%	1
Use Of Resources Rating		1		1

Our year end performance maintains Use of Resources rating of '1', the lowest financial risk rating.

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	Mar-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	0.60
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	1.34
% 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%	4.4%
% 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%	9.9%
Agency Ceiling	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8.0%	8.0%	8.0%
5% stretch target	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5.0%	5.0%	5.0%

Agency costs were £600k in March and £8.8m YTD. We are continuing to operate well below our NHSi ceiling of 8% or £11.3m.

Agency costs remain substantially below levels seen earlier in the year however costs rose by £89k this month and represent a second month of increase from the low point in January. The increase compared to February was mainly driven by Mental Health Inpatients (£13k), Mental Health East (£12K), Mental Health West (£32K) and CYPF (£14k).

Bank costs have increased in March by £392k due mainly to cover annual leave and bank holidays. £202k of this increase was in Community Health West (of this Westcall increase was £111k and Inpatients £85k), £65k in Mental Health East and £57k in Mental Health Inpatients.

4.0 Balance Sheet Summary

Statement of Financial Position

The current Statement of Financial Position (Balance Sheet) is provided below. This reflects the increase in PPE and Intangibles arising from the capital expenditure programme; increase in cash as described below, 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	31st Mar 2018 (Actual) £'000s	31st March 2017 (Actual) £'000s
Non Current Assets (Intangible, Propery Plant and Equipment)	92,843	95,243	88,483
Inventory	109	274	113
Current Receivables (Trade and Other Debtors)	10,111	10,940	11,977
Cash	22,241	22,264	20,696
Non-current assets for sale and assets in disposal groups	0	1,000	0
Current Payables (Trade and Other Creditors)	(25,569)	(23,859)	(26,049)
Other Liabilities (Deferred Income)	(1,469)	(1,843)	(2,012)
Provisions (Current & Non Current)	(1,612)	(1,991)	(2,098)
PFI Finance Lease Creditor (Current & Non Current)	(30,753)	(30,751)	(31,704)
Total Net Assets / (Liabilities)	**65,901**	**71,277**	**59,408**
Financed by:			
Public Dividend Capital	15,985	15,985	14,210
Revaluation Reserve	31,243	37,031	31,243
Income and Expenditure Reserve	18,673	18,261	13,955
Total Reserves	**65,901**	**71,277**	**59,408**

Cash

The closing cash balance for March 2018 was £22.3m, against a plan of £19.5m resulting in a favourable variance of £2.8m.

The main factors contributing to the cash balance variance were:

- Slippage against capital expenditure **(+£3.3m)**,
- STF bonus funds from 2016/17 received in 2017/18 that were not in the cash plan **(+£0.8m)**,
- Offset by aged debtors over 30 days totalled **(-£1.3m)**, mainly relating to cluster of CCGs (£0.7m), NHS PS (£0.2m) and RBH (£0.1m),

Actions have been taken to resolve the aged debtors with the respective organisations.

The trust completed the sale of The Little House to Finefair Housing Limited on Thursday 29th March 2018 for the price of £800K and the payment was been received on 3rd April 2018.

Trade Receivables

The overall receivables balance was £4.7m, which is a decrease of £1m from February 2018 (£5.7m). The movement has been primarily driven by decrease in 60-90 days receivables (£0.7m) and current receivables (£0.5m), offset by increase in 30-60 days (£0.2m), mainly relating to NHSPS (£0.1m).

Trade Payables

Trade Payables at the end of March 2018 were £7.7m, which is an increase of £0.3m from February 2018 (£7.4m). The main driver for the movement was an increase in current payables by (£1.7m), offset by decrease in 31-60 days (£1.9m). The increase in 61-90 days was mainly caused by South Reading CCG (£0.2m) and NHS PS (£0.1m). The increase in over 90 days payables related to Frimley Health (£0.2m).

6.0 Capital Programme

Capital Expenditure March 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	51	(49)	120	76	44	120	76	44
- Leased Non Commercial (NHSPS)	245	131	114	615	231	384	615	231	384
- Leased Commercial	7	(1)	8	82	10	72	82	10	72
- Statutory Compliance	75	36	39	640	157	483	640	157	483
- Locality Consolidations	160	19	141	820	1,179	(359)	820	1,179	(359)
- PFI	33	224	(191)	2,223	958	1,265	2,223	958	1,265
Subtotal Estates Maintenance & Replacement	**522**	**460**	**62**	**4,500**	**2,610**	**1,890**	**4,500**	**2,610**	**1,890**
Development Expenditure									
- IM&T Refresh & Replacement	446	455	(9)	2,076	1,073	1,003	2,076	1,073	1,003
- IM&T Business Intelligence and Reporting	0	127	(127)	378	186	192	378	186	192
- IM&T System & Network Developments	0	30	(30)	795	56	739	795	56	739
- IM&T RIO	0	0	0	447	8	439	447	8	439
- IM&T Other	20	(16)	36	151	86	65	151	86	65
- IM&T Locality Schemes	18	78	(60)	200	183	17	200	183	17
Subtotal Development Expenditure	**484**	**673**	**(189)**	**4,047**	**1,592**	**2,455**	**4,047**	**1,592**	**2,455**
Other Locality Schemes									
- Other Locality Schemes	100	7	93	100	31	69	100	31	69
Subtotal Other Locality Schemes	**100**	**7**	**93**	**100**	**31**	**69**	**100**	**31**	**69**
Subtotal Capital Expenditure	**1,106**	**1,140**	**(34)**	**8,647**	**4,234**	**4,413**	**8,647**	**4,234**	**4,413**
Capital expenditure additional funding									
GDE capital cost funded by NHS Digital	0	(9)	9	0	1,775	(1,775)	1,775	1,775	(0)
Renal Unit at WBCH funded by donation	0	75	(75)	0	1,703	(1,703)	2,400	1,703	697
Grand Total Capital Expenditure	**1,106**	**1,206**	**(100)**	**8,647**	**7,712**	**935**	**12,822**	**7,712**	**5,110**

YTD

2017/18 ended behind plan with an underspend of £5.1m. This was due to:

- Estates £1.9m:-
  - Mainly due to slippage of the LD to Jasmine project (£1.3m) which has now been re-profiled to commence in 2018/19

    Statutory Compliance projects (£0.5m), which includes Trust Wide projects such as Fire Risk Assessments (£0.1m), Security Improvements (£0.1m), Environment/carbon reduction (£0.1m), Health & Safety (£0.1m), and Green Travel Plan (£0.1m). Changes to planned timing of works do not increase statutory risk profile.

  - The underspends against these schemes is offset by in-year funding approvals against Estate schemes, primarily funding for University of Reading (-£0.3m) and Reconfiguration of Southcote & Tilehurst Clinic (-£0.2m).

- IM&T £2.5m:-
  - Mainly due to some of the Trust's planned expenditure being reclassified to Global Digital Exemplar Programme, specifically Refresh and Replacement (£0.6m); eEPMA (£0.5m); Clinical Correspondence (£0.3m) and EOBS (£0.1m). The remaining underspend relates to projects that didn't commence during the year: Finance System Replacement (£0.2), RiO Reconfiguration (£0.2m) and Skype interface (£0.1m).

The Trust received funding of £1.8m for the Global Digital Exemplar (GDE) for year one of this 3.5 year programme. This was spent on ePMA (£0.6m), Second Generation Mobile Workforce (£0.6m), IAPT online therapies (£0.2m), EOBS (£0.2m), Digital Appointment Correspondence (£0.1m) & PMO costs (£0.1m).

In addition to Trust funded schemes, the charitable funded Renal Unit incurred £1.7m on shell & core work. Charity funding of £0.7m will be carried forward to 2018/19 and is planned to be fully spent on the fit out work.

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	8th May 2018
Title	**Summary Board Performance Report M12 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 March 2018. **Month 12** **2017/18 <u>EXCEPTIONS</u>** **The following Trust Performance Scorecard Summary indicator grouping is Red rated:** The "red" indicator grouping has been rated on an override basis, related to 1 specific indicator; • NHS Improvement (non-financial) – 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)** • **DM-01** - 6-week compliance for Audiology Diagnostics **(NHS Improvement non-financial)** • **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-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.

Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

Board Summary Performance Report

M12: 2017/18 March 2018

Performance Scorecard Summary: Month 12, 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)	Red	No	N/A
	MA-16	NHS Improvement (financial)	Green	No	N/A
SE	SE-01 to SE-11	Service Efficiency & Effectiveness	Green	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:
SOF 01-05 & 07-10

% 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; M12: March 2018:

- Mental Health 7 day follow up
- Mental Health new EIP cases seen within 2 weeks
- DM01 Diagnostics for Audiology – percentage of those waiting 6 weeks or more
- MHSDS – Data Quality Maturity Index
- A&E maximum waiting time of 4 hours, RTT Incomplete Pathways, IAPT 6 Weeks and 18 weeks, reduction in OAPS against agreed trajectory
- Failure against published thresholds for Infection Control rates for Clostridium Difficile, E-Coli, MSSA and MRSA

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

Subjective

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

Performance Scorecard Summary: Month 12: 2017/18

Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

Exception report

Summary of Red Exceptions M12: 2017/18			
Indicator	**Indicator No**	**Comments**	**Section**
Self-Harm incidents	US-05	Increased from 291 to 321	User Safety
Prevention and Management of Violence and Aggression (PMVA)	US-18	Increased from 52 to 69	User Safety
Staff Turnover	PM-01	Remained at 16.4%	People Management
Gross Vacancies	PM-02	Remained at 12.5%	People Management
6-week compliance for Audiology Diagnostics	DM-01	97.43% below 99% target	NHS Improvement
MH Acute Length of Stay	SE-03	Decreased from 36 days to 35 days	Service Efficiency
MH Average Length of Stay Snapshot	SE-03a	Increased from 52 to 57 days	Service Efficiency
MH Acute Occupancy Rate by Locality and Ward	SE-06 a & b	Decreased from 98% to 95%	Service Efficiency
New Birth Visits	SE-08	Decreased from 91.6% to 90.3%	Service Efficiency
Clustering	SE-10	Decreased from 88.2% to 86.9%	Service Efficiency

User Safety Commentary

There were 7 serious incidents in March 2018. These were; 1 apparent suicide of a Bracknell CMHT client, 1 alleged sexual assault of a Rose ward patient, 1 unexpected death of a Rowan ward client, 1 suspected overdose of a detained client whilst AWOL from Daisy ward, 1 fall with harm on Henry Tudor ward, and 2 information governance breaches (Diabetic Eye screening and Westcall).

The number of assaults on staff decreased to 60 in the rolling quarter to March 2018 and remains amber rated. In the rolling quarter, Mental Health Inpatients reported 50 incidents (41 last month), 10 incidents were reported on Sorrel ward (5 last month), 5 on Daisy ward (2 last month), 4 incidents on Bluebell ward (5 last month), 11 on Snowdrop ward (20 last month), 4 on Rowan ward (3 last month), 4 incidents were reported on Rose ward (2 last month) and 4 on Orchid ward (same last month). In addition, 6 incidents took place at the Place of Safety. In the rolling quarter 8 incidents were reported at Willow House (CAMHS). In the community there were 2 incidents reported by CAMHS and Talking Therapies. One incident on Bluebell ward has initially been rated as moderate. All other incidents in March 2018 were rated as low or minor risk. This shows an increasing trend.

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

Patient to Patient Assaults - in Mental Health Inpatient services has increased to 36 in the rolling quarter to March 2018 and remains rated as amber against a local target. In the rolling quarter these occurred as follows; 14 incidents took place on Sorrel ward (6 last month), 3 on Rowan ward (1 last month), 2 on Daisy ward (6 last month), 4 on Rose ward (4 last month), 1 on Bluebell ward (same as last month), 4 on Snowdrop ward (6 last month). 5 incidents were reported at Willow House in the rolling quarter. 1 incident has been reported in the community by Talking Therapies and 2 by West Berkshire Older Adults services. All incidents in March 2018 were reported as low or minor risk. At the time of reporting a total of 21 clients carried out assaults on other patients including 1 client who has carried out 5 assaults. This shows an increasing trend.

Learning Disability - Patient to Patient Assaults decreased to 9 (previously 16) in the rolling quarter to March 2018. All incidents were rated as low or minor risk and the assaults were carried out by 4 clients including 2 clients responsible for 3 incidents each. This shows a decreasing trend.

Slips Trips and falls – all areas below target. As part of the fall safe project, Orchid 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.

Self-Harm incidents have increased to 321 in the rolling quarter to March 2018, and remains rated as red. In the rolling quarter, 126 incidents (132 last month) have been reported by Willow House at the time of reporting these were for 9 clients, including 30 for 1 client and 26 incidents for another. All incidents reported at the Willow House were rated as low or minor risk. There were a total of 175 incidents reported in the rolling quarter to March 2018 by Mental Health Inpatients which is an increase from 139 in the rolling quarter to March 2018. Of these, 55 incidents were reported on Rose ward (41 last month), 42 incidents on Bluebell ward (same as last month) and 13 on Snowdrop ward (increased from 12) and 47 on Daisy ward (28 last month) and 1 on Sorrel ward. There were also incidents reported as follows; 4 each at Prospect Park Hospital, patient home and public place or street, 2 were at another or unknown location and 1 at MH Reception. At the time of reporting 23 inpatients self-harmed during the rolling quarter with one client responsible for 34 incidents and another client responsible for 18 incidents. 1 incident in Mental Health Inpatients

in March 2018 was rated as moderate. All other incidents in Mental Health Inpatients in March 2018 were rated as low or minor risk. In the community in the rolling quarter, the following incidents were reported; 8 for IAPT, 2 for CMHT (1 for Reading and 1 for WAM), 5 for the Crisis Resolution team, 3 for IMPACTT and 1 each for Criminal Justice Liaison and Diversion service and Common Point of Entry. This shows an increasing trend. For Mental Health inpatients including Willow House this is a Quality Improvement programme breakthrough objective.

Learning Disability Self-Harm remained at 4 in the rolling quarter to March 2018. 1 low risk incident was reported in March 2018. This shows a decreasing trend.

AWOLS and Absconsions - the data covers only those clients detained on a Mental Health Act section and is measured against a local target. AWOLS decreased (19 to 15) and Absconsions increased (12 to 15) in the rolling quarter to March 2018. In March 2018, there were a total of 7 AWOLs reported; 1 each from Bluebell ward and Snowdrop ward, Daisy ward and Rose ward, 2 from Public Place or street and 1 from Hospital Grounds. All incidents in March 2018 were rated as low risk. In March 2018 there were 5 absconsions; 1 each from Bluebell ward, Orchid ward and Snowdrop ward and 2 from Daisy ward. Both AWOLs and Absconsions show decreasing trends.

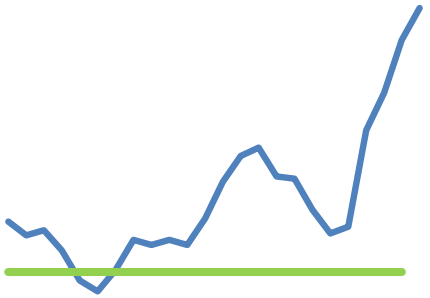
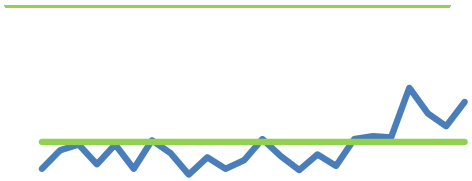
PMVA (Control and Restraint of Mental Health patients) – at the time of reporting in March 2018, there were 69 uses on 15 clients with 11 uses on 1 Willow House client. There were 26 uses at Willow House, 11 uses on Daisy ward, 10 uses on Sorrel ward, 8 uses on Bluebell ward, 5 on Rose ward, 6 uses on Snowdrop ward and 2 uses at the place of safety. One incident on Bluebell has been rated as moderate.

There were 14 incidents of prone restraint in March 2018. These occurred on the wards as follows; 5 at Willow House, 3 each on Bluebell and Snowdrop and 2 on Rose ward. At the time of reporting there was one use on Campion Unit, which is being investigated. 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 6 uses of Strategy for Crisis Intervention and Prevention on 2 Learning Disability clients.

Seclusion in March 2018 for Mental Health Inpatients - there were 12 uses of seclusion for 6 patients in March 2018. The longest episode of seclusion was for 13 hours and 25 minutes relating to on-going presentation and risk management of the client. There were no uses of seclusion by Learning Disability Services.

User Safety Exception Report Month 12: 2017/18

KPI	Target	Mar-18	Trend	Context/Reasons	Commentary of Trend
Self-Harm incidents	<75	321		**Self-harm incidents increased in Adult Mental Health Inpatients and CAMHS Inpatients, with 4 individuals driving the increase.**	
Preventing and Managing Violence and Aggression (PMVA)	<41	69		**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 Patient to Patient Assaults worsened from 29 in the rolling quarter to February 2018 to 36 in the rolling quarter to March 2018.
- Mental Health Self-harm has worsened from 291 incidents in the rolling quarter to February 2018 to 321 in the rolling quarter to March 2018.
- Absconsions have worsened from 12 in the rolling quarter to February 2018 to 15 in the rolling quarter to March 2018.
- Prevention and Management of Violence and Aggression has worsened from 52 in the month of February 2018 to 69 in the month of March 2018.
- Prone Restraint has worsened from 5 uses in February 2018 to 14 in March 2018.

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

- Mental Health Physical Assaults on staff improved from 68 in the rolling quarter to February 2018 to 60 in the rolling quarter to March 2018.
- Learning Disability Physical Assaults on staff improved from 47 in the rolling quarter to February 2018 to 40 in the rolling quarter to March 2018.
- Learning Disability Patient to Patient Assaults improved from 16 in the rolling quarter to February 2018 to 9 in the rolling quarter to March 2018.
- Learning Disability Strategy for Crisis Intervention and Prevention has improved from 9 in February 2018 to 6 in March 2018.
- AWOLs have improved from 19 in the rolling quarter to February 2018 to 15 in the rolling quarter to March 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) 1 is amber (Fire) and 4 are green (Statutory training - Health and Safety and Manual Handling, Mandatory training - Information Governance and Sickness). The PDP target was for June 2017 and this was achieved.

Sickness Absence

• The confirmed Trust-wide monthly sickness rate for February 2018 is 3.76%, a significant decrease from 4.46% in January and compares to a monthly sickness rate of 3.82% in February 2017.

• The decrease in the monthly sickness rate is largely attributed to a decrease in absences due to cold/cough/flu. The total sickness rate for cold/cough/flu absences in February has decreased to 0.69%, from a peak of 1.07% in January, with decreases evident in both the short-term and medium-term sickness rates for this reason. The sickness rate attributed to cold/cough/flu remains higher than the same period last year (total sickness rate for this reason was 0.59% in February 2017).

• There has been a significant reduction in the short-term sickness rate in February to 1.21% (from 1.63% in January). This is due to the decrease in short-term cold/cough/flu absences identified above and a decrease in the short-term sickness rate due to gastrointestinal problems following the increases reported in the previous two months. The long-term sickness rate in February remains consistent with the January figure at 1.83% and compares favourably with the rate in February 2017 of 2.03%.

• The total sickness rate attributed to musculoskeletal/back problems has reduced in February to 0.72% (from 0.84% in January). This decrease is also evident in the long-term sickness rate for this reason which has decreased from 0.58% in January to 0.49% in February (with an average of 0.59% in the previous six months). Work is on-going within the localities to sustain both this reduction in the sickness rate and the recent increase seen in the number of referrals to the early intervention physiotherapy service.

• There has been an increase in the long-term sickness rate in February attributed to genitourinary and gynaecological disorders, which requires further analysis to identify any issues or trends.

• All staff in West Berkshire Adult services have been sent an information letter providing an overview of the Trust sickness absence management process, including reporting requirements, use of return to work interviews, sickness triggers, and the informal and formal absence management process. The letter was accompanied by a template for an individual ‘Health and Wellbeing Plan’ which prompts staff to reflect on triggers at work which impact on their wellbeing and facilitates staff to take ownership of their wellbeing, with support from their manager. This initiative is also being rolled out across other localities and any measureable impact on sickness rates will be analysed and learning shared by the HR Managers.

Recruitment

• Attendance at 10 job fairs has resulted in 17 accepted offers of employment for community nursing roles: 4 have started, 4 have start dates pending and 9 are undergoing pre-employment checks. No offers have yet been made for community mental health or mental health inpatient roles.

• A total of 293 students have now been registered to the Talent Pool database as a result of attendance at job fairs (37% of whom are mental health nursing students).

• Seven rounds of community nursing recruitment hubs have taken place with a total of 36 applications for vacancies in bands 4-6 (56% for band 5 roles). 2 individuals have commenced employment, 4 have start dates pending, 5 are undergoing pre-employment checks and there are 3 further interviews pending.

Turnover

• The Trust-wide turnover rate in March has increased to 16.42% from 16.35% in February. The turnover rate in Oxford Health (January 2018) increased to 18.71%.

• Preliminary work is on-going to analyse the turnover data within District Nursing in East Berkshire, in order to inform an action plan to deliver a measurable reduction in the turnover rate. A retention project group is also being established within Children's Services which will focus on turnover and will also link with plans to refresh the wellbeing work within the locality.

Statutory and Mandatory Training

Statutory Training – Fire Training has reduced to 91% with only Mental Health Inpatients above target. 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 who are non-compliant. The largest area of non-compliance are Estates and Facilities who are being offered training with a paper-based test.

Mandatory Training - Information Governance has increased to 95% and is at target. 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 the highest number of non-compliant staff. For the Information Governance Toolkit submission in March 2018, the Trust achieved the 95% target.

PDP - Target for June 2017 was achieved.

People Exception Report Month 12 2017/18

KPI	Target	Mar-18	Trend	Context/Reasons	Commentary of Trend
Staff Turnover (% YTD): Percent	<15.2%	16.42%		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 have been challenges 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.

Other Key Performance Highlights for this Section

- Sickness has improved from 4.46% January to 3.79% in February 2018.
- Information Governance training has improved from 94% in February 2018 to 95% in March 2018.

NHS Improvement Non-Financial and Financial Commentary

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

DM01 – 6-week compliance for Audiology Diagnostics – 226/232 of those waiting at the end of March 2018 for a diagnostic test were waiting within 6 weeks. This is 97.43% compliance and is below the 99% target. These breaches are because of the unprecedented increase in the number of balance assessment referrals from Frimley Health which is above and beyond the demand the capacity we are contracted to support. The Trust has communicated this to our colleagues in Frimley Health Ear Nose and Throat Department, who have had a new consultant join the Frimley team in October. Frimley Health have confirmed expectation for referrals to come back to expected/contractual levels and additional clinics have been established to clear the backlog.

• Introduction of the Data Quality Maturity Index (for the Mental Health Services Data Set (MHSDS) 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 2017/18 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 - each STP area has to produce a trajectory to eliminate the number of Out of Area placements by 2020/21 for submission by 17th November 2017 and monitoring will commence in Quarter 1 2018/19. The latest published data on NHS Digital website as at 20th March 2018 shows that for January 2018 the Trust had 5 inappropriate OAPs and 1,095 beds days were used by patients sent out of area. For the calendar year 2017, the Trust had a total of 120 OAPS and 6,580 bed days were used by patients sent out of area. The OAPS Board will ensure there is a robust process and sign off for the return from April 2018.

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

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. For March 2018 1 case of Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI) was reported on Donnington ward. 1 Clostridium Difficile case has occurred in March 2018 on Ascot ward and a post infection review is being undertaken. 1 Clostridium Difficile case on Windsor ward which occurred in February has been attributed as a lapse in care; the Trust did not have a central target but a contractual target of below 4 cases in the West and 2 in the East.

The Single Oversight Framework will continue to include an annual rating on the Cardio Metabolic CQUIN which is designed to reduce premature mortality rates amongst people with severe mental illness. The Trust rates for Q4 2016/17 show that we are above targets published in the Single Oversight Framework; for 2017/18 the RPsych 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

KPI	Target	Mar-18	Trend	Context/Reasons	Commentary of Trend
Audiology Diagnostics 6 week wait	**99%**	**97.40%**		**6 out of 232 clients waiting over 6 weeks at the end of March for Audiology tests. New indicator in Single Oversight Framework 2017/18 published 13th November 2018.**	**Increase in referrals from Frimley Health ENT has led to breaches in Quarter 4. Being raised through contracting route.**

Service Efficiency and Effectiveness Commentary

There are 13 indicators within this category, 6 are rated as “Green” including DNA rates, CHS Length of stay and CHS Occupancy, Crisis plans, and Mental Health Readmissions and Mental Health Non-Acute Occupancy. None are rated as “Amber”, 6 are rated “Red”; MH Average and Snapshot Length of Stay, Mental Health Acute occupancy by ward and by locality, Clustering and Health Visiting, and 1 of which does not have a target (place of safety).

The DNA rate reduced from 4.96% in February 2018 to 4.91% in March 2017 and remains green. Slough East Mental Health (6.22%) and CYPF (6.89%). This indicator shows a decreasing trend.

In CPE, the DNA rate increased from 9.65% in February 2018 to 12.07% (109/903).

In Children and Families, Community Paediatrics at 9.78%, Health Visiting 6.82%, School Nursing 8.41%, CAMHS 8.05% are above the 6% target. Looked after Children have improved from 16.13% in February 2018 to 4.17% in March 2018.

For Mental Health; West Berkshire 6.12% (last month 5.70%), Reading 8.62% (7.67% last month), and Slough 7.25% (last month 6.65%), Wokingham 2.54% (last month 4.80%) all worsened. Bracknell 6.66% (last month 6.76%) WAM 3.54% (last month 4.32%) and Slough 6.65% (last month 8.63%) improved. SMS text messaging can be used for reminders for appointments which take place in clinics provided that a mobile number is collected and entered onto RiO in the correct format. In March 2018, 17,349 text messages were sent.

CHS Inpatient Average Length of Stay reduced to 24 days and is within target, with West Berkshire (29 days) the only area above target. Delayed transfers have an adverse impact on length of stay. There have been some improvements in Slough 2.79% (last month 3.11%), Wokingham 10.16% (last month 12.28%) and Reading 22.45% (23.49% last month) and West Berkshire 10.16% (16.14% last month), but WAM 5.77% (last month 3.58%) worsened. A total of 60 patients’ discharges were delayed in March 2018, 24 of these are the responsibility of the NHS, and 21 are the responsibility of social care and 15 are joint health and social care responsibility. The most common reason for a delay was awaiting care package in own home (total 30; 13 social care, 4 NHS responsibility, 13 joint responsibility health and social care). 12 are awaiting either Care home or nursing home placement (2 are the responsibility of the NHS, 4 Social Care and 1 is joint responsibility).

Mental Health Acute Occupancy excluding home leave reduced to 95% in March 2018.

The average length of stay for Mental Health reduced to 35 days in March 2018 and the acute snapshot length of stay increased to 57 days in March 2018 and continues to remain above target. Of the 212 clients discharged during January 2018 to March 2018, 58% (126) had lengths of stay below 30 days. 17 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 several clients who have accommodation needs for which funding must be obtained and placements sought before they can be discharged from the ward. At 11th April 2018 there were a total of 10 acute clients who were agreed delayed transfers of care (an increase from 9 on last month), with a further 2 potential delays. Including potential delays by locality, there are 3 delays each for Reading, Slough and 2 for Windsor and Maidenhead, and 2 each for West Berkshire and Wokingham. By ward on 12th April 2018, there were 5 delays on Bluebell ward, 5 on Rose ward, and 1 on Snowdrop. Additionally there is 1 delay on Sorrel ward.

There are 2 clients delayed on Campion Unit, both detained under the Mental Health Act. By locality there is 1 for Slough and 1 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 and Wokingham are above target.

At the 10th April 2018 there were 14 Out of Area Placements; 11 Acute Adult Mental Health and 3 PICU clients. The national return for March 2018 showed that 22 acute overspill patients using 291 bed days and 4 PICU clients using 29 bed days were sent out of area.

Older Adults Mental Health wards length of stay is 59 days for Rowan ward and 89 days for Orchid ward for clients discharged.

CHS Occupancy has remained at 83%. The CCGs have asked that 10 beds on Highclere ward be repurposed.

MH Readmission rates reduced to 6.3 % in March 2018 with only Slough were above target.

Mental Health Benchmarking following a discussion on the specification at the reference group on 23rd March 2018, data collection for 2017/18 will open on 30th April 2018.

Learning Disability 2016/17 – NHS Benchmarking reports were issued on 23rd March 2018; a fuller report will be available next month.

Community Services benchmarking – NHS Benchmarking were published at the end of December 2017, following a period of final validation. There is a separate paper on this. Following discussion at the reference group on 14th March 2018 data collection for 2017/18 opens on 21st May 2018 and closes on 10th August 2018.

Mental Health Benchmarking – the 2017/18 data collection was discussed by the reference group on 23rd March 2018. Collection is due to open on 30th April 2018 and close on 29th June 2018.

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

CAMHS Benchmarking – following a discussion on the specification at the reference group on 23rd March 2018, data collection for 2017/18 will open in April 2018. Collection is due to open on 14th May 2018 and close on 13th July 2018.

Clustering –has reduced to 86.9% compliance and remains below the 95% target. With the exception of Wokingham Care Pathways (96.0%) all services are below target. Common Point of Entry 65.8% (98 out of 147 clients clustered), Trauma 57.7% (183/316) and Perinatal at 60.7% (81/134). Focus is on ensuring that services do not only change the date of the cluster but 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 33 uses in March 2018, with no uses for minors. Of these 33 uses of the place of safety, 16 were admitted following assessment including 9 under Section 2 and 1 Community Treatment Order recall. 10 clients waited over 8 hours for an assessment. The reasons for the delays in assessment include bed availability, patient intoxication and availability of AMHP/assessing Doctor. 31 out of the 33 assessments were carried out by Berkshire Healthcare NHS Foundation Trust Section 12 Doctors. The most common time in March 2018 to be brought to the place of safety was between was 6pm to 9pm and then 9pm to midnight. The most common days for detention in March 2018 was Thursday with 9 detentions followed by Saturday with 6 uses.

Crisis plans – this remains at 94% overall with Slough below target.

Health visiting – the Trust attained 90.3% in March 2018 with all areas below target. Reasons for the 41/525 (8.7%) new births not being seen within 14 days. Of those not seen the reasons were 60% were still in hospital and 40% a mixture of no access (16%, that is to say the family was out when the appointment was scheduled), family declined (11%), no response from family (4%) and staff capacity 9% (that is to say insufficient staff to do the visit within time due to other safeguarding priorities).

System Resilience – Frimley Health NHS Foundation Trust achieved 83.1% for Type 1 A&E attendances in March 2018.

In the West – the A&E waiting times national return for March 2018 show the Royal Berkshire Hospital achieved 78.9% Tier 1 A&E attendances and 83.1% against Tier 1-3 attendances. Nationally only 83.1% 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 84.6% for all Tier 1-3 attendances during March 2018, with Tier 1 still lower at 76.4%. The Trust's Minor Injury Unit achieved 99.93% 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 13th April 2018. In terms of Inpatients on 13th April 2018, there were a total of 3 community beds available at Wokingham Hospital, but none at other community hospitals. There were a total of 26 patients waiting for a bed.

Service Efficiency And Effectiveness Exception Report Month 12: 2017/18

KPI	Target	Mar-18	Trend	Context/Reasons	Commentary of Trend
Mental Health: Acute Average LoS: Number	<30 Days	35		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	57		This is an increase on the preceding month and reflects the acuity of clients and number of delayed transfers of care.	

KPI	Target	Mar-18	Trend	Context/Reasons	Commentary of Trend
MH Acute Occupancy rate (exc. HL - by Ward/ Locality) SE-06 a & b 2 indicators)	**< 90%**	**95%**		**Reading and Wokingham are above target. New bed management process including gatekeeping of clients has been introduced.**	**Increase in the number of patients admitted whilst detained under the Mental Health Act. For 2016/17 there was a 41% increase in detained patients in comparison with 2015/16. 2017/18 shows a further 20% increase on 2016/17 totals. The cumulative total is 70% increase in admisisons of clients detained under the Mental Health Act.**
Health Visiting: New Birth Visits Within 14 days	**95%**	**90.3%**		**Of those not seen, the reasons were 60% still in hospital and 40% were a mixture of no access (family out for arranged visit (16%), family declined (11%), no response from family (4%) and staff capacity 9% (insufficient staff to do visit within time due to other safeguarding priorities)).**	**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.**

KPI	Target	Mar-18	Trend	Context/Reasons	Commentary of Trend
Clustering within target	95%	87%		**There are frequent reviews required for certain clusters which mean that it is challenging to achieve the target.**	**Teams with high numbers of outliers are being targeted. Clustering Lead is attending the Locality Managers Business Meeting to ensure that focus is maintained.**

Other Key Performance Highlights for this Section

- DNA rates have improved from 4.93% in February 2018 to 4.91% in March 2018.
- CHS Length of Stay improved from 27 days in February 2018 to 24 days in March 2018.
- Mental Health Readmission rates improved from 7.1% in February 2018 to 6.3% in March 2018.
- Mental Health Acute occupancy has improved from 98% to 95%.
- Mental Health Non-Acute occupancy has improved from 81% to 69%.
- New Birth Visits within 14 days have worsened from 92% to 90.3%.
- Clustering reduced from 88.2% compliance to 86.9% compliance in March 2018.
- Prospect Park Place of Safety worsened from 30 uses in February 2018 to 32 uses in March 2018.

Contractual Performance Commentary

For 2017/19, updates are as follows:

• CQUIN 2017/18 - Q3 Submission is with commissioners for review. We expect formal feedback in the April Commissioners Quality Review Meeting. The Trust have recommended provision for Health and Well-being (1C) taken at 100%. CQUIN 9c (% of staff who felt unwell due to work related stress) we are suggesting one third of value risk provision to be taken, we would hope to close the gap in Q4. CQUINs 4 (Improving services for people with mental health need who present to A&E), 8 (Supporting proactive and safe discharge) and 11 (Personalised care and support planning) are system wide CQUINs and we have been clear with commissioners that the Trust can only be judged on elements we control. The Trust had an all CQUIN review meeting on 21st February 2018 to ensure robust CQUIN submission for Q4 and we are in the process of taking a full risk assessment.

• Joint piece of work with the CCG and BHFT on revised CPE model now referred to as the Wellbeing service. East and West have confirmed non-recurrent income in 2018/19 for Wellbeing service. Finances are agreed and now working on the transition of services.

• All SDIPs - no risks and or questions being raised by commissioners and the first submission is underway. CCG have confirmed Q1 milestones met. Q3 submission made in March 2018.

• AQP conversations underway to move into the block and align service offering to funding; East MSK has been resolved with £1.75m funding working with CCG to resolve fiscal position at year end and have appropriately positioned for 2018/19. Podiatry operating under AQP and the Trust hope to close the financial position in April 2018. Audiology on-going discussions to remain in separate contracts and tariff proposals with CCG, hoping to complete in April 2018.

• Dental services - NHSE and BHFT are having productive conversations to future proof the service by looking at referral to treatment waits and projected increase in patient flow for patients requiring general anaesthetic to avoid a build in wait times. NHSE confirmed additional funding of £180K would be recurrent if the contract is extended. NHSE have strongly indicated that the contracts will be extended to 2020/21 and we will talk to them about our overall funding for the service before any agreement to extend.

• NHSE funding challenges regarding CAMHS Tier 4 are resolved and funding confirmed for 2018/19. March 2019 NHSE hope to be in a position to negotiate a new Occupied Bed Day rate for the new contract which will reflect the development of a 12 bedded CAMHS General Adolescent Unit in Reading.

• Local Authority - Sexual Health (all East), there are on-going discussions with Unitary Authorities taking place and they have now confirmed the service will be tendered around June 2018.

• 86% of income contracts >£50k and 71%< £50K unsigned; review with Operations/Contracts team to assess risk being carried out.

• Berkshire West and Frimley Integrated Care Systems: contracting discussions are continuing with a view to the development of system control total, new payment mechanisms and consideration of risk/reward sharing across the local healthcare system. All to be supported with capacity released by reducing burden of commissioner/provider non value add contracting and information sharing activities.

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper – public

Board Meeting Date	8th May 2018
Title	**Summary Financial Plan 18/19 – final**
Purpose	To note the summary of the final 18/19 financial plan as submitted to NHSI.
Business Area	Finance
Author	Alex Gild – Chief Financial Officer
Relevant Strategic Objectives	
CQC Registration/Patient Care Impacts	
Resource Impacts	
Legal Implications	
SUMMARY	This paper summarises the final 18/19 financial plan submitted to NHSI, before the deadline of 30th April. The April board delegated approval of the submission to the April FIP committee. The final plan submission is in line with the final draft reviewed by FIP. The key points to note are: • The plan delivers the Trust's £2.4m Control Total • The Use of Resource Rating is maintained at an overall UoR Rating "1" • We submitted the plan with no revised guidance on System Control Totals • The cost improvement challenge is £4.8m • Planned capital expenditure is £10m • Cash forecast shows a net £0.2m outflow taking the forecast for YE 18/19 to £22.1m There are risks within the plan which should be noted: • Without delivery of the CIP programme, the Trust will not deliver its Control Total. If savings do not materialise, a continual review of new initiatives will be required to mitigate shortfalls. • The plan does not restrict recruitment, but does make assumptions on the pace, and ability, to recruit staff. Should the Trust find it is able to recruit at a rate greater than planned; offsetting reductions in non-permanent staffing and/or further cost improvement initiatives may be

	required. • Although the cash forecast shows a small -£0.2m reduction in cash, it should be noted the forecast relies upon the delivery of the financial plan and the receipt of PS Funding to maintain cash levels. Missing plan will deteriorate our cash, which would need to be mitigated through review of the capital programme and/or working capital management.
ACTION	The Board is to note the summary of the final 18/19 plan submitted to NHSI.

Trust Board – 8th May 2018

Final Financial Plan FY18/19

1.0 Executive Summary

This paper provides a final plan update for FY18/19, from previous draft plan papers to the Trust Board and FIP committee, summarising the annual planning templates submitted to NHSI on the 30th April.

The key points to note are:

- The plan delivers the Trust's £2.4m Control Total
- The Use of Resource Rating is maintained at an overall UoR Rating "1"
- We submit with no revised guidance on System Control Totals
- The cost improvement challenge is £4.8m
- Planned capital expenditure is £10m
- Cash forecast shows a net £0.2m outflow taking the forecast for YE 18/19 to £22.1m

2.0 System Update

The plan has been submitted without further guidance from NHSI on benefits of delivering in excess, or implications on individual partners or the system as a whole, of missing an aggregate system control total. Partners in the Frimley and Berkshire West ICSs therefore agreed to submit individual plans which deliver stated organisation Control Totals.

3.0 Summary Financial Plan FY18/19

The Trust has been set a Control Total of £2.4m for 18/19. This assumes the Trust delivers a broadly breakeven position, for which we will receive £2.4m of Provider Sustainability Funding (PSF).

The plan recognises £4.0m of commissioner growth, which in total revenue has been partially offset by divestment and loss of Ryeish Green Children's Complex Needs, Slough Health Visiting & School Nursing, and Diabetic Eye Screening services. Other income has reduced due to non-recurrent funding received in 17/18.

The pay plan reflects inflation at a rate of 1% plus incremental drift. As instructed by NHSI, the plan makes no allowance for the 18/19 pay settlement currently in discussion. The process for addressing the cost and associated funding has yet to be confirmed by the regulator.

The pay plan further reflects current recruitment challenges, and has assumed a shortfall against recruitment plans of £6.0m over the year. This has been assumed across operational and corporate areas, reflecting current shortfalls and run rate.

Non Pay expenditure increases with inflation and internal pressures, which are predicted to outpace Procurement savings. Healthcare Purchase costs are planned to fall, driven by our targeted cost reduction efforts to reduce our Out of Area Placement costs.

Our financing costs recognise non recurrent impairment costs in 17/18 and higher depreciation and PDC costs resulting from the increased capital programme spend. A summary of the financial plan can be seen in the table below:

	17/18 FOT	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12	18/19	+/-
	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m
Operating Income	226.0	19.0	18.9	18.9	18.9	18.9	18.9	18.9	18.9	18.9	18.9	18.9	18.9	***227.1***	*1.0*
Other Income	19.4	1.6	1.6	1.6	1.6	1.5	1.5	1.5	1.6	1.6	1.5	1.5	1.5	***18.6***	*(0.8)*
Total Income	***245.4***	***20.5***	***20.5***	***20.5***	***20.5***	***20.5***	***20.4***	***20.4***	***20.5***	***20.5***	***20.4***	***20.4***	***20.4***	***245.6***	***0.2***
Staff in Post	150.0	12.9	12.9	12.9	12.8	12.8	12.9	12.9	12.9	12.9	12.9	12.9	12.9	***154.5***	*4.6*
Bank Spend	11.2	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.1	1.0	1.0	1.0	***12.3***	*1.1*
Agency Spend	8.9	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	***5.3***	*(3.6)*
Total Pay	***170.1***	***14.4***	***14.4***	***14.3***	***14.3***	***14.3***	***14.3***	***14.3***	***14.3***	***14.4***	***14.4***	***14.3***	***14.3***	***172.1***	***2.1***
Purchase of Healthcare	14.5	1.0	1.1	1.0	1.0	1.0	0.9	0.9	0.9	0.9	0.9	0.8	0.9	***11.3***	*(3.2)*
Drugs & Supplies	10.7	1.0	1.0	1.0	1.0	1.0	1.0	0.9	0.9	0.9	0.9	0.9	1.0	***11.4***	*0.7*
Other Non Pay	33.1	2.7	2.7	3.1	2.8	2.9	2.9	2.9	2.7	2.4	2.7	2.9	2.7	***33.4***	*0.3*
PFI Lease	6.2	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	***6.3***	*0.2*
Total Non Pay	***64.5***	***5.2***	***5.3***	***5.6***	***5.3***	***5.4***	***5.3***	***5.3***	***5.0***	***4.7***	***5.1***	***5.1***	***5.1***	***62.4***	***(2.0)***
Total Operating Costs	***234.5***	***19.6***	***19.6***	***19.9***	***19.7***	***19.7***	***19.7***	***19.6***	***19.4***	***19.2***	***19.4***	***19.4***	***19.4***	***234.6***	***0.0***
EBITDA	***10.8***	***0.9***	***0.9***	***0.6***	***0.8***	***0.8***	***0.8***	***0.8***	***1.1***	***1.3***	***1.0***	***1.0***	***1.0***	***11.0***	***0.2***
Interest (Net)	3.7	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.4	***3.8***	*0.1*
Impairments	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	***0.0***	*(0.1)*
Disposals	(0.1)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	***0.0***	*0.1*
Depreciation	4.8	0.4	0.4	0.4	0.5	0.5	0.5	0.5	0.5	0.5	0.6	0.6	0.6	***5.7***	*0.9*
PDC	1.5	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	***1.6***	*0.1*
Total Financing	***9.9***	***0.8***	***0.8***	***0.8***	***0.9***	***0.9***	***0.9***	***0.9***	***0.9***	***0.9***	***1.0***	***1.0***	***1.1***	***11.1***	***1.1***
Surplus/ (Deficit) for PSF	***0.9***	***0.1***	***0.1***	***(0.2)***	***(0.1)***	***(0.1)***	***(0.1)***	***(0.1)***	***0.2***	***0.4***	***0.0***	***0.0***	***(0.1)***	***(0.0)***	***(0.9)***
Cumulative for PSF		*0.1*	*0.2*	***(0.0)***	*(0.1)*	*(0.2)*	***(0.3)***	*(0.5)*	*(0.3)*	***0.0***	*0.0*	*0.0*	***(0.0)***		
PS Funding	***3.5***	***0.1***	***0.1***	***0.1***	***0.2***	***0.2***	***0.2***	***0.2***	***0.2***	***0.2***	***0.3***	***0.3***	***0.3***	***2.4***	***(1.1)***
Cumulative PS Funding		***0.1***	***0.2***	***0.4***	***0.5***	***0.7***	***0.9***	***1.1***	***1.3***	***1.6***	***1.9***	***2.2***	***2.4***		
Surplus/ (Deficit) for CT	***4.4***	***0.2***	***0.2***	***(0.1)***	***0.1***	***0.0***	***0.0***	***0.1***	***0.4***	***0.6***	***0.3***	***0.3***	***0.2***	***2.4***	***(2.0)***
Cumulative for CT		***0.2***	***0.4***	***0.3***	***0.4***	***0.5***	***0.5***	***0.6***	***1.0***	***1.6***	***1.9***	***2.2***	***2.4***		
Impairments (Non CT)	0.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	***0.0***	*(0.5)*
Donated Income	1.7	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	***0.0***	*(1.7)*
Donated Depreciation	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	***0.1***	*0.0*
Surplus/ (Deficit) Statutory	***5.6***	***0.2***	***0.2***	***(0.1)***	***0.1***	***0.0***	***0.0***	***0.1***	***0.4***	***0.6***	***0.3***	***0.3***	***0.2***	***2.3***	***(3.3)***
Cumulative Statutory		***0.2***	***0.4***	***0.3***	***0.4***	***0.5***	***0.5***	***0.6***	***1.0***	***1.6***	***1.9***	***2.2***	***2.3***		

4.0 Use of Resource Metrics

The plan delivers an overall Use of Resource Rating of '1'. Due to the level of debt being carried on the two PFI contracts, the Capital Service Cover rating cannot be increased beyond a '2'. The additional S&T Funding allocated for 17/18 performance has increased the Liquidity rating to a '1' for the year. The I&E Margin is a '2' as the plan assumes a small (<£100k) cumulative loss, excluding PS Funding, from the end of Q1 and for the remainder of the year. A breakdown of the equally weighted metric ratings and the overall UOR rating can be seen in the table below.

Use of Resources Ratings	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12
Capital Service Cover	2	2	2	2	2	2	2	2	2	2	2	2
Liquidity	1	1	1	1	1	1	1	1	1	1	1	1
I&E Margin	1	1	2	2	2	2	2	2	2	2	2	2
Var From Control Total	1	1	1	1	1	1	1	1	1	1	1	1
Agency Spend	1	1	1	1	1	1	1	1	1	1	1	1
Use of Resource Rating	1	1	1	1	1	1	1	1	1	1	1	1

5.0 Cost Improvement Programme

The overall cost improvement programme required to deliver the 18/19 Control Total has been set at £4.8m. Of the overall plan, 90% has been identified and allocated to specific schemes, with 20% of the plan viewed as secure in terms of delivery. On submission only £170k of the overall plan remains unidentified, and it is fully anticipated this

will be allocated and delivered in year, through an increased focus on the identification of new opportunities. The plan is phased towards the end of the year, reflecting time taken to gain traction on schemes and risk of delivery. The key programmes are summarised below, along with delivery risk and phasing:

Cost Improvement Programme	Current	Confidence			R/NR	RAG		Proposed Phasing			
		Secure	Identified	At Risk		ID	DEL	Q1	Q2	Q3	Q4
	£'m	£'m	£'m	£'m				£'m	£'m	£'m	£'m
OAPs Project	2.40										
- Inappropriate Placements			*1.70*		*Rec*			*0.00*	*0.13*	*0.79*	*0.79*
- Long Term Placements			*0.35*		*Rec*			*0.09*	*0.09*	*0.09*	*0.09*
- Patient Funding Status				*0.35*						*0.18*	*0.18*
Tender Style Service Line Review	1.00										
- WestCall			*0.50*		*Rec*				*0.05*	*0.20*	*0.25*
- CRHTT			*0.50*		*Rec*				*0.05*	*0.20*	*0.25*
Procurement: NHSP Bank & Agency	0.18	*0.18*			*Rec*			*0.05*	*0.05*	*0.05*	*0.05*
Procurement Other	0.30		*0.30*		*Rec*			*0.07*	*0.08*	*0.08*	*0.08*
Community NCA	0.25	*0.25*			*Rec*			*0.06*	*0.06*	*0.06*	*0.06*
Liaison & Diversion Contribution	0.25	*0.25*			*Rec*			*0.06*	*0.06*	*0.06*	*0.06*
Other Contract Contribution	0.26	*0.26*			*Rec*				*0.05*	*0.08*	*0.13*
Unidentified	0.17			*0.17*							*0.17*
Total Cost Improvement Programme	***4.80***	***0.94***	***3.35***	***0.52***				***0.32***	***0.61***	***1.77***	***2.09***
		20%	*70%*	*11%*				*3%*	*6%*	*16%*	*19%*

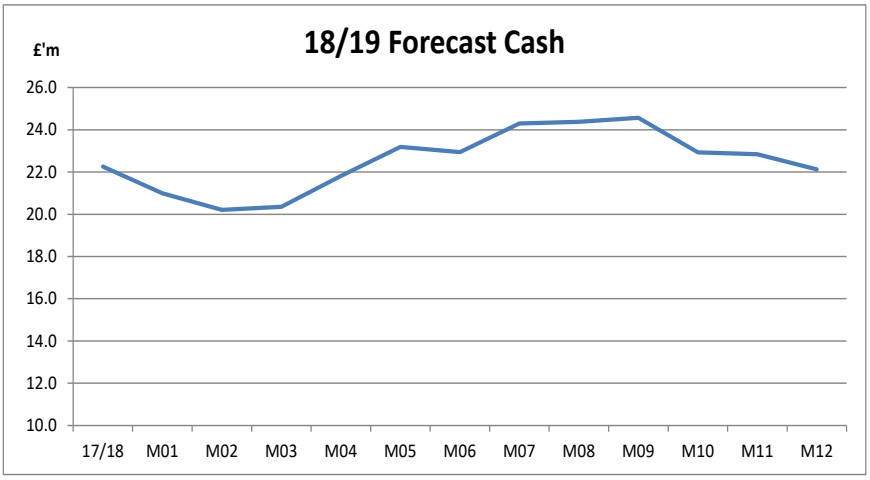
6.0 Cash Forecast, Capital Plan 2018/19 & Balance Sheet

The capital plan for 18/19 has been set at £10.0m and represents a £4.4m increase in investment compared to the previous year. The plan includes the second year of our GDE programme, for which we will receive £0.35m of national funding. The summary of the programme is outlined below:

Capital Schemes Summary 2018/19	£'000	
Reading clinical service co-location: uni campus dev. phase 3	1,600	50% 18/19
Other estate / compliance works incl. community sites	1,183	
Prospect Park Hospital - patient safety/improvement schemes	720	
Prospect Park Hospital - LD ward move and improvements	650	50% 18/19
Hillcroft House - community site improvements (patients/staff)	460	
Total Estate investments	**4,613**	
IT Desktop Equipment Refresh	2,186	
Global Digital Exemplar (GDE) projects - Trust Funded	1,985	
IT Server, Network & Mobile Refresh	751	
GDE projects - National Funding	335	
Data Warehouse & BI developments	130	
Total IM&T investments	**5,387**	
Total Capital Programme	***10,000***	

The closing cash position for 17/18 was £22.3m and we are forecasting that there will be a net cash outflow of £0.2m during 18/19, taking the YE 18/19 forecast to £22.1m. This assumes the 17/18 Q4 S&T bonus and incentive payment in October, and Q4 18/19 being paid in 19/20. The cash from the Little House disposal was received in April. No further disposals are assumed in the plan. The key movements are illustrated in the table below, along with a profile of our anticipated month end balances throughout the year:

	£'m
Closing Cash	***22.3***
Forecast Surplus	(0.0)
Provider Sustainabilty Fund	2.2
17/18 STF Bonus Payment	1.8
Depreciation	5.7
Capital Programme	(10.0)
GDE Funding	0.3
Disposals (Little House)	0.8
PFI Finance Lease	(1.0)
Other Working Capital Movements	0.1
Net Cash Inflow / (Outflow)	***(0.2)***
Closing Cash	***22.1***



The impact of this year's plan is reflected in the balance sheet below:

	17/18	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12	+/-
	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m
Fixed Assets	39.6	39.6	39.6	39.7	39.9	40.1	40.4	40.7	41.0	43.0	43.3	43.7	44.0	*4.4*
PFI Asset	55.6	55.5	55.5	55.5	55.4	55.4	55.4	55.3	55.3	55.3	55.2	55.3	55.6	*(0.0)*
Total Non Current Assets	95.2	95.1	95.1	95.2	95.3	95.5	95.8	96.0	96.3	98.2	98.5	98.9	99.6	4.3
Stock	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	*0.0*
Debtors	13.4	14.9	15.9	15.9	14.9	13.4	13.4	11.8	11.8	11.8	11.8	11.8	11.8	*(1.6)*
Cash	22.3	21.0	20.2	20.4	21.8	23.2	22.9	24.3	24.4	24.6	22.9	22.8	22.1	*(0.2)*
Total Current Assets	35.9	36.2	36.4	36.5	37.0	36.8	36.6	36.3	36.4	36.6	35.0	34.9	34.2	(1.7)
Creditors	(23.7)	(23.7)	(23.8)	(24.2)	(24.4)	(24.4)	(24.6)	(24.5)	(24.6)	(26.2)	(24.7)	(24.8)	(24.6)	*(0.9)*
Current Loan Commitment	(1.0)	(1.0)	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.2)	(1.2)	(1.2)	(1.2)	(1.2)	*(0.2)*
Other Current Liabilities	(2.3)	(2.3)	(2.3)	(2.3)	(2.3)	(2.3)	(2.3)	(2.3)	(2.3)	(2.3)	(2.3)	(2.3)	(2.3)	*0.0*
Total Current Liabilities	(26.9)	(27.0)	(27.1)	(27.5)	(27.7)	(27.8)	(27.9)	(27.9)	(28.0)	(29.6)	(28.1)	(28.3)	(28.1)	(1.1)
Non Current Loan Commitments	(29.7)	(29.6)	(29.5)	(29.4)	(29.3)	(29.2)	(29.1)	(29.0)	(28.9)	(28.8)	(28.7)	(28.6)	(28.5)	*1.2*
Other Non Current Liabilities	(1.6)	(1.6)	(1.6)	(1.6)	(1.6)	(1.6)	(1.6)	(1.6)	(1.6)	(1.6)	(1.6)	(1.6)	(1.6)	*0.0*
Total Non Current Liabilities	(31.3)	(31.2)	(31.1)	(31.0)	(30.9)	(30.8)	(30.7)	(30.6)	(30.5)	(30.4)	(30.3)	(30.2)	(30.1)	1.2
Total Net Assets	***72.9***	***73.1***	***73.3***	***73.2***	***73.7***	***73.7***	***73.7***	***73.8***	***74.2***	***74.8***	***75.1***	***75.4***	***75.6***	***2.7***
Public Dividend Capital	16.0	16.0	16.0	16.0	16.3	16.3	16.3	16.3	16.3	16.3	16.3	16.3	16.3	*0.3*
Revaluations Reserve	37.0	37.0	37.0	37.0	37.0	37.0	37.0	37.0	37.0	37.0	37.0	37.0	37.0	*0.0*
Income & Expenditure Reserve	19.9	20.1	20.3	20.2	20.3	20.3	20.4	20.5	20.9	21.4	21.7	22.0	22.2	*2.3*
Total Taxpayers Equity	***72.9***	***73.1***	***73.3***	***73.2***	***73.7***	***73.7***	***73.7***	***73.8***	***74.2***	***74.8***	***75.1***	***75.4***	***75.6***	***2.7***

Fixed assets will increase with capital spend planned in excess of depreciation charge. Cash and working capital is phased to accommodate forecast PSF payments. Our Public Dividend Capital increases as a result of this year's GDE funding.

7.0 Risks & Mitigations

There are risks within the plan which should be noted.

- Without delivery of the CIP programme, the Trust will not deliver its Control Total. If savings do not materialise, a continual review of new initiatives will be required to mitigate shortfalls.

- The plan does not restrict recruitment, but does make assumptions on the pace, and ability, to recruit staff. Should the Trust find it is able to recruit at a rate greater than planned; offsetting reductions in non-permanent staffing and/or further cost improvement initiatives may be required.

- Although the cash forecast shows a small -£0.2m reduction in cash, it should be noted the forecast relies upon the delivery of the financial plan and the receipt of PS Funding to maintain cash levels. Missing plan will deteriorate our cash, which would need to be mitigated through review of the capital programme and/or working capital management.

8.0 Board Action

- To note the summary of the final 18/19 plan submitted to NHSI.

Paper prepared by: Paul Gray, Director of Finance
Presented by: Alex Gild, Chief Financial Officer

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	8 May 2018
Title	2018/19 Strategy Implementation Plan
Purpose	This paper provides the Board with an overview of the development and content of the 2018/19 Strategy Implementation Plan
Business Area	Corporate
Author	Director of Strategic Planning and Business Development
Relevant Strategic Objectives	Supports the delivery of all of our True North goals
CQC Registration/Patient Care Impacts	The plan includes activities to maintain our CQC registration and improve standards of patient care, outcomes and experience
Resource Impacts	Budget and resource implications are the responsibility of the governing body of each strategic project
Legal Implications	None
Equality and Diversity Implications	The plan includes delivery of our Equality and Inclusion Strategy. Equality and Diversity implications of each initiative are the responsibility of its governing body.
SUMMARY	The attached paper provides the Trust Board with an overview of the development and content of the Strategy Implementation Plan for 2018/19. It also sets out the outcomes of initiatives in the 2017/18 plan, as a basis for the development of this year's plan. Significant progress has been made towards the achievement of Berkshire Healthcare's strategic aims during 2017/18. Our strategy implementation plans for 2018/19 demonstrate our commitment to our Vision "To be recognised as the leading community and mental health service provider by our staff, patients and partners". They are a comprehensive and stretching set of initiatives which focus on providing services which are safe, highly regarded by people who access them, and achieve good or

	outstanding CQC ratings. The plan reflects our investment in service quality and innovation through our Quality Improvement programme, our workforce strategy, estates strategy and information technology roadmap. We are also full partners in our wider health and social care systems, supporting integration, improving efficiency, and developing new ways of working together. The Strategy Implementation Plan will be used to monitor our progress to meet our True North goals during 2018/19 through monthly reports to the Business and Strategy Executive and quarterly progress reports to the Board.
ACTION REQUIRED	The Board is asked to review and note the attached paper and summary Plan.

APPROVAL OF STRATEGY IMPLEMENTATION PLAN 2018/19

Author: Jenny Vaux, Director of Strategic Planning and Business Development

Director: Bev Searle, Director of Corporate Affairs

Date: 26 April 2018

Purpose

This document has been prepared to update the Trust Board on the development of the Strategy Implementation Plan 2018/19. This plan summarises the major strategic initiatives planned for the year and beyond to deliver the Trust's vision and True North Goals.

Members of the Trust Board are asked to note the plan.

Document Control

Version	Date	Authors	Comments
1	26/04/18	Jenny Vaux	For Trust Board

This document is considered to be Commercial in Confidence and is therefore not to be disclosed outside of the Trust without the prior consent of the Author or a Director of the Trust.

Distribution:

All Trust Board members

Document References

Document Title	Date	Published By

CONTENTS

INTRODUCTION

1. The Strategy Implementation Plan captures the key activities required over the financial year and beyond to ensure successful implementation of the Trust's strategy. Progress against the 2017/18 Plan was reviewed every two months at Business and Strategy Executive meetings during the year. Progress reports were presented to the Board in September, November and February.

2. This paper presents the summary Strategy Implementation Plan for review and approval by the Trust Board, highlighting those initiatives that have concluded during 2017/18 or are now 'business as usual' and therefore will not feature in the 2018/19 Strategy Implementation Plan, those initiatives that will continue from 2017/18 into 2018/19, and those initiatives that are new for 2018/19.

3. The detailed Strategy Implementation Plan, showing activity gateways and target dates, and setting out delivery structures, is used by the senior leadership team to monitor delivery. This detailed plan is available to the Board on request.

2017/18 PLAN

4. 2017/18 has been another challenging year in the NHS with resource constraints, particularly in the recruitment and retention of staff, and the implementation of initiatives for long term sustainability set out in the Five Year Forward View. For Berkshire Healthcare this has meant a focus on initiatives to maintain or improve service quality and efficiency, organisational development to support our staff, and working with our system partners to establish effective structures and programmes within our Sustainability and Transformation Partnerships and Integrated Care System (ICS) areas. Both Berkshire West and Frimley Health and Social Care areas were awarded ICS vanguard status, recognising the significant progress achieved.

5. We have invested in a Quality Improvement Programme, designed to empower and equip staff to solve problems locally, and ensure the whole organisation is aligned on the delivery of our core strategy, described within our "True North" goals). Our digital maturity and innovation has been recognised, with the award of Global Digital Exemplar status, attracting significant additional investment to improve our clinical and staff support systems. Within our Workforce Strategy, we have focussed on attracting and retaining staff in a challenging labour market and developing robust workforce plans. Through our Equality and Inclusion Strategy we have invested in initiatives to support equality in opportunity for our staff, particularly those from Black Asian and Minority Ethnic backgrounds, and to promote fairness in the way we support staff and deliver our services.

6. We have also significantly reduced our use of agency staff, thereby promoting patient safety and experience of care while also reducing costs. Other major programmes last year included optimising our use of estates, particularly in Reading where we are bringing together dispersed services and offices into a hub on the University of Reading campus. We have continued our focus on mental health services with the delivery of our Mental Health Strategy, including our Zero Suicide initiative and implementing a programme plan at Prospect Park Hospital (PPH), which provides services for

people with mental health needs. Initiatives have included workforce planning, optimising the use of inpatient beds, and developing the hospital as a centre of excellence.

7. During the year we completed the integration of mental and physical health services into the Children Young People and Families service. We also continued to develop our integrated IAPT (Improved Access to Psychological Therapies) services, securing onward funding; and our Health Hub, which now provides clinical hub support to the local 111 service, working with the South Central Ambulance Service and other key partners.

2018/19 PLAN DEVELOPMENT

8. Development of the 2018/19 plan has been informed by our strategy deployment process, introduced this year as a key workstream in our Quality Improvement (QI) programme. Initiatives in our 2018/19 plan are expressed within the framework of our four True North Goals (replacing the four strategic goals). Trust projects and programmes are assessed using a strategic filter designed to prioritise against these goals, and inform the effective deployment of our resources.

9. The Strategy Implementation Plan sets our development initiatives pertinent to the delivery of our strategy. This means that well established initiatives on annual cycles which are strategically important and are regularly monitored by the executive are not included. There are also some projects which are less critical for the delivery of our overall strategy but are operational priorities; these are not included in the plan however the executive will regularly review these through the monthly Projects Report at Business and Strategy Executive meetings.

10. The plan has been compared with the major projects featuring in the Programme Management Office and with our strategic risk register. The plan has been reviewed and approved by the executive team.

11. Progress related to the delivery of the 2018/19 Strategy Implementation Plan will be reviewed monthly at Business and Strategy Executive meetings through a joint report with Projects, and reported to the Trust Board quarterly during the course of the financial year through summary reports.

2017/18 INITIATIVES NOT INCLUDED IN THE 2017/18 STRATEGY IMPLEMENTATION PLAN

12. The following initiatives/programmes in the 2017/18 plan have not been included in the 2018/19 plan (set out in the framework of our previous 4 strategic goals.)

Strategic Goal 1: To provide safe services, good outcomes and good experience of treatment and care.

- The *Children Young People and Families* service integration has been removed from the plan as this has been fully implemented.

- Good progress has been made in the implementation of *Electronic Prescribing and Medicines Administration.* The remaining elements of this programme will be included within our Global Digital Exemplar initiative.

Strategic Goal 4: Understanding and responding to local needs as part of an integrated system

- Our contribution to the *Connected Care* (Interoperability) programme has been significant during 2017/18, enabling the sharing of records with partner organisations and improving patient care and experience. This initiative will continue within our Global Digital Exemplar programme.

- During 2017/18 our local health and social care systems have been establishing structures and programmes to operate as Integrated Care Systems. Therefore the *Sustainability and Transformation Plan* initiative in our 2017/18 plan will be replaced with local system initiatives where we have a significant role and/or are strategically important to Berkshire Healthcare.

- The *Integrated IAPT* service has secured recurrent funding to continue the service developments achieved with early implementer funding. This service is now business as usual and has been removed from the plan.

- *Health and Social Care Integration* will be taken forward within local system initiatives in the 2018/19 plan

- The *NHS 111/Urgent Care Clinical Coordination Hub* is now fully operational, and there are no further plans for development of our Health Hub in this year's plan

- *One Public Estate* will be not included in the 2018/19 plan, however activities to optimise the use of estates with our system partners continue. Relevant system estates programmes are included in the 2018/19 plan, and any further major programmes with a material impact on the Trust will be reflected in the plan as and when they arise.

INITIATIVES THAT WILL CONTINUE FROM 2017/18 INTO 2018/19

13. The following initiatives/programmes will roll forward to 2017/18. These are shown in the framework of our True North Goals, with initiatives appropriately re-classified (from the previous strategic goals).

True North Goal 1: To provide safe services, prevent self-harm and harm to others

- The *Quality Improvement Programme* will continue in 2018/19, establishing our Quality Management improvement System (QMIS) throughout a range of services, Rapid Improvement Projects and consolidating processes and systems supporting our QI approach to strategy deployment and continual improvement. We have also identified three QI Breakthrough Objectives to meet our targets in the reduction of falls, the reduction of self-harm, and the reduction of harm to staff

- The *Zero Suicide* programme will continue with activities to promote a 'no blame' culture within the Trust and wider system partnership activities with the Zero Suicide Alliance.

True North Goal 2: To strengthen our highly skilled and engaged workforce and provide a safe working environment

- Our *Workforce Strategy* continues into 2018/19, now organised around the 6 key elements of our strategy, including activities to meet our workforce metric targets. Major projects include staff recruitment and retention, and building our strategic workforce planning capability. We also have workstreams to ensure our workforce reflects service changes as a result of our QMIS activity, and improving our use of data and digital literacy. In addition, we are involved in system workforce planning initiatives, working closely with partner trusts and health education to address current and future staff shortages.

- The *Embracing Diversity* programme, implementing our Equality and Inclusion Strategy and ensuring we comply with our mandatory/statutory reporting requirements, will also continue. A major element of our activity in 2018/19 will be rolling out our Making it Right programme pilot to all Black, Asian and Minority Ethnic staff, and to staff with other protected characteristics. The Making it Right programme is intended to support staff to achieve their ambitions and reach their full potential.

True North Goal 3: To provide good outcomes from treatment and care.

- Our *Mental Health Services Development* initiative will continue into 2018/19, with the completion of the new seclusion suite and staff office on Sorrel Ward at PPH, and an engagement programme to develop plans for the hospital to become a Centre of Excellence. Our Mental Health Pathways project will continue during the year, focussing on the rollout of pathways for each cluster, and engaging with people using our services and their carers in future service planning.

- Some elements of our *Optimising Estates* initiatives will be reflected in Goal 3, in particular the development of the University of Reading Whiteknights campus as our major hub in Reading, with improved facilities and environments for staff and patients

- Our *Learning Disability Service Development* will continue into 2018/19 as we work with our commissioners and partners to redesign our community and inpatient services in line with national policy. The community based Intensive Intervention Service will become fully operational this year, and we will be making significant progress in our plans to move our Assessment and Treatment Unit from the current Campion Unit to Jasmine Ward at Prospect Park Hospital

- Within the *Child and Adolescent Mental Health Service Development* the proposed move of Willow House (Tier 4 inpatient service) from Wokingham Hospital to Prospect Park Hospital will

continue into 2018/19. This is dependent on the Campion Unit move to Jasmine Ward. We will also be consolidating Berkshire East CAMHs community services into Upton Community Hospital

- The *Sustainability and Transformation Plan* initiatives shown in the 2017/18 plan are replaced in the 2018/19 plan with *health and social care system* programmes and activities where we have significant resource or strategic implications. The development of the service model and contract to deliver an integrated adult MSK/physiotherapy service in Berkshire East will continue into the next plan as we are a material partner/sub-contractor for the delivery of community services.

- The *Information Technology Roadmap* programme will continue in 2018/19, implementing our Global Digital Exemplar programme and the Information Technology Architecture Strategy to replace our data network, deploying Windows 10 and using the Cloud for document storage. Our GDE programme has 19 projects structured around 4 objectives: Direct Patient Access and Communication, Digital Wards and Services; Digital Workforce; and Research and Quality Improvement. This a major programme for the Trust with significant investment, which will deliver benefits for patient outcomes and experience, enhance staff working experience, and improve our operating efficiency.

True North Goal 4: To deliver services that are efficient and financially sustainable.

- The *New Renal/Cancer Care Unit* at West Berkshire Community Hospital will be completed this year, with services delivered by the Royal Berkshire Hospital NHS Foundation Trust, and the Sue Ryder charity

- Our *Cost Improvement Plans* (CIPs) initiative in last year's plan is within the *Maintaining our NHS Improvement Use of Resource Rating of 1* in the 2018/19 plan, together with meeting our 2018/19 Control Total and effectively managing staff numbers within funded establishments. The Finance, Performance and Risk Executive and the Trust Business Group receive detailed reports on financial management on a monthly basis, with the strategy implementation plan providing an overview

- *Optimising the use of mental health inpatient services*, previously part of *Mental Health Service Development*, is now reflected in this section of the plan. A major programme has been established to deliver the national requirement to reduce the number of Berkshire residents who receive non-specialist acute mental health inpatient services outside of the county (Out of Area Placements) to zero by 2020/21, and to improve rehabilitation and recovery services. This reflects the importance of this initiative for improved patient care and experience, and also meeting our financial sustainability challenge.

- We will continue to explore options for our *Trust Headquarters* during the year, with our current building part of the Bracknell town centre redevelopment/regeneration programme

- The *Agency and Bank Project* will also continue into 2018/19, with activities to reduce our use of agency staff, and to meet our NHS Improvement ceiling of spending on framework agencies

INITIATIVES NEW TO THE 2018/19 STRATEGY IMPLEMENTATION PLAN

14. The following initiatives/programmes have been introduced to the 2018/19 Strategy Implementation Plan.

True North Goal 1: To provide safe services, prevent self-harm and harm to others.

- The *Development of Integrated Hubs* is a major programme in the Frimley Health and Care Integrated Care System (ICS), focusing on the development of an integrated care model within communities for residents with moderate to severe care needs, improving health outcomes for people with long term conditions or frailty. Our community health services in East Berkshire form a significant element of this programme.

True North Goal 2: To strengthen our highly skilled and engaged workforce and provide a safe working environment,

- The *Quality Improvement System (QMIS)* programme, which is part of our Quality Improvement initiative, is reflected in goal 2 of the plan, providing a proven training and coaching programme to empower front line staff to improve services locally

- During 2018/19 we are planning to replace our *Intranet*, subject to the approval of the business case. Considerable preparatory work has been undertaken during 2017/18.

True North Goal 3: To provide good outcomes from treatment and care.

- Within our *Mental Health Service Development* initiative, we are using QI service improvement methodology to develop an 'end to end' operational and clinical blueprint for adopting a revised *Personality Disorder Pathway*. This will be implemented during 2018/19, with the objective of improving the long term recovery of patients, and thereby reducing demand for services

- The *Improving Patient Experience* initiative reflects activities to improve rates of satisfaction in our Friends and Family Tests, and more staff using feedback to inform the way they deliver services

- Within *Health and Social Care System* initiatives, covering system programmes not shown elsewhere in the plan, we will be working with our partners on:

    - Optimising the use of our estates in the Berkshire Oxfordshire and Buckinghamshire (BOB) Sustainability and Transformation Partnership area, which will inform an estates strategy for the Berkshire West ICS

    - The integration and pathway development of neurology services within the Frimley Health and Care ICS, to enable Berkshire residents currently receiving outpatient acute services outside of Berkshire access to services closer to home in the county, and

moving to a more community/outpatient service model. We provide a small community service as part of the overall clinical pathway

- The Wellbeing project, which spans both Berkshire East and West, is a one year system pilot to support patients with self-care techniques and prevention. It involves our Common Point of Entry to mental health services, and Talking Therapies service.

True North Goal 4: To deliver services that are efficient and financially sustainable.

- There are no new initiatives in this section of the plan, however there are a number of programmes brought forward from the 2017/18 plan which are continuing or have further significant developments in 2018/19.

CONCLUSION

Significant progress has been made towards the achievement of Berkshire Healthcare's strategic aims during 2017/18. Our strategy implementation plans for 2018/19 demonstrate our commitment to our Vision "To be recognised as the leading community and mental health service provider by our staff, patients and partners" and delivering our four True North goals and metrics. They are a comprehensive and stretching set of initiatives which focus on providing services which are safe, highly regarded by people who access them, and achieve good or outstanding CQC ratings. The plan also reflects our investment in service quality and innovation through our Quality Improvement programme, our workforce strategy, estates strategy and information technology roadmap. We are also full partners in our wider health and social care systems, supporting integration, improving efficiency, and developing new ways of working together.

ACTION

Members of the Trust Board are asked to note the summary 2018/19 Strategy Implementation Plan.

2018/19 Strategy Implementation Plan Summary Report

INITIATIVE	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
True North Goal 1: To provide safe services, prevent self-harm and harm to others.												
QUALITY IMPROVEMENT (QI) PROGRAMME												
Strategy Deployment (overal programme delivery)												
Improvement Projects (overall programme delivery)												
Breakthrough Objectives (BO) - Reduction of falls												
BO - Reduction of self-harm												
BO - Reduction of harm to staff												
BO - overall programme delivery												
Quality Improvement Business Intelligence (QIBI)												
Comments:												
ZERO SUICIDE												
Comments:												
FRIMLEY INTEGRATED CARE SYSTEM: DEVELOPMENT OF INTEGRATED HUBS												
Comments:												
True North Goal 2: To strengthen our highly skilled and engaged workforce and provide a safe working environment.												
WORKFORCE STRATEGY												
Grow our own workforce												
Develop and promote our employer brand												
Align our workforce and service models												
Plan and meet demand sustainably												
Know our numbers												
Build our strategic workforce planning capability												
Achieving our workforce metrics												
Comments:												
QUALITY MANAGEMENT IMPROVEMENT SYSTEM (QMIS) - programme delivery												
Comments:												
INTRANET												
Comments: *Awaiting approval of business case.*												
DELIVERING OUR EQUALITY AND INCLUSION STRATEGY 2016-20												
Mandatory/Statutory requirements												
Other priorities												
Comments :												
True North Goal 3: To provide good outcomes from treatment and care.												
MENTAL HEALTH SERVICE DEVELOPMENT												
Prospect Park Hospital Development Programme - Centre of Excellence												
Mental Health Pathways												
QI Improvement Project: Personality Disorder (PD) Pathway												
Comments:												
IMPROVING PATIENT EXPERIENCE - PATIENT SATISFACTION												
Comments:												
DEVELOPMENT OF UNIVERSITY OF READING AS A PRIMARY TRUST SITE												
Phase 2 STC - Royal Berkshire Hospital NHS Foundation Trust services relocation												
Phase 3 STC (final phase) - relocation of services to STC												
Sale of Craven Road												
Erleigh Road - options appraisal for future use following transfer of services												
Comments:												
LEARNING DISABILITY SERVICE DEVELOPMENT												
Intensive Intervention Service												
Move of Assessment & Treatment Unit from Campion to Jasmine Ward												
Comments:												
CHILD AND ADOLESCENT MENTAL HEALTH SERVICE (CAMHS) DEVELOPMENT												
Integration of servicesi nto the Children Young People and Families Service												
Tier 4 (Willow House) relocation to Prospect Park Hospital												
Comments: *Relocation of Willow House dependent on move of Campsion Unit to Jasmine Ward, and the approval of the business case.*												
HEALTH AND SOCIAL CARE SYSTEMS INITIATIVES (not covered elsewhere)												
Berkshire West Integrated Care System (ICS) - Adult MSK/Physio services												
Berkshire West ICS - System use of estates (part of BOB STP programme)												
Frimley Health and Care ICS - Integrated Neurology												
Berkshire wide initiative - Wellbeing Project												
Comments:												
INFORMATION TECHNOLOGY ROADMAP												
Global Digital Exemplar (GDE) - Direct patient access and communication												
GDE - Digital Wards and services												
GDE - Digital workforce												
GDE - Research and quality improvement												
GDE - Payment milestones												
Information Technology Architecture Strategy												
Comments:												
True North Goal 4: To deliver services that are efficient and financially sustainable.												

INITIATIVE	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
NEW RENAL/CANCER CARE UNIT - WEST BERKSHIRE COMMUNITY HOSPITAL												
Comments:												
MAINTAINING OUR NHS IMPROVEMENT USE OF RESOURCE RATING OF 1												
Achieving our Control Total												
Delivering our Cost Improvement Plan												
Effective management of our staff vacancy factor												
Comments:												
OPTIONS FOR TRUST HEADQUARTERS												
Comments:												
AGENCY AND BANK PROJECT												
Comments:												
OPTIMISING THE USE OF MENTAL HEALTH INPATIENT SERVICES												
Eliminating overspill; optimising rehabilitation and recovery												
Comments:												

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	08 May 2018
Title	Draft Annual Report 2017/18 - approval
Purpose	This paper provides the Trust Board with the Draft Annual Report 2017/18 for approval
Business Area	Corporate
Author	Chief Executive Officer/Company Secretary
Relevant Strategic Objectives	N/A
CQC Registration/Patient Care Impacts	N/A
Resource Impacts	N/A
Legal Implications	Maintaining compliance with terms of authorisation and meeting regulatory requirements
Equalities and Diversity Implications	N/A
SUMMARY	Attached is a draft of the Trust's Annual Report 2017/18 for comment and approval. The financial figures contained within the draft Annual Report are subject to verification by the Auditors and details of the Annual Accounts will be included/appended following the Audit Committee meeting on 23 May 2018. Board members will note that a small number of items of information are awaited/require clarification and these will be added as soon as they become available. It is not expected that this will materially affect the content of the report. If any changes of significance arise then these will be discussed with and approval sought from the Trust Chair and Chief Executive and notified to other Trust Board members as appropriate. The report will also be further reviewed for consistency, typographical/grammatical accuracy and style.

ACTION REQUIRED	The Board is invited to: 1. Consider and offer any comments on the draft Annual Report 2017/18; 2. Approve the draft for submission subject to any final necessary additions and amendments and to delegate authority to the Chair and Chief Executive to give Board approval to the final document in light of the timetable for submission to NHS Improvement.

ANNUAL REPORT
AND ACCOUNTS

2017/18

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	8 May 2018
Title	Board declarations re FT Provider Licence conditions
Purpose	The Board is asked to agree positive certifications in support of 2018/19 licence condition compliance assurance process outlined by NHS Improvement.
Business Area	Corporate governance
Author	Chief Financial Officer
Relevant Strategic Objectives	N/A
CQC Registration/Patient Care Impacts	Contributes to the Well-Led CQC domain.
Resource Impacts	None
Legal Implications	Meeting regulatory requirements
SUMMARY	Each year certain declarations are required as part of the FT provider licence self-certification assurance process. For 2018/19, and similar to last year, NHSi do not require the attached certifications to be submitted, but do ask that Boards complete certification by the deadlines outlined below. NHSI will audit a selection of providers from July 2018. There are four declarations. In each case the Board is being invited to positively declare 'Confirmed' against the relevant statements attached, in respect of the following conditions: ➢ ***General Condition 6*** *of the NHS provider license: Systems For Compliance with License Conditions* ➢ *See positive assurance statements proposed* ➢ *Due 31 May 2018* ➢ *This statement is required to be published within a month following sign off.*

	➢ ***Continuity of Services Condition 7*** *of the NHS provider license: Availability of resources and accompanying statement for Foundation Trusts designated Commissioner Requested Services (CRS) providers only* ➢ *See positive assurance statements proposed* ➢ *Due 31 May 2018* ➢ ***Corporate Governance Statement*** *- in accordance with Foundation Trust condition 4 (Foundations Trusts and NHS trusts)* ➢ *see positive assurance statements proposed and proforma risk mitigation evidence as required* ➢ *Due 30 June 2018* ➢ ***Certification on Training of Governors*** *- in accordance with s151(5) of the Health and Social Care Act (Foundation Trusts only)* ➢ *see positive assurance statement proposed* ➢ *Due 30 June 2018*
ACTION REQUIRED	The Board is asked to confirm the positive assurance statements attached in relation to the provider licence conditions outlined above, and approve the signing by the Chair and CEO of the certifications.

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with license conditions (FTs and NHS trusts)

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed	OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this	Confirmed	Please fill details in cell E22

OR

3b	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.		Please Respond

OR

3c	In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.		Please Respond

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

Commissioner requested services are contracted for the two year period 2017-2019, with sufficient resources available to deliver contracted clinical services. These have been reviewed and confirmed during the 18/19 planning process.

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Martin Earwicker	**Name**	Julian Emms
Capacity	Chairman	**Capacity**	CEO
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

A

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

1	Corporate Governance Statement	Response	Risks and Mitigating actions	
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	Well led review found the Trust to benchmark positively	Please complete Risks and Mitigating actions
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	Company secretary communicates updates. Audit Committee receives updates from internal and external audit. NHSi communications routinely reviewed.	Please complete Risks and Mitigating actions
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	Clear Board governance, committee and reporting framework in place as confirmed by well led review	Please complete Risks and Mitigating actions
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and	Confirmed	Mitigations include: Board performance and financial reporting, audit functions, internal audit plan / annual governance statement and assurance over system of internal controls. Annual operating plan and budget approval. Board assurance and risk management frameworks. Compliance and assurance reporting re CQC and other regulator standards.	Please complete Risks and Mitigating actions
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	Assurance provided by well led review findings. CQC comprehensive inspection and follow up findings confirming good overall quality of care rating. Quality Accounts including engagement with external stakeholders / governors. Quality governance framework including quality executive committee and board quality assurance committee.	Please complete Risks and Mitigating actions
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	Workforce shortage risks for key staff groups and service lines identified within workforce BAF risk and workforce reporting and risk mitigations tracked through FIP and Audit committees of the Board.	Please complete Risks and Mitigating actions

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature **Signature**

Name Martin Earwicker **Name** Julian Emms

Further explanatory information should be provided below where the Board has been unable to confirm declarations under

A

Please Respond

Certification on training of governors (FTs only)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

2 Training of Governors

1	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Confirmed	OK

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Martin Earwicker	**Name**	Julian Emms
Capacity	Chairman	**Capacity**	CEO
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act

A

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper

Meeting Date	8 May 2018
Title	Data Security Protection Requirements Compliance Report
Purpose	To provide assurance to the Audit Committee about the Trust's compliance with NHS Improvement's Data and Cyber Security Standards
Business Area	Trust wide
Author	Director of IM&T
Relevant Strategic Objectives	Relevant to all Strategic Standards
CQC Registration/Patient Care Impacts	Maintaining data and cyber security standards is essential to ensure the confidentiality of patient records.
Resource Impacts	N/A
Legal Implications	NHS Improvement requires Trusts to complete a return on Data and Cyber Security Standards.
Equality and Diversity Implications	N/A
SUMMARY	To improve data security and protection for health and care organisations, the Department of Health and Social Care, NHS England and NHS Improvement published a set of 10 data and cyber security standards called the 2017/18 data security protection requirements that all providers of health and care must comply with. The 2017/18 DSPR standards are based on recommendations by Dame Fiona Caldicott, the National Data Guardian (NDG) for health and care, and confirmed by the government in July 2017. NHS Improvement requires all NHS providers to confirm by **Friday 11 May** whether they have implemented (fully, partially or not) the 10 standards outlined in the data security protection requirements. The submission was reviewed by the Audit Committee at its meeting on 25 April 2018 (the minutes of the meeting are elsewhere on the agenda)
ACTION REQUIRED	The Trust Board is asked to approve the Trust's submission to NHS Improvement.

2017/18 Data Security Protection Requirements: guidance

April 2018

Background

In January 2018, to improve data security and protection for health and care organisations the Department of Health and Social Care, NHS England and NHS Improvement published a set of 10 data and cyber security standards – the 17/18 Data Security Protection Requirements (2017/18 DSPR) – that all providers of health and care must comply with.

The 2017/18 DSPR standards are based on those recommended by Dame Fiona Caldicott, the National Data Guardian (NDG) for health and care, and confirmed by government in July 2017.

We are asking all providers to confirm to us whether or not you are complying with the 2017/18 DSPR standards. To do this, you must submit a response using the web form.

The questions set out below are the same as those found in the web form. They are designed to test whether you have implemented (fully, partially or not) the 10 standards outlined in the 2017/18 DSPR.

As part of the assurance process, the board must sign off your response before it is submitted.

Any questions about the data collection process should be directed to nhsi.17-18dsprsubmission@nhs.net

Leadership obligation 1: People

1. Senior level responsibility

There must be a named senior executive responsible for data and cyber security in your organisation.

Ideally this person will also be your senior information risk owner (SIRO), and where applicable a member of your organisation's board.

Fully implemented ✔	Partially implemented	Not implemented
The organisation has a named senior executive who reports to the board who is responsible for data and cyber security and this person is also the SIRO		

Please provide the contact details of the named senior executive responsible for data and cyber security if they are in place.

Name	Alex Gild
Job title	Chief Financial Officer
Name of organisation	Berkshire Healthcare NHS Foundation Trust
Email	Alex.gild@berkshire.nhs.uk
Telephone number	01344 415652

2. Completing the Information Governance toolkit v14.1

By 31 March 2018 organisations are required to achieve at least level 2 on the Information Governance (IG) toolkit. More information about the IG toolkit v14.1 can be found here: www.igt.hscic.gov.uk/help.aspx

For more information on how to complete the toolkit, please refer to the guidance:

- NHS foundation trusts: acute trusts, mental health trusts, ambulance trusts, community health providers, commissioning support units, NHS England
- independent providers: NHS business partners, commercial third parties, secondary use organisations, hosted secondary use teams, any qualified providers − clinical and any qualified providers − non clinical.

NOTE: the new Data Security and Protection toolkit is being introduced for 2018/19. This will replace the current IG toolkit.

Fully implemented ✔	Partially implemented	Not implemented
The organisation has completed the IG toolkit, submitted its results to NHS Digital and obtained either level 2 or 3. The Trust attained a level of 82% for the IG TK V14.1 which was rated Satisfactory.		

3. Preparing for the introduction of the General Data Protection Regulation in May 2018

The beta version of the Data Security and Protection toolkit was released in February 2018 and will help organisations understand what actions they need to take to implement the General Data Protection Regulation (GDPR) which comes into effect in May 2018.

Detailed information about the implementation of the GDPR can be found in the implementation checklist produced by the Information Governance Alliance (https://digital.nhs.uk/information-governance- alliance/General-Data-Protection-Regulation-guidance)

Fully Implemented ✔	Partially Implemented	Not
By May 2018, the organisation will have an approved plan to detail how it will achieve compliance with the GDPR. This will have board-level sponsorship and approval. The Trust has an implementation plan for GDPR which has been submitted to the board and is monitored by the IG Group		

4. Training staff

All staff must complete appropriate annual data security and protection training.

As per the IG toolkit, staff are defined as: all staff, including new starters, locums, temporary, students and staff contracted to work in the organisation.

A new training programme has been introduced: https://www.e-lfh.org.uk/programmes/data-security-awareness/. This programme replaces the previous IG training whilst retaining key elements of it. More information about the previous IG training resources can be found

at https://www.igt.hscic.gov.uk/NewsArticle.aspx?tk=431663506918390&lnv=1&cb=6fa0a573-a4df-45f3-8af1-5c5ff58cce87&artid=170&web=yes

Providers must ensure staff have completed either the new IG training tool or the previous IG training tool.

Fully implemented ✔	Partially implemented	Not implemented
At least 95% of staff have completed either the previous IG training or the new training in the last twelve months. The trust achieved a total of 95.2% of staff trained.		

Leadership Obligation 2: Processes

5. Acting on CareCERT advisories

Organisations must:

- Identify a primary point of contact for your organisation to receive and co-ordinate your organisation's response to CareCERT advisories, and provide this information through CareCERT Collect
- act on CareCERT advisories where relevant to your organisation
- confirm within 48 hours that plans are in place to act on High Severity CareCERT advisories, and evidence this through CareCERT Collect

Fully implemented ✔ The organisation has registered for CareCERT Collect	Not implemented

Yes ✔	No	Not applicable
The organisation has plans in place for all CareCERT advisories up to 31/3/2018 that are applicable to the organization (**Note**: the plan could be that the board accepts the residual risk) All CareCERT advisories are logged on the IT corrective actions log, these are managed by the IT Compliance & Audit Manager, all applicable alerts are disseminated to the IT Team for action.		

Fully implemented ✔	Partially implemented	Not implemented
The organisation has clear processes in place that allow it to confirm within 48 hours of a High Severity CareCERT advisory being issued that a plan is in place. A procedure is in place to ensure that all high severity alerts are confirmed within 48 hours and that a remediation plan is in place.		

Fully implemented ✔	Partially implemented	Not implemented
The organisation has in post a primary point of contact who is responsible for receiving and co- ordinating CareCERT advisories. The IT Compliance & Audit Manager is responsible for receiving and coordinating advisories.		

6. Business continuity planning

Comprehensive business continuity plans must be in place to support the organisation's response to data and cyber security incidents.

Fully implemented ✔	Partially implemented	Not implemented
The organisation has an agreed business continuity plan(s) for cyber security incidents in place. The plan(s) take into account the potential impact of any loss of services on external organisations in the health and care system. The Trust has an overarching major incident response plan and each service has business continuity plans to mitigate the impact of a loss of services as a result of a cyber-attack. The IT department has an incident response plan for a cyber incident to mitigate loss of service and plan for service recovery.		

If there is a business continuity plan in place has it been tested in 2017/18?

Yes	No ✔ The business continuity plan for data and cyber security incidents has not been tested in 2017/18. A table top exercise has taken place to test business continuity for a cyber incident but not a physical test. The Trust Audit Committee has discussed the need to review business continuity plans and part of this will involve testing plans but this is dependent on mitigating disruption to services.

7. Reporting incidents

Staff across the organisation must report data security incidents and near misses, and incidents should be reported to CareCERT in line with reporting guidelines.

Incidents should be reported to CareCERT via carecert@nhsdigital.nhs.uk or 03003035222 if part of a national cyber incident response.

Fully implemented ✔	Partially implemented	Not implemented
The organisation has a process or working procedure in place for staff to report data security incidents and near misses The Trust has a policy for reporting data security incidents which is being reviewed in line with GDPR requirements. The IT Department also has a reporting policy that includes NHS Digital for incident reporting.		

Leadership obligation 3: Technology

8. Unsupported systems

Your organisation must:

- identify unsupported systems (including software, hardware and applications)
- have a plan in place by April 2018 to remove, replace or actively mitigate or manage the risks associated with unsupported systems.

NHS Digital's good practice guide on the management of unsupported systems is at: https://digital.nhs.uk/cyber-security/policy-and-good-practice-in-health-care.

Other guidance and general documents are on the main CareCERT website.

Fully implemented ✔	Partially implemented	Not implemented
The organisation has reviewed all its systems and any unsupported systems have been identified and logged on the organisation's relevant risk register Unsupported systems have been logged and actions taken to mitigate the risk of these devices being active on the network whilst they are upgraded/replaced. All information is logged on the IM&T Risk register.		

For any unsupported systems identified, has the organisation developed a plan for how it will remove, replace or actively mitigate or manage the risks of unsupported systems. Organisations are not required to submit a plan as part of this data collection process but should be prepared to submit their plan to NHS Digital if requested.

Fully implemented ✔	Not implemented
By May 2018 the organisation will have developed a plan to remove, replace or actively mitigate or manage the risks associated with unsupported systems By May 2018 the Trust does not anticipate that any of the unsupported systems will be present on the network.	

9. On-site cyber and data security assessments

Your organisation must:

- have undertaken or have signed up to an on-site cyber and data security assessment by NHS Digital
- act on the outcome of that assessment, including any recommendations, and share the outcome of the assessment with your commissioner.

Fully implemented ✔	Partially implemented	Not implemented
The organisation has undergone an NHS Digital on-site cyber and data security assessment The Trust has had an on-site assessment by Dionach who were commissioned by NHS Digital		

For organisations who have undergone an NHS Digital on-site cyber and data security assessment:

Fully implemented	Partially implemented ✔	Not implemented
	The organisation has an improvement plan in place on the basis of the findings of the assessment, but has not yet shared the outcome with the relevant commissioner(s) An improvement plan has been created and is in progress. The Trust will discuss who this needs to be shared with.	

Please tell us if the organisation has used an external organisation to audit the organisation's data and cyber security risks. Please note there is no requirement to use an external organisation to audit data and cybersecurity risks.

Yes ✔ The organisation has used an external vendor to audit the organisation's data and cyber security risks Dionach, commissioned by NHS Digital	No

10. Checking Supplier Certification

Organisation should ensure that any supplier of critical IT systems that could impact on the delivery of care, or process personal identifiable data, has the appropriate certification (suppliers may include other health and care organisations).

Depending on the nature and criticality of the service provided, certification might include:

- ISO/IEC 27001:2013 certification: supplier holds a current ISO/IEC27001:2013 certificate issued by a United Kingdom Accreditation Service (UKAS)-accredited certifying body and scoped to include all core activities required to support delivery of services to the organisation.

- Cyber Essentials (CE) certification: supplier holds a current CE certificate from an accredited CE certification body.

- Cyber Essentials Plus (CE+) certification: supplier holds a current CE+ certificate from an accredited CE+ Certification Body.
- Digital Marketplace: supplier services are available through the UK Government Digital Marketplace under a current framework agreement.

- Other types of certification may also be applicable. Please refer to Cyber Security Services 2 Framework via Crown Commercial (https://ccs-agreements.cabinetoffice.gov.uk/contracts/rm3764ii)

NHS Digital contracts for/supplies a number of IT systems and solutions in use by multiple NHS organisations. Please note that NHS Digital ensures in each of its system procurements that appropriate data security certifications are in place from its suppliers.

Fully implemented	Partially implemented ✔	Not implemented
	The organisation has checked that the suppliers of IT systems that relate to patient data, involve clinical care or identifiable data have appropriate certification, and can evidence that all suppliers have such certification. All of our core critical systems, suppliers are appropriately certified. We have some small scale solutions which are hosted within the Trust for which we are currently checking the supplier certification applicability and status. The Trust itself is ISO27001 certified, and is currently going through the Cyber Essentials + process.	

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	8 May 2018
Title	**Audit Committee – 25 April 2018**
Purpose	To receive the unconfirmed minutes of the meeting of the Audit Committee of 25 April 2018.
Business Area	Corporate
Author	Company Secretary for Chris Fisher, Audit Committee Chair
Relevant Strategic Objectives	Strategic Goal 4: to deliver services that are efficient and financially sustainable
CQC Registration/Patient Care Impacts	N/A
Resource Impacts	None
Legal Implications	Meeting requirements of terms of reference.
Equality and Diversity Implications	N//A
SUMMARY	The unconfirmed minutes of the Audit Committee meeting held on 25 April 2018.
ACTION REQUIRED	The Trust Board is asked to receive the minutes and to seek any clarification on issues covered.

Berkshire Healthcare NHS
NHS Foundation Trust

Unconfirmed Draft Minutes

Minutes of the Audit Committee Meeting held on

Wednesday, 25 April 2018, Fitzwilliam House, Bracknell

Present:	Chris Fisher, Non-Executive Director, Committee Chair Naomi Coxwell, Non-Executive Director Mehmuda Mian, Non-Executive Director
In attendance:	Alex Gild, Chief Financial Officer Martin Earwicker, Chair Heidi Ilsley, Interim Deputy Director of Nursing *(deputising for Debbie Fulton, Deputy Director of Nursing)* Debbie Kinch, Counter Fraud, TIAA Clive Makombera, Internal Auditors, RSM Amanda Mollett, Head of Clinical Effectiveness and Audit Minoo Irani, Medical Director Ben Sheriff, Deloittes, External Auditors Julie Hill, Company Secretary Paul Gray, Director of Finance Mark Davison, Director of IM&T (*present for items 5 and 12)* Richard Watson, IT Compliance and Audit Manager *(present for items 5 and 12)*

Item	Title	Action
1.A	**Chair's Welcome and Opening Remarks**	
	Chris Fisher, Chair welcomed everyone to the meeting.	
1.B	**Apologies for Absence**	
	Apologies were received from: Debbie Fulton, Deputy Director of Nursing.	
2.	**Declaration of Interests**	
	There were no declarations of interest.	
3.	**Minutes of the Previous Meeting held on 31 January 2018**	
	The Minutes of the meeting held on 31 January 2018 were approved as a correct record.	
4.	**Action Log and Matters Arising**	
	The action log had been circulated. The following items were discussed further: **a) Counter Fraud Services Single Waiver Benchmark Report**	

	The Chair asked whether there was a reason why the Trust had not completed Counter Fraud's Single Waiver Survey. The Chief Financial Officer said that this had been an oversight and that the Trust would take part in the next survey. **b) Board Assurance Framework** Naomi Coxwell, Non-Executive Director referred to risk 7 on the Board Assurance Framework and asked when the Trust Board would receive the results of the Trust's Stakeholders Survey. The Chief Financial Officer confirmed that the outcome of the Stakeholder Survey would be presented to the May 2018 Trust Board In Committee meeting. The Committee noted the Action Log.	
5	**IT Business Continuity "Deep Dive" Presentation**	
	The Chair welcomed the Director of IM&T and the IT Compliance and Audit Manager to the meeting and invited them to give their presentation on IT Business Continuity. During the presentation, the following points were made: • The Trust had around 60 IT systems (including 20 patient information systems). All systems had risk assessments in place and had been reviewed over the last twelve months. • The Trust used penetration testing to identify any vulnerabilities in the system. • Business continuity planning included arrangements for disaster recovery and work arounds for IT system failures. • The business continuity IT counter measures varied depending on potential risks, impacts and costs of any IT system failure. For example, Prospect Park Hospital had a generator on site if there was a power failure. • The RiO system (electronic patient record system) had data centres in different parts of the country which meant that if one centre went down, data could be switched over to another centre in a matter of minutes. • If the RiO data authentication process failed, staff would not be able to log-in to the system, but they would still have read only access to patient records which would require clinicians to manually update the records when the system was back up and running. • Every opportunity was taken to test systems during periods of planned maintenance etc. Desk top exercises were useful but live testing of systems which involved a disruption to the service was problematic and needed careful planning. • There were three possible scenarios for a "deep dive" IT business continuity exercise: to simulate a loss of a building or power, the loss of a core data centre or a specific system failure. The Chair suggested opting to rigorously test a particular system, for example, one which recovery would take a longer timeframe. The Director of IM&T said that he would involve the Risk Team in deciding which system. It would need careful planning to do a "deep dive" test. The Chair reminded the meeting that one of the reasons the Audit Committee	

	had requested the presentation was to gain assurance that the Trust had effective systems and processes in place both in terms of cyber security and in terms of IT business continuity. The Chair said that the Governors had also raised the issue of cyber security following the publicity around the "Wannacry" Ransomware attack which had affected some NHS organisations. The Chief Financial Officer said that the Committee could take assurance from the fact that the Trust had resilient IT systems and had a rigorous testing system in place. The Chief Financial Officer suggested asking the Chief Operating Officer (the Executive lead for business continuity) to present a paper on the Trust's wider business continuity planning process to a future meeting of the Committee. Ben Sheriff, Deloittes (External Auditors) said that it was good that the Committee was discussing the important issue of IT Business Continuity and was considering a range of different scenarios, from a power failure to an IT system failure. The Chair said that he looked forward to receiving a report on the outcome of the Deep Dive exercise and an update on the Trust's business continuity planning process. On behalf of the Committee, the Chair thanked the Director of IM&T and the IT Compliance and Audit Manager for their presentation.	**AG/DT** **AG/MD**
6.A	**Board Assurance Framework**	
	The full Board Assurance Framework had been circulated. Updates since the last Audit Committee were highlighted in red type. The Chair reminded the meeting that during 2017-18, in addition to the quarterly reviews of both the Board Assurance Framework and the Corporate Risk Register, the Committee had received a number of reports on different aspects of the Board Assurance Framework (for example, a "deep dive "report in respect of risks 4 and 7, a report on the gaps in controls and assurance and a report setting out the evidence that the controls were working). The Chair requested that the Executive Team review the Board Assurance Framework risks in the light of the Trust's strategic priorities for 2018-19 and report back to the July 2018 Audit Committee with any recommendations to change any of the risk profiles, mitigations etc. The Chair said that he would then invite the external representatives in attendance at the meeting for their views. The Medical Director pointed out that the only members of the Executive who routinely attended the Audit Committee were the Chief Financial Officer and himself and that any questions relating to specific risks may need to be referred back to the relevant Executive Director risk owner. The Chair referred to risk 1 risk on the Board Assurance Framework (page 24 of the agenda pack) and congratulated the Trust on developing a Nursing Apprenticeship with the University of West London. The Chair referred to risk 8 on the Board Assurance Framework and asked for more information about the "Heat Map".	**AG/JH**

	The Medical Director explained that the "Heat Map" highlighted services which were currently under pressure and was discussed at the monthly Operational Leadership Team meetings. The Committee noted the Board Assurance Framework.	
6.B	**Corporate Risk Register**	
	The Corporate Risk Register had been circulated. The Chief Financial Officer presented and report and highlighted that there was a new ligature risk on the Corporate Risk Register and the risk scores in respect of the Mental Health Act Office had decreased and the risk score in respect of Inpatient Bed Pressures had increased. The Chair asked why the risk score had been reduced in respect of the Mental Health Act Office risk on the Corporate Risk Register. The Company Secretary agreed to contact the Director of Nursing and Governance to find out the rationale behind reducing the risk score. The Chair noted the increase in the risk score in respect of the Inpatient Bed Pressures risk on the Corporate Risk Register and commented that the focus of the Cost Improvement Programme for 2018-19 was around reducing the number of inappropriate Out of Area Placements. Naomi Coxwell, Chair of the Finance, Investment and Performance Committee reported that the Committee had received an update on the Trust's Bed Optimisation Programme earlier that day. Ms Coxwell said that the Trust was taking a number of actions to reduce the number of inappropriate Out of Area Placements and commented that it was clear that one size did not fit all and that decisions had to be taken at an individual patient level. The Chief Financial Officer said the commitment in the Five Year Forward View for Mental Health to eliminate inappropriate Out of Area Placements was a helpful lever for the Trust when working with system partners. The Chief Financial Officer added that a key focus of the Bed Optimisation Programme was to ensure that patients had a 72 hour review after admission to ensure that there was clarity around the purpose their admission and to determine a discharge date to ensure that patients did not spend more time in hospital than they clinically needed to. The Chair reported that he had recently visited Sorrell Ward and was surprised to see that the female side of the ward was still closed and boarded up when it appeared that the refurbishment works had been completed. The Chief Financial acknowledged that communication between the Ward and the Estates team could have been better, but pointed out that on a more positive note, when the refurbishment works were completed there would be new seclusion and high dependency rooms for Sorrell ward. The Committee: a) Noted the report; b) Approved the revised risk scores in respect of the Mental Health Act Officer risk (subject to confirmation by the Director of Nursing and	**JH**

	Governance about why the risk score had been reduced) and the Inpatient Bed Pressures risk; and c) Approved the new Ligature risk.	
7.	**Single Waiver Tenders Report**	
	A paper setting out the single waivers approved between 1 January-31 March 2018 had been circulated. The Chief Financial Officer presented the paper and reported that there was a new single waiver authorisation process in place which meant that he would not approve single waiver requests until the Procurement Team had reviewed the reasons for not going through the standard procurement process. The Chair asked whether there were any repeat single waivers. The Chief Financial Officer confirmed that NHS Professionals was the only repeat single waiver and that this was because of the delays in agreeing the new contract. The Committee approved the single waivers as set out in the report.	
8.	**Information Assurance Framework Update Report**	
	The Chief Financial Officer presented the report and highlighted the following points: • A total of six indicators were audited during Quarter 4. Two were rated as Green (high assurance) and four were rated as Red (low confidence) for data quality, but all received Green Data Quality ratings. Action plans had been put in place to address any issues. • The indicators in the Quarter were prioritised due to audit recommendations for regular review (seven day follow-up and Delayed Transfers of Care), access targets (Diabetes and IAPT) and audits that were required within the financial year (Care Programme Approach reviews). • The Trust had received positive overall assurance on the Internal Data Quality audit and Data Quality elements of the 2016-17 Quality Accounts are part of an external audit review. • Use of these systems made information and data quality a crucial element in providing assurance and the ability to monitor availability, completeness, accuracy and timely data to support effective patient care, clinical governance, management and service agreements for healthcare planning and governance. • The new Data Quality Improvement Plan required increased scrutiny of the data quality of our datasets, therefore additional data quality audits would be undertaken in line with contract requirements. These audits would be factored in alongside the Information Assurance Framework audit schedule. The Chair referred to page 64 of the agenda pack and commented that out of 62 records audited relating to Mental Health Care Programme Approach records, only 29 had been properly completed. The Chief Financial Officer confirmed that the results of the audits were fed back to the services.	

	The Chair referred to page 65 of the agenda pack and asked in respect of the Mental Health Diabetes Referral to Treatment Waiting Times records whether there was any evidence to suggest that staff had deliberately mis-stated the date of the referral. The Chief Financial Officer confirmed that there was no evidence that staff were deliberately putting the wrong date on referral records. Ben Sheriff, Deloitte said that one of the audited records was date stamped with a date which did not match the Referral to Treatment start date. Naomi Coxwell referred to the same section in the report and noted the reference to the "Diamond" clinical system and commented that using two separate computer systems was not best practice. The Medical Director explained that the Diamond computer system was a specialist system for Diabetes which was primarily used by the acute hospitals who ran the majority of Diabetes Services. The Committee noted the report.	
9.	**Losses and Special Payments Report**	
	The Chief Financial Officer reported that the total net value of losses reported between January 2018 and 31 March 2018 was £46,404.77. All of these losses were included in the outturn position for the Trust up to the end of Quarter 4 2017-18. The Chair referred to page p75 of the agenda pack and asked for more information about the larger of the two overseas bad debts. The Chief Financial Officer said that the Royal Berkshire NHS Foundation Trust had admitted the patient as an emergency but was not fit enough to be discharged and was referred to West Berkshire Community Hospital. The Committee approved the losses and special payments.	
10.	**Clinical Audit Progress Report**	
	The Head of Clinical Audit and Effectiveness presented the report and highlighted the following points: • In total there were 23 national quality account reportable projects, 3 national projects with the majority linked to CQUINs and 1 project requested by the Quality Assurance Committee. • All national timescales had been met. • There were currently no risks identified with implementation of the remaining programme of work, all of which was in line with national reporting. • Open projects would automatically transfer to the 2018/19 plan together with the new National Clinical Audit and Patient Outcomes Programme CAPOP audits planned for 2018/19.	

	• The new Clinical Audit Plan included 30 projects which would be challenging for the team, especially as the team were also supporting services to develop action plans and were proactively monitoring the implementation of the actions. The Medical Director explained that the Clinical Audit Team comprised 2.6 members of staff and pointed out that the number, size and complexity of national clinical audits was continuing to increase year on year. The Committee noted the report.	
11.	**Clinical Claims and Litigation Report Quarterly Report**	
	The Interim Deputy Director of Nursing and Governance presented the report and highlighted the following points: • During Quarter 4 there were 3 new claims received, this was consistent with 2 received in Quarter 2 and 4 received in Quarter 3 • There was two were related to Employer Liability and one related to patient care. This brought the total claims opened in 207/18 to 17. Of these, 7 were around employee liability and 10 were clinical negligence claims • During Quarter 4 there were 3 claims closed as set out in the report. • This brings the total closed in 2017/18 to 16, 6 of these were around clinical negligence, 9 around employee liability and 1 around public liability. 3 of these were repudiated with the remaining 13 being settled either in or out of court. Mehmuda Mian, Non-Executive Director asked how the Trust benchmarked against similar trusts. The Interim Deputy Director agreed to find out whether appropriate benchmarking data was available. The Committee noted the report	**HI/DF**
12.	**Data Security Protection Compliance Report**	
	The Director of IM&T presented the report and highlighted the following points: • The Department of Health and Social Care, NHS England and NHS Improvement had published a set of 10 data and cyber security standards called the 2017-18 Data Security Protection Requirements that all health and social care organisations must comply with. • NHS Improvement required all NHS providers to confirm by 11 May 2018 whether or not they had implemented (fully, partially or not) the 10 standards. The Chair referred to standard number 3 and reminded the meeting that the Audit Committee had received a report at the last meeting which set out the Trust's work to ensure compliance with the requirements of the new General Data Protection Regulation. The IT Compliance and Audit Manager reported that the Information Commissioners Office had not yet published the final guidance on the new Data Protection Act. The IT Compliance and Audit Manager also pointed out that the final guidance relating to children's information had not yet been published but confirmed that the Trust was compliant with the requirements as set out in the draft consultation guidance.	

	It was noted that there was a new privacy notice published on the Trust's website. The Director of IM&T pointed out that there was a health exemption in terms of data which was stored for the purposes of delivering health care but said that it was important clinicians explained to patients in what circumstances their data was shared with other health and social care providers. The Director of IM&T referred to standard number 5 and proposed changing "partially implemented" to "fully implemented" in relation to high severity alerts. The Chair proposed rewording the response to question 6 to make reference to Committee's earlier discussion about developing a structured work programme to test systems without the need of a physical check. The Chief Financial Officer thanked the Committee for their comments and confirmed that the submission would be revised in the light of the Audit Committees comments and would be submitted to the May 2018 Trust Board meeting for approval. The Committee noted the report.	**AG/MD** **AG/MD** **AG/JH**
13.	**Internal Audit**	
	A) Internal Audit Progress Report Clive Makombera, Internal Auditors, RSM, presented the Internal Audit Progress Report and reported that: • Eight reports had been finalised. Two draft reports were out for management comment (Key Financial Controls – General Ledger and Payroll) and Workforce (Recruitment and Retention and Temporary Staffing and Rostering) • Since the last meeting, the Information Governance Toolkit report had been issued with no major issues identified. • The Internal Auditors were working with the Chief Financial Officer to implement any outstanding actions as set out at section of the report. Naomi Coxwell, Non-Executive Director commented that some of the actions had been outstanding for some time. The Chief Financial Officer said that he was working with the Internal Auditors to put in tighter systems and processes around the completion of audit actions. The Chair asked Mr Makombera whether any of the outstanding actions were of concern. Mr Makombera confirmed that there were no particularly concerning outstanding actions but he was keen to reduce the number of outstanding actions to a small manageable number going forward. **B) Annual report and Draft Head of Internal Audit Opinion** Clive Makombera presented the Annual Report and the Draft Head of Internal Audit Opinion and pointed out that there were four levels of opinion ranging from 1 to 4 and that the Trust was rated at level 2. This meant that the Trust had an adequate and effective framework for risk management, governance and internal control. However further enhancements were required to the framework of risk management, governance and internal	

	control to sure ensure that it remained adequate and effective. The Chair asked whether RSM had awarded any level 1 ratings for 2017-18. Mr Makombera confirmed that on level 1 ratings had been awarded. The Committee noted the report.	
14.	**Counter Fraud**	
	A) Counter Fraud Progress Report Debbie Kinch, Counter Fraud Service, TIAA presented the paper and highlighted the following points: • The table on page 133 of the agenda pack provided a summary of reactive work undertaken by the Counter Fraud Service since the last meeting. • The Counter Fraud Service had received 15 queries relating of overseas patients and the nature of the queries was getting more complex. Naomi Coxwell, Non-Executive Director asked whether the Trust had a register of gifts and hospitality. The Chief Financial Officer confirmed that this was the case and any gift or hospitality over £25 had to be registered. **B) Counter Fraud Risk Assessment and Strategic Work Plan 2018-19** Debbie Kinch, Counter Fraud Service, TIAA presented Work Plan for 2018-19 and explained that the number of days were fixed but the Counter Fraud Service was flexible and was happy to vary the Work Programme if more urgent areas emerged during the course of the year. The Committee noted the report and approved the Risk Assessment and Strategic Work Plan 2018-19.	
15.	**External Audit Report**	
	Ben Sheriff, Deloittes, External Auditors presented the paper and reported that the Internal Audit had started auditing the Trust's Accounts and was receiving good co-operation from the Finance Team. The Chair commented that the Trust Board had delegated the responsibility of approving the Trust's final accounts to the Audit Committee at its special meeting on 23 Ma 2018, but requested that in future years, the timing of the May Trust Board meeting should be changed to fit into NHS Improvement's deadline for the submission of the Annual Report and Accounts. The Committee noted the report.	**AG/JH**
16.	**Minutes of the Finance, Investment and Performance Committee held on** 31 January 2018, 27 February 2018 and 28 March 2018	
	The minutes of the Finance, Investment & Performance Committee meetings of 31 January 2018, 27 February 2018 and 28 March 2018.were received and noted.	

17.	**Minutes of the Quality Assurance Committee held on 20 February 2018**	
	The minutes of the Quality Assurance Committee meeting of 20 February 2018 were received and noted.	
18.	**Minutes of the Quality Executive Committee held on 8 January 2018, 12 February 2018 and 12 March 2018**	
	The minutes of the Quality Executive meetings of 8 January 2018, 12 February 2018 and 12 March 2018 were received and noted.	
19.	**Annual Review of Effectiveness**	
	The Company Secretary reported that the Committee would normally review their terms of reference and committee effectiveness at this meeting, but in view of the fact that the Trust had new External Auditors and Naomi Coxwell, Non-Executive Director was new in post, it was proposed that this would be deferred until the July 2018 meeting. The Committee agreed to defer this item until the July 2018 meeting.	**JH**
20.	**Annual Work Plan**	
	It was agreed that the Audit Committee's work programme for July 2018 would include a report back from the Executive on their review of the Board Assurance Framework Risks.	**AG/JH**
21.	**Any Other Business**	
	The Committee noted that no other business was raised.	
22.	**Date of Next Meeting**	
	23 May 2018 2pm *(this was a special meeting to approve the Annual Accounts)*	

These minutes are an accurate record of the Audit Committee meeting held on 25 April 2018.

Signed:- _____

Date: - 25 July 2018 _____