BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

TRUST BOARD MEETING HELD IN PUBLIC

10:00am on Tuesday 10 July 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 8 May 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	Freedom to Speak Up Annual Report	Elaine Williams, Freedom to Speak Up Guardian	Enc.
6.3	Annual Complaints Report	Helen Mackenzie, Director of Nursing and Governance	Enc.
6.4	Quality Assurance Committee – 15 May 2018 a) Minutes of the Meeting b) Learning from Deaths Quarterly Report c) Guardians of Safe Working Quarterly Report	Ruth Lysons, Chair of the Quality Assurance Committee Dr Minoo Irani, Medical Director	Enc.
6.5	Revalidation Annual Report 2017/18	Dr Minoo Irani, Medical Director	Enc.
	EXECUTIVE UPDATE		
7.0	Executive Report	Julian Emms, Chief Executive	Enc.
	PERFORMANCE		
8.1	Month 2 2018/19 Finance Report*	Alex Gild, Chief Financial Officer	Enc.
8.2	Month 2 2018/19 Performance Report*	Alex Gild, Chief Financial Officer	Enc.
8.3	a) Finance, Investment & Performance Committee – 27 June 2018 b) Revised Terms of Reference for Ratification	Naomi Coxwell, Chair of the Finance, Investment and Performance Committee	Verbal Enc.

No	Item	Presenter	Enc.
	**The Month 2 Finance Report and Performance Report were reviewed by the June 2018 FIP Committee*		
STRATEGY			
9.0	Vision Metrics Report	Alex Gild, Chief Financial Officer	Enc.
9.1	Strategy Summary Document 2018-21	Bev Searle, Director of Corporate Affairs	Enc.
9.2	Mental Health Strategy Update Report	Bev Searle, Director of Corporate Affairs	Enc.
9.3	Equalities Annual Report	Bev Searle, Director of Corporate Affairs	Enc.
CORPORATE GOVERNANCE			
10.1	Audit Committee Minutes – 23 May 2018	Chris Fisher, Chair, Audit Committee	Enc.
10.2	Constitutional Changes Report	Julie Hill, Company Secretary	Enc.
10.3	Use of the Trust Seal Report	Alex Gild, Chief Financial Officer	Enc.
10.4	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 –11 September 2018 *(a meeting is scheduled on 14 August 2018 if required)*	Martin Earwicker, Chair	Verbal
13.	**CONFIDENTIAL ISSUES:** To consider a resolution to exclude press and public from the remainder of the meeting, as publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted.	Martin Earwicker, Chair	Verbal

Berkshire Healthcare NHS
NHS Foundation Trust

AGENDA ITEM 5.1

Unconfirmed minutes

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

Minutes of a Board Meeting held in Public on Tuesday 8 May 2018

Boardroom, Fitzwilliam House

Present:	Martin Earwicker	Chair
	David Buckle	Non-Executive Director
	Naomi Coxwell	Non-Executive Director
	Mark Day	Non-Executive Director
	Julian Emms	Chief Executive
	Chris Fisher	Non-Executive Director
	Alex Gild	Chief Financial Officer
	Dr Minoo Irani	Medical Director
	Ruth Lysons	Non-Executive Director
	Helen Mackenzie	Director of Nursing and Governance
	Mehmuda Mian	Non-Executive Director *(present from 10.30)*
	Bev Searle	Director of Corporate Affairs
	David Townsend	Chief Operating Officer
In attendance:	Julie Hill	Company Secretary

18/079	**Welcome** (agenda item 1)
	Martin Earwicker, Chair welcomed everyone to the meeting, including the observers: Liz Barter, Care Quality Commission, Tom Lake, Public Governor and Tom O'Kane, Public Governor.
18/080	**Apologies** (agenda item 2)
	There were no apologies. Apologies for lateness were received from Mehmuda Mian, Non-Executive Director.
18/081	**Declaration of Any Other Business** (agenda item 3)
	There was no other business declared.
18/082	**Declarations of Interest** (agenda item 4)
	i. Amendments to Register – none
	ii. **Agenda Items** – none
18/083	**Minutes of the previous meeting – 10 April 2018** (agenda item 5.1)

	The Minutes of the Trust Board meeting held in public on Tuesday 10 April 2018 were approved as a correct record of the meeting.
18/084	**Action Log and Matters Arising** (agenda item 5.2)
	The schedule of actions had been circulated. The following items were discussed further: **Quality Assurance Committee and Audit Committee – Overlaps and Gaps** Chris Fisher, Chair of the Audit Committee reported that he had discussed the linkages between the Board Sub-Committees with Mehmuda Mian, Non-Executive Director (and member of both the Quality Assurance Committee and the Audit Committee) and Naomi Coxwell, Chair of the Finance, Investment and Performance Committee and member of the Audit Committee) and confirmed that there were no significant overlaps or gaps identified. **The Trust Board**: noted the schedule of actions.
18/085	**Patient Story** (agenda item 6.1)
	The Director of Nursing and Governance presented the patient story which concerned a Service User. It was noted that the service user was married and was in his 50s and had taken early retirement after a successful career. The Director of Nursing and Governance said that around about the same time as the Service User's retirement, his mother had died and his first grandchild was born. These key life changing events happening all together led to the Service User developing an adjustment disorder, anxiety and depression which culminated in a number of suicide attempts. It was noted that after contacting the Common Point of Entry, the Service User was referred to the Slough Community Mental Team. At the time, the Service User did not find his treatment helpful and his condition worsened. The Service User was admitted to Prospect Park Hospital for further treatment and had five mental health in-patient hospital admissions in 18 months. The Service User was referred to the Trust's ASSiST (*Assertive Intervention Stabilisation Team*) Programme for people with non-psychotic, borderline personality disorders and other emotional problems. As part of the programme, service users had weekly individual sessions with a Psychology Assistant to help manage anxiety and panic attacks; weekly Psychological Therapy sessions to help manage issues around trauma, self-esteem and depression; morning telephone support; and carer involvement and family sessions. It was noted that there was a weekly group meeting for service users called EMBRACE (*Emotionally Educated Minds Bring Reason and Choices Everyday*) which had a strong focus on recovery. In addition, service users were provided with a Peer Buddy, Peer Mentoring and were able to access the Slough Recovery College programmes. It was noted that the Service User had recovered and was now actively involved in many areas of the Trust and was helping with the Trust's co-production work and was a Peer Mentor. The Service User also visited Prospect Park Hospital to support in-patients. The Director of Nursing and Governance reported that the Service User and along with others had been invited to share their experiences of the ASSiST Programme at the Joint Trust Board and Council of Governors meeting on 16 May 2018.

	The Director of Nursing and Governance said that service users were an invaluable resource and provided a different perspective which helped the Trust to develop more effective services. Mark Day, Non-Executive Director commented that the Service User had spent a significant amount of time prior to being referred to the ASSiST programme and asked whether there was scope to accelerate the referral process. The Chief Operating Officer explained that the Trust followed the relevant NICE Guidance and that patients needed to be stabilised before they could participate in the ASSiST Programme and said that the Programme was not appropriate for all service users. The Chief Executive reported that he had recently met with Claire Murdoch, NHS England's Mental Health Director and she had confirmed that there was not a national evidence base on how best to treat people with Personality Disorders. The Chief Executive also pointed out that for very depressed and suicidal patients like the Service User, the Clinician's first priority was to prevent them ending their own life and that until patients were stable, they would not be receptive to the ASSiST Programme. The Chair thanked the Director of Nursing and Governance for sharing the Service User's story and looked forward meeting him and other ASSiST service users at the Joint Trust Board and Council of Governors meeting on 16 May 2018.
18/086	**Patient Experience Quarter 4 Report** (agenda item 6.2)
	The Director of Nursing and Governance presented the paper and highlighted the following points: • The top reasons for complaints continued to be: care and treatment; attitude of staff; and communication. There were no new trends in the Quarter; • During Quarter 4, the Trust had received 55 complaints. • During Quarter 4, the Trust continued to sustain a complaint response rate of 100%, having achieved this for over two years. The Chair referred to page 20 of the agenda pack and asked for more information about Reading Borough Council's decision to reduce the number of Social Workers and to no longer have shared posts between the Council and the Trust. The Director of Nursing and Governance reported that the Community Mental Health Teams tended to be integrated teams with Social Workers and Health Service Staff working together. It was noted that Reading Borough Council had reduced their Social Worker team by 11 posts and had removed the Social Workers from the integrated team. It was noted that the Trust's Patient Experience Team had commissioned a "deep dive" review into the service in order to gain a better understanding of the impact of the changes on all patients and not just those who chose to make a complaint about the service. Chris Fisher, Non-Executive Director asked whether Local Authorities were required to undertake quality impact assessments prior to making decisions to reduce services. The Chief Executive confirmed that Local Authorities were required to do quality impact assessments, but cuts to their funding meant that many Local Authorities were now only providing statutory services. The Chief Executive pointed out that whilst there were a few statutory functions which

	Social Care staff employed in a local authority undertook, ongoing care co-ordination in a Community Mental Health team was not one of them and as such was a discretionary service. Ruth Lysons, Non-Executive Director asked whether having a Secretary of State for Health and Social Care was likely to make a difference. The Chief Executive confirmed that this was unlikely to have much bearing because the accountability for delivering balanced budgets resided with Councils. Ruth Lysons, Non-Executive Director said that the Community Mental Health Teams continued to receive relatively high numbers of complaints and noted that the service was under pressure. Ms Lysons asked whether the Trust's strategic review of beds would take account of the capacity of the Community Mental Health Teams, especially if the direction of travel was to treat more people in the Community. The Chief Operating Officer confirmed that the capacity of the Community Mental Health Teams was not within the scope of the strategic review of beds. It was noted that the focus on the strategic review of beds was to work out the Trust's bed requirement over the next 10-20 years based on the projected population and demand for beds. The Chief Executive reported that the Executive Team and Clinical Directors had held an event with the Complaints Team to celebrate their 100% performance in responding to complaints within the timescale. On behalf of the Trust Board, the Chair congratulated the Complaints Team. Ruth Lysons, Non-Executive Director referred to page 21 of the agenda pack and reported that she had recently undertaken a 15 Steps Visit to the Campion Unit and she had been impressed by the efforts made by staff to ensure that people with learning disabilities were able to complete the Friends and Family Test. This included developing forms which were accessible for people with learning disabilities. The Director of Nursing and Governance thanked Ms Lysons for her comments and agreed to feed this back to the Learning Disabilities Service. **Action: Director of Nursing and Governance** Mark Day, Non-Executive Director said that his recent 15 Steps and Board Visits to Willow House and Oakwood Ward had provided him with an opportunity to find out first hand whether what he read in the Trust Board papers chimed with what was actually happening on the front line. The Chief Executive reported that in the In Committee meeting later today, the Trust Board would be reviewing the draft Strategy Summary Document and suggested that it would be helpful to expand the Document to make reference to the national rise in demand for some services, for example, CAMHS. **Action: Director of Corporate Affairs** *Mehmuda Mian, Non-Executive Director joined the meeting at 10.30.* **The Trust Board:** noted the report.
18/087	**BHFT Quality Report** (agenda item 6.3)

	The Medical Director presented the item and reported that the Quality Assurance Committee had received and discussed the previous three draft quarters of the Quality Accounts 2017-18. It was noted that the Quality Accounts quarter three version had also been shared with the Governors and with the Trust's stakeholders and their responses have been included in the final version. It was noted that the Trust's External Auditors were currently auditing the content of the Quality Accounts to ensure that the content met NHS Improvement's requirements. The External Auditors would provide an independent assurance report to the Council of Governors later in the year and the report would be presented to the Audit Committee on 23 May 2018. The final Quality Accounts would be submitted to NHS Improvement by noon on 29 May 2018 as part of the Trust's Annual Report and Accounts submission. Chris Fisher, Non-Executive Director referred to page 78 of the agenda pack asked whether there was more scope for the Trust to work with the broader Public Health system to reduce the number of suicides in Berkshire. The Medical Director pointed out that the majority of people who committed suicide had had no prior contact with the Trust's Mental Health Services prior to their death. The Director of Nursing and Governance reported that the Trust was part of the Berkshire Suicide Prevention Steering Group which included representatives from Health, Local Government, the Voluntary Sector and the Police. It was noted that the Trust had recently screened a film entitled "The Ripple Effect" which highlighted the important role of friends and family in supporting people at risk of suicide. Naomi Coxwell, Non-Executive Director referred to page 90 of the agenda pack and commented that the staff survey result for KF26 (percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months) was relatively high. The Chief Executive said that the Trust's performance was average when benchmarked against other similar Trusts and reminded the meeting that the Trust had undertaken some targeted work over the last year to try and eliminate the differential experiences of BAME and white staff. It was noted that the *Making it Right* programme for BAME staff was starting to make a positive impact. Ruth Lysons, Non-Executive Director referred to page 100 of the agenda pack and suggested expanding the reference to the Electronic Prescribing and Medicines Administration (ePMA) system to include patient safety benefits, such as reducing the risk of drug missed doses etc. The Medical Director pointed out that the benefits of the implementing the ePMA system had not yet been formally evaluated but agreed to mention the quality aspect of ePMA in the Quality Accounts. **Action: Medical Director** Ms Lysons referred to page 91 of the agenda and queried whether the section on values based recruitment should make reference to challenges posed by workforce shortages in some areas. The Chair preferred to page 86 of the agenda pack and pointed out that the shortage of permanent nursing and therapy staff was listed as a Quality Concern. The Chair asked the Trust Board to consider the wording of the Statement of Directors' Responsibilities in respect of the Quality Accounts. The Trust Board: a) Confirmed that they were satisfied with the Quality Accounts in relation to the

	requirements as set out in the Statement of Directors' Responsibilities; b) Confirmed that to their best knowledge and belief, the Quality Accounts complied with the requirements of NHS Improvement, as set out in the NHS Foundation Trust Annual Reporting Manual and Supporting Guidance; c) Delegated responsibility for signing the Statement of Directors' Responsibilities to the Chair and Chief Executive.
18/088	**Six Monthly Safe Staffing Report** (agenda item 6.4)
	The Director of Nursing and Governance presented the paper and highlighted the following points: • Nationally, the Trust was only required to report on Safe Staffing in respect of In-patient wards, but it was important for the Trust Board to be aware that Community Nursing Services were also under pressure because of the national shortage of qualified staff; • The Finance, Investment and Performance Committee received monthly Safe Staffing reports. The six monthly report enabled the Trust Board to review the data over a longer time frame and made it easier to identify any key trends; • Prospect Park Hospital had continued to experience challenges with high bed occupancy, patient dependencies and staffing vacancy rates; • To support Rowan and Sorrell wards, 12 whole time equivalent additional unregistered Activity Co-ordinators had been recruited which would enhance the consistency of care and increase the proportion of permanent staff; • Stable leadership was now in place at the Campion Unit and the closure of Little House meant that the Trust was using less temporary staff. Staffing vacancies at Willow House had reduced but recently there had been a slight increase; • Over the six months period, the Trust had declared Safe Staffing levels, but the high use of temporary staff meant that care and patient experience were not always optimal. Mark Day, Non-Executive Director commented that the Activity Care Co-ordinators had been appointed to increase patients' levels of engagement and asked how this was measured. The Director of Nursing and Governance said that patients verbally fed back to Occupational Therapy staff. The Director of Nursing and Governance said it was hoped that reducing patient boredom would also reduce the incidence of self-harm and the levels of violence and aggression on the wards. The Chair reported that he had written to the Secretary of State for Health and Social Care to point out that it was not helpful that staff undertaking the Nursing Degree Apprenticeship programme could not be counted as substantive staff on the wards. **The Trust Board:** noted the report.
18/089	**Executive Report** (agenda item 7.1)
	The Executive Report had been circulated. **The Trust Board**: noted the report.

18/090	**NHS Staff Survey 2017 Report** (agenda item 7.2)
	The Director of Corporate Affairs presented the report and highlighted the following points: • The Trust's overall Staff Engagement score had improved for the sixth consecutive year; • This year, there were 22 key findings in which the Trust had better than average scores, compared with 20 in 2016; • For 6 of the 22 better than average scores, the Trust's scores equaled the best compared with 4 in 2016; • 6 key findings were average scores; compared with 7 in 2016; • 4 key findings were worse than the average scores, compared with 4 in 2016; • The paper provided a summary of the Trust's top 5 and bottom 5 scores together with benchmarking data in relation to similar trusts; • The report also provided information on staff experience, workplace race equality and health and wellbeing ratings, together with a summary of the actions the Trust was taking in response to the NHS Staff Survey results 2017; • The proposed actions were focussed on understanding the variations between services and localities. • The progress made towards implementing the action plan would be reported to the Business and Strategy Executive Group. The Chair commented that the NHS Staff Survey results for 2017 were very positive, especially in terms of the staff engagement. The Chair reported that he had attended the recent Trust Equality Champions event and had been impressed by the enthusiasm of the delegates and by their belief that the Trust genuinely wanted to make a difference. The Chair referred to page 170 of the agenda pack and commented that it was disappointing that the Trust had not improved its performance in relation to health and well-being. The Director of Corporate Affairs agreed but commented that benchmarking data showed that no organisation had significantly improved in this area, unless they had started from a low base. Naomi Coxwell, Non-Executive Director commented that the response rate was 44% and asked why some sections of the workforce chose not to complete the Staff Survey. The Chief Executive pointed out that some Trusts opted to undertake a random sample of 450 staff, but the Trust chose to conduct a full census of all staff. In addition, the Trust also ran a number of other internal surveys, such as the Staff Friends and Family Test and its quarterly PULSE surveys. The Chief Executive said that he was satisfied with the response rate which was statistically valid and provided valuable data. It was noted that the *Making it Right* programme developed last year in response to the 2016 NHS Staff Survey results which highlighted differential experiences between white and BAME staff had been extended to LGBT staff and staff with disabilities. **The Trust Board:** noted the report.
18/091	**Gender Equality Pay Report** (agenda item 7.3)
	The Director of Corporate Affairs presented the paper and highlighted the following points:

	• The paper outlined the six gender pay calculations which were required for national reporting and publication alongside narrative information. It was the first time that NHS organisations were nationally required to report on the gender pay gap. • The results of the Trust's analysis had been reviewed by the Diversity Steering Group. The Trust's results were broadly comparable with other similar trusts. • The exercise showed that female staff were under-represented at the upper quartile pay level. • It should also be noted that a high percentage of the Trust's workforce was part-time, with the majority of these (92.6%) being female. • The Trust would be progressing a number of actions over the coming year aimed at narrowing the gender pay gap. This included encouraging female consultants to apply for clinical excellence awards, encouraging female staff to apply for more senior positions and identifying ways of supporting flexible working opportunities, particularly at more senior positions. The Chief Executive reported that the Joint Staff Consultative Committee had discussed the gender pay gap data and were keen to ensure that any actions put in place to reduce the gender pay gap did not adversely impact on other initiatives which were valued by staff, such as term time working and other flexible working schemes. The Chief Executive confirmed that the Trust would work closely with the Trade Unions on this issue. Mark Day, Non-Executive Director reported that on a recent Service visit he had met two Psychologists who had mentioned that they would have left the Trust had they not been able to work part time by job sharing. Mr Day added that examples such as this should be used to publicise how flexible working was being used by people across the Trust to encourage others to consider fresh approaches and thereby avoid further resignations. **The Trust Board:** noted the report.
18/092	**Month 12 2017-18 Finance Report** (agenda item 8.1)
	The Month 12 financial summary report had been circulated. The Chief Financial Officer reported that the Finance, Investment and Performance Committee meeting held on 25 April 2018 had reviewed the pre-audited Year End accounts. The Chief Financial Officer presented the finance paper and reported that the Trust had recently run a successful two-week "Spring to Green" event aimed at increasing bed capacity at Prospect Park Hospital. The Chief Operating Officer reported that there had been a spike in bed occupancy over the Easter break. The aim of the "Spring to Green" event was to undertake a concentrated piece of work to reduce bed occupancy down to 85%. At the end of the two week initiative, bed occupancy had reduced to 86% with 12 beds available. The Chair asked whether the reduction in bed occupancy was sustainable. The Chief Operating Officer explained that the "Spring to Green" event was resource heavy and was not intended to deliver sustainable results. The aim was to have a short burst of focussed activity in order to quickly improve patient flow. The Chief Operating Officer reported that Prospect Park Hospital was holding a workshop

next week to identify sustainable long term solutions to reduce bed occupancy which in turn would reduce the number of Out of Area Placements because of acute overspill.

On behalf of the Trust, the Chair congratulated the Executive Team for marginally exceeding the control total at a time when a significant number of other NHS provider organisations were reporting deficits.

Naomi Coxwell, Non-Executive Director asked whether there had been any feedback from staff about the Trust over-achieving its control total.

The Chief Executive said that there had not been any feedback from staff and explained that the Trust's message to the Senior Leadership Team was that the Trust had delivered a break-even financial position and that staff recognised that the additional money was the result of national funding rather than from cuts to services.

The Trust Board noted: the following summary of the pre-audited financial performance and results for month 12 2017/18 (March 2018):

The Trust had delivered and marginally exceeded its 2017/18 surplus control total of £2.4m (1% margin). As a result, a Year End award was made by NHS Improvement of incentive and bonus Sustainability and Transformation funding of £1.8m (£3.5m of Sustainability and Transformation funding achieved in total).

Year To Date (Use of Resource) metric:

- Overall rating 1 (plan 1 – lowest risk rating)
    - Capital Service Cover 2.1 (rating 2)
    - Liquidity days 9.5 (rating 1)
    - Income and Expenditure Margin 1.1% (rating 1)
    - Income and Expenditure Variance 0.1% (rating 1)
    - Agency -35.0% (rating 1)

Year To Date Income and Expenditure (for control total including Sustainability and Transformation funding):

- Plan: £2.4m surplus
- Actual: *£4.4m
- Variance: £2.0m favourable

*(including £1.8m bonus and incentive payments)

Year End Cash: £22.3m (Plan £19.5m)

Key variances:

- Year to Date Capital was underspent due to re-phasing of Estates and IM&T expenditure +£3.3m
- Aged debtors over 30 days totals -£1.3m
- Sustainability and Transformation Funding bonus not in the plan 2016/17 +£0.8m

Year To Date Capital Expenditure: £7.7m (Plan £12.8m)

Key variances:

- Estates - revised timings of ward configuration at Prospect Park Hospital (PFI) to

	2018-19 (lower by £1.9m) • IM&T re-phasing of IT replacement programme following the focus on the Global Digital Exemplar programme (lower by £2.5m). **The Trust Board**: noted the report.
18/093	**Month 12 2017-18 Performance Report** (agenda item 8.2)
	The Month 12 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 March 2018 and NHS Improvement (non-financial) was RAG rated red. The Chair referred to page 117 of the agenda pack and commented that the incidence of self-harm was increasing. The Director of Nursing and Governance explained that the Trust was caring for patients with higher acuity, particularly at Willow House. It was noted that reducing self-harm was one of the Quality Improvement Programme breakthrough objectives and wards were encouraged to report all incidences of self-harm and therefore it was not surprising that the reporting of incidents had increased. The Director of Nursing Governance reported that wards were reviewing the data and were identifying counter measures and would be experimenting to find out what measures had the greatest impact on reducing the incidence of self-harm. **The Trust Board**: noted the report.
18/094	**Financial Plan 2018-19** (agenda item 8.3)
	The Chief Financial Officer presented the summary paper of the Financial Plan 2018-19 and highlighted the following points: • The April 2018 Trust Board meeting had delegated authority to approve the Financial Plan 2018-19 to the Finance, Investment and Performance Committee in order to meet NHS Improvement's submission deadline of 30 April 2018. • The Financial Plan 2018-19 was to deliver the control total of £2.4m and to maintain the Use of Resources Rating of "1"; • The Cost Improvement Programme challenge was £4.8m; this was focussed on reducing both short term acute overspill and specialist Out of Area Placements; • Planned capital expenditure was £10m; • The Cash forecast showed a net £0.2m outflow taking the forecast for Year End 2018-19 to £22.1m; • The key risks to delivery of the Financial Plan 2018-19 included: non delivery of the Cost Improvement Programme and acceleration in the pace of recruitment. The Chair asked for confirmation that there would be no pressure on staff to delay recruitment. The Chief Financial Officer confirmed that this would be the case and pointed out the vacancy factor reflected the current recruitment reality and there were no indications that this would improve over the coming year. The Chief Financial Officer reported that the Trust was still waiting for the Centre to issue revised guidance on the system wide Control Total.

	The Trust Board: noted the report.
18/095	**Finance, Investment and Performance Committee Meeting – 25 April 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 discussed the Year End financial position and the challenges around delivering the 2018-19 Cost Improvement Programme. Ms Coxwell reported that the Committee had also received an update on the Trust's Bed Optimisation Programme and pointed out that the national Five Year Forward View for Mental Health included an ambition to eliminate inappropriate Out of Area Placements by 2021 and that this was a helpful lever in terms of engaging partners in the issue. **The Trust Board:** thanked Naomi Coxwell, Chair of the Finance, Investment and Performance Committee for her update. The Trust Board: noted the report.
18/096	**Strategy Implementation Plan Update Report** (agenda item 9.1)
	The Director of Corporate Affairs presented the paper and highlighted the following points: • The paper provided an overview of the development and content of the Strategy Implementation Plan for 2018-19. • The paper also set out the outcomes of initiatives in the 2017-18 plan. • Significant progress had been made towards the achievement of the Trust's strategic aims during 2017-18. • The Strategy Implementation Plan 2018-19 will be used to monitor the Trust's progress to meet the "True North" goals through monthly reporting to the Business and Strategy Executive Group and through the quarterly reports to the Trust Board. The Chair said that it was helpful that the Strategy Implementation Plan included the "True North" headings. **The Trust Board:** noted the report.
18/097	**Annual Report 2017-18** (agenda item 10.1)
	The Chief Executive presented the draft annual report and requested that any minor corrections be forwarded direct to the Company Secretary. It was noted that the draft Annual Report had been circulated to members of the Trust Board only and had been deleted from the published agenda pack on the website because it was a legal requirement that the Annual Report could not be published until it had been laid before Parliament. Mark Day, Non-Executive Director referred to the section on the Board's Self-Assessment against NHS Improvement's Well-Led Framework and suggested adding a couple of examples of the actions that had been taken following the review. **Action**: **Company Secretary** Ruth Lysons, Non-Executive Director referred to the Sustainability Section and asked whether there was more the Trust could do to reduce the cost of gas, water and electricity which had all increased compared with the previous financial year.

	The Chief Operating Officer said that the price of utilities had increased across the board and that the cold winter had also increased the cost of heating. The Chief Operating Officer agreed to find out more information about the increased cost of utilities over the last year. **Action: Chief Operating Officer** Chris Fisher, Chair of the Audit Committee pointed out that section 5 (Annual Accounts 2017-18) of the Annual Report was not included with the agenda pack as this would be approved by the special Audit Committee meeting on 23 May 2018. **The Trust Board:** a) delegated authority to the Chair and Chief Executive to approve the final version of the Annual Report b) delegated authority the Audit Committee to approve the Annual Accounts for 2017-18 at its meeting on 23 May 2018
18/098	**NHS Improvement Board Declarations** (agenda item 10.2)
	The annual NHS Improvement Board Governance Declarations had been circulated. The Chief Financial Officer reported that the Trust was able to provide positive confirmation and pointed out that this was supported by evidence from the Trust's last external Well-Led review in 2015. **The Trust Board**: confirmed the positive assurance statements as set out in the report in relation to the Trust's Provider Licence Conditions and approved the signing of the Submissions by the Chair and Chief Executive.
18/099	**NHS Improvement Data Security Protection Requirements Compliance** (agenda item 10.3)
	The Chief Financial Officer reported that the Audit Committee meeting on 25 April 2018 had reviewed and approved NHS Improvement's Data Security Protection Requirements Compliance submission. Chris Fisher, Chair of the Audit Committee referred members of the Trust Board to pages 332 and 333 of the agenda pack which contained the minutes of the Audit Committee's deliberations. **The Trust Board:** approved the submission to NHS Improvement on Data Security Protection Requirements Compliance.
18/100	**Audit Committee – Minutes of the Meeting held on 25 April 2018** (agenda item 10.4)
	Chris Fisher, Chair of the Audit Committee reported that the meeting on 25 April 2018 had received an excellent presentation from the Director of IM&T and IT Compliance and Audit Manager on IT Business Continuity. Mr Fisher reported that over the course of 2017-18, the Audit Committee had reviewed the full Board Assurance Framework and the Corporate Risk Register at each meeting and in addition had identified particular aspects of the Board Assurance Framework for closer scrutiny. This included a "deep dive" report into two of the risks, a report on the gaps in controls and assurance and the actions being taken to address those gaps and a report setting out the evidence that the controls were effective.

	Mr Fisher reported that he had requested that the Executive Team review the risks on the Board Assurance Framework in light of the new strategic plan to see if any changes were required. The Chair thanked Mr Fisher for his update. The Trust Board: noted the minutes of the last Audit Committee meeting.
18/101	**Council of Governors Update** (agenda item 10.5)
	The Chair reported that Marion Child had recently been joined the Council of Governors as a partnership governor representing the Alzheimer's Society. The Chair reported that the Company Secretary was arranging a governor and stakeholder event for the Berkshire West Integrated Care System along similar lines to the Frimley Health and Care Integrated Care System event. **The Trust Board:** noted the update.
18/102	**Any Other Business** (agenda item 11)
	There was no other business.
18/103	**Date of Next Meeting** (agenda item 12)
	Tuesday, 10 July 2018
18/104	**CONFIDENTIAL ISSUES:** (agenda item 13)
	The Board resolved to exclude press and public from the remainder of the meeting on the basis that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted.

I certify that this is a true, accurate and complete set of the Minutes of the business conducted at the Trust Board meeting held on 8 May 2018.

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

Berkshire Healthcare NHS
NHS Foundation Trust

AGENDA ITEM 5.2

BOARD OF DIRECTORS MEETING: 10/07/2018

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
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.	10.07.18	**BS**	Completed
13.02.18	18/015	Annual Health and Safety Report	Future reports to include a section on the number of fires involving patients together with benchmarking data from similar trusts.	April 2019	**DT**	
13.02.18	18/019	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	20.06.18	**JH**	Completed – the proposed changes to the Constitution as recommended by the Council of Governors

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Status
			to the Council of Governors.			is on the agenda of this meeting.
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	18/057	Council of Governors Update	The Company Secretary to seek feedback from the Governors on refreshing the format of formal Council meetings.	19.09.18	**JH/ME**	There will be an item on the agenda of the formal Council meeting on 19 September 2018.
08.05.18	18/086	Patient Experience Quarter 4 Report	The Director of Nursing and Governance to feedback the Trust Board's positive comments concerning the efforts to the Learning Disability team to seek Friends and Family Test responses from service users.	10.07.18	**HM**	Completed
08.05.18	18/086	Patient Experience Quarter 4 Report	The draft Strategy Summary Document *(to be discussed at the In Committee private session of the Trust Board meeting – the final document will be presented to the Public Trust Board meeting in July 2018)* to be updated to make reference to the national rise in demand for some services,	10.07.18	**BS**	Completed

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Status
			eg CAMHS.			
08.05.18	18/087	BHFT Quality Report	The Quality Report to be amended to include the quality aspects of the benefits to using the new electronic prescribing and medicines administration system.	23.05.18	**MI**	The Medical Director has added the following narrative to the Improvements in Pharmacy section of the Quality Account: EPMA is currently being rolled-out in the Trust and benefits realisation evaluations are expected in the future. Standard benefits noted in other NHS trusts where the system has been implemented include legible prescriptions, no missing drug charts, improved audit trail and surveillance and ability to prescribe remotely. Dispensing processes have also been noted to be safer and timelier.
08/05.18	18/097	Draft Annual Report	The Draft Annual Report to include a couple of examples of the outcome of the	23.05.18	**JH**	Completed

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Status
		2017-18	Trust Board's self-assessment exercise against NHS Improvement's Well-Led Framework.			
08/05.18	18/097	Draft Annual Report 2017-18	The Chief Operating Officer to find out more information about the increased cost of utilities over the last year.	10.07.18	**DT**	Information attached at Appendix 1

Appendix 1

Briefing on increased cost of Utilities

The Trust Board requested more information about the increased cost of utilities which we reported in our Annual Report 2017-18. The report included the table below, showing energy usage and costs for this year compared to last -

Area		Non-financial data (applicable metric) 2016/17	Non-financial data (applicable metric) 2017/18		Financial data (£) 2016/17	Financial data (£) 2017/18
Waste minimisation & management	General (t) Recycling (t) Clinical (t)	273*	357 67 141	Total cost of waste disposal	£109,461	£190,587
Finite Resources	Water (M^3)	36,321	45,142	Water	£81,103	£100,817
	Electricity (GJ)	15,741	20,676	Electricity	£565,791	£677,164
	Gas (GJ)	29,977	38,528	Gas	£289,726	£307,287

In the Annual report it states –
"there are apparent marked increases in usage and cost for both waste and utilities which can be attributed to improved data collection and reporting as well as the provision of information by NHS Property Services for the areas that the Trust leases and occupies".

The PFI sites are the two largest single users of electricity, gas and water for the Trust and are responsible for 45% of the electricity, 53% of the gas and 59% of the water the Trust consumed in 2017/18.

For the two PFI sites there is a marked difference in utility consumption;

- At Prospect Park Hospital (PPH) (where 100% of costs are attributable to BHFT) the electricity consumption has remained relatively static with small incremental increases. In contrast the gas consumption on this site is comparatively high.

- At West Berkshire Community Hospital (WBCH) (where 55% of costs are attributable to BHFT) the electricity consumption has increased whereas the gas consumption for heating is comparatively low.

As reported above, improved data collection has allowed greater accuracy and apportionment of utility costs. In addition there are two key reasons for the increases in utility costs.

1. Consumption has increased due to the cold weather over winter which caused increases in gas and electricity usage for heating purposes.

2. Prices have increased in utility costs for 2017/18 - we saw an increase in price of 23% for gas and 18% for electricity. Prices are made up of fuel costs and non-energy costs including transmission, distribution and carbon taxes. There have been big increases in the non-energy costs, which is particularly significant in electricity. At present just over half of the electricity bill is made up of

these charges. The non-energy cost part of the electricity bill is set to continue to increase and in 2019 it is predicted it will be responsible for around 70% of the total electricity cost.

Other factors impacting on cost increases are where there has been an increase in service provision which may include extra clinics, additional equipment, extended working hours or increase in staff on a particular site.

Actions taken

The actions that have been taken have helped to minimise the increase in utility consumption for the estate that the trust has direct influence over. Specific actions include -

1. Installation of Voltage optimisation equipment. Units were installed at PPH and WBCH which resulted in reducing consumption by 5% and 8% respectively. A further two units were installed in 2014 at St Marks and Wokingham and were funded by NHS Property Services.

2. Installation of LED lighting technology across the estate, where there is the ability to make change. In general LED technology will have an instant saving of 50% over traditional lighting equipment and require less maintenance and last a lot longer than traditional lighting technology.

3. Building selection/refurbishment/upgrades – has provided the opportunity to improve the energy efficiency to keep energy overhead to a minimum.

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	10 July 2018
Title	**Freedom to Speak Up Guardian Annual Report**
Purpose	The purpose of the report is to update the Trust Board on the work of the Freedom to Speak Up Guardian over the last 12 months
Business Area	Corporate
Author	Freedom to Speak Up Guardian
Relevant Strategic Objectives	To strengthen our highly skilled and engaged workforce and provide a safe working environment
CQC Registration/Patient Care Impacts	The Care Quality Commission assesses the Trust's "Speaking Up" Culture as part of its Well-Led Inspection
Resource Impacts	None
Legal Implications	NHS Provider organisations are required to appoint a Freedom to Speak Up Guardian
Equality and Diversity Implications	N/A
SUMMARY	The Freedom to Speak up Guardian is a new role in the NHS and was a recommendation of the Freedom to Speak Up Review by Sir Robert Francis published in 2015. The Freedom to Speak up Guardian (FTSUG) came into post in this Trust in March 2017. This is a report directly to the Trust Board for the period June 2017 – June 2018. The Freedom to Speak Up Guardian will be attending the Trust Board meeting to present the report.
ACTION REQUIRED	The Trust Board is asked: a) to note the contents of this report by the Freedom To Speak Up Guardian; and b) to amend previous agreement for a yearly annual public report to the Trust Board with a mid-year report to the Quality Executive Group to a six monthly public board report in line with recommendations from the National Guardians Office.

Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

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

July 2018

Freedom to Speak up Guardian - Report for last 12 months (June 2017 – June 2018)

For: Information

Executive Summary

The Freedom to Speak up Guardian is a new role in the NHS and was a recommendation of the Freedom to Speak up Review by Sir Robert Francis published in 2015. The Freedom to Speak up Guardian (FTSUG) came into post in this Trust in March 2017. This is a report directly to the Trust Board for June 2017 – June 2018.

The Freedom to Speak up Guardian is a part-time post, two days a week, which provides independent and confidential support to staff who want to raise concerns and promotes a culture in which staff feel safe to raise those concerns.

There have been twenty contacts or cases of concerns raised in the last twelve months. Contacts are described as 'enquiries from colleagues that do not require any further support from the FTSUG'. Cases are described as 'those concerns raised which require action from the FTSUG'. Of the twenty contacts, the themes have included:

- Elements of bullying and harassment;
- Communication and relationships within teams;
- Patient safety;
- Contact from service users;
- Requests for guidance;
- Information about the whistleblowing process; and
- A contact which did not fit within the post holders' remit (checked via National Guardians Office).

The concerns have been resolved through varying degrees of intervention depending on what the person who is speaking up wants. Examples include: signposting; a listening ear; facilitating a conversation; and requesting internal and external investigation. The post holder has been able to quickly obtain support from the Executive Team and the Senior Leadership Team as required.

In addition, other activities have been undertaken to raise awareness of the role and to encourage cultural change in the Trust. The post holder attends the regular Trust Corporate induction sessions, Essential Knowledge for New Managers course, Junior Doctors' Rotation and team meetings as invited. Over the last 12 months, the post holder has attended 43

team meetings (66 in total since taking up the post). The post holder is currently supporting the Equality and Diversity roadshows.

Since January 2018, the post holder has provided those staff who have raised a concern an opportunity to provide feedback via an anonymous survey. This provides the post holder with the opportunity to learn from others' experience and change practices accordingly. An example of one of the question is at Appendix A. There is the opportunity for free text within the survey, however there was not any explanation given to the reply 'do not know'.

The post holder meets with the Chief Executive on a monthly basis to reflect on concerns raised, support received and to discuss themes. The Director of Nursing and Governance has been invited to join this monthly meeting from July 2018. It was felt that this may help triangulate knowledge and support.

Learning from the National Guardians Office is shared via Teamnet and during presentations to teams. The post holder plans to work with Champions to consider how to best share internal learning without inadvertently breaching confidentiality or exposing teams.

The post holder has recruited five 'Freedom to Speak up Champions' and will be providing training on 18th July 2018, using the materials from the National Guardians Office. There will be an ongoing campaign to recruit Champions.

The FTSUG is supported to attend the National Guardian Office conference which happens twice yearly. In addition to this, the post holder attends the regional FTSU network and has attended the national Community and Mental Health FTSU network. The post holder has asked the network to include Learning Disability in its title as there is not a specific Learning Disability Network.

Recommendation

The Trust Board is asked to note the contents of this report by the FTSUG.

The Trust Board is asked to amend previous agreement for a yearly annual public report to the Trust Board with a mid-year report to the Quality Executive Group to a six monthly public board report in line with recommendations from the National Guardians Office.

Author and Title:

Elaine Williams, Freedom to Speak Up Guardian

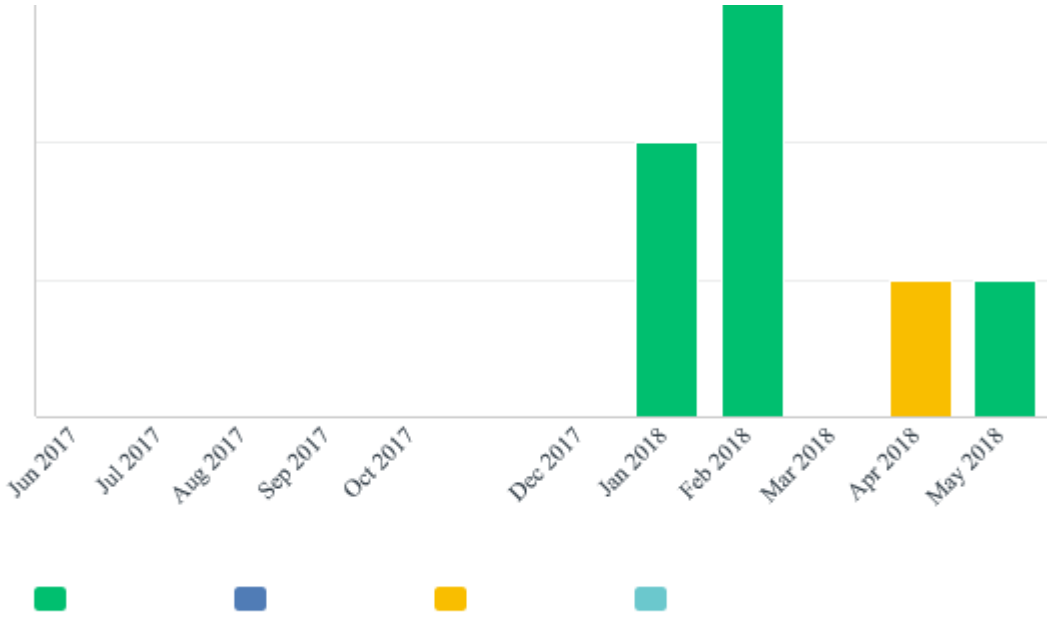
June 2018

Appendix A

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

Answered: 7 Skipped: 0

First: 1/24/2018 Range: Jun 2017 to May 2018



Green = yes; Blue = no; yellow = maybe; turquoise= don't know

Raising concerns...

Verbally

- To the line manager
- To the Freedom to Speak Up Guardian
- To locality clinical director
- To Director of Nursing or Medical Director
- To Non-executive Director or CEO

By phone

- Speak to the **Freedom to Speak Up Guardian: 0791 929 3570**
- Speak to relevant manager or director.
- Independent whistleblowing service: (CIC) **0800 197 2814**

Online

- Find out more on **TeamNet** under '**Supporting You**'/'**Freedom to Speak Up**'
- Direct to relevant manager or director, or use the '**Speak up for safety**' button on **TeamNet**, under '**Your Tools**'

By email

- Freedom to Speak Up Guardian: **speakup@berkshire.nhs.uk**
- Independent whistleblowing service: **blowingthewhistle@cic-eap.co.uk**

Trust Board Paper

Board Meeting Date	10 July 2018
Title	Complaints Annual Report 2017-18
Purpose	The purpose of this report is to provide the Board with an overview of the complaints process within the trust during 2017/18.
Business Area	Nursing and Governance
Author	Liz Chapman, Head of Service Experience and Engagement
Relevant Strategic Objectives	3 – To provide good outcomes from treatment and care
CQC Registration/Patient Care Impacts	Supports maintenance of CQC registration and supports maintaining good patient experience
Resource Impacts	N/A
Legal Implications	N/A
Equality and Diversity Implications	There is a need to improve the recording of demographic data and ethnicity status within the complaints process.
SUMMARY	The Trust is required to produce an annual complaints report. The attached report collates information received each quarter by the Trust Board. The number of complaints received is similar to last year and the 100% performance of responding to complainants within timescale has been maintained which continues to be an excellent achievement. Similar to last year the services which received the highest number of complaints were Community Mental Health Teams, Child and Adolescent Mental Health Services, Crisis Resolution Home Treatment Team and Mental Health Inpatients. Examples of changes to these services as a result of complaints are included in the report. These services will continue to be monitored closely in 2018/19, as will the trends of overall complaints. Just under of 65% complaints closed in 2017/18 were upheld or partially upheld. 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
ACTION	The Trust Board is asked to: Note the report

Berkshire Healthcare NHS Foundation Trust
Annual Complaints Report
April 2017 to March 2018

Elizabeth Chapman – Head of Service Engagement and Experience
June 2018

Contents

1. Introduction and Executive Summary

This report contains the annual complaint information for Berkshire Healthcare (The Trust) as mandated in The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009. The Trust formally reports patient experience through our Quality Executive and Trust Board on a quarterly basis, alongside other measures including compliments, the Friends and Family Test, Patient Advice and Liaison Service (PALS) and our internal patient survey programme.

This report looks in more detail at the application of the Complaints Process within the Trust from 1 April 2017 to 31 March 2018 and uses data captured from the Datix reporting system.

Factors (and best practice) which affect the numbers of formal complaints that Trusts receive include:

• Processes in place to resolve potential and verbal complaints before they escalate to formal complaints. These include developing systems and training to support staff with local resolution

• Awareness of other services such as the Patient Advice and Liaison Service (PALS – internal to the Trust) and external services such as Healthwatch and advocacy organisations which ensure that the NHS listens to patients and those who care for them, offers signposting and support

• Highlighting the complaints process as well as alternative feedback mechanisms in a variety of ways including leaflets, poster adverts and through direct discussions with patients, such as PALS clinics in clinical sites

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.

The number of local resolution complaints that the Patient Experience team have been notified about has remained consistent with 205 received in 2017-18, compared to 210 received in 2016-17. Information on local resolution complaints is captured in real time on a dashboard that is accessible to the Locality and Clinical Directors. There have been 20 informal complaints logged, which is slightly lower than 24 in 2016-17.

Highlights of this report;

- 100% of complaints responded to within timescale
- Highest number of complaints received by service were Community Mental Health Teams (CMHT), Child and Adolescent Mental Health Services (CAMHS), Crisis Resolution Home Treatment Team (CRHTT) and Mental Health Inpatients
- Increase in complaints for Older Adults CMHT
- There were no complaints for Highclere ward and the Oakwood Unit
- Positive feedback has been received on complaint handling training
- The complaints process has been positively assured following a visit by the local Clinical Commissioning Groups

Nationally, complaint statistics are reported on a quarterly and annual basis, with 2017-18 annual reporting due to be available from September 2018. During 2016-17, nationally clinical treatment accounted for 26.7% of complaints by subject area, comparatively in 2017-18 27.8% of all formal complaints were categorised against care and treatment as their main subject.

Complaints about communication, with patients and other organisations, medical records and confidentiality have the potential to be avoidable; these accounted for 23.5% of the formal complaints received within the Trust for 2017-18.

2. Complaints received - activity

The information in this report excludes complaints which are led by an alternative organisation, unless specified.

Table 1 shows the number of formal complaints received into Berkshire Healthcare for 2017-18 by service and compares them to the previous financial year. Whilst the overall number of formal complaints have remained the same, along with the top four services in terms of complaint activity, there has been an increase of note for CMHT/Care Pathways, CAMHS - Child and Adolescent Mental Health Services and the Older Adults Community Mental Health Team (the latter whilst receiving 5 in total, saw an increase from 2 in 2016-17).

Table 1 – Formal complaints received

	2017-18						Change	2016-17					
Service	Q4	Q3	Q2	Q1	Total	% of Total		Q4	Q3	Q2	Q1	Total	% of Total
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	

The Trust Business Group structure (also known as reporting locality) has previously been used as the main mechanism for reporting complaint information, however as this may differ from the geographical locality of where the service is based, we feel it brings more value to report the latter. This enables us to identify themes and trends more easily. The following tables show a breakdown for 2017-18 of the formal complaints that have been received and where the service is based.

Table 2 – Mental Health Service complaints (114 complaints/ 55%)

	Locality of Service						
Service	Bracknell	Reading	Slough	West Berks	Windsor, Ascot and Maidenhead	Wokingham	Grand Total
CMHT/Care Pathways	9	16	5	6	4	4	44
Inpatient Admissions – Prospect Park Hospital		23					23
CRHTT	2	10	3	2	1	2	20
Common Point of Entry	1	2			1	1	5
Older Adults Community Mental Health Team	1	1			3		5
Psychological Medicine Service RBH		4					4
Talking Therapies	1				1	1	3
Older Peoples Mental Health (Ward Based)		3					3
Eating Disorders Service					2		2
Community Team for People with Learning Disabilities (CTPLD)		1	1				2
Neuropsychology		1					1
Traumatic Stress Service					1		1
Early Intervention in Psychosis					1		1
Grand Total	14	61	9	8	14	8	114

36% of CMHT complaints were about the Reading based Service.

A senior oversight group was established at the end of 2017 to resolve and support the main issues which were leadership, vacancies, robust supervision and challenges with delivery partner, Reading Borough Council.

The Trust has commissioned a Deep Dive project which aims;

- To analyse complaints and establish themes, drivers, links and priorities
- To compare and contrast against other CMHTs – and set a context for this insight
- To consult people who have made complaints to better understand their background, experiences and feelings and to explore what should have happened in their view
- To share patient feedback with staff and get their views, whilst also assessing local resolutions and understanding their processes and procedures around complaints, learning from complaints and knowledge management throughout the team
- To capture best practice among the Reading team and compare with other team leads

Table 3 shows the main subject for formal complaints about the CMHT. 29.54% of complaints were about care and treatment, the majority of these being for the Reading based service. Complaints about communication with patients and other organisations, medical records and confidentiality have the potential to be avoidable. Complaints with these as the main subject areas accounted for 18.18% of the total complaints received for CMHTs and the team are working to see these reduced in 2018/19.

Table 3 - CMHT complaints

	Locality of Service						
Main subject of complaint	Bracknell	Reading	Slough	West Berks	Windsor, Ascot and Maidenhead	Wokingham	Grand Total
Care and Treatment	2	7	3		1		13
Clinical Care Received	2	3	1	1		3	10
Medication			1	1	1		3
Communication		1		2			3
Failure/Delay in specialist Referral	1	1		1			3
Access to Services	1				1		2
Healthcare Professional	2						2
Confidentiality					1		1
Information; written to Patients		1					1
Information; verbal to Patients		1					1
Other		1					1
Communication with Other Organisations		1					1
Delay or failure to visit				1			1
Medical Records	1						1
Failure/incorrect diagnosis						1	1
Grand Total	9	16	5	6	4	4	44

Table 4 – Adult mental health inpatient wards

	Location of complaint					
Main subject of complaint	Bluebell Ward	Daisy Ward	Rose Ward	Snowdrop Ward	Non ward specific	Grand Total
Clinical Care Received	3	1	1	2	1	8
Care and Treatment	1	2	1	1	1	6
Admission		1				1
Attitude of Staff				1		1
Discharge Arrangements				1		1
Discharge Planning		1				1
Lost Property				1		1
Medication	1					1
Verbal to Patients			1			1
Communication to Patients		1				1
Delay or failure to visit		1				1
Grand Total	5	7	3	6	2	23

Table 5 – Older Adults mental health inpatient wards

	Location of complaint		
Main subject of complaint	Orchid Ward	Rowan Ward	Grand Total
Care and Treatment	2	1	3
Grand Total	2	1	3

Formal complaints to CRHTT remained consistent with 2016-17, with a slight decrease from 21. A Deep Dive undertaken in 2016-17 showed that complaints had increased by 30% from 2015-16 but in the same time period, compliments have doubled. Increased complaints were about attitude of staff, service access and discharge arrangements. Conversely, compliments analysis by number of mentions speaks of supportive, helpful and enabling staff, as well as general commentary around quality of service. 50% of the formal complaints are showing for the Reading based team, which is a main hub (base) for the CRHTT.

There have been no formal complaints about the Psychological Medicines Service based in Wexham Park Hospital in Slough, with the complaints logged being allocated to the serviced based out of the Royal Berkshire Hospital in Reading.

Formal complaints about the Older Adults Community Mental Health Team have increased from 2 in 2016-17 to 5 in 2017-18, with 3 of these complaints relating to the team based in Windsor, Ascot and Maidenhead. Overtime, there has been a shift in the team receiving complaints as demonstrated in Table 6, which also shows that there have no complaints about access to services or attitude of staff since 2015-16. During 2017-18, the services based in Bracknell, Slough and Wokingham did not receive any formal complaints.

Table 6 - Older Adults Community Mental Health Team complaints

	Access to Services	Attitude of Staff	Care and Treatment			Communication			Medical Records		
Locality of Service	15/16	15/16	15/16	16/17	17/18	15/16	16/17	17/18	16/17	17/18	Grand Total
Bracknell	1	1			1	2					5
Reading		1								1	2
Slough		1									1
West Berks							1				1
Windsor, Ascot and Maidenhead					2			1	1		4
Wokingham			1	1							2
Grand Total	1	3	1	1	3	2	1	1	1	1	15

Table 7 – Community Health Service Complaints

	Locality of Service						
Service	Bracknell	Reading	Slough	West Berks	Windsor, Ascot and Maidenhead	Wokingham	Grand Total
Community Nursing	2	2	2	1	3	2	12
Community Hospital Inpatient			3	2	3	3	11
Out of Hours GP Services		6		3			9
Sexual Health	1		4				5
Minor Injuries Unit				5			5
Integrated Pain and Spinal Service		4					4
Physiotherapy Musculoskeletal			1	1	1		3
Hearing and Balance Services	1				1		2
Mobility Service	1					1	2
Podiatry						2	2
Heart Failure Team			1				1
Physiotherapy - Rehabilitation			1				1
Grand Total	5	12	12	12	8	8	57

The Community Nursing Service (sometimes referred to as District Nursing Service) received the highest number of formal complaints for community based services, with 36.84%. The complaints were spread across the services, with the service based out of West Berkshire receiving one less, and the one in Windsor, Ascot and Maidenhead receiving one more than in the other areas.

Table 8 shows the main subject of the formal complaints received about the Community Nursing Service. Care and treatment and delays or failure to visit were two highest reasons for people to make formal complaints. A co-created project is underway to hold a series of 'getting to know your local Community Nursing Service' events, primarily targeted towards carers for the areas in the East of Berkshire. This is being co-created with a carer who raised concerns about the care of her mother and the communication she had with the service.

Table 8 – Community Nursing Service

	Locality of Service						
Main subject of complaint	Bracknell	Reading	Slough	West Berks	Windsor, Ascot and Maidenhead	Wokingham	Grand Total
Care and Treatment		1	1		2		4
Delay or failure to visit	1				1	1	3
Clinical Care Received	1		1				2
Failure to examine/examination cursory				1			1
Healthcare Professional						1	1
Confidentiality		1					1
Grand Total	2	2	2	1	3	2	12

Care and treatment continues as the main subject for complaints received about community inpatient wards. Of the 3 complaints for Henry Tudor Ward based at St Marks Hospital in Maidenhead two were about communication and attitude of staff. Highclere ward based at West Berkshire Community Hospital did not receive any formal complaints during 2017-18.

Table 9 – Community Health Inpatient ward Complaints

	Location of complaint					
Main subject of complaint	Ascot Ward	Donnington Ward	Henry Tudor Ward	Jubilee Ward	Windsor Ward	Grand Total
Care and Treatment	2	1		2		5
Attitude of Staff			1	1		2
Healthcare Professional		1				1
Failure to examine/examination cursory					1	1
Communication			1			1
Clinical Care Received			1			1
Grand Total	2	2	3	3	1	11

For sexual health services complaints, the majority are showing for the service based out of the Garden Clinic in Slough. This is the main sexual health service base, with a smaller, satellite service available in Bracknell. Three of the 5 complaints were about clinical care, with two about the interaction with staff.

Table 10 – Children, Young People and Family Service Complaints

	Locality of Service						
Service	Bracknell	Reading	Slough	West Berks	Windsor, Ascot and Maidenhead	Wokingham	Grand Total
CAMHS	6	4	6	1	1	8	26
Health Visiting		2	2			1	5
Children's Speech & Language Therapy - CYPIT					2		2
Paediatrics			1				1
Nursery					1		1
Grand Total	6	6	9	1	4	9	35

CAMHS have seen an increase in complaints (26) compared with 18 received in 2016-17. During 2015-16 there were 28 formal complaints about CAMHS, the majority of which were about waiting times and access to treatment. CAMHS have seen a reduction in waiting times due to the introduction of an initial assessment through the Trust Common Point of Entry service and the introduction of the CAMHS Urgent Care Service has seen positive clinical outcomes for young people.

The services based out of Bracknell, Slough and Wokingham have received the highest number of formal complaints, with the Wokingham service receiving the only complaints about a delay or failure to make an onward referral. Bracknell, West Berkshire and the Windsor, Ascot and Maidenhead services did not receive complaints about waiting times.

Table 11 – CAMHS Complaints

	Locality of Service						
Main subject of complaint	Bracknell	Reading	Slough	West Berks	Windsor, Ascot and Maidenhead	Wokingham	Grand Total
Failure/Delay in specialist Referral						3	3
Waiting Times for Treatment		1	1			1	3
Healthcare Professional	1		2				3
Care and Treatment	1					2	3
Information; written to Patients	3						3
Failure to prescribe/incorrect prescription			1			1	2
Clinical Care Received		1				1	2
Communication	1			1			2
Breach of Patient Confidentiality			1				1
Alleged Abuse, Bullying, Physical, Sexual, Verbal		1					1
Attitude of Staff					1		1
Failure/incorrect diagnosis			1				1
Failure to examine/examination cursory		1					1
Grand Total	6	4	6	1	1	8	26

All of the complaints about the Health Visiting Service were about communication and information sharing; including complaints about information shared for child protection purposes. There were no complaints about the clinical care provided.

Both of the complaints about Speech and Language Therapy were about delays in paperwork, resulting in not being kept informed on the progress of being seen within the service.

Table 12 – Complaints about other services

	Locality of Service		
Service area	Bracknell	Reading	Grand Total
MHA Tribunal process		2	2
Corporate/Policy	1		1
Grand Total	1	2	3

3. Complaints closed – activity

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). Table 13 shows the outcome of complaints.

When compared against the national reporting statistics for 2016-17;

Upheld	36.5%
Partially Upheld	21.8%
Not Upheld	41.7%

The Trust has lower % of complaints that are upheld or not upheld, with a greater proportion found to be partially upheld; complaints often cover a number of services and issues which are investigated as individual points which contributes to this. There is further development around the apportioning a finding to an investigation that is being taken forward by the Complaints Office in 2018-19 which it is hoped will give further clarity over how the outcome is reported.

Table 13 – Outcome of closed formal complaints

	2017-18						Change	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	

Table 14 shows the response rate within a negotiated timescale, as a percentage total. The sustained 100% response rate achieved since 2016-17 demonstrates the commitment of the complaints office, Clinical Directors and clinical staff to work alongside complainants. There are weekly open complaints situation reports (SITREP) sent to Clinical Directors, as well as on-going communication with the complaints office throughout the span of open complaints to keep them on track as much as possible.

Table 14 – 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 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.

4. Complaints as a mechanism for change – learning

Berkshire Healthcare supported the project 'How Slough organisations can learn from feedback and complaints', led by Slough Healthwatch at the end of quarter four 2016-17. The findings report published in quarter one, highlighted good practice examples by the Trust and other health and social care organisations, and the Patient Experience Team continue to signpost and support Healthwatch organisations within Berkshire with any concerns or complaints on behalf of the public.

Our Clinical Directors were given the opportunity to showcase actions and learning from complaints as part of this report;

Mental Health Inpatients -
Introduced carers welcome meetings, updated ward information packs and made a film clip for staff, based on a service user's experience of admission. Implementing an allocated worker model and one ward has introduced the role of a security nurse.

Community Mental Health East -
Bracknell CMHT has altered the way they deal with referrals by introducing a task team and Slough CMHT has made improvements to their duty processes.

Community Mental Health East -
The prompt reallocation of care coordinator when staff leave service; sickness absence cover to ensure patients have contact at these times – systems and processes reviewed to ensure prompt reallocation wherever possible and contact to patients when sickness absence arises.

Good practice –
Timely responses to complaints raised around care packages; proactive engagement with patients, families and loved ones during times of crisis; excellent carer's group feedback for CRHTT.

Examples of learning from complaints include:

What we were told: A carer feeling that they were not involved in risk/care plan.
What we have done: 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.

What we were told: 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.
What we have done: 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 education.

What we were told: Links to information have been sent out, but cannot be accessed.
What we have done: 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.

What we were told: It is important to understand how long it will be before an appointment with the Berkshire Traumatic Stress Service.
What we have done: 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.

What we were told: When a care co-ordinator in the CMHT left, there was a breakdown in communication and trust.
What we have done: Ensured a thorough CMHT supervision process where clear handover plans are in place when care coordinators are handing over care to support the transition to a new allocated lead professional. Provide copies of care plans agreed with individuals following initial meeting or review which is monitored via supervision. Actions that are agreed during face to face or telephone interactions will be clear and reflected in the documentation on case note plans. CMHT is providing written information to individual clients using the service to inform them of CMHT DUTY system and how access crisis to support after hours where allocation to new care coordinator is not immediately possible.

What we were told: People didn't understand the role of a Learning Disability Nurse, what happens when allocated staff aren't around and why people open to the Learning Disability Services aren't cared for under a CPA (Care Programme Approach).
What we have done: The Head of Learning Disability Services will take the gap identified in CPA provision in the community to commissioners to review. The Community Team for People with a Learning Disability will review and document handover processes when a staff member is absent. The Learning Disability (LD) Nurses will review the information provided to families regarding the role of the LD nurse and the level of support that can be expected.

What we were told: We could have done better to support a patient and their admission to Prospect Park Hospital.
What have we done: CMHT's must ensure that relapse information and actions to be taken when relapse is evident are clearly recorded in a safety plan with a copy to the patient and carer. CMHT and CRHTT ensure that a face to face assessment takes place when admission is indicated. Bluebell ward manager is now ensuring that patients who are admitted to Bluebell have a CPA or discharge planning meeting recorded and copy provided to patient and carer.

The Bluebell ward team have had a learning session to ensure the lessons from this complaint about physical and mental health care, documentation and communication as well as staff attitude is implemented in the ward practice.

What we were told: The ward didn't respond to the concerns we sent in to Henry Tudor Ward
What have we done: The Ward Manager proactively visits new patients and explains how to share their feedback or concerns.

What we were told: Admin backlogs and errors caused a delay in Children's Speech and Language Therapy.
What have we done: Ensure that when taking a message this has been passed on to relevant medical secretary / consultant along with a progress note on RiO. Communications go out to the team in the absence of staff members for work areas to be monitored, prioritised and senior management alerted if there are any issues. Blood letters / test requests are sent out prior to a clinic letter to avoid delay.

What we were told: It is distressing waiting for a visit from CRHTT which does not happen.
What have we done: Changes made to the structure of home treatment teams in each locality to include an advanced mental health practitioner. All staff ensure that they add any agreed contact on the daily team planner and where the contact is for the same day, they need to speak to the shift lead and communicate with the respective team directly. For all staff attending Multi-Disciplinary Team meetings ensure that the previous agreed plan is maintained. If there are any changes to the plan, this needs to be communicated to the service user.

5. Parliamentary and Health Service Ombudsman

The Parliamentary and Health Service Ombudsman (PHSO) are independent of the NHS and facilitate 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 15 – 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

6. Multi-agency working

In addition to the complaints detailed in 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).

Table 16 – Formal complaints led by other organisations

Lead organisation	Service area of complaint
CCG	Access to the Slough Walk-In Health Centre
Acute Trust	Care from 2014 involving our High Tech Care service
NHS England	Care and treatment on Henry Tudor Ward
CCG led	Access and communication with the District Nursing Out of Hours Service
Commissioning Support Unit	Care and treatment on Donnington Ward
Acute Trust	Care and treatment on Ascot Ward
Acute Trust	Health Visiting
Commissioning Support Unit	Community Nursing Service
Mental Health Trust	Criminal Justice Liaison and Diversion Service

7. Complaints training

The Complaints Office offer a programme of complaint handling training through the Learning and Development Department. In addition, bespoke sessions are available when requested to teams or service areas that are having specific challenges. As a result of a formal complaint, a session on complaint handling has been arranged for Doctors at the Medical Staffing Committee, with the opportunity to attend the further, fuller training.

The course content is adapted following feedback from staff and people who have used the complaints process, an example as an outcome from complaint being the addition of guidance around the documentation and recording of meetings. Examples of delegate feedback include;

I think this format is very helpful - I feel less fearful of undertaking a complaint investigation as the process was made very clear and details of where to get help and support.

The training needs to be shared to staff across BHFT. It is knowledgeable and staff awareness is important on how complaints are managed. The NHS needs to prepare and equip their staff fully to avoid any disputes escalating and how to defuse complaints at an early stage to save time and costs.

8. External review

The Berkshire West CCG confederation undertook a quality assurance observation visit in January 2018. There was review against the CQC quality domains and the subsequent report highlighted ‘What Works Well’ as:

- Strong leadership
- Good team working with clear shared responsibilities
- Development of staff

There is a CCG led recommendation to explore the options of working with Royal Berkshire Hospital Foundations Trust to form a system-wide complaints team as part of the Integrated Care System model.

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	10 July 2018
Title	**Quality Assurance Committee – 15 May 2018**
Purpose	To receive the unconfirmed minutes of the meeting of the Quality Assurance Committee of 15 May 2018
Business Area	Corporate
Author	Company Secretary for Ruth Lysons, Committee Chair
Relevant Strategic Objectives	Goal 3 – Good Patient Experience - To provide good outcomes from treatment and care.
CQC Registration/Patient Care Impacts	Supports ongoing registration
Resource Impacts	None
Legal Implications	Meeting requirements of terms of reference.
Equalities and Diversity Implications	N/A
SUMMARY	The unconfirmed minutes of the Quality Assurance Committee meeting held on 15 May 2018 are provided for information. Attached to the minutes are the following reports which were discussed at the Quality Assurance Committee meeting and are presented to the Trust Board for information: • Learning from Deaths Quarterly Report • Guardians of Safe Working Hours Quarterly Report
ACTION REQUIRED	The Trust Board is requested to receive the minutes and the quarterly Guardians of Safe Working Hours and Learning from Deaths Reports and to seek any clarification on issues covered.

Berkshire Healthcare NHS
NHS Foundation Trust

Minutes of the Quality Assurance Committee Meeting held on Tuesday, 15 May 2018, Fitzwilliam House, Bracknell

Present:	Ruth Lysons, Non-Executive Director (Chair) David Buckle, Non-Executive Director Julian Emms, Chief Executive Dr Minoo Irani, Medical Director Dr Guy Northover, Lead Clinical Director Helen Mackenzie, Director of Nursing and Governance *(present until 11.30)* Amanda Mollett, Head of Clinical Effectiveness and Audit David Townsend, Chief Operating Officer
In attendance:	Julie Hill, Company Secretary Jagjit Sethi, Clinical Director Nathalie Zacharias, Allied Health Professional Lead Caroline Attard, Head of Quality Improvement *(present for agenda items 1-5.1)*

1 Apologies for absence and welcome

The Chair welcomed everyone to the meeting.

Apologies had been received from: Mehmuda Mian, Non-Executive Director.

The Director of Nursing and Governance said that she had another engagement and would have to leave the meeting at 11.30.

2. Declaration of Any Other Business

There were no items of Any Other Business.

3. Declarations of Interest

There were no declarations of interest.

4.1 Minutes of the Meeting held on 20 February 2018

The minutes of the meeting held on 20 February 2018 were confirmed as an accurate record.

4.2 Matters Arising Log

The Matters Arising Log had been circulated. The Committee noted the schedule of actions.

5. Patient Safety and Experience

5.0 Quality Improvement Programme Breakthrough Objective – Reducing Falls Presentation

Nathalie Zacharias, Allied Health Professional Lead gave a presentation on the Quality Improvement Programme Break Through Objective on Reducing Falls and highlighted the following points:

- Preventing falls was one of the three Breakthrough Objectives which made up the Quality Improvement Programme's "True North" – Harm Free Care goal. The other two Breakthrough Objectives being: reducing the rate of suicide and reducing patient self-harm incidents.
- The Trust's individual in-patient wards were at different stages on the Quality Improvement Falls Reduction journey.
- The data from the wards showed some common themes but each ward had some unique data which would result in developing individualised countermeasures.

The Chief Executive thanked Nathalie Zacharias for her presentation and pointed out that the focus on data was useful in educating clinical staff, managers and the Trust Board about not relying on intuition.

The Director of Nursing and Governance asked whether the wards were engaged in the falls reduction work.

Nathalie Zacharias reported that as part of the Quality Improvement Programme work, events were held so that staff could come together and share good practice and confirmed that there was strong engagement from the frontline staff.

It was noted that Oakwood Ward had completed the Academic Health Science Network's (AHSN) Fallsafe project from start to finish but there had been no reduction in the number of falls.

The key difference was that the Fallsafe project approach was to use a prescribed care bundle, in contrast to the Quality Improvement methodology which was for each ward to use their individual data to develop bespoke countermeasures.

The Chair asked whether the target of a 50% reduction in the number of unwitnessed falls in the wave 1 wards in six months was realistic.

Nathalie Zacharias said that it was an ambitious target and commented that the wave 1 wards were currently developing their countermeasures so it was too early to tell whether these would be effective in reducing the number of falls.

The Chair asked whether technology could help to reduce the number of falls.

Nathalie Zacharias said that most products used wires which posed a ligature risk and reported that Rowan ward had trialled a wireless product but the trial had to be stopped after ten days because of concerns about the safety issues around the plastic box which housed the battery.

It was noted that the Trust was working with a company which built the technology into furniture.

On behalf of the Committee, the Chair thanked Nathalie Zacharias for attending the meeting and presenting on the Quality Improvement Programme's Falls Breakthrough Objective.

5.1 Reducing the Use of Prone Restraint Presentation

It was noted that the Trust was an outlier in terms of its relatively high use of prone restraint. The Quality Assurance Committee had received a report on the Trust's work to reduce the use of prone restraint at Prospect Park Hospital at its meeting in August 2017.

Caroline Attard, Head of Quality Improvement gave a presentation and updated the Committee on the Trust's work to reduce the use of prone restraint using Quality Improvement methodology. During the presentation, the following points were highlighted:

- The Datix incident reporting form had been changed to include the rationale for using prone restraint and the length of the prone restraint.
- From the data it was possible to build up a clear understanding of the use of prone restraint which was mainly used when patients were violent and aggressive, to administer rapid tranquilisation and to enable staff to safely exit seclusion.
- The Trust had looked for new techniques and innovative solutions, such as using bean bags for seclusion exit and training staff how to administer rapid tranquilisation using supine rather than prone restraint.
- Current data showed that there had been a slight decrease in number of prone restraints but it was too soon to identify this as a trend.
- A detailed review of the recent Datix prone restraint incidents had highlighted that staff were likely to use prone restraint as a reactionary measure when patients were assaulting staff.
- The Trust was working with service users to gain their insights.
- The next stage of the work was to develop, pilot and select solutions that addressed the root causes and to implement and evaluate the solutions.

The Director of Nursing and Governance commented that staff did recognise the risks posed by prone restraint. Caroline Attard pointed out that until now, the prevention and management of violence and aggression training did not provide staff with alternatives to prone restraint to use in crisis situations and that the current focus was around training staff in the use of different techniques.

The Chief Operating Officer said that it was hoped that the introduction of the new Activity Co-ordinators posts would reduce patient boredom and create a more therapeutic environment at Prospect Park Hospital. It was hoped that this in turn would reduce the level of violence and aggression on the wards and thereby reduce the need for restraint of any kind.

David Buckle, Non-Executive Director said that he liked the way the Trust was focussing on the data in order to gain a full understanding of the use of prone restraint.

The Chair asked whether the data was able to identify those staff who had the skills to defuse a situation.

The Chief Operating Officer said that the data did not identify any individual staff who were high users of prone restraint. The Chief Operating Officer also pointed out that all frontline staff were trained in conflict resolution.

On behalf of the Committee, the Chair thanked Caroline Attard for her presentation.

5.2 Quality Concerns Status Report

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

- The March 2018 Quality Executive Group meeting had approved the removal of the quality concern around the Prospect Park Hospital Leadership as there was now stable leadership in place.
- The highest quality concern remained workforce shortages and high bed occupancy at Prospect Park Hospital.
- The May 2018 Quality Executive Group meeting had received a report on how the Trust was managing the interface between the Common Point of Entry Service, the Crisis Resolution Home Treatment Team and the Community Mental Health team.
- The Mental Health Act Office was now fully staffed and additional resources had been brought in to oversee processes.
- There was now stable leadership on Bluebell Ward.
- The Trust was undertaking a "deep dive" exercise in order to understand the totality of patient experience in relation to the Reading Community Mental Health Team and not just those who had made a formal complaint about the service.
- The Trust was concerned about the impact on patients in respect of Reading Borough Council's decision to remove joint management arrangements from in respect of the Reading Community Mental Health Team from 1 July 2018.
- A Physical Health Lead Nurse was now in post at Prospect Park Hospital.

David Buckle, Non-Executive Director said that it was a very helpful paper and asked whether the Trust had raised concerns about the forthcoming changes to the Reading Community Health Mental Health Team with the Care Quality Commission.

The Chief Executive confirmed that the Trust had raised the issue with the Care Quality Commission but pointed out that cuts to local authority funding had resulted in a number of local authorities withdrawing from non-statutory functions.

The Lead Clinical Director reported that figures from the Department of Health and Social Care revealed that around 22% of integrated Community Mental Health teams had now ceased to be integrated.

The Chair asked for an update on the Sorrell Ward works in relation to the female wing. The Chief Operating Officer reported that there had been some delays during phase 1 of the works but it was hoped that the works would be completed in late July or early August 2018.

The Chair reported that in her capacity as a Mental Health Act Manager, she had seen an improvement in the Mental Health Act Office.

The Chair asked when the outcome of the "deep dive" into the patient experience of the Reading Community Mental Health Team service would be reported. The Director of Nursing and Governance said that the report was

planned for Quarter 2 and that the findings of the “deep dive” would be reported to the Quality Executive Group in the first instance.

The Chair welcomed the appointment of a Physical Health Nurse Lead for Prospect Park Hospital and asked what more was needed to improve physical health monitoring of mental health patients.

The Chief Executive reported that the Director of Nursing and Governance was in touch with the clinical staff training providers to ensure that physical health monitoring was part of the curriculum.

The Chief Executive asked whether physical health monitoring was included on the Band 5 nurse role profile. The Director of Nursing and Governance agreed to find out.

Action: Director of Nursing and Governance

The Chair asked whether the Trust could do more to address the obesity issue.

The Medical Director explained that the Trust addressed the associated physical health effects of obesity, for example, type II Diabetes and high blood pressure etc.

The Chief Operating Officer also pointed out that the Trust employed Dieticians to advice on healthy eating.

David Buckle, Non-Executive Director asked for a report on the Trust’s work on reducing Obesity at a future meeting.

Action: Chief Operating Officer

The Chair commented that she had recently read an article about the higher level of dental decay amongst mental health patients compared with the rest of the population.

The Director of Nursing and Governance reported that Dentists did not visit Prospect Park Hospital but pointed out that the Community Mental Health Teams encouraged patients to have dental checks.

The Chief Operating Officer reported that the Trust’s Community Dental Service provided a service for people with Learning Disabilities and was starting to reach out to homeless people.

The Chair asked whether checks on in-patients included dental checks.

The Lead Clinical Director said that if during the initial patient assessment, a problem with a patient’s teeth was identified, this would be addressed.

The Director of Nursing and Governance said that it was important that the wards concentrated on getting the fundamentals right

The Chief Executive reported that the May 2018 Quality Executive Group had discussed whether increasing waiting times for some services should be added as a new concern.

Action: Director of Nursing and Governance

The Committee noted the report.

5.3 Serious Incidents Report – Quarterly Report

The Director of Nursing and Governance presented the paper reported that during Quarter 4, there were initially 16 serious incidents reported with one incident being subsequently downgraded following further information.

David Buckle, Non-Executive Director referred to page 29 of the agenda pack and asked about the frequency of ward staff receiving resuscitation training.

The Director of Nursing and Governance reported that the Trust had recently increased the frequency of resuscitation training from every year to every six months. In addition, staff participated in regular emergency scenario training sessions.

The Chair referred to the information governance breaches and commented that there had been an increase in the number of reported incidents.

The Medical Director said that following the appointment of a new Clinical Information Governance Manager in the Trust, there was more awareness of information governance amongst clinical staff and that this had increased reporting.

The Committee noted the report.

5.4 Bluebell Ward Serious Incident Action Plan

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

- Each of the acute wards now had 20 new safer bed frames (the remaining two rooms on each ward have original beds in place which allowed for patients with physical disabilities and those requiring the use of manual handling equipment);
- There was one remaining open action which related to the Trust's Quality Improvement Programme work on developing the new Cluster 8 pathway.

The Chair asked whether there was any feedback from Bluebell Ward staff about the Quality Management and Improvement Systems (QMIS) work.

The Chief Operating Officer reported that Bluebell Ward was in Wave 3 of the QMIS work and that Waves 2 and 3 had benefitted from the learning from Wave 1. The Chief Operating Officer confirmed that the QMIS work was well received by Bluebell Ward staff.

The Committee noted that report.

5.5 Learning from Deaths Quarterly Report

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

- Since the Trust had started its Learning from Deaths reporting, several themes and areas of learning were being implemented and the Quarter 4 learning built and supported the learning identified in Quarters 2 and 3.

- During Quarter 4, new areas for learning were identified specific to community hospital wards and working with families and carers.
- The Trust was hoping to engage one of the Patient Leaders in the learning from deaths process, using anonymised patient data;
- The national mortality review guidance for mental health trusts had not yet been published.

The Chair confirmed that she was reassured by the robustness of the Trust's learning from deaths systems and processes.

David Buckle, Non-Executive Director echoed the Chair's comments and that he also had a high level of assurance but cautioned against becoming complacent.

The Committee noted the report.

5.6 Care Quality Commission Compliance Actions Report

The action plans in relation to the Care Quality Commission "must do" and "should do" compliance actions had been circulated.

In relation to the Should Do" action plan, it was noted the CAMHS waiting times was increasing in line with the national trend.

The Chair asked whether there was anything more the Trust could do to reduce CAMHS waiting times.

The Chief Operating Officer reported that the Trust reported quarterly to the Commissioners on waiting times and had flagged the issue of the increased level of referrals.

The Chief Operating Officer reported that the greatest increase in referrals was around autistic spectrum disorder (ASD) diagnosis. The Medical Director explained that a positive ASD diagnosis meant that children and young people may be able to access additional resources and support at school.

David Buckle, Non-Executive Director asked whether the Committee could receive a brief update on the extent of the CAMHs waiting times.

Action: Chief Operating Officer

The Committee noted the two reports.

The Director of Nursing and Governance left the meeting at 11.30.

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

The Committee's updated Board Assurance Framework Risks (1, 2 and 5) had been circulated.

The Chief Executive reported that the May 2018 Quality Executive Group meeting had also reviewed the quality risks.

The following comments were made:

Risk 1 – Workforce
The action around the recruitment of a new Director of People had been completed and Carol Carpenter, Director of People was now in post.

Risk 2 – Involvement of Clinicians and Patients in the development of new care pathways
The Trust's work on improving physical health checks to be added as one of the controls.

Action: Company Secretary

Risk 5 –Regulatory Standards Compliance
The gaps in controls and assurance to be cross referenced to risk 1 (workforce)

Action: Company Secretary

The Committee noted the report.

Clinical Effectiveness and Outcomes

6.1 Quality Accounts Report 2017-18

The Head of Clinical Effectiveness and Audit reported that the draft External Auditors report on the Quality Accounts had identified three low level recommendations in respect of their audit on the three quality indicators.

It was noted that the External Auditors would present their report at the Audit Committee meeting on 23 May 2018 which was a special meeting convened to approve the Trust's final Accounts for 2017-18. It was noted that the External Auditors would also present their report to the Council of Governors.

The Committee noted the report.

6.2 Clinical Audit Reports

The Chair thanked the Head of Clinical Effectiveness and Audit for circulating copies of the full Clinical Audit reports in addition to the summaries provided in the agenda pack.

a) Chronic Obstructive Pulmonary Disease (COPD) National Audit

The Chair thanked Jagjit Sethi, Clinical Director and Clinical Lead for the COPD national audit for attending the meeting.

It was noted that the audit highlighted that in both the East and West services, only 33% and 41% of patients respectively were offered a start date within 90 days of receipt of referral. It was noted that in the East, reduced staffing levels had contributed to the delay in patients starting the pulmonary rehabilitation programme.

The Chair noted the comment in the report which stated that most patients were happy to wait for an appointment to attend their local service asked whether patients were offered transport to attend an alternative clinic with a shorter waiting time.

Jagjit Sethi confirmed that patients who required transport would receive it.

David Buckle, Non-Executive Director reported that he had visited the West service around six months ago.

An action plan had been developed to address the recommendations from the clinical audit which at attached at appendix D of the Committee Report.

It was noted that there was variation in practice across the East and West and that the national audit had been helpful in highlighting this.

b) Use of Depot/long-acting injectable antipsychotic medication for relapse prevention National Audit

The Lead Clinical Director reported that the main areas for improvement identified in the audit were:

- Some patients had gaps in the documentation of patients relapse 'signature' (signs and symptoms of relapse);
- Some patients did not have a robust crisis plan outlining the response to default from treatment (ie if a patient failed to attend an appointment for administration of their depot injection or declines their Depot injection).

An action plan had been developed to address the recommendations and was attached at appendix B of the Committee Report.

The Chair asked whether Depo patients should be discharged to the care of GPs.

The Medical Director reported that NHS England had recently published a new set of guidelines which stated that it was the responsibility of primary care to manage patients who required annual reviews and were stable on Depo injections. The Medical Director said that he hoped that GPs would increasingly take of over the care of these patients once they were stable on their medication.

David Buckle, Non-Executive Director said that the counter argument was that GPs may not have experience of treating this cohort of patients.

The Medical Director reported that the third audit was the National Audit of Intermediate Care and since this was a benchmarking report and not a clinical audit, it would be received by the Finance, Performance and Risk Committee.

The Committee noted the report.

Update Items for Information

7.1 Guardians of Safe Working Hours Quarterly Report

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

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

The Medical Director reported that since the last report to the Committee two exception reports had been received. The first report concerned a late finish due to attending to appropriate clinical matters. The second report was a planned diversion from the work schedule with time off in lieu appropriately taken.

It was noted that on both occasions, the trainee and consultant had acted appropriately, particularly with the speed of response from the completion of the form to resolution of the exceptions.

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

On behalf of the Committee, the Chair thanked the Guardians of Safe Working Hours for their report.

The Committee noted the report.

7.2 Quality Executive Committee Minutes

The minutes of the Quality Executive Committee meetings held on: 12 February 2018, 12 March 2018 and 9 April 2018 were noted.

Closing Business

8.0 Annual Review of Effectiveness

The Company Secretary reported that in agreement with the Chair, in view of the changes to the way the Committee reviewed clinical audit reports introduced at the last meeting, the annual review of the Committee's effectiveness had been delayed until after this meeting.

The Company Secretary reported that she would be circulating the questionnaire shortly and urged everyone to complete it. The outcome of the review would be reported to the August 2018 Committee meeting.

Action: Company Secretary

8.1 Standing Item – Horizon Scanning

The following were identified for inclusion on the Committee's Work Programme:

- CAMHs waiting times
- Carers Strategy
- Physical health of mental health patients

The Medical Director agreed to discuss with the Director of Nursing and Governance whether it would be better for the physical health of mental health patients to be discussed at a Trust Board Discursive meeting or at the Quality Assurance Committee.

Action: Medical Director

8.2. Any Other Business

There was no other business.

8.3. Date of the Next Meeting

It was noted that both the Medical Director and the Head of Clinical Effectiveness and Audit would be on leave for the meeting. The Lead Clinical Director would deputise for the Medical Director and a member of the Clinical Effectiveness and Audit Team would attend the meeting.

21 August 2018 at 10.00

These minutes are an accurate record of the Quality Assurance Committee meeting held on 15 May 2017.

Signed:-

Date: - 21 August 2018

Quality Assurance Committee Paper	
Meeting Date	15 May 2018
Title	**Learning from Deaths Quarter 4 Report**
Purpose	To provide assurance to the Trust Board that the trust is appropriately reviewing and learning from deaths
Business Area	Clinical Trust Wide
Authors	Head of Clinical Effectiveness and Audit, Medical Director
Relevant Strategic Objectives	2 – To provide good outcomes from treatment and care
Resource Impacts	None in this quarter
Legal Implications	None
Equality Diversity Implications	A national requirement is that deaths of patients with a learning disability are reviewed to promote accessibility to equitable care. This report provides positive assurance of learning from these deaths
SUMMARY	964 deaths were recorded on the clinical information system during Q4 where a patient had been in contact with a trust service in the year before they died. Of these 82 met the criteria to be reviewed further. All 82 were reviewed by the executive mortality review group and the outcomes were as follows: • 36 were closed with no further action • 8 were classed as Serious Incident Requiring Investigation • 33 required further review using an initial findings review (IFR) • 5 currently open and further information required During Q4 the mortality review group reviewed the findings of 26 IFR reports (detailed on p8), 6 IFRs related to patients with a learning disability (these are cases reviewed in Q4 and will include cases reported in previous quarters). **Lapse in care** Each case is reviewed to identify if there has been a lapse in care prior to the patient's death, In Q4 no lapse in care was identified. **Learning** Several themes and areas of learning from a review of the deaths are being implemented and the Q4 learning builds and supports the learning identified in Q2, Q3. In Q4 we identified a number of new areas for learning specific to community hospital wards (section 9.3) and working with families and carers (section 9.1). Key learning themes which continue are as follows: • Management of patient's physical health whilst they are under our care for their mental health (Both SI and Non SI deaths). • Communication with Families • Potential learning around the transfer of patients at the end of life

	from acute to our community hospitals and also from the community into our wards. In Q1 of 2018/19 we will undertake a review of these cases to see if further trends and learning can be specifically identified.
ACTION REQUIRED	The Committee is asked to receive and note the Q4 learning from deaths report in order to provide assurance to the Trust Board that the Trust is complying with NHS Improvement requirements in respect of learning from deaths.

Table of Contents

1.0 Purpose

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

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

2.0 Scope

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

3.0 Introduction

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

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

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

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

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

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

4. Data

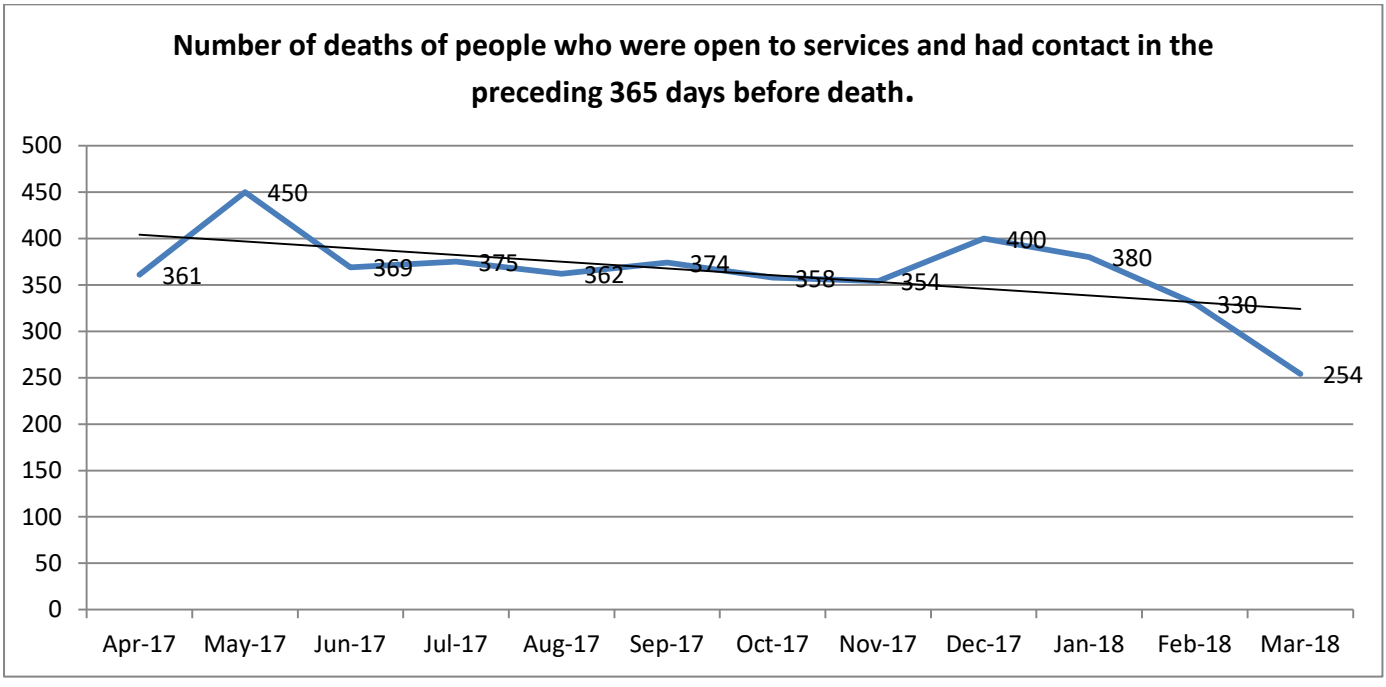
4.1 Total Number of deaths in Q4

The trust electronic patient record (RiO) is directly linked to the national spine which allows information regarding deaths to be shared amongst providers of health care. Figure 1 uses this information and is generated from our Rio system. It identifies all deaths where a patient had any contact with one or more of the trust services in the preceding 365 days before their death and was on an active caseload of the service at the time of death.

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

Note: These are the last Specialty Teams seen before death	January 2018	February 2018	March 2018	Grand Total
NURSING EPISODE	181	170	131	482
DIETETICS	49	38	30	117
OLD AGE PSYCHIATRY	36	26	22	84
COMMUNITY HEALTH SERVICES MEDICAL	30	27	17	74
SPEECH AND LANGUAGE THERAPY	21	19	12	52
PODIATRY	23	12	12	47
PALLIATIVE MEDICINE	10	14	11	35
ADULT MENTAL ILLNESS	4	5	2	11
REHABILITATION	3	4	3	10
CARDIOLOGY	5	3	2	10
PHYSIOTHERAPY	6	1	3	10
RESPIRATORY MEDICINE	5	3	1	9
GENERAL MEDICINE	1	3	4	8
CLINICAL PSYCHOLOGY	1	1	2	4
GENITO-URINARY MEDICINE	2	1	1	4
LEARNING DISABILITY	2		1	3
GERIATRIC MEDICINE		2		2
INTERMEDIATE CARE		1		1
COMMUNITY PAEDIATRICS	1			1
Grand Total	380	330	254	964

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



*** Note Figures revised for 17/18 at April 18, March figure will be lower due to time lag in reporting.**
We also report the number of deaths by age range, this has allowed us to also ensure we are aware of all children's deaths which are reviewed in detail by the child death overview panel (CDOP) hosted by the Local Authority.

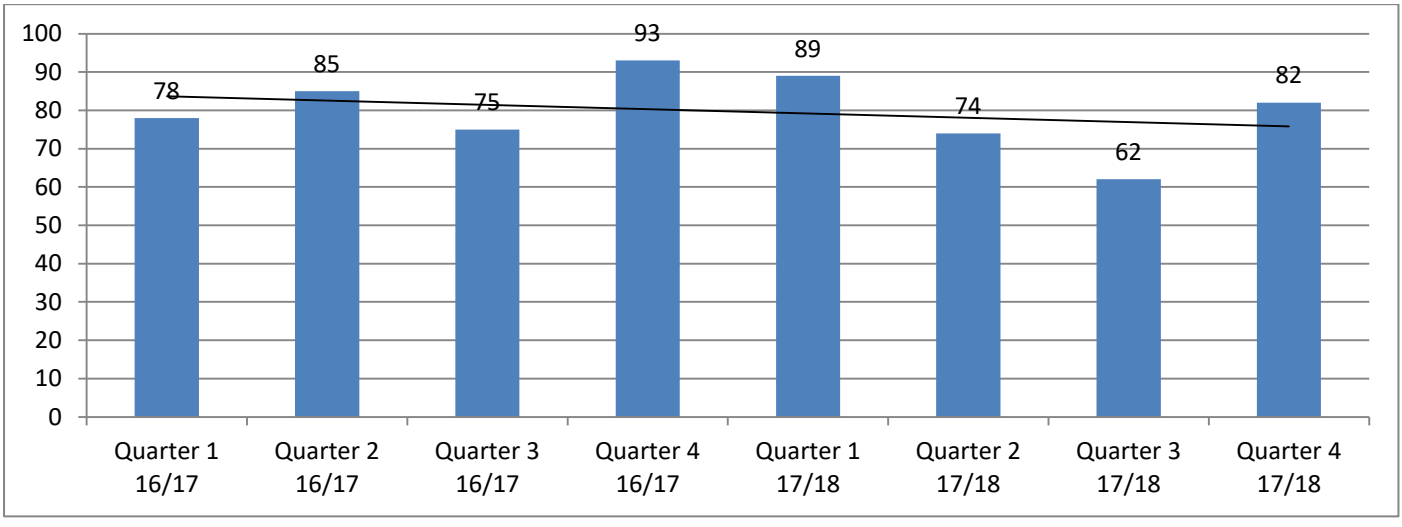
These are the last Specialty Teams seen before death	April 2017 to March 2018				
	A:0-17	B:18-65	C:66-75	D:Over 75	Grand Total
NURSING EPISODE	17	235	335	1460	2047
DIETETICS	2	92	99	355	548
OLD AGE PSYCHIATRY		5	28	366	399
SPEECH AND LANGUAGE THERAPY	1	16	41	210	268
PODIATRY		24	42	178	244
COMMUNITY HEALTH SERVICES MEDICAL		18	19	225	262
PALLIATIVE MEDICINE		51	39	73	163
REHABILITATION		19	19	37	75
ADULT MENTAL ILLNESS		60	12	1	73
GENERAL MEDICINE		11	19	37	67
RESPIRATORY MEDICINE		8	16	28	52
CARDIOLOGY		6	9	34	49
PHYSIOTHERAPY		4	8	33	45
GENITO-URINARY MEDICINE		1	3	13	17
LEARNING DISABILITY		9	4	3	16
CLINICAL PSYCHOLOGY		7	6	4	17
GERIATRIC MEDICINE			2	9	11
INTERMEDIATE CARE		1	1	6	8
COMMUNITY PAEDIATRICS	4				4
OCCUPATIONAL THERAPY	1				1
Grand Total	25	567	702	3072	4366

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

4.2 Deaths reported for review

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

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



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

Figure 5 breaks down the deaths reported on the Datix system by the service the patient was in contact with. These are all reviewed weekly by the Executive Mortality Review Group (EMRG) which consists of the Medical Director, Director of Nursing and Governance, Lead Clinical Director, Deputy Director of Nursing and Quality and the Head of Clinical Effectiveness & Audit.

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

Service	January	February	March	Total
Community Hospital Inpatient	12 (t3)	6 (t2)	17 (t4)	**35 (t9)**
Community Mental Health	7	2	2	**11**
Community team for people with learning disabilities	4	4	4	**12**
Crisis response and home treatment team	1	1	1	**3**
Children's and young people's services	4			**4**
District Nursing /Intermediate care		2	3	**5**
Community Mental Health Older Adults	1	1	1	**3**
Criminal liaison and justice	1	2		**3**
Common point of entry	1		2	**3**
Mental Health inpatients	1		1	**2**
Talking Therapies	1			**1**
Total Datix	**33**	**18**	**31**	**82**

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

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

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

All deaths classified as SI will follow the existing SI investigation process using Root Cause Analysis methodology and learning will be shared within this report.

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

Figure 6. Outcome following review at EMRG in Q4

	Number
Datix closed no further action required	36
Classified as a Serious Incident (SI)	8
Initial findings report (IFR) requested	33
Open further information required	5
Total	82

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

Figure 7: Number of SI relating to a patient death in Q4

Service (**Source Q4 Serious Incident Report)**	**Number**
Mental Health Inpatients	1
Wokingham Community Mental Health	1
WAM Community Mental Health	2
Slough Community Mental health	1
Crisis Resolution and Home Treatment Team (CRHTT)	1
Bracknell CMHT	1
Talking Therapies	1
Total	**8**

5 suicides/suspected suicide and 3 unexpected deaths.

5. Involvement of families and carers in reviews and investigations

5.1 For all deaths which are categorised as an SI

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

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

Telephone contact was made with all 8 families in Q4 and this was followed up with a written request for a meeting. All families/ carers were offered the opportunity for a face to face meeting, 4 families accepted this opportunity, 4 initially declined although subsequent to initial contact we have met with one of these families

Following a Serious Incident, the Investigating Officer (IO) will contact the family and arrange to meet with them to ensure that they are part of the investigation process; the IO will note any questions or concerns that the family has for inclusion in the investigation. The investigating officer provides contact details and explains that they will be in touch further during the investigation and once it is finished, to share the findings of the investigation. Once the investigation is complete, the investigating officer makes contact with the family to agree how they would like to receive feedback and findings of the investigation. A face to face meeting is offered to do this and a copy of the report is provided to the family if they would like one. This meeting is also followed up with a letter to the family..

5.2 For non SI deaths

The learning disability team make contact with the family following the reported death of a person with a learning disability. Telephone contact was made for each of the 12 individuals in order to offer support and condolences to those that the individual lived with, be they family or staff members from supported living. This action was completed by the local community learning disability team members who knew and had a relationship with those that supported the individual.

The Head of Learning Disability Services also sends a card of condolence to the family with information on how to contact the team if the family would like to discuss the person's care and treatment prior to death. This has recently been updated to include details regarding the LeDeR programme. Of the 12 individuals who were reported, 4 had no known family –as a result only 6 cards and letters were sent to those identified as next of kin during this quarter, with 2 remaining to be sent upon provision of next of kin details. To date, from the 6 cards/letters sent in this quarter, there have been 2 responses from family members.

Both were complimentary about the services being provided to their next of kin (although this wasn't specifically related to BHFT input). There have been no concerns/issues about BHFT services identified as a result of this engagement with families in this quarter. It is important to note that this process applies to deaths of all individuals with a learning disability where they would have had contact with the trust's learning disability service in the past 12 months.

6. Mortality Review Group

6.1 Reviews Conducted

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

The mortality review group meets monthly and is chaired by the Medical Director; the following reviews (IFRS) have been received and considered by the group in Q4.

Figure 8: Reviews Conducted in Q4

	Total Number	Services
January	6 IFRs reviewed	Learning Disability – 1 cases Crisis Resolution and Home Treatment Team -1 case Court Liaison and Divert Services – 1 case Reading CMHT – 1 case Care Coordinators Care Programme Approach – 1 case Common Point of Entry– 1 case
February	15 IFRs reviewed	Learning Disability –4 cases Children and Young Peoples services – 2 cases Court Liaison and Divert – 1 case Intermediate care services -1 case Oakwood Ward -2 cases Wokingham Community Hospital -1 case Upton Community Hospital – 1 case East CMHT – 3 cases
March	5 IFRs reviewed	Learning Disabilities – 1 cases East CMHT – 1 case West CRHTT – 1 case West Berkshire Community Hospital - 1 case Court Liaison and Divert – 1 case

Note: these are cases reviewed in Q4 and will include cases reported in previous quarters.

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

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

An action log is maintained and reviewed by the group to ensure that all actions are completed. The following section details the recommendations and learning which have been identified in Q4.

6.2 Deaths of patients receiving community nursing care including palliative care

Figure 1 shows that the highest proportion of deaths of people who have been under the care of one of our services in the year before they died were under the care of nursing or palliative medicine, where death may be expected.

For Inpatients we require all deaths to be reported on the Datix system including patients who are expected to die and receiving palliative care.

In Q4, 23 expected deaths (patients admitted for end of life care) were reported on our community health inpatient wards (compared to 16 in Q3). These were reviewed by the executive mortality review group where sufficient information had been provided to give assurance that appropriate and of life care had been given.

In addition 1 patient died unexpectedly whilst an inpatient on our physical health wards an IFR was completed which was reviewed by the EMRG in March.

5 deaths were reported by community nursing services; all were reviewed by the executive mortality group and IFRS were requested for 4. 1 IFR was received and closed in February, 3 are still to be reviewed.

6.3 Deaths of Children and Young People
4 deaths were reported where the child or young person had been in contact with one of our services in the year before their death.

Of these 1 required an IFR and this is due to be reviewed at the May meeting, the other 3 cases were closed with no further action required, all were under the care of acute services at the time of death and had complex health needs.

6.4 Deaths of adults with a learning disability
In Q4 a total of 11 deaths of adults with learning disabilities who were known/open to the learning disability services in the 12 months prior to their death have been reported. 1 further death occurring in Q3 was reported to the service part way through Q4, making a total of 12 reported deaths during Q4.

Of these 12 deaths, 9 have been reviewed by both the LD Clinical Review Group and subsequently 6 by the Trust Mortality Review Group. The remaining 3 people died at the end of March and the reviews of these deaths are to be completed by the LD CRG / TMRG.

Of the 6 deaths where the Trust review process has been completed there were no identified lapses in care provided by BHFT services.

Demographics of adult patients with a learning disability
Gender:

Female	4
Male	8

Age:
The age at time of death ranged from 21 to 96 years of age (median age: 54.5 yrs)

Severity of Learning disability:

Mild	0
Moderate	4
Severe	4
Profound	1
Not known	3

Ethnicity:

White British	9
Other White	1
Asian Pakistani	1
Other Asian	1

National Learning Disability Mortality Review Process (LeDeR)
From the 1st September 2017 the Learning Disability Service has provided notification to LeDeR (national Learning Disability Mortality Review process) of all deaths of individuals with learning disabilities known to the Trust. Locally in Berkshire, the CCGs are responsible for the coordination of the LeDeR process – the

Trust participate in the Steering Groups in both East and West Berkshire and support the LeDeR process practically with staff trained as LeDeR reviewers (and these staff attend LeDeR Reviewer Forums)

LeDeR Notifications
Notifications have been made to LeDeR for each of the 12 people who died in the quarter.

7. Additional Case Review
7.1 End of Life Care National audit
The End of Life Care national audit is now live and Berkshire Healthcare Trust are registered to participate in this. The audit will review all inpatients who are at the end of life and die between April and June 2018. Systems are in place to capture this information and an information leaflet has been made available from the national team to share with Carers.

In Q1 of 2018/19 we will also review the length of stay of those patients who are receiving end of life inpatient care, to see if there any specific trends or areas to review.

8. Was a Lapse in care identified?
Of the 26 initial findings reports and serious incident investigations which have been concluded in Q4, no lapse in care was identified.

9. Learning from Deaths
The aim of the policy and procedure is to ensure that we learn from deaths and improve care even when the death may not be due to an avoidable cause. The following section details updates on learning identified in Q2 , 3 and the new learning identified in Q4 .

9.1 Theme: Working with families and carers

Previous quarterly reports have highlighted the theme of the importance of involving families and carers during the care and treatment of mental health patients. This theme continues with the importance around hearing concerns and gaining information from family and friends to help inform risk assessments; treatment and safety plans. There is a significant amount of work being undertaken to support which was idenitifed including

- Safety planning: a number of investigations have highlighted the importance of robust safety planning that is updated to reflect the persons current circumstances, involves family and friends and is shared with the patient family and friends (new for Q4).
- Work is ongoing as part of risk and suicide training for staff with a focus on the importance of safety planning
- Zero suicide resource with information on supporting carers
- Guidance for carers on questions to ask staff so they can be more involved in care has been developed and a dedicated carer's webpage went live in Dec 2017. Mental health first aid is offered to our carers who want to attend this (new for Q4).
- Emphasis on carers and guidance on how to tackle confidentiality and information sharing in our zero suicide guide currently being updated is near completeion.
- Using feedback from carers to inform scenarios for real play within the training
- A Film clip is being developed for staff on the importance of involving carers as well as services users in risk assessments and safety plan a service user has been recruited to help with this production and the first meeting was held on 1st January 2018.
- E- learning is available from the zero suicide alliance for all staff - a simple but effective training video that combines facts about suicide with stories of real people who have experienced the impact of it on their lives. It also provides advice on how to speak to someone with suicidal thoughts and real life scenarios to give the skills to be able to deal with difficult conversations with loved ones, friends or colleagues
- An infographic to help carers, staff and service users know how to work together on safety plans is now complete and a simialr resource has been developed on saftey planning.

9.2 Theme: monitoring and supporting the physical health of patients being managed for their mental health
Mental Health Inpatient Wards
A number of initiatives and training sessions are being provided to up- skill the staff working within Prospect

Park on Physical Healthcare this includes:

- Diabetes training sessions are being delivered.
- SALT/ choking training- 6 sessions were delivered in November by the Speech and Language therapy (SALT) therapist. Training for all clinical and support staff on 'Communication and Challenging Behaviour' and 'Dysphagia Awareness'.
- Changes to coding on menus has been implemented to provide clarity for staff around which foods meet the requirement of soft/ puree diet
- Further training planned around hydration/ nutrition/ Food and fluid monitoring is being completed.

9.3 Themes from our Physical Health Inpatient Wards

In Q4 we idenitifed the following learning from the review of end of life care of patients who were inpatients and also where patients have transferred from a community hospital to an acute hospital and died within a week of transfer:

- Use of our electronic patient record (Rio) and access to medical and nursing notes to review deaths on transfer, a number of reviews have been delayed due to delayed acces to paper notes, the use of Rio will ensure that we have access in a timely manner to review patient records when a death has occurred.
- Do not attempt cardio pulmonary resusitation (DNACPR) forms to be completed appropriately and placed in a prominent position in clinical records to enable rapid access.
- Involving families in a timely manner when a patient's condition deteriorates in community physical health wards.
- Appropriate, clear and timed documentation by all members of staff including doctors visiting community health wards.
- Elevated national early warning (NEWS) scores need to be escalated and doctors to be involved in a MDT discussion for patients with high NEWs scores.
- Ward handover sheets to include action points and nursing staff to record actions to be taken during daily handover.

Learning events have been held in both the east and west community hospitals to review and address the points raised above. The reviews have also highlighted potential learning around the transfer of patients at the end of life both into our community hospitals and also from the community into our wards. In Q1 we will undertake a review of these cases to see if further trends and learning can be specifically identified.

9.4 Theme Community Mental Health

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

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

9.5 Learning from deaths of patients with a learning disability

Actions and learning identified during the previous quarter has been completed / shared.

In Q4 there has been similar learning identified, including the recording and completion of mental capacity assessments, and also the importance of considering the need for physical health checks and impact of physical ill-health impacting on mental health.

The Learning Disability service continues to provide regular updates to staff via the bi-monthly Learning Disability Service Patient Safety Quality and Governance meeting. Feedback is also provided to the relevant teams regarding any lessons learned following review of the IFR by the Clinical Review Group.

Good practice identified has included effective support from Community Nursing and Palliative care by helping to meet the spiritual needs of an individual prior to death. Also the rapid and comprehensive response by Speech and Language Therapy to respond to care needs of an individual, and in another case there was good evidence of regular contact from District Nursing and appropriate interventions and follow up by Psychiatry.

Some of the reviews completed have identified recommendations for the LeDeR review process to consider as part of the wider system review (including arrangements for discharge planning from local acute hospitals)

9.6 Learning from LeDeR reviews

Since implementing the LeDeR process in Berkshire there has been one review completed and reported back. There was no direct learning for BHFT services from this review – however there was positive feedback on the quality of the Initial Findings Report and the process undertaken by us.

Quarterly reports from the LeDeR programmes in Berkshire are shared with via the Learning Disability Service Patient Safety Quality and Governance meeting and Trust Mortality Review Group

9.7 Learning from Complaints where the patient died

In Q4 we received one complaint in January which is being reviewed through our serious incident process, and learning will be included in future reports.

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

In Q3 we reported on the internal audit which was undertaken to review the mortality review and learning from deaths process, the audit gave substantial assurance that the controls upon which the organisation relies to manage the identified risk are suitably designed, consistently applied and operating effectively. The audit identified 2 low priority issues requiring management actions, these have both now been completed.

1. National guidance on specific methodology for review of deaths of mental health patients (which are not Serious Incidents) is awaited. Following publication of this guidance, training requirements will be considered by the trust and appropriate training will be offered to staff involved in the process of review of deaths'. A number of our senior clinical staff have now completed the structured judgement review (SJR) train the trainer workshop, the SJR tool is a validated tool to review deaths and identify lapse in care, in May 2018 we will be identifying the roll out plan for use of this methodology.

2. Quarterly reports to the Board will include reference to themes and learning identified in the previous quarter and an update whether progress with implementing learning has been made. This has been completed and the reports build on previous learning and trends.

11. Conclusion

In Q4, of the 26 deaths concluded as through the mortality review group and serious incident process, no lapse in care was identified.

Several themes and areas of learning from a review of the deaths are being implemented and the Q4 learning builds and supports the learning identified in Q2, Q3. In Q4 we identified a number of new areas for learning specific to our community hospital wards

Key learning themes which continue are:

- Management of patient's physical health whilst they are under our care for their mental health (Both SI and Non SI deaths).
- Communication with Families
- The reviews have also highlighted potential learning around the transfer of patients at the end of life both into our community hospitals and also from the community into our wards. In Q1 we will undertake a review of these cases to see if further trends and learning can be specifically identified.

Quality Assurance Committee	15 May 2018
Title	Guardian of Safe Working Hours: quarterly report
Purpose	Quarterly reporting for information for Quality Assurance Committee of the Trust Board, covering the period 7 February 2018 to 30 April 2018
Business Area	Medical Director
Author	Dr James Jeffs, Dr Matthew Lowe, Ian Stephenson
Relevant Strategic Objectives	Goal 3 – To provide good outcomes from treatment and care
SUMMARY	The Guardians give assurance to the Trust Board that no unsafe working hours have been identified and no other patient safety issues requiring escalation have been identified. No trainee has breached the key mandated working limits of the new contract. Since the last report to the Committee, we have received 2 exception reports as set out in the report.
ACTION REQUIRED	The QAC is requested to: Note the report on safe working hours

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

This report covers the period 7th February – 30th April 2018

Executive summary

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

This report focusses on the period 7th February – 30th April 2018. Since the last report to the Trust Board we have received 2 exception reports.

We have as you can see below changed the way we report the number of gaps and the reasons behind them. We felt that the previous tables were not as clear as they could be.

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

Introduction

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

High level data

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

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

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

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

b)

Exception reports by department				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Psychiatry	0	2	2	0
Dentistry	0	0	0	0
Sexual Health	0	0	0	0
Total	0	2	2	0

Exception reports by grade				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
CT 1-3	0	0	0	0
ST 4-6	0	2	2	0
Total	0	2	2	0

Exception reports by rota				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Psychiatry	0	2	2	0
Dental	0	0	0	0
Total	0	0	0	0

Exception reports (response time)				
	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
CT1-3 / ST1-3	0	0	0	0
ST4-6	2	0	0	0
Total	0	0	0	0

In this period there have been two exception reports. On the first the trainee stayed 1.25 hours after their regular finish time to complete clinical work. This was discussed with the Educational Supervisor and agreed to be appropriate for time off in lieu that week. For the second the trainee chose to be part of a clinical activity that took place out of hours and was granted that 3.5 hours time off in lieu that week. Both reports were dealt with within 24 hours of the report being placed on the system. There is no pattern to these reports and there has been appropriate discussion between the Guardians and the Supervisor.

c) Work schedule reviews

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

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

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

d) **Gaps**

(All data provided below for bookings (bank/agency/trainees) covers the period 7th February – 30th April 2018).

Psychiatry	Number of shifts requested	Number of shifts worked	Number of shifts worked by:			Number of hours requested	Number of hours worked	Number of hours worked by:		
			Bank	Trainee	Agency			Bank	Trainee	Agency
	39	39	34	3	2	364	364	328	12	24
Total	39	39	34	3	2	364	364	328	12	24

Reason	Number of shifts requested	Number of shifts worked	Number of shifts worked by:			Number of hours requested	Number of hours worked	Number of hours worked by:		
			Bank	Trainee	Agency			Bank	Trainee	Agency
Gap	36	36	32	2	2	352	352	320	8	24
Sickness	3	3	2	1	0	12	12	8	4	0
Maternity	0	0	0	0	0	0	0	0	0	0
Total	39	39	34	3	2	364	364	328	12	24

The period 7th February – 30th April 2018 covers the period from the beginning of the February rotation to date. We anticipated two gaps (one pregnancy, the other HEETV did not recruit) and we filled both gaps by recruitment, however, a third gap was created by one doctor choosing not to rotate to the Trust in February. The number of shifts that needed covering is higher than we would have expected given the recruitment situation, however, a number of doctors were new to psychiatry and needed to gain experience before joining the OOH rota, we therefore had to ensure that the shifts were covered while they were trained We have since had a resignation that will create a gap from the 30th April. We have covered all of these shifts, predominantly internally although we were forced to use agency on one weekend. What the figures also show is the strength of the Trust's bank which we are continuing to grow.

The MTI (medical training initiative) and WAST (widening access to specialty training) schemes should see us receive one doctor from each scheme in August of this year.

e) **Fines**

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

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

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

Qualitative information

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

Issues arising

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

Actions taken to resolve issues

The Guardians of Safe Working continue to communicate through the MSC to ensure that trainers have an understanding of the exception reporting process. There is on-line training which trainers have been reminded to complete in regard to the exception reporting process and we will continue to encourage them to complete this. It has been noted that this could be enquired about at Consultant Appraisal.

Summary

All rotas are currently compliant.

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

The two exception reports discussed above for this period relates to two different kinds of exceptions. Firstly a late finish due to attending to appropriate clinical matters. Secondly a planned diversion from the work schedule with time off in lieu appropriately taken. On both occasions the trainee and consultant acted appropriately, particularly with the speed of response from the completion of the form to resolution of the exception.

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

Questions for consideration

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

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

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

Appendix A: Glossary of frequently used terms and abbreviations

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

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

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

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

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

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

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

Trust Board Paper

Board Meeting Date	10 July 2018
Title	Revalidation Annual Report 2017/18
Purpose	To provide the Board with assurance with respect to Revalidation in line with NHS England requirements
Business Area	Medical Directorate
Executive Director	Minoo Irani, Medical Director, Responsible Officer for Revalidation
Relevant Strategic Objectives	Goal 1 – To provide safe services, prevent self-harm and harm to others Goal 3 – To provide good outcomes from treatment and care
CQC Registration/Patient Care Impacts	Supports on-going registration with the Care Quality Commission
Resource Impacts	The Trust Board is required to support the provision of necessary resources to assist the Responsible Officer (RO) with respect to Medical Revalidation requirements. The RO is currently supported by a 0.5 wte Band 5 appraisal and revalidation administrator to manage the process.
Legal Implications	Compliance with The Medical Profession (Responsible Officers) Regulations, 2010 (as amended 2013) and the GMC (Licence to Practise and Revalidation) Regulations 2012
Equalities and Diversity Implications	N/A
SUMMARY	The annual report provides details for the 2017/18 year of revalidation with respect to doctor numbers, appraisal numbers, revalidation recommendations and governance arrangements to support revalidation. The Responsible Officer believes that, since the revised policy and enhanced processes introduced in 2016, there is good compliance with the requirements of high quality medical appraisal process in BHFT; this is expected to support professional development of trust doctors which would eventually improve the quality of patient care.
ACTION REQUIRED	The Board is asked to receive the annual board report on medical revalidation and to agree to the submission of an annual statement of compliance to the NHS England higher level Responsible Officer prior to 30th September 2018, signed by the Chair or Chief Executive.

Contents

Medical Revalidation Annual Report 2017/18

1. Executive Summary

The annual report provides details for the year of revalidation 2017/18 with respect to doctor numbers, appraisal numbers, revalidation recommendations and governance arrangements to support revalidation. Engagement with medical appraisal and revalidation from doctors has been high. The Responsible Officer (RO) believes that the revised policies and enhanced processes in place since 2016, satisfy the requirements for a good and robust medical appraisal process and these necessary changes have now been implemented and adequately embedded.

With respect to medical revalidation regulations, Berkshire Healthcare is a 'designated body' with associated statutory responsibilities. Doctors working within the Trust are referred to as having a 'prescribed connection' with respect to medical revalidation. There were a total of 128 doctors with a prescribed connection with the Trust for revalidation in 2017/18.

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

Doctors with a prescribed connection to BHFT in 2017/18 include 79 consultants, 35 Specialty doctors and 14 doctors with temporary or fixed term contracts. The number of completed medical appraisals for doctors with a prescribed connection with the Trust during the year was 126 (78 consultants, 34 specialty doctors and 14 fixed term doctors). 2 doctors were in the category of 'approved incomplete or missed appraisal' at the end of the year with adequate reason provided (medium to long term sick leave). In the case of one Consultant (of the 78 completed), although the appraisal was timely, the appraisal summary sign-off was delayed beyond 28 days.

Doctors require revalidation every five years. 9 doctors were due for revalidation in 2017/18. 8 doctors were recommended for revalidation during the year and there was one deferral. All recommendations were accepted by the GMC. There were no declarations of non-engagement. There were no delays in the recommendations made by the RO to the GMC.

The Responsible Officer notes that the governance processes in the Trust to support revalidation are robust and these have been enhanced in 2016/17 following recommendations arising from the 'Independent Verification Visit' in May 2015. In addition, recommendations from the audit of medical appraisal process (July 2016, internal auditors) have been implemented. Appraisers have access to training opportunities to maintain their skills and trust appraiser forum meetings are well attended. The RO is confident that the medical appraisal process in BHFT complies with national good practice requirements and can provide this assurance to the trust Board to submit the annual statement of compliance to NHS England.

2. Purpose of the Paper

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

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

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

An 'Annual Organisational Audit' has been completed by the Responsible Officer and submitted to NHS England in April 2018. This sets out numbers with respect to medical appraisal and revalidation and confirms that the necessary systems, policies and resources are in place to support the process.

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

3. Background

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

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

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

4. Governance Arrangements

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

The revalidation team is led by the Medical Director who is the Responsible Officer (RO) for the organisation. From May 2016, the Appraisal Leads support the RO with this function. The administrator for medical appraisal & revalidation (and medical education) compiles

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

and monitors appraisals and supports doctors in preparing for these. Details and links on the Trust intranet also guide doctors on the requirements for revalidation.

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

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

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

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

All doctors use an approved and validated electronic 'Medical Appraisal Guide' MAG form to record medical appraisals which includes all revalidation requirements. All medical appraisers within the organisation have attended approved appraisal training. The RO has arranged appraiser refresher training events in the trust (18 October 2016, 17 January 2018). In addition, appraisers are regularly encouraged to attend appraiser training events in the region to maintain their skills.

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

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

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

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

A sample of completed MAG forms is subject to Quality Assurance by the appraisal leads using the PROGRESS tool. The RO receives this information. Additionally, the RO Quality Assures a sample of the completed MAG and PROGRESS forms. This way, the Responsible Officer scrutinises a sample of Medical appraisal forms in detail to monitor quality and consistency and liaises with the appraisal leads where necessary.

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

5. Policy and Guidance

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

Significant policy updates from the GMC related to medical appraisals is brought to the attention of appraisers and doctors in the trust and implications for practical application of the policy are discussed at appraisal forums.

6. Medical Appraisal

6.1 Appraisal and Revalidation Performance Data 2017/18

Detailed activity levels of appraisal outputs:

- Number of doctors **128**
- Number of completed appraisals: **126**
- Approved incomplete or missed appraisal: **2**
- Unapproved incomplete or missed appraisal: **0**
- (Number of doctors in remediation or disciplinary processes: **0)**

A review of missed or incomplete appraisals has been carried out. The main reasons for delayed appraisals with adequate reason are sickness (2 doctors). One Consultant appraisal fell into the completed appraisal (1b category) due to delayed sign-off, even though the appraisal in this case was completed on time. The Board can be assured that the appraisals provide a sound basis for supporting revalidation recommendations.

6.2 Appraisers

The recommended proportion of trained appraisers in a designated body is between 1:5 and 1:20. There have been between 28 and 30 trained medical appraisers in the Trust which is more than sufficient, given the number of doctors with a connection to the trust. Loss of appraisers through retirement is balanced by appointment of new appraisers who have completed their training and meet the requirements to be a trust appraiser. The appraiser forum meeting (chaired by the RO or appraisal leads) occurs three times a year to provide peer support and updates with respect to revalidation and appraisal requirements, policy and good practice. Appraisers have historically performed variable number of appraisals per year; with a system of allocation and matching appraiser and appraise introduced in 2016, appraisers are now expected to appraise on average 5 doctors annually.

6.3 Quality Assurance

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

Since 2016, appraisal leads assess the quality of a sample of completed appraisal MAG forms using a standardised tool (PROGRESS). The appraisal leads regularly present a

summary of their quality reviews to the appraiser forum to facilitate improvement in practice and standardisation of the appraisal content and output. The RO has reviewed a small sample of the appraisal leads PROGRESS reports and corresponding MAG forms and is satisfied with the current process.

Feedback about the appraisal process from doctors is received and coordinated by the revalidation administrator. The medical appraisers reflect on this to improve appraisal quality. The RO has reflected on 2 specific instances of feedback received from doctors and with the support of appraisal leads has resolved the issues raised—in one instance the doctor was not satisfied that the appraiser understood all the complexities of their niche area of clinical practice; in another, the doctor perceived the appraiser was being too rigid with their expectation of appraisal documentation. After analysing both scenarios, including discussions with the doctors and appraisers involved, both situations were resolved to the satisfaction of doctor and appraiser.

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

6.4 Access, security and confidentiality

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

In response to reporting of a high profile case in the medical and general press, where there was concern about potential inappropriate use of reflection documented in appraisals, the RO has assured doctors of the confidential nature of medical appraisals and that reflection should remain at the core of appraisal discussions and documentation.

6.5 GPs in BHFT

Although GPs employed by BHFT do not get appraised within the Trust, the Medical Director of Westcall has provided assurance that the scope of GP practice in Westcall feeds into their appraisal process in primary care. Additionally, since 2016, the revalidation administrator provides Westcall GPs contracted/ employed by the trust with a Datix summary of their governance data for use in their appraisal process.

7. Recruitment and engagement background checks

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

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

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

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

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

8. Revalidation Recommendations

8 recommendations for revalidation were completed between April 2017 and March 2018. All were completed in time. All positive recommendations were accepted by the GMC. There was 1 deferral request and no non-engagement notifications.

9. Monitoring Performance

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

10. Responding to Concerns and Remediation

Whilst individual doctors have reflected on incidents, complaints and prescribing errors where they have been involved, formal remediation programmes have not been required during this year for any doctor with a prescribed connection to the Trust.

11. Audit of Medical Appraisal Process

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

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

12. Risk and Issues

In the opinion of the Responsible Officer there are currently no serious risks with respect to medical appraisal and revalidation which require the Board's attention. The current resource for administering the appraisal process is modest.

13. Recommendations

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

The Trust Responsible Officer is confident that following implementation of all improvement actions in 2016 (recommendations from the 'Independent Verification Visit' in 2015) and subsequently the internal audit management actions in 2016/17, the Trust is in line with good practice in similar organisations with respect to medical appraisals.

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

Dr Minoo Irani
Medical Director and Responsible Officer
July 2018

Appendix A – Statement of Compliance

Designated Body Statement of Compliance

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

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

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

   Comments: Dr Minoo Irani, Medical Director

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

   Comments: Revalidation administrator maintains an up to date list

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

   Comments: 28-30 trained appraisers for 128 doctors with prescribed connection is sufficient

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

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

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

   Comments: Medical appraisal rates monitored by RO (and Appraisal Leads). 2 delayed appraisals have been accounted for and both doctors have been notified of appraisal dates.

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1], which includes [but is not limited to] monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues, ensuring that information about these is provided for doctors to include at their appraisal;

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

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

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

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

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

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

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

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

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

Comments: Improvement actions arising from previously identified weaknesses have been implemented in 2016/17 and embedded into practice in 2017/18.

Signed on behalf of the designated body

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

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

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

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

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper

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

Trust Board Meeting 10 July 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. NHS Funding and Finances

Prime Minister, Theresa May has announced a new five-year funding settlement for the NHS, giving the service real-terms growth of more than 3% for the next five years. In a major speech announcing the decision, she also tasked the NHS with producing a 10-year Plan to improve performance, specifically on Cancer and Mental Health Care, and unpick barriers to progress.

The Prime Minister also confirmed that there would be no additional funding for Social Care until 2020 at the earliest.

The announcements come just a few weeks after the NHS Provider sector recorded a £1bn deficit for the last financial year according to figures from NHS Improvement.

Executive Lead: Julian Emms, Chief Executive

3. Integration and System Working

The Health and Social Care Committee published a new report on Integrated Care in mid-June which concluded that the case for change had not been explained clearly or persuasively. The report also added that further integration of services, and the organisations planning and delivering them, was too often hampered by current legislation. A summary of the report produced by NHS Providers is provided as an appendix to the Executive Report.

Executive Lead: Julian Emms, Chief Executive

4. 2018-19 Operational Plan Feedback

The Trust received feedback from NHS Improvement on our 2018/19 Operating Plan refresh (second year of the existing two year plan).

The Plan refresh covered submission of Finance and Workforce templates, with System Operating Plan narrative submitted by each of our two Integrated Care Systems. The NHS Improvement feedback letter is attached as an appendix to the

Executive report. The feedback letter highlights two specific points. The following information should be noted by the Trust Board for assurance:

- **Planned Agency spend reduction of 41% (to £5.3m) versus 17/18 outturn of £8.9m.** The Trust will benefit full year from the transfer of Westcall agency GP expenditure to internal bank arrangements. This accounts for a significant element of the reduction in agency expenditure planned, with GP bank arrangements commencing in 2017/18. The £5.3m agency plan for 2018/19 is a stretching target, being well below the Trust's agency expenditure cap of £10.4m. Agency spend is running just ahead of plan at month 2.

- **41% of Cost Improvement Plans (CIPs) to be delivered in the final quarter of 18/19.** The CIP is phased in line with expected delivery, with the material phasing and delivery sensitivity on the reduction of mental health placement expenditure. Appropriate contingency has been set to offset delivery risk and CIP performance year to date is line with plan. If material risks are identified during the year alternative CIPs will be reviewed and brought on stream.

The NHS Improvement request to confirm details of the Trust's capacity underpinning the Operational Plan will be responded to during July 2018, once both our Integrated Care Systems have confirmed a shared view of the systems' Acute and Community capacity. We have made good progress on assessing Mental Health Bed Capacity requirements, and work is in progress to provide a similar view across the Berkshire West Integrated Care System for Physical Health Beds (Acute and Community). The capacity planning response to NHS Improvement will be shared with the Trust Board.

Executive Lead: **Alex Gild, Chief Financial Officer**

5. Trust Board agreement to 2018-19 System Control Totals for Frimley and Berkshire West Integrated Care Systems (ICSs)

Between meetings, due to national time pressure on ICSs, the Trust Board agreed with system partners (under "urgency rules"), to commit an element of the Trust's 2018/19 Provider Sustainability Funding (PSF) (£1m of £2.4m PSF available), at risk of performance against the system level financial plans of our two Integrated Care Systems.

The system risk element of PSF is payable to the Trust on system achievement of the aggregate of organisation financial control totals, as set by NHS Improvement and NHS England. The Trust is supporting the "full PSF" system control total option for the Frimley ICS (£0.7m PSF committed), and "partial PSF" system control total option for the Berkshire West ICS (£0.3m PSF committed).

Trust Board is asked to ratify the decision made between meetings.

Executive Lead: Alex Gild, Chief Financial Officer

6. Care Quality Commission Inspection

During June 2018, the Care Quality Commission (CQC) commenced their unannounced inspections prior to our Well-Led Inspection between 10–12 July 2018. The following services have been inspected:

- Crisis Resolution Home Treatment Team
- Older People's Mental Health Inpatient Wards
- Acute Adult Mental Health and Psychiatric Intensive Care Inpatient Wards
- Learning Disability Inpatient Unit
- Minor Injuries Unit
- Adult Community Services
- Children and Young People's Services
- Westcall is due to be inspected on 5 and 12 July 2018.

Feedback has been positive, with the CQC finding our staff welcoming and engaging. Following the completion of the Well Led Inspection, the CQC will publish the overall report within 65 days.

Executive Lead: Helen Mackenzie, Director of Nursing and Governance

7. Succession Planning Update

The Remuneration Committee reviewed the arrangements for Succession Planning regarding Executive Directors and their Direct Reports at their meeting in May 2018. The paper presented to the Remuneration Committee outlined the results of the Talent Review Board which took place in February 2018. Key points discussed were as follows:

- The Talent Review process identified individuals who would be capable of providing immediate cover, potential candidates for succession within 12 months and potential candidates for succession within 12-24 months.
- The Trust has a deep talent pool with most posts having identifiable individuals able to provide immediate cover, succession now and in 24 months. For some niche posts, it was more difficult to identify suitable internal candidates for succession.
- The Trust's Succession Planning process was also outlined to the Remuneration Committee, to provide assurance regarding the objectivity of the process, through an Independent Chair and criteria used for Talent Management. It was noted that Ernst and Young, who undertook the Trust's last independent Governance Review in 2015 concluded that the Trust had robust succession planning systems and processes in place.
- Succession planning would continue to feature at future Talent Review Board meetings which took place twice a year. The outcome of the Talent Review Board discussions was reported to the Trust Board on an annual basis.

The Remuneration Committee also discussed arrangements for appointments to Executive posts, and it was confirmed that the Trust's Chair was a part of all Board level appointments and that there was Board member involvement in appointments of staff on Very Senior Manager (VSM) contracts.

It was noted that in the recent recruitment of a Director of People, the Trust Chair and Naomi Coxwell, Non-Executive Director participated in the selection process in an advisory capacity. It was noted that Executive Directors were responsible for making the appointments to posts that were not at Board level and were non-VSM posts.

The effectiveness of our talent management process was considered by the Non-Executive members of the committee, and assurance was provided through the following:

- Our Trust compares favourably with other NHS organisations in our region which were still developing their procedures.
- Our appraisal documentation enables a career development conversation with all staff.
- The Chief Executive and Chairman confirmed the arrangements for immediate cover, which were supported by the "grand parent" review of the Executive Director appraisals undertaken by the Chairman as well as the existence of our strategy implementation plan which provides continuity.
- Work in progress to support a representative proportion of female staff and those from a black, Asian or minority ethnic background taking up senior posts.

It was agreed that a report on succession planning would continue to be provided to the Remuneration Committee on an annual basis, to provide assurance to the Trust Board about the resilience of our senior leadership functions.

Executive Lead: Bev Searle, Director of Corporate Affairs

8. Stakeholder Survey 2017-18

This survey was developed to help track progress against our Trust Vision metrics – to identify the views of our stakeholders about our organisation and its leadership. It was informed by the national survey undertaken by Clinical Commissioning Groups annually, and aimed to provide a short list of questions that can be responded to quickly, while covering key points relevant to our role as a service provider.
The survey recipients were senior leaders of local partner organisations who have been working with us for some time and therefore able to form a view based on evidence over the medium – longer term. Representatives of Acute Trusts, Commissioners, and Local Authorities were all included.

21 individuals were surveyed, with 13 responses – which represents a 62% response rate.

Summary of results

The percentage of responses in each category were as follows:

Very good	Fairly good	Neither good nor poor	Fairly poor	Very poor
49%	40%	11%	0	0

Responses and comments relating to individual questions

1. How satisfied are you with the way in which we have engaged with you over the last year?

Very satisfied	Fairly satisfied	Neither satisfied nor dissatisfied	Fairly dissatisfied	Very dissatisfied
31%	54%	15%	0	0

2. How would you rate your working relationship with us?

Very good	Fairly good	Neither good nor poor	Fairly poor	Very poor
54%	46%	0	0	0

3. Are there any comments you would like to make about overall engagement between us and local stakeholders?

Key themes in response to this question were the good engagement at senior level, with some areas for further development. Concern was expressed about the challenge presented by working across two Integrated Care Systems while managing service delivery.

4. How well, if at all, would you say we are working together with your organisation to develop long term strategies and plans?

Very well	Fairly well	Neither well nor poorly	Fairly poorly	Very poorly
39%	46%	15%	0	0

5. How effective do you feel we are as a local system leader?

Very effective	Fairly effective	Neither effective nor ineffective	Fairly ineffective	Very ineffective
62%	23%	15%	0	0

6. Do you agree that our leadership has the necessary blend of skills and experience?

Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree
23%	62%	15%	0	0

7. Are there any comments you would like to make about our leadership?
   Key themes in response to this question were the recognition of the strong contribution from senior leadership, with a smaller number of comments about variability at different levels of the organisation.

8. What is your level of confidence in our arrangements for monitoring quality and safety of services?

High	Moderate	Neither high nor low	Moderately low	Low
54%	38%	8%	0	0

9. If you had concerns about the quality of local services provided by Berkshire Healthcare, would you feel able to raise them with us?

Yes – 100%
No – 0%

10. What is your level of confidence that we will act on your feedback about the quality of our services?

High	Moderate	Neither high nor low	Moderately low	Low
77%	15%	8%	0	0

11. Are there any comments you would like to make about our service provision and planning? Key points in response to this question were the good relationships and ability to raise concerns/receive response, along with a solid approach to service planning and delivery.

Executive Lead: Bev Searle, Director of Corporate Affairs

Presented by: Julian Emms
Chief Executive
July 2018

on the day BRIEFING

NHS Providers

Health and Social Care Select Committee report Integrated care: organisations, partnerships and systems

The Health and Social Care Select Committee (the Committee) has published the report of its inquiry into 'the development of new integrated ways of planning and delivering local health and care services[1]. This timely inquiry focusses on the development of Sustainability and Transformation Partnerships (STPs), Integrated Care Systems (ICSs) and Accountable Care Organisations (ACOs). This briefing provides an overview of the Committee's key findings and recommendations.

Unusually, in addition to providing oral evidence to the inquiry, NHS England (NHSE) and NHS Improvement (NHSI) published a written submission to the Committee, which effectively summarises the shift in national policy focus from competition to collaboration.

Summary of key recommendations

- The Government and the NHS must improve how they communicate NHS reforms to the public, making the case for change in the health service, clearly and persuasively.
- The Department of Health and Social Care (DHSC) and national bodies should adopt an evolutionary, transparent and consultative approach to determining the future shape of health and care. The law would need to change to enable the structural integration of health and care.
- The national bodies should clearly define the outcomes they are seeking to achieve for patients by promoting more integrated care, and the criteria they will use to measure this.
- DHSC, NHS England (NHSE), NHS Improvement (NHSI), Health Education England (HEE), Public Health England (PHE) and Care Quality Commission (CQC), should develop a joint national transformation strategy setting out how they will support STPs and ICSs.
- STPs should be encouraged to adopt the principle of subsidiarity so that decisions are made at the most appropriate local level
- ACOs should be introduced in primary legislation as NHS bodies, if a decision is taken, following a careful evaluation of pilots, to extend their use. The national bodies must take proactive steps to dispel misleading assertions about the privatisation and Americanisation of the NHS including the publication of an annual assessment of private sector involvement in NHS care.

[1] P.4 of the Committee's report

- The greatest risks to accelerating progress are the lack of funding and workforce capacity to design and implement change. The Government must recognise the importance of adequate transformation and capital funding in enabling service change. The long-term funding settlement should include dedicated, ring-fenced funding for service transformation and prevention.

Integrated care

The Committee found that more integrated care will improve patient experience, particularly for those with long-term conditions. However while it may reduce demand on hospital services, the Committee concluded there is a lack of evidence that integration, at least in the short term, saves money.

The Committee recommends that:

- DHSC, NHSE and NHSI clearly define what outcomes should be delivered from integrating care, from the patient's perspective, and the criteria they will use to measure this.
- Government should confirm whether it will meet its target to achieve integrated health and care across the country by 2020, as well as plans for 50% of the country to be covered by new care models.

STPs and ICSs

Sustainability and transformation partnerships

The Committee highlights the challenges which local bodies have faced in coming together through STPs to make very difficult decisions about changes to local health and care services within a very tight timeline. These challenges have been exacerbated in those areas without a history of collaborative working. In many STPs, proposals were not supported by robust evidence of population need or workforce plans.

The national bodies' initial mismanagement of the process, including misguided instructions not to share plans, made it very difficult for local areas to explain the case for change. Poor consultation, communication and financial constraints have fuelled concerns that STPs were secret plans and a vehicle for cuts.

The practical issues arising from STP boundaries have significantly affected progress so far. STP footprints with a smaller population, a smaller number of partners, boundaries that align with patient flows between services and coterminous organisational boundaries between partners tend to be further ahead.

STPs have become the vehicle for delivering national priorities and targets, improving financial management across the system and managing demands, particularly on acute care, despite the governance and infrastructure being fragile and in development. However the STP dashboard has no indicators to measure integration or the progress local areas have made in transforming care, such as progress made against their STP plans.

The Committee recommends that:

- STPs, particularly those with more complex geographical boundaries, should be supported to allow local areas to identify, define and develop meaningful boundaries within their patch in which local services can work together around the needs of the population.
- STPs should be encouraged to adopt the principle of subsidiarity in which decisions are made at the most appropriate local level. NHSE and NHSI should set out in their planning guidance for 2019/20 advice and support to achieve these recommendations.
- Although STPs provide a useful forum through which local bodies can come together in difficult circumstances to manage finite resources, they are not, the sole solution to the funding and workforce pressures on the system. The national bodies must not overburden STPs by increasingly making them the default footprint for the delivery of national policies.

Integrated Care Systems

The Committee explored the achievements of the ICSs, and the challenges still facing them. The Committee recommends that:

- The national bodies, including the DHSC, NHSE, NHSI, HEE, PHE and CQC, develop a joint national transformation strategy setting out how national bodies will support STPs, at different stages of development, to progress to achieve integrated care system status. This strategy should:
  - set out how national bodies plan to support local areas to cultivate strong relationships;
  - strengthen the programme infrastructure of STPs;
  - consider whether, and how, support, resources and flexibilities currently available to ICSs could be rolled out to other help other areas;
  - develop a more sophisticated approach to assessing the performance of STPs and their readiness to progress to integrated care status. This should include an assessment of local community engagement, the strength of local relationships and the progress towards preventative and integrated care. An assessment of prevention should encompass a broader definition than preventing demands on hospitals and integration should focus on how to improve patients' experience and outcomes;
  - how they will judge whether an area is ready to be an ICS;
  - how they will support STP areas to become ICSs;
  - what they will do in areas that fail to meet the criteria or which will never meet the criteria;
  - how they will monitor the performance of existing ICS areas and provide support including the necessary funding to ensure they continue to make progress; and
  - how they will address serious performance problems in ICS areas.

Accountable Care Organisations (ACOs)

The Committee reviewed the arguments for and against ACOs. It concludes that, rather than leading to increasing privatisation and charges for healthcare, the consequence of the introduction of ACOs is more likely be less competition and a diminution of the internal market and private sector involvement.

Given the controversy surrounding their introduction in the NHS, the Committee recommends that:

- ACO models should be piloted before being rolled-out. There should be an incremental approach to the introduction of ACOs, with areas choosing to go down this route carefully evaluated.
- If a decision is made to introduce ACOs more widely, they should be established in primary legislation as NHS bodies. This will require a fundamental revisiting of the Health and Social Care Act 2012 and other legislation. These organisations should have the freedom to involve, and contract with, non-statutory bodies where that is in the best interests of patients.
- The national bodies take proactive steps to dispel misleading assertions about the privatisation and Americanisation of NHS. The DHSC should publish an annual assessment of the extent of private sector in the NHS, including the value, number and percentage of contracts awarded to NHS, private providers, charities, social enterprises and community interest companies.

The case for change

The Committee concludes that there has not been a sufficiently clear and compelling explanation of the direction of travel and the benefits of integration to patients and the public. It recommends that:

- The case for change must be made in a way that is meaningful to patients and local communities. The DHSC and national bodies should develop a narrative in collaboration with representatives of communities, NHS bodies, local government, national charities and patient groups and should explain how they plan to support efforts to engage and communicate with the public.
- NHSE and NHSI should make clear that they actively support local areas in communicating and co-designing service changes with local communities and elected representatives.

Funding and workforce pressures

The Committee believes that funding and workforce pressures on NHS, social care and public health services present significant risks to the ability of the NHS to maintain standards of care, let alone to transform. The NHS and local government have not been given adequate investment, support and time to embark on the scale of transformation envisaged.

The Committee recommends that:

- Government's long-term funding settlement should include dedicated, ring-fenced funding for service transformation and prevention.
- National and local bodies should develop an estimate of the transformation funding they require by looking at the experience of new care models and Greater Manchester. This should include an estimate of funding required in each area to provide staff with the capacity to engage in transformation, develop new skills and facilitate the double running of services.

Oversight and regulation

The Committee reports there is a widespread perception of competing priorities between the key national bodies, particularly the DHSC, NHE, NHSI and the CQC and concludes that incoherence in the approach of national bodies is a key factor holding back progress. The Committee therefore welcomes the recent

announcement from NHSE and NHSI on how they will work more collaboratively and align priorities and processes. The Committee did not hear clear evidence about how the arms-length bodies, particularly NHSE and NHSI, are seeking to accelerate the scale-up and spread of transformative changes to the delivery of care, such as the new models of care.

The Committee recommends that:

- CQC and NHSI conduct a joint survey in one years' time to assess whether these commitments have made a tangible difference to those on the frontline.
- NHSE and NHSI undertake a review of the first cohort of ICSs in April 2019, including the level of financial support underpinning transformation, and make the key findings available to all STP areas.

The Committee requests:

- A joint response from the DHSC, NHSE, NHSI, HEE and CQC setting out how their roles, responsibilities, functions and policies support the factors that are critical to transformation and integrated care including skills and capacity of frontline staff; NHS leadership; financial incentives; infrastructure; and coherent oversight and regulation.

Governance and legislation

The Committee has set out the main problems and challenges posed by the current legislation and views on legislative reform. It highlights that legal decision-making powers rest with the organisations involved rather than the STPs or ICSs. These constituent NHS and local government bodies have different legal duties and powers. For example, local councils are democratic institutions in their own right, and are unable to run a deficit, unlike NHS bodies.

The Committee is concerned that providers and commissioners are operating with significant risks to their governance and decision-making, as these arrangements increase the distance of decision-makers from the decisions they are taking. This approach is also time-consuming. The most limiting aspect of the existing framework are requirements covering CCGs' procurement of NHS services. There are also immediate legal obstacles that the Government and national bodies should seek to address to enable local areas to progress before primary legislation can be introduced, for example, differences in VAT exemptions covering NHS and local government.

- The Committee believes the law will need to change to enable greater collaboration and integration. The Department and NHSE should establish an advisory group, or groups, comprised of local leaders from across the country, including areas that are more advanced and those further behind, and representatives from the health and care community, to lead on and formulate legislative proposals to remove barriers to integrated care.
- Until legislation is introduced, national bodies should support local areas to develop transparent and effective governance arrangements that allow them to make progress within the current framework. National bodies should also provide greater clarity over what is permissible within current procurement law and develop support for local areas in working through these issues.

NHS Providers' view

The Committee's report offers a valuable insight into the challenges, opportunities and complexities, facing providers and their partners as they seek to integrate health and care services. This is all the more pertinent as the NHS approaches its 70th birthday with the promise of a new funding settlement and a ten year plan for delivery.

We were pleased to engage with the Committee as it shaped its inquiry (including suggesting a number of trusts and local areas they chose to visit) and we are pleased that the committee has reflected many of the concerns we raised both in our written submission and during the oral evidence session.

We need a clearer strategy to support the move to integrated care. But as the Committee highlights, there is a growing tendency to pin performance and financial obligations on STPs, even though they lack the mandate, the means and the legal authority to deliver them. We are concerned that providers are operating with significant risks to their governance and decision-making and are pleased that the Committee has recommended that the national bodies provide more support for local areas on governance frameworks that allow them to make progress within the current legislation.

Our recent regulation survey demonstrated that NHS trusts do not feel the current direction of travel is clear and that considerable duplication and fragmentation persists among the national bodies. We believe that the Committee's recommendation for the national bodies to develop a joint national transformation strategy could play an important part in giving providers and their local partners a clearer, enabling framework within which to lead transformation programmes locally.

Press statement

Saffron Cordery, Director of Policy and Strategy and Deputy Chief Executive said:

"This is a valuable and timely report which reflects many of the concerns we raised with the committee.

"It highlights the growing tendency to pin performance and financial obligations on STPs, even though they lack the mandate, the means and the legal authority to deliver them.

"The report also helpfully identifies the conditions and characteristics required for closer integration, while recognising that some areas have been able to move ahead much more quickly than others.

"We agree with the committee that much of the debate around accountable care organisations (ACOs) has been confused and misleading.

"We need a clearer strategy to support the move to integrated care.

"The forthcoming long term funding settlement presents a good opportunity to invest in transforming the NHS, adapting it to meet the changing needs of local communities."

Contact: Ella Jackson, Policy Advisor (Regulation) ella.jackson@nhsproviders.org

Anne Eden
Executive Regional Director
NHS Improvement
Skipton House, 3rd Floor
80 London Road
London SE1 6LH
Email: anne.eden1@nhs.net

Sent via email to:
Martin Earwicker,
Chairman
Berkshire Healthcare NHS Foundation Trust

7 June 2018

Dear Martin,

2018/19 Operational plan feedback

Thank you for the submission of your Board-approved operational plan for 2018/19. This letter follows NHS Improvement's review of that plan and highlights next steps.

It is critical that each trust meets the commitments in its annual plan to deliver safe, high-quality services and the agreed access standards for patients within the resources available. Our central commitment to delivering a strong provider landscape can only be achieved through your success and a robust set of plans, and wherever possible we will work to support you to deliver the ambitions set out in your plan.

We recognise that a significant amount of work has already been undertaken by your organisation in the development of your plan and our review has not highlighted any areas of significant concern. However, we have identified some areas which we would like the Board to consider as feedback on the plans in place for 18/19.

The areas highlighted as requiring further consideration:

Agency

Your trust had agency staff spend of £8.9m in 2017/18 and the submitted plan for 2018/19 indicates an agency spend of £5.3m which represents a planned reduction of 41%.

Finance

Delivery of your bottom line position is dependent on successful implementation of your quality impact assessed cost improvement plans (CIPs). The level of risk in your cost improvement programme is material, with 41% of the programme to be delivered in the final quarter of 2018/19.

Next Steps

We are not requiring your organisation to undertake a further plan submission, however should your trust wish to make any further amendments to the plan already submitted, NHS Improvement have put in place the facility for a further submission. The deadline for resubmission is 20 June and detail of the technical process for completing this will be sent to the trust's key planning contacts shortly. The revised plan will then be used in national reporting from month 3 onwards and NHS Improvement will use your Board approved plan to monitor and assess your trust's delivery during 18/19.

Please confirm with your relationship management team by 18 June if you wish to make a further plan submission.

In addition to the feedback outlined above there are concerns nationally about whether providers have sufficient capacity to deliver the plans which have been submitted to date. We expect every trust Board to ensure that appropriate demand and capacity planning has been undertaken by their organisation, the output of which provides assurance that sufficient capacity exists to deliver the plan submitted. We also expect that where bed closures are planned there are robust plans to reduce length of stay or alternative measures are in place to offset the capacity reduction. Across the country we are aware that a lack of community beds and packages of care are common reasons for delay in patients being discharged from acute trusts. In addition, a lack of capacity in Mental Health services is on occasion resulting in patients in crisis being cared for in an inappropriate acute hospital setting. Increasing numbers of 12 hour breaches declared by A&E departments relate to Mental Health patients awaiting access to Mental Health inpatient beds or other Mental Health services. We expect the plans your organisation has submitted to take into consideration the capacity necessary to ensure that patients requiring on going non-acute care is in place to support the length of stay reduction requirement.

We would be grateful if by separate return you could send confirmation to your relationship management team that appropriate demand and capacity planning has been completed by your trust, along with confirmation of the number of Community and Mental Health beds in place in your trust as at 31 March 2018 and planned in each quarter thereafter through 2018/19.

We expect this letter to be shared with your Board and would ask that as part of the move towards greater transparency and closer system working you consider sharing it with your ICS leadership.

If you wish to discuss the above or any related issues further, please contact me or your relationship management team.

Yours sincerely,

Anne Eden
Executive Regional Director
NHS Improvement

CC: Julian Emms, Chief Executive
Alex Gild, Chief Financial Officer
Elizabeth O'Mahony, Chief Financial Officer NHSI
Spencer Prosser, Regional Director of Finance (South) NHSI
Amanda Lyons, Delivery & Improvement Director NHSI

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	10 July 2018
Title	Financial Summary Report – M2 2018/19
Purpose	To provide the Month 2 2018/19 financial position to the Trust Board
Business Area	Finance
Author	Chief Financial Officer
Relevant Strategic Objectives	4. - Strategic Goal: To deliver services that are efficient and financially sustainable
CQC Registration/Patient Care Impacts	N/A
Resource Impacts	None
Legal Implications	Meeting regulatory requirements
Equalities and Diversity Implications	N/A
SUMMARY	The Financial Summary Report provides the Board with a summary of the M2 2018/19 financial position.
ACTION REQUIRED	The Trust Board is invited to note the following summary of financial performance and results for Month 2 2018/19 (May 2018): The Trust reports to NHS Improvement its 'Use of Resources' risk rating, which monitors risk monthly, 1 being the lowest risk rating possible and 4 the highest. **YTD (Use of Resource) metric:** • Overall rating 1 (plan 1) o Capital Service Cover rating 2 o Liquidity days rating 1 o I&E Margin rating 1 o I&E Variance rating 1 o Agency target rating 1

	YTD Income Statement (including PSF Funding): • Plan: £0.4m surplus • Actual: £0.7m surplus • Variance: £0.3m better than plan. **YTD Cash** £21.8m vs Plan £21.0m - £0.8m better than plan due to working capital timings. **YTD Capital expenditure:** £0.7m vs Plan £0.7m.

Berkshire Healthcare NHS
NHS Foundation Trust

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

Finance Report

Financial Year 2018/19

Month 2 (May 2018)

Purpose

To provide the Board and Executive with a summary of the Trusts financial performance as at 31st May 2018.

Document Control

Version	*Date*	*Author*	*Comments*
1.0	14.06.18	Tom Stacey	1st Draft
2.0	18.06.18	Paul Gray	2nd Draft
3.0	20.06.18	Paul Gray	Final

Distribution

All Directors

All staff needing to see this report.

Contents

1.0 Key Messages

Key Metric	Actual £'m	YTD Plan £'m	Variance £'m	vs Last Mth	vs Prior YTD
Surplus / (Deficit) for PSF	0.4	0.2	0.3	▲	▲
PSF - System	0.1	0.1	0.0		
PSF - Trust	0.1	0.1	0.0		
Control Total Surplus / (Deficit)	**0.7**	**0.4**	**0.3**	▲	▲
Statutory Surplus / (Deficit)	0.7	0.4	0.3	▲	▲
CIP Delivery	0.3	0.3	(0.0)	▲	▲
Agency Spend	1.1	0.9	0.2	▲	▼
OAPs - Specialist Placements (incl LD)	1.7	1.6	0.1	▲	▲
OAPs - Overspill Beds	0.4	0.3	0.1	▼	▼
Capital Expenditure	0.7	0.7	(0.0)	▲	▲
Cash	21.8	21.0	0.8	▲	▲

NHSI Compliance	Actual	Plan	
Capital Service Cover	**2**	**2**	
Liquidity	**1**	**1**	
I&E Margin %	**1**	**2**	▲
I&E Variance From Plan %	**1**	**1**	
Agency vs Target	**1**	**1**	
Use Of Resources Rating	***1***	***1***	

Key Messages & Actions

- The Trust delivered a £0.5m surplus in May; £0.3m over Control Total, bringing the YTD surplus to £0.7m; £0.3m over Control Total.
- Our overall staff costs are in line with the recruitment assumptions built into the plan.
- 'Spring to Green' had a positive impact on Overspill bed costs, reducing costs by £0.2m .
- Capital spend is on plan and Cash is £0.8m higher than planned due to working capital timings.
- Overall Use of Resources rating remains at a"1" overall.
- It is the intention to undertake an initial 18/19 forecast following the Q1 financial close.

Key Risks

- Following the 'Spring to Green' initiative, the number of patients placed out of area increased in early June and this is likely to have a detrimental financial impact.

2.0 Income & Expenditure

Income Statement	In Month			YTD			FY	Prior YTD		
	Act £'m	Plan £'m	Var £'m	Act £'m	Plan £'m	Var £'m	Plan £'m	Act £'m	Var +/-	%
Operating Income	18.9	19.0	(0.0)	37.9	38.0	(0.0)	227.2	37.8	0.2	0.4%
Other Income	1.7	1.6	0.1	3.3	3.1	0.1	18.6	3.1	0.2	6.3%
Total Income	***20.6***	***20.5***	***0.1***	***41.2***	***41.1***	***0.1***	***245.8***	***40.9***	***0.4***	***0.9%***
Staff In Post	12.8	12.9	(0.1)	25.4	25.8	(0.4)	154.6	25.2	0.2	0.9%
Bank Spend	1.0	1.0	(0.0)	2.2	2.1	0.1	12.3	2.0	0.2	10.7%
Agency Spend	0.5	0.4	0.1	1.1	0.9	0.2	5.3	1.4	(0.3)	(22.0)%
Total Pay	***14.4***	***14.4***	***(0.0)***	***28.7***	***28.8***	***(0.1)***	***172.2***	***28.6***	***0.1***	***0.5%***
Purchase of Healthcare	1.4	1.3	0.1	2.8	2.5	0.3	13.7	2.6	0.2	6.6%
Drugs	0.4	0.4	(0.0)	0.8	0.8	(0.0)	5.0	0.8	0.0	4.7%
Premises	1.2	1.2	0.0	2.4	2.4	0.1	14.3	2.6	(0.2)	(6.6)%
Other Non Pay	1.6	1.8	(0.2)	3.4	3.7	(0.4)	23.4	3.5	(0.2)	(5.4)%
PFI Lease	0.5	0.5	0.0	1.1	1.1	0.0	6.3	1.0	0.0	3.5%
Total Non Pay	***5.1***	***5.2***	***(0.2)***	***10.4***	***10.5***	***(0.0)***	***62.7***	***10.5***	***(0.1)***	***(1.1)%***
Total Operating Costs	***19.4***	***19.6***	***(0.2)***	***39.1***	***39.3***	***(0.1)***	***234.9***	***39.1***	***0.0***	***0.0%***
EBITDA	***1.2***	***0.9***	***0.3***	***2.1***	***1.8***	***0.3***	***10.9***	***1.7***	***0.3***	***19.5%***
Interest (Net)	0.3	0.3	(0.0)	0.6	0.6	(0.0)	3.6	0.6	(0.0)	(0.0)%
Impairments	0.0	0.0	(0.0)	0.0	0.0	(0.0)	0.0	0.0	(0.0)	
Disposals	0.0	0.0	(0.0)	0.0	0.0	(0.0)	0.0	0.0	(0.0)	
Depreciation	0.4	0.4	0.0	0.8	0.7	0.0	5.6	0.9	(0.2)	(17.1)%
PDC	0.2	0.2	(0.0)	0.3	0.3	(0.0)	1.6	0.2	0.1	35.3%
Total Finanacing	***0.8***	***0.8***	***(0.0)***	***1.6***	***1.6***	***(0.0)***	***10.9***	***1.7***	***(0.1)***	***(4.9)%***
Surplus/ (Deficit) for PSF	***0.4***	***0.1***	***0.3***	***0.4***	***0.2***	***0.3***	***(0.0)***	***0.0***	***0.4***	***1,628.1%***
PSF - Trust	***0.1***	***0.1***	***0.0***	***0.1***	***0.1***	***0.0***	***1.5***	***0.2***	***0.1***	***39.8%***
PSF - System	***0.0***	***0.0***	***0.0***	***0.1***	***0.1***	***0.0***	***1.0***			
Surplus/ (Deficit) for CT	***0.5***	***0.2***	***0.3***	***0.7***	***0.4***	***0.3***	***2.4***	***0.2***	***0.5***	***245.2%***
Donated Income	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	181.9%
Donated Depreciation	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.1)	(0.0)	(0.0)	14.5%
Surplus/ (Deficit) Statutory	***0.5***	***0.2***	***0.3***	***0.7***	***0.4***	***0.3***	***2.3***	***0.2***	***0.5***	***245.7%***

Key Messages

The Trust has delivered a £0.5m surplus taking our YTD surplus to £0.7m; £0.3m ahead of plan. This includes £0.2m of PSF funding.

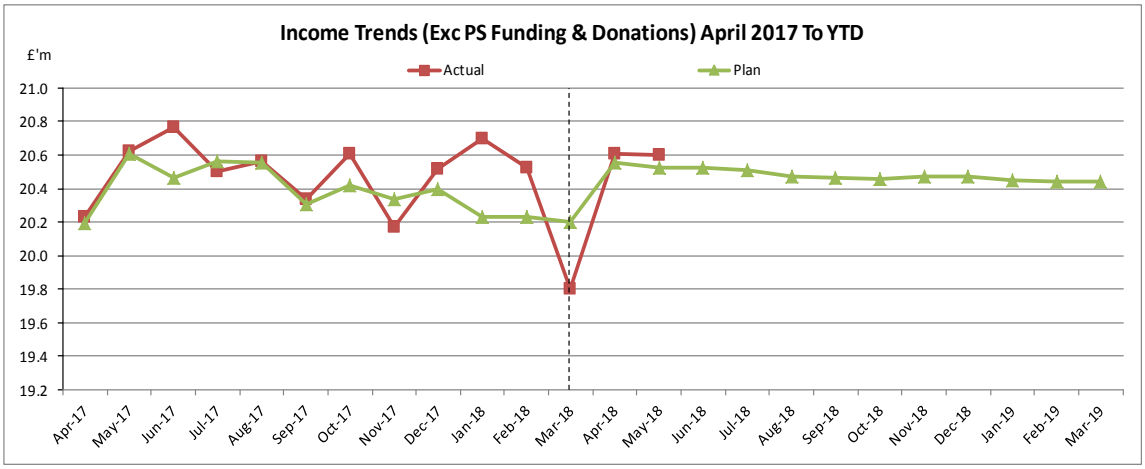
Overall our staff costs continue in line with the recruitment assumptions built into this years plan. Most areas remain within planning assumptions with the exception of IAPs where investment slippage and staff growth assumptions are adverse to plan. In addition, both CHRTT and WestCall continue to overspent by, £80k and £129k respectively, the latter of which includes identified bed management pressures which are subject to a live investment case.

The 1% pay ward is being accrued centrally. The financial impact of the recently agreed pay awards is not included, per guidance from NHSI, and we await confirmation on the timing and funding of the award.

Non Pay costs overall are to plan YTD, with higher OAPs costs being offset by other non pay underspends.

Income & Contracts

Income Statement	In Month			YTD			FY	Prior YTD		
	Act	Plan	Var	Act	Plan	Var	Plan	Act	Var	
	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	+/-	%
Block Income	16.5	16.5	0.0	33.1	33.1	0.0	198.2	32.4	0.7	2.2%
Tariff Income	0.3	0.3	0.0	0.5	0.5	(0.0)	3.1	0.5	(0.0)	(8.2)%
Pass Through Income	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Other Income	3.8	3.7	0.1	7.6	7.5	0.1	44.5	7.9	(0.3)	(3.9)%
Total Operating Income	***20.6***	***20.5***	***0.1***	***41.2***	***41.1***	***0.1***	***245.8***	***40.9***	***0.4***	***0.9%***
PSF - Trust	0.1	0.1	0.0	0.1	0.1	0.0	1.5	0.2	0.1	39.8%
PSF - System	0.0	0.0	0.0	0.1	0.1	0.0	1.0			
Donated Income	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	181.9%
Total Reportable Income	***20.7***	***20.6***	***0.1***	***41.5***	***41.3***	***0.2***	***248.2***	***41.0***	***0.4***	***1.1%***



Income

YTD	£'m
2018/19	41.2
2017/18	40.9
▲	*1%*

Prior Yr	£'m
May-18	20.6
May-17	20.6
▼	*1%*

Key Messages

Income was £0.1m better than planned YTD, with the most material benefit being additional CAMHs funding of £59k. To note this extra income is offset by pay costs within the service.

The Audiology AQP risk flagged in April has been forecast at £0.2m this year. The contract is likely to be the subject of a re-tender in the coming months, however in the interim, the service is focusing on initiatives which increase activity within their existing capacity.

YTD we have accrued both Trust and System PSF to plan.

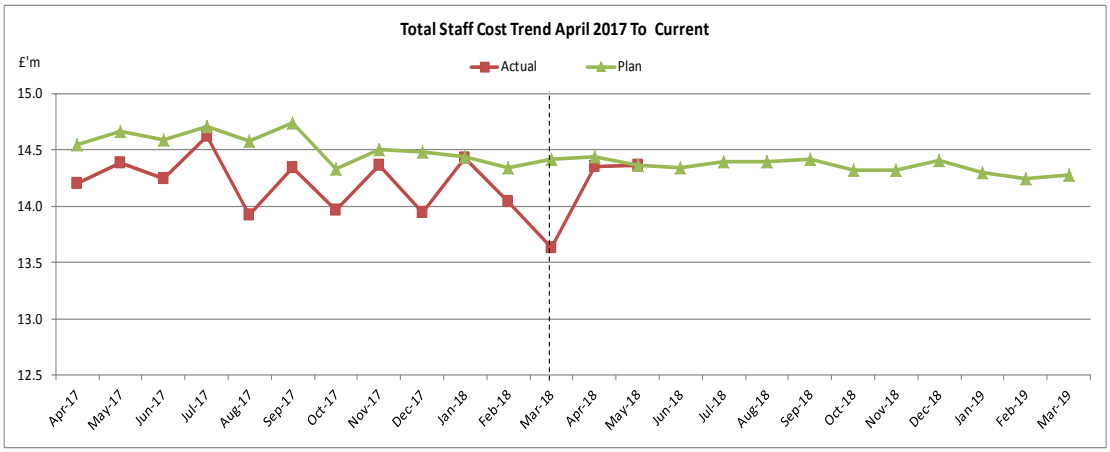
Commissioner Focus

The contracts for 18/19 are agreed with only a few minor contractual amendments remaining to be resolved. We are preparing for the first quarterly review with commissioners which will resolve the outstanding issues.

System Focus

Guidance was issues by NHSI in May outlining the options available to individual organisations as to the level of PSF funding to be allocated at an ICS level. The payment of this funding would therefore rely on the ICS hitting its collective control total. Following discussion, and with the agreement of the Board, it has been agreed that Trust will allocate £1.0m of its £2.4m PSF as system PSF. Our reporting has been adjusted accordingly to split the elements and processes are to be agreed across the ICS to report early divergence.

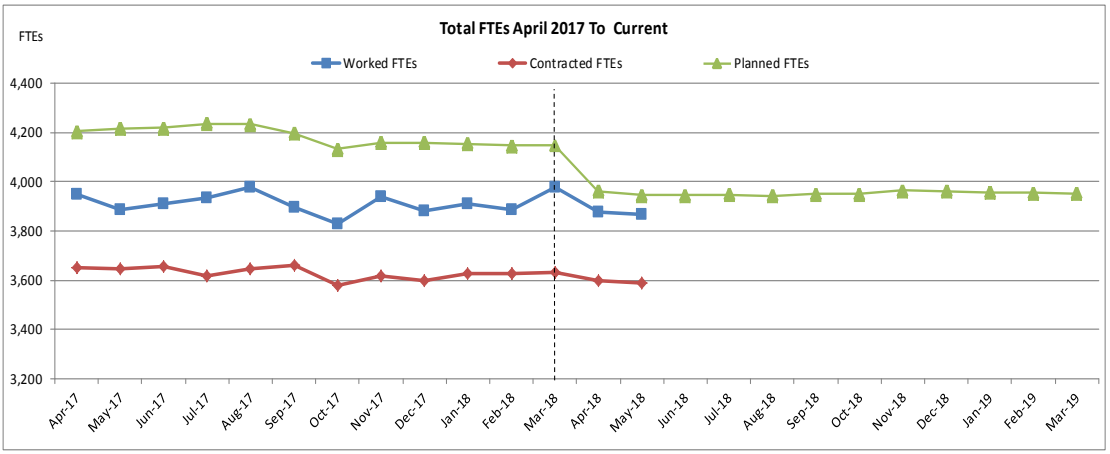
Workforce



Staff Costs

YTD	£'m
2018/19	28.7
2017/18	28.6
▲	0%

Prior Yr	£'m
May-18	14.4
May-17	14.4
▼	0%



FTEs

Prior Yr	CFTE	WFTE
May-18	3,590	3,867
May-17	3,644	3,886
	2% ▼	0% ▼

Prior Mth	CFTE	WFTE
May-18	3,590	3,867
Apr-18	3,598	3,876
	0% ▼	0% ▼

Key Messages

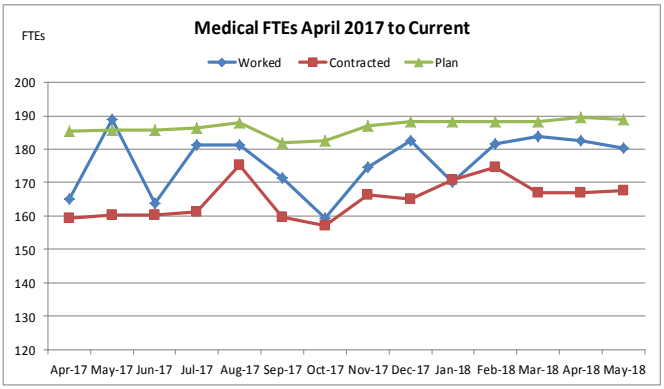
Pay costs were marginally below plan overall, with costs tracking in line with last year.

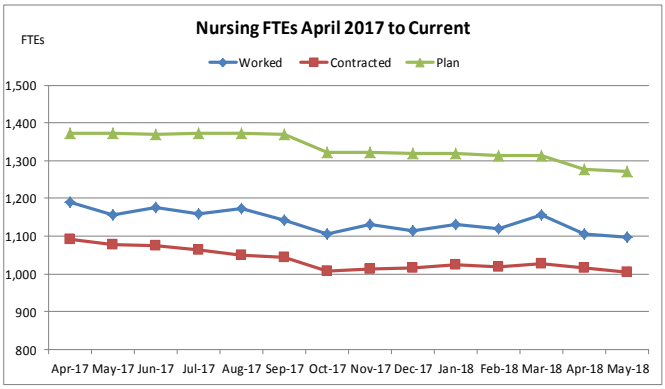
The YTD position includes a central accrual for the 1.0% pay award only. We are currently awaiting confirmation of when the recently agreed pay award will be paid, but we believe every effort is being made to ensure it is enacted into staff pay in July. Equally we have not received any guidance from NHSI on the calculation or process for funding the award at a Trust level. The question has been asked of NHSI and we await their response.

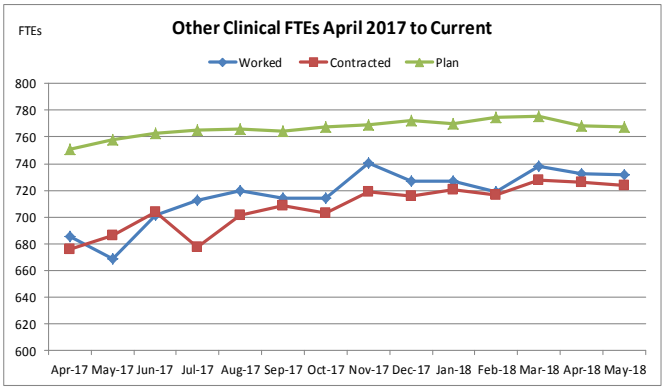
Although underspend overall, WestCall and CRHTT are over spent by £80k and £129k respectively. As part of the Service Reviews, clarity has been provided to the overspend within CRHTT, to include a financial pressure resulting from unbudgeted bed management costs, FY £0.3m. This is now the subject of a live investment case, which if approved will reduce the level of savings being targeted within CRTHH, with the result being £0.3m of savings to be identified from elsewhere.

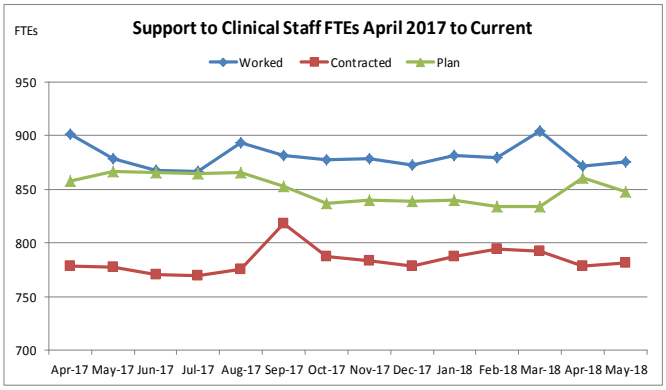
Whilst the worked FTEs continue below plan, pay costs are to plan, indicating a premium paid on agency in particular.

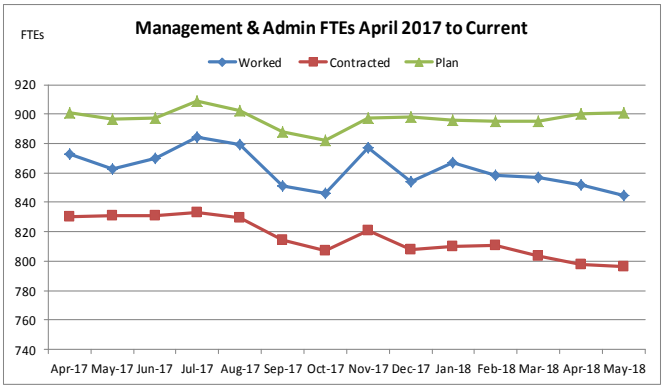
Workforce: Staff Groups

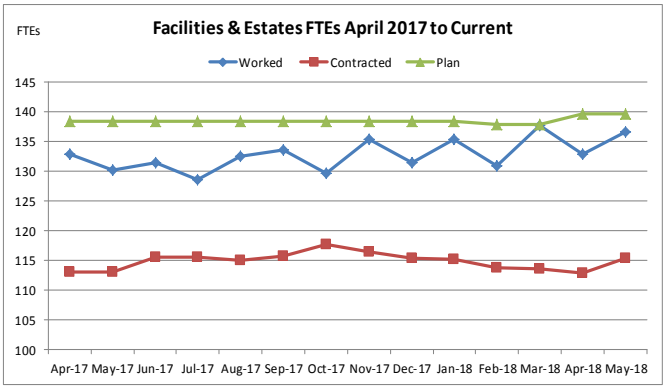












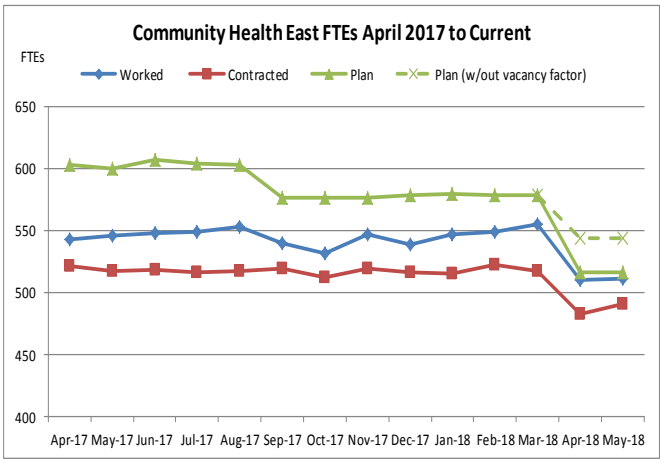
Key Messages

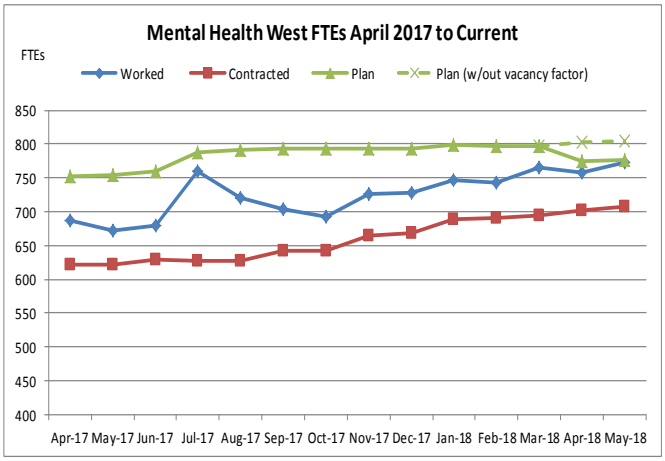
The charts reflect the Trusts major staffing groups as reflected in the finance system. Both the Nursing and Other Clinical charts portray qualified staffing numbers, with their unqualified support staff being reflected in the Support to Clinical Staff chart. The FTE numbers reflect payroll data, with the Worked FTE line also including additional Bank and Agency usage. The plan line is net of savings and recruitment assumptions.

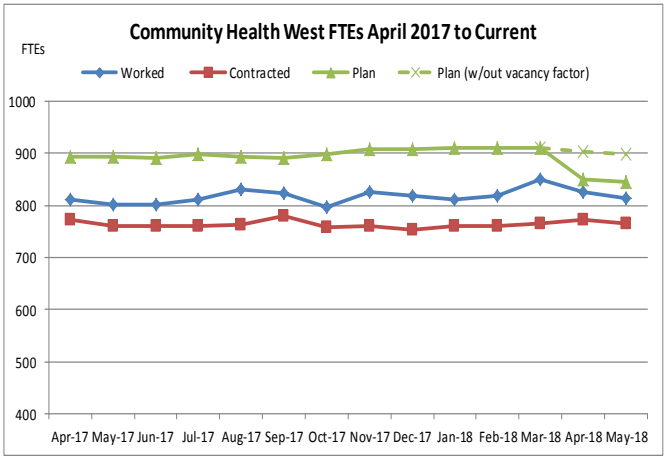
The charts clearly indicate that, excluding our recruitment control assumptions, all staffing groups are operating below established levels, with the exception of Clinical Support staff, who are ahead of plan, in some instances due to over recruitment to offset qualified vacancies.

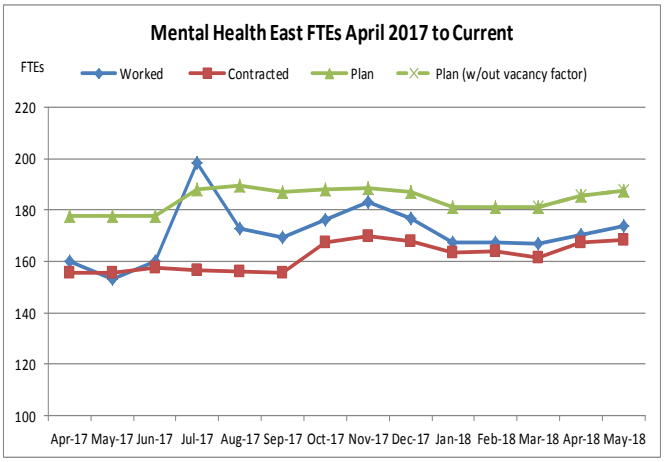
The staffing increase seen within the Other Clinical staffing group reflect the an increase of 47 over the period Apr 17 to May 18 and is largely due to investment in Talking Therapies, which accounts for 39 FTE of the overall increase.

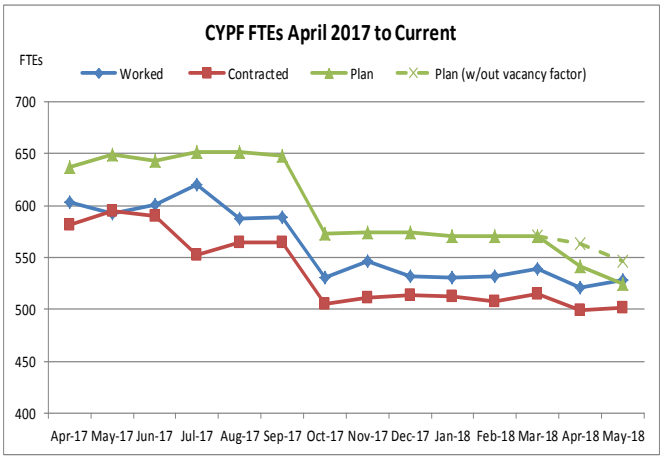
Workforce: Divisional

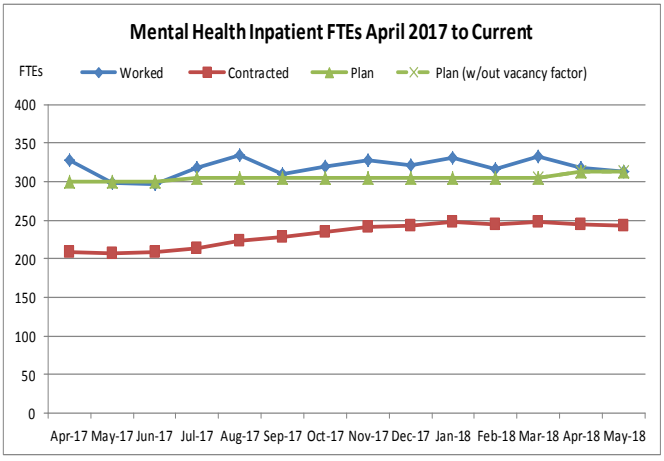


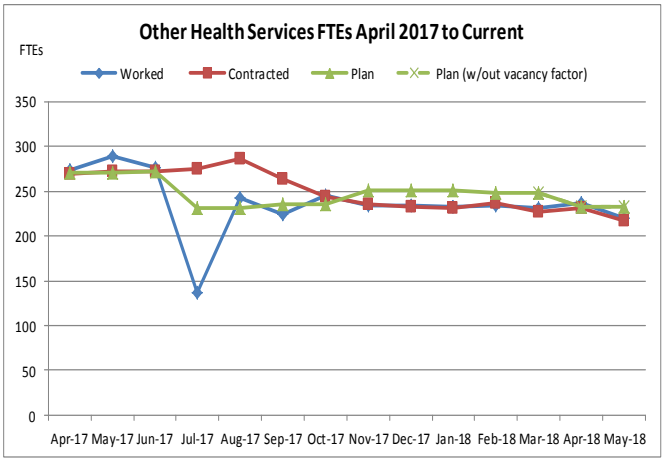


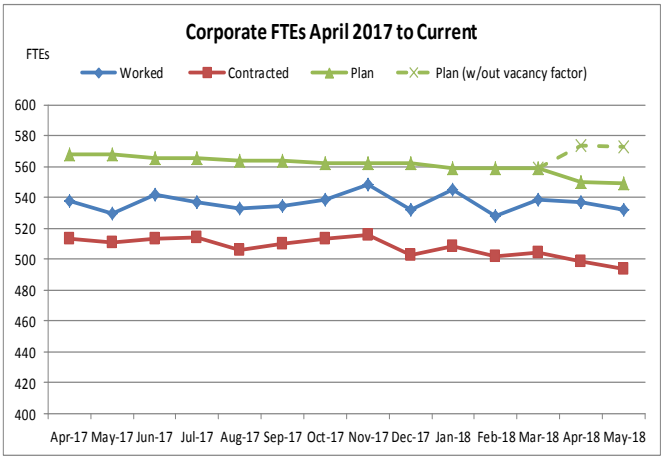




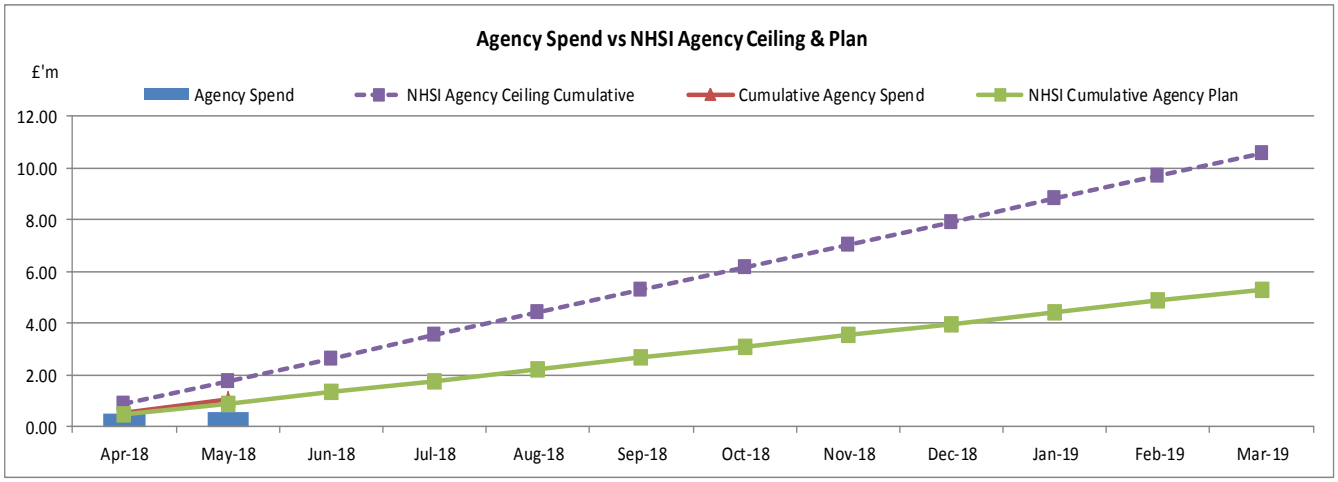


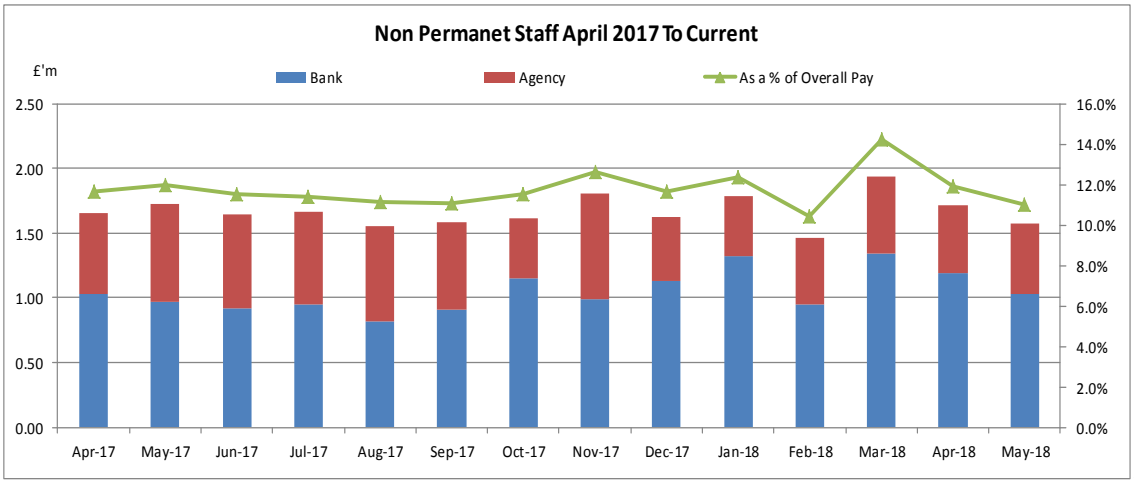






Non Permanent Pay

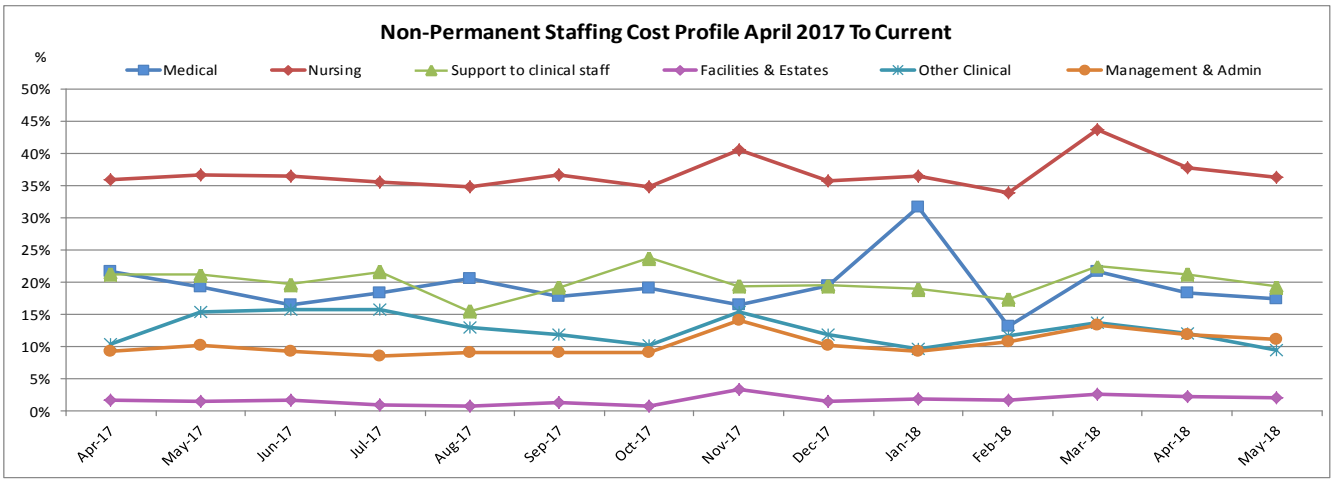




Non Permanent Pay

Prior Yr	Bank	Agency
May-18	1.0	0.5
May-17	1.0	0.7
	5% ▲	-36% ▼

Prior Mth	Bank	Agency
May-18	1.0	0.5
Apr-18	1.2	0.5
	-15% ▼	4% ▲



Key Messages

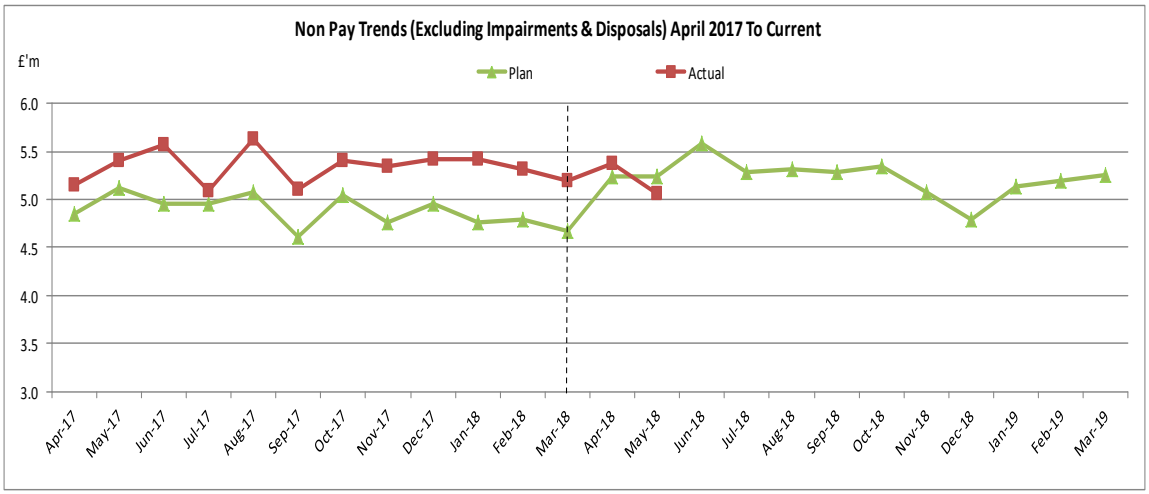
Non permanent staffing spend in May was £1.5m, £0.2m lower than in April, driven by lower Bank costs. The most notable single reductions was within WestCall, an element attributable to non recurrent bank holiday payments.

YTD overall Non Permanent staffing spend has risen to £3.3m.

Agency cost have risen to £1.1m YTD but these remain well below our YTD NHSI Agency Ceiling of £1.8m.

Non Pay Expenditure

Non Pay	In Month			YTD			FY	Prior YTD		
	Act	Plan	Var	Act	Plan	Var	Plan	Act	Var	
	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	+/-	%
Purchase of Healthcare	1.4	1.3	0.1	2.8	2.5	0.3	13.7	2.6	0.2	6.6%
Drugs	0.4	0.4	(0.0)	0.8	0.8	(0.0)	5.0	0.8	0.0	4.7%
Premises	1.2	1.2	0.0	2.4	2.4	0.1	14.3	2.6	(0.2)	(6.6)%
Supplies and services – clinical	0.4	0.4	(0.1)	0.8	0.9	(0.1)	5.2	0.8	0.0	0.1%
Transport	0.3	0.3	(0.1)	0.5	0.7	(0.1)	3.9	0.5	0.1	12.6%
Establishment	0.3	0.3	0.0	0.6	0.5	0.1	3.1	0.8	(0.2)	(23.8)%
Other Non Pay	0.7	0.8	(0.1)	1.4	1.7	(0.3)	11.2	1.5	(0.1)	(3.9)%
PFI Lease	0.5	0.5	0.0	1.1	1.1	0.0	6.3	1.0	0.0	3.5%
Total Non Pay	**5.1**	**5.2**	**(0.2)**	**10.4**	**10.5**	**(0.0)**	**62.7**	**10.5**	**(0.1)**	**(1.1)%**



Non Pay

YTD	£'m
2018/19	10.4
2017/18	10.5
▼	***-1%***

Prior Yr	£'m
May-18	5.1
May-17	5.4
▼	***-6%***

Key Messages

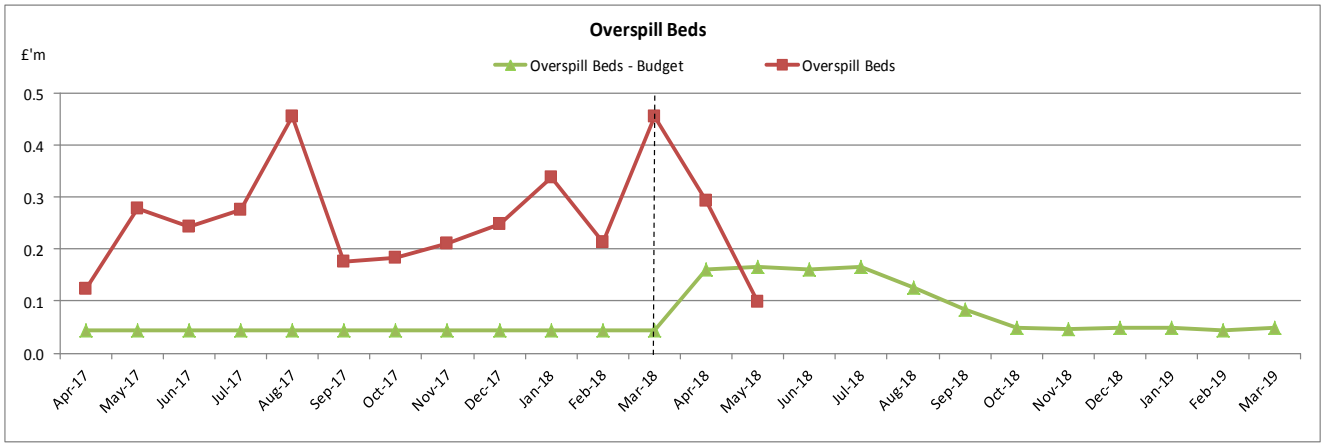
Non Pay expenditure fell by £0.2m in May, taking YTD expenditure in line with plan.

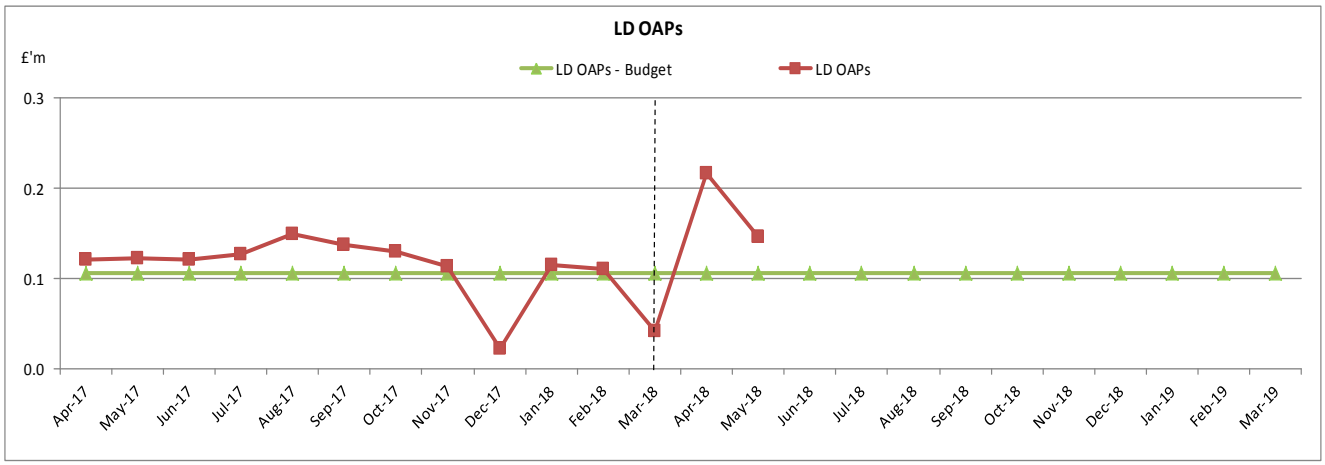
The two areas of financial overspend highlight last month have both seen improvement. As indicated, the success of the 'Spring to Green' initiative has reduced OAPs expenditure in May, with costs reducing by £0.2m. Whilst this is encouraging, the number of patients in OAPs increased in early June, and it is likely that costs will be higher. The delivery of our OAPs target remains key to the delivery of this years financial plan.

It should also be noted that even with the reduction seen in May, OAPs spend remains higher than planned with LD OAPs and Specialist Placements both £0.1m overspent. At present this overspend is being offset by our inflation contingency.

Estates spend, which tracked higher than plan over the latter months of last financial year and into April, fell in May and was contained within budget.

Non Pay Expenditure - Focus on OAPs





Key Messages

Overspill beds spend in May was £0.2m lower at £98k following the success of the 'Spring to Green' initiative.

Specialist Placements spend remains in line with run rate, with a small increase seen in month.

LD OAP costs was fell, but remains higher than planned, driven by 1 patient being accommodated higher than planned.

3.0 Divisional Summary

Income Statement	In Month Act £'m	In Month Plan £'m	In Month Var £'m	YTD Act £'m	YTD Plan £'m	YTD Var £'m	FY Plan £'m	Prior YTD Act £'m	Prior YTD +/-	Prior YTD Var %
Community Health West										
Income	0.4	0.5	(0.0)	0.9	0.9	(0.0)	5.5	0.6	0.2	34.4%
Pay	2.8	2.8	(0.0)	5.7	5.8	(0.1)	34.3	5.6	0.1	1.9%
Non Pay	0.5	0.5	(0.0)	0.9	0.9	(0.1)	5.6	0.9	(0.0)	(3.3%)
Net Cost	***2.8***	***2.9***	***(0.0)***	***5.7***	***5.8***	***(0.1)***	***34.4***	***5.9***	***(0.1)***	***(2.5%)***
Mental Health West										
Income	0.2	0.3	(0.0)	0.5	0.5	(0.0)	3.0	0.4	0.1	23.3%
Pay	2.7	2.7	0.1	5.4	5.3	0.1	32.7	5.0	0.4	8.6%
Non Pay	0.6	0.5	0.1	1.3	1.0	0.3	5.1	1.1	0.2	15.6%
Net Cost	***3.1***	***2.9***	***0.2***	***6.2***	***5.8***	***0.5***	***34.8***	***5.7***	***0.5***	***8.9%***
Community Health East										
Income	0.2	0.3	(0.0)	0.5	0.5	(0.0)	3.2	1.1	(0.6)	(51.6)%
Pay	1.7	1.7	0.0	3.5	3.5	0.0	20.8	3.8	(0.3)	(8.6%)
Non Pay	0.5	0.6	(0.1)	1.1	1.2	(0.1)	7.0	1.1	(0.0)	(1.4%)
Net Cost	***2.0***	***2.0***	***(0.1)***	***4.0***	***4.1***	***(0.1)***	***24.6***	***3.8***	***0.2***	***6.1%***
Mental Health East										
Income	0.2	0.1	0.0	0.3	0.2	0.1	1.4	0.3	0.0	17.3%
Pay	0.6	0.7	(0.0)	1.2	1.3	(0.1)	7.8	1.2	0.1	8.3%
Non Pay	0.8	0.8	(0.0)	1.6	1.7	(0.0)	9.5	1.6	0.0	0.5%
Net Cost	***1.3***	***1.4***	***(0.1)***	***2.6***	***2.7***	***(0.2)***	***16.0***	***2.5***	***0.1***	***2.2%***
CYPF										
Income	0.3	0.2	0.0	0.5	0.5	0.1	2.7	0.5	0.0	0.2%
Pay	1.8	1.8	(0.0)	3.6	3.7	(0.1)	21.7	4.2	(0.5)	(13.0%)
Non Pay	0.2	0.1	0.0	0.3	0.3	0.0	1.6	0.3	(0.0)	(10.9%)
Net Cost	***1.7***	***1.7***	***0.0***	***3.4***	***3.5***	***(0.1)***	***20.7***	***4.0***	***(0.6)***	***(14.5%)***
Mental Health Inpatients										
Income	0.0	0.0	(0.0)	0.0	0.0	(0.0)	0.0	0.0	(0.0)	(41.1)%
Pay	0.9	0.9	0.0	1.8	1.8	0.0	10.7	1.8	0.0	0.5%
Non Pay	0.1	0.1	(0.0)	0.2	0.2	(0.0)	1.1	0.2	(0.0)	(13.3%)
Net Cost	***1.0***	***1.0***	***(0.0)***	***2.0***	***2.0***	***0.0***	***11.8***	***2.0***	***(0.0)***	***(0.8%)***
Other Health Services										
Income	0.4	0.3	0.1	0.7	0.6	0.1	3.8	0.7	0.1	9.9%
Pay	1.4	1.4	(0.0)	2.8	2.9	(0.0)	17.1	3.0	(0.2)	(6.0%)
Non Pay	0.2	0.2	0.0	0.4	0.3	0.0	2.0	0.3	0.0	12.7%
Net Cost	***1.2***	***1.3***	***(0.1)***	***2.4***	***2.5***	***(0.1)***	***15.3***	***2.7***	***(0.2)***	***(7.8%)***
Corporate										
Income	1.1	1.1	0.0	2.3	2.2	0.1	13.2	2.4	(0.1)	(4.1)%
Pay	2.3	2.3	(0.0)	4.5	4.6	(0.1)	27.0	4.0	0.6	14.3%
Non Pay	2.3	2.4	(0.2)	4.8	4.9	(0.2)	30.8	4.8	(0.1)	(1.6%)
Net Cost	***3.4***	***3.6***	***(0.2)***	***7.0***	***7.4***	***(0.3)***	***44.6***	***6.5***	***0.6***	***9.1%***
Corporate Income & Financing										
Income	17.9	17.9	(0.0)	35.7	35.8	(0.1)	215.4	35.1	0.7	1.9%
Financing	0.8	0.8	(0.0)	1.6	1.6	(0.0)	11.0	1.7	(0.1)	(4.9%)
Surplus/ (Deficit) Statutory	***0.5***	***0.2***	**0.3**	***0.7***	***0.4***	**0.3**	***2.3***	***0.4***	**0.3**	**84.9%**

Key Messages

All localities are to plan at the end of May with the exception of Mental Health West.

The Mental Health West overspent is due to a combination of Overspill Beds, £67k, CRHTT £128k and LD OAPs £158k, costs all being higher than planned. All of these are ongoing pressures being addressed through our Cost Improvement Programme.

Corporate Non Pay costs fell in month, with spend in Estates being contained within plan.

4.0 Cost Improvement Programme

The table below illustrates current performance of the Trusts Cost Improvement Programme.

Scheme	In Month			YTD			Full Year		
	Act £'m	Plan £'m	Var £'m	Act £'m	Plan £'m	Var £'m	Forecast £'m	Plan £'m	Var £'m
OAPS Project									
Specialist Placements	0.04	0.03	0.01	0.12	0.06	0.07	0.59	0.59	0.00
Overspill Beds	0.00	0.02	(0.02)	0.00	0.05	(0.05)	1.82	1.82	0.00
Total OAPS Saving	***0.04***	***0.05***	***(0.01)***	***0.12***	***0.11***	***0.02***	***2.40***	***2.40***	***0.00***
Service Line Review									
WestCall	0.00	0.00	0.00	0.00	0.00	0.00	0.50	0.50	0.00
CRHTT	(0.00)	0.00	(0.00)	0.00	0.00	0.00	0.50	0.50	0.00
Total Service Line Savings	***(0.00)***	***0.00***	***(0.00)***	***0.00***	***0.00***	***0.00***	***1.00***	***1.00***	***0.00***
Procurement									
NHSP Contract	0.02	0.02	0.00	0.03	0.03	0.00	0.18	0.18	0.00
Procurement Spend	0.00	0.03	(0.02)	0.00	0.05	(0.05)	0.30	0.30	0.00
Total Procurement Savings	***0.02***	***0.04***	***(0.02)***	***0.03***	***0.08***	***(0.05)***	***0.48***	***0.48***	***0.00***
Other Schemes									
Community NCA	0.03	0.02	0.01	0.04	0.04	0.00	0.25	0.25	0.00
Liaison & Diversion Contract	0.02	0.02	0.00	0.04	0.04	0.00	0.25	0.25	0.00
Other Contracts	0.02	0.02	0.00	0.04	0.04	0.00	0.25	0.25	0.00
Scheme to be Identified	0.00	0.00	0.00	0.00	0.00	0.00	0.17	0.17	0.00
Total Other Savings	***0.07***	***0.06***	***0.01***	***0.12***	***0.12***	***0.00***	***0.92***	***0.92***	***0.00***
Total CIP Delivery	***0.13***	***0.16***	***(0.03)***	***0.28***	***0.31***	***(0.02)***	***4.80***	***4.80***	***0.00***

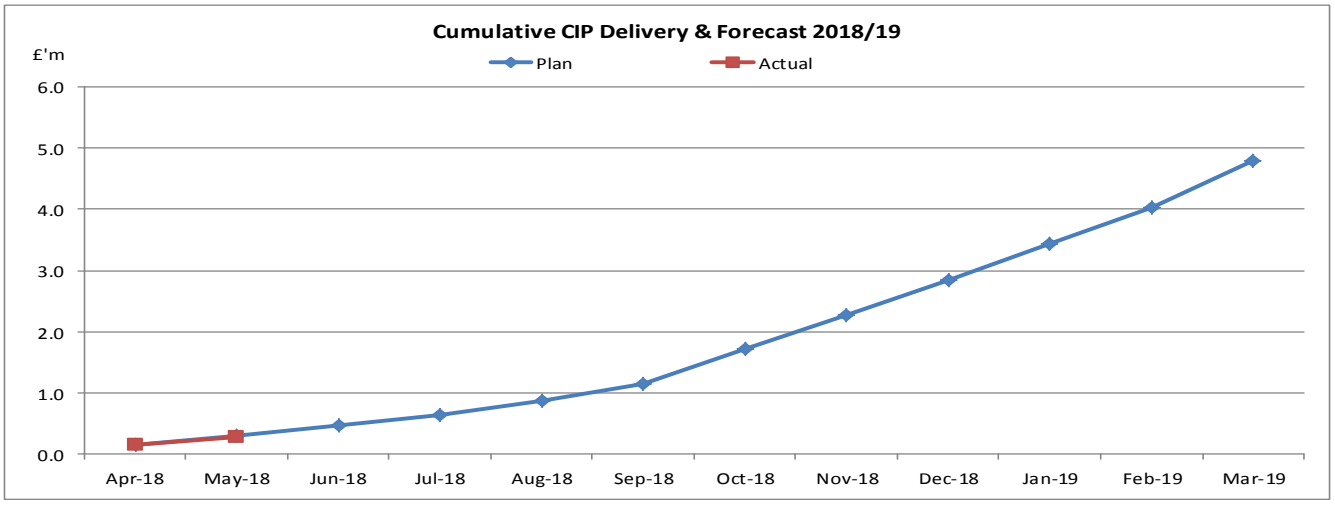
Key Messages

The Trust delivered a £0.28m of savings YTD against a plan of £0.31m, with Specialist Placements savings of £0.12m being achieved of particular note.

The recent 'Spring to Green' initiative has reduced overspend within Overspill Beds; although this needs to be maintained to deliver the CIP targets.

Neither WestCall or CRHTT have seen reductions in spend below last years levels and so no saving have been recorded from the initiatives.

Although not reflected in the actuals, Procurement have finalises the Enteral Feeding contract which will lower our costs by £142k full year and savings are also anticipated from our cleaning contract on the University of Reading site c£50k.



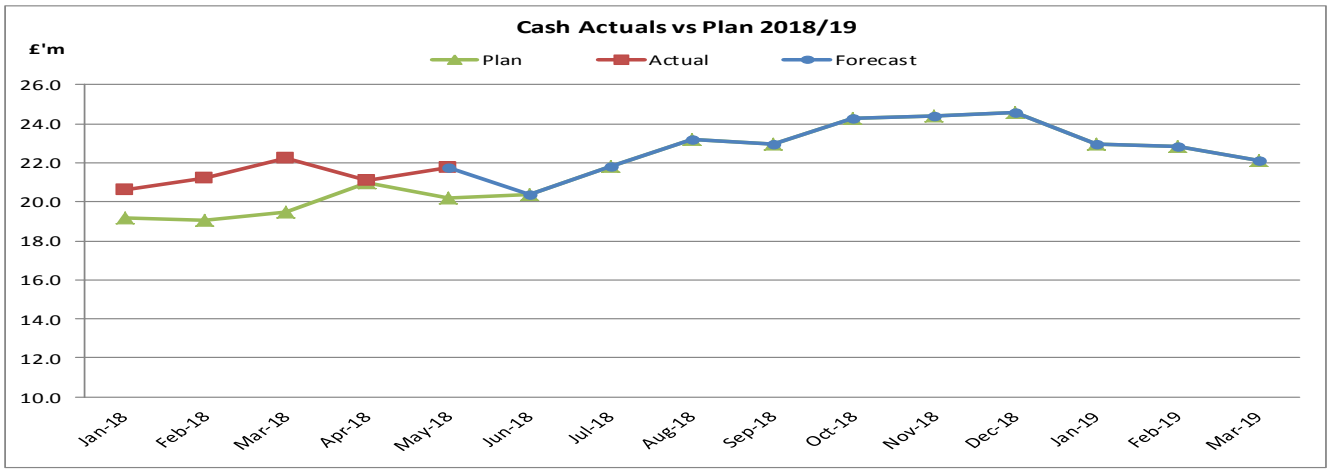
5.0 Balance Sheet & Cash

		17/18 Actual £'m	Current Month Act £'m	Current Month Plan £'m	Current Month Var £'m	YTD Act £'m	YTD Plan £'m	YTD Var £'m	18/19 Plan £'m
Intangibles		4.5	4.3	4.6	(0.2)	4.3	4.6	(0.2)	5.5
Property, Plant & Equipment (non PFI)		35.1	31.1	35.0	0.4	31.1	35.0	0.4	38.5
Property, Plant & Equipment (PFI)		55.6	59.7	55.5	(0.1)	59.7	55.5	(0.1)	55.6
Total Non Current Assets		**95.2**	**95.1**	**95.1**	***0.0***	**95.1**	**95.1**	***0.0***	**99.6**
Trade Receivables & Accruals		13.4	14.1	13.9	0.2	14.1	13.9	0.2	10.8
Other Receivables		0.3	0.7	1.3	(0.6)	0.7	1.3	(0.6)	1.3
Cash		22.3	21.8	21.0	0.8	21.8	21.0	0.8	22.1
Trade Payables & Accruals		(23.7)	(23.6)	(23.7)	0.0	(23.6)	(23.7)	0.0	(24.6)
Current PFI Finance Lease		(1.0)	(1.1)	(1.0)	(0.0)	(1.1)	(1.0)	(0.0)	(1.2)
Other Current Payables		(2.3)	(2.3)	(2.3)	0.0	(2.3)	(2.3)	0.0	(2.3)
Total Net Current Assets / (Liabilities)		**9.0**	**9.6**	**9.2**	***0.4***	**9.6**	**9.2**	***0.4***	**6.1**
Non Current PFI Finance Lease		(29.7)	(29.5)	(29.6)	0.1	(29.5)	(29.6)	0.1	(28.5)
Other Non Current Payables		(1.6)	(1.6)	(1.6)	0.0	(1.6)	(1.6)	0.0	(1.6)
Total Net Assets		***72.9***	***73.6***	***73.1***	***0.5***	***73.6***	***73.1***	***0.5***	***75.6***
Income & Expenditure Reserve		19.9	20.6	20.1	0.5	20.6	20.1	0.5	22.2
Public Dividend Capital Reserve		16.0	16.0	16.0	(0.0)	16.0	16.0	(0.0)	16.3
Revaluation Reserve		37.0	37.0	37.0	0.0	37.0	37.0	0.0	37.0
Total Taxpayers Equity		***72.9***	***73.6***	***73.1***	***0.5***	***73.6***	***73.1***	***0.5***	***75.6***

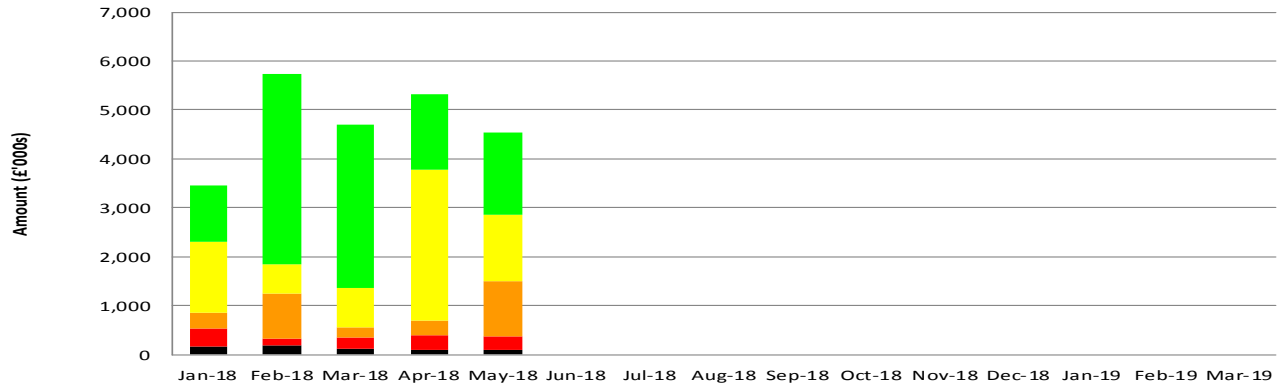
Cashflow									
Operating Surplus/(Deficit)	+/-	10.7	1.0	0.7	0.3	1.6	1.3	0.3	7.8
Depreciation and Impairments	+	5.4	0.4	0.4	0.0	0.8	0.7	0.0	5.7
Operating Cashflow		***16.1***	***1.3***	***1.0***	***0.3***	***2.3***	***2.0***	***0.3***	***13.4***
Net Working Capital Movements	***+/-***	***(2.1)***	***0.2***	***(1.1)***	***1.3***	***(2.1)***	***(3.6)***	***1.5***	***1.6***
Proceeds from Disposals	+	0.0	0.0	0.0	0.0	0.8	0.8	0.0	0.0
Donations to fund Capital Assets	+	1.7	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Donated Capital Assets	-	(1.7)	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Capital Expenditure (Net of Accruals)	-	(8.0)	(0.5)	(0.3)	(0.2)	(0.8)	(0.5)	(0.2)	(9.1)
Investments		***(10.2)***	***(0.5)***	***(0.3)***	***(0.2)***	***0.0***	***0.3***	***(0.2)***	***(7.5)***
PFI Finance Lease Repayment	-	(1.0)	(0.1)	(0.1)	0.0	(0.2)	(0.2)	0.0	(1.0)
Net Interest	+/-	(3.5)	(0.4)	(0.3)	(0.1)	(0.6)	(0.6)	0.0	(3.6)
PDC Revieved	+	1.8	0.0	0.0	0.0	0.0	0.0	0.0	0.3
PDC Dividends Paid	-	(1.6)	0.0	0.0	0.0	0.0	0.0	0.0	(1.7)
Financing Costs		***(4.3)***	***(0.5)***	***(0.4)***	***(0.1)***	***(0.8)***	***(0.8)***	***0.0***	***(6.1)***
Other Movements	+/-	0.0	0.2	0.0	0.2	0.0	0.0	0.0	0.0
Net Cash In/ (Out) Flow		***1.6***	***0.8***	***(0.8)***	***1.5***	***(0.5)***	***(2.1)***	***1.6***	***(0.3)***
Opening Cash		20.7	21.1	21.0	0.1	22.3	22.3	0.0	22.3
Closing Cash		***22.3***	***21.8***	***20.2***	***1.6***	***21.8***	***20.2***	***1.6***	***22.0***

Key Messages

The closing cash balance for May was above the plan by £1.6m. The main contributing factors were decrease in overall debtors, £0.6m, and a late payment of an NHSP invoice, £0.5m. The cash relating to the sale of Little House was received in April, following the recognition of the sale in our March accounts.



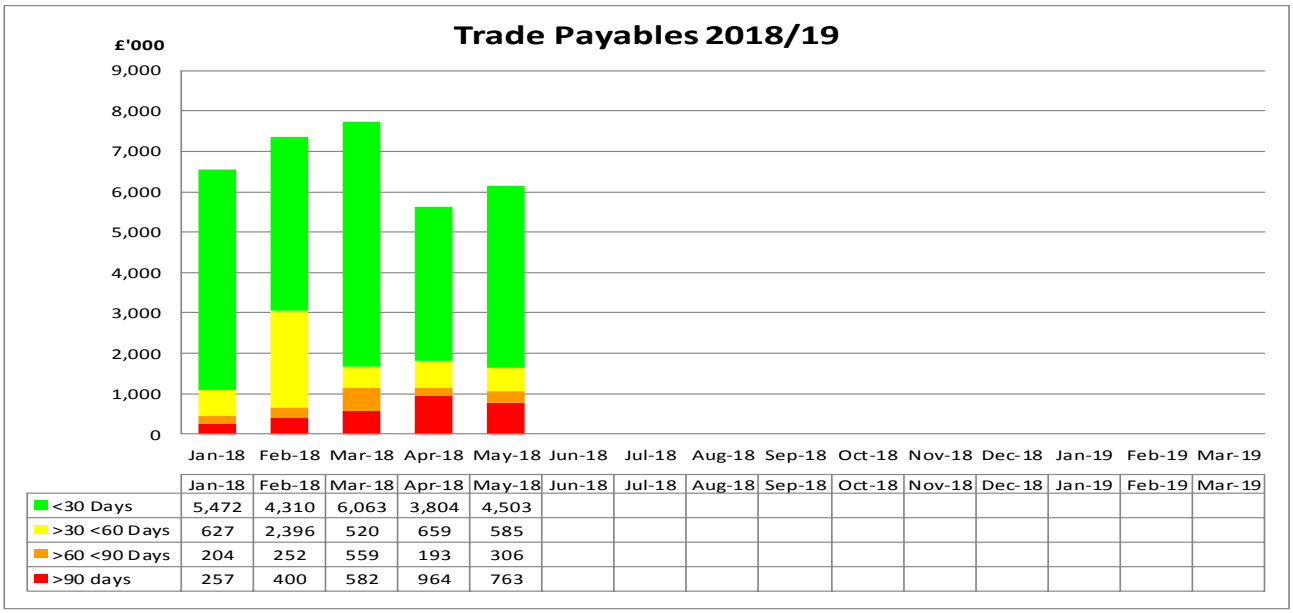
Cash Management



	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
<30 Days	1,155	3,890	3,353	1,547	1,697										
>30 <60 Days	1,452	586	806	3,080	1,351										
>60 <90 Days	337	941	196	313	1,141										
>90 < 180 Days	361	128	246	297	272										
>180 Days	161	188	110	94	88										

Key Message

Trade Receivables decreased overall by £0.8m. There was a notable increase in >60 <90 days debt, which was due to balances with Slough and Bracknell & Ascot CCGs. Payment has been received in June clearing a proportion of the debt, with action been taken to resolve the payment of the remaining balances by the end of June. We do not consider these to be at risk.



	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
<30 Days	5,472	4,310	6,063	3,804	4,503										
>30 <60 Days	627	2,396	520	659	585										
>60 <90 Days	204	252	559	193	306										
>90 days	257	400	582	964	763										

Key Message

Trade Payables increased by £0.5m, due to an increase in current balances relating to NHS Professionals in-voice, which was processed late due to changes in invoicing processes. There was a small increase in >60 <90 days offset by reduction in <30 <60 balances and balances over 90 days.

6.0 Capital Programme

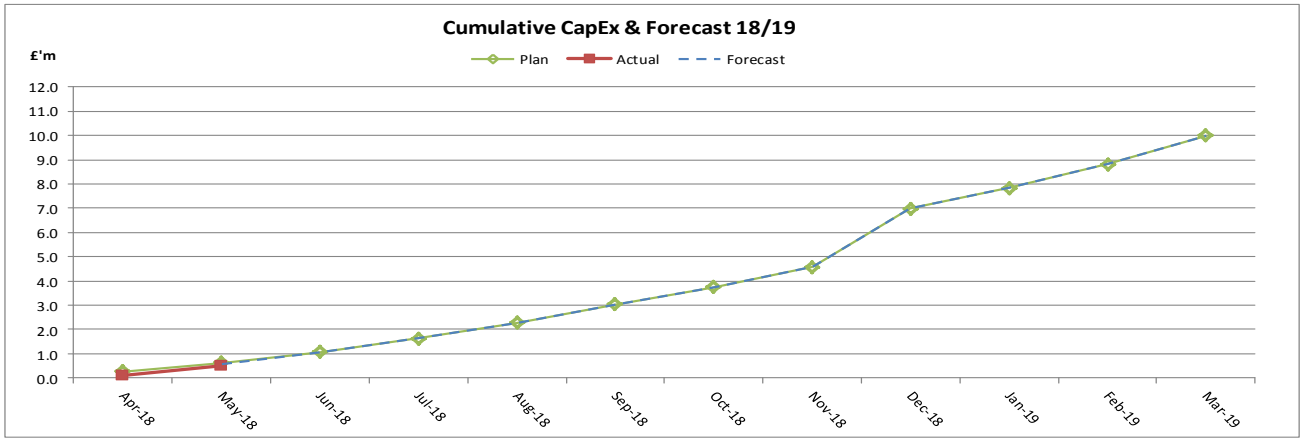
Schemes	Current Month Actual £'000	Current Month Plan £'000	Current Month Variance £'000	Year to Date Actual £'000	Year to Date Plan £'000	Year to Date Variance £'000	FY Plan £'000
Estates Maintenance & Replacement Expenditure							
Trust Owned Properties	2	8	(6)	2	31	(29)	755
Leased Non Commercial (NHSPS)	79	70	9	72	76	(4)	735
Leased Commercial	0	0	0	0	0	0	0
Statutory Compliance	24	1	23	25	6	19	448
Locality Consolidations	4	20	(16)	6	30	(24)	1,600
PFI	94	49	45	104	67	37	1,380
Subtotal Estates Maintenance & Replacement	**203**	**148**	**55**	**207**	**210**	**(3)**	**4,918**
IM&T Expenditure							
IM&T Refresh & Replacement	55	51	4	63	102	(39)	3,187
IM&T Business Intelligence and Reporting	(9)	15	(24)	2	30	(28)	130
IM&T System & Network Developments	0	0	0	0	0	0	0
IM&T Other	0	4	(4)	0	8	(8)	95
IM&T Locality Schemes	28	0	28	54	0	54	200
Subtotal IM&T Expenditure	**73**	**70**	**3**	**120**	**140**	**(20)**	**3,612**
GDE Expenditure							
GDE Trust Funded	73	27	46	19	55	(36)	1,985
GDE funded by NHS Digital	112	112	0	223	223	0	335
Subtotal GDE Expenditure	**185**	**139**	**46**	**242**	**278**	**(36)**	**2,320**
Other Locality Schemes	38	0	38	38	0	38	150
Subtotal Capital Expenditure	**500**	**357**	**143**	**607**	**628**	**(21)**	**11,000**
Assumed Slippage within NHSI Plan		0	0		0	0	(1,000)
Subtotal Capital Expenditure vs NHSI Plan	**500**	**357**	**143**	**607**	**628**	**(21)**	**10,000**
Donated Assets							
Renal Unit at WBCH	48	48	0	49	49	0	697
Subtotal Donated Assets	**48**	**48**	**0**	**49**	**49**	**0**	**697**
Total Capital Expenditure	**548**	**405**	**143**	**657**	**677**	**(21)**	**10,697**

Key Messages

The Trust has submitted a £10m annual capital plan to NHSI. This plan is fully funded by the Trust except for £0.4m GDE funding from NHS Digital, due to be received in July. The plan assumes that £1m of schemes planned to be completed in the year will slip, and this is articulated in the summary above. In addition to the £10m, we anticipate spending £0.7m of donated income to complete works on the Renal Unit at WBCH.

Spend in May was £0.2m above plan, mainly relating to Estate PFI projects and GDE programme capitalisation. The YTD spend is now broadly to plan.

The Trust has accepted £0.2m of capital funding from NHS Digital to extend Wifi coverage. This will be funded by PDC.



Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	10th July 2018
Title	**Summary Board Performance Report Month 2 2018/19 (31st May 2018)**
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	Relevant to all strategic objectives
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 May 2018. **Month 2** **2017/18 <u>EXCEPTIONS</u>** **The following Trust Performance Scorecard Summary indicator grouping is Red rated:** The "red" indicator grouping has been rated on a % rules basis for number of underperforming metrics; • Service Efficiency and Effectiveness – RED **The following Trust Performance Scorecard Summary indicator groupings are Amber rated:** • People • Contractual Performance Further detail on the AMBER dashboard ratings is narrated within the section commentaries of the summary performance report.

	The following individual performance indicators are highlighted by exception as RED with their link to the Trust Performance Dashboard Summary identified in brackets: • **US-01a -** Mental Health Physical Assaults on Staff **(User Safety)** • **US-02a -** Mental Health Physical Patient to Patient Assaults **(User Safety)** • **US-02b –** Learning Disability Patient to Patient Assaults **(User Safety)** • **US-05 -** Self-harm incidents: Number **(User Safety)** • **US-06 –** Absent without Leave (AWOLs) **(User Safety)** • **US-18** – Prevention and Management of Violence and Aggression (PMVA) **(User Safety)** • **PM-01** - Staff Turnover **(People)** • **PM-08** – Personal Development Plans / Appraisals **(People)** • **SE-03** - Mental Health: Acute Average LOS (bed days) **(Service Efficiency & Effectiveness)** • **SE-03a** - Mental Health: Acute Average LOS Snapshot **(Service Efficiency & Effectiveness)** • **SE-05 –** Community Health Services Occupancy Rate **(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-09 -** Crisis Plans for Clients on Care Programme Approach (CPA) (**Service Efficiency & Effectiveness)** • **SE-10** - Mental Health Clustering within target **(Service Efficiency & Effectiveness)** Further RED KPI performance detail and trend analysis is provided in the summary performance report.
ACTION	The Board is asked to note the above.

Board Summary Performance Report

Month 2: 2018/19 (31st May 2018)

Performance Scorecard Summary: Month 2 2018/19

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
SOF	SOF 01-05 & SOF 07-10	NHS Improvement (non-financial)	Green	No	N/A
	SOF-06	NHS Improvement (financial)	Green	No	N/A
SE	SE-01 to SE-11	Service Efficiency & Effectiveness	Red	No	No
CP	CP-01	Contractual Performance	Amber	No	Yes

Key :

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

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

The mapping rules to be applied to the performance scorecard categories are detailed below:
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 2018 - 2019; M2: May 2018:

- Mental Health 7 day follow up
- Mental Health newEarly Intervention in Psychosis (EIP) cases seen within 2 weeks
- DM01 Diagnostics for Audiology – percentage of those waiting 6 weeks or more
- Mental Health Services Data Set (MHSDS) Data Quality Maturity Index (DQMI)
- Accident & Emergency (A&E) maximum waiting time of 4 hours, Referral to Treatment (RTT) Incomplete Pathways, Improving Access to Psychological Therapies (IAPT) 6 Weeks and 18 weeks, reduction in Out of Area Placements (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.

Exception report

Summary of Red Exceptions M2: 2018/19			
Indicator	**Indicator No**	**Comments**	**Section**
Mental Health Physical Assaults on Staff	US 01a	Increased from 70 to 80	User Safety
Mental Health Physical Patient to Patient Assaults	US 02a	Increased from 50 to 52	User Safety
Learning Disability Patient to Patient Assaults	US 02b	Increased from 19 to 22	User Safety
Self-Harm incidents	US 05	Decreased from 381 to 377	User Safety
Absent Without Leave (AWOLs)	US 06	Increased from 20 to 27	User Safety
Prevention and Management of Violence and Aggression (PMVA)	US 18	Decreased from 110 to 45	User Safety
Staff Turnover	PM 01	Increased from 16.3% to 16.4%	People Management
Personal Development Plans/Appraisals	PM 08	Increased from 10.9% to 41%	People Management
Mental Health Acute Length of Stay	SE 03	Remained at 40 days	Service Efficiency
Mental Health Acute Snapshot Length of Stay	SE 03a	Reduced from 61 days to 52 days	Service Efficiency
Community Health Services Occupancy rate	SE 05	Reduced from 78% to 74%	Service Efficiency
Mental Health Acute Occupancy Rate (exc. Home Leave) by Ward	SE 06a	Decreased from 96% to 95%	Service Efficiency
Mental Health Acute Occupancy Rate (exc. Home Leave) by Locality	SE 06b	Decreased from 96% to 95%	Service Efficiency
New Birth Visits within 14 days	SE 08	Decreased from 93% to 92.2%	Service Efficiency
Crisis Plans for Clients on Care Programme Approach (CPA)	SE 09	Decreased from 87% to 86%	Service Efficiency
Mental Health Clustering within target	SE 10	Increased from 81.7% to 84.3%	Service Efficiency

User Safety Commentary

There were 7 serious incidents in May 2018. These were; 1 suspected suicide (West Berkshire CMHT), 1 allegation of inappropriate sexual behaviour by a member of staff at Willow House, 1 information governance breach relating to missing records (CAMHS), 1 unexpected death (Ascot ward), 1 deliberate self-harm (CAMHS), 1 fall with harm Windsor Ward, and 1 attempted suicide (Crisis).

The number of assaults on staff increased to 80 in the rolling quarter to May 2018 and is now red rated. In the rolling quarter, Mental Health Inpatients reported 50 incidents (43 last month), 17 incidents were reported on Sorrel ward (16 last month), 6 on Daisy ward (5 last month), 6 incidents on Bluebell ward (same as last month), 6 on Snowdrop ward (5 last month), 6 on Rowan ward (7 last month), 1 incident was reported on Rose ward (same as month) and none were reported on Orchid ward (1 last month). In addition, 3 incidents each took place at the Place of Safety and other or unknown location, the Royal Berkshire Hospital, and Prospect Park Hospital and 1 in the Hospital Grounds. In the rolling quarter, 25 incidents were reported at Willow House, CAMHS (24 last month). In the community there were 5 incidents reported, 4 for Mental Health West (1 each for Older Persons Mental Health, Early Intervention in Psychosis and Criminal Justice and Liaison service, 1 by Liaison services at Royal Berkshire Hospital) and 1 Slough CMHT. All incidents which occurred in May 2018 were rated as low or minor risk. This shows an increasing trend.

For Learning Disabilities there was an increase in the number of assaults on staff from 46 to April 2018 to 47 to May 2018. All incidents in May 2018 were rated as low or minor risk. This shows an increasing trend.

Patient to Patient Assaults has increased to 52 in the rolling quarter to May 2018 and remains red rated against a local target. There were 47 reported incidents in Mental Health Inpatients in the rolling quarter and these occurred as follows: 22 incidents took place on Sorrel ward (21 last month), 5 on Rowan ward (3 last month), 6 on Daisy ward (5 last month), 3 on Rose ward (1 last month), 2 on Bluebell ward (same as last month), 5 on Snowdrop ward (3 last month). 2 incidents were reported at Willow House in the rolling quarter (7 last month). In the rolling quarter; 3 incidents were reported by West Berkshire (1 CMHT and 1 Older Adults services) and 1 by Criminal Justice and Liaison. All incidents in May were reported as low or minor risk. At the time of reporting a total of 26 clients carried out assaults on other patients including 1 client who has carried out 6 assaults. This shows an increasing trend.

Learning Disability - Patient to Patient Assaults increased to 22 (previously 19) in the rolling quarter to May 2018 and is now red rated. All incidents were rated as low or minor risk and the assaults were carried out by 6 clients including 1 client responsible for 8 incidents and 1 client responsible for 7 incidents. This shows a decreasing trend.

Slips Trips and Falls – Rowan ward (4 falls), Orchid ward (14 falls), Oakwood (5 falls) were all above target. The increase on Orchid ward has been driven by 2 patients. Six wards (Donnington, Highclere, Henry Tudor, Rowan, Orchid and Oakwood) have chosen falls as a Quality Improvement programme breakthrough objective and have identified counter measures to reduce the number of falls. Each of these 6 wards has a monthly baseline to reduce falls.

Self-Harm - These have decreased to 377 in the rolling quarter to May 2018, and remains rated as red. In Willow House there were 184 incidents (167 last month) reported in the rolling quarter with 49 incidents for one patient and 48 incidents for another. All incidents at Willow House in the month of May 2018 were rated as low

or minor risk. There were a total of 170 incidents reported in the rolling quarter to May 2018 by Mental Health Inpatients; which is a reduction from 195 in the rolling quarter to April 2018. Of these, 48 incidents were reported on Rose ward (58 last month), 23 on Bluebell ward (50 last month) 51 on Daisy ward (60 last month) and 39 on Snowdrop ward (14 last month). There were also incidents reported as follows; 2 each Mental Health Facility, Prospect Park, Other Unknown location and 1 each A&E & public place street and Adult Acute Admissions. At the time of reporting, 15 inpatients self-harmed during the rolling quarter with two clients responsible for 12 incidents each. All incidents in Mental Health Inpatients in the month of May 2018 were rated as low or minor risk. In the community in the rolling quarter; 19 incidents were reported by Mental Health West; 4 each Talking therapies and Crisis services, 3 each Common Point of Entry and Care Pathways, and 1 each psychiatry, Older Persons services, Mental Health Liaison, Criminal Justice and Liaison service and Traumatic stress service. 4 Incidents by Mental Health East; care Pathways and 1 for IMPACTT. This shows an increasing trend. For Mental Health inpatients including Willow House this is a Quality Improvement programme breakthrough objective.

Learning Disability Self-Harm increased to 8 in the rolling quarter to May 2018. This shows a decreasing trend.

AWOLS and Absconsions - this data covers only those clients detained on a Mental Health Act Section and is measured against a local target. Both AWOLs (20 to 27) and Absconsions (19 to 23) increased in the rolling quarter to May 2018. In May 2018 there were a total of 12 AWOLs reported; 2 each from Daisy ward and Bluebell ward, and 1 from Rose ward, 3 each public place or street or other or unknown location and 1 from the car park. All incidents in May 2018 were rated as low risk. In May 2018, there were 7 absconsions; 3 from Sorrel ward these were by the same client who is now in an appropriate out of area placement, 3 from Bluebell ward and 1 from Daisy ward. Both AWOLs and Absconsions show decreasing trends.

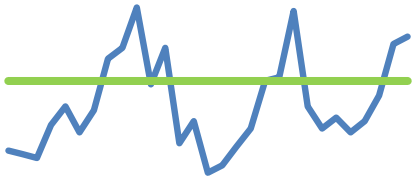
PMVA (Control and Restraint of Mental Health patients) – At the time of reporting, there were 45 uses of PMVA in May 2018. There were 18 incidents on Snowdrop ward, 3 incidents on Bluebell ward, 8 on Daisy ward, 7 on Sorrel ward, and 2 each on Rose ward and Rowan ward. In addition, 3 incidents were reported at other or unknown location and 1 each from car park and public place or street.

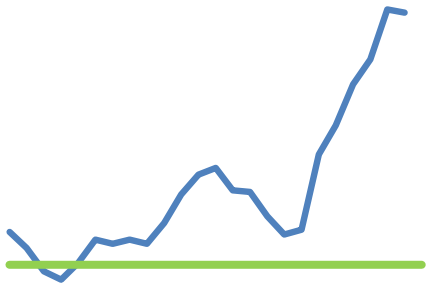
There were 6 incidents of prone restraint in May 2018 and these occurred on the wards as follows; 3 on Snowdrop ward, 2 on Daisy ward and 1 on Sorrel ward. The trend for use of prone restraint is downwards, when measured over a 3 year period. A programme of work is in place to reduce the use of prone restraint on the wards by 90% by the end of 2018/19 with a Rapid Improvement Event scheduled to take place in July 2018.

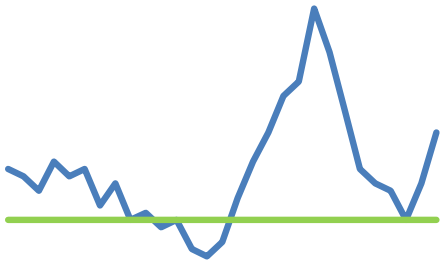
There were 8 uses of Strategy for Crisis Intervention and Prevention in May 2018 on 3 Learning Disability clients.

Seclusion, in May 2018 in Mental Health Inpatients - There were 8 incidents of seclusion with the longest incident lasting 68 hours and 15 minutes, for a client who absconded from Sorrel ward. There were no uses of seclusion by Learning Disability Services.

User Safety Exception Report Month 2: 2018/19

KPI	Target	May-18	Trend	Context/Reasons	Commentary of Trend
Mental Health Physical Assaults on Staff	<70	80		**Increase in Mental Health Physical Assaults on Staff driven by an increase in incidents reported at the CAMHS and Adult Inpatient services in the rolling quarter. This is measured against a local target.**	**In 2016/17 Mental Health NHS Benchmarking exercise, this Trust was in the upper quartile of incidences of physical violence to staff at 867 incidents per 100,000 occupied bed days excluding leave.**
Mental Health Physical Patient to Patient Assaults	<40	52		**Physical Patient to Patient Assaults were carried out by 26 patients in the rolling quarter. 1 of which carried out 6 assaults. This is measured against a local target.**	**In 2016/17 Mental Health NHS Benchmarking exercise, this Trust was in the upper quartile of incidences of physical patient to patient assaults at 512 incidents per 100,000 occupied bed days excluding leave.**

KPI	Target	May-18	Trend	Context/Reasons	Commentary of Trend
Learning Disability Patient to Patient Assaults	<20	22		Physical Patient to Patient Assaults were carried out by 6 patients in the rolling quarter, 1 of whom carried out 8 assaults. This is measured against a local target.	In the 2016/17 Learning Disabilities Benchmarking exercise the Trust was in the upper quartile for patient to patient assaults at 32.2 incidents per 10,000 occupied bed days excluding home leave.
Self-Harm incidents	<75	377		Self-harm incidents increased in Adult Acute Mental Health Inpatients and CAMHS Inpatients. 2 individuals have driven the increase. This is measured against a local target.	

KPI	Target	May-18	Trend	Context/Reasons	Commentary of Trend
AWOLs on Mental Health Act (MHA) Section	<15	27		**AWOLs increased in the rolling quartet to May 2018. There was increase reported in non-ward environments such as public place or street. This is measured against a local target.**	**In the 2016/17 NHS Benchmarking exercise, the Trust was in the upper quartile at 128 AWOL incidents per 100,000 bed days excluding leave.**
Preventing and Managing Violence and Aggression (PMVA)	<41	45		**This is the number of physical restraints of patients on our Mental Health Inpatient wards. This shows a reduction. This is measured against a local target.**	**In the 2016/17 NHS Benchmarking exercise, the Trust was amongst the lowest users of restraint at 677 uses per 100,000 bed days excluding leave.**

Other Key Performance Highlights for this Section

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

- Mental Health Physical Assaults on staff increased from 70 in the rolling quarter to April 2018 to 80 in the rolling quarter to May 2018.
- Mental Health Patient to Patient Assaults worsened from 50 in the rolling quarter to April 2018 to 52 in the rolling quarter to May 2018.
- Learning Disability Physical Assaults on staff worsened from 46 in the rolling quarter to April 2018 to 47 in the rolling quarter to May 2018.
- Learning Disability Physical Patient to Patient assaults worsened from 19 in the rolling quarter to April 2018 to 22 in the rolling quarter to May 2018.
- Learning Disability Strategy for Crisis Intervention and Prevention has worsened from 6 uses in April 2018 to 8 in May 2018.
- AWOLs have worsened from 20 in the rolling quarter to April 2018 to 27 in the rolling quarter to May 2018.
- Absconsions have worsened from 19 in the rolling quarter to April 2018 to 23 in the rolling quarter to May 2018.

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

- Mental Health Self-Harm incidents have improved from 381 in the rolling quarter to April 2018 to 377 in the rolling quarter to May 2018.
- Prevention and Management of Violence and Aggression has improved from 110 in the month of April 2018 to 45 in the month of May 2018.
- Seclusion has improved from 20 uses in April 2018 to 8 in May 2018.
- Prone Restraint has improved from 10 uses in April 2018 to 6 in May 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 PDP), 1 is amber (Fire), 5 are green - Gross Vacancies, Statutory training - Health and Safety and Manual Handling, Mandatory training - Information Governance and Sickness for April 2018. The provisional sickness figure is no longer reported, and the PDP target was for May 2018.

Sickness Absence

• The final Trust-wide monthly sickness rate for April was on target at 3.50%, sustaining the reduction seen in March. The number of whole time equivalent (wte) days lost due to sickness absence across the Trust in April was 3,898 and based on hourly rates, the cost of this absence was £347,708.

• There has been a decrease in the short-term sickness rate in April to 0.83%, attributed to a further decrease in absences due to cold/cough/flu during the winter months, although absences for this reason continue to be higher than the same period last year. Over the last five months, the impact of absences due to cold/cough/flu on the overall Trust sickness rate has been higher and more prolonged than the same period in previous years.

• There has been an increase in the long-term sickness rate in April to 2.00%, following improvements in the rate over the previous 3 months, although the rate continues to be lower than the same period last year. The increases seen in April are attributed to anxiety/stress/depression, musculoskeletal/back problems and also an increase in the long-term sickness rate due to cold/cough/flu. The latter requires further analysis to understand the root cause of the increase, any hot spots and actions required.

• In addition to an increase in the long-term rate noted above, the total sickness rate attributed to anxiety/stress/depression has also increased in April to 0.91% (from 0.86% in March). Although the figures have not varied significantly month-on-month, the sickness rate for this reason is showing an upward trend, which is evident across all localities. The number of wte days absence for anxiety/stress/depression in April was 995.6 and based on hourly rates, the cost was £97,220 (28% of the total monthly cost). Sickness for this reason accounts for 25.5% of all sickness in May. This has increased proportionally month-on-month for the last three months, from 18.8% in January. Work is underway to analyse the data in more detail to inform focused action plans to address this trend.

• The total sickness rate attributed to musculoskeletal/back problems also increased in May to 0.66% (from 0.53% in March). The sickness rate for this reason is still showing a downward trend since August 2017, when the rate peaked at 0.93%, and the rate remains lower than the average over the previous 3 months of 0.80%. The cost of time lost to musculoskeletal related absence in April was £59,923 (17% of the monthly cost). The HR Managers will be working within their localities to ensure that this downward trend continues.

Recruitment

• The Trust is attending the Royal College of Nursing (RCN) student conference in June with input from services with hard to fill vacancies. Arrangements are in place for students to be interviewed on the day.

• Work is underway to recruit to mental health nursing vacancies via a coordinated approach involving open days, a single advert for all vacancies and a simplified application process and support by a social media campaign. The open days will be advertised via universities and direct approaches will be made to students registered on the talent pool.

Turnover

• The Trust-wide turnover rate in May has increased to 16.44%, from 16.34% in April. The turnover rate in Oxford Health (March 2018) has increased to 18.99%.

• Retention work continues within the localities: East and West Community Adult services are finalising a 'stay survey' which will be circulated to all District Nurses and the feedback will further inform the action plans which are currently in draft form. Children's Services have analysed their turnover data and as a result, will focus on retention within CAMHS, OT and Health Visiting. An initial action plan has been drafted, based on input and learning from the work undertaken in Crisis Resolution / Home Treatment Team (CRHTT).

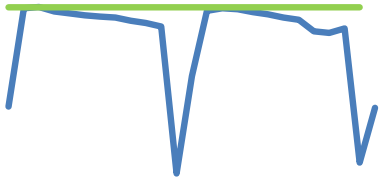
Statutory and Mandatory Training

Statutory Training – Fire Training increased to 92% with only Mental Health Inpatients, Community Health West and Children, Young Persons and Families 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 remained at the 95% target. For Information Governance, the reporting has changed to reflect the requirement for annual "refresher" training for all staff. Again weekly reports are being sent to Locality Directors and for Corporate staff reports on non-compliance have been sent to the relevant Director/Heads of Service. Estates and Facilities staff and Medics have 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 May 2018 was not achieved; weekly reports are being sent out.

People Exception Report Month 2 2018/19

KPI	Target	May-18	Trend	Context/Reasons	Commentary of Trend
Staff Turnover (% YTD): Percent	<15.2%	16.40%		Increase in turnover target from September 2016. This remains a challenging stretch target for the Trust. Turnover rates have reduced over 12 months. This includes end of fixed term contracts, retirements as well as voluntary resignations.	The most recently published data on NHS Workforce statistics show that for NHS England there was a 1.6% increase in Full Time Equivalents from March 2017 to March 2018. The Trust has increased by 0.17% in the same period.
Appraisals/PDP	>97%	41%		The Trust requested that all staff had Appraisals by 31st May 2018.	Weekly reports are being issued and instructions on how to record appropriately on ESR, aim now is to complete appraisals for staff in scope by end of June 2018.

Other Key Performance Highlights for this Section

- Sickness at target at 3.50%.
- Information Governance training has remained at 95% compliance.

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 remains at 100% for May 2018.

• Introduction of the Data Quality Maturity Index (Mental Health Services Data Set (MHSDS) dataset score) that covers data set submissions of the following fields and published scores for Quarter 3 2017/18 are listed:

- Ethnic Category (100%)
- GMC practice code (patient registration) (100%)
- NHS Number (100%)
- Organisation code (code of commissioner) (89%)
- Person stated gender code (100%)
- Postcode of usual address (99%)

The Trust was given an overall data set a DQMI Score 97.5% for the MHSDS, against a target of 95% for the MHSDS according to Quarter 3 2017/18 data which was published by NHS Digital on 16th May 2018. This was higher than the Oxford Health at 95.7%, Surrey Borders 95.3% and Southern Health at 95.1% for the MHSDS.

• Inappropriate Out of Area placements, the Single Oversight Framework measures progress against the Integrated Care System (ICS) trajectories for Frimley and Berkshire West. A query has been raised with NHSi as to whether the Trust will be monitored against a single trust-wide trajectory or separately against the two ICS targets and we are currently awaiting a response. For May 2018 the Trust is on plan to achieve the target position against the end of June 2018 trajectory target, which is as follows:

- Berkshire West CCG - 186 bed days against June 2018 target of 436 bed days. This is 43% of the Quarter 1 target.
- East Berkshire CCG - 253 bed days against June 2018 target of 418 bed days. This is 61% of the Quarter 1 target. This forms part of the Frimley ICS.

• Proportion of people completing treatment who move to recovery (from Improving Access to Psychological Therapy (IAPT) minimum dataset). For May 2018 the Trust achieved 56.75% with all CCGs, above the 50% recovery threshold target.

In addition, Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI) will be included. Work in partnership with acute trusts/CCGs is on-going with organisations within Berkshire seeking to ensure a consistent approach to surveillance. A joint action plan was produced in September 2017 and system targets apply however the Trust has not been allocated a target. Methicillin-sensitive Staphylococcus aureus (MSSA) has also been added but again the Trust has not been allocated a target. For May 2018 - 1 Methicillin-sensitive Staphylococcus aureus was reported on Highclere ward and 1 Methicillin-Resistant Staphylococcus Aureus (MRSA) case for Community Services in the West, but a post infection review considered the care given by the Trust services as appropriate care given with the bacteraemia unavoidable.

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 Royal College of Psychiatrists audit data has been submitted and results for June 2018 are as follows:

- Inpatients – 97.86% compliance against 90% target
- Community – 100% compliance against 65% target
- Early Intervention in Psychosis (EIP) services - 93% compliant against 90% target

There are no other matters to report in relation to NHSI's Single Oversight Framework: constitutional standards or operational performance indicators. Performance reviewed at Finance, Performance and Investment committee.

Service Efficiency And Effectiveness Commentary

There are 13 indicators within this category, 4 are rated as “Green” including Did Not Attend (DNA) rates, Community Health Services (CHS) Length of stay and Mental Health Readmissions and Mental Health Non-Acute Occupancy. None are rated as “Amber”. 8 are rated “Red”; Mental Health Average and Snapshot Length of Stay, Mental Health Acute occupancy by ward and by locality, CHS Occupancy, Crisis Plans, Clustering and Health Visiting and 1 of which does not have a target (place of safety).

The DNA rate increased from 4.80% in April 2018 to 4.85% in May 2018 and remains green. East Mental Health (7.50%) and West Mental Health (7.96%), Children, Young Persons and Families (CYPF) (7.08%) are above target. This indicator shows a decreasing trend.

In Common Point of Entry (CPE) the DNA rate decreased from 8.6% in April 2018 to 8.13% in May 2018.

In Children and Families Community Paediatrics at 10.2%, Health Visiting 8.2%, School Nursing 8.9%, CAMHS 8.5% are above the 6% target.

For Mental Health East; IMPACTT at 15.2%, East Adult Community Mental Health Teams (CMHT) at 9.9% are above target. In West Mental Health, Clinical Health Psychology 27.5%, Adult Mental Health 7.3%, Trauma 11.3%, Early Intervention in Psychosis (EIP) 6.6% are above target. SMS text messaging can be used for reminders for appointments which take place in clinics provided that a mobile number is collected and entered into RiO in the correct format. In May 2018, 17,871 text messages were sent.

CHS Inpatient Average Length of Stay reduced to 23 days and is within target, with all areas below target. Delayed transfers have also reduced overall, though there has been some worsening in Slough 5.9% (last month 3.7%) Wokingham 6% (last month 4.7%) and Windsor Ascot and Maidenhead (WAM) 6.65% (last month 4.0%), but improvements in Reading 8.4% (18.3% last month) and West Berkshire 3.3% (4.4% last month). A total of 29 patients’ discharges were delayed in May 2018; 14 of these are the responsibility of the NHS, and 10 are the responsibility of social care and 3 are joint health and social care responsibility. The most common reason for a delay was awaiting care package in own home (a total 16; 7 each for health, and social care and 2 joint responsibility health and social care). 4 are awaiting either further NHS Non Acute Care.

Mental Health Acute Occupancy excluding home leave decreased to 95% in May 2018. The Spring to Green initiative ran from 23rd April 2018 to 8th May 2018.

The Average Length of Stay for Mental Health remained at 40 days in May 2018 and the acute snapshot length of stay reduced to 52 days in May 2018 and continues to remain above target. Of the 219 clients discharged during March 2018 to May 2018, 62% (137) had lengths of stay below 30 days. 22 clients who were discharged in the period had lengths of stay above 90 days, including 19 above 100 days and 1 at 384 days. There are a number of clients who have accommodation needs for which funding must be obtained and placements sought before they can be discharged from the ward. As at 13th June 2018 there were a total of 7 acute clients who were agreed delayed transfers of care (an increase from 4 last month); 3 on Bluebell ward, 2 on Rose ward, 1 each on Daisy ward and Rose ward. By locality, there is 1 delay each for Reading, Slough, Bracknell and Windsor and Maidenhead and 3 for West Berkshire.

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

An additional metric on bed occupancy by locality has been included and work has been developed to facilitate localities managing their allocation of beds and out of area placements. Reading, Slough, Wokingham and West Berkshire are above target.

As at the 13th June 2018 there were 6 out of area placements for Adult Mental Health, and 3 for Psychiatric Intensive Care Unit (PICU). For May 2018, at total of 5 patients were sent out of area for Adult Acute Overspill and 3 patients sent out of area for PICU.

Older Adults Mental Health wards length of stay is 48 days for Rowan ward and 33 days Orchid Wards for clients discharged.

CHS Occupancy is below the 80% lower threshold at 74% and is therefore red rated. The Commissioning Care Groups (CCG) have asked that 10 beds on Highclere ward be repurposed; a proposal has been written by the Head of Service and was presented at the Trust Business Group meeting on 5th June 2018.

MH Readmission rates increased to 8.6% in May 2018 which is below the 9% target, with only Slough and Wokingham (11%) above target. Slough's readmissions have reduced to 9% and the service have been doing a deep dive on their readmissions and look at documentation in Safety plans regarding appropriateness of admission.

Community Services benchmarking data collection for 2017/18 opened on 21st May 2018 and closes on 10th August 2018.

Mental Health Benchmarking collection has opened and will close on 30th June 2018.

A supplementary audit of a Mental Health services workforce skills mix was launched on 11th October 2017. The Trust made submissions including Unitary Authorities. A high level report has been issued that aside from Clinical Psychology the Trust had lower levels of staffing. A toolkit is due to be issued and further analysis will be presented when this is available.

Child and Adolescent Mental Health Services (CAMHS) Benchmarking for 2017/18 has opened and will close on 13th July 2018 and data collection is underway.

Mental Health Clustering has fallen to 86% compliance and remains below the 95% target. There were issues with the clustering tool not working correctly on RiO for a period of 2 and half weeks from April to the beginning of May which have impacted on the ability of teams to cluster clients. This has now been resolved but teams will take time to recover their position.

Place of Safety – This reduced to 41 uses in May 2018, with 3 uses for minors. Of the 41 uses of the place of safety, 18 were admitted following assessment including 12 under Section 2 of the Mental Health Act. 11 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. 18 out of the 41 assessments were carried out by Berkshire Healthcare NHS Foundation Trust Section 12 Doctors. The most common time in May 2018 to be brought to the place of safety was between was 3pm to 6pm followed by 6pm to 9pm. The most common days for detention in May 2018, was Wednesday with 9 detentions followed by 6 uses on Monday, Tuesday and Saturday.

Crisis plans – fell below target to 86% with only Bracknell above target.

Health Visiting New Birth visits within 14 days is below target at 92.2%. Of the cases not seen within target, 47% were still in hospital, 19% no access, 16% family declined and 10% were due to staff capacity.

System Resilience – Frimley Health NHS Foundation Trust achieved 88% for Type 1 A&E attendances in May 2018.

In the West the A&E waiting times national return for May 2018 show the Royal Berkshire Hospital achieved 95.4% Tier 1 A&E attendances and 96.1% against Tier 1-3 attendances. Nationally only 85.1% 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 90.4% for all Tier 1-3 attendances during May 2018. The Trust's Minor Injury Unit (MIU) achieved 99% for discharged, admitted transferred within 4 hours of arrival.

The system wide report showed West Berkshire, Reading and Wokingham Rapid Access teams had capacity on 14th June 2018. In terms of Inpatients on 14th June 2018, there were a total of 22 community beds available at our community hospitals in Berkshire West including 10 at Oakwood ward.

Service Efficiency And Effectiveness Exception Report Month 2: 2018/19

KPI	Target	May-18	Trend	Context/Reasons	Commentary of Trend
Mental Health: Acute Average Length of Stay (LoS): Number	**<30 Days**	**40**		**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.**
Mental Health Acute Length of Stay Snapshot	**<30 Days**	**52**		**This is an increase on the preceding month and reflects the acuity of clients and number of delayed transfers of care.**	

KPI	Target	May-18	Trend	Context/Reasons	Commentary of Trend
Mental Health Acute Occupancy rate (exc. Home Leave by Ward/ Locality) (**Note** - Combined graph for 2 indicators)	**< 90%**	**95%**		**Reading and Wokingham are above target. New bed management process including gatekeeping of clients 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 a 70% increase in admissions of clients detained under the Mental Health Act.**
Community Health Services Occupancy Rate	**< 80%**	**74%**		**In May 2018, Oakwood and West Berkshire Community Hospital were below target. 10 beds on Highclere ward are being repurposed.**	**The availability of Community Health beds is discussed in the daily system wide calls. These also cover the acute hospital, community services including wards and services where patients can be discharged to their place of residence and Unitary Authority provision.**

KPI	Target	May-18	Trend	Context/Reasons	Commentary of Trend
Health Visiting: New Birth Visits Within 14 days	**95%**	**92.2%**		**Of those not seen the reasons were 47% still in hospital, and 19% no access (family out for arranged visit), family declined (16%), no response from family (4%) and 10% staff capacity (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.**
Mental Health Crisis Plans for Clients on Care Programme Approach (CPA)	**90%**	**86%**		**The Community Mental Health Services have been asked to complete a new Safety plan which includes the Crisis Plan. This was launched in January 2017.**	

KPI	Target	May-18	Trend	Context/Reasons	Commentary of Trend
Mental Health Clustering within target	**95%**	**84.3%**		**There are frequent reviews required for certain clusters which mean that it is difficult to achieve the target. At the end of April 2018 / the beginning of May 2018 the RiO tool used for clustering was not working. Services are working to catch up.**	**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

- Did Not Attend (DNA) rates have worsened from 4.80% in April 2018 to 4.85% in May 2018.
- Community Health Services Length of Stay improved from 24 days in April 2018 to 23 days in May 2018.
- Mental Health Readmission rates worsened from 8.3% in April 2018 to 8.6% in May 2018.
- Mental Health Acute occupancy has improved from 96% to 95%.
- Mental Health Non-Acute occupancy worsened from 62% to 80%.
- New Birth Visits within 14 days have worsened from 93% to 92.2%.
- Mental health clustering improved from 81.7% compliance in April 2018 to 84.3% in May 2018 but is below target.
- Prospect Park Place of Safety improved from 55 uses in April 2018 to 41 uses in May 2018.

Contractual Performance Commentary

For 2017/19 this section has been revised to provide focus and traction on contract monitoring. Updates are as follows:

Commissioner	Contract	Total Contract Value	Sub-Contract	Sub-Contract Element	Risk	Commentary
CCG	Main Block Contract	£187.4m	Overall			All Long stop issues are on track .We have asked for an updated on MSK beyond Sept 18. We have flagged with commissioners pressure in CHS – Heart Failure, Falls, MH – CAMHS , ASD/ADHD, IPS ongoing funding
NHSE	Main Block Contract	£6.95m	Overall			Content of CV for 18/19 agreed
			CAMHS T4	£2,290k		Agreement has been given to restore original funding for 17/18 and 18/19 with a view to new contract negotiations for 19/20 along with plans to move to PPH 12 bed unit. NHSE have expressed concern over low occupancy levels and a perceived lack of willingness from the service to accept referrals. BHFTs held position is that we admit appropriate level of acuity when beds are available . Meeting is to be organised with NHSE to discuss the issues that have caused low occupancy.
			HIV Drugs	£2,934k		Pass through costs
Reading BC	Public Health Nursing 0-19 Service	£3.2m	Overall			Contract to Sept 2019 fully signed
			Enuresis	£15k		Awaiting contract variation
NHSE	Dental	£2.75m	Overall			Contract signed. NHSE to ask Trust to consider a contract extension for up to 2 years. Support in principle subject to funding.
			General Anaesthetic	£588k		Contract expires 31st March 2019
			Special Care	£1,865k		Contract expires 31st March 2019
			Access Centres	£294k		Contract expires 31st March 2019
Berkshire CCGs	AQP	Variable	Podiatry			Agreed 2.5% uplift on tariff, draft contract under review, aim to sign in June
East Berks CCG	AQP	Variable	Audiology			Invoicing adjusted in response to CSU data challenges. Indication service to be re-tendered summer 2018. Service pushed to increase activity to cover current contract shortfall.
Berkshire CCGs	17/18 CQUIN					Negotiation on-going on final elements. Financial risk fully provided for and expect to be paid. Specifically: CQUIN 1a) Improvement of health and wellbeing of NHS staff - £145k CQUIN 8a) Supporting Proactive and Safe Discharge – Community Trusts - £341k CQUIN 9) Tobacco / Alcohol Screen & Advice (Various) - £170k
RBH	Inter Provider Contract	£2,087k	Overall			
Frimley	Inter Provider Contract	£323k	Overall			

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	10 July 2018
Title	**Finance, Investment & Performance Committee – Changes to the Committee's Terms of Reference**
Purpose	To ratify the proposed changes to the Committee's Terms of Reference as highlighted in red type.
Business Area	Corporate
Author	Company Secretary on behalf of Naomi Coxwell, Committee Chair
Relevant Strategic Objectives	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.
Equalities and Diversity Implications	N/A
SUMMARY	The Committee has reviewed its terms of reference and has identified a number of minor changes (highlighted in red type).
ACTION REQUIRED	The Trust Board is requested to ratify the proposed changes to the Committee's Terms of Reference as agreed by the Committee on 27 June 2018.

Berkshire Healthcare NHS
NHS Foundation Trust

Finance, Investment & Performance Committee

Terms of Reference

Document Control

Version	Date	Author	Comments
1.0	28 Jan 08	Philippa Slinger	
2.0	5 Feb 08	Philippa Slinger	Following comments by F&I Chair
3.0	5 March 08	Garry Nixon	Following Approval by Board
4.0	7 May 09	John Tonkin	Amendments following F&I Committee meeting 29 April 2009
5.0	16 August 2010	John Tonkin	Amendments following F&I Committee meeting 28 July 2010
6.0	10 March 2011	John Tonkin	Amendment to include scrutiny of integrated performance information following agreement at Board meeting 8 March 2011
7.0	8 May 2012	John Tonkin	Amendment to membership on recommendation of Committee following Board consideration on 8 May 2012
8.0	25 February 2015	John Tonkin	Amended following review by F,I&P Committee – for Board approval – June 2015
9.0	22 February 2017	Julie Hill	Amended following review by F,I&P Committee – for board approval July 2017
10.0	27 June 2018	Julie Hill	Amended following review by F, I&P Committee – for board approval July 2018

1. Authority

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

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

2. Purpose

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

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

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

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

2.1.4 examine the Trust's medium term financial strategy and provide assurance that the Trust's future strategic service plans support continued compliance with NHS Improvement's Provider Licence and the Single Oversight Framework.

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

2.1.6 review the relevant risks on the Board Assurance Framework.

3. Membership

3.1 The members of the Committee shall be as follows:

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

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

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

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

4. Frequency and Administration of Meetings

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

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

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

5. Remit

5.1 Financial Policy and Performance

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

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

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

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

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

5.2 Investment Policy and Performance

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

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

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

5.2.4 To ensure adequate safeguards on investment of funds.

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

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

5.2.7 To review investment performance and risk.

5.3 Organisational Performance Assurance

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

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

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

Amended: June 2018

Approved by Trust Board:

For review: June 2019

Trust Board Paper – Public

Board Meeting Date	10 July 2018
Title	**Board vision metrics: performance update to end May 2018**
Purpose	To update the Board on performance against our agreed vision metrics
Business Area	Performance
Author	Alex Gild – Chief Financial Officer
Relevant Strategic Objectives	Relevant to all Strategic Objectives
CQC Registration/Patient Care Impacts	Relates to the Well-Led CQC Domain
Resource Impacts	N/A
Legal Implications	N/A
Equalities and Diversity Implications	N/A
SUMMARY	During 2017/18 the Trust Board agreed a set of metrics to indicate progress on our journey towards our Vision. The metrics were chosen by the Board as they are easy to understand, visual and are by their nature very stretching. Our Vison is: **"To be recognised as the leading community and mental health service provider by our staff, patients and partners."** This paper, presented in public for the first time to support transparency and accountability re Vision intention, updates the Board on performance against Trust vision metrics YTD at end of May 2018 (see dashboard shown in Appendix 1 of the included report). Performance highlights are noted as follows: • Latest National Confidential Inquiry data on suicide rates per 10,000 in mental health services (7, now below 8.2 target – target aligned with Mental Health Five Year Forward View intention). • Latest NHS staff survey engagement score: Trust is second highest scoring in cohort of 32 combined mental health and community trusts. An improvement from third in last staff

	survey. • Integrated Care System(s) partner stakeholder survey completed with very positive responses. Indicator green whilst target agreed. • Stretch benchmark target trend improvement on use of restraint between 15/16 and 16/17 data. • Deterioration in stretch benchmark target and trend for patient on staff assaults and patient on patient assaults, between 15/16 and 16/17 data. These areas are a focus for our quality improvement programme. • Improvement in Friends and Family Test response rate from last update. • Mental Health inpatient deaths from self-harm (at Prospect Park Hospital): no incidents in last 12 months, compared to one in the prior 12 month period.
ACTION	The Trust Board is asked to note current performance against vision metrics.

Board Vision Metrics: performance update to end May 2018

Supporting delivery of the Trust's Vision

Trust Board – public meeting

Alex Gild, Chief Financial Officer
10th July 2018

Purpose

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

Document control

Version	*Date*	*Author*	*Comments*
0.1	26/06/2018	I Hayward & C Magee	
1.0	27/06/2018	I Hayward & C Magee	Updates from I Hayward and A Gild

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

Distribution

Finance, Performance and Risk Executive Committee and Trust Board

Document references

Document title	*Date*	*Published by*

Contents

1. Introduction

Background

1.1. During 2017/18 the Trust Board agreed a set of metrics to indicate progress on our journey towards our Vision. The metrics were chosen by the Board as they are easy to understand, visual and are by their nature very stretching.

1.2. Our vision is:

> **"To be recognised as the leading community and mental health service provider by our staff, patients and partners."**

1.3. The Board Vision metrics monitor the Trust's progress across key indicators of vision delivery, split into the following sections:

- Quality
- Safety
- Engagement
- Regulatory Compliance

1.4. These sections cover the key indicators in order to assure the Trust on its progress towards the vision.

1.5. This is a performance update as per the bi-annual interval (or as agreed with the Board) over the next three years. A number of the indicators are annual, so updates will occur when information is available via a dashboard, see Appendix 1.

1.6. The national benchmarking network has expanded participants in the Mental Health project to include providers from Wales, Northern Ireland, the Channel Islands and Scotland. The data here shows the rankings against the 55 English providers and the 32 Combined Mental Health and Community Trust respondents in 2016/17. Indicator performance has been updated from the 2015/16 data set previously reported, to the latest available.

2. Rationale for Metric Inclusion

Sections

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

Quality

2.2. Key quality metrics that indicate how well we treat and care for our patients, predominantly focused on care experience metrics for mental health inpatients, and uses our benchmarked scores.

2.3. A long-term stretch performance measure is maintained in the dashboard to achieve top 3 ranking of all Mental Health service providers in the national benchmarking cohort, however, where data is available we have shown how we compare to the combined community and mental health trust cohort in the descriptions below. The 2016/17 benchmarking results have been updated to the dashboard as follows:

- **Mental Health Patient on Patient Physical Assaults** – The benchmark position target shown here is a long-term stretch target. The Trust was above the mean for 2016/17 and is in the upper quartile per 100,000 occupied bed days excluding leave and is ranked 51st out of 55 English Mental Health respondents. The Trust ranks 28th out of 32 combined Mental Health & Community Health Trust respondents. This is a worsening of our performance from 2015/16.

- **Mental Health Patient on Staff Assaults** – The benchmark positon target shown here is a long term stretch target. The Trust was above the mean for 2016/17 and is in the upper quartile per 100,000 occupied bed days, excluding leave. The Trust is ranked 44th out of 55 English Mental Health benchmarking respondents. Trust ranks 23rd out of 32 combined Mental Health & Community Trust respondents. This is a worsening of our performance from 2015/16. Absolute and benchmark improvement in this area is a driver metric (seeking "breakthrough" improvement) within our Quality Improvement (QI) programme.

- **Mental Health Use of Restraint** – The benchmark position target shown here is a long-term stretch target. The Trust was below the mean for 2016/17 and the Trust is ranked 19th out of 55 English benchmarking respondents, which shows an improvement in our position from 2015/16. The Trust ranks 13th out of 32 combined Mental Health & Community respondents. The Trust has improved in performance in the use of restraint in 2016/17. Absolute and benchmark improvement in this area is a driver metric (seeking "breakthrough" improvement) within our QI programme.

Safety

2.4. Key metrics that indicate how safe our services are, performance being within our control and influence:

- **Falls –** where the fall results in significant harm due to a lapse in care. The process for identifying where falls with significant harm have been the result of a lapse in care was developed and approved by the Safety Experience and Clinical Effectiveness Group in April 2017. In the financial year 2017/18: 2 relevant incidents occurred in the year, but there have been no incidents so far in 2018/19. Reduction in falling is a focus for a QI programme breakthrough objective.

- **Mental Health Inpatient Deaths as a consequence of self-harm –** the metric has been updated to zero mental health inpatient deaths resulting from self-harm within a 12-month period. The last incident of an inpatient death from self-harm was in June 2017. The metric requires further consideration to confirm inclusion and definition of inpatient deaths from lapse in care, and whether this covers patients who were expected to be on a ward at the time of death. Reduction

of all self-harm is a QI programme breakthrough objective.

- **Mental Health Bed occupancy** – for mental health acute beds. The figure shown here were occupancy rates in May 2018 and shows 95% against a target of 85%. This is an improvement from 98% in February 2018. A "Spring to Green" initiative, which sought to reduce bed occupancy and use of out of area placements, took place between 26th April 2018 to 8th May 2018, which reduced bed occupancy to 86% on the 8th May 2018.

- **Never Events –** all never events that occur in the Trust. None reported.

- **Pressure Ulcers -** Reduction in the level of developed category 3 and 4 pressure ulcers due to lapse in care in our community health services. The cumulative total is 18 incidents in the period 1st April 2017 to 31st March 2018, and 2 so far in 2018/19. Pressure ulcers are an improvement focus under the QI programme's Harm Free Care domain.

- **Suicide Rate -** By 2020/21, the Five Year Forward View for Mental Health set the ambition that the number of people taking their own lives will be reduced by 10% nationally compared to 2015/16 levels. The Trust's suicide rate reduced to 7.0 per 10,000 people under mental health care in 2016/17, and is below the local target of 8.2 suicides per 10,000 people under mental health care. This local target was based on a 10% reduction on the 2015/16 suicide level of 9.2 per 10,000 people under mental health care. The next update will be in Quarter 4 2018/19. Our zero suicide initiative and QI programme self-harm focus provide complementary improvement activity in this critical safety area.

Engagement

2.5. Key metrics on how our patients, carers, staff and stakeholders view us and our contribution to the local system and performance:

- **Commissioner Satisfaction - Net Commissioner Investment Maintained –** achieved in line with last three years for 2018/19, with commissioner investment in mental health and community physical health contract demand growth, FYFV IAPT service expansion into Long Term Conditions and NHSE investment in Individual Placement Support (employment) services for people with severe mental illness, and court liaison and diversion services.

- **Stakeholder Satisfaction - Survey of System Partners –** a survey was developed in the second half of 2017/18; the survey closed on 8th February 2018. Results were very positive with only 11% giving a neutral response to the Trust's leadership, quality, governance and service delivery within the two Integrated Care Systems it operates in. Survey respondents included our six local authorities, and NHS commissioner and provider system partners. Target to be agreed.

- **Patient Friends & Family Test Response Rate –** 13.10% in March 2018 against the target of 15% is an improvement from February 2018 (9.56%). This is a QI driver metric.

- **Staff Survey Engagement Rating –** latest available performance ranking published on 6th March 2018, shown against our cohort of 32 combined mental health and community Trusts (2nd).

Regulatory Compliance

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

- **Care Quality Commission Rating –** Good rating
- **NHSI Segmentation -** maintained segment 1 of the Single Oversight Framework in latest assessment. Highest autonomy, with no NHSI support required. Also maintaining NHSI Use of Resources rating of 1 (lowest financial risk rating available on scale of 1 to 4).
- **Number of CQC Compliance Actions –** to the date of the report there were five compliance actions, three for Bluebell ward, one for Daisy Ward, and one for Willow House. Review of these compliances issues are subject to the outcome of the current CQC core services inspection.

3. Quality Improvement Programme: supporting delivery of our vision

3.1. The Quality Involvement programme (QI) aims to improve the services we provide to our patients and their families, and will help us achieve our vision, which is to be recognised as the leading provider of community and mental health services.

3.2. The QI programme is being introduced to implement sustainable changes to the way we work. QI is about empowering and enabling staff to make improvements and feel they can make a difference at work; it is a bottom up process which equips people with the tools and techniques they need, making sure the Trust is aligned in its work and focused on achieving key objectives.

3.3. The QI programme consists of four work streams:

3.3.1. Strategy deployment – making all staff aware of our key priorities

3.3.2. Quality Management and Improvement System (QMIS) (phased approach) – daily changes in the way we work, reinforced by nine integrated tools and techniques

3.3.3. Quality improvement projects (on-going) – significant and complex change projects

3.3.4. QI Office – a team dedicated to the sustainability of the programme

3.4. All four work streams will link in to the four main priorities that we have identified (otherwise known as 'True North'), these will translate into the four primary goals of our annual plan:

3.5. True North:

3.5.1. To provide 'harm free care' with a focus on reducing self-harm and physical harm

3.5.2. To improve our staff experience by focusing on staff engagement and reducing violence and aggression from patients

3.5.3. To improve the patient experience, evidenced by an increase in the number of returned Friends and Family Tests and improve results

3.5.4. To support financial sustainability across the organisation, by improving net surplus

performance.

3.6. As the QI programme develops during 2018/19, the underpinning driver and tracker metrics aggregating to the performance view of True North delivery will be integrated into the Trust Board's summary performance reporting, supported by review at Finance Investment and Performance (FIP) committee.

It is not surprising that a number of our QI / True North metrics align with the Trust's vison metrics in Appendix 1, given True North's purpose is to align quality improvement activity to delivery of our vision.

Appendix 1 – Board Vision Metrics

Trust Board Vision Metrics

As at: end May 2018

		Quality			Safety					
		Mental Health Patient on Patient Assaults	Mental Health Patient on Staff Assaults	Mental Health Use of Restraint	Falls Due to Lapse in Care (YTD)	Mental Health Inpatient Deaths from Self-Harm (last 12 months at PPH)	Mental Health Bed Occupancy (YTD)	Never Events	Pressure Ulcers (YTD)	Suicide Rate per 10,000 under Mental Health care
Target		Top 3	Top 3	Top 3	0	0	85%	0	Better than Last Year	10% Reduction Target 8.2
	Performance trend since last data	↓	↓	↑	↑	↑	↑	↔	↔	↑
Actual	All English NHS Mental Health Providers (out of 55)	51st	44th	19th	0	0	95%	0	2	7
	Joint English Mental Health and Community Trusts (out of 32)	28th	23rd	13th						
	Map to QI programme "True North" metrics	Harm-free care, Tracker metric	Supporting our staff, Driver metric	Harm-free care, Driver metric	Harm-free care, Driver metric	Harm-free care	Money Matters, Tracker metric	Harm-free care	Harm-free care, Tracker metric	Harm-free care, Driver metric

		Engagement				Regulatory Compliance		
		Commissioner Net Investment	System Partner Satisfaction Survey	Patient FFT Response Rate	Staff Survey Engagement Rating (out of 32)	CQC Rating	CQC Compliance Actions	NHSI
Target		Green	To be defined	15%	3rd	Outstanding	0	SOF Segment 1
		↔	-	↑	↑	↔	↔	↔
Actual		✓	✓	13.10%	2nd	Good	5	✓
		-	-	Patient Experience, Driver Metric	Supporting our staff, Driver Metric	-	-	

Berkshire Healthcare NHS
NHS Foundation Trust

TRUST BOARD PAPER

Board Meeting Date	10 July 2018
Title	Strategic Plan Summary 2018-21 - Final Draft
Purpose	The Strategic Plan Summary sets out our key priorities to deliver our vision for the next 3 years.
Business Area	Corporate Affairs
Author	Bev Searle
Relevant Strategic Objectives	This paper is relevant to the achievement of all strategic objectives.
CQC Registration/Patient Care Impacts	The Strategic Plan Summary will support the CQC 'well-led?' domain and provide assurance regarding the prioritisation and alignment of our work to provide good quality patient care.
Resource Impacts	Each strategy and initiative has its own governance structure responsible for its delivery, including the appropriate allocation of resources.
Legal Implications	The responsible lead/governing body for each strategy or initiative is accountable for any legal implications. Some strategies, such as our Equality and Inclusion Strategy, ensure our compliance with statutory requirements.

Equality and Diversity Implications	An Equality Impact Analysis forms part of the document. In addition, there is a summary of our Equality and Inclusion Strategy.
SUMMARY	The purpose of this document is to set out our key priorities and what we want to achieve by 2021. Our strategy summary brings together in one place the highlights of our current strategies and plans, describing both what we are aiming to achieve and how we intend to go about it. We have set out our plans for our organisation as a whole, as well as for each of our major service areas. Summaries of our approach to financial planning and our work with our two Integrated Care Systems are also included. Feedback received from strategic leads of partner organisations will be reported verbally at the Trust Board meeting, informing any further additions required.
ACTION	The Trust Board is asked to APPROVE the Strategic Plan Summary 2018-21.

Berkshire Healthcare
NHS Foundation Trust

Strategic Plan Summary 2018 – 2021

Berkshire Healthcare NHS Foundation Trust

Final Draft

Healthcare from the heart of your community

www.berkshirehealthcare.nhs.uk

Introduction and contents

Berkshire Healthcare NHS Foundation Trust

Welcome to our 3 year strategy summary for 2018 – 2021.

The purpose of this document is to set out our key priorities and what we want to achieve by 2021. We want to be clear about our commitments – and to be specific about the difference we aim to make – with patients and service users, with our partner organisations and within our whole organisation.

Our strategy summary brings together in one place the highlights of our current strategies and plans, describing both what we are aiming to achieve and how we intend to go about it. We have set out our plans for our organisation as a whole, as well as for each of our major service areas. Summaries of our approach to financial planning and our work with our 2 Integrated Care Systems are also included.

We know that the next three years will present us with many challenges – but we also know that we have the opportunity and capability to make a real difference – by building on the progress we have already achieved and setting ourselves ambitious targets for the future.

Contents

Healthcare from the heart of your community

Our vision and values

Berkshire Healthcare NHS Foundation Trust

Our ambition is **to be recognised as the leading community and mental health service provider by our staff, patients and stakeholders**.

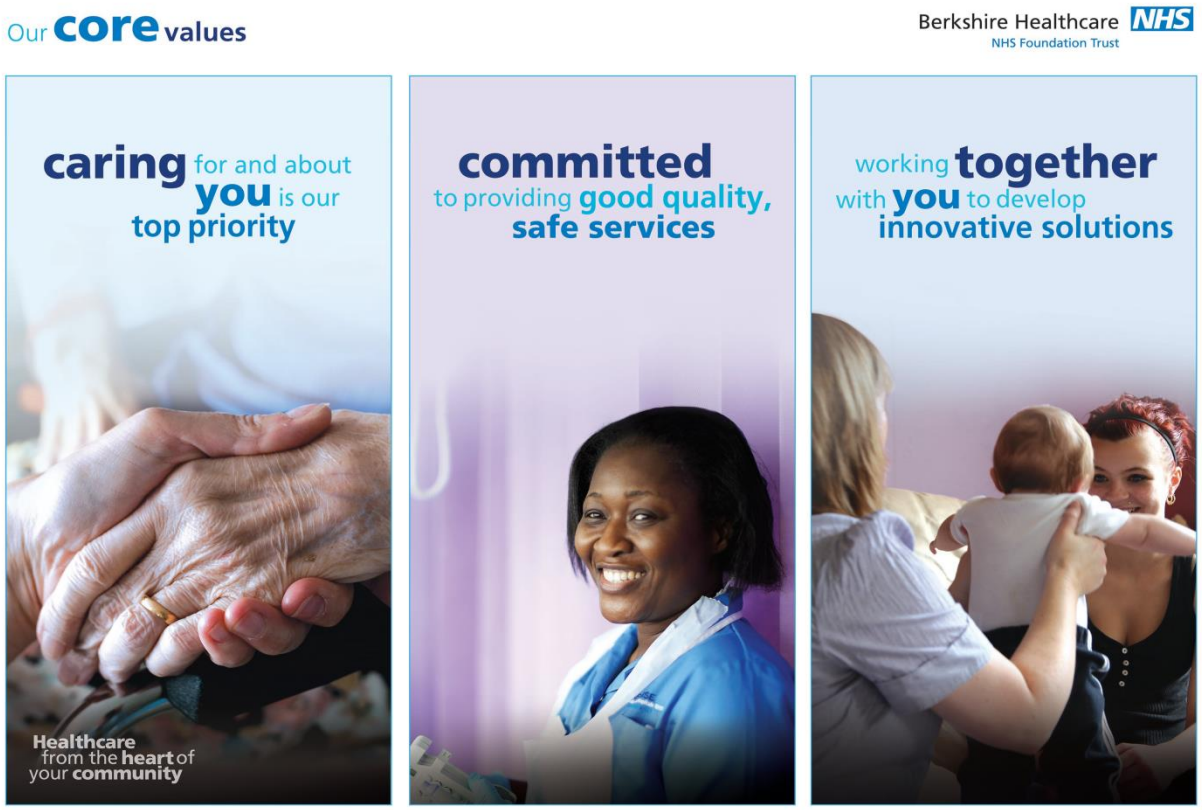
We created this vision statement to guide us in our work, and to underline the importance of measuring our progress through the experience of our staff, the quality of our services and the outcomes we are achieving with patients and service users, as well as from the perspective of our partners and commissioners.

Our values were developed through a series of discussions with our staff, patients and stakeholders which gradually distilled what were the most important commitments we wanted to make as an organisation.

We are using our values to guide us in the way we recruit our staff and conduct our individual performance appraisals, as well as how we approach our major plans and strategies.

This illustration of our values is on display throughout our organisation, and they are stated on each of our annual plans to help us remain focused on the fundamentals of what we are trying to achieve.

Healthcare from the heart of your community



Background

Berkshire Healthcare NHS Foundation Trust

About us

Berkshire Healthcare provides care and treatment for people with physical and mental health problems across the county and its borders. We operate from approximately 100 sites and employ around 4,500 staff – split roughly 50/50 between mental health and community health services.

Berkshire Healthcare was established in 2001, and secured Foundation Trust status in 2007. More recent major change programmes include:

- Responsibility for running community health services in 2012
- Centralising our mental health inpatient services into a purpose built site at Prospect Park in Reading
- Establishing the Health Hub and Common Point of Entry as single points of access for community physical health and mental health services respectively
- Implementing an Organisational Development Strategy helping us achieve year on year improvements to staff engagement
- Prioritising the use of technology to support efficient and effective service delivery – including mobile working, a single electronic patient record, joining up health and social care records, delivering services online and electronic prescribing
- Key partners in 2 "exemplar" integrated care systems, providing a opportunities to improve services and use of resources.

Our services

We provide a wide range of services, most of which are delivered in patients' own homes, and mental health and community inpatient services in Reading, Newbury, Maidenhead, Slough and Wokingham. Please visit our website to find out more.

Our local health profile

Berkshire comprises of 6 unitary authorities, with a population of 891,000 (2015) predicted to rise by 4% by 2020. Berkshire has a range of rural and urban areas, affluence and deprivation, and ethnic diversity. Most of the population has a higher than average life expectancy and good health compared with the national average. However the life expectancy of men living in Reading and Slough is less than the national average, there are higher levels of deprivation, and people's overall health is more varied. Detailed health profiles are available on page 25.

Our operating context

Like all NHS organisations, we are working with significant funding constraints, and experiencing continued growth in demand as our population increases and ages. We recognise that, following the Health and Social Care Act of 2012, there is not likely to be further, centrally driven NHS reorganisation. We are actively participating in the system work outlined in the Five Year Forward View, including new integrated models of care.
Our NHS partner organisations performing strongly, with the Royal Berkshire Hospital and Frimley Health NHS Foundation Trust achieving "outstanding" ratings from the CQC. Our unitary authority partners are challenged by significant funding reductions – and the lack of a clear policy direction for funding social care presents a significant risk.
We remain committed to delivery of integrated services, but we operate in a complex commissioning environment, which presents a particular challenge for our children's services. National workforce shortages are compounded locally by high housing costs/low unemployment.

Where are we now?

Berkshire Healthcare NHS Foundation Trust

How do others see us?

The CQC rated Berkshire Healthcare "good" with "outstanding" community mental health services for older people. We recognise areas of improvement needed, and are working hard towards achieving "outstanding" overall. NHSi has placed us in segment 1, which reflects the highest level of performance across 5 themes, including finance and use of resources.

National Mental Health and Community Health Benchmarking results show that we provide efficient services, with higher than average demand.

We have achieved national accreditation for our Memory Clinics, Learning Disability Inpatient Services and our IAPT (Talking Therapies) service.

Our stakeholder survey results showed that commissioner and partner providers rated us as "very good" or "fairly good" in 89% of categories, with 11% "neither good nor poor" and 0% "fairly poor" or "very poor".

Views of patients, service user and carers are used to inform our service development and we work closely with Healthwatch to ensure that we access an independent view of our services.

How do we assess ourselves?

We complete an analysis of our strengths, weaknesses, opportunities and threats each year to inform our annual plan. Our main strengths include: highly engaged & motivated staff; stable leadership; strong organisational development focus; well-developed use of technology; consistent financial plan delivery. Our development areas are linked to the risks included in our Trust Board Assurance Framework and include: workforce; demand growth; specific quality concerns (outlined in our Quality Account); and the need to develop more standardised approaches to clinical pathways across the full range of services we provide.

Our strategic journey…

Our strategy has been consistently focussed and informed by our desire to provide very good quality, safe services in a way that is sustainable in the medium to long term. Analysis undertaken as part of our previous 5 year strategy refresh indicated limited benefit in merging our organisation with another, or seeking major acquisition of new business. Our approach has therefore been to develop our services within Berkshire or on our borders where this makes sense in terms of patient pathways.

We work in partnership with GP practices but do not directly provide them. Similarly, we work closely with social care providers but are focussed on integrated service models rather than providing social care.

We now have a major focus on the contribution we can make to the 2 Integrated Care Systems that we are part of – maximising the opportunity presented by collaboration with commissioners and partner providers through new ways of working and whole pathway development.

Alongside this, we are continuing to strengthen our internal improvement work through our Quality Improvement Programme, maintaining a strong focus on workforce planning and development and prioritising our use of technology as described on slides 16, 17 and 19.

What do we want to achieve by 2021?

Berkshire Healthcare NHS Foundation Trust

We have identified a range of measures that will help us **achieve our vision**, provide **outstanding care to patients** and provide an **outstanding place to work** by 2021.

The vision metrics, shown on the next page, enable us to track our progress **to be recognised as the leading community and mental health service provider by our staff, patients and stakeholders.**

Our targets are deliberately stretching – and will require consistent and sustained effort to achieve our ambition.

In terms of **quality** improvements, we have prioritised reduction of assaults on staff and patients and use of restraint in our mental health inpatient services. These are measures that are really important to patients and staff alike, and are fully aligned with our values as an organisation.

To drive improvements in **safety**, we have chosen a range of key measures across our community and mental health services.

We have also included measures that enable us to understand how well we engage with our **staff, patients and stakeholders** , and we are actively working on additional ways of measuring the views of patients and service users and how they influence our service development.

Finally, we have included a **regulator** perspective, recognising the importance of their objective assessment.

We recognise that we need to maintain our commitment to organisational development to achieve our goals, and that building our digital and informatics capability is a key part of this.

Our **annual plan on a page** specifies measurable targets for our true north goals each year. These will be adjusted annually to support achievement of our vision and our targets for 2018-19 are shown on page 13.

Our **True North Goals** are**:**

Harm-free care

✓ To provide safe services, prevent self-harm and harm to others

Supporting our staff

✓ To strengthen our highly skilled and engaged workforce and provide a safe working environment

Good patient experience

✓ To provide good outcomes from treatment and care

Money matters

✓ To deliver services that are efficient and financially sustainable

We have identified 3 strategic initiatives to support delivery of our goals which are:

- **Workforce.** Our Workforce Strategy summary is on page 16
- **Quality Improvement.** An outline of our programme is on page 14
- **System work.** A summary of the priorities and key initiatives in progress in our two Integrated Care Systems are on pages 21 and 22.

What do we want to achieve by 2021?

Berkshire Healthcare NHS Foundation Trust

Our **vision metrics** are designed to enable the delivery of our vision "to be recognised as the leading community and mental health service delivery by 2021".

Trust Board Vision Metrics

(March 2018)

	Quality			Safety					
Category	Mental Health Patient on Patient Assaults	Mental Health Patient on Staff Assaults	Mental Health Use of Restraint	Falls Due to Lapse in Care	Mental Health Inpatient Deaths	Mental Health Bed Occupancy	Never Events	Pressure Ulcers	Suicide Rate per 10,000 under Mental Health care
Our Target	Top 3	Top 3	Top 3	0	0	85%	0	Better than Last Year - 9	10% Reduction Target 8.2
Performance trend since last report (Nov 2017)	↓	↓	↑	↔	↔	↓	↔	↓	↑
Our position in all English NHS Mental Health Providers (out of 55)	51st	44th	19th	2	1	98%	0	18	7
Our position in joint English Mental Health and Community Trusts (out of 32)	28th	23rd	13th						

	Engagement				Statutory Compliance		
Category	CCG Net Investment	Stakeholder Satisfaction Survey	Patient FFT Response Rate	Staff Survey Engagement Rating (out of 32)	CQC Rating	CQC Compliance Actions	NHSi
Our Target	Green	Over 80% Good or Very Good	15%	3rd	Outstanding	0	Segment 1
Performance trend since last report (Nov 2017)	↔	-	↑	↑	↔	↔	↔
Current performance	✓	✓	9.56%	2nd	Good	5	✓

Further information about what each metric means is available on page 23.

What do we want to achieve by 2021?

Mental Health

Berkshire Healthcare NHS Foundation Trust

The focus of our Mental Health Strategy is on the delivery of **safe services**, continuous **improvement in quality**, achieving good **outcomes** for service users, supported by **technology**.

We welcome the **Five Year Forward View for Mental Health**, and have a strong foundation for delivering its targets. The Delivery Plans for each of our ICSs prioritise the following:

Elimination of Acute Out of Area Placements by 2021 – achieving a 33% reduction each year, we will improve our bed management, ensuring an enhanced offer to patients (including 72 hour review, and completion of our Personality Disorder and discharge pathways). Our bed modelling has identified no requirement for additional beds, if we are able to reduce our length of stay.

Achieving access targets – for CAMHS, IAPT, EIP, and IPS. This represents a significant challenge given workforce shortages and demand growth. We will work with commissioners to achieve a smooth transition from NHSE non-recurrent funding, maintaining service developments.

Implementation of our Mental Health Workforce Plan – to mitigate the key risks presented by staff shortages, and include development of new roles as well as recruitment and retention initiatives.

Securing benefits to service users and staff from our **Global Digital Exemplar status**, and being an **early implementer of increased access to Talking Therapies**, we will drive innovation in our models of service delivery, use of data and shared electronic records.

We will develop a **Centre of Excellence** at **Prospect Park Hospital** by 2025, including establishing an effective service model and skill mix in both CRHTT and CMHTs. Our **QI programme** will empower our front line staff to work together with patients and carers. Our **workforce plan** will mitigate workforce risks, reducing vacancies and turnover.

Our **mental health pathways** – will provide a clear offer to service users, reducing internal variation, and achieve good outcomes for patients and effective use of resources. We will **reduce both acute and longer term out of area inpatient treatment** and work to mitigate the risk presented by reductions in local authority funding.

Managing increasing demand – in line with national trends, demand for mental health services are increasing, with pressures in our community services, the length of time patients stay in hospital and high bed occupancy rates. We will collaborate with partners to build a **new model for our Common Point of Entry** and **greater capacity for prevention/early intervention and recovery** through recovery colleges and community asset based approaches.

Suicide prevention – is a key priority for us and our **Zero Suicide Programme** outlines our work to develop additional staff training and development of safety plans with patients.

Physical health – we are committed to **reducing the inequality in life expectancy** for people with severe mental illness, achieve the national targets for **physical health checks and interventions** and improve communication with primary care. Mental health will be included in integrated service planning in our ICSs, **reducing avoidable urgent admissions** to acute hospitals, and our liaison services will continue to **reduce ED attendances**.

What do we want to achieve by 2021?

Community Health

Berkshire Healthcare NHS Foundation Trust

Simplifying referral arrangements and leadership structures were important priorities when we took responsibility for providing the large number and variety of community services in Berkshire. We now have a well-established "Health Hub" and a range of integrated services which benchmark well nationally. Our services operate in a complex environment with multiple partners, and demand for services and complexity of need are both increasing. Community Health Services do not have a Five Year Forward View policy document – although each ICS is prioritising development of community services to reduce avoidable hospital admissions.

Our key priorities are:

Establishing a sustainable service and staffing model for **Community and District Nursing** – including workforce planning, a recruitment & retention project and service development projects.

Using the results of bed modelling work currently in progress, we will complete longer term planning for our **Inpatient Services** – We will reduce variation in average length of stay, standardise processes and engage with our system partners to adopt and spread good practice.

Our **GP Out of Hours service** is experiencing cost pressures and staff shortages. We will work in partnership to develop solutions and new skill mix models to continue providing high quality care.

Planned Care – MSK/Audiology/podiatry/sexual health/dental services are operating in a commercially competitive environment – our offer will be clear and clinically/financially sustainable. We will develop use of technology in our service models and support self management.

We are participating in a number of system initiatives:

Ensuring the right number of beds are in right place, sustainably staffed. This is a bed modelling project in Berkshire West which will inform system planning to ensure effective use of resources. We will continue to contribute to reduction of delayed transfers of care in all inpatient services.

Transformation of primary care and establishment of local "cluster" teams. We will make a major contribution to the Frimley ICS initiative to develop I**ntegrated Care Decision Making** (ICDM) **Hubs** aiming to reduce non-elective admissions and delayed transfers for people with higher levels of need. We will work with Berkshire West partners to develop and implement similar plans across localities, moving towards "**population health**" solutions including Community Health, Primary Care, Social Care and Voluntary sectors.

Shared care record. The Connected Care programme is progressing well and will facilitate further development of our mobile working capability and facilitate new ways of working with patients online.

Optimum use of buildings. The One Public Estate initiative will enable co-location of services to enable delivery of new models – particularly ICDM hubs.

Workforce development. Introducing new roles to support evidence based, innovative ways of working.

In addition, we will work with our partners to develop services and our **Health Hub** to achieve the following system objectives:

- Rapid access to multi-agency services
- Commitment to reduction of duplication, seamless delivery of services and shared care plans.

What do we want to achieve by 2021?

Children and Young People

Berkshire Healthcare NHS Foundation Trust

We have brought together physical and mental health services for children and young people into a **single directorate** – reflecting the national drive to provide joined up services. The new directorate has faced a considerable volume of tenders for health visiting, school nursing and integrated therapies (CYPIT) services but has made excellent progress in use of technology and service user participation. The operating environment includes unitary authority partners facing significant challenges, and a limited appetite for joint commissioning to date.

We will prioritise achievement of targets within the Five Year Forward View for Mental Health:

- 70,000 more children will access evidence based mental health care interventions. Community eating disorder teams are in place for children & young people. We will work with commissioners and partners to meet targets alongside agreed waiting times, and play our part in achieving a good experience of transition between services.
- There will be the right number of CAMHS inpatient beds in the right place, reducing the number of inappropriate out of area placements. Locally, this means relocating Willow House to establish a 10 to 12 bedded Tier 4 unit at Prospect Park Hospital by 2021, and actively supporting the New Model of Care for CAMHS with regional partners, for those needing access to specialist inpatient services.

Our objectives are:

Retention of Health Visiting, School Nursing and CYPIT Service contracts – cuts to local authority funding means careful work is needed to ensure quality and safety. We will benchmark our services against others and strive to demonstrate better performance and outcomes.

System work to identify pathway opportunities to improve experience, outcomes and use of resources – addressing unwarranted variation and improving our use of data to inform decision making

Implementation of SEND (Special Educational Needs and Disability) plans – providing a clear offer, simplifying access and improving experience, making best use of staff with specialist skills.

Delivery of evidence based system working resulting in **smooth transition** from local authority/third sector CAMHS providers and **reduction in "non accepted" referrals**

Delivery of the benefits of our **CYP Integration Programme** – using the opportunity presented by scale but understanding local needs. We will continue to develop our **Online Toolkit** and improving access to self help, signposting and access to services for young people and families as well as referrers. **Transition** between our services will be a good experience for CYP and their families.

Completion of a **Workforce Plan** for our Children and Young People's Directorate, addressing shortages in specific roles, improving recruitment and retention, developing new roles and responding to the development of new service models and ways of working.

What do we want to achieve by 2021?

People with a learning disability

Berkshire Healthcare NHS Foundation Trust

Our services are a small, but important part of our overall offer, and we have a clear focus on our direction and goals.

The national policy direction is to reduce provision of care and support in inpatient settings, address premature mortality and health inequality and ensure that action is taken to address serious quality /safety concerns. Our priorities reflect these themes along with work that is specifically relevant to Berkshire.

We are a partner in the Berkshire-wide **Transforming Care Programme**, working with commissioners, local authority and third sector partners to continuously improve service quality and outcomes, informed by the views of people using our services and carers.

In support of this programme, we have already **rationalised our inpatient services**, enabling our assessment and treatment beds to be focussed at our Prospect Park Hospital site. This service has gained **national accreditation**, providing assurance to people using the service and their families, staff and commissioners about the quality of services provided. We are also establishing **intensive community support team** working with people may require admission into hospital, to avert the need for admission where appropriate, and when admission is the correct approach , to minimise the time spent in hospital.

Our priorities are:

Promoting good health and wellbeing of people with a learning disability – tackling health inequality and premature mortality. We are working with partner organisations to ensure that people with a learning disability are able to access healthcare services that they need for their physical and mental health. We have a robust "Learning from Deaths" process which includes sensitive and compassionate communication with bereaved families and carers, careful review of health and care provided and transparency about the results of our process which are reported to the Trust Board.

To create a clear Community Service Offer –to people with a learning disability and their families – setting out what the g Community Teams for People with a Learning Disability and Intensive Community Support services will provide.

The development of a **Centre of Excellence at Prospect Park Hospital** incorporates the Campion Unit – our inpatient service for people with a learning disability. We will meet targets for reducing patient assaults to other patients and to staff.

We will develop a **sustainable staffing model** – addressing the risks of an aging workforce, and the effect of reductions in nurse training places and closure of education programmes available – resulting in fewer learning disability nurses available to work inpatient and community services.

What do we want to achieve by 2021?
Financial Planning

Berkshire Healthcare NHS Foundation Trust

Internal Focus: Improving our underlying surplus to £3.5m excluding Sustainability and Transformation Funding

We will:

- Retain sufficient cash for the continued investment in the development of our estate, equipment and IT infrastructure
- Establish and maintain a finance business partnering and rolling forecast model, aligned with front-line quality improvement activity
- Continue recurrent delivery of our financial targets, maintaining our low level risk profile with regulators
- Have a clear understanding of patient level and service costs, informing decisions about allocation of resources
- Achieve an affordable and sustainable workforce, with substantially reduced reliance on agency staffing
- Maintain a continual process for the identification, and delivery of cash releasing savings
- Complete clear, multi year, deliverable capital programmes
- Review and act upon opportunities identified in the Carter Report, to improve operational productivity and unwarranted variation.

External Focus: Achieving our system control total

We will:

- Work with commissioners to ensure our contracts recognise sufficient growth in our Mental Health and Community services
- Ensure we retain our core services, and take advantage of tendering opportunities which will benefit existing services and patients
- Continue to be seen as key partner in our local ICSs, contributing to the financial success of partners and attainment of system financial targets
- Ensure we have made maximum use of opportunities to secure funding through local and national initiatives
- Work with partners to complete capital plans linked to system wide priorities and investments

Appendices

Berkshire Healthcare NHS Foundation Trust

The appendices in the following pages contain:

True North: Plan on a page 18/19

Berkshire Healthcare NHS Foundation Trust

Our **vision:** To be **recognised** as the **leading community** and **mental health** service provider by **our staff, patients and partners**.

True North: Goal 1 - Harm-free care

✓ **To provide safe services, prevent self-harm and harm to others**

- We will align our efforts and work to deliver our 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
- All our services will contribute to an Outstanding Care Quality Commission rating

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

True North: Goal 2 - Supporting our staff

✓ **To strengthen our highly skilled and engaged workforce and provide a safe working environment**

- We will achieve improvements in 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
  - 20% reduction in assaults on staff
- Our recruitment and retention plans will reduce vacancies by 10%
- An additional 24 services will be trained in our Quality Improvement System
- We will achieve the objectives set out in the Equality Plans for each area

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

True North: Goal 3 - Good patient experience

✓ **To provide good outcomes from treatment and care**

- We will achieve 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
- We will reduce our use of prone restraint by 90% by the end of 2018/19
- All our services will focus on understanding and supporting outcomes of care that are important to patients

At a system level: We will contribute to Integrated Care System work streams to improve patient experience and outcomes.

True North: Goal 4 – Money matters

✓ **To deliver services that are efficient and financially sustainable**

- We will deliver our financial plan for the year and achieve £5m internal savings
- We will continue to improve our efficiency in the way we buy goods and services and further reducing our use of agency staff
- People needing mental health inpatient care will be able to access it locally, eliminating the need for acute out of area treatment by 2021
- We will achieve our environmental targets, reducing our use of fuel and water

At a system level: We will contribute to the achievement of the financial targets in Berkshire West and Frimley Health and Care Integrated Care Systems.

Quality Strategy 2016 – 2020

The six elements

Berkshire Healthcare NHS Foundation Trust

1. Safety

Avoid harm from care that is intended to help.

We will:

Build a culture of patient safety through our Quality Improvement approach. We will also be open, honest and transparent with incidents and complaints ensuring that lessons are learnt and shared.

2. Clinical Effectiveness

Providing services based on best practice and innovation.

We will:

Use Quality Improvement methodology, clinical audit and research to drive improvement and advances in the use of technology.

Follow relevant NICE guidance

3. Patient Experience and Involvement

Patients have a positive experience of our service and receive respectful, responsive personal care.

We will:

Demonstrate a compassionate approach in our treatment and care of patients.

Engage people in their care, supporting them to take control and get the most out of their life

Ask for and act on both positive and negative patient feedback.

Our vision:

To be **recognised** as the **leading community** and **mental health** service provider by **our staff, patients** and **partners.**

4. Organisational Culture

Achieving satisfied patients and motivated staff.

We will:

Act in line with our values, with a strong focus on delivering services which provide good outcomes for patients and their families.

Listen and respond to our staff and provide support and opportunities for training, development.

5. Efficiency

Providing care at the right time, in the right way and in the right place.

We will:

Review our services to make sure they're well organised and efficient. Use our Quality Improvement approach to eliminate waste.

6. Equity

Providing equal care regardless of personal characteristics, gender, ethnicity and socio-economic status.

We will:

Provide services based on need.

Mental Health Strategy Summary 2016 - 2021

NHS
Berkshire Healthcare
NHS Foundation Trust

Effective & compassionate help

- *Evidence-based pathways*
- *Safe, effective services achieving outcomes which are meaningful to service users*
- *Inpatient services represent a "centre of excellence"*
- *Suicide Prevention*

Supporting our staff

- *Recruiting and retaining skilled and compassionate staff*
- *Developing new roles*
- *Enabling creativity, innovation and effective delivery*
- *Building strong clinical and managerial leadership, a quality improvement and research culture*

Working with service users and carers

- *Guiding development of our services*
- *Supporting self management*

Safer, improved services with better outcomes, supported by technology

Good experience of treatment and care

- *Personalised care supporting recovery & quality of life*
- *Meeting both physical and mental health needs*

Straightforward access to services

- *Meeting national targets*
- *Effective and integrated urgent care*
- *Expanding online and telehealth services*
- *Tackling discrimination and stigma*

Working with partners and communities

- *Partnerships with primary care, social care and voluntary sector organisations*
- *Integrating mental health within locality services, and system sustainability and transformation plans*
- *Supporting prevention, early intervention & peer support*

Workforce Strategy 2016 – 20

The 6 Key Elements

Berkshire Healthcare NHS Foundation Trust

1. Grow our own workforce

Offer attractive and structured career pathways and pay progression in critical / hard to fill roles

We will:

Develop new roles, increase apprenticeships and recruitment of recently qualified clinicians

Reduce staff turnover by investing in development and career progression.

2. Develop and promote our employer brand

Promote the benefits of working for the Trust to maximise recruitment

We will:

Use our refreshed Trust website and social media to develop an authentic brand based on high levels of staff engagement and organisational performance

Our aim: a workforce with the capabilities and capacity needed to provide great care and treatment in a financially sustainable way

3. Align our workforce and service models

Optimise quality and workforce productivity

We will:

Design and deliver evidence based ways of working, supported by benchmarking, accreditation, peer review and Quality Improvement methodology.

We will develop the digital capability of our workforce.

4. Plan and meet demand sustainably

Aligning workforce capacity and capabilities with service demands

We will:

Complete and implement evidence based workforce plans for mental health & community inpatient, physical and community adult and children's services.

5. Know our numbers

Monitor, manage and improve workforce utilisation, and efficiency.

We will:

Embed e-rostering and temporary staffing best practices to manage staffing resources efficiently.

6. Build our strategic workforce planning capability

Fit for purpose processes, information and decision-making

We will:

Develop in-house expertise, draw on best practice and bring together activity, financial and staffing data to strengthen planning and monitoring.

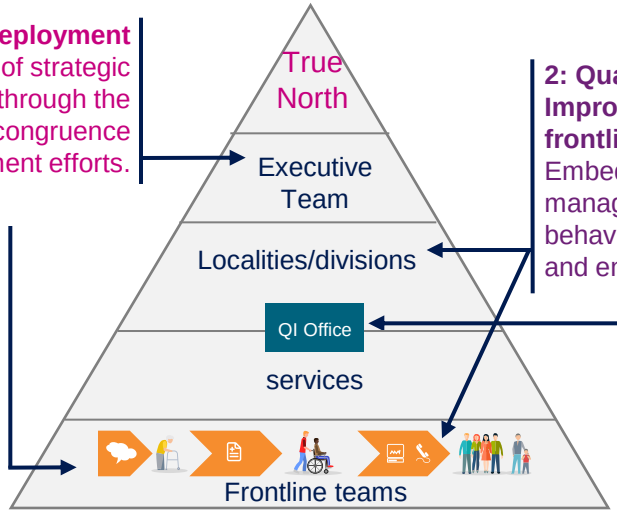
Quality Improvement Programme

Berkshire Healthcare NHS Foundation Trust

Overview: The purpose of our QI Programme is to support the Trust deliver its aim of providing the best quality and financially sustainable care, and being the provider of choice – in particular achieve an Outstanding CQC rating. The programme is based on Lean methodology and has four workstreams:

1: Strategy Deployment
Identifying a small number of strategic priorities and cascading these through the organisation to achieve goal congruence and align improvement efforts.

3: Quality Improvement Projects
Making improvements in areas that are too complex to be resolved through daily continuous improvement techniques



2: Quality Management Improvement System (QMIS) – frontline & senior management
Embedding a common set of management routines and behaviours to align performance and enable daily improvements

4: QI Office. Ensuring structured accountability, support and dedicated resources for improvement activities. Developing capabilities for improvement across the Trust..

Key milestones

Year	2018							2019				2020
Month	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar
Strategy Deployment	Objectives dialogues			Revised FP&R and division Performance Meetings								
		Review governance structure & Non-Executive Director development			Plan on a Page and annual planning review						Annual Planning	
Senior management QMIS roll out			Wave 2					Wave 3				
Frontline QMIS roll out				Wave 4				Wave 6		Wave 8		Wave 10
	Wave 3			Wave 5					Wave 7		Wave 9	Wave 11
Projects	EUPD Pathway				Other Projects					Other Quality Improvement Projects		

Equality and Inclusion Strategy 2016 – 20

NHS
Berkshire Healthcare
NHS Foundation Trust

Our Approach

We use the following frameworks to comply with legislation , regulator and commissioner requirements:

- The NHS Equality Delivery System (EDS2)
- The NHS Workforce Race Equality Standard (WRES)
- The Stonewall Workplace Equality Index (Sexual orientation)
- Accessible Information Standard (Disability).

We also reference our Time to Change health check undertaken in 2014 when considering progress on mental ill-health.

We will meet with community and staff equality panels every two years to grade our performance and set priorities.(EDS2) .

We will use the Stonewall Workplace Index annually.

We will develop local equality plans for each major service area to drive progress in delivering our Equality and Inclusion Objectives. These plans will also reflect local engagement with people who use our services, community and voluntary sector groups and our own staff.

Our Equality and Inclusion Strategy

sets out specific targets for our **leadership**, continued development of our **staff networks**, our approach to **communication** and support required from our **learning and development team.**

Our CARE Principles:
Challenging unfairness
Appreciating difference
Respecting the individual
Everyone's business

Why it is important to us

Achieving our equality and inclusion objectives is a key part of our vision

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

as well as being true to our values:

caring, committed, together.

Our Objectives

1. 20% representation of black and minority ethnic staff in (Agenda for Change) bands 7 and 8a-d
2. No difference in perceptions of equal opportunity in career progression between white and BME staff (in annual staff survey)
3. Lowest quartile rankings for harassment and bullying (reported in the annual staff survey) and equity in reporting between BME and white staff.
4. Improvement in the well-being of disabled staff and a reduction in the proportion of staff experiencing stress related illness
5. Maintain Top 100 Workplace Equality Index Employer status with a ranking in the top five health and social care providers
6. Engage with BME, LGBT and disabled people to inform our understanding of their needs, ensuring good patient experience and equity of access in both mental and community health.
7. A more robust approach to making reasonable adjustments for disabled people – in particular implementation of the NHS Accessible Information Standard.

Our Information Management & Technology Roadmap....central to the achievement of safe, quality services for patients, good job satisfaction for staff and effective use of resources

NHS
Berkshire Healthcare
NHS Foundation Trust

Building the foundations

Our **Mobile Working** initiative has enabled significant efficiency benefits, enhanced by extended use of **Skype for Business**
We have established a **single electronic patient record system** across physical and mental health services.
We have developed **online talking therapy services** and expanded our **Support Hope and Recovery Online Networks** (SHaRON) across a range of services.
Our **Health Hub** and **Children and Young People Service Online Toolkit** enable improved access to our services. We use **Tableau data analysis reports** to inform service monitoring and development and will continue to prioritise informatics development

By 2021 we will have:

- Developed our **IT Architecture** through a new data network, email, skype, document and data storage in the cloud and moved to Windows 10 and Office 365 desktops
- Completed our **phase 2 mobile working.**

Our GDE Programme

Being awarded "Global Digital Exemplar" status will enable us to achieve important outcomes in terms of: digital patient access and communications; digital wards & services; digital workforce; analytics for research, safety & quality improvement.

By 2021 we will have:

- Established e-observations, patient safety monitoring and alerts and fully implemented e-prescribing
- Implemented electronic bed monitoring, health analytics for clinical teams, digital care pathways and online supervision
- Significantly expanded online consultations, online therapy, therapeutic networks and signposting, and online support to care homes
- Developed a plan (through our workforce strategy) to build our digital competency and confidence.

System Working

We are committed to the ongoing development of the Berkshire-wide **Connected Care** programme which will deliver joined up care planning and delivery across health and social care.

By 2021 we will have:

- Achieved **shared care records** with acute, primary and social care partners.
- Established our **patient portal**, enabling people to access and contribute to their own records
- Built our **population health management** capability
- Implemented greater use of **e-referrals** and the Cancer Care Information Exchange
- Progressed our **Local Health and Care Record Exemplar** (subject to outcome of bid in progress). This is a significant multi-system initiative led by our AHSN.

Our Estate Strategy

Berkshire Healthcare NHS Foundation Trust

Building the foundations

We have established **two strategic hubs** for core services , enabling release of 6 leased buildings and disposal of 3 legacy properties to fund investments into new buildings

We extended our **contract with NHS Property Services to provide Estates and Facilities Management (EFM) services across Berkshire**, protecting our commercial and strategic influence, and income. We have created **Agile Working** space across Berkshire to support our **Mobile Working** initiatives.

We developed our Berkshire Adolescence Unit (Willow House) **24*7 Tier 4 In-patient Services**

By 2021 we will have:

- Established our Whiteknights site as a **centre of excellence** for **Children's services** and **Specialist Learning Disability** services
- Established a new **highly functional and technology enabled HQ** site in central Berkshire and consolidated our back office
- Completed **LD Campion Unit move to Jasmine Ward** and transfer of **Willow House Tier 4 In-patient Services** to leading edge facilities at Prospect Park Hospital

Our Vision

Delivering effective high quality EFM services and safe, clean, efficient work environments for staff to support the delivery of outstanding care to patients and service users - taking pride in delivering excellent services

Key Principles

1. Our **estate is an enabler**, not a driver, of service delivery.
2. We will ensure our estate is in the **right condition**, **functionally suitable**, **complies with the law**, and **adheres to healthcare standards and codes of practice**.
3. We will **maximum flexibility** & **optimise utilisation** of our estate.
4. We will **maximise the use of 'committed' assets**.
5. We will ensure our estate is **in the right place**.
6. Our estate will be **sustainable.**
7. We will **maximise value for money** from the estate.
8. We will **embrace the benefits** of the **NHS Premises Assurance Model** (PAM).

System Working

We are committed to our role as a system partner within the two local Sustainability and Transformation Partnerships (STP) and two Integrated Care Systems (ICS), and One Public Estate initiatives. We will actively seek to maximise system estate synergies, and the efficient use of buildings & services.

By 2021 we will have:

- Developed and implemented the **Integrated Care Hub** strategy across Berkshire East ICS including the development of Upton and St Marks Hospitals
- Delivered the **West Berkshire Renal and Cancer Care Unit**
- Integrated CYPF, CAMHs and services currently at Dingley at **Whiteknights**
- Integrated Skimped Hill community services at **Brants Bridge** and enabled disposal of the NHSPS site.
- Developed an exit plan for premises on Bath Road, enabling **improved facilities** for Berkshire West CCG and our IT services, and release the site.

Berkshire West ICS Priorities

NHS
Berkshire Healthcare
NHS Foundation Trust

Next steps on the NHS Five Year Forward View

Deliver the Five Year Forward View along with national priorities

- Cancer
- Mental Health
- Urgent Care
- Primary Care
- Maternity
- Learning disabilities

Local transformation priorities

- Outpatient transformation
- Respiratory Service
- High Intensity Users programme
- MSK
- Diabetes

Deliver financial sustainability

- Payment Mechanism
- System Control Total
- New contractual forms
- 10 point efficiency plan

Embed a population health approach

- Risk stratification
- Health profiling
- Prevention and self care

Berkshire West Integrated Care System – Governance and Leadership
Enablers – Back office, Estates, Digital, Workforce, Bed modelling

Frimley Health & Care ICS Plan on a Page

Berkshire Healthcare NHS Foundation Trust

Five Year Priorities

National

National 'must do's':
Primary Care
Urgent and Emergency Care
Referral to treatment times
Cancer
Improving quality
Financial sustainability
Development of high quality STP

Local

Priority 1: Making a substantial step change to improve wellbeing, increase prevention, self-care and early detection

Priority 2: Action to improve long term condition outcomes including greater self management & proactive management across all providers for people with single long term conditions

Priority 3: Frailty Management: Proactive management of frail patients with multiple complex physical & mental health long term conditions, reducing crises and prolonged hospital stays

Priority 4: Redesigning urgent and emergency care, including integrated working and primary care models providing timely care in the most appropriate place

Priority 5: Reducing variation and health inequalities across pathways to improve outcomes and maximise value for citizens across the population, supported by evidence

Transformation Initiatives

1.Prevention & Self-care: Ensure people have the skills, confidence and support **to take responsibility for their own health and wellbeing**

2.Integrated care decision-making: Develop **integrated decision making hubs** to provide single points of access to services such as rapid response and re-ablement

3.GP Transformation: Lay foundations for a new model of **general practice provided at scale**, including development of GP federations to improve resilience and capacity.

4.Support Workforce: Design a **support workforce** that is fit for purpose across the system

5.Care and Support: Transform **the social care support market** including a comprehensive capacity and demand analysis and market management

6.Reducing clinical variation: Reduce **clinical variation** to improve outcomes and maximise value for individuals across the population.

7.Shared Care record: Implement a **shared care record** that is accessible to professionals across the STP footprint.

Cross cutting Programmes

Cross cutting Programmes

- Urgent & Emergency Care
- Mental Health & Learning Disabilities
- Maternity
- Children & Young People
- Cancer

Enablers

Enablers

- Workforce
- Analytics
- Estates
- Digital & Technology

Healthcare from the heart of your community

Vision Metrics explained

Berkshire Healthcare NHS Foundation Trust

Our vision metrics are framed around 4 areas which the Board have identified to demonstrate progress towards achieving our vision.

Quality

These have been selected to reflect our highest areas of risk to service quality, benchmarked against other similar trusts in England:

- Assaults on patients by other patients in our mental health services
- Assaults on staff by patients
- The use of restraint (where staff restrain patients physically to prevent harm to themselves or others)

Further measures demonstrating the quality of our services are shown in our regulatory compliance section.

Safety

Safety, or harm-free care, is an area of high importance to both people receiving services, and staff. The following metrics have been identified:

- The number of times patients are harmed due to falling while in our care, where this could have been avoided
- The number of patients who die while receiving care in an inpatient setting
- The proportion of beds being used in our mental health inpatient services (best practice is to have some beds available to provide safe services and for people requiring admission, who may otherwise require services outside of Berkshire)
- The number of 'never events' – these are serious, largely preventable patient safety incidents which should have been avoided
- The number of category 3 or 4 pressure ulcers developed by patients, which could have been avoided - reducing occurrences year on year
- The number of people who commit suicide for every 10,000 people receiving mental health services. We are committed to the national Zero Suicide programme, with a target of reducing the numbers of people who commit suicide by 10% by 2021 (compared to 2016/17).

Engagement

The following measures are intended to reflect the levels of confidence key stakeholders have in our services, and how well we engage with our staff – which is an important indicator of staff satisfaction and the quality of services we provide:

- The additional investment our commissioners make into our services each year, reflecting their confidence to develop and improve services
- The levels of satisfaction from our major stakeholders, including our commissioners, with our services, taken from a regular survey
- The response rate of people using our services to our Friends and Family Test, which is an indicator of their satisfaction with our services
- The scores from our independent annual staff survey for staff engagement, benchmarked against scores from similar trusts.

Regulatory compliance

These metrics provide an independent assessment of service quality, and our performance financially and as a business:

- Our rating by the Care Quality Commission, who monitor, inspect and regulate all health and social care services against standards of quality and safety
- The number of CQC compliance actions, where we have fallen short of the regulatory standards required
- NHS Improvement, which is responsible for overseeing organisations who provide NHS services, assesses each trust on five themes of: quality of care, finance and use of resources, operational performance, strategic change and leadership and improvement capability. Segment 1 is the highest rating; with maximum autonomy and no potential support needs identified.

Equality Impact Analysis of our Strategic Plan Summary

Our approach

Our **Equality and Inclusion Strategy**, summarised on page 18, sets out our objectives for 2016-20. Equality and inclusion is central to our vision and values because everyone has a right to be treated with dignity and respect. To ensure all our activities are inclusive, we undertake **Equality Impact Analyses** (EIA) for our policies and major strategies, and **Quality Impact Analyses** for our service development plans (including cost improvements) which enable us to understand the potential impacts on people who use our services.

We are continuing to develop our approach to EIA, to ensure that it is well embedded in our planning processes as well as implementation arrangements.

Our **Diversity Steering Group** monitors our progress on delivering our Equality and Inclusion Strategy, and each of our localities has a **Local Equality Plan**. This is informed by our use of the NHS **Equality Delivery System** which includes assessment against specific outcomes relating to our role as service provider and employer.

Our **Strategy Implementation Plan** provides the Board and senior leadership team oversight of the delivery of all of our strategies and major programmes, including our equality and inclusion activities.

Some of our priorities to promote inclusion and equality within services include:

Mental Health

Our Mental Health Strategy (summarised on page 7) addresses the inequality in physical health status and life expectancy for people with longer term mental health problems. We have also undertaken analysis of the proportion of people from black and minority ethnic backgrounds who are compulsorily admitted to hospital, to inform actions regarding early intervention.
Our "Time to Change" initiative aims to address stigma and encourage awareness and support for our staff in terms of their own mental health.

Community Health

The development of Integrated Hubs and extended primary care teams (described on page 8) enable our services to be closely linked to the diverse communities they serve. We are providing person-centred services to people with long term health problems, and physical disabilities of all ages.

Children and Young People

Our arrangements for service user participation continue to develop well and include the need for inclusion of the diverse communities we serve. Our online service offer will support increased and simplified access to services for local young people and their families.

Learning Disability

We are prioritising the physical health needs of our services users, to address health inequality issues and also reduced life expectancy. We also have a well established and robust process for learning from deaths. (More details are available on page 10).

Reference documents and resources

Berkshire Healthcare NHS Foundation Trust

Our key documents

Equality and Inclusion Strategy
Mental Health Strategy
Quality Strategy
Quality Account
Workforce Strategy
Strategic Plan Summary 2014-19
Operational Plan 2017-19

Our regulators

Care Quality Commission overview and inspections (webpage)
NHS Improvement Berkshire Healthcare (webpage)
NHS Improvement Single Oversight Framework (webpage)

National documents

Five Year Forward View
Five Year Forward View for Mental Health
Implementing the Five Year Forward View for Mental Health
The Mental Health Provider Challenge (NHS Providers' webpage)
NHS Equality Delivery System 2

System documents

Frimley Health and Care STP/ICS (webpage)
Berkshire West Oxfordshire and Buckinghamshire STP (webpage)
Berkshire West ICS
Frimley Health and Care ICS 2018-19 System Operational Plan (when available)
Berkshire West ICS 2018-19 System Operational Plan (when available)

Joint Strategic Needs Assessment for West Berkshire (webpage)
Joint Strategic Needs Assessment for Reading (webpage)
Joint Strategic Needs Assessment for Wokingham (webpage)
Joint Strategic Needs Assessment for Slough (webpage)
Joint Strategic Needs Assessment for Windsor and Maidenhead (webpage)
Joint Strategic Needs Assessment for Bracknell Forest (webpage)

Health profile for West Berkshire 2017 (Public Health England)
Health profile for Reading 2017 (Public Health England)
Health Profile for Wokingham 2017 (Public Health England)
Health Profile for Slough 2017 (Public Health England)
Health Profile for Bracknell Forest 2017 (Public Health England)
Health Profile for Windsor and Maidenhead 2017 (Public Health England)

Glossary of terms

Berkshire Healthcare NHS Foundation Trust

AHSN	Academic Health Science Network
BME	Black and Minority Ethnic
CAMHS	Child and Adolescent Mental Health Services
CCG	Clinical Commissioning Group
CMHT	Community Mental Health Team
CQC	Care Quality Commission
CRHTT	Crisis Resolution and Home Treatment Team
CYP	Children and Young People
CYPF	Children, Young People and Families
CYPIT	Children and Young People Integrated Therapies
ED	Emergency Department
EDS2	Equality Delivery System (version) 2
EFM	Estates and Facilities Management
EIP	Early Intervention in Psychosis
EUPD	Emotionally Unstable Personality Disorder
FP&R	Finance Performance and Risk (Executive meeting)
GDE	Global Digital Exemplar
HQ	Headquarters
IAPT	Improving Access to Psychological Therapies
ICDM	Integrated Care Decision Making (hub)
ICS	Integrated Care System
IPS	Individual Placement and Support
IT	Information Management
LD	Learning Disability
LGBT	Lesbian Gay Bisexual and Transsexual
NHSE	NHS England
NHSi	NHS Improvement
NHSPS	NHS Property Services
PAM	Premises Assurance Model
QI	Quality Improvement programme
QMIS	Quality Management Improvement System
SEND	Special Educational Needs and Disability
SHaRON	Support Hope and Recovery Online Network
STP	Sustainability and Transformation Partnership
WRES	Workforce Race Equality Standard

Trust Board Paper

Board Meeting Date	10 July 2018
Title	Mental Health Strategy Progress Update
Purpose	To provide a progress report on the implementation of the Board's strategy at the end of June 2018.
Business Area	Corporate
Author	Director of Corporate Affairs
Relevant Strategic Objectives	Supports all strategic objectives
CQC Registration/Patient Care Impacts	Our mental health strategy supports delivery of safe, good quality care and a good experience of care for patients.
Resource Impacts	Achievement of the key priorities within our mental health strategy will provide financial benefits and mitigation of financial risk.
Legal Implications	None
Equality and Diversity Implications	Our Mental Health Strategy aims to address inequalities experienced by people with mental health problems through the achievement of Five Year Forward View for Mental Health Targets. This includes physical health inequalities resulting in lower life expectancy. Inclusion and equality of opportunity for our mental health workforce is addressed within our overall Workforce Strategy, and we will reflect relevant aspects of this in our Mental Health Workforce Plan submissions to Health Education England/NHS England.

SUMMARY	The attached paper provides a report on progress against the key priorities within the strategy approved by the Trust Board in December 2016.
	The paper provides an overview of:
	• Developments in national policy/local operating context since November 2017 when the last progress update was provided
	  • Mental Health workforce
	  • System working
	• What we have done in terms of:
	  • Establishing governance

	• Taking forward key initiatives and strategic intentions • Progress against key targets
ACTION	The Board is asked to note the progress made against the strategy priorities.

Berkshire Healthcare NHS
NHS Foundation Trust

Mental Health Strategy 2016 – 21

Progress Update

July 2018

Berkshire Healthcare NHS Foundation Trust

Healthcare from the heart of your community

www.berkshirehealthcare.nhs.uk

Mental Health Strategy Summary 2016 - 2021

Berkshire Healthcare NHS
NHS Foundation Trust

Effective and compassionate help

- Evidence-based pathways
- Safe, effective services achieving outcomes which are meaningful to service users
- Inpatient services represent a "centre of excellence"
- Suicide Prevention.

Supporting our staff

- Recruiting and retaining skilled, compassionate staff
- Developing new roles
- Enabling creativity, innovation and effective delivery
- Building strong clinical and managerial leadership, a quality improvement and research culture.

Working with service users and carers

- Guiding development of our services
- Supporting self management.

Safer, improved services with better outcomes, supported by technology

Good experience of treatment and care

- Personalised care supporting recovery and quality of life
- Meeting both physical and mental health needs.

Straightforward access to services

- Meeting national targets
- Effective and integrated urgent care
- Expanding online and telehealth services
- Tackling discrimination and stigma.

Working with partners and communities

- Partnerships with primary care, social care and voluntary sector organisations
- Integrating mental health within locality services, and system sustainability and transformation plans
- Supporting prevention, early intervention and peer support.

Our Mental Health Strategy – progress since December 2016

The Trust Board approved our strategy in December 2016, ensuring it was aligned with our vision, values and key strategic objectives. The priority areas of focus were confirmed as:

Safer, improved services with better outcomes, supported by technology

Progress updates were provided to the Trust Board in May and November 2017, and this paper provides an overview of changes since then:

- Developments in national policy/local operating context since Nov 2017
    - Mental Health Workforce
    - System working
- What we have done in terms of:
    - Ensuring effective governance
    - Taking forward key initiatives and strategic intentions
    - Progress against national targets
- Planned next steps

Developments in national policy since November 2017

We have continued to submit Mental Health Delivery Plans to NHS England through our Sustainability and Transformation Partnerships . In addition, we have provided Mental Health Workforce Plans via Health Education England. These are now being triangulated with Mental Health Investment Plans to ensure delivery of the Five Year Forward View for Mental Health (FVMH), to ensure planned investment is reaching services., resulting in staff increases in line with national commitments.

As anticipated, there has been a continuation of the process used by NHSE to provide non-recurrent funding to support progress against FYFVMH targets. At the time of the last progress update, working with partners on bids for Individual Placement Support Services which facilitate people with serious mental illness into employment, and have been successful in securing funding to develop services in both Berkshire West and Frimley.

We are part of a group of Integrated Care System Mental Health Leads established in October 2017with support from Claire Murdoch, national mental health director for NHS England, who visited Berkshire West in May 2018. Very positive feedback was provided following this visit, which provided an opportunity to outline some of our key achievements as well as discuss areas of work presenting the biggest challenge. Claire Murdoch will attend the Mental Health Steering Group for the Frimley ICS in July, when a similar approach will be taken.

Mental Health Strategy and system working

Berkshire Healthcare NHS
NHS Foundation Trust

Developments in Berkshire-wide Initiatives

Mental Health has continued to attract a higher profile in **A&E Delivery Boards** in both halves of the county, and work on reduction of delayed transfers of care includes mental health as well as community and acute beds. However, significant pressure on inpatient services has continued, with high bed occupancy and longer lengths of stay, along with greater number of compulsory admissions to Prospect Park Hospital. More recent work has started to achieve positive progress, however, sustained change presents a significant challenge. We have completed a bed modelling exercise to analyse the needs of our local population over the next few years and inform medium – longer term planning.

Our **Early Implementer IAPT Programme** to increase access and develop services for people with long term physical health problems is demonstrating evidence of impact in terms of reduced GP and A&E attendances. A Thames Valley Suicide Prevention and Intervention Network is well established and linked with the Crisis Care Concordat and our own Zero Suicide Strategy. The **Connected Care** Programme has progressed well and Berkshire Healthcare staff are now accessing shared electronic records as planned.

We have secured NHS England funding to expand our Individual Placement Support service across Berkshire to enable people with serious mental health problems to secure employment.

We are continuing to work on the establishment of a joint commissioner and provider team to lead strategic planning and transformation in mental health across Berkshire, aligned with Surrey and Hampshire organisations for the Frimley Health and Care Sustainability and Transformation Partnership (STP)

Berkshire East

The Frimley Health and Care STP has established a Mental Health Steering Group to oversee delivery of FYFVMH targets as well as to ensure focus on all 7 STP priority initiatives to develop:

- **Support for peoples own responsibility for health and wellbeing**
- **Integrated decision making hubs**
- **A new model of General Practice at scale**
- **The support workforce across the system**
- **Social Care market analysis and management**
- **Analysis and reduction of clinical variation**
- **A Shared Care Record accessible across the system**

Mental Health Delivery Plans and Workforce Plans have been completed in partnership with Surrey and Borders Partnership Trust and local commissioners. Workshops have been held to identify work required to reduce out of area placements, and to consider the interface with GP Transformation work in progress. A mental health reference group has been established to enable engagement of service users and voluntary sector organisations.

Berkshire West

Our mental health service staff continue to be part of the following clinical work streams of the **Integrated Care System**:

- **The system-wide bed review**
- **The response to high Intensity service users.**
- **The analysis and approach to physical and mental health co-morbidities.**

The **Berkshire West 10 Integration Programme** has increased its focus on mental health and has facilitated improvements in the decision making progress for funding support for people subject to section 117 of the Mental Health Act.

We have contributed to mental health delivery plan submissions for the B**uckinghamshire, Oxfordshire and Berkshire West (BOB) STP**, trajectories for decreasing numbers of out of area placement, and also completed our local mental health workforce plans. Our Berkshire West Mental Health Delivery Group continues to oversee delivery of FVFVMH targets and report progress to the ICS and Integration Boards.

Work is in progress to confirm key priorities for action for BOB STP, to be coordinated by our Director of Corporate Affairs and the Chief Executive of Oxford Health.

Mental Health Strategy priorities and governance

Berkshire Healthcare NHS
NHS Foundation Trust

Key priorities
There is a good alignment between our vision, values, organisational priorities and our mental health strategy priorities:
Safer, Improved services with better outcomes, supported by technology

Our Trust Board Vision metrics that are specifically relevant to our mental health strategy priorities include:

- Patient assaults
- Use of restraint
- Inpatient deaths
- Suicide rate for people under mental health care
- Bed occupancy

As part of our Quality Improvement Programme, we have identified a number of "True North" metrics that are specific to our mental health services:

- Number of self harm incidents
- Violence and aggression incidents to staff

We have also prioritised implementation of our Quality Management Improvement System within Prospect Park Hospital.

We have used our Strategy Deployment process to help us prioritise key initiatives, which is now starting to incorporate local projects and initiatives.

This will guide our project resourcing decisions and guard against individual clinical or corporate services being over-burdened at any one time.
The following slide shows the significant initiatives within our mental health strategy, which will be enabled by technology and use of quality improvement methodology. This is followed by an outline of progress regarding each of the initiatives, a summary of our plans for technology enabled service delivery, the targets against which we will measure our progress and our planned next steps.

Governance
Our **Mental Health Programme Board**, accountable to the Business and Strategy Executive continues to oversee implementation of the Mental Health Strategy, Prospect Park Development Programme and Mental Health Pathways and Clustering. This group enables project leads to address interdependencies between initiatives.

Our IAPT service development is now implemented as "business as usual", reporting progress into Trust Business Group and Quality and Finance Executive meetings. There are also 2 Steering Boards in East and West Berkshire with commissioners.

The **Zero Suicide** initiative reports to our Quality Executive and is linked to the Berkshire suicide prevention steering group.

Urgent Care developments are managed through our operational management structures and our membership of A&E Delivery Boards. The management of "acute overspill" **out of area placements** is managed through a project board led by the Director of Nursing and Governance.

Our Trust Business Group provides oversight of contractual arrangements for the provision of **Longer Term Care.**

A **Global Digital Exemplar Board, chaired by our Chief Executive is well** established and oversee delivery of objectives set out within our bid.

The following slide provides the high level implementation "road map" for the key initiatives included in the strategy approved by the Trust Board

Mental Health Strategy
Implementation roadmap December 2016

Berkshire Healthcare NHS
NHS Foundation Trust

	2016 - 18	2018 - 19	2019 - 21
PPH Development	Staffing, bed optimisation and centre of excellence projects established and meeting targets	Medium –term actions delivered, pathways and patient/carer engagement well established	Long term actions delivered. Strategy reviewed and future priorities confirmed
Pathways	Implementation of priority pathways – initial focus on people with personality disorder	All evidence based pathways established and tariff implications confirmed with commissioners	Outcomes reviewed and benchmarked to inform further work required
Zero suicide	Completion and implementation of strategy linked to system suicide prevention plan	Medium –term actions delivered	Long term actions delivered. Strategy reviewed and future priorities confirmed
Urgent Care	System reviewed including PMS, PoS, CRHTT and CMHT pathways	Alternatives to admission reviewed and priority actions confirmed and implemented	Long term actions delivered. Strategy reviewed and future priorities confirmed
IAPT	Early implementer programme: increasing access and delivering for priority long term conditions	Plans for future sustainability completed and agreed with commissioners	Services covering wide range of long term conditions and delivering positive outcomes
Longer term care	Priority actions for Out of Area Placement reduction confirmed and implemented	Partnership actions with UAs, Vol. sector & housing providers confirmed and implemented	Long term actions delivered. Strategy reviewed and future priorities confirmed

Technology enabled service delivery: online programmes, skype and SHaRON expansion. Informatics development.

Quality Improvement methodology enabling safer, evidence-based services with better outcomes

Progress on Key Initiatives

Berkshire Healthcare NHS
NHS Foundation Trust

Prospect Park Hospital Development

Bed Optimisation:
This project was established to achieve:

- No Out of Area Placements (OAPs) as a result of acute overspill
- Acute adult bed occupancy consistently below 90%

A "spring to green" initiative has been successful in reducing placement numbers and work is in progress to ensure sustainable ways of maintaining low numbers. This includes the introduction of robust procedures for approval at Executive level. Support is needed from partner providers and commissioners to achieve our objectives and reduction of out of area placements is a key area of focus in both STP Delivery Plans. This project is now part of the "Eliminating Overspill , Optimising Recovery and Rehabilitation" described on page 8.

Staffing:
The Staffing Project has primarily focused on new roles and new approaches to recruitment. New Band 4 and Band 6 roles were established and filled. A benchmarked review of safe staffing was undertaken and work on the overall skill mix completed.. Further work is planned to address remaining challenges regarding vacancies in Band 5 nursing posts and further reduce turnover. This will be informed by a "deep dive" understanding of the challenges being experienced by front line staff, and their views about how to improve our current staffing challenges. Although good progress has been made, we will need a sustained focus to reduce vacancies in the long term.

Centre of Excellence:
Definition and confirmation of scope was deferred to enable prioritisation of Bed Optimisation, Staffing and Quality Improvement Initiatives. However, work has been completed to seek the views of service users, which will inform planning to be completed by October 2018. A physical health lead has been appointed and good progress made in addressing issues which contribute to health inequalities experienced by people with serious mental health problems.

IAPT

Our key initiatives are now incorporated into regular operational management and reporting arrangements. These include:

- Early Implementer pilot
- Skype pilot
- Development of online packages in partnership with Silvercloud
- Surrey AQP
- Healthmakers

Good progress is being made, and the Early Implementer pilot is continuing to show reductions in A&E and GP attendances of patients receiving Talking Therapies. Agreement was reached with commissioners to identify 18/19 funding beyond the non-recurrent NHSE funding.
Development of employment advisor roles is continuing, with additional funds secured from Department of Work and Pensions.

Zero suicide

This include four key priority areas of focus :

- A reduction in the rate of suicide of people under mental health care
- Increase in positive staff attitude and a proactive approach to suicide prevention
- An optimised RiO system for recording risk
- Families, carers and staff will feel supported and know where they can get support after a suicide

Progress updates provided to our Quality Executive have highlighted progress in terms of:

- meeting target of 10% reduction from 2015/16 baseline, but this need to be viewed over a sustained period.
- 3 day suicide awareness course continues to be well evaluated and attended.
- Risk audits continue to show steady progress
- Carer training on suicide awareness available.

BHFT will host a Zero Suicide Conference in December

Progress on Key Initiatives

Berkshire Healthcare NHS
NHS Foundation Trust

Pathways and Clustering

This programme was set up to optimise service delivery and to understand and improve outcomes for service users, while also positioning the Trust to meet anticipated changes to commissioning arrangements. There is no longer a strong policy focus on the link with potential changes to payment mechanisms, as this has shifted to population based funding as part of the development of Integrated Care Systems.

Since November 2017, work has focussed on reducing the number of people within clusters 1-3 (representing mild – moderate mental health problems) receiving our services, and transferring back to primary care. As at May 2018, numbers had reduced by 60%.

Resources allocated to this initiative were redirected to focus on improvements required in record keeping and risk assessment at Prospect Park Hospital, but, work will continue on clusters 1 -3 from June 2018and expand through 2018/19 with C4, 11, 12 and 18 prioritised.

A full set of pathways has been completed for all secondary care clusters, and "Pathways on a Page" are published on our intranet.

Emotionally Unstable Personality Disorder (EUPD) End to End Pathway QI Project

This initiative has been prioritised to enable effective support to be provided to people who are over-represented in our inpatient and crisis services. Project resourcing and planned benefits are confirmed, to achieve an evidence based pathway throughout our services, along with:

- Reduction in occupied bed days for people with EUPD
- Reduction in self harm incidents, OAPS expenditure and re-referrals relating to inpatient services
- Improvement in friends and family recommendation scores and staff engagement within inpatient services.

Longer term care

The **Eliminating Overspill, Optimising Rehab and Recovery** seeks to address the 5YFV aim of eliminating acute out of area placements as well as development of a range of rehabilitation & recovery options. This includes specialist placements, but also looks to develop the provision so that bed-based options become the final resort rather than the rule. A revised approach to assessing and approving out of area placements has been piloted and rolled out, and the position at Q2 shows rate of placements has almost returned to target trajectory.

The regional work to develop a New Model of Care for people needing **low and medium secure services** has progressed well and the number of people repatriated to Oxford is higher than planned. Year 2 of the pilot will focus on reducing length of stay in specialist placements and will be informed by an analysis of need across the areas covered (Oxfordshire, Bucks, Berkshire, Hampshire and Dorset) Berkshire work will focus on development of step up and step down services.

Urgent Care

Work is continuing to optimise the performance of our Common Point of Entry, Crisis Response Home Treatment Services, and our Inpatient Wards. This is in response to ongoing high levels of demand and capacity challenges within other parts of the system which is resulting in:

- High referral numbers of people to CPE
- Increased length of stay at Prospect Park Hospital

Action is being taken to address these issues, which needs to be continued into the medium/long term, and supported by commissioners and partner providers to ensure sustainable solutions.
We have undertaken a review of our CRHTT, using a "tender" model to review our use of resources in this service, which has been experiencing high referral numbers leading to significant cost pressure. This has identified a number of key actions being taken forward by the operational managers and progress reported into Trust Business Group.
We are working to ensure that accurate data is used to inform agreed actions. through our A&E Delivery Boards in East and West of Berkshire, including numbers of bed days lost due to delayed transfers of care.

Technology enabled service delivery

Berkshire Healthcare NHS
NHS Foundation Trust

The use of technology to enable the delivery of a new model of care in mental health is at the centre of our ambition as a "Global Digital Exemplar" for mental health, confirmed in April 2017.
The table below provides a summary of progress against the key initiatives as at June 2018.

Initiative	Progress	RAG
Skype platform to support clinical Consultations enabling IAPT & EIP services to offer Skype as standard	The solution will be trialled July-Sept with IAPT & EIP services	A
Digital Appointment Correspondence	Procurement completed, and system implementation commenced. Adult MH services live with digital appointment correspondence	G
E-observations	Implemented into Mental Health wards – Phase 1	G
Real time capacity monitoring	Messaging enabled and dashboard developed. Implemented in inpatient and crisis services	G
EPMA - inpatients	Implemented and in use in all MH Wards	G
EPMA - outpatients	Revised go-live date in August	A
Care Pathways	Clinical delivery and audit to evidence NICE concordant treatment	G
Enhanced care home support	Pilot completed in 5 Care Homes. Further work needed as a result of WiFi survey	A
Supervision and training via web conferencing	Online access to clinical support available. Skype clinics for RiO running since Oct 2017	G
Second generation mobile workforce	Platform 1 in pilot, 2 in procurement, 3 awaiting supplier	G
Quality Improvement	Completion of initial lean projects	G

Progress in other related programmes

Information Technology Architecture Strategy Implementation Programme
Progress is on target, with the new data network in place and migration to windows 10 complete across 22% of the laptops/desktops running the system as planned.

Connected Care shared record programme
The Berkshire Connected Care Portal went live at the end of January 2016, and has been developed to enable access to GP data and acute hospital admissions, discharge & transfer data.
Berkshire Healthcare staff make extensive use of the Connected Care facility to view information which supports delivery of safe, good quality care, improved patient experience, and effective use of resources.
Training materials and user guidance are provided on our intranet.
EPMA and Connected Care links are in place.
Procedures have been implemented to comply with changes required as part of GDPR.

We have continued to develop our use of **online programmes** as part of our **Talking Therapies** service, enabling us to achieve access targets and expand our offer across major long term physical health conditions. Our partnership with Silvercloud has enabled us to collaborate on the development of programmes for people with long term physical health problems , which is showing encouraging results as identified on page 7.

The application of our **Support Hope and Recovery Online Network** is continuing across our services, from its inception in eating disorder services.

Informatics development remains an important priority – and we are now able to access a wide range of "tableau" dashboards for our mental health services, enabling staff and managers to understand referral, activity and caseload information, at service and team level. We have also aligned ESR and financial information to provide vacancy reports which are crucial to our workforce planning activity.

Measuring our progress and next steps

Berkshire Healthcare NHS
NHS Foundation Trust

Our Mental Health Delivery Plan Submissions identified overall good progress in delivery of FYFVMH targets (please see page 11 for a summary of the key targets from NHS England).
Having secured funding to expand our Individual Placement Support services, areas prioritised as requiring further work are:

- Elimination of out of area placements for people requiring acute care by 2021. As described on page 7 this is linked to our bed optimisation work and requires work on internal as well as system solutions.
- Achievement of CAMHS access targets, given continued growth in demand.

Our Trust Board Vision measures and True North metrics described on page 5 provide a clear focus on our priorities as an organisation. These are at the centre of our Quality Improvement work, which will enable improvements identified by our front line staff.

We have robust arrangements for measuring progress against key mental health targets, and reviewing qualitative and quantitative information through our Executive meetings:

- User safety, people, NHS Improvement, service efficiency and effectiveness and contractual metrics monitored at our Finance Executive
- Patient Safety and Experience issues are reported to our Quality Executive
- Progress of key projects is monitored by our Business and Strategy Executive

These groups support the work undertaken by our Trust Board Committees (Quality Assurance, Finance, Investment & Performance and Audit) in their detailed review of performance and key risks to delivery of Trust Board priorities for our mental health services.

Next Steps

The following activities are currently being prioritised for action :

- Continued focus on our **Quality Improvement** initiatives to reduce restraint and assaults in our inpatient services. Maximising the impact of our Quality Management Improvement System linking front line staff and senor leadership.
- **Progressing mental health initiatives within our ICSs**. This will include work with partners to reduce out of area placements and ensuring mental health is effectively represented in all work streams.
- Implementation of our **Delivery Plans** for the achievement of FYFVMH targets – with a particular focus on those areas we have identified as needing further work.
- Continuing to refine and implement our **Workforce Plan** for mental health – in liaison with ICS partners and Health Education England. This will include addressing specific risks regarding inpatient, IAPT and CAMH Services.
- Working with commissioners to ensure that the **Mental Health Investment Standard** is met, and that Mental Health Investment Strategies reflect funding provided to commissioners to achieve FYFVMH targets.
- **Beginning our forward planning for 2019/20** will ensure that our True North metrics are embedded within our Plan on a Page, which will guide team planning and individual objectives for staff working in our mental health services.

Five Year Forward View for Mental Health. **By 2020:**

70,000 more children will access evidence based mental health care interventions . Community eating disorder teams in place for children & young people

Intensive home treatment will be available in every part of England as an alternative to hospital

No acute hospital is without all age mental health liaison services with at least 50% meeting the "core 24" standard

At least 30,000 more women each year can access evidence-based specialist perinatal mental health care

10% reduction in suicide and all areas to have multi-agency suicide prevention plans in place by 20 17

Increased access to evidence-based psychological therapies will reach 25% of need, helping 600,000 more people

The number of people with SMI who can access evidence-based Individual Placement Support will have doubled

280,000 people with SMI will have access to evidence based physical health checks and interventions

60% of people experiencing a first episode of psychosis will access NICE concordant care within 2 weeks

Inappropriate out of area placements will have been eliminated for adult acute mental health care

New models of care for tertiary MH will deliver care closer to home, reduced inpatient spend and increased community provision

There will be the right number of CAMHS inpatient beds in the right place, reducing the number of inappropriate out of area placements

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	10 July 2018
Title	Summary Annual Equality Report
Purpose	The production of an Annual Equality report is required as part of our compliance with the Equality Act 2010, and provides an important overview of information about the people who use our services, our staff and our progress against key objectives.
Business Area	Corporate
Author	Stef Abrar, Equality Manager Nolan Victory, Human Resources Equality Manager
Relevant Strategic Objectives	Supports all strategic objectives
CQC Registration/Patient Care Impacts	Our Equality Strategy supports delivery of safe, good quality care and a good experience of care for patients, and this report is relevant to the CQC "well led" domain.
Resource Impacts	Any agreed actions require full costing approval prior to implementation. This report is part of the requirements of our core contracts.
Legal Implications	As stated under "purpose" above.
Equality and Diversity Implications	This report provides a summary of key information reflecting our organisation and initiatives being taken forward as part of our Equality Strategy.
SUMMARY	This report consists of five sections: 1. Introduction 2. A summary of our workforce and service user diversity 3. A summary of our performance against the NHS Equality Delivery System, our benchmarking tool 4. Actions taken to progress our equality objectives – as required by the Equality Act 2010 5. Public Sector reporting duties

	6. Recommendations The specific duties of the Act require the Trust to publish relevant and proportionate information relating to our workforce and service users. We are making detailed data tables for the period 1 April 2017 - 31 March 2018 available to view on our website.
ACTION	The Board is asked to note the report, including the progress made against the strategy priorities.

Berkshire Healthcare
Diversity and Inclusion

Annual Equality Report 2018

How we meet the public sector duty

Contents

1. Introduction

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

1.1 The Public Sector Equality Duty

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

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

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

The protected characteristics covered by the equality duty are:

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

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

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

Our seven equality objectives are shown in Box 1 below.

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

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

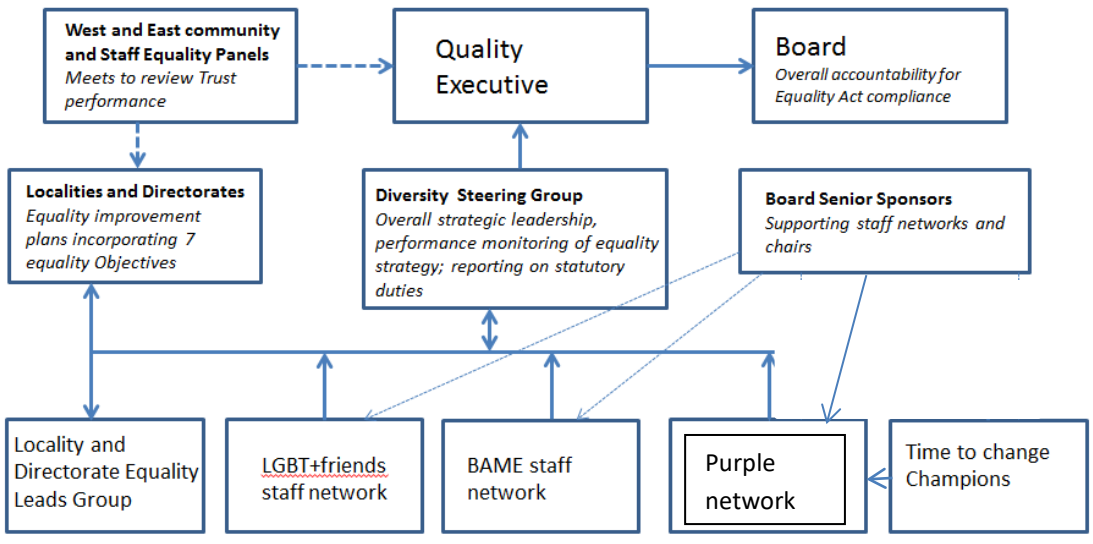
2. Ensure there is no difference in perceptions of equal opportunity in career progression between white and BME staff (as measured by our annual staff survey)
3. Reduce harassment and bullying as reported in the annual staff survey, in particular by BME staff. We are aiming to reduce experiences of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

1.2 Our approach to governance on equality and inclusion

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

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

Figure 1: Berkshire Healthcare governance of equality and inclusion



1.3 Compliance with the equality duty

This summary report describes the progress we have made since the publication of the last Annual Equality Report in January 2017, highlighting key achievements and activity towards fulfilling our equality objectives. It also provides recommendations for next steps.

This report consists of four sections:

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

The specific duties of the Act require the Trust to publish relevant and proportionate information relating to our workforce and service users. Detailed data tables for the period 1 April 2017 - 31 March 2018 will be available to view on our website on publication of this report. In line with NHS data protection standards we cannot publish data that relates to less than five people.

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

2. Data headlines

2.1 Berkshire demographic

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

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

20% of the Berkshire population are from an ethnic minority background. When we refer to ‘Black and minority ethnic’ (BME) in this report we are counting only non-white ethnic minorities. In terms of age bands, the proportion of minority ethnic people is significantly less for older age groups: 7.2% at 65-84 years and 3% for those aged over 85 years.

We have used the following summary categories in this report:

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

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

2.2 Workforce data summary

2.2.1 Workforce diversity

The Trust employed staff as at 31 March 2018. Workforce diversity is outlined below:

As at 31st March 2018 the Trust employed 4,304 members of staff:

- 83.2% were female and 16.8% were male
- 22.6% of staff were from visible minority ethnic backgrounds, compared with 20% of the Berkshire population (2011 census); 9% were from non-British white backgrounds compared to 7% of the Berkshire population.
- 4.8% were disabled people compared with 7.7% of the workforce in the South East (Labour Force survey).
- 51.7% of our workforce identify themselves as Christian, 11.8% Atheist, 2.9% Hindu, 13.0% other religious beliefs, and 20.7 % do not declare;
- 1.9% (80) staff identify themselves as lesbian, gay or bisexual, 80.9% heterosexual, and 17.3% do not declare.

The workforce profile has remained broadly similar for six years. This year there has been a 3% increase in the proportion of male staff, and a 1.6% increase in BME staff compared with last year. Efforts to encourage staff to review equality data held on their staff record this year led to a very small 1.5% increase in data completeness in data fields relating to sexual orientation, disability and religion and belief.

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

Senior Management/Leadership ethnic diversity

Senior Managers/Leaders As at 31st March 2018	Gender		Ethnicity		
	Male	Female	White	Non-White Minority ethnic	Undisclosed
Non-Executive Board (7)	57.1%	42.9%	85.7%	14.3%	
Executive Board (6)	66.7%	33.3%	83.3%	16.7%	
Directors (Locality, Clinical and other)	33.3%	66.7%	66.7%	20.0%	13.3%
Heads of service	12.8%	87.2%	89.7%	10.3%	
Senior managers (8c and above)	37.0%	63.0%	85.2%	7.4%	7.4%
Berkshire Healthcare staff (total headcount)	725	3579	3148	970	186

2.2.2 Recruitment and selection

In the financial year 2017/18 there were a total of 9839 job applicants, 3697 shortlisted applicants and 946newly appointed staff. Applicant data is collected by NHS Jobs on gender, age, ethnicity, disability, religion and belief and sexual orientation.

- Last year saw a change in the success rates for minority ethnic short-listed candidates. BAME applicants were 1.1 times more likely to be appointed after being shortlisted in 2016/17; however this year white applicants are 1.33 times more likely to be appointed after being shortlisted.
- 80.8% of all applicants were female, and women are 1.34 times more likely to be appointed than male.
- 30.6% of all applicants were age 45 and over. Applicants aged 45 years or more were 1.05 times more likely to be appointed than those who were under 45 years, a reversal from last year when applicants under age 45 were 1.1 times more likely to be appointed.
- Disabled applicants were equally likely to be shortlisted compared with non-disabled staff, but non-disabled staff are 1.37 times more likely to be appointed
- 48.6% of all applicants were Christian and Christian applicants are 1.10 times more likely to be appointed
- Staff who declare that they are LGBT are equally likely to be shortlisted compared with heterosexual staff; however, heterosexual staff are 1.04 times more likely to be appointed.

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

2.2.3 Career development

In common with many other NHS trusts, ethnic minorities are under-represented in our workforce at senior grades. On average 29.2% of BME staff hold posts in job bands 1 – 6. Under representation starts at Band 8a for clinical 14.9% and 8a for non-clinical posts 13.8%. There were 52 posts at Bands 8a – 8d in the Trust as at June 2018.

2.2.4 Grade increase

369 internal candidates achieved a grade increase this year. Of these, 76.15% were white and 20.6% were BME. This in line with the workforce average. More females achieved a grade increase compared to men; and on average more younger staff compared to older staff.

2.2.5 Continuing professional development

Continuing professional development (CPD) opportunities and/or training and development are linked to career progression. 363 staff had access to CPD training this year. BME staff are 1.11 times more likely to be to receive CPD funded training than White staff. This is an improvement from last year's report when white staff were 1.4 times more likely to receive CPD funded training.

Box 1: The Launch of MIR

In September 2017, we launched Our Making it Right pilot programme in collaboration with the BAME network. Making It Right is the Trust positive action training initiative. This has now successfully trained and mentored a cohort of 20 BME staff at bands 5 – 7 over a three month period. Five graduates from the programme have been successful in gaining new jobs within the Trust, and one has secured a promotion outside the Trust. The next stage of development includes piloting diverse recruitment processes at Band 7 and 8. Further work is needed on turnover and career development staff at Bands 8b, 8c and 8d. Currently 2 members of staff are completing the NHS Leadership Academy Ready Now Programme aimed at senior BAME band 8 staff and 1 further member of staff was accepted onto the new cohort starting in spring 2018.

2.2.6 Equal Pay

The majority of the Trust's posts are on the Agenda for Change pay banding system, which is designed, together with the policy on starting salaries, to reduce pay inequality between the sexes. Based on average hourly rates of basic salaries, the average pay gap between female and male staff on Agenda for Change was 6.3% which is .6% lower than in the previous year. Men earned on average £15.96 per hour compared with the average for women of £14.96 when those who are not on Agenda for Change are included (medical doctors and directors), the gap increased. The average hourly rate for men was £19.49 and for women it was £15.64.

2.2.7 Disciplinary

There has been national concern for some years around levels of BME disciplinary cases in the NHS. Over the last 12 months 46 staff were formally disciplined, 6 cases less than last year.

This included closed and current cases. 28 were white staff, 16 were BME staff and 2 undisclosed. BME staff are 1.85 times more likely to be disciplined compared to a white staff.

Box 2 The BAME network

The Trust's Black, Asian and Minority Ethnic (BAME) staff network membership now stands at over 200 members following the combined Black History Month and MIR conference (October 2017). The network is in the process of training members to be part of selection processes for a selection of Band 7 & 8 jobs to fulfil our commitment to diverse recruitment processes. Members have also attended mediation training sessions with a view to supporting BME staff in the disciplinary and grievance process.

2.2.8 Harassment and victimisation

In the 12 month period, there were less than 6 cases brought under the Dignity at Work policy, which addresses allegations of harassment, bullying or victimisation. None of the staff who brought these cases stated their ethnicity.

2.2.9 Turnover

Over the reporting period, 727 staff left the Trust, giving an average turnover rate of 16.6%, one per cent down from last year. The turnover rate for men 15.9% was slightly lower than for women 16.8%. The turnover rate for BME staff varied from a low of 14.5% for Black staff, to a higher rate of 17.1% for Asian staff. For white staff the turnover rate was 16.5%.

The turnover rate varied across the age bands. The highest rate was for those under 25 years old at 31.1%. The turnover rate was 20.9% for those age 25 to 34 down 2.6% from last year and 25.6% are aged 60 years plus. The LGB turnover reduced this year to 10.9% down from 17.7% from last year and 34% in 2016. The turnover for disabled staff was 23.9% an increase of 6.8% compared to last year.

2.3 Service Delivery

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

2.3.1 Age

We provide universal health visiting to families of children aged 0-5 years and a range of other services targeted at children and young people, adults and older people. We also provide a number of services open to all age groups. Some of these are disproportionately used by older people as a result of disability or ill health in older age. For example, rehabilitation services, memory clinics, and hearing and balance.

Box 3: IAPT reaching both ends of the age spectrum

Improving Access to Psychological Services, which was originally designed to meet the needs of working age adults, has been expanding its service provision to meet the mental health needs of younger people. It has seen an almost fourfold increase in its service offering to younger service users compared to 2016/17. 1% (189) IAPT service users were under 18 years of age. However, treatment completion rates were poorer than average at 35%.

In line with last year, the service maintained its reach to older people with over 1,397 people over 65 years of age making use of the service. Of these, 31 service users were over 90 years of age. Completion rates for over 65s were in line with the average of 63%.

2.3.2 Gender

Patterns of service access by gender are in line with previous years, with women slightly outnumbering men as adult service users in many key services. Women's service usage increases with age. For example, in our inpatient rehabilitation[2] services, 57% of those service users aged over

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

85 years were women (though there was a 5% increase in male usage of this service this year). This mirrors the higher prevalence of disability among women of this age. There are proportionately more men using hearing and balance services aged 85 than might be expected (43%).

Historically men have been over-represented in tertiary mental health services and under-represented in primary mental health services. This pattern continues this year. Men comprise 53% of mental health inpatient service users aged 20-64 years of age, 62% of learning disability mental health ward patients, 42% community mental health service users and 34 % of Improving Access to Psychological Therapy service users.

2.3.3 Ethnic minorities

Data quality

One of the main problems in assessing equality of access according to ethnic background has been recording of accurate data. We have had modest success in improving our data in this area and this is being addressed through locality equality improvement plans. Data from mental health inpatients and Improving Access to Psychological services continues to be exemplary (with un-coded or 'not stated' data rates of 1.7 % and 3.6 % respectively). Community mental health service ethnicity data capture is broadly in line with last year – with 10.1% of data 'not stated'.

Over the past three years steps have been taken to address ethnicity data gaps in community health services generally. However, this has plateaued this year. 20% of community health ethnicity data is 'not stated', compared to 19.4% last year. However this is still an improvement compared to 25% in 2014/15. Capturing ethnicity data from non-mental health services continues to prove difficult with the exception of sexual health services where 'not stated' is only 1.4%. Corporate improvement initiatives have focused on our main patient data base RiO. Improving ethnicity data quality in other smaller patient databases such as Hearing and Balance and urgent care services such as West Call and Minor Injuries remains a challenge that we are working on .

Mental health

An area of national concern over the past 20 years is the over-representation of people from a Black background (i.e. people from an African, African-Caribbean and other Black background) in mental health inpatient services. Data from the Mental Health Foundation shows that in England people from a Black background are 3 to 5 times more likely than any other group to be diagnosed and admitted to hospital for schizophrenia. In Berkshire, people from a Black background comprise 6.4 % (61) of the mental health inpatient population in 2017/18 – this is a slight increase (0.8%) on 2016/17. This compares with 3.5% of people from a Black background as recorded by the 2011 census.

Rates of Crisis Response and Home Treatment and community mental health service usage by people of a Black background (4%) are in line with population averages but may not reflect need. People from a Black background are slightly under-represented as IAPT service users (2.6%) and have slightly lower than average treatment completion rates of 58% compared with the average of 63%.

People from an Asian background comprised 10.6 % of mental health hospital admissions this year (a 1% rise) though this was actually almost the same number of people (101) compared to the 2015/16 headcount. A similar proportion used Crisis Response and Home Treatment (9.5%), community mental health (8.9%) and IAPT (9%). Completion rates for IAPT treatment were 57 % for Asian people compared to the average of 63%. Asians make up 13% of the Berkshire population overall.

Of the 21 patients on our learning disability mental health wards this year, only 1 was from an ethnic minority background.

Memory clinic data shows that ethnic minorities are using these services in line with the demographic. 7.5% of service users over 65 years are from a minority ethnic background compared with 7.2% of the population aged 65 years plus; 4.7% (103) of service users over 85 years are from a minority ethnic background compared with 3.02% of the population at this age – an increase of 21 people from the year before.

Community health

Overall, visible ethnic minority usage of generic community health services appears is just under expected levels (18.5%), with a slight under-representation of non-British white groups of 3%. Ethnic minorities are under-represented in services with an older service user population such as rehabilitation wards (by 3%). However, this might be explained by the fact that the majority (94%) of rehabilitation ward service users are over 65 years of age and the ethnic minority population accounts for 7.2% of the population over 65 years; but also by 16% of missing ethnicity data. 34% of our sexual health services client group is from a BME background, reflecting the demographic of the East of Berkshire.

2.3.4 Religion and belief

Religious belief data is collected inconsistently as it is not a mandatory data requirement. The most reliable data in this area is from IAPT where 53.2% (8,847) of service users declared they had no religious belief, 25.7% (4,277) were Christian, 4% (688) were Muslim, 1.5% were Hindu, 1.7% (276) were Sikh, 0.1% (22) were Jewish. 2.7% declined to disclose or did not state their religion. Treatment

completion rates for people of different religious beliefs were in line with average. There were slightly lower rates compared to the average for people from a Muslim background (53%).

Mental health inpatient services (Prospect Park Hospital) collect patient data on religion and belief and provides a multi-faith chaplaincy.

2.3.5 Disability

Disability codes are rarely used at the Trust since many of our patients attend specific services dealing with long-term or disabling conditions. Following the implementation of the NHS Accessible Information Standard in July 2016, 2,571 records have been established by staff to record the communication needs of disabled service users. This is an increase of 513 records compared to last year. The highest rate of completion is in the Slough CCG area, the lowest is for Bracknell and Ascot CCG patients.

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

2.3.6 Sexual orientation

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

Mental health inpatient data shows that 1.8 % (17) of inpatients were gay or lesbian, 1.6% (15) were bisexual, 0.2% (2) defined as 'other' and 1.78% (17) preferred not to disclose their status. This year no LGB patients filled out the mental health inpatient patient experience survey.

Improving Access to Psychological (IAPT) services' work with the LGBT community continues to be one of the Trust's successes. 4.4% (727) of IAPT service users identified as lesbian gay or bisexual this year; 1.06% (194) were gay, 1.17% (176) were lesbian and 2.2% (357) were bisexual. Overall this is a 0.4% (128) increase in LGB IAPT service users compared with 2015/16. This level of declaration is higher than the average of 1.7% as recorded by the Annual Population Survey (APS) which may indicate any one of the following: that patients feel safe in declaring their sexual orientation to their IAPT counsellor, higher prevalence of depression and anxiety in this population group; the unreliability of the APS as a comparative population benchmark. This year LGBT IAPT treatment completion rates are in the line with the average.

Sexual health services continue to be accessible to the LGB communities. 4.6% (647) of the client group is LGB.

2.3.7 Interpretation services

To promote equality and ensure people who use our services are not discriminated against in clinical assessment and care planning, we provided around £146,600 of interpretation services for people whose first language is non-English or who are hard of hearing/deaf. This is a £40,600 increase on the levels reported in 2015/16 due to supplier problems at the beginning of the financial year and rising demand. The Trust has retendered the contract starting in April 2018 with a view to effective management of resources and increasing efficiency.

2.3.8 Patient experience

Patient experience data is collected for six protected characteristics. However, although this provides valuable insights, numbers of respondents with protected characteristics are often small. Minorities are significantly under-represented in all samples. To provide understanding of the minority experience, this year Reading locality conducted a deep dive of the BME experience of discharge and admission to psychiatric hospital, using a focus group, two surveys, a literature review, and exploring the patient journey of a limited number patients over time. Results will be available later in 2018. Work has also been taking place to capture the patient experience from people with a range of protected characteristics.

2.3.9 Complaints

213 formal complaints were made this year. 9.85% were from ethnic minorities, of these 2.8% were from 'other white' minorities. Further work is needed to reduce the number of "not stated" responses regarding ethnicity data.

3. NHS Equality Delivery System

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

Equality Delivery System grades are agreed at panel meetings where detailed evidence is reviewed. Our last panel meetings took place in Spring and Summer 2016, and the process for 2018 is currently being confirmed. Each of the outcomes listed below are graded against a range of criteria. Grades are awarded at four levels: Underdeveloped - Red; Developing - Orange; Achieving – Green; Excelling – Purple. The Trust will grade on EDS Goals 4.1 and 4.2 which covers Inclusive leadership and equality impact assessment during 2018/19. EDS guidance recommends these areas for peer review.

Box 4 Taking steps to embed inclusive leadership Trust leaders were praised by the Stonewall Workplace Equality Index (2018) benchmark for showing inclusive leadership on LGBT which was some of the best in class. We now plan to extend this our Senior Management Team.

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

Goals and Outcomes of the EDS2 Toolkit			2013	2014/15	2016	Priority
Goal 1 **Better Health Outcomes**	1.1	Services are commissioned, procured, designed and delivered to meet the health needs of local communities			*Not graded this year*	
	1.2	Individual people's health needs are assessment and met in appropriate and effective ways				
	1.3	Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed				✓
	1.4	When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse				
	1.5	Screening, vaccination and other health promotion services reach and benefit all communities				

Goal 2 **Improved Patient Access and Experience**	2.1	People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds.				
	2.2	People are informed and supported to be as involved as they wish to be in decisions about their care				
	2.3	People report positive experiences of the NHS				
	2.4	People's complaints about services are handled respectfully and efficiently.				
Goal 3 **A represent-ative and supported workforce**	3.1	Fair NHS recruitment and selection processes lead to a more representative workforce at all levels				
	3.2	The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to fulfil their legal obligations				
	3.3	Training and development opportunities are taken up and positively evaluated by staff				
	3.4	When at work, staff are free from abuse, harassment, bullying and violence from any source				
	3.5	Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives				
	3.6	Staff report positive experiences of their membership of the workforce/health and wellbeing				
Goal 4 **Inclusive Leadership**	4.1	Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations				
	4.2	Papers that come before the Board and other major committee identify equality-related impacts including risks, and say how these risks are to be managed	*New outcome*	*Not graded*	*Not graded*	
	4.3	Middle managers and other line manager support their staff to work in culturally competent ways within a work environment free from discrimination.				

These priorities have been integrated into locality equality improvement plans and the HR Equality Delivery System plan.

4. Public Sector Equality objectives

The Trust's equality objectives for the period 2016 - 2020 were agreed by the Board in September 2016. These were introduced to over 100 Equality Champions by Julian Emms, CEO, at the Trust's first equality conference on 13 October 2016. During 2017/18 12 equality leads conducted audits, set local key performance indicators and launched year-long plans. Local equality improvement plans are now in place. Progress is monitored every two months at locality equality leads meetings and quarterly through the Diversity Steering Group.

Following our initial launch conference in October 2016, the East region equality leads held a Listening into Action equality event on 5 December 2017 attended by around 60 staff with a number of key recommendations around inclusive leadership and awareness raising. On 17 April 2018, 70 Equality Champions were trained to raise awareness of the Trust's approach to diversity and inclusion via the Trust's Diversity Roadshow project. This aims to engage with staff at all levels particularly those at lower bands who do not ordinarily attend corporate events. A range of

resources were developed such as branded postcards, inspirational fortune cookies, video, posters, staff network pop-ups. Staff were trained to develop an elevator pitch on diversity and inclusion and in how to speak about diversity and inclusion, using personal experiences.

To support these plans, the Trust launched its positive action pilot training programme – *Making It Right* in October 2017 in collaboration with the BAME staff network. This started by addressing issues of fairness in employment raised by the NHS Workplace Race Equality Standard. The programme focused on three development workshops and a mentoring programme delivered through a series of internal development centres for BME staff and establishing mentoring relationships.

The equality dashboard pages within our informatics system "Tableau" are being used successfully, alongside our Human Resources Dashboard to enable directorates and teams to easily review staff survey results by service level, learning and development data and BAME staff workforce profiles across grades and services. We now have the capability to report against the equality strategy's baseline (2016). The dashboard contains three years of staff survey data tracking perceptions of equal opportunities in career development, harassment & bullying, and experiences of stress.

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

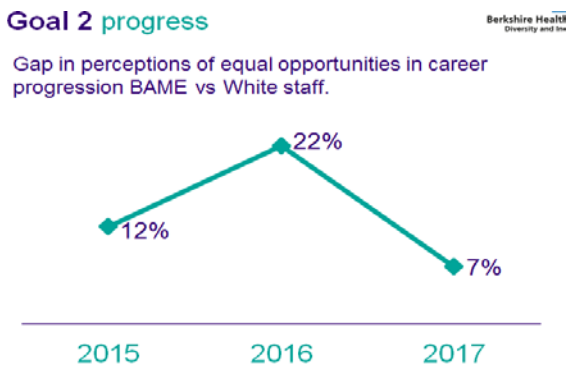
In comparison with our baseline, there has been a 3.6% decrease in representation of BME staff in Band 7 non-clinical managerial jobs (now 20%) and a 5.3% increase in Band 7 clinical managers (22%) meaning that we have met our aspirations for Band 7. There has been a slight improvement at Band 8a: 14.9% of band 8a clinical staff and 13.8% of non-clinical staff are at Band 8b, an increase of 1% and 2.3% respectively. At Band 8b 9.2% clinical staff are from a BME background (no change from last year) and 19.4% of non-clinical staff are from a BME background (a 9.4% increase from last year). Numbers are too small to publish at Bands 8c and 8d.

Action taken: *Locality and Directorate Equality improvement plan targets were set in April 2017 based on detailed local audits of current performance. Equality leads worked the Equality Human Resources Manager to identify 20 recruits to the Making it Right pilot programme.*

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

According to the October 2017 Staff survey, 89% of white staff believed the Trust provides equal opportunities for career progression compared with 74% of BME staff, a gap of 7%. This is an

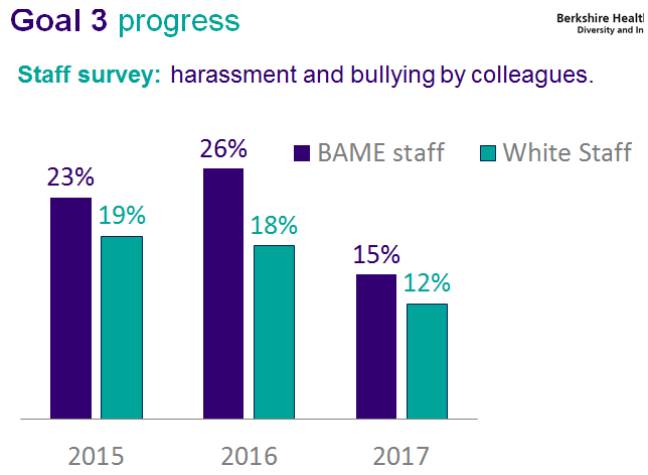
improvement on last year when the gap in perceptions was 22%. Our data shows that BME staff (all grades) are accessing external training broadly in line with their proportion in the workforce: 24% staff accessing external training were from a BME background compared to 23% of the workforce.



Action taken: *BAME committee members have been trained in values based recruitment/unconscious bias training. Also, our pilot internal development programme 'Making It Right' was designed to address barriers and perceptions of unfairness recruited 20 participants. The programme will be rolled out to approximately 3 additional cohorts of BME staff later in the year.*

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

In the 2017 NHS staff survey, 15% of BME staff reported experiencing harassment and bullying from a colleague, compared with 12% of white staff, a gap of 3%. The incidence of harassment and bullying among colleagues appears to have reduced since 2016 when reported harassment experienced by BME staff was 26% and for white staff was 18%. During this period, no formal harassment claims were raised by BME staff; total harassment claims were less than 6 in number.



Action taken: *Increasingly, the BAME staff network acts as a first point of contact for BME staff. BME committee members have been trained in mediation. In 2017/18, the Trust stepped up its efforts to address hate crime against staff and patients. Mandatory recording of incidents of a racial and sexual nature is now required by our incident database DATIX.*

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

Our recorded sickness absence due to stress related illness was 22.3% of total sickness absence for 2017/18 and has increased by 1.3%. The staff survey showed no significant reduction in stress experienced by respondents, and this is a focus of our work on improving staff welbeing.

In terms of disability, 52% of disabled respondents felt stress due to work and 36% of non-disabled staff also experienced stress – very little change from last year. 27% of disabled staff survey respondents felt that they did not have adequate reasonable adjustment in place. 75% of disabled respondents felt they received support from their immediate line manager in a personal crisis compared to 79% non-disabled staff.

Action taken: *In Autumn 2017, the Disability Steering group agreed a number of initiatives to further our strategy objectives around disability: a summary of policies/reasonable adjustment processes, a tool-kit for managers, support for the government's Disability Confident Scheme and the launch of a new staff network, the Purple network. The Purple Network comprises disabled staff, staff with long-term conditions including mental ill-health and carers and integrates the Time to Change programme approach. Following a successful launch meeting in January 2018 attended by over 40 staff facilitated by Kate Nash (OBE), the Purple Network co-chairs and a steering group are now in place. The Trust participated successfully in the fourth annual Time to Talk Day in February 2018 to raise awareness of mental health stigma in the workplace. The Trust continues to offer stress reduction workshops and monitors sickness absence monthly at our Finance and Performance Executive.*

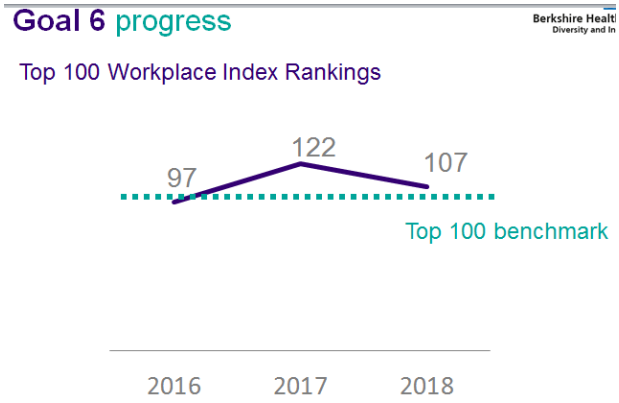
Objective 5: Take a more robust approach to making reasonable adjustments for disabled people – in particular implement the NHS Accessible Information Standard.

2,571 patient records specifically recording reasonable adjustments were established on 31 March 2018, an increase of 513 compared with last year. The staff survey shows that 73% of staff who required reasonable adjustments, had these in place.

Action taken: *A small working group reviewing accessibility in service provision was established in February 2018 to ensure accessibility issues are dealt with appropriately – this approved a three month secondment to review accessibility for staff and service users and make recommendations for changes.*

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

In January 2018, the Trust was ranked 107 out of 434 employers in Stonewall's Workplace Equality Index. This was an increase of 15 places in the overall ranking compared with last year, missing the Top 100 threshold by only 1.5 marks. Berkshire Healthcare is now ranked 8 out of 52 social and health care providers an improvement of 3 places compared to last year.



Action taken:

Detailed feedback on performance was received from Stonewell in February 2018. A task and finish group is in place to meet the requirements of the 2019 WEI Index. This focuses on the employee life-cycle, further development of the LGBT staff network, role modelling and allies.

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

Action taken:

Our community engagement lead in the West organised a number of events with BME and other communities to promote our services and improve patient experience/access: notably the health inequalities event (March 2018), Equality Delivery System consultation exercise (February 2018), FGM awareness day (February 2018), World Mental Health awareness day (October 2017) and participated in numerous community events.

BME: A project to better understand the over-representation of patients from a black heritage in Prospect Park Hospital is underway led by Reading locality. Following quantitative data analysis and case review, a focus group with former patients and carers took place on 26 January 2018; two surveys were undertaken during November – February.

LGBT: Highlights of our work this year were the production of a clinical guidance document for staff working with transgender service users available on our intranet site which covers inpatient and service issues of all kinds. We have also implemented changes to the patient database to facilitate appropriate recording of the status/name of transgender service users. This was launched via a post-card entitled 'Mr Ms Mx' and a video featuring one of our service users who cares for a transgender child in 2017. Reading Pride ran successfully in September with good engagement activity through quizzes and give-aways, and our popular health-checks and Talking Therapy stall. The LGBT&Friends' staff network held an awayday on 16 August 2017 identify priorities for the year ahead and a celebration event on October 2017 to thank Pride supporters. We continued to co-ordinate the Thames Valley LGBT+ workplace network which met three times in 2017-18 at Reading University. This promotes good employment practice among Thames Valley employers. We are now working with Support U to provide clinical supervision to their volunteer counsellors.

5. Public Sector duty and other specific reporting requirements

In line with the specific duties of the Equality Act 2010, we will publish our Equality Performance Report in July 2018 on the Trust website. This publication is also required as part of our contract with Clinical Commissioning and is monitored through a Quality Schedule.

In line with NHS England requirements, we publish data for the Workplace Race Equality Standard (WRES) on our website every August. We also started publishing data required as part of the public sector Gender Pay gap reporting in March 2018. We are preparing to report on the NHS Workplace Disability Equality standard in 2019.

5. Next Steps

51. To review the process for conducting equality impact analysis with the aim of putting in place a more robust user friendly system.

5.2 To conduct full grading of Equality Delivery System 2 including Goal 4 – Well Led Domain.

5.3. To continue implementation of actions designed to achieve the objectives of our Equality Strategy, ensuring that these are communicated effectively to staff and stakeholders.

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	10 July 2018
Title	**Audit Committee – 23 May 2018**
Purpose	To receive the unconfirmed minutes of the meeting of the Audit Committee of 23 May 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 23 May 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

Minutes of the Audit Committee Meeting held on

Wednesday, 23 May 2018, Fitzwilliam House, Bracknell

Present: Chris Fisher, Non-Executive Director, Committee Chair
Naomi Coxwell, Non-Executive Director

In attendance: Alex Gild, Chief Financial Officer
Graham Harrison, Head of Financial Services
Monika Paluszek, Financial and Capital Accountant
Paul Gray, Director of Finance
Amanda Mollett, Head of Clinical Effectiveness and Audit
Ben Sheriff, External Auditors, Deloitte

Julie Hill, Company Secretary

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: Mehmuda Mian, Non-Executive Director and Minoo Irani, Medical Director.	
2.	**Declaration of Interests**	
	There were no declarations of interest.	
3.	**Annual Accounts 2017-18, including the Annual Governance Statement**	
	The Annual Accounts 2017-18 and Annual Governance Statement had been circulated. The Committee noted that the Chair had been given the opportunity to review the draft Annual Governance Statement and Accounts prior to the meeting. The Chair confirmed that his queries had been satisfactorily answered (the questions and answers are annexed to the minutes but are excluded from minutes to the Public Trust Board meeting because of the confidential nature of some of responses). A table setting out the amendments to the Annual Accounts 2017-18 since the Audit Committee papers were printed had been tabled. **a) Annual Governance Statement** The Committee reviewed the Annual Governance Statement page by page and the following key points were highlighted:	

	• **Annual Governance Statement** – (page 10 of the agenda pack) stated that the Trust was not fully compliant with the registration requirements of the Care Quality Commission. It was noted that whilst the statement was correct because the Care Quality Commission had placed compliance actions on the Trust, an additional sentence should be added to provide the context which was that the Care Quality Commission had rated the Trust as "good" across all its domains. • **Annual Governance Statement** – (page 10 of the agenda pack) – 2nd bullet point at the top of the page to include the percentage figure in relation to the zero suicide reduction target. Ben Sheriff, External Auditors, Deloitte referred to page 13 of the agenda pack and said that the key statement for the Committee was that in the Chief Executive's opinion, there were no significant internal control issues identified by the Trust in 2017-18 and that the Annual Governance Statement was a balanced reflection of the management position throughout the year. **b) Annual Accounts 2017-18** The Committee reviewed the Annual Accounts 2017-18 page by page and the following key points were highlighted: • **Statement of Changes in Taxpayers Equity – Revaluation Reserve** – it was noted that the fixed asset revaluation reserves and balance sheet did not match and that this related to a historic accounting practice. Mr Sheriff confirmed that this was a housekeeping matter and was something for the Trust to address in the current financial year. • **Future Changes in Accounting Policy** – the Chair requested that the Chief Financial Officer undertake an impact analysis in relation to the changes in accounting policy for discussion at a future meeting of the Audit Committee. • **Critical Accounting Estimates and Judgements** – Ben Sheriff, Deloitte, External Auditors suggested that for next year, the Trust may want to consider selecting the material critical accounting judgements for further scrutiny. • **Apprenticeship levy** – the Chair said that it would be useful for the Finance, Investment and Performance Committee to receive an update on how the Trust was deploying the apprenticeship levy. Naomi Coxwell, Non-Executive Director asked about the deadline for submission of the Annual Report and Accounts 2017-18 to NHS Improvement. Ben Sheriff, External Auditors, Deloitte confirmed that the NHS Improvement's deadline was 12 noon on Tuesday, 29 May 2018. The Committee noted the questions and answers on the Annual Accounts 2017-18 and the Annual Governance Statement.	**AG** **AG** **AG** **AG** **AG** **AG/BS**
5.A	**ISA 260 Audit Memorandum**	
	Ben Sheriff, External Auditors, Deloitte, referred to the ISA 260 Memorandum which summarised the key issues identified during Deloitte's audit of the Trust's financial statements and quality accounts. It was noted that Deloitte was hoping to sign the final ISA 260 Audit Memorandum on	

	Thursday, 24 May 2018. Mr Sheriff thanked the Finance and Quality Accounts teams for their co-operation and help during the course of the external audit. It was noted that the External Auditors' key judgements in the audit process related to: • The assumptions made in completion of the land and buildings revaluation; and • Key judgements affecting achievement of control totals and the Sustainability and Transformation Funding income received, in particular, setting fixed asset useful economic lives; • There were no significant audit adjustments or disclosure deficiencies. • The External Auditors did not anticipate reporting any matters within the audit report in respect of the Trust's arrangements for securing the economy, efficiency and effectiveness of the use of resources. • The Trust had followed the format prescribed by NHS Improvement in the Trust Annual Reporting Manual. • The External Auditors were planning to issue a clear Quality Report opinion. The findings from the External Auditors' work were set out in the separate Quality Report External Assurance Review paper and would be presented to the Council of Governors. Mr Sheriff reported that based on the current status of the audit work, the External Auditors' envisaged issuing an unmodified audit opinion, with no reference to any matters in respect of the Trust's arrangements to secure economy, efficiency and effectiveness in the use of resources, or the Annual Governance Statement. The Chair referred to the section on the management override of controls and asked whether the External Auditors' comments were specific to the Trust or applied across the sector. Mr Sheriff explained that every audit presumed that there was a risk of fraud through the management override of controls. Mr Sheriff reported that Deloitte's property specialists had been engaged to review the assumptions and methodology used to value the estate. It was noted that the Trust's valuation was based on a number of judgemental assumptions, including assumptions on Modern Equivalent Asset areas, but the assumptions were in line with other Trusts and fell within the expected range. The Chair asked when the Trust's next property re-valuation would take place. The Head of Financial Services confirmed that there would be an interim re-valuation exercise next year. Mr Sheriff asked the Audit Committee whether they were aware of any fraud issues which had not been referred to the Local Counter Fraud specialists. Members of the Audit Committee confirmed that they were not aware of any fraud issues which had not been or were in the process of being investigated by the Trust's Local Counter Fraud specialists. On behalf of Deloitte, Ben Sheriff thanked the Chief Financial Officer and the Finance Team for their work in finalising the Trust's financial	

	statements. The ISA 260 Audit Memorandum was received and noted.	
4B.	**Assurance Report on the 2017/18 Quality Report**	
	Ben Sheriff, External Auditors, Deloitte, introduced the report which summarised the findings of Deloitte's external assurance work completed on the 2017/18 Quality Report. It was noted that the work was mandated by NHS Improvement and that the work had been completed in line with the requirements laid out in the detailed guidance for external assurance of Quality Reports. Mr Sheriff reported that the Trust had selected Inappropriate Out of Area Placements (OAPs) and Early Intervention in Psychosis (EIP) as its publically reported indicators and that the Governors had selected Improving Access to Psychological Therapies (IAPT) as the local indicator. The Head of Clinical Effectiveness and Audit referred to page 6 of the Quality Report External Assurance paper and highlighted that the Trust had worked hard to make the Quality Report more readable and asked whether it would be possible to provide a bit of context around the External Auditors' use of the Flesch Readability software to calculate the Trust's readability score. Mr Sheriff confirmed that he was happy to amend the report accordingly. It was noted that the External Auditors had made three low priority recommendations: • **OAP – Policy for Care Coordinators** – the Trust should ensure that there was a formal policy document which defined the frequency in which the patient was visited by a Care Coordinator or equivalent; • **OAP** – **Billing Data Reconciliation Exercise** – the Trust should further formalise and strengthen the reconciliation control around OAPs to ensure this control was performed each month and formally signed off on. The Trust should also include a further step of amending any validated records to ensure the bed days were accurate on record; • **EiP/IAPT** – **Time Stamping of Referrals** – the Trust should ensure that there was a policy in place to time stamp all physical letters to ensure that the dates were correct and consistently recorded. The Chief Financial Officer confirmed that the Trust had accepted the recommendations and that plans had been put in place to address the issues. The Head of Clinical Effectiveness and Audit confirmed that the recommendations would be implemented by the end of May 2018. The Audit Committee noted that the report's conclusion was that Deloitte were satisfied that there was sufficient evidence to provide a limited assurance opinion on the content of the Quality Report. On behalf of Deloitte, Ben Sheriff thanked the Trust's Quality Accounts Team for their support.	**BSh**

6.	**Independent Auditor's Report and Management Representation Letter in respect of the Financial Statements and the Quality Accounts**	
	Ben Sheriff, External Auditors, Deloitte reported that the Trust was required to sign management representation letters in respect of the Financial Statements and the Quality Accounts. On behalf of the Trust Board, the Committee authorised the Chief Executive to sign the Management Representation Letter.	
7.	**Formal Approvals**	
	It was noted that the Trust Board had delegated full authority to the Audit Committee to issue all necessary approvals in respect of the 2017/18 Annual Accounts on its behalf. It was also noted that the Trust Board had approved the Annual Report, Quality Accounts and that Quality Assurance Committee had provided detailed scrutiny of the Quality Accounts on behalf on the Trust Board. The Committee noted and approved the following relating to the Annual Accounts for 2017/18: • *Audit Memorandum* The ISA 260 Audit Memorandum was received and noted. • *Annual Accounts 2017/18* The Annual Accounts for 2017/18 were approved: • *Management Representations* The proposed Trust Management Representations response to Deloitte was approved: • *Annual Governance Statement* The Annual Governance Statement was approved.	
8.	**Chair's Closing Remarks**	
	The Chair thanked the Finance Team and the Quality Accounts Team for their work on the Trust's Annual Accounts 2017-18 and the Quality Accounts 2017-18.	
9.	**Date of the Next Meeting**	
	25 July 2018 at 2pm	

These minutes are an accurate record of the Audit Committee meeting held on 23 May 2018.

Signed:- _____

Date: - _____

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board

Meeting Date	10 July 2018
Title	**Review and Revision of the Trust's Constitution**
Purpose	This paper seeks the Trust's Board's approval of a revision of the Trust's constitution following a thorough review undertaken by the Trust's Solicitors
Business Area	Corporate
Author	Company Secretary
Relevant Strategic Objectives	N/A
CQC Registration/Patient Care Impacts	N/A
Resource Impacts	None
Legal Implications	Compliance with Standing Orders and relevant statutory and regulatory requirements
Equalities and Diversity Implications	N/A
SUMMARY	At its meeting in February 2018, the Trust Board received a paper proposing a number of amendments to the Trust's Constitution following a review by the Trust's Solicitors. Changes to the Constitution require the approval of both the Trust Board and the Council of Governors. The Governors requested that a group of interested Governors meet with the Company Secretary to review and refine the proposed Constitutional changes. The Governor Group comprising of: Paul Myerscough (Lead Governor), Andrew Horne, Linda Berry, Peter Stratton, Tom Lake, Verity Murricane met with the Company Secretary on 29 May 2018 and proposed a number of additional amendments. The Council of Governors meeting approved the proposed changes to the Constitution at its meeting on 20 June 2018. The paper sets out the additional changes proposed by the Council of Governors.

ACTION	The Trust Board is invited to approve the proposed changes to the Trust's Constitution. If approved, the Annual Members Meeting will be requested to ratify the changes.

Revision of Trust Constitution

Introduction

1. The Constitution of the Trust is a key document which frames much of the governance of the organisation, e.g. the standing orders that govern Board and Council meetings. It is a statutory requirement that changes have to be approved by both the Board and Council of Governors.

2. The Trust's legal advisers were requested to undertake a thorough review of the BHFT constitution and to propose changes that:

    - Ensured full statutory and regulatory compliance;
    - Reflected improvements that had developed since the introduction of the FT model;
    - Addressed the Trust's own actual experience of operating with the current constitution
    - Provided clarity in any areas of potential confusion or uncertainty.

3. Changes to the constitution require approval of both the Board and Council of Governors.

4. The Trust Board approved the proposed changes at its February 2018 meeting. In addition, the Trust Board agreed that references to "he" should be changed to "he or she".

5. At the request of the Lead Governor, the Company Secretary set up a meeting of interested Governors to review the proposed Constitutional changes in more detail. The meeting took place on 29 May 2018 and was attended by:

    - Paul Myerscough, Lead Governor
    - Andrew Horne
    - Peter Stratton
    - Verity Murricane
    - Linda Berry
    - Tom Lake
    - Julie Hill, Company Secretary.

6. The Group made a number of further proposed amendments which are set out in the Appendix.

7. The Annual Members Meeting on 19 September 2018 will be asked to ratify the changes to the Constitution.

8. It is a requirement of the Health and Social Care Act that a Governor presents the changes to an NHS Foundation Trust's Constitution to the Annual Members Meeting.

APPENDIX

Summary of Proposed Key Changes to Trust Constitution – July 2018

Para No.	Section/Area	Proposed Change
	The proposed change relates to the full Constitution document.	The February 2018 Trust Board meeting proposed changing references to "he" to "he or she". Governor requested additional Constitutional Change: It is proposed to change "Chairman" to Chair" throughout the document.
Section 7.2	Staff Constituency	Governor requested additional Constitutional Change: Section to read: "Individuals who exercise functions for the purposes of the Trust, otherwise than under a contract of employment with the Trust, may become or continue as members of the staff constituency if they have exercised these functions continuously for a period of at least 12 months. For the avoidance of doubt, the definition of individuals who exercise functions for the purposes of the Trust includes individuals who are ~~employed by the designated Trust Subcontractor or who are a Volunteer~~Volunteers."
Section 8.3.3	Restrictions on membership	Governor requested amendment: Section to read: "has demonstrated aggressive or violent behaviour at any Hospital or other trust premises or during any other interaction with Trust staff or Sub-Contractors or Volunteers."
Section 11.6	Tenure of Governors	Governors recommended that this section should remain unchanged ie "Public governors and appointed governors may hold office for a maximum of nine consecutive years."
12.7	Council of Governors Disqualification and Removal	Governor recommended change: To add: "The Governors shall consider the findings of the investigation and the response of the Governor whose conduct is being investigated. The governors may

		decide whether to approve a statement setting out the investigated Governor's non-compliance, provided this is approved by two thirds of the governors present and voting and by a simple majority of the public governors present and voting".
Section 41	Annual Members' Meeting	Governor recommended change: "The Trust shall hold an annual meeting for its members and members of the public each year."
Annex 6 Standing Orders of the Council of Governors – 2.10.8	Voting	Governor recommended change: "A written resolution shall be passed only when at least a majority of the Governors, including a majority of Governors who are members of the public constitutency…"
Standing Orders of the Council of Governors – Section 2.15	Quorum	Governor recommended change: To read: "No business shall be transacted at a meeting unless at least one third of all Governors are present, including at least one third of the public governors."
Standing Orders of the Council of Governors – Section 4.3	Committees	Governor recommended change: "The Council of Governors shall approve the members of the Appointments and Remuneration Committee"
Annex 8 – Further Provisions	Appointments Committee	This section is not required in the Constitution. It is recommended that this section be deleted on the basis that the Council of Governors' Appointments and Remuneration Committee is responsible for developing the recruitment and selection process of the Chair and Non-Executive Directors and reports on the process to the full Council.

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	10 July 2018
Title	**Use of Trust Seal**
Purpose	This paper notifies the Board of use of the Trust Seal
Business Area	Corporate
Author	Chief Financial Officer
Relevant Strategic Objectives	N/A
CQC Registration/Patient Care Impacts	N/A
Resource Impacts	None
Legal Implications	Compliance with Standing Orders
Equalities and Diversity Implications	N/A
SUMMARY	The Trust's Seal was affixed to the following documents: • Lease relating to part of the Science and Technology Centre, University of Reading, Whiteknights, Reading • A Farm Tenancy Agreement pertaining to land on the South Side of Turnpike Road, Thatcham, Newbury. The tenancy agreement will regularise the current tenant's occupation of the agricultural land to the east of West Berkshire Community Hospital); • Underlease relating to 1st Floor, Unit 2, Progress Business Centre, Whittle Park Way, Bath Road, Slough (short term lease extension of the above premises until 31 August 2018); • Lease relating to clinical space at the Harry Pitt Building, University of Reading.
ACTION	To note the update.