BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

TRUST BOARD MEETING HELD IN PUBLIC

10:00am on Tuesday 11 September 2018
Boardroom, Fitzwilliam House,
Skimped Hill Lane, Bracknell, RG12 1BQ

AGENDA

No	Item	Presenter	Enc.
	OPENING BUSINESS		
1.	Chairman's Welcome	Martin Earwicker, Chair	Verbal
2.	Apologies	Martin Earwicker, Chair	Verbal
3.	Declaration of Any Other Business	Martin Earwicker, Chair	Verbal
4.	Declarations of Interest i. Amendments to the Register ii. Agenda Items	Martin Earwicker, Chair	Verbal
5.1	Minutes of Meeting held on 10 July 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	Verbal
6.2	Involving Patients and Carers Proactively within Children, Young People and Family Services Report	Helen Mackenzie, Director of Nursing and Governance/ Lucy Cooke, Clinical Director, Children and Young People and Family Services	Enc.
6.3	Patient Experience Quarter 1 Report	Helen Mackenzie, Director of Nursing and Governance	Enc.
6.4	Quality Assurance Committee – 21 August 2018 a) Minutes of the Meeting b) Learning from Deaths Quarterly Report c) Guardians of Safe Working Quarterly Report d) Changes to the Committee's Terms of Reference	Ruth Lysons, Chair of the Quality Assurance Committee Dr Minoo Irani, Medical Director	Enc.
	EXECUTIVE UPDATE		
7.0	Executive Report	Julian Emms, Chief Executive	Enc.
	PERFORMANCE		
8.1	Month 4 2018/19 Finance Report*	Paul Gray, Director of Finance	Enc.
8.2	Month 4 2018/19 Performance Report*	Paul Gray, Director of Finance	Enc.
8.3	Finance, Investment & Performance Committee – 25 July 2018	Naomi Coxwell, Chair of the Finance, Investment and Performance Committee	Verbal Enc.

No	Item	Presenter	Enc.
	**The Month 4 Finance Report and Performance Report were reviewed by the June 2018 FIP Committee*		
STRATEGY			
9.0	Mental Health Bed Capacity Actions and Bed Optimisation Programme Update Report	David Townsend, Chief Operating Officer	Enc.
9.1	Strategy Implementation Plan Update Report	Bev Searle, Director of Corporate Affairs	Enc.
9.2	Berkshire West Integrated Care System Memorandum of Understanding (Local)	Bev Searle, Director of Corporate Affairs	Enc.
CORPORATE GOVERNANCE			
10.1	Audit Committee – 25 July 2018 a) Minutes b) Terms of Reference c) Board Assurance Framework	Chris Fisher, Chair, Audit Committee	Enc.
10.2	Remuneration Committee – Change to the Membership of the Committee	Julie Hill, Company Secretary	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 – 9 November 2018	Martin Earwicker, Chair	Verbal
13.	**CONFIDENTIAL ISSUES:** To consider a resolution to exclude press and public from the remainder of the meeting, as publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted.	Martin Earwicker, Chair	Verbal

Berkshire Healthcare NHS
NHS Foundation Trust

AGENDA ITEM 5.1

Unconfirmed minutes

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

Minutes of a Board Meeting held in Public on Tuesday 10 July 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
	Carol Carpenter	Director of People
	Sue McLaughlin	Clinical Director (*present for agenda item 6.1*)
	Elaine Williams	Freedom to Speak Up Guardian (*present for agenda item 6.2*)

18/120	**Welcome** (agenda item 1)
	Martin Earwicker, Chair welcomed everyone to the meeting, including the observers: Katie Kapernaros, Gatenby Sanderson's Non-Executive Director Insight Programme and the Governors: Ray Fox and Linda Berry. The Chair also welcomed, Serena Allen, CQC who was observing part of the Trust Board meeting.
18/121	**Apologies** (agenda item 2)
	There were no apologies.
18/122	**Declaration of Any Other Business** (agenda item 3)
	There was no other business declared.
18/123	**Declarations of Interest** (agenda item 4)
	i. Amendments to Register – none
	ii. **Agenda Items** – none

18/124	**Minutes of the previous meeting – 08 May 2018** (agenda item 5.1)
	The Minutes of the Trust Board meeting held in public on Tuesday 08 May 2018 were approved as a correct record of the meeting after a minor change had been made to minute no: 18/087 Quality Report (page 7 of the agenda pack): The sentence to read: "Ms Lysons referred to page 91 of the agenda pack and queried whether the section on values based recruitment should make reference to the challenges around the quality of recruits posed by workforce shortages in some areas".
18/125	**Action Log and Matters Arising** (agenda item 5.2)
	The schedule of actions had been circulated. The following items were discussed further: **Cost of Utilities** Chris Fisher, Non-Executive Director commented that domestic energy users were often able to fix their gas and electricity costs and asked what the Trust did to ensure that costs were kept down. It was noted that the PFI contract arrangements (Prospect Park Hospital and West Berkshire Community Hospital) included achieving utility cost value for money. Mr Fisher referred to the figures set out in the appendix to the action list and commented that he was surprised by the level of increase in the cost of utilities. The Chief Executive requested that the Chief Operating Officer reviews whether the Trust can take any further actions to reduce of cost of utilities. **Action: Chief Operating Officer** **The Trust Board**: noted the schedule of actions.
18/126	**Patient Story** (agenda item 6.1)
	The Director of Nursing and Governance played a short video in which a patient described his experience of being admitted to Prospect Park Hospital. In the video, the patient talked about feeling very uncertain about where anything was and how the ward operated in the first few hours and days of admission. The patient mentioned that fellow patients helped him, but it would have been better if some very basic information about the ward routine was available. The patient had a positive experience, but it was these first few days that he remembered vividly. The Chair welcomed Sue McLaughlin, Clinical Director, Prospect Park Hospital and invited her to talk about how the patient was helping the Trust to improve patient experience at Prospect Park Hospital. The Clinical Director reported that the Trust had let the patient down because there was a lack of ownership about his care and treatment on admission and it took time for this information to reach him. The Trust was now refreshing the Key and Allocated Worker model in which a patient would be assigned to an individual nurse who would be responsible for overseeing the patient's care and treatment. There were also arrangements in place to ensure cover when the key nurse was not on duty. The Clinical Director reported that the patient was working with the Trust to improve the experience of Prospect Park Hospital patients. It was noted that the Trust had developed an information pack but feedback from the patient was that this would be too much to take in upon admission and therefore patients

	should only be given the basic information about what to expect on a typical day when they were admitted to a ward at Prospect Park Hospital and further information could be provided at a later stage. The Clinical Director said that the two actions were simple things but made a real difference to patients and that the challenge was to ensure that the minute a patient arrived on the ward, no matter who was on duty, someone would greet the patient and give out the basic information about the ward. It was noted that this way of working would apply to Agency staff as well as the Trust's staff. The Clinical Director commented that the patient had mentioned the value of the support he had received from other patients on the ward and reported that the Trust was piloting the role of Peer Mentors. It was noted that the scheme had only been up and running for three weeks, but so far, the feedback was very positive. The Director of Nursing and Governance reported that service users were helping the Trust to develop its Service Users Strategy. The Chief Executive suggested that the Trust Board receive a report on the Peer Mentor Pilot in due course. **Action: Director of Nursing and Governance** The Chief Financial Officer asked whether the ward staff had seen the patient video. The Clinical Director confirmed that staff had watched the video and reported that the Trust had a rolling programme of patient videos which were used for training purposes. Mark Day, Non-Executive Director asked whether the 15 Step Visits and Board Visits guidance could be amended to include consideration of the patient perspective. **Action: Director of Nursing and Governance** The Chair thanked the Clinical Director for presenting the patient's story. On behalf of the Trust Board, the Chair also thanked the patient for sharing his story.
18/127	**Freedom to Speak Up Annual Report** (agenda item 6.2)
	The Chair welcomed, Elaine Williams, the Trust's Freedom to Speak Up (FTSU) Guardian and invited her to present the Annual Freedom to Speak Up Guardian Report: It was noted that the FTSU Guardian was 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 FTSU Guardian reported that from June 2017 to June 2018, 20 members of staff had contacted her with a range of issues, including elements of bullying and harassment; communication and relationships within teams; patient safety; and requests for guidance. The FTSU Guardian reported that she had attended 43 team meetings over the last year to raise awareness about the role of the Guardian. The FTSU Guardian also attended a range of other events, including Corporate Induction sessions, Junior Doctors' Rotation meetings and the Essential Knowledge for New Managers training courses. It was noted that the FTSU Guardian met with the Chief Executive on a monthly basis to reflect on concerns raised, support received and to discuss any themes. Going forward, the Director of Nursing and Governance would also attend these meetings.

	The FTSU Guardian reported that she was also supporting the Equality and Diversity Road Shows. In addition, the FTSU Guardian had recruited five "Freedom to Speak Up" Champions to support her in her role. Ruth Lysons, Non-Executive Director asked what proportion of the 20 cases had been resolved by providing a listening ear and how many had resulted in an external investigation. The FTSU Guardian reported that two members of staff had raised a similar issue and that this had resulted in an external investigation. The remaining cases had been resolved internally. The Chief Executive stressed that the FTSU Guardian was only one of a range of channels staff could use to raise concerns and that the Director of Nursing and Governance triangulated staff and patient feedback in the round in order to identify themes and areas for improvement. The Chair thanked the Freedom to Speak Up Guardian for her report. **The Trust Board:** noted the report and agreed that the Freedom to Speak Up Guardian would present a six monthly rather than an annual report to the Trust Board in line with the recommendations from the National Guardians Office.
18/128	**Annual Complaints Report** (agenda item 6.3)
	The Director of Nursing and Governance presented the report and highlighted the following key points: • The annual report collated the information received each quarter by the Trust Board. • The number of complaints received by the Trust was similar to last year. The 100% performance of responding to complainants within timescale had been maintained which continued to be an excellent achievement. • Similar to last year, the services which had received the highest number of complaints were: Community Mental Health Teams, Child and Adolescent Mental Health Teams, Crisis Resolution Home Treatment Team and Mental Health Inpatients. Examples of changes to these services as a result of complaints were included in the report. The Chair referred to the Equalities Annual Report (agenda item 9.3) which mentioned that further work was needed to reduce the number of complaints where the complainants' ethnicity was "not stated". The Chair referred to page 33 of the agenda pack and asked when the Trust Board would receive the outcome of the "deep dive" review into the Reading Community Mental Health Team. The Director of Nursing and Governance confirmed that this was scheduled in Quarter 2. The Director of Nursing and Governance explained that the Trust had commissioned the "deep dive" because of the number of complaints relating to Reading Community Mental Health Team but pointed out that the review would include feedback from service users who had not made a formal complaint in order to get a balanced view. **Action: Director of Nursing and Governance**

	Naomi Coxwell, Non-Executive Director said that it would helpful if future reports included the volume of recipients of a particular service in order to put the number of complaints received into context. **Action: Director of Nursing and Governance** David Buckle, Non-Executive Director commented that in his experience as a GP, managing the interface between organisations was particularly challenging. The Director of Nursing and Governance said that the Trust was responsible for managing the whole Mental Health Pathway and pointed out that the key challenge for the Trust was around managing the interfaces between teams. The Director of Nursing and Governance reported that complaints which related to more than one organisation were investigated by one of the organisations and the responses were signed off by all the relevant organisations. The Chief Executive reminded the Trust Board that he personally signed every complaint letter and confirmed that the responses were comprehensive and addressed the issues raised by the complainants. **The Trust Board:** noted the report.
18/129	**Quality Assurance Committee Meeting – 15 May 2018** (agenda item 6.4)
	a) Minutes of the meeting held on 15 May 2018 Ruth Lysons, Chair of the Quality Assurance Committee reported that the meeting had discussed the following issues: • Presentation on the Quality Improvement Breakthrough Objective to reduce the number of inpatient falls – the presentation had highlighted how the wards were using data to find out when falls were most likely to happen and that each ward was different. • It was too early to tell whether the Trust would be able to meet its ambitious target of reducing the number of inpatient falls by 50%; • Presentation on Reducing the Use of Prone Restraint**;** • Quality Concerns – in particular, workforce shortages and high bed occupancy; and increased waiting times, particularly in relation to autistic spectrum diagnosis; • The outcome of the clinical audit into the use of Depo medication; and • Guardians of Safe Working Hours and Learning from Deaths quarterly reports which had been circulated with the agenda papers for the meeting. Chris Fisher, Non-Executive Director reported that the Audit Committee was responsible for reviewing the Clinical Audit Programme and had discussed the increase in the number of national clinical audits. Mr Fisher said that the Clinical Audit team was managing to deliver the Clinical Audit Programme but at some point, the resourcing of the team may need to be reviewed in order to meet the demands of the increasing number of national clinical audits. **b) Learning from Deaths Quarterly Report** The Medical Director said that the purpose of the quarterly reporting was to provide assurance to the Board that the Trust was appropriately reviewing and learning from deaths. It was noted that there were no lapses in care identified during quarter 4.

	The Chair commented that it was a reassuring report and asked whether there would be merit in commissioning an occasional external review. The Medical Director reported that the Internal Auditors who had given "significant assurance" to the Trust's mortality review systems and processes. The Medical Director said that he was not aware of any external validation process. The Chief Executive pointed out that the Care Quality Commission was responsible for reviewing mortality review systems and processes as part of their "Well-Led" inspections. The Chair referred to page 65 of the agenda pack and asked for more information about the Trust's Zero Suicide Programme in relation to working with families. The Director of Nursing and Governance agreed to update the Trust Board. **Action: Director of Nursing and Governance** **c) Guardians of Safe Working Hours Quarterly Report** The Medical Director said that during quarter 4, the Guardians of Safe Working Hours had not identified any unsafe working hours and no other patient safety issues requiring escalation had been identified. During the quarter, there were two exception reports. The first exception report related to a trainee who stayed 1.25 hours after their regular time in order to complete clinical work and was given appropriate time off in lieu that week. The second exception report concerned a trainee who chose to be part of a clinical activity that took place out of hours and was granted 3.5 hours' time off in lieu that week. The Chief Executive pointed out that for the Trust, junior doctors working additional hours was less of an issue than for some other staff groups who were under pressure because of workforce pressures and increased demand. **The Trust Board:** noted the minutes of the Quality Assurance Committee and the quarterly Learning from Deaths and Guardians of Safe Working reports.
18/130	**Revalidation Annual Report 2017-18** (agenda item 6.5)
	The Medical Director presented the report and highlighted the following key points: • The annual report was a requirement of NHS England and provided details for the 2017-18 year of revalidation with respect to doctor numbers, appraisal numbers, revalidation recommendations and governance arrangements to support revalidation. • Out of 128 doctors, only two doctors did not complete their annual appraisal because of long term sick leave. David Buckle, Non-Executive Director asked how the Trust was assured that the medical appraisal process added value and was not just a tick box exercise. The Medical Director said that following completion of every appraisal, the doctor was sent a feedback form for completion. Feedback to date had been very positive and all matters related to appraisal and revalidation were discussed monthly at the Decision Making Group meeting attended by the Medical Staffing Lead, Appraisal Administrator, Appraisal Lead and Medical Director. **The Trust Board:** a) Noted the report;

	b) Agreed the submission of the annual statement of compliance to the NHS England Higher Level Responsible Officer prior to the deadline of 30 September 2018 signed by the Chair and Chief Executive.
18/131	**Executive Report** (agenda item 7.1)
	The Executive Report had been circulated. The following issues were discussed further: **a) Stakeholder Survey** The Chief Executive reminded the meeting that the detailed results of the Stakeholder Survey had been discussed at the last In Committee meeting. The anonymised results had been included in the public meeting agenda pack. **b) Integration and System Working** Ruth Lysons, Non-Executive Director asked whether the Health and Social Care Select Committee report on Integrated Care which concluded that further integration of services and the organisations planning and delivering them was often hampered by current legislation and asked whether it was likely that this would lead the Government to consider introducing legislation to remove the barriers to integration. The Chief Executive reported that he was not aware of any plans for the Government to introduce new legislation and given the Government's focus on Brexit it was unlikely there would be Parliamentary time set aside for changes to health service legislation during this parliamentary term. **c) 2018-19 System Control Totals for Frimley and Berkshire West Integrated Care Systems** Due to national time pressures on Integrated Care Systems, the Trust Board had agreed with systems partners (under the Trust's urgency rules as set out in the Constitution) 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 Chief Financial Officer reported that the system risk element of the PSF was 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 was supporting the "full PSF" system control total option for the Frimley Integrated Care System (£0.7m PSF committed), and "partial PSF" system control total option for the Berkshire West Integrated Care System (£0.3m PSF committed). **The Trust Board:** a) Noted the report; and b) Ratified the decision as set out above which was made between meetings in accordance with the "urgency rules" as set out in the Trust's Constitution.
18/132	**Month 02 2018-19 Finance Report** (agenda item 8.1)
	The Month 2 financial summary report had been circulated. The Chair commented that he liked the new format of the Finance Report.

	The Chief Financial Officer reported that the Finance, Investment and Performance Committee meeting held on 27 June 2018 had reviewed the month 2 Finance Report.
	
	The Chief Financial Officer presented the finance paper and highlighted the following points:
	
	• The Trust's financial performance was tracking slightly ahead of the financial plan.
	• The Trust had delivered a £0.5m surplus in May 2018 (£0.3m over the Control Total), bringing the year to date surplus to £0.7m
	• Overall staff costs were in line with the recruitment assumptions built into the financial plan.
	• "Spring to Green" had had a positive impact on Acute Overspill beds costs, reducing costs by £0.2m.
	• Following the "Spring to Green" initiative, the number of patients placed Out of Area increased in early June 2018 and this was likely to have a detrimental financial impact.
	• Capital spend was on plan and cash was £0.8m higher than planned due to working capital timings;
	• Overall Use of Resources rating remained at a "1" overall.
	• The Trust was planning to undertake an initial 2018-19 forecast review following the Quarter 1 financial close.
	
	The Chair noted the positive impact of the "Spring to Green" initiative and asked how the learning would be embedded.
	
	The Chief Operating Officer explained that the "Spring to Green" initiative was resource intensive and its purpose was to address the spike in the number of Out of Area Placements. It was noted that the Bed Optimisation Programme included a number of actions which were designed to deliver sustainable change, including the introduction of a 72 hour review post admission, reducing the length of stay and improving the flow through the hospital.
	
	The Trust Board noted: the following financial summary of the financial performance and results for Month 2 2018-19:
	
	Year To Date (Use of Resource) metric:
	
	• Overall rating 1 (plan 1 – lowest risk rating)
	  o Capital Service Cover rating 2
	  o Liquidity days rating 1
	  o Income and Expenditure Margin rating 1
	  o Income and Expenditure Variance rating 1
	  o Agency target rating 1
	
	Year To Date Income and Expenditure (for control total including Provider Sustainability Funding):
	
	• Plan: £0.4m surplus
	• Actual: £0.7m
	• Variance: £0.3m better than plan.
	
	Year To Date Cash: £21.8m (Plan £21.0m) - £0.8m better than plan due to working capital timings

18/133	**Month 2 2018-19 Performance Report** (agenda item 8.2)
	The Month 2 2018-19 Performance Summary Scorecard and detailed Trust Performance Report had been circulated. It was noted that the Finance, Investment and Performance Committee had reviewed the month 2 Performance Report at its meeting on 27 June 2018. It was noted that People and Contractual Performance were RAG rated amber for May 2018 and NHS Improvement (non-financial) was RAG rated red. **The Trust Board**: noted the report.
18/134	**Finance, Investment and Performance Committee Meeting – 27 June 2018** (agenda item 8.3)
	a) Naomi Coxwell, Chair of the Finance, Investment and Performance Committee reported that the Finance, Investment and Performance Committee had discussed the outcome of the Committee's Annual Review of Effectiveness and had agreed to develop a programme of "deep dives" into particular key topics. b) Naomi Coxwell reported that the Committee had made a small number of amendments to its terms of reference (shown in tracked changes). **The Trust Board:** a) Noted the verbal report back from the Finance, Investment and Performance Committee meeting and; b) Ratified the changes to the Committee's Terms of Reference.
18/135	**Vision Metrics Report** (agenda item 9.0)
	The Chief Financial Officer presented the paper and highlighted the following points: • During 2017-18 the Trust Board had agreed a set of metrics to indicate progress towards implementing the Trust's Vision. • The Vision Metrics were aligned to the Trust's Quality Improvement Programme. • The Vision Metrics Report was presented in public for the time to support transparency and accountability regarding the Trust's Vision intentions. • Appendix 1 of the agenda paper sets out the year to date position as at the end of May 2018. The Chair commented that the Vision Metrics provided a useful visual dashboard of the Trust's performance in its key areas of focus. The Chief Executive said that the performance metrics were challenging and required long term cultural change and different working practices. Mark Day, Non-Executive Director asked whether the Quality Improvement initiative timescales could be part of the Vision Metric reporting. **Action: Chief Financial Officer** **The Trust Board:** noted the report.

18/136	**Strategy Summary Document 2018-21** (agenda item 9.1)
	The Director of Corporate Affairs presented the paper and highlighted the following points: • The purpose of the document was to set out the Trust's key priorities for 2018-21. • The Strategy Summary brought together in one place, the highlights of the Trust's current strategies and plans. • Summaries of the Trust's approach to financial planning and involvement with the two Integrated Care Systems were also included. • The Strategy Summary Document has been shared with partners and was discussed at the Executive Committee. The key areas of feedback were: the document was short and concise and there was a good mix of system and organisational initiatives; more emphasis was needed on the informatics requirements; and more emphasis was needed around the importance of prevention and self-care. The Chair commented that it was good document and provided a useful overview of the Trust's strategies and plans. The Chief Executive suggested that going forward it would be helpful to be able to distill the Trust's strategy into three to four lines of text. The Director of Corporate Affairs suggested that this was something to consider as part of the Trust Board's Strategic Planning Away Day in October 2018. The Away Day would also provide an opportunity to identify any new areas of focus for next year. **Action: Director of Corporate Affairs/Company Secretary** The Chief Financial Officer said that it would be helpful to have a discussion about system working, new models of care and what the Trust wanted to achieve as part of the Strategic Planning Away Day **Action: Chief Financial Officer/Company Secretary** The Chief Executive said that it would be helpful to include a slide on system working as part of the Strategy Summary Document. **Action: Director of Corporate Affairs** **The Trust Board:** approved the Strategic Plan Summary 2018-21.
18/137	**Mental Health Strategy Update Report** (agenda item 9.2)
	The Director of Corporate Affairs presented the paper and highlighted the following points: • The paper provided an update on progress against the key priorities within the Mental Health Strategy approved by the Trust Board in December 2016. • In particular, the paper provided an overview of developments in national policy and the local operating context since November 2017 when the last progress report was provided. • The paper also set out the progress against key targets. The Chair commented that the paper provided information about the implementation of the Mental Health Strategy but there was a lack of information about what had changed as a result of the various initiatives.

	Chris Fisher, Non-Executive Director referred to the section on the Zero Suicide Programme and commented that over half of the deaths by suicide were people who had had no contact with the Trust's services. Mr Fisher asked what more could the Trust do to work with its partner organisations to address this issue. The Director of Nursing and Governance reported that as part of the Zero Suicide Programme, the Trust was working with Public Health and a range of other agencies. Naomi Coxwell, Non-Executive Director said that it would be helpful if the next progress report included a section on progress being made in relation to integrated services and how the Trust was managing the various service interfaces. **Action: Director of Corporate Affairs** **The Trust Board**: noted the report.
18/138	**Equality Strategy Annual Report** (agenda item 9.3)
	The Director of Corporate Affairs presented the paper and reported that the Annual Equality Report was required as part of the Trust's compliance with the Equality Act 2010. The Chair commented that it would be helpful if future reports included more information about what the Trust was doing to address gender pay inequality. The Director of Corporate Affairs reminded the meeting that when the Equality Strategy 2016-2020 was developed, gender pay equality had not been identified as an area of focus. The Chief Executive suggested that when the Equalities Strategy was refreshed there should be a section on gender pay equality. **Action: Director of Corporate Affairs** **The Trust Board:** noted the report.
18/139	**Audit Committee – Minutes of the Meeting held on 23 May 2018** (agenda item 10.1)
	Chris Fisher, Chair of the Audit Committee reported that the meeting on 23 May 2018 was a single issue meeting to approve the Annual Accounts 2017-18 and to receive the External Auditors reports on the Annual Accounts and the Quality Accounts. Mr Fisher paid tribute to the work of the Chief Financial Officer and his team for the production of the Annual Accounts. The Chair thanked Mr Fisher for his update. **The Trust Board:** noted the minutes of the last Audit Committee meeting.
18/140	**Constitutional Changes Report** (agenda item 10.2)
	The Company Secretary reported that the Trust Board had approved the proposed changes to the Constitution following a review by the Trust's Solicitors. The Company Secretary reported that changes to the Constitution required the approval of both the Trust Board and the Council of Governors. It was noted that the Company Secretary had met with a group of Governors (Linda Berry,

	Paul Myerscough, Andrew Horne, Tom Lake, Verity Murricane and Peter Stratton) to review the proposed changes in more detail. The additional changes recommended by the Governors (approved at the Council of Governors meeting in June 2018) were set out in the report. Mark Day, Non-Executive Director queried the discrepancy between the length of tenure of Governors at nine years compared to Non-Executive Directors at six years. The Company Secretary explained that the Governor and Non-Executive Directors' length of tenure as set out in the Constitution reflected Monitor's (now known as NHS Improvement) Model Constitution for NHS Foundation Trusts and Monitor's NHS Foundation Trust's Code of Governance. The Company Secretary thanked the members of the Governor Group for their help in reviewing the Constitution. **The Trust Board**: approved the changes to the Trust's Constitution as set out in the report. The changes would also be referred to the Annual Members' Meeting for ratification.
18/141	**Use of the Trust Seal Report** (agenda item 10.3)
	The Trust Board: noted the use of the Trust's seal as set out in the report
18/142	**Council of Governors Update** (agenda item 10.4)
	The Chair reported that there were a number of new Partnership Governors, in particular, Marion Child, Alzheimer's Society, Cllr Natasa Pantelic, Slough Borough Council, Cllr Jenny Cheng, Wokingham Borough Council and Cllr Graeme Hoskin. Reading Borough Council. The Chair reported that he had invited Governors to have a discussion with him about what could be done to ensure that all Governors felt confident to participate fully in the Council meetings. Chris Fisher, Non-Executive Director said that he was pleased that there would be another Non-Executive Director "speed dating" session at the Joint Non-Executive Director and Council of Governors meeting on 18 July 2018 as this provided an opportunity for Governors to have small group discussions. **The Trust Board:** noted the update.
18/143	**Any Other Business** (agenda item 11)
	There was no other business.
18/144	**Date of Next Meeting** (agenda item 12)
	Tuesday, 11 September 2018
18/145	**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 10 July 2018.

Signed…….Date 11 September 2018
(Martin Earwicker, Chair)

Berkshire Healthcare NHS
NHS Foundation Trust

AGENDA ITEM 5.2

BOARD OF DIRECTORS MEETING: 11/09/2018

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	18/015	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**	
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 the joint Council meetings.	19.09.18	**JH/ME**	There will be an item on the agenda of the formal Council meeting on 19 September 2018.
10.07.18	18/125	Action Log	The Chief Operating Officer to review whether the Trust can take any further	11.09.18	**DT**	We currently purchase our energy via Crown

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Status
			actions to reduce the cost of utilities.			Commercial Services (CCS). Over the years we have had discussions with a range of energy brokers to ensure we are getting the best value and service for the Trust with regards to our utility supply contracts. We believe that the CCS framework does provide this for a number of reasons. - The CCS has considerable buying power as it is purchasing energy for a huge part of the public sector, including central government, MoD, health, education and local authorities - They provide a good level of customer service and support

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Status
						- This level of support is mirrored by the actual energy providers on the framework. We have spoken to peers from other Trust's that have switched away from CCS framework have in general not made any financial savings and often experienced poor customer service.
10.07.18	18/126	Patient Story	The Director of Nursing and Governance to consider whether to amend the 15 Step Visits and Board Visits guidance to include consideration of the patient perspective.	11.09.18	**HM**	15 steps is a national programme which is meant to be from the patient's perspective. The Director of Nursing and Governance has asked the team to review how they conduct the 15 step visits in light of this feedback. The Board visit guidance can be amended as requested.

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Status
10.07.18	18/126	Patient Story	The Trust Board to receive an update on the Peer Mentor Pilot Project	February 2019	**HM**	The peer mentor pilot has commenced in Prospect Park Hospital. An update will be provided in February 2019
10.07.18	18/128	Annual Complaints Report	The outcome of the patient experience "deep dive" review into Reading Community Mental Health Team to be reported to the Trust Board.	13.11.18	**HM**	The deep dive review will be reported in the Quarter 2 Patient Experience Report
10.07.18	18/128	Annual Complaints Report	Future Complaints Reports to include information about the volume of recipients of a particular service in order to put the number of complaints into context.	July 2019	**HM/NZ**	The Complaints Team will explore how this can be included in next year's Annual Complaints Report.
10.07.18	18/129	Quality Assurance Committee – May 2018 minutes	The Director of Nursing and Governance to update the Trust Board on how the Trust was working with families and carers as part of the Zero Suicide Programme.	TBC	**HM**	A presentation on the progress of the Zero Suicide Programme can be scheduled when required.
10.07.18	18/135	Vision Metrics	Consideration to be given to including Quality Improvement Initiatives and timescales as part of the Vision Metrics	26.09.18	**AG**	This will be considered alongside the review of the new "True North" performance scorecard

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Status
			reporting.			reporting due to be reviewed at the September 2018 meeting of the Finance, Investment and Performance Committee.
10.07.18	18/136	Strategy Summary Document 2018-21	The Trust's strategy to be distilled into three or four lines of text which would be discussed at the Board's Annual Strategic Planning Away Day in October 2018.	09.10.18	**BS**	
10.07.18	18/136	Strategy Summary Document 2018-21	The Board's Annual Strategic Planning Away Day in October 2018 to include a discussion about what the Trust wanted to achieve from system working and new models of care.	09.10.18	**AG/JH**	The draft Trust Board Away Day agenda will be discussed as part of the In Committee meeting.
10.07.18	18/136	Strategy Summary Document 2018-21	The Strategy Summary Document to be updated to include a slide on system working.	09.10.18	**BS**	Completed. Draft taken to Executive Committee for approval on 20 August 2018. Final version to be included as an appendix in papers for the Trust Board Away Day in

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Status
						October 2018
10.07.18	18/137	Mental Health Strategy Update Report	The next update report to include a section on the progress being made in relation to integrated services and how the Trust was managing the various service interfaces.	13.11.18	**BS**	
10.07.18	18/138	Equality Strategy Annual Report	The Director of Corporate Services to include a section on gender pay equality when the Strategy was refreshed.	TBC	**BS**	

Trust Board Paper

Board Meeting Date	11 September 2018
Title	Involving patients and carers proactively within children, young people and family services
Purpose	To inform the board of progress on involving patients and carers within services
Business Area	Nursing & Governance
Author	Lucy Cooke, Clinical Director Daryl Nicholas, Service User Experience and Participation Lead
Relevant Strategic Objectives	1 – To provide accessible, safe and clinically effective services that improve patient experience and outcomes of care
CQC Registration/Patient Care Impacts	Supports maintenance of CQC registration and supports maintaining good patient experience
Resource Impacts	N/A
Legal Implications	N/A
Equality and Diversity Implications	Patient experience has equality and diversity implications and this information is used to consider and address these.
SUMMARY	This report summarises: • Progress against levels of participation across CYPF services with examples. • Focus is to highlight satisfaction levels and encourage action in response to feedback • Examples regarding the proactive involvement of service users, carers, and family members. • Demonstrates how participation representatives from all services now act as champions for service user feedback and participation.
ACTION	The Board is asked to: Consider the report

Involving patients and carers proactively within children, young people and family services.

1. Context

The participation and feedback strategy was developed with staff and service users across children, young people and family (CYPF) services and is contained in appendix 1. This strategy was agreed by senior management team within CYPF services with the support of the Director of Nursing at Berkshire Healthcare. The strategy outlines a series of levels to participation which will allow the monitoring of progression of participative practices in a meaningful and encouraging way across CYPF services.

The focus is on highlighting satisfaction levels and encouraging action in response to feedback, as well as encouraging the proactive involvement of service users, carers, and family members. Participation representatives from all services act as champions for service user feedback and participation.

2. Progress

We have identified participation champions across CYPF services. The champion role provides opportunities for passionate and enthusiastic staff, at all levels, to play an active role in generating a positive focus towards the progression of service user feedback and participation. The role of the champion provides local service knowledge, a link with each of the CYPF teams, additional participation capacity, and opportunities for peer support across the CYPF teams.

Through the provision of workshops, catch up meetings and 1:1 skype meetings, champions are given training, guidance, support and challenge to bring energy and ideas to their service to enable teams to meet an appropriate level as defined within our levels of participation.

A reporting tool has been set up on Datix to monitor the progress each service is making towards achieving each participation level. All services have made progress against the participation levels. The focus has been on high quality processes which ensure meaningful, respectful and purposeful engagement, to avoid the unnecessary collection of feedback and inaction.

3. Some examples of proactive involvement

Willow House

Young people admitted to Willow House found the welcome booklet to be very adult focused and did not feel it gave them the right information that they needed to know. The service began to work with service users. Three initial working groups were facilitated to gather ideas from the young people. The young people felt it would be good to be able to see some of the rooms and what a bedroom looked like, so professional photographs were taken. A different group of young people reviewed the first draft of the booklet to ensure that this met their needs. Young people have stated that the booklet now gives them a clear understanding of Willow House and what could be expected of their admission.

Children and young people integrated team (CYPIT)

Two focus groups for Parents, of children under 5 years old who accessed Speech and Language Therapy in West Berkshire, have been held within the CYPIT service. This formed part of a needs audit for service users who require support relating to both Autism and Speech and Language development. The parents gave their views on the needs of this group of young people and their families, the areas of support that they believe have worked well up until now, and their ideas for change. The focus groups were complemented with additional telephone consultations with parents who were unable to attend the groups. This review allowed for comparisons to be made between the experience of families accessing support in East Berkshire where the service operates within a different structure.

School Nursing

West Berkshire team held a workshop in March 2018 with three secondary schools; feedback was sought about how young people would prefer to access the service, what support they feel they need from school nursing, where and when they would like to be able to meet members of the team. The outcomes have been discussed within team meetings and plans are in place to respond to the participants within a 'you said…we did' format.

Actions included:

> Many suggestions such as calling directly or texting the service were already in place but young people told us they were not aware of this. As a result the service will be sharing all our contact methods and details again with the school health champions and asking for their help to share this within their schools. The service will also will be offering assemblies to remind young people about the services we offer and how they can contact us.
>
> The service will review the school spaces allocated to us to see if improvements need to be made.
>
> Youth Health champions said they would like to receive personal, health, social and economic (PHSE) sessions on subjects such as mental health, sexual health, smoking and other substances; the current specification does not allow this to be delivered in a universal way in West Berks. As a result we are offering to meet with the youth health champions in our schools and/or with their co-ordinator from public

health. With notice we have offered to help them with ideas and resources for them which will enable them to support their peers in the areas they have outlined.

Young people suggested School Nurses are part of C-card system; those who currently have an active drop-in already are but we will discuss this idea with other School Nurses to see if they feel undertaking this would be beneficial in their schools or if there already another provision.

A small sample of parents took part in a consultation on a new RIO health assessment/report template which is being developed. These findings contributed immediately to the development of the health assessment as they worked directly on the testing alongside the transition team who were building the template.

A further focus group was held in Reading with a group of vulnerable students at a pupil referral unit, in which young people were consulted about the school nursing and immunisation service within the trust.

The feedback and actions taken:

- That some students were on a part-time timetable. Therefore a drop-in on a regular day excluded some students, as a result drop in days will now be alternated.
- Regarding immunisations, students identified that they preferred to be immunised in school, contrary to what we thought they would say, so current practice will continue.
- Students identified that whilst they valued their School Nurse and some had accessed her, the boys felt that there were some things they would only talk to a man about. The service are unable to provide a male member of staff for the boys but, as a result of the feedback, the service has contacted male professionals from other council services (for example youth work and the edge of care service). Both services have agreed to a one off visit along with the school nurse for a specific PSHE activity, and details to be confirmed.

An opportunistic conversation with a twenty three year old man, who was known to a member of the team and had used substances on occasion recreationally when younger and had received health promotion from his School Nurse, led to some challenging feedback. A single question was circulated to all 10 secondary educational provisions in Reading and a request for teachers of Year 9 to ask them the following question;

‘what information do you think should be included in a teaching session about substances’?

Significant amounts of feedback were received from the students from 5 of the schools

The following areas were identified as the most important in order to engage our school-aged population;

- Real people
- ….telling real stories…
- ……..in real language….

The service asked for support from a local school in order to create a film made by the young people of Reading, for the young people of Reading. The film is called 'Taylor's Story' and will form the centrepiece to a health promotion session. It is not the story of the twenty three year old but is based on his experiences. It contains an introduction to the main character and three scenarios and is designed to be stopped after each scenario to hold an interactive discussion about what Taylor's choices are and what the consequences might be. However, the scenarios will be connected with information to read so that if there is limited time, the film can be run straight through, for example within an assembly. In addition to the film, a powerpoint presentation is also being developed showing still photographs and aims to teach the children and young people first aid around substance use, how to identify problematic drug use in their peers and where to go for help. Students from Prospect School in Reading will be depicted in these photographs. It is anticipated that the film will be shared more widely with teams in Berkshire Healthcare, including the other School Nursing teams and the Looked After Children's team.

Looked After Children (LAC)

The LAC team are proud of the Health Passports that have been introduced for Care Leavers. Young people's views were consulted, initially through the 6 Children in Care Councils, which then followed onto a focus group. Young people decided on the content and design of the passports, selecting the information that they feel will allow them to be most equipped when accessing further adult health services, within a design and format that they felt would meet their needs.

Young people's views and experiences have been incorporated within the training delivered by the team to other health practitioners via the safeguarding forums; young people took part in a film and consented to their experiences being shared to improve better understanding and service provision. This led them to feeling empowered and listened to.

Child and Adolescent Mental Health Services (CAMHS)

Service users, parents, carers, and other family members, share their experience of the service via monthly participation meetings, with over 100 service users being involved within the past year. This allows for both consultation and co-production.

> Conversation: Service users take part in many consultations both internally, on aspects of CAMHS pathways or overall service provision, and working with commissioners and external partners. Please see appendix 2 for examples of group consultations that CAMHS service users have taken part in between May 2017 and July 2018. Over 30 consultations have taken place with CAMHS service users within the past year.

Further examples of time limited active involvement:

- The participation group have been involved in recording some 'test' podcasts which capture their experience and views on mental health. There are plans in place to upload podcasts, such as these, on the new CYPF website.
- Two CAMHS service users were involved in a BBC Radio Berkshire interview, as part of a Radio Berkshire series which focusses on mental health.

- A member of the CAMHS participation group organised a world mental health day mental health lesson at the Madejski Stadium. The event was supported by CAMHS service users and staff, with the lesson being delivered to over 400 secondary school students.
- Service users, parents and carers were invited to the CAMHS wide away day in October 2017.

On-going active involvement

Co-production: Young people and parents have had the opportunity to share their experience and ideas for the improvement both within tier 3 CAMHS and in the wider mental health service provision during our monthly participation groups. Service users raise their priorities for the service via these groups. Their experiences are added to further qualitative data collected through the Experience of Service Questionnaire (ESQ), Friends & Family comments section, and through external partners to determine the overall priority themes for the service. Service users are kept up to date on the different stages of the development of themes of feedback, exploration and decision making.

Service user priorities at CAMHS, and recent relating participation activity:

'The need for timely support':

- Service users support the collaboration between CAMHS and commissioners to assist in bringing more timely mental health support to families within Berkshire.
- Service users assisted commissioners in East Berkshire to develop a survey to capture the needs of young people. The survey is now in circulation with roughly 800 responses.
- The participation group helped the commissioners in West Berkshire by designing a format for communicating the refreshed future in mind strategy update.
- Two consultations with parents/carers and young people relating to the future of mental health commissioning and service provision in East Berkshire.
- A planning consultation has been held with Wokingham Borough Council regarding Tier 2 provision within the locality.
- The participation group provided feedback on Reading's 'Local Offer'.
- Our service users have reviewed a new model of pre-assessment information meetings within the anxiety and depression pathway, reviewing the process and the accompanying documentation.

'Creating the right environment within CAMHS buildings':

- The relocation of the Reading clinic from Craven Road to Reading University. The service users shared their priorities for the CAMHS building and have given assistance in determining how the rooms are named.

- Young people and parents took part in two consultations to outline their preferences, and concerns, in response the clinic move from Nicholson House to Upton Hospital and St Marks Hospital.
- An art and pizza event was held, where service users created canvasses and other artwork for display within the new Reading CAMHS building.

'Understanding the CAMHS service':

- Young people and parents/carers were involved in consultations around the new CYPF website.
- Service users have helped to plan a 'CAMHS journey' information sheet to show young people the route into, and through, the CAMHS service.
- Review of schools information leaflets about our Anxiety & Depression pathway
- Reviewed information put together to support young people/families who have not received a diagnosis of ASD on the AAT pathway.

'We need to recruit the right people':

Service users, parents and carers have taken part in the recruitment process for new staff across the CAMHS pathways. 18 service users have received training in recruitment. They have helped to design a set of questions for staff interviews, designed bespoke scoring criteria, and taken part in service user interview panels as well as joining management interview panels.

Examples of group consultations that CAMHS service users have taken part in between May 2017 and July 2018 Appendix 2

4. Aims for 2018 – 2019

A scoring criteria will be put in place to provide a clearer picture of how well services are progressing within the participation strategy. We aim for all services to be achieving at least one additional participation level by the end of 2018-2019.

We will continue to support all of the CYPF teams to increase their level of proactive participation. The success of the champions model within CYPF services may lead to the roll out of the framework within other areas of the trust. We have begun to work with our colleagues in adult service to inform them of our learning and to showcase how the model works.

Daryl Nicholas, Service User Experience and Participation Lead

Children, Young People and Family services (CYPF)

Berkshire Children, Young People and Family Services (CYPF) Participation Strategy 2017-2020

Definition

Participation is the active involvement of young people and parents in making decisions about Children, Young People and Family services. This is not just about consultation – asking for their views and opinions – but genuinely involving young people and their families in decision-making processes, highlighting their experience, and giving feedback on how their contribution has made a difference.

(Appendix 1: Key principles of participation within CYPF)

What do service users feel is important?

Service User Aspirations for Participation July 2017(Appendix 2)

Participation Drivers

Legislation, commissioning requirements, human rights, and a series of inquiries (Appendix 3), present us with legal requirements, contractual obligations and strategic drivers to ensure that CYPF services take the active involvement of our service users seriously, ensuring that feedback mechanisms and participation are meaningful and effective.

We believe that to ensure that we are giving high quality, effective care aligned with our Trust Values we need to learn by listening to the views and experiences of people who use our services, and to families carers and members of the public.

Berkshire Healthcare Values states we are;

'Working together with you to provide innovative solutions'

What are the benefits of implementing a Participation Strategy?

The movement from 'Good' services to 'Outstanding' services is a by-product of 'doing it right'. Listening to our service users, being responsive to their experience, allowing them to have influence, and to set our service priorities, form a means of 'doing it right' for our service users.

By engaging effectively and consulting with our service users as early as possible, we can provide services that are accessible and meet with the needs of the user. It can improve our reputation and supports collaboration between all organisations Participation provides many benefits to our services (Appendix 4).

What do we know: Where we are today?

We have conducted a Service User feedback and participation audit through a survey monkey with staff from across CYPF services. Additional information was gathered from meetings held with staff teams/managers (Appendix 5). Our findings demonstrate some positive examples of feedback mechanisms and service user participation across some of the services, which in turn have led to operational changes. It was clear that services undertook many feedback initiatives but often these did not feed into an accountable structure of review, response, and action. Results of quantitative satisfactions measures were often not made visible to staff and service users. Staff regularly reported uncertainty regarding the development of surveys, their outcomes, and, sometimes, the rationale for undertaking them. Staff teams seemed passionate and keen to learn about the processes involved in participation.

Vision and Aim

The Vision of Berkshire Healthcare NHS Foundation Trust Patient Engagement Strategy is:

'To measure and report the experience of care and through working in partnership enhance the services we provide to the community'.

We want to shape our services based on service user experience, allowing them to have a high level of meaningful influence in service design and delivery.

(Appendix 6: Examples of good participative practice).

What we would like to see

We have worked with service user's, staff teams, and the Service Engagement and Experience department, to outline a series of levels to participation, which will allow the progression of participative practices in a meaningful way across CYPF services.

These levels can act as a mechanism for encouraging and monitoring meaningful service user feedback and participation. The focus is on highlighting satisfaction levels and encouraging action in response to feedback. Engagement with diverse groups i.e. BAME, LGBT and disabled people, should play a central part in the attainment of each level. Through the understanding of these group's needs deliver good patient experience and equity of access to all of our services.

Level	To achieve, the service needs to demonstrate….	Measurement
Friends and Family test	That 15% of patients discharged from treatment have completed the friends and family test and that the results have been uploaded onto Teamnet.	Aligned to Trust Objective Monitored monthly/quarterly Quarterly reports to CYPF Performance and Leadership Group Quantitative
Further opportunities for young people and families to give quantitative feedback Visible feedback	Further opportunities for young people and families to rate their service experience, providing quantitative data beyond the friends and family test, and that service users are encouraged to complete the feedback. This could take the form of a rating/satisfaction scale in electronic or paper form. Feedback collected from service users is made visible to both service users, for example through the website or in waiting areas, and staff teams, for example on team minutes or in staff rooms.	Quantitative Monitored via service visits/15 Step visits/CQC reviews Quarterly reports to CYPF Performance and Leadership Group
Further opportunities for young people and families to give qualitative feedback	Further opportunities for young people and families to give service specific qualitative feedback on their service experience and that service users are encouraged to complete the feedback. This could take the form of a patient experience survey, a comments box or a feedback area within a waiting room for example. Services will be required to document the process through which the information gathered is explored by the service and how service users are made aware of the service response.	Qualitative Results are available to view in services 'You said, we did' Monitored via service visits/15 Step visits/CQC reviews/Quarterly reports to CYPF Performance and Leadership Group.
Conversation	Service users are given opportunities for active, meaningful dialogue with the service. This may take the form of focus groups or the involvement of service users within staff meetings/away days for example. Service users play a meaningful role in determining the priorities for the service.	Engagement with staff – named champions or leads in the service Expenses - funded by services Quarterly reports to CYPF Performance and Leadership Group

Level	To achieve, the service needs to demonstrate….	Measurement
Co-creation	Opportunities for service users to play an active role in the design and delivery of the service. Service users are involved, meaningfully, in participation groups and/or project teams and/or staff recruitment, where they are able to set priorities, and their experience and ideas influence decision making and service provision.	Embedded Mapped by what people want/need Aligned with QI strategically and locally Joint decision making – PROMS methodology Quarterly reports to CYPF Performance and Leadership Group/CQC reviews

Key features of developing a participative approach

When targeting a level of effective feedback and participation, a service should consider the following questions:

- Who takes responsibility for starting this / gathering and sharing information?
- How is this information reviewed?
- How is the information turned into improvement of outcomes?
- How is the information shared amongst stakeholders – service users and carers, the team, service management, PPI?
- What are the barriers? What resources or support is needed to make this happen well?
- When and where are young people involved in the analysis, generation of improvement priorities, actions and monitoring of action plans, together with staff?
- Finally, how is all of this communicated?

How do we get there?

Participation representatives from all services will act as champions for service user feedback and participation. The champion role will provide opportunities for passionate and enthusiastic staff, at all levels, to play an active role in generating a positive focus towards the progression of service user feedback and participation.

Providing workshops for champions will enable guidance, support and challenge to bring energy and ideas to their service to enable teams to meet an appropriate level as defined within our levels of participation.

(Appendix 7: young people's suggestions for feedback mechanisms and participation)

How do we measure success?

- Young people and parents have assisted us in the establishment of our 'levels of participation'.
- Services will be able to self-assess their performance, in line with these levels, on datix.
- Through internal supportive visits services will be asked for further information and evidence of the meeting of the reported level.

Ultimately, CYPF aspire to service user's engagement in measuring participation success, allowing them to set our priorities and methods of evaluation. To get to this point, CYPF need to embark on the involvement of service users within each of our services.

Remuneration

Young people and adults make an important contribution to the development of CYPF services and through doing so; donate their time and energy towards improving our service. It is important that service users feel their contribution is appreciated that they are valued and that further involvement is encouraged. CYPF will align with the Trusts 'Payment of Service Users & Carers' Policy & Procedures, which outlines the provision of reimbursement of service user expenses and payment. There are also a number of other ways that services

can provide additional remuneration for service users at no financial cost to CYPF services (Appendix 8).

Daryl Nicholas, Service User Experience and Participation Lead

Berkshire Children, Young People and Family services (CYPF)

Berkshire Healthcare NHS Foundation Trust

References

Berkshire Healthcare (2017), '*CYPF Plan On A Page 2017 – 2018'*

Berkshire Healthcare (2017), *'Equality Goals Team Plan CYPF June 2017'*

Berkshire Healthcare (2017), '*Trust Patient Engagement Strategy'*

Berkshire Healthcare Teamnet, '*Patient Experience'*, July 2017

Coulter, A, and Collins, A, (2011), 'Nothing about me without me to Real Involvement'

Equity & Excellence: Liberating the NHS (2010)

Lord Darzi (2008), '*High Quality Care for All'* report'

NHS Constitution (2009-2010)

Section 242 the Statutory Duty to Involve Section 242(1B), National Health Service Act 2006 (as amended by the Local Government & Public Involvement in Health Act 2007)'

The Equality Act (2010)

The NHS Outcomes Framework (2012)

The Francis Report into Mid-Staffordshire (2010)

Appendix 1

Key points of our principles on participation in CYPF

- Participation should include people of all abilities and ages, including service users, parents, carers and other family members.
- We aim to create an environment of mutual respect and encourage shared responsibilities amongst staff and service users so that we can work together as a team.
- We will challenge others if they ignore or discard this, and break down misconceptions about the involvement of children, young people, and families, and the value this brings to our services.
- We will aspire to provide opportunities for training and provide resources for children, young people and adults to assist us in our work.
- Participation will be facilitated in a way that encourages individuals to engage in new opportunities that allow them to work towards achieving their potential.
- All work with children and young people should involve young people's Input, views, values and experiences.

Appendix 2: Service User Aspirations for Participation July 2017

Appendix 3

Participation Drivers

The Health and Social Care Act, 2012, introduced significant amendments to the NHS Act 2006. The new duties require CCGs to ensure that they commission services which secure that users of those services are involved in –

(a) the planning of the provision of those services,

(b) the development and consideration of proposals for changes in the way those services are provided, and decisions to be made by that body affecting the operation of those services.

Commissioned services will also need to demonstrate that they promote involvement of patients across the full spectrum of prevention or diagnosis, care planning, treatment and care management.

The active involvement and participation of children and young people within service delivery is supported through the United Nations Convention on the Rights of the Child (UNICEF, 1989) and throughout government policy and guidelines. '*Children and young people have the right to participate in decision-making that is relevant in their lives and to influence decisions taken within the family, the school or the community that affect them*.' Article 12, United Nations Convention on the Rights of the Child (UNCRC). Every Child Matters (2004) and The Children's Plan (2007) play a key role in taking forward the Government's commitment to the engagement of children and young people.

Likewise, involvement of parents and carers is crucial. The Government's commitment to putting parents and carers at the heart of services is highlighted in documents such as The Children's Plan (2007) and Every Parent Matters (2007).

The integral role of patient engagement is further outlined within the following papers:

- The clinical '*Nothing about me without me to Real Involvement'*
- Section 242 the Statutory Duty to Involve Section 242(1B) of the National Health Service Act 2006 (as amended by the Local Government & Public Involvement in Health Act 2007.)'
- High Quality Care for All – Lord Darzi's report (2008)
- NHS Constitution (2009-2010)
- The Equality Act (2010)
- Equity & Excellence: Liberating the NHS (2010)
- The NHS Outcomes Framework (2012)
- The Francis Report into Mid-Staffordshire (2010)

Appendix 4

Benefits of Participation

- Service users produce thoughts, insight and solutions that only they could come up with, and often provide more innovative and effective solutions than would have otherwise been possible.
- CYPF services will become better informed about the young people and families we work with, which allows us to provide services that reflect the true needs of the young people leading to improved service provision.
- Young people can take more control over the things that affect them and this can enhance their confidence and ability to apply this to other aspects of their lives.
- By involving service users, CYPF services will be seen by young people and families as services that values their input and opinions as much as we do our own. There becomes a sense of shared ownership from both a service point of view as well as in relation to their own individual care.
- Participation can strengthen accountability and build trust for local services and improve communication between staff and service users and their relatives and carers.
- Through asking sensible outcomes-related questions, participation can home in on pertinent issues that are currently important to service users and reduce resistance to challenging and changing outdated practice.
- We will be better placed to provide what children and young people and their families need, ensuring that CYPF services are cost efficient and targeted.
- Participation encourages a climate of feedback between services and patients and carers, and supports a learning environment where service improvement based on experience can be successfully achieved.
- Through participation, CYPF services fulfil a duty (see participation drivers) to ensure that children, young people, and families, have opportunities to express their views about matters that affect them.
- By participating, service users can share their experiences, see that they are not alone and establish a supportive friendship group that sits alongside and enhances their individual therapeutic intervention.
- Young people and their families can gain the understanding, desire and skills to positively contribute to their communities beyond their work with CYPF services.
- Patient Engagement can lead to more positive health outcomes for patients and more informed choices about their health and social care.

(Participation works, 2013).

Appendix 5: **Feedback and Participation audit with CYPF staff**

Service	F&F test	Staff Survey	Staff Meetings	Ideas gained from staff	Barriers identified by staff
Specialist children's services	Q1 17-18 68 responses recorded	Total number of responses: 1 Evidence of gaining feedback: Evaluations conducted after training	Currently: Various surveys conducted with service users within different teams. Feedback collected on tablets at receptions. 20 telephone interviews conducted with families connected to respite care. Quarterly newsletter provides the opportunity to feedback to service users. Use of 'blue card' for complements and suggestions. Actions taken as a result: Further car parking spaces converted to disabled and parent & child spaces. Service environments made 'more engaging'.	A systematic approach to explore and action feedback responses. Development of service specific questions could be based on patient experience model. Opportunity for focus groups: Stable group of parents connected with respite care and pre-school parent's group meeting on alternate Thursdays. Specialist school nurses could begin to capture feedback. Patient feedback could become an agenda item at team leads meetings. Linking in with 'Special voices' groups in Slough, Bracknell and Maidenhead.	Accommodating service users who do not speak English. Uncertainty about how many service users to involve. Feedback/participation can 'slip' when prioritising. An approach needed for engagement for young people with learning difficulties.
Berkshire Eating Disorder service (young people)	Q1 17-18 0 responses recorded	Total number of responses: 0	Currently: A service evaluation audit is about to take place. The service is collating experience surveys, and working to give service users the option to send in responses anonymously (to encourage those CYP with	Plans in place to review experience surveys quarterly. The service will begin peer support participation groups in the summer (combining self-support education with participation	Capacity – difficult to fit in alongside clinical work. The staff are currently 'getting their heads around' a new clinical model and client group. Uncertain about opportunities to

			negative experiences/suggestions for improvement to take part). The main service user concern is traveling to central Berkshire for their appointments.	opportunities)	remunerate service users attending participation group with vouchers. Due to the nature of the issues involved, some service users are likely to dislike the service and may not want to engage during the early part of their treatment journey.
CYPIT	Q1 17-18 0 responses recorded	Total number of responses: 16 81% of respondents thought that the service collects additional information from/actively involves service users 83% of respondents felt that additional feedback/involvement drives service improvement. Actions: improved feedback when assistant present. This will become permanent. Letters and information given to	Currently: Various survey monkeys used for school staff, young people and 'certain' families. Some do not gain a significant response. Physio use a 'smiley face' rating forms for planning. Two clinicians conducted telephone interviews with families regarding transitions. Parent rating scale (Michael Palin centre) used with stammers and leads to participation in the therapeutic process. Some good examples of participation at a therapeutic level, especially regarding stammers and education, health and care planning, rather than at an operational level.	The service would like to invite families into schools to talk about their experience. More information is collected than action taken. A systematic approach to exploring and responding is needed. Leads feel they are not asking the right questions: Work to be completed in reviewing the questions service users are being asked within surveys. Time, guidance and structure emphasised as being needed to take participation feedback forward.	Lack of time was emphasised within the survey and during the meeting. Technology is not being embraced. Participation and feedback is not a high priority. Staff fear they'll be told service users will want more (of the service/their time). Staff feel that, unless they are present, service users will not fill out surveys. Challenging for surveys to be filled in anonymously. Some schools are easier to engage with than others.

		families have been amended according to feedback. Staff noted that they often do not hear about the feedback. Compliments reinforce good work.	Actions as a result: Home to school communication has changed to more direct communication between families and clinicians.	Allowing service users to set priorities for improvement (service change has been constant in recent years, service users need to play a role here).	IT has been a block to uploading and storing forms. The Hanen approach to language delays is a licenced programme which would be challenging to change through local feedback. Outcome measures were seen as not being 'public friendly'.
CAMHS	Q1 17-18 0 responses recorded	Total number of responses: 10 80% of respondents thought that the service collects additional information from/actively involves service users 100% of these respondents felt that additional feedback/involvement drives service improvement.	Currently: Active participation and outcomes structure. Participation groups running in three localities. Additional participation events. Service users and parents take part in electronic consultations. Service users involved in the recruitment of staff. Service users priorities: • Waiting times • Communication • The CAMHS Environment • Having the right staff Various projects have taken place to enhance communication, service users involved in developing	Coverage of all CAMHS localities. Feedback from questionnaires is not circulated sufficiently for staff. More needs to be done to inform staff of service user priorities and progress made against these. Service users could be used more widely within staff recruitment. Benefits of giving feedback and participation are not explained widely enough	Technology is often a barrier for outcomes data submission within CAMHS. Time for staff to prepare and recruit young people and parents.

			the CAMHS environments and within staff recruitment. Individual pathways/teams have conducted specific audits leading to change in assessments, care plans and communication. Staff are clearer on outcomes requirement.	to all service users. Clarity on how to refer young people to groups. More admin support for audits.	
Health Visiting	Q1 17 – 18 6-8 week assessments. 110 responses recorded.	Total number of responses: 32 75% of respondents thought that the service collects additional information from/actively involves service users 78% of respondents felt that additional feedback/involvement drives service improvement. Some staff unaware of results of feedback. Feedback is mostly positive.	Currently: Survey in place. Hits target 5 per team per month Positive feedback. Distribution of survey by nurses in between HV visits helps to provide some anonymity.	Students/apprentices conducting surveys: Children's centres Voluntary sector organisations Libraries High street Facebook/twitter Support needed to develop participation: • Ring fenced time • Management support Anonymity for service users may allow them to give open feedback (not just the positives). 'We need to speak to service users face to face, rather than via surveys'. Increased staff time was	Funding keeps being reduced and impacts on our ability to meet service user suggestions. Finance. Staff time and resources. Language barriers. Versions for children/those families with low reading levels/learning difficulties (pictorial versions?). Set procedures for reviewing and reporting back to service users unclear. Some areas (inc Slough) parents are not 'groupies', therefore holding groups may be difficult.

				seen as being needed. Staff would like to ask more open questions to highlight service user views. Staff favoured working with groups of parents to gain feedback. Sharing feedback and highlighting successful changes.	"the Trust is backward in use of technology". The most vulnerable service users do not attend groups. Seen as a 'tick box' exercise. Commissioners.
Immunisations	Q1 17 – 18 549 responses recorded	Total number of responses: 4	Currently: Immunisations 1-2 tablets for both East and West teams which are used to conduct surveys.	Electronic options could provide more anonymity. Students/apprentices conducting surveys: Schools (Suggestion: choose one school) Catch up clinics Token could be used: service users asked to place token into either happy or sad box.	Resources (staffing) Very little time to capture immunisations feedback. Anonymity. Translation of feedback material into different languages. Versions for children/those families with low reading levels/learning difficulties (pictorial versions?) Only recent access to tablets for immunisation team Immunisation. Uncertainty regarding how often staff are using tablets. Set procedures for

					reviewing and reporting back to service users unclear. Inequalities work currently not covered by feedback. E.g. travelling community. Families/young people do not understanding the importance of vaccine, children will not understand the benefits.
School Nursing	Q1 17 - 18 School Nursing - Nocturnal Enuresis 6 responses recorded.	Total number of responses: 5 Action: Feedback on teacher training has led to improvements to presentations.	Currently: Two PPI satisfaction surveys are being used through iPhone's, one with young people at secondary schools and another with parents who access the Enuresis clinic. The service gains feedback from school staff on the training provided.	Idea: to make use of existing groups for feedback and participation. Increase awareness of the service. Develop further opportunities for electronic feedback. A small number of CYP have several visits. We could conduct qualitative surveys on, for example, a 5th appointment. Commissioners require us to conduct surveys with CYP at different ages – we could add to these with questions on our	Technology: we currently cannot find the PPI data. We mainly conduct one-off appointments – young people are not invested in our service. CYP don't want to fill out surveys – many CYP have been told they need the service/they've not asked for it. Time. Availability of face to face contacts. Some CYP have low literacy levels. Difficulty in finding opportunities that encourage CYP to fill out surveys anonymously.

				service. We feel participation champions need to be clinicians within our service – as they know the service. We could make use of virtual forums, such as SHaRON. Groups: We could advertise through Facebook, Instagram and the immunisation team.	
LAC named nurses		Total number of responses: 0	Information provided by service management: A positive example of participation within the development of a health passport for young people leaving care. Young people were involved in the design and content of the document. Service users take part in interviewing candidates applying for positions within the service.		

Appendix 6

Good participative Practice

Participation within children, young people and family services includes the involvement of children, young people, and families at a number of levels:

- Where individual decisions are being taken about young people's lives.
- Where services for young people are being developed and provided within Berkshire children, young people and family services.
- Involving young people and parents in opportunities that arise to contribute to the commissioning cycle, strategic decisions taken within Berkshire Healthcare, and national frameworks and policy.

The aim of the participation strategy for children and young people is to:

- Create meaningful opportunities for young people and parents/carers to express their views and opinions about the way services are delivered and impact on their lives.
- Ensure that young people and parents have a direct input and say on decision-making about the design, delivery and evaluation of services.
- Provide a framework for evaluating the impact of participation of children and young people.
- Give clear information and feedback on how the views of young people and parents/carers have influenced the development of services.

Good participative practice should not be a 'tick box' exercise which limits the involvement of the service users to these targets. Excellent practice in service user participation involves a people centred approach where we aim to involve our service users in the design, development and implementation of our participation project work leading to measurable improvement in service user experience. Building partnerships with other local, regional and national organisations and seeking innovation to make effective use of our available resources form important components of a positive participation approach. Through participation we aim to promote diversity and, through doing so, to highlight and reduce health inequalities experienced by service users and their families.

Appendix 7

Young people's suggestions for feedback mechanisms and participation

- Make it as easy and accessible as possible, and make sure that it's tailored to the needs of the children and young people you work with.
- Always leave a space on questionnaires to write 'anything else' – it can be really frustrating just having to fit in with limited options
- Always 'complete the loop' by sharing feedback and your response - you said/we did - so that people can see the point of giving feedback. Be honest about the reason why certain suggestions cannot be implemented.
- Be clear about confidentiality and anonymity of feedback – that this won't affect people's care.
- Offering incentives will increase how much feedback you get and also acknowledge the time spent completing.
- Where possible allow us (young people and families) to help develop the feedback systems with you - e.g. What options there are, how a form looks, how the questions are worded, how you send them out.
- Think about how the feedback is going to be used before you start. It's important not to ask us about aspects of the service that you cannot change.

Appendix 8

Additional remuneration of service users, at no financial cost to our services.

Simply saying ‘thank you’ and providing an environment which is comfortable and enjoyable can go a long way to acknowledging the work of the children, young people, and families, and respecting their needs.

We also recognise that opportunities to learn new skills and meet new people and groups form major outcomes and incentives for young people and adults to remain involved in participation. Building self-confidence, having the opportunity to take part in debates, learning about decision-making processes and seeing some of their ideas come to life are all important ways in which we can encourage and value the involvement of service users. Young people will also receive opportunities to enhance their ‘record of achievement’ as they progress through the education system and the world of work.

Appendix 2.0

Examples of group consultations that CAMHS service users have taken part in between May 2017 and July 2018

- The development of a new survey to gain feedback from service users accessing the Common Point of Entry.
- The participation group took part in a consultation about young men and mental health. The feedback is being shared with Young Minds, who are currently running a young men and mental health campaign.
- The service users also decided to hold a mental health in school discussion, as a development of their assistance to the CCG roll out of 'The Little Blue Book of Sunshine', upon which they were consulted in the autumn. The feedback and ideas with the Thames Valley Strategic Clinical Network.
- Young people conducted a review of a new video introducing the Autism assessment team to service users.
- 'What makes a good mental health assembly' in schools consultation.
- Service experience audit of the Anxiety and Depression pathway.
- A review of CYPF participation plans.
- Young people have set their aspirations for participation across CYPF services.
- Received an update on CYPF integration programmes, where service users asked questions and provide their thoughts and ideas on the progress that has been made.
- The group have worked on the communication of the chaperone policy to other service users.
- Young people and parents have been heavily involved in both electronic consultations and group discussions to shape the process of 'Consent to share information'.
- Families have given feedback on the transitions questionnaire which captures their experience of transitions.
- A review of the ADHD pathway 'was not brought policy'.
- An initial consultation on review of waiters protocol.
- A review of the Rapid response service.
- Planning more transparent communication of CAMHS waiting times.

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	11 September 2018
Title	Patient Experience Quarter 1 report
Purpose	The purpose of this report is to provide the Board with information on patient experience within the trust
Business Area	Nursing and Governance
Author	Liz Chapman, Head of Service Engagement and Patient Experience Nathalie Zacharias, Professional Lead for Allied Health Professionals Helen Mackenzie, Director of Nursing and Governance
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	Patient experience has equality and diversity implications and this information is used to consider and address these.
SUMMARY	Boards are required to review patient feedback in detail. The Director of Nursing and Governance has provided an overview at the beginning of the paper. In quarter one, the Trust received 60 formal complaints. The top reasons for complaints being made during quarter one continue to be: • care and treatment • attitude of staff • communication The formal complaint response rate, including those within a timescale re-negotiated with complainants was 100% for the quarter which continues to be exceptional performance. **Patient and Public Involvement** 90.8% of patients rated our services as good or better in the trust's internal patient survey.

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

Overview

This overview report is written by the Director of Nursing and Governance so that Board Members are able to gain her view of services in light of the information contained in the quarter one patient experience report. The Board is required to consider detailed patient feedback because it provides insight into how patients, families and carers experience our services. In my overview I have considered elements of the feedback received by the organisation, information available from other areas and drawn conclusions. The picture across the trust remains consistent with reporting in 2017/18.

In quarter one the trust received 60 complaints across a range of services and continued to sustain a complaint response rate of 100%. Just fewer than 70% of complaints closed during the quarter were upheld or partially upheld.

The services which were identified for close monitoring by the board all received complaints and in choosing these services other quality indicators are also examined:

- Community Mental Health Teams (CMHTs) continue have received 22% (16) of the complaints received in the quarter with Slough receiving the most (5). Themes of the complaints include breaches of confidentiality along with care and treatment. Reading CMHT continues to cause concern as the Council disaggregate the social service staff from the integrated team however there is a transition board in place which is overseen by the clinical director. The patient experience team have commissioned a deep dive into the service so that we are able to understand the experience of all patients not just those that choose to complain and agree appropriate actions. The patient experience team are also looking to compare our CMHTs complaint levels with other CMHTs.

- Child and Adolescent Mental Health Services received 5 complaints. The main theme of the complaints was care and treatment. CAMHS is under pressure as a service with increases in caseload, activity and wait times. The impacts of this are being partly mitigated by the improved productivity and service improvements. A significant amount of time is invested in supporting families whilst waiting for appointments.

- Acute Mental Health Inpatients received 9 complaints in quarter 1.The complaints are predominantly around care and treatment. The hospital continues to have band 5 qualified nursing staff vacancies which result in higher levels of temporary staff on the wards which is not optimal.

- Westcall, GP out of hours service received 4 complaints. The complaints theme was communication. This service is mentioned as the CQC raised concerns about the underpinning systems and processes of the service in their feedback following the inspection earlier in July. The service is participating in our ‘Always Events’ programme.

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

There were 56,906 patients eligible to complete the FFT during quarter one, and we received 6625 returns, this resulted in a response rate of 11.64% overall, which is the highest ever. Where responses are received patients are generally positive about the care they receive. Individually our community health services had a response rate of 14% with a recommendation rate of 97% and mental health services a response rate of 8% with a recommendation rate of 92%. Actions continue to try and increase our response rate

The patient and public involvement information collection is our long standing internal patient survey which asks patients how they rate their experience, 90.8% reported the service they received as good or better.

Conclusion

Patient experience is an important indicator of quality and this report provides good intelligence when considering quality concerns. In terms of volume, the level of positive feedback received by services far outweighs the negative feedback received. In this first quarter, there are no new emerging trends however breaches of confidentiality appear to be on the increase. I do not take these lapses in care lightly and it is important services recognise and take steps to prevent similar incidents and that this is shared across the organisation. This continues to be work in progress.

Helen Mackenzie, Director of Nursing and Governance

1. Introduction and Executive Summary

This report contains the quarterly patient experience information for Berkshire Healthcare (The Trust) incorporating; complaints, compliments, the Friends and Family Test, PALS and our internal patient survey programme.

This report looks in detail at information gathered from 1 April 2018 to 30 June 2018 and uses data captured from the Datix reporting system, CRT (our internal survey) and the results of the Friends and Family Test captured via SMS, online and hard copy feedback.

Highlights of this report;

- 100% of complaints responded to within timescale
- Top four services for complaints received were CMHT, CAMHS, Community Inpatient Wards and Mental Health Inpatients
- There has been a decrease in complaints for CRHTT
- There were no complaints for mental health wards for older people
- There were no complaints for Highclere ward and Henry Tudor Ward

Complaints linked to communication with patients and other organisations, medical records and confidentiality have the potential to be avoidable; these accounted for 36.7% of the formal complaints received during quarter one. The Head of Service Engagement and Experience has made contact with the Learning and Development Department to discuss the way that how communication skills training is delivered across the Trust. Different courses and training sessions are available to staff on a local and corporate level, which gives the potential for different guidance to be given, for example, on effective telephone call handling.

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 and quarter one 2018-19 by service. There has been an increase in the number of complaints received overall. The details of complaints received can be found in appendix 1.

Table 1 – Formal complaints received

Service	Q1	% of Total	% Comparison to Q4	Q4	Q3	Q2	Q1	Total	% of Total
CMHT/Care Pathways	16	26.67	↑	10	12	11	11	44	22.08
CAMHS - Child and Adolescent Mental Health Services	5	8.33	↑	4	6	9	7	26	14.29
Crisis Resolution & Home Treatment Team (CRHTT)	2	3.33	↓	6	4	6	4	20	9.09
Adult Acute Mental Health Admissions	9	15.00	↑	6	4	9	4	23	11.04
Community Nursing	1	1.67	↓	3	1	4	4	12	5.84
Community Hospital Inpatient	6	1.00	no change	6	1	1	3	11	3.25
Common Point of Entry	3	5.00	↑	2	1	-	2	5	1.95
Out of Hours GP Services	4	6.67	↑	2	3	2	2	9	4.55

Service	Q1	% of Total	% Comparison to Q4	Q4	Q3	Q2	Q1	Total	% of Total
PICU - Psychiatric Intensive Care Unit	0	0.00	no change	-	-	-	-	0	-
Minor Injuries Unit (MIU)	1	1.67	↓	2	1	2	-	5	1.95
Older Adults Community Mental Health Team	1	1.67	↓	3	1	1	0	5	2.39
7 other services in Q4– no trends identified	12	20.00	↑	11	19	14	5	49	23.44
Grand Total	60			55	53	59	42	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. The following tables show a breakdown of the formal complaints that have been received during quarter one and where the service is based.

Table 2 – Mental Health Service complaints

	Locality of Service					
Service	Reading	Slough	West Berkshire	Windsor, Ascot and Maidenhead	Wokingham	Grand Total
CMHT/Care Pathways	3	5	1	3	4	16
Inpatient Admissions – Prospect Park Hospital	9					9
CAMHS - Child and Adolescent Mental Health Services	3			2		5
Psychological Medicine Service	1	2				3
Common Point of Entry	2				1	3
Crisis Resolution & Home Treatment Team (CRHTT)			1		1	2
IMPACTT	1					1
Older Adults Community Mental Health Team					1	1
Grand Total	19	7	2	5	7	40

Table 3 shows the main subject for formal complaints about the CMHT. 56.25% of complaints were about care and treatment with the majority of these being for the Reading based service. The Slough based service received the highest number of complaints overall. Complaints linked with communication and confidentiality are potentially avoidable. Complaints with these as the main subject areas accounted for 25% of the total complaints received for CMHTs. This is where clear, consistent guidance to staff would be helpful. This would need to be led by the Learning and Development Department. Of the complaints received, confirming understanding with patients and following this up could have had a positive impact, as some of these complaints were specifically around misunderstanding and miscommunication. This has been shared with the teams by the Service Managers as part of the learning from the complaint.

Table 3 - CMHT complaints

	Locality of Service					
Main subject of complaint	Reading	Slough	West Berks	Windsor, Ascot and Maidenhead	Wokingham	Grand Total
Alleged Abuse, Bullying, Physical, Sexual, Verbal		1				1

Attitude of Staff					1	1
Care and Treatment	3	2	1	1	2	9
Communication				1	1	2
Confidentiality		1		1		2
Failure/incorrect diagnosis		1				1
Grand Total	3	5	1	3	4	16

The findings of the Deep Dive project into Reading CMHT are being presented, initially, to the Quality Executive Group in September 2018. The findings and recommendations will be reported in the quarter two report. This project has aimed to:

- 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 4 – Adult mental health inpatient wards

	Ward					
Main subject of complaint	Bluebell Ward	Daisy Ward	Rose Ward	Snowdrop Ward	No specific ward*	Grand Total
Attitude of Staff		1				1
Care and Treatment	1	2	1		1	5
Clinical Care Received	1			1		2
Communication	1					1
Grand Total	3	3	1	1	1	9

* This complaint was a multi-agency complaint about the admission process

There were no complaints received about Sorrel Unit (PICU), our wards for Older People at Prospect Park Hospital or Psychological Medicines Service based out of Wexham Park Hospital in Slough and the Royal Berkshire Hospital in Reading.

Table 5 – Crisis Resolution/Home Treatment Team (CRHTT)

	Locality of Service		
Main subject of complaint	West Berks	Wokingham	Grand Total
Attitude of Staff	1		1
Discrimination, Cultural Issues		1	1
Grand Total	1	1	2

Formal complaints to CRHTT have decreased compared with the average of 5 per quarter.

Table 6 - Older Adults Community Mental Health Team complaints

	Locality of Service	
Main subject of complaint	Wokingham	Grand Total
Communication	1	1
Grand Total	1	1

Table 7 – Community Health Service Complaints

	Locality of Service					
Service	Reading	Slough	West Berks	Windsor, Ascot and Maidenhead	Wokingham	Grand Total
Community Hospital Inpatient	2	1	3			6
Continence					1	1
Community Nursing	1					1
Community Nursing Out of Hours Service	1					1
Integrated Pain and Spinal Service	1					1
Minor Injuries Unit			1			1
Multiple Sclerosis		1				1
Out of Hours GP Services	3		1			4
Parkinson's - Specialist Nursing				1		1
Grand Total	8	2	5	1	1	17

Community Inpatient wards received the highest number of formal complaints across community services during quarter one, followed by the GP Out of Hours Service, WestCall.

Table 8 – Community Health Inpatient ward Complaints

	Ward			
Main subject of complaint	Jubilee Ward	Oakwood Unit	Donnington Ward	Grand Total
Attitude of Staff	1			1
Care and Treatment		2	2	4
Clinical Care Received			1	1
Grand Total	1	2	3	6

Care and treatment continues as the main subject for complaints received about community inpatient wards.

Table 9 – GP Out of Hours Service, WestCall Complaints

	Locality of service		
Main subject of complaint	Reading	West Berks	Grand Total
Care and Treatment		1	1
Communication	3		3
Grand Total	3	1	4

Table 10 – Community Nursing Service Complaints

		Locality of Service	
Service	Main subject of complaint	Reading	Grand Total
District Nursing	Care and Treatment	1	1
District Nursing Out of Hours Service	Attitude of Staff	1	1
Grand Total		2	2

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. Community Phlebotomist is also actively supporting this group.

Table 11 – Children, Young People and Family Service Complaints

	Locality of Service		
Service	Reading	Windsor, Ascot and Maidenhead	Grand Total
CAMHS - Child and Adolescent Mental Health Services	3	2	5
Grand Total	3	2	5

CAMHS were the only service within the Children, Young People and Family services locality to receive any complaints in quarter one.

Table 12 – CAMHS Complaints

	Locality of Service		
Main subject of complaint	Reading	Windsor, Ascot and Maidenhead	Grand Total
Care and Treatment	2	2	4
Communication	1		1
Grand Total	3	2	5

In addition there were two corporate complaints about policies – information sharing and access to records and one complaint about the patient information provided with medication.

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.

Table 13 – Outcome of closed formal complaints

	2018-19			2017-18					
Outcome	Q1	% of Total	Comparison to Q4	Q4	Q3	Q2	Q1	Total	% 17/18
Case not pursued by complainant	0	0	↓	1	1	1	1	4	1.95
Consent not granted	2	3.77	↓	4	0	1	0	5	2.44
Local Resolution	0	0	↓	2	6	3	3	14	6.83
Managed through SI process	0	0	↓	4	Reported from Q4			4	1.95
Referred to other organisation	0	0	↓	1	0	1	0	2	0.98
No further action	1	1.89	no change	1	2	0	0	3	1.46
Not Upheld	13	24.53	↑	7	7	20	6	40	19.51
Partially Upheld	25	47.17	↓	28	22	19	18	87	42.44
Upheld	12	22.64	↑	10	10	18	8	46	22.44
Grand Total	53			58	48	63	36	205	

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

2018-19	2017-18				2016-17			
Q1	Q4	Q3	Q2	Q1	Q4	Q3	Q2	Q1
100%	100%	100%	100%	100%	100%	100%	100%	100%

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

Below are examples of learning from complaints found to be partially upheld or upheld during quarter one.

What we were told: A carer wasn't kept informed about care provided by the Parkinson's' Service.
What we have done: Introduced peer reviews to observe practice, creating the opportunity to generate discussion and reflection, recognising where improvements can be made to individual practice and service delivery. SBAR (Situation, Background, Assessment, Recommendation) tool is looking to be implemented to standardise documentation. The staff are to contact GP's if struggling to understand content of letters.

What we were told: The father of a patient said that there a lack of advanced care planning for his daughter and a lack of communication between organisations which meant that she was left feeling unsafe.
What we have done: There were two Psychological Medicines Service (PMS) referrals due to how the patient presented to and their pathway in the Emergency Department. The contact with the service and the discharge plan were entered against one referral (the first one) and not the one leading to discharge (the second). This meant that the discharge plan and relevant information was not shared.
Staff did not know that this was possible within RiO (our electronic patient record system). The learning from this has been to ensure that there are not multiple referrals to the PMS open for the same patient and attendance, and that direct contact is to be made to the discharge destination of a patient with the discharge plan.

What we were told: A patient arrived for alcohol detox at 10am and had to wait till 1pm to be allocated a room and then not reviewed by a doctor until 5pm and did not receive withdrawal medication until 7-8pm.
What we have done: This has highlighted that Wednesday is not the best day for detox admissions and this has now been changed to a Tuesday.
What we were told: The family of a patient who has since passed away were unhappy with the care provided by the Community Nursing Out of Hours Service.
What we have done: The nurse administered an injection into the leg of the patient when they shouldn't have due to their clinical presentation. She is now having a period of supervised practice and additional training.

What we were told: A leg ulcer was not treated in the best way.

What we have done: Team Leads are to ensure that staff have received appropriate training and are competent in the assessment and treatment of leg ulcers. Wound Care Assessment must be completed in the first instance and the wound should be reassessed with an electronic assessment updated weekly. A comprehensive holistic care plan should be commenced within 1 week of initial assessment. Support must be given to less experienced staff and team leads must regularly review the assessments and treatments given by them to ensure appropriate care is being given.

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 since April 2017. There were no PHSO cases received in quarter one; one investigation was closed and found to be Not Upheld.

Table 15 – PHSO activity

Month open	Service	Month closed	Current Stage
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	Apr-18	Not Upheld
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	Care from the WestCall Primary Care Centre
NHS England	Care on Henry Tudor Ward
SCAS	NHS 111 advised a home visit however WestCall telephoned the patient
SCAS	Patient did not get a call back from WestCall following a call with 111

7. MP enquiries, locally resolved complaints and PALS

In addition to raising formal complaints on behalf of their constituents, Members of Parliament (MPs) can also raise service and case specific queries with the Trust.
Table 17 – Enquiries from MP Offices

Service	Enquiries from MPs
CAMHS - Child and Adolescent Mental Health Services	6
Crisis Resolution & Home Treatment Team (CRHTT)	1
Eating Disorders Service	1

Talking Therapies	1
Grand Total	9

The complaints office will discuss the options for complaint management when people contact the service, to give them the opportunity to make an informed decision as to whether they are looking to make a formal complaint or would prefer to work with the service to resolve the complaint informally. Some concerns are received to and managed by the services directly and the complaints office is not involved. These are called Local Resolutions and services log these so that we can see how services are doing at a local level.

Table 18 – Concerns managed by services

Service	Number of concerns managed directly by services
Community Nursing	6
Physiotherapy Musculo-skeletal	5
Health Visiting	5
Podiatry	4
Older Adults Community Mental Health Team	3
Out of Hours GP Services	2
Community Hospital Inpatient	2
Community Dietetics	2
CAMHS - Child and Adolescent Mental Health Services	1
Mobility Service	1
Respite Care	1
Mental Health wards for older people	1
Diabetes	1
Minor Injuries Unit	1
CMHT/Care Pathways	1
Grand Total	36

Table 19 – Informal complaints received

Service	Number of Informal Complaints
Adolescent Mental Health Inpatients	1
Adult Acute Admissions	1
CAMHS	1
Community Team for People with Learning Disabilities (CTPLD)	1
Crisis Resolution & Home Treatment Team (CRHTT)	2
Estates	1
Neuro-Rehab	1
Grand Total	8

NHS Choices; There were 26 postings during quarter one.

Issues relating to the Garden Clinic were a long wait to be seen and the attitude of staff. Skimped Hill Health Centre featured Audiology and Podiatry. Patient was very pleased with the service at Podiatry. Was confident about help and advice and felt listened to. The clinic within Audiology was late starting.

MIU at West Berkshire Community Hospital was praised by a patient particularly staff/ patient interaction. One patient had problems navigating the system to get the treatment that she needed.

The Physiotherapy service at Dedworth Medical Centre was highly praised by patients. Staff/ patient interaction and the standard of care were highlighted.

PALS Activity; There were 446 PALS contacts during quarter one, in addition there were 82 contacts that were about non-Trust services.

The main reasons for contacting PALS were:

- General Information requests and signposting
- Communication with other organisations
- Choice and flexibility of access to services
- Concerns about clinical care received

Themes around choice and flexibility of access to services were:

Needing access to mental health services but unwilling to go to GP
Patients needing access to services but currently out of the country or out of area
Wanting appointment brought forward or fast tracked
Criteria for making online referrals
Wanting an appointment that doesn't interfere with working arrangements or personal commitments
Wanting an appointments at a specific location or at home
Wants discharge reversed as missed correspondence and contact asking to opt in

Themes around concerns about clinical care received were:

Not receiving help with specific conditions and requesting referrals to specialist services
Service not providing input as expected. A lack of response.
Concerns about side effects of medication
Problems navigating the system to obtain appropriate care.

8. The Friends and Family Test

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

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

An on-going project to widen the use of SMS (text messaging) has previously been suspended due to other priorities within the Clinical Transformation Team. A number of services, including CPE which is predominantly telephone based are keen to introduce this as a mechanism to collect feedback, and this project is now back on track. MSK Physio and Reading CMHT will be the first services to go live with SMS as an initial pilot at the end of August 2018.

Table 20 - Number of Friends and Family Test responses

		Number of responses	Response Rate
2018/19	Q1	6625	11.64%
2017/18	Q4	5463	11.24%
	Q3	4105	6.81%
	Q2	4987	9.63%
	Q1	4238	7.04%
2016/17	Q4	3696	5.10%
	Q3	4024	5.10%
	Q2	5357	2.20%
	Q1	6697	2.70%
2015/16	Q4	4793	2.10%
	Q3	5844	4.20%
	Q2	6130	4.50%
	Q1	7441	6.60%

Based on the number of discharges from our services, there were 56906 patients eligible to complete the FFT during quarter one, and we received 6625 returns, giving our highest response rate to date.

Table 21 - FFT results for Inpatient Wards showing percentage that would recommend to Friends and Family

		2018/19	2017/18			
Ward	Ward type	Q1	Q4%	Q3%	Q2%	Q1 %
Oakwood Ward	Community Inpatient Ward	95.83	100	72.97	93.75	100
Highclere Ward		93.98	94.64	96.7	100	100
Donnington Ward						
Henry Tudor Ward		97.78	97.59	42.86	98.86	93.5
Windsor Ward		88.00	95.24	94.44	100	100
Ascot Ward		100.00	100	100	100	100
Jubilee Ward		97.50	97.83	100	100	100
Bluebell Ward	Mental Health Inpatient Ward	-	-	-	100	40
Daisy Ward		100.00	33.33	-	66.67	50
Snowdrop Ward		70.59	100	85.71	76.19	60
Orchid Ward		100.00	-	-	100	-
Rose Ward		100.00	33.33	100	50	100
Rowan Ward		-	-	-	-	100

- = no responses received

Table 22 - Carer FFT Responses

Number of responses			
2018/19		2017/18	
Q1	67	Q4	86
-	-	Q3	39
-	-	Q2	32
-	-	Q1	111

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

Table 23 - Community Health services FFT data; May 2018

	May-18		Feb-18		Nov-17		Aug-17		May-17	
Trust Name	Response Rate	% RR	Response Rate	% RR	Response Rate	% RR	Response Rate	% RR	Response Rate	% RR
Berkshire Healthcare	14%	97%	9%	97%	6%	99%	9%	98%	6%	97%
Solent NHS Trust	5%	96%	5%	96%	4%	97%	4%	96%	3%	96%
Southern Health NHS FT	9%	97%	12%	94%	7%	97%	5%	98%	8%	94%
Oxford Health NHS FT	4%	97%	5%	97%	4%	97%	3%	97%	3%	97%

%RR – Recommendation rate

Table 24 - Mental Health services FFT data; May 2018

	May-18		Feb-18		Nov-17		Aug-17		May-17	
Trust Name	Response Rate	% RR	Response Rate	% RR	Response Rate	% RR	Response Rate	% RR	Response Rate	% RR
Berkshire Healthcare	8%	92%	8%	88%	6%	87%	4%	88%	7%	92%
Solent NHS Trust	8%	83%	8%	93%	12%	93%	11%	93%	6%	92%
Southern Health NHS FT	4%	89%	2%	91%	3%	89%	3%	86%	3%	89%
Avon and Wiltshire MH Partnership	15%	90%	14%	89%	13%	88%	11%	86%	13%	89%
Oxford Health NHS FT	10%	90%	10%	91%	9%	92%	9%	92%	2%	79%

%RR – Recommendation rate

9. Our internal patient survey

The Trust received 3438 responses to the internal patient survey during quarter one, an increase from 2720 the previous quarter.

- 90.8% reported the service they received as good or better than good.
- 14 services were rated 100%
- 16 services were rated 85% or above

Following feedback from services, the Trust is investing in more hand held devices to support the collection of the survey. This will make the process for collecting and reporting feedback more time efficient and increase the quality of our responses.

10. Patient Leaders, Always Events and Patient Participation and Involvement Champions

The Head of Service Engagement and Experience has worked more closely with the delivery of the most recent Patient Leader course at the Royal Berkshire Hospital. We have struggled with the recruitment of Patient Leaders, and more strategic planning to link with our volunteer services will be taking place in quarter two.

The most recent Patient Leaders to complete the course have expressed an interest in working with Berkshire Healthcare and the Royal Berkshire Hospital in a more integrated

way, and there will be a push on heightening the awareness and value that they bring both within our services and our communities.

An existing Patient Leader is supporting a project led by the PPI Lead called Always Events. This is an NHS England programme which focuses on Evidence Based Co-Design (EBCD) and co-creation. WestCall has been keen to be involved in a PPI activity and is the Trust's first Always Event service. The implementation team has been identified and the next step is to attend the Primary Care Centre at the Royal Berkshire Hospital to speak with patients and carers about what they feel the project focus and event to 'always happen is'.

Patient Participation and Involvement (PPI) Champions within the Children, Young People and Families locality are now established and are highlighting and sharing the local improvements and engagement activities they are undertaking. A 'beg, borrow or steal' part of the regular catch up is being set into the agenda to enable services to share a project or activity, or a wicked problem they would like support with.

PPI Champion roles are going to be implemented in Prospect Park Hospital and within the community mental health services based across the West.

Appendix Two contains the 15 Steps report for quarter one. There were 6 visits during this period; 3 to mental health inpatient wards, 2 to community (physical) health wards and one community (physical) health clinic.

11. Compliments

There were 1008 compliments reported during quarter one.

The services with the highest number of compliments are in the table below.

Table 25 - Compliments

Service	Compliments
Talking Therapies	267
ASSiST	179
Cardiac Rehab	57
Community Hospital Inpatients	52
District Nursing	41
Diabetes	39
Community Respiratory Service	36
Older Adults Community Mental Health Team	29
Community Based Neuro Rehab	20
Adult Acute Admissions	20
Care Home In-reach Team	20
Continence	20

Table 26 - Compliments, comparison by quarter

	2018/19	2017/18					
	Q1	Q4	Q3	Q2	Q1	17/18	16/17
Total Compliments	1008	968	1163	1165	1488	4784	5950

Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

Formal Complaints received during quarter one 2018/19

Geographical Locality	Service	Business Group	First received	Complaint Severity	Descripatention	Outcome code	Outcome	Subjects	Sub-subject
Reading	Medicines Management	Corporate	05/04/2018	Moderate	Patient believes the wrong instructions were put on the medication box and as a result he failed his driving test and is struggling to go about his normal life.	Not Upheld	Complaint was that the instructions were wrong on the box, however, it was correct for patient to take them in the morning, and not the evening as he thought.	Medication	Wrong medication dispensed/wrong dose/Wrong Quantity
Reading	IMPACTT	Slough	18/04/2018	Moderate	Patinet is struggling with the fact she was discharged from being seen twice a week to nothing, she feels NICE guidance for BPD was not followed, all of this has caused her undue distress following the birth of her first child	Partially Upheld	Whilst most of the complaint is not upheld there is an acknowledgement that that patient could have benefitted from a set number of meetings in order to process the ending of therapy, which has now been arranged.	Discharge Arrangements	Discharge Planning
Wokingham	Crisis Resolution & Home Treatment Team (CRHTT)	Reading	25/04/2018	Moderate	Deaf patient has not been provided with a lip speaker who is cognoscente in Mental Health. Our door entry systems are not Deaf person friendly. Advocate wishes to know what training our staff receive in deaf awareness.	Upheld	There are a number of issues raised about how we communicated with this patient, how our buzzer systems do not work in his favour and generally how we provide for deaf people. The investigation has showed that as an organisation we need to make a better provision for deaf people, whether patients or carers	Discrimination, Cultural Issues	Needs interpreter, translator, sign language
Slough	Community Hospital Inpatient	Slough	11/04/2018	Minor	Complainant has been to the Ombusdman who have advised that we need to have exhausted local resolution before they will investigate. Complainant feels there are many inaccuracies in our response and wishes someone impartial to do a re-investigation ORIGINAL COMPLAINT BELOW Complainant feels the staff on the ward were extremely rude to her, so much so she feels she was made to cry. Complainant feels the staff were unprofessional and lacking in empathy	Partially Upheld	No clinical failings identified, however much of the complaint is around communication and the difficulties staff experienced with the complainant. Staff are to undergo further training such as conflict resolution and handling difficult conversations.		Attitude of Staff

Geographical Locality	Service	Business Group	First received	Complaint Severity	Descripatention	Outcome code	Outcome	Subjects	Sub-subject
Reading	Intergrated Pain and Spinal Service	Community Health West	01/05/2018	Minor	patent unhappy that the service wrote to the RBH sharing information about her MH which she considers to be inaccurate. patent feels this is unaccepatentable, humiliating and very degrading and a breach of her Data protection. She wishes an apology for sharing inaccurate info, an investigation into who wrote the letter as it has caused distress to her and a letter sent to the RBH to say the information was inaccurate.	Partially Upheld	Although we have apologised that the letter may have been worded in a more sensitive manner, it was correct for the mental health history to be mentioned.	Confidentiality	Breach of Patient Confidentiality
Reading	Adult Acute Admissions	Mental Health Inpatients	12/06/2018	Moderate	Adolescent patient admitted to PPH, patent wishes to know why they were placed in PPH as they feel staff were very ill prepared to support a young person. An apology is required for poor administration of the admission and alleged bad communication between teams. Apology for attitude of staff questioning as well as not being able to see a Dr. Assurance that improvement to services will occur as a result of this complaint.	Partially Upheld	Complaint centres around the fact that the patient, who is 16, was placed into an adult ward, which she found unaccepatentable. We have apologised that the discussions held did not prepare her for the reality of the environment.	Care and Treatment	Clinical Care Received
Wokingham	Common Point of Entry	Mental Health West	10/04/2018	Minor	patent is dissatisfied with the Trusts response feeling that we have failed to address certain areas and believes many points are inaccurate. ORIGINAL COMPLAINT BELOW patient is complaining about the way she has been treated by CPE. She says they have caused a number of issues and she is still awaiting treatment.	Partially Upheld			Communication
Slough	CMHT/Care Pathways	Mental Health East	10/04/2018	Low	Patient says he was misdiagnosed with schizophrenia in 2004 and this has impacted on his life. He wants the diagnosis removed, an explanation and apology.	Not Upheld	Not upheld as the diagnosis patent is asking we remove is not the current diagnosis.		Care and Treatment

Geographical Locality	Service	Business Group	First received	Complaint Severity	Descripatention	Outcome code	Outcome	Subjects	Sub-subject
Reading	CAMHS - Child and Adolescent Mental Health Services	Children Young People and Families	10/04/2018	Minor	Following the Trust response to the MP the complainant is unhappy that we seem to have focused on his behaviour rather than the fact his son is 'depressed and suicidal' he feels no help is actually being put forward for his suicidal child.	Not Upheld		Care and Treatment	Clinical Care Received
West Berks	Out of Hours GP Services	Community Health West	10/04/2018	Low	Patient with dental issues presented to MIU in extreme pain having already seen the dentist and the GP all of whom diagnosed neuralgia, WestCall gave the same diagnosis and increased the pain medication. 2 days later the patent went to Basingstoke who again diagnosed neuralgia and suggested he go the John Radcliffe Maxillofacial Depatent where he was diagnosed with an abscess and subsequently operated on. Wife wishes to know what the Doctor based their diagnosis on? Also wishes the Doctor to know what the outcome was so they may consider and alternative diagnosis if and patent presented with the same sympatentoms going forward.	Not Upheld	Although the patient did have an abscess, which was diagnosed later, it was reasonable for him to diagnose trigeminal neuralgia at the outset, based on patient's presentation.	Care and Treatment	Clinical Care Received
Reading	CMHT/Care Pathways	Mental Health West	12/04/2018	Minor	Father feels meds are responsible for patents lack of motivation and focus resulting in him being unable to work. He would like proper therapy sessions for him and a more senior consultant to review his care.	Partially Upheld		Care and Treatment	Clinical Care Received
Reading	Adult Acute Admissions	Mental Health Inpatients	16/04/2018	Minor	patent appeared to be non compliant with medication, brother wishes to know he was not placed on a CTO (Community Treatment Order) as it was alluded to by a ward staff member and thus why he was discharged at all. Brother is concerned he is not taking his medication	Partially Upheld	Although it was appropriate to discharge without CTO, we did not communicate that to the family, causing unnecessary anxiety.	Care and Treatment	Clinical Care Received
Reading	Corporate/Policy	Corporate	11/04/2018	Minor	Father wishes to complaint that the Trust would not give Oxford Health's records despite being told we would.	Upheld	Complainant was given incorrect information on how to access records from OUH	Communication	Communication

Geographical Locality	Service	Business Group	First received	Complaint Severity	Descripatention	Outcome code	Outcome	Subjects	Sub-subject
Reading	Corporate/Policy	Corporate	02/05/2018	Minor	Father wishes to complaint that the Trust would not give Oxford Health's records despite being told we would - remained dissatisfied.	Upheld	Complainant was given incorrect information on how to access records from OUH. Policy updated to reflect sharing third party information.	Communication	
Wokingham	CMHT/Care Pathways	Mental Health West	16/04/2018	Minor	Wife believes staff members gave her husband advice they were not qualified to give around the DVLA	Not Upheld	No evidence to support allegation that staff advised patient not to contact DVLA, assessed patient's driving or advise on a motor accident.	Communication	Verbal to Patients
Slough	Psychological Medicine Service	Mental Health East	16/04/2018	Moderate	patent has a safety plan which mother says has proven difficult to action. Catalogue of events from 30th March to 7th April led the patent to become an inpatent in London, mother wishes the event to be investigated	Not Upheld	cannot uphold complaint as patient did not wait for PLT to arrive in the ED to assess her. The ED could not forcibly keep patient in the ED without MH assessment. patent refused informal admission.	Care and Treatment	Failure to examine/examination cursory
Slough	Psychological Medicine Service	Mental Health West	16/04/2018	Moderate	Mother does not agree with the Trust response and feels we have not taken on board her opinions ORIGINAL COMPLAINT - patent has a safety plan which mother says has proven difficult to action. Catalogue of events from 30th March to 7th April led the patent to become an inpatent in London, mother wishes the event to be investigated	Not Upheld	cannot uphold complaint as patient did not wait for PLT to arrive in the ED to assess her. The ED could not forcibly keep patient in the ED without MH assessment. patent refused informal admission. Re-investigation remains not upheld.	Care and Treatment	Failure to examine/examination cursory
Reading	CMHT/Care Pathways	Mental Health West	16/04/2018	Minor	Following a request to have funding redirected to the Dr at the Priory instead of at Bethlam Royal Hospital, patent was asked by BHFT to attend an apatent to consider treatment opatentions. patent attended and the Dr discharged her from all services. patent believes that under Section 117 she is entitled by law to free after care.	Not Upheld	No clinical failings. A clear explanation of care pathway given	Care and Treatment	Clinical Care Received
Windsor, Ascot and Maidenhead	CMHT/Care Pathways	Mental Health East	17/04/2018	Moderate	Since October when the complainant was advised support for the patent would be coming from CMHT, the complainant says a care plan has not yet been started let alone supported living.	Partially Upheld		Care and Treatment	Delay or failure to visit

Geographical Locality	Service	Business Group	First received	Complaint Severity	Descripatention	Outcome code	Outcome	Subjects	Sub-subject	
West Berks	Crisis Resolution & Home Treatment Team (CRHTT)	Mental Health West	19/04/2018	Moderate	Member of staff attempatented to pick the patent up from a petrol station for his planned admission but Guardian would not allow this and said he needed to come to the house and be respectful of the patents issues.	Investigation underway		Attitude of Staff	Healthcare Professional	
Wokingham	Continence	Community Health West	26/04/2018	High	patent ordered 6 catheters as going away on holiday. When he called to chase the healthcare professional was unhelpful, rude and racist, he wishes this addressed and he would like to opatent out of the continence prescripatention service as he says it does not work.	Upheld	Both aspects upheld. We did not process order timely, which resulted in patient having to call the service. Staff member apologises for offence taken by patient in his tone and use of referral to the Bible. Training will be given to staff member and he will use reflective practice.	Attitude of Staff	Healthcare Professional	
Reading	Adult Acute Admissions	Mental Health Inpatients	23/04/2018	Low	patent states she does not have a care plan following her discharge from PPH and there are issues around collaborative care which is allegedly paid for by BHFT	Partially Upheld	Point one upheld as no CPA notes on record. Point 2 not upheld as evident that support and effective medication monitoring was in place. Points 3 and 4 - nothing to uphold. Points 5 and 6 not upheld	Care and Treatment	Clinical Care Received	
Reading	Adult Acute Admissions	Mental Health Inpatients	23/04/2018	Low	patent unhappy with her response and wishes to discuss this with the IO ORIGINAL COMPLAINT BELOW patent states she does not have a care plan following her discharge from PPH and there are issues around collaborative care which is allegedly paid for by BHFT	Partially Upheld	Point one upheld as no CPA notes on record. Point 2 not upheld as evident that support and effective medication monitoring was in place. Points 3 and 4 - nothing to uphold. Points 5 and 6 not upheld	Care and Treatment	Clinical Care Received	

Geographical Locality	Service	Business Group	First received	Complaint Severity	Descripatention	Outcome code	Outcome	Subjects	Sub-subject
Reading	Adult Acute Admissions	Mental Health Inpatients	26/04/2018	Minor	Following BHFT response of the 20th April the complainant has come back on each point raised with further issues. - 1.A planning meeting took place 3 weeks ago and a plan was made to offer support to the family, a course for and other support was also promised. This plan has not been fully implemented. 2.Following serio self harm and admission to other hospital, information from Prospect Park Hospital. This resulted in them not knowing the risk history and patent was left in a room with access to scissors and safety pins resulting in further self harm. 3.The decision for home leave was done without practical help to manage self harming behaviour when she is at home. 4.Was told on return from leave she can never be admitted to Bluebell Ward despite her CPA stating attempatents should always be made to locate a bed on Bluebell Ward to minimise further trauma of a strange environment. 5.Not given her medication for diabetes for 48 hours when she returned from the general hospital.	Partially Upheld	Call not made by CRHTT to carer as agreed. Multiple PMS referrals due to presentation and pathway in ED: contact and discharge plan entered against the first and not the one leading to discharge - meaning that information was not shared. As an outcome, direct contact to be made to discharge destination with plan. On-going care and support has been proportionate. The patient and their carer has declined housing opatentions including supported living and the Recovery college.	Care and Treatment	Clinical Care Received
Reading	Adult Acute Admissions	Mental Health Inpatients	27/04/2018	Moderate	Father states his son was deprived of his antipsychotic for 3 days he wants to know why nothing was done and why no one seemed to understand the implications. Father also wants to know why the staff act so aggressively on the ward. Why the discharge letters and prescribing was unsafe.	Partially Upheld	Point one not upheld. Point two cannot be upheld as staff cannot recall but apology offered. Point three upheld as discharge letter was incorrect	Care and Treatment	Wrong medication dispensed/wrong dose/Wrong Quantity
West Berks	Minor Injuries Unit	Community Health West	30/04/2018	Minor	young patent was not xrayed on examination and it was later established they had a buckle fracture. Mother has no confidence of the MIU service now	Partially Upheld	patient did not display any signs that arm was fractured, no bony tenderness, no distress, and was happy and compliant. Based on the risk of x-ray, they decided not to x-ray as clinical presentation did not suggest it needed. However arm was fractured and practitioner will reflect.	Care and Treatment	Failure to examine/examination cursory

Geographical Locality	Service	Business Group	First received	Complaint Severity	Descripatention	Outcome code	Outcome	Subjects	Sub-subject
Reading	Adult Acute Admissions	Mental Health Inpatients	30/04/2018	Low	patent moved from Elysium Hospital in Potters Bar to PPH without any consultation or with the family's knowledge. patent does not speak English so there are translator issues. Several issues on the ward highlighted in 7 points.	Investigation underway		Communication	
Reading	CMHT/Care Pathways	Mental Health West	30/04/2018	Moderate	patent feels she is not receiving sufficient help to keep her safe and wishes for a review of her care	Upheld	The care plan was not to the standard it should have been, appearing to have been drawn up quickly, not meeting needs of patient and was poorly communicated. Repeated lateness and poor timekeeping of support worker.	Care and Treatment	Clinical Care Received
Slough	CMHT/Care Pathways	Mental Health East	01/05/2018	Minor	Dr interrupatented the interpreter in front of everyone to ask if she personally was still under CMHT? patent/interpreter feels this was a breach of confidentiality which has left her being unable to work through her agency for BHFT anymore. patent wishes to know how this was able to happen and she wishes an apology for the impact it has had on her, she therefore wishes the ban to be lifted.	Upheld	Confidentiality was breached. Investigation underway outside the complaints process.	Confidentiality	Breach of Patient Confidentiality
West Berks	Community Hospital Inpatient	Community Health West	01/05/2018	Moderate	DECEASED patent - Family feel their was a lack of patient centred care with poor communication whilst their mother was on the ward they also feel there was no concern for relatives or visitors.	Partially Upheld	Reminder around access to notes by patients and family members. Medication omission was previously reported as an incident with learning points including TTO checked by RN on discharge.	Care and Treatment	Clinical Care Received

Geographical Locality	Service	Business Group	First received	Complaint Severity	Descripatention	Outcome code	Outcome	Subjects	Sub-subject	
West Berks	Community Hospital Inpatient	Community Health West	01/05/2018	Moderate	Family wish clarity on medical records procedure/policy and a response following the IO's meeting with the Chaplin regarding the way forward with multi-faith text provided on the ward ORIGINAL COMPLAINT BELOW DECEASED patent - Family feel their was a lack of patient centred care with poor communication whilst their mother was on the ward they also feel there was no concern for relatives or visitors.	Partially Upheld	Reminder around access to notes by patients and family members. Medication omission was previously reported as an incident with learning points including TTO checked by RN on discharge.	Care and Treatment	Clinical Care Received	04/05/2018
Reading	Common Point of Entry	Mental Health West	02/05/2018	Minor	patent referred to CPE from GP, had 20 min assessment which he did not feel was sufficient and a referral was put into Trauma which was rejected due to insufficient information. patent wishes to know why no one called him to ask for additional information and wants an explanation as to the why his Trauma referral was turned down. The patent has also advised that there has been a breach of DPA as an email was sent to the wrong address with all his patent identifiable info.	Partially Upheld	timeline shows many dates where interactions with patient took place. Main issue has been with sending letters to an address we did not know patient had moved from so patient experience of service was not good Re-investigation shows that the remaining concerns are not related to the Trust. Advised to go to the GP/NHSE. Confirmed that the GP has not received instruction to restrict medication.	Care and Treatment	Clinical Care Received	

Geographical Locality	Service	Business Group	First received	Complaint Severity	Descripatention	Outcome code	Outcome	Subjects	Sub-subject
Reading	Common Point of Entry	Mental Health West	02/05/2018	Minor	patent wishes his complaint to be escalated with immediate effect and adds that his consultants assessment is missing from his medical records resulting in his GP refusing to prescribe Valium ORIGINAL COMPLAINT patent referred to CPE from GP, had 20 min assessment which he did not feel was sufficient and a referral was put into Trauma which was rejected due to insufficient information. patent wishes to know why no one called him to ask for additional information and wants an explanation as to the why his Trauma referral was turned down. The patent has also advised that there has been a breach of DPA as an email was sent to the wrong address with all his patent identifiable info.	Partially Upheld	timeline shows many dates where interactions with patient took place. Main issue has been with sending letters to an address we did not know patient had moved from so patient experience of service was not good Re-investigation shows that the remaining concerns are not related to the Trust. Advised to go to the GP/NHSE. Confirmed that the GP has not received instruction to restrict medication.	Care and Treatment	Clinical Care Received
Reading	Community Hospital Inpatient	Community Health West	02/05/2018	Minor	Son is complaining that when his mother was discharged her leg dressing was infected and had to be soaked off by the district nurse. He says he is going to contact the CQC.	Not Upheld	No upheld. Leg dressings were not infected and wound care had been appropriate. Patient had been able to mobilise prior to discharge	Care and Treatment	Clinical Care Received
Windsor, Ascot and Maidenhead	Parkinsons's - Specialist Nursing	Community Health East	03/05/2018	Minor	family are unhappy with attitude of Parkinson's nurse and claims there has been a breach of patient confidentiality when PN discussed their conversations with care home staff.	Partially Upheld	Records show evidence of the support to the patient and family. Communication with the GP about prescribing should have been proactive.	Attitude of Staff	
Windsor, Ascot and Maidenhead	CMHT/Care Pathways	Mental Health West	08/05/2018	Minor	patent attended STEPPS but found the sessions too distressing. Spoke to the 3 leads on separate occasions to advise of her distress. patent is unhappy with her discharge letter as she feels it is inaccurate and wishes it to be re written.	Partially Upheld	Point one - Partially upheld. No failings by the service but we have apologised for that patient found discharge letter upsetting. Point 2 - not upheld. Point 3 - partially upheld as patient misunderstood comment and we have apologised.	Communication	Written to Patients

Geographical Locality	Service	Business Group	First received	Complaint Severity	Descripatention	Outcome code	Outcome	Subjects	Sub-subject	
Reading	Adult Acute Admissions	Mental Health Inpatients	09/05/2018	Low	patent wishes to complain about the fact their mother made a written complaint to PPH back in February 2017 raising concerns with the patent's care whilst on Rose Ward from Dec 2016 - March 2017 as 3 different Consultant Psychiatrists and conflict with medications. The patient wishes a response to that letter and the concerns she has raised since regarding PPH and New Horizons	Partially Upheld	Investigation did not show any failings in clinical care. However we have apologised for rudeness of staff and loss of property, which had been resolved prior to complaint.	Care and Treatment	Clinical Care Received	
Slough	Multiple Sclerosis	Community Health East	09/05/2018	Moderate	Staff did not hang up the phone after leaving a message to her patient and the family have the recording of the derogatory comments left by the nurse about the patient.	Upheld	Clear evidence that staff member failed to treat patient with respect. Formal HR process to be followed.	Attitude of Staff	Healthcare Professional	
Reading	District Nursing	Community Health West	09/05/2018	Moderate	DN's had been visiting the patent twice weekly since the 8th Feb to treat leg ulcer but the patent was admitted to the RBH on the 3rd May, when the nurses removed the bandages from the leg they were horrified	Upheld	The nursing care was below the standard expected. The treatment pathway was not fully followed and their was a breakdown in communication between the TV nurses and community nurses.	Care and Treatment	Clinical Care Received	
Windsor, Ascot and Maidenhead	CMHT/Care Pathways	Mental Health East	15/05/2018	Moderate	Service breached confidentiality regarding patients mental health with her employer who is now planning to use this in a employment tribunal where it was suggested before that he would settle out of court regarding her pay. patent wants compensation	Partially Upheld	The clinicians acted on the information available to them. However, they should have actively made contact with the GP to confirm that they would manage and prescribe psychiatric prescripatentions.	Confidentiality	Breach of Patient Confidentiality	
Reading	Out of Hours GP Services	Community Health West	16/05/2018	Minor	new complaint patient does not believe our response where we say Dr attempatented to call twice. Original complaint SCAS would like us to investigate why the patient did not get a call back WestCall following their call to 111	Partially Upheld	WestCall did make two attempatents to call patient back but were not successful, however, following this complaint a review of service will take place.	Communication	Communication	

Geographical Locality	Service	Business Group	First received	Complaint Severity	Descripatention	Outcome code	Outcome	Subjects	Sub-subject
Reading	Out of Hours GP Services	Community Health West	16/05/2018	Minor	patent attended WestCall on the 12th May with their daughter who acted as interpreter. Daughter concerned that the Doctor did not understand what she or the patient was saying as the Doctor also was unclear what the nurse said her name was on 4 occasions. Family wish this investigated.	Not Upheld	Apology for experience - clinical records showed that the encounter was well managed.	Communication	Verbal to Patients
Slough	CMHT/Care Pathways	Mental Health East	21/05/2018	Moderate	patent DECEASED - CLINICAL CARE BEING INVESTIGATED AS AN SI Mother believes confidential information regarding a patient was divulged to her employee (University) mother wants the staff held to account	Investigation underway		Abuse, Bullying, Physical, Sexual, Verbal	Bullying and harrassment
Slough	CMHT/Care Pathways	Mental Health East	21/05/2018	Moderate	Complaint relating to various services following the patent's attempatented suicide. 1. Mother wishes to know why she was not contacted when services knew she was planning a suicide attempatent 2. Mothers feels CMHT should have advised her to call CRISIS if her daughters mood was low 3. Why did CMHT not contact mother following meeting of the 31.1.18 4. CRISIS Said they could not see the patent for 4-7hours despite her being suicidal why was this not seen as a priority? 5. Why did New Horizons not call for an ambulance? 6. mother wonders if the policy needs reviewing around which doctors can admit patent's to hospital 7. Why has the IMPACT referral taken longer than advised? 8. Mother wishes to know the patent's assumed risk due to a contradiction in the care plan	Partially Upheld	Much of this complaint is about us not informing mother what was happening but, without patient's consent, we could not do so. Crisis acted appropriately based on what patient said over the phone and advice was given of what to do. Only point of learning is risk was rated differently in two documents. IO will share with team.	Care and Treatment	Delay or failure to visit
Wokingham	CMHT/Care Pathways	Mental Health West	22/05/2018	Minor	patient feels his current psychologist is rude and he does not understand why she sent him to the GP for a medication review as the GP said he could not do this.	Partially Upheld	The clinicians acted on the information available to them. However, they should have actively made contact with the GP to confirm that they would manage and prescribe psychiatric prescripatentions.	Attitude of Staff	Healthcare Professional

Geographical Locality	Service	Business Group	First received	Complaint Severity	Descripatention	Outcome code	Outcome	Subjects	Sub-subject
Reading	District Nursing Out of Hours Service	Community Health West	23/05/2018	Moderate	PATIENT DECEASED: escalated from a PALS as unhappy with response, which they say was unsatisfactory and judgemental. Complaint is about 'unprofessional and disrespectful behaviour of the OOH nurse.	Upheld	The nurse administered an injection into the leg of the patient when they shouldn't have due to their clinical presentation - she is now having a period of supervised practice and additional training. The initial response to their concern was the information supplied to PALS which should not have been sent in that format.	Attitude of Staff	Healthcare Professional
Reading	Community Hospital Inpatient	Community Health West	04/06/2018	Moderate	Daughter believes her fathers calls for help were ignored when he asked for additional pain relief, she also says the patent feels he was ganged up on.	Investigation underway		Care and Treatment	Delay or failure to visit
Reading	Adult Acute Admissions	Mental Health Inpatients	14/06/2018	Moderate	Detox patent expressed concerns about the lack of medics on the ward and the attitude of staff on the ward. Allegedly a glass vial was noticed by the patent in their medication pot.- media interest	Investigation underway		Attitude of Staff	Healthcare Professional
Reading	Out of Hours GP Services	Community Health West	15/06/2018	Moderate	patent feels she was fobbed off by the Dr regarding a rash who advised her to attend a clinic that was not open on the day they were advised to go.	Investigation underway		Communication	Healthcare Professional
Windsor, Ascot and Maidenhead	CAMHS - Child and Adolescent Mental Health Services	Children Young People and Families	13/06/2018	Moderate	Long delays for meeting to be arranged re EHCP for young patient who has expressed a wish to die and who is too depressed and anxious to attend school	Investigation underway		Care and Treatment	Clinical Care Received
Windsor, Ascot and Maidenhead	CAMHS - Child and Adolescent Mental Health Services	Children Young People and Families	13/06/2018	Low	ADHD diagnosis of patent following BHFT requesting Great Ormond Street Hospital Neurodisability team to do the primary assessment in spring 2017. Mother believes they were assured a medication specialist would review before December 2017 but they are still waiting	Investigation underway		Care and Treatment	Failure/Delay in specialist Referal

Geographical Locality	Service	Business Group	First received	Complaint Severity	Descripatention	Outcome code	Outcome	Subjects	Sub-subject	
Reading	CAMHS - Child and Adolescent Mental Health Services	Children Young People and Families	15/06/2018	Moderate	In 4 years the patent has been diagnosed with ADHD but the mother believes has not received any support or medication which is felt by family and school would help. patent has tried to take his own life and he self harms regularly but has been discharged.	Investigation underway		Care and Treatment	Clinical Care Received	
Slough	CMHT/Care Pathways	Mental Health East	20/06/2018	Low	patent wishes to know why at discharge her risk rating had been lowered. Why her medication review responsibilities were transferred to the GP. Why CMHT did not pick up on issues before she was admitted to psychiatric hospital and why she was treated from EUPD when she says this was not her diagnosis.	Investigation underway		Care and Treatment	Clinical Care Received	
West Berks	Community Hospital Inpatient	Community Health West	21/06/2018	Moderate	Stroke patent discharged from RBH to WestBerks. DOLS completed to assess whether bed rails were necessary which they were not. patent fell from bed. Family would like to know why they are not being kepatent informed of Fathers care. They would like an explanation into our DOLS decision. An explanation into conversations had with an HCA. Request for advice on whether to invoke an LPA.	Investigation underway		Care and Treatment	Clinical Care Received	
Reading	Psychological Medicine Service	Mental Health West	21/06/2018	Low	DECEASED patent - Multi agency complaint BHFT to answer questions relating to our input when the patient was in A&E at the RBH and a subsequent in-patient. Family want to know why the rationale behind decisions made by our psychiatric team.	Investigation underway		Care and Treatment	Clinical Care Received	
Wokingham	CMHT/Care Pathways	Mental Health West	25/06/2018	Minor	Carer/father of a patent suffering with vertigo feels the patent is not getting any support and that he was not allowed in the room at a recent meeting in Wokingham. He feels her condition is not being taken into as a mental health condition	Investigation underway		Care and Treatment	Clinical Care Received	

Geographical Locality	Service	Business Group	First received	Complaint Severity	Descripatention	Outcome code	Outcome	Subjects	Sub-subject	
Reading	CAMHS - Child and Adolescent Mental Health Services	Children Young People and Families	26/06/2018	Minor	Complainants son in need of Melatonin prescripatention which the GP has sort permission to prescribe from us but she feels nothing has been forth coming in the 3 months since the request	Investigation underway		Communication	Communication with Other Organisations	
Wokingham	CMHT/Care Pathways	Mental Health West	26/06/2018	Low	patent's mother feels her and her daughter's Asperger's are not understood by Trust. She would like answers as to comments that have been put on RiO notes pertaining to her actions to her daughter and the attitudes of staff over the last 27 years	Investigation underway		Care and Treatment	Clinical Care Received	
Wokingham	CMHTOA/COAMHS - Older Adults Community Mental Health Team	Mental Health West	28/06/2018	Low	Family feel left out of the patent's care and feels there is a lack of communication with them. Family also state there is unexplained physical injury to the patent	Investigation underway		Communication		
West Berks	CMHT/Care Pathways	Mental Health West	28/06/2018	Minor	Patient is unhappy that his care coordinator has been absent for two months and he has not received any support during that time.	Investigation underway		Care and Treatment	Clinical Care Received	

Appendix 2

15 Steps Challenge, Quarter 1 2018/19

A total of six visits were carried out in quarter 1. To maintain an independent perspective and a fresh pair of eyes, non-clinical members of staff, from other localities and not routinely involved in patient care, have been co-opted onto the teams on the occasions when volunteers have been difficult to find.

Daisy Ward
The team found the staff to be professional and the ward felt safe. Although there was a good programme of activities for the patients the team felt that there could be more therapeutic interaction between staff and patients.

Donnington Ward
The team had a very positive visit and the impression was that the ward was well led and well managed. There was a calm atmosphere throughout the ward and the team were impressed by the caring and compassionate attitude of all staff they encountered.

Oakwood Unit
The team found the ward to be exceptionally welcoming with committed, professional, caring staff that were observed to be engaged with patients throughout the visit.

Podiatry – WBCH
Unfortunately at the time the team visited the department there was no clinic running due to staff meeting, so observations were made visiting the environment and meeting with staff. The staff were engaged and positive about the varied and professional service they provide.

Rose Ward
Access to the ward feels daunting, in the depths of the hospital and much of the area is internal without windows. However, outside areas are available on the ward and patients were supported to leave the ward when appropriate. All staff appeared to be engaged with their patients and dedicated to their care.

Sorrel Ward
At the time of the visit, some areas, including the female corridor, bedrooms and the original office, were closed for refurbishment. Therefore only a reduced number of male patients were inpatient on the ward.

Staff member accompanying the team was confident, knowledgeable and very attentive to safety. The staff on the ward showed a high degree of professionalism and it was clear that safety of both staff and patients was a top priority.

Friends and family team discussion:
All the teams that made visits during this quarter all agreed that should a family member or friend be admitted to any of the areas that they would receive a high standard of professional care.

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

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	11 September 2018
Title	**Quality Assurance Committee – 21 August 2018**
Purpose	To receive the unconfirmed minutes of the meeting of the Quality Assurance Committee of 21 August 2018
Business Area	Corporate
Author	**Office Manager and Assistant 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 21 August 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 The Committee also agreed minor changes to its terms of reference (changes are shown in red tracked changes) which are presented to the Trust Board for ratification.
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. The Trust Board is also requested to ratify the changes to the Committee's Terms of Reference.

Minutes of the Quality Assurance Committee Meeting held on Tuesday, 21 August 2018, Fitzwilliam House, Bracknell

Present:
Ruth Lysons, Non-Executive Director (Chair)
David Buckle, Non-Executive Director
Julian Emms, Chief Executive *(present until 12 noon)*
Helen Mackenzie, Director of Nursing and Governance
David Townsend, Chief Operating Officer
Dr Guy Northover, Lead Clinical Director
Debbie Fulton, Deputy Director of Nursing

In attendance:
Jenni Knowles, Office Manager & Assistant Company Secretary
Mike Wakefield, Clinical Audit Manager – *in attendance for items 6.1- 6.2*
Jason Hibbitt, Clinical Effectiveness Facilitator- NICE – *in attendance for items 6.1- 6.2*

Opening Business

1 **Apologies for absence and welcome**

The Chair welcomed everyone to the meeting.

Apologies had been received from:

Dr Minoo Irani, Medical Director
Amanda Mollett, Head of Clinical Effectiveness and Audit
Julie Hill, Company Secretary
Mehmuda Mian, Non-Executive Director

The Chair noted the Clinical Audit Manager and Clinical Effectiveness Facilitator were attending on behalf of the Head of Clinical Effectiveness and Audit. It was agreed that agenda items 6.1 and 6.2 would be discussed first at this Committee meeting.

2 **Declaration of Any Other Business**

There were no items of Any Other Business.

3 Declarations of Interest

David Buckle, Non-Executive Director, informed the Committee of having advised the Trust Chair, of the following declarations:

1 Confirmed as a Trustee of the Stroke Association
2 Future Non-Executive Director at East and North Hertfordshire NHS Trust (provider of acute physical health services)

4.1 **Minutes of the Meeting held on 15 May 2018**

The minutes of the meeting held on 15 May 2018 were confirmed as an accurate record.

4.2 **Matters Arising**

The Matters Arising Log had been circulated.

The Committee acknowledged the schedule of completed actions.

The Committee noted the Horizon Scanning "Deep Dive" action in relation to meeting the physical health needs of mental health patients; a presentation is planned for the November 2018 Trust Board meeting.

The Chair drew attention to Appendix 1 of the action list around the Trust's work on reducing obesity. The Chair commented there is clearly work being undertaken but queried if this is specifically funded.

The Chief Executive responded that the Trust has a role to play in health and equality and to ensure there is good access to the local population. This work is not driven by the Trust and is considered to be part of the domain of System work of which the Trust will be a key contributor.

The Lead Clinical Director explained the Trust's work is more around support and prevention work for patients with this condition whose weight gain is a contributory factor as a side effect of medication received. In response to a question from David Buckle, Non-Executive Director, it was confirmed that people are supported and/or signposted to additional support as appropriate.

The Director of Nursing and Governance made the point there is not a cohesive approach for managing obesity nationally.

The Chief Executive suggested this is included in a broader discussion around funding from Commissioners at the Board Away Day, as this would allow the opportunity to prepare a coherent approach around particular issues for Commissioners to consider.

The Chair agreed it would be helpful to raise this at the Board Away Day and consider those priorities.

Action: Chief Operating Officer

Patient Safety and Experience

5.0 Serious Incident Investigation and Inquest Processes Presentation

The Deputy Director of Nursing gave a short, high level presentation to the Committee, the slides having already been shared with the Committee in advance of the meeting.

The following points were noted:

- NHS Improvement (NHSI) has a framework for what is a serious incident. There are not any action lists held nationally or locally; it is expected that each incident should be looked at on its own merit, based on Root Cause Analysis (RCA). Linking to RCA, all Serious Incident reports have action plans that are closely monitored through Patient Safety and Quality locality meetings, the Quality Executive Group and the Quality Assurance Committee.
- If a Trust does not complete the investigation within given deadlines a fine of up to £1,000 can be imposed on the Trust.
- Never Events – the NHSI national guidance list provides examples such as wrong site surgery, administering incorrect medication or not having collapsible bed rails

in mental health inpatient settings. There is significant research and evidence around Never Events that it should be simple to take steps to avoid these things happening; the Trust also has very robust processes in place.

- Reporting arrangements follow strict national guidelines on when and what should be reported. There is a requirement to report on the national system within working 2 working days of the decision that an incident is confirmed as serious. All our regulators have sight of the reports.
- A serious incident will require duty of candour if a patient is involved.
- Investigating Officers are staff within the Trust who have received specific training to conduct investigations. A list is held within the Governance team and Investigating Officers will undertake 2 investigations per year on top of their day job. There is a maximum of 60 working days permitted to complete each investigation.
- The Deputy Director of Nursing meets with monthly with Commissioners where investigations are signed off at these meetings.
- Coronial deaths – a family can request there is an inquest and it is very unlikely for the Coroner to deny this request. It was confirmed that many of the Trust's Serious Incidents do go to inquest.
- To date the Coroner has relied on the Trust to determine who we want to provide witness statements and who should attend inquest hearings. Preparation and support is offered and provided to staff particularly when they have not previously attended an inquest.
- The Coroner looks very closely at the Serious Incident action plans and what actions the Trust has implemented as a result of learning noted.
- The standard of proof for suicide changed, in July, due to a case in Oxford and is now considered on the balance of probability, rather than beyond reasonable doubt.
- Article 2 cases are related to detained patients who have died in our care. In some of those cases a more judgmental narrative that can be critical of the organization can be published.
- Regulation 28 (also known as Prevention of Future Deaths) can be issued by the Coroner at end of an inquest where the Coroner believes the Trust has not addressed the concerns and not mitigated against their recurrence. A Regulation 28 could also be issued sometime after the inquest where the Coroner has given the incident further consideration.
- Staff learning from incidents and inquests helps to inform staff training; this includes the Trust's Zero Suicide initiative.

The Chair thanked the Deputy Director of Nursing for the informative presentation and noted the value of recording information and learning from incidents and inquests for our performance statistics.

5.1 **Caring for Carers Report**

The Chief Operating Officer presented the paper prepared by Lucy Cooke, Carers Executive Lead and highlighted the following points:

- The Trust has delivered the 3 year Carers Strategy 2011-2014.
- The Carers Strategy Group has been meeting for a number of years. The Group drives the agenda, taking feedback from carer groups.
- The paper outlines delivery on priorities to date of which the Triangle of Care is a primary focus. The Triangle of Care is very advanced in mental health services and less so in community health services.
- The priorities for the next 2 years are to continue Triangle of Care work in mental health and extend this more into community services as well as increase carer feedback and participation.

David Buckle, Non-Executive Director suggested there will be some carers the organisation is not aware of as well as other carers that do not attend carer groups and do not make themselves known to the Trust. The Chief Operating Officer confirmed where the Trust has knowledge of carer involvement with a patient it is our business to support them. The Trust has a duty to the patient in terms of data sharing but services do as much as possible without breaching confidentiality. Carer involvement is recorded on RiO but work with carers and carer involvement is very wide and very varied. It was noted that the involvement of carers in some physical health matters is not necessary or required.

The Chair noted the point of differing relevance but in the case of carers of mental health inpatients the Chair queried how success is measured and whether any available statistics are reviewed.

The Director of Nursing and Governance explained there is a clear process in RiO to record carer information in the risk assessment and action plan; there is a section that must include feedback from a carer before the record can be closed. The Director of Nursing and Governance continued that with improved carer and patient involvement it is more likely that the patient will stay safe and be supported in the community once discharged. It is anticipated that the CQC inspection report will demonstrate the Trust's involvement of carers and improvement.

The Chief Operating Officer referred to the one of the priorities of working more on obtaining carer feedback over the next 2 years to understand the experience they had of their interaction with the Trust and what we have provided what was expected, for their family or friend they care for.

The Chair made reference to the item noted in the report around Prospect Park Hospital having a Triangle of Care action plan. The Committee's discussion implies that action is happening rather than the hospital working towards achieving the standard as noted in the paper.

The Lead Clinical Director clarified that the Triangle of Care has its own self-assessment process which means services routinely assess themselves against the standards set. The Chair suggested it would be helpful to see this included in the report.

Action: Chief Operating Officer

The Director of Nursing and Governance added that the Trust currently has 2 stars awarded by the Triangle of Care which is a good achievement.

The Chief Operating Officer said that progress is noted quarterly by the Carers Strategy Group; these updates help to determine priorities. Carers did not want to have metrics to drive priorities, instead they wanted to talk and work on things that were important to them. The Chief Operating Officer concluded that it is possible to start reporting numbers of carers on RiO and through the Triangle of Care although to date this has not been what carers want to see.

5.2 **CAMHS Waiting Times Report**

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

- The acute headlines and challenges were noted by the Committee.
- A continued increase in referrals and activity are coming into the CAMHs service resulting in the service being faced with a number of challenges including a danger of a return to pre-investment levels of pressure against staff able to

manage this.
- The service has a very good team and they are doing good work, they are engaged and working in the System with the CCGs but the service is now at a point where more support is required for the team at lower tiers which is what has been taken out over the years.

David Buckle, Non-Executive Director confirmed it is a national issue around the increase in demand for diagnostic services. The Chief Executive concurred that demand is not what was expected for Berkshire and is instead, increasing exponentially. Increase in demand has also been affected by the withdrawal of pastoral support by schools and academies.

The Chief Executive highlighted the Government's 10 year plan whereby it is expected that CAMHs will receive specific attention. It is likely that more information will be available for the next Committee meeting in November 2018. Currently from the Trust's perspective the organisation is unable to take more resource into tier 3 as it remains a challenge to recruit staff, instead the Trust needs to look more at and identify what are the tier 2 gaps. It was suggested this is reviewed as part of the strategy review at the Board Away Day.

Action: Chief Operating Officer

The Director of Nursing and Governance noted from a quality perspective the CAMHs service is managing very well. In response to the Chair asking if that was sustainable, the Chief Executive commented that the detrimental impact on the morale of staff has to be acknowledged and alongside patient and carer experience which is an issue for the Trust.

The Chief Operating Officer explained this is being reviewed at the Quality Executive Group with a plan in place to seek more funding from the CCG for the whole service for next year's contract. Quarterly updates are received at Executive meetings and the Executive has approved a decision to over recruit.

It was noted that the eating disorder contract will be reviewed. Quality Improvement work is underway with the service to look at process to identify improvements and make services more efficient. Productivity is increasing but additional outside support is also being considered as well as being monitored by the Executive on a monthly and quarterly basis.

The Director of Nursing and Governance and the Deputy Director of Nursing both agreed the importance of understanding from the report that the service is safe despite the waits. The Chief Executive asked that information around relevant Serious incidents is also included, the non-urgent cases, what the waits are and what action the Trust is taking.

Action: Chief Operating Officer

The Chair asked if this should be added to the Trust's Quality Concerns. The Director of Nursing and Governance confirmed this is already included on that report.

The Chief Executive reported that where children waiting for CAMHs services has increased, the dissatisfaction and parental concern is greater and has increased significantly.

The Director of Nursing and Governance confirmed the increase in demand has been added to the Trust Board Assurance Framework. It was noted that a lot of resource has been spent on managing the waiting list and although this is not an efficient use of resource it is not considered to be a quality risk. The Chief Executive pointed out that

harm occurs within clinical services and is not happening in CAMHs and it is these other areas that require the organisation's critical attention.

David Buckle, Non-Executive Director requested a headline report in 6 months' time. It was agreed this piece of work will come back to the Committee in February 2019.

Action: Director of Nursing and Governance

5.3 **Quality Concerns Status Report**

The Director of Nursing and Governance presented the paper that includes updated actions on all levels of quality concern risks within the Trust's services. Work is happening in all areas noted and progress is being made. The following points were highlighted:

- Actions around workforce have been updated and made more specific.
- Campion Unit is included but is doing well with no current concerns.
- Following the Care Quality Commission's inspection of Westcall, the Director of Nursing and Governance has had follow-up discussions with the Care Quality Commission.
- From a corporate perspective, Westcall provides a good, quality service and patient feedback is good.
-

The Chair drew attention to an action in the Quality Executive Group minutes about EPMA, where GP prescriptions not being on that system poses an issue for community health patients. The Lead Clinical Director outlined the prescribing process and explained that some out of hours GPs need training on the system. The decision was taken that the process was not safe and the roll out was halted. It was noted that the best way forward for prescribing on the ward is under review and is to be addressed. Consideration is being given to changing prescribing processes or EPMA.

The Chief Executive highlighted that some services are fully and safely staffed but it is helpful to keep sight of pressures in the organisation. Inpatient services, CRHTT and West community services are of most concern and the organisation will focus particular attention on these areas.

The Chair commented on Reading CMHT having been an issue and queried the deep dive that was proposed. The Director of Nursing and Governance explained the deep dive was concluded in July and will be reported in Quarter 2; the Board will be informed.

5.4 **Serious Incidents Report**

The Deputy Director of Nursing presented the quarterly report for Quarter 1 2018/19. The following points were noted:

- The 17 serious incidents reported in Quarter 1 remain, with none currently downgraded.
- There has been an increase locally in suicides in particular around men taking their lives by the means of hanging. The men have not been in contact with mental health services. The number of suicides associated with our services remains at similar levels.
- The recurring theme around physical aspects of mental health patients was noted.

The Chief Executive referred to benchmarking data that demonstrates that Primary care is seeing more than those in Secondary care. With the Trust's IAPT services there is

focus on referral routes and engagement.

David Buckle, Non-Executive Director noted his level of good confidence gained from this report together with the earlier presentation given in Item 5 of the Committee minutes. David Buckle asked to understand the impression given by Commissioners. The Director of Nursing and Governance explained that Commissioners meet monthly with the Deputy Director of Nursing in whom they have confidence as well as with Trust processes in place.

The Deputy Director of Nursing drew attention to NEWS scores and lack of action; this is around deteriorating patient observations. The Deputy Director of Nursing went on to explain that NEWS scores is a National system. There have been some challenges around staff picking up deteriorating patients and this is an ongoing piece of work with staff, including building in emergency scenario situational training on wards. The Chair observed that this is a challenge but the Trust is not exceptional in this matter. The Deputy Director of Nursing and Lead Clinical Director agreed the Trust is not alone with this challenge but that this is being considered from a number of angles in order to address.

5.5 **Learning from Deaths Quarterly Report**

The Quarter 1 Report 2108/19 was received by the Committee.

The Chair noted this is the first time as a result of this process that a lapse of care has been identified and subsequently reported as a Serious Incident.

The Lead Clinical Director suggested that 2-5% of deaths will be as a result of lapse in care. The Trust Mortality Review Group look at deaths that meet the criteria to be reviewed further; thereby the Trust already has good mortality reporting processes in place and this is ahead of national reporting requirements.

The Chief Executive confirmed there are robust processes in place and these are internally audited. The Medical Director also reviews processes at a national level and we will continue to comply with those. Assurance is received from the internal auditors that processes are working. In particular this report provides positive assurance of learning from deaths of patients with a learning disability to promote accessibility to equitable care. This is a national requirement.

The Chair noted participation in the audit of care at end of life and queried any any connection with the Gosport item at 5.8 in the agenda. The Director of Nursing and Governance confirmed a connection.

5.6 **Thematic Review of Choking Incidents Mental Health Inpatients Action Plan**

The action plan was noted by the Committee and the Chief Executive commented on the good progress being made.

5.7 **Board Assurance Framework – Risk 1**

The Committee read the paper and agreed there were no further changes to note.

5.8 **Gosport Memorial Hospital Patient Deaths between 1989-2001**

The Director of Nursing and Governance presented the report and the following key points were noted:

- It is anticipated that spikes will be seen as a result of implementing processes in

place.

- The Mortality review process reviews all deaths and in particular where formal complaints have been raised.
- The Freedom to Speak Up Guardian and other ways offer opportunities for staff to raise concerns. The staff survey indicates staff know how to raise concerns.
- Assurance has been gained on the use of Grasby syringe drivers; concerns were quickly identified before national instruction and these were removed.
- EPMA is a great source of assurance but is not in community wards. The Chief Executive expects to see an improvement in quality once EPMA is rolled out to community wards as well.
- The national end of life audit is currently being completed, looking at how patients got on a particular pathway and the associated medical prescribing as well as talking to relatives about concerns.
- A prescribing audit of Westcall is required; this will include antibiotics and controlled drugs. The Trust has knowledge of what controlled drugs are kept in vehicles; if a gap is identified the Accountable Officer is made aware and an investigation is undertaken.
- A review of the management of formal and informal complaints involving patient deaths is to be undertaken.
- A national response will be available later in 2018 and the Trust will look at that report, whilst being mindful that it cannot be assume these incidents would not happen again.

The Chief Executive left the meeting at 12 noon.

Clinical Effectiveness and Outcomes

6.1 Quality Accounts Report 2018-19

The Clinical Effectiveness Facilitator introduced the report.

The report has been updated to reflect the Trust's True North Goals:

1. Harm free care
2. Supporting Our Staff
3. Good Patient Experience

In addition much of the narrative in the report is new, with new sections added as well. It was important to recognise that the information included in the report is as of the end of Quarter 1. Some sections will not be populated with information until Quarters 2-4 due to external and national reporting time frames. Progress has already been made on a number of recommendations and the report will updated again at Quarter 2 to reflect these.

Attention was drawn to the reduction in use of prone restraint. The Trust aims to reach 90% aim and the chart to date indicates the organisation could be on track to reach that. The Director of Nursing and Governance confirmed work being undertaken is making improvements but this does require ongoing monitoring. Datix information received is showing that staff are adopting different methodologies.

David Buckle, Non-Executive Director thanked the Clinical Audit team for the report that demonstrates a sound start to this financial year and that good work is happening. There was some discussion around the visual presentation of the overall report and the Chief Executive reminded that the visual format had been changed at the request of Non-Executive Directors. The report is seen by a wide audience including Trust Board, Health and Wellbeing Boards and CCGs.

The Chief Operating Officer queried the assurance process of the report by this Committee. The report was previously received annually and the Committee looked at the report with the understanding it had already been reviewed and scrutinised by other committees and groups. The current process requires the Committee to look back at information that is seen in other meetings on a quarterly basis.

The Chief Executive clarified the purpose is for a high level sense check by the Committee to review and comment on how the report is building. It also provides an opportunity to look at any key targets, highlight any problems and have a body of work in place to mitigate issues to avoid any adverse publicity prior to the report being published at year end. The Clinical Effectiveness Facilitator explained that service leads are notified of any changes such as spikes in trends.

To support the Committee with the assurance process it would be helpful moving forward for the Clinical Audit Team to highlight to the Committee in the front page summary paper any changes and whether items are on track or not.

Action: Clinical Audit Manager

6.2 **Clinical Audit Reports**

The Chair reminded that the Committee had requested to review a detailed summary of all national audits and their associated action plans.

There were two national audits received by the Clinical Effectiveness Group in July that were published in April 2018:

1. POMH prescribing of sodium valproate for patients for bipolar disorder
2. Early Intervention in Psychosis Network (EIPN) self-assessment report 2017/18

1. POMH prescribing of sodium valproate for patients for bipolar disorder

It was noted that this is the second national audit on valproate. The Trust has a specific action plan in place against the safety alert and new standards are in place; these are monitored by the Medicines Safety Group.

Changes include noting women of child bearing age and clarified this is from 16 years to 64years. Valproate is not prescribed in CAMHs. The Lead Clinical Director advised that a very robust action plan was produced and put in place and would like to hear comments from the Committee around the robustness of the action plan.

David Buckle, Non-Executive Director noted concerns from last year and suggested as this is not a new drug there has already been the opportunity for a long time to test this. Valproate is dangerous to take when pregnant with a high risk of malformations and causing learning difficulties at certain times of pregnancy. Although numbers reported are small this is still of concern.

A new European regulation came out in February 2018. Valproate is recognised as a useful drug but there is a need to balance risk with risk. David Buckle, Non-Executive Director noted the issue is the interface between the initiators and repeat prescriptors and what happens in between these. David Buckle, Non-Executive Director offered to help discuss this in more detail outside this Committee meeting. The Director of Nursing and Governance asked the Lead Clinical Director to take this away for consideration.

Action: Lead Clinical Director

The Director of Nursing and Governance highlighted the Serious Incident process which

provides further assurance that minutes of meetings are not able to deliver around changes in practice and where change has actually been implemented. The Director of Nursing and Governance said the Trust must not wait for the next national audit but rather to undertake an internal audit with the results reported to the Quality Executive Group and any issues to be escalated to this Committee. Information should be available and reported in Quarter 3. The E-prescribing action will be outstanding but the Director of Nursing and Governance expects all others to be addressed and closed by then.

Action: Clinical Audit Manager

The Chair queried the inclusion in the action plan of the interface around patients being handed over to the GP. David Buckle, Non-Executive Director also questioned the need to have a discussion with the CCG on this matter. The Lead Clinical Director pointed out that is it likely to become a legal requirement for every woman on valproate to have a medical review and this would also be something to discuss with the CCG.

The Chair noted the exclusion of CAMHs in terms of licensing requirements. CAMHs service users with certain behaviours and conditions such epilepsy have to be closely monitored and managed and there is no recognised requirement for valproate to be prescribed. It was noted that information is reported to the CAMHs meeting with the CAMHs consultant in attendance. The Early Intervention in Psychosis (EIP) service has one consultant who is also fully aware of these risks.

2. Early Intervention in Psychosis Network (EIPN) self-assessment report 2017/18

The Lead Clinical Director informed the Committee that the audit highlights areas of good practice in accessibility to treatment and effectiveness of treatment and also identifies the EIP service is performing well nationally. The Well Led aspect stands out, although this is not officially measured in the report.

The Lead Clinical Director noted the action plan is very clear on how issues will be addressed. It also makes it very clear for service users on how that data will be interpreted and used. It was agreed that outcomes data demonstrates that services are more efficient as a result of evidence although there is a dispute around the frequency of patients as this is a formula that in itself has no evidence base. The Chair asked if services need to understand about collecting more value added data, including Well led criteria. The Lead Clinical Director suggested the CQC have a good process to capture this. The Chief Executive highlighted other ways to capture data via the EIP accreditation process, staff survey, patient survey as well as compliance all being contributory proxy indicators.

The Lead Clinical Director confirmed there are no consequences to the Trust in response to the Chair's question.

The Clinical Audit Manager and Clinical Effectiveness Facilitator left the meeting at 10.35 am.

Corporate Governance - Update Items for Information

7.1 **Guardians of Safe Working Hours Quarterly Report**

The report was noted by the Committee.

7.2 **Annual Safeguarding Report**

The report was noted by the Committee.

7.3 **Infection Prevention and Control Annual Report**

The report was noted by the Committee.

7.4 **Place of Safety Annual Report**

The report was noted by the Committee.

7.5 **Annual Trust Mental Health Act [MHA] Comparator Report for 2017-18**

The report was noted by the Committee.

7.6 **Annual Mental Health Act Report**

The Director of Nursing and Governance noted an increase in Mental Health Act activity and the use of the Place of Safety.

The report was noted by the Committee.

7.7 **Quality Executive Group Minutes**

The minutes of the Quality Executive Group meetings held on 14 May 2018, 11 June 2018 and 9 July 2018 were noted by the Committee.

Closing Business

8.0 **Annual Review of Effectiveness**

The Chair drew attention to the paper prepared by the Company Secretary setting out the results of the self-assessment exercise. The Chair noted the overall scoring was very positive.

The Chair commented on issues highlighted, including:

- Induction of new committee members. The Company Secretary has agreed to ensure there is a programme of appropriate training and briefings in place.
- Time keeping versus frequency of meetings. The Chair refuted that over half the Committee meetings over run and countered that if timing is of concern there should be more meetings.

The Director of Nursing and Governance felt time was well spent and points were discussed appropriately. David Buckle, Non-Executive Director added that it would not be appropriate for the Chair to curtail important discussions.

The Director of Nursing and Governance commented on the number of papers, including annual reports coming to this meeting that need to be considered and noted, within the 2 hours allotted. The Director of Nursing and Governance also acknowledged there have been some timing issues within her own team around providing reports.

The Chair proposed that the current format should continue. The Committee members all agreed.

The Chair also drew attention to the Committee's Terms of Reference. The Company Secretary has asked for Committee members to review and identify any other changes in order for the revised version to be submitted to the next Trust Board for approval.

Action: Committee members

8.1 **Quality Assurance Committee Horizon Scanning**

David Buckle, Non-Executive Director highlighted the discord between mental health and community health and commented that the prevalence of incidents will increase and this will be more likely be due to social factors than is currently predicted. There is a process by which matters are predicted, but if this is not calculated correctly it will become an issue, such as for society reasons people now want diagnosis whereby they did not previously.

The Director of Nursing and Governance explained that within physical health there is a lot of work being undertaken and in particular in conjunction with the GDE programme where there is some great work going on. It would be helpful to be clear if this is a matter for this Committee or for the Trust Board.

The Lead Clinical Director said that pathways work is being reviewed and how interventions are provided for clusters in mental health; what should be provided and to understand that the right service is being provided is an important part of this consideration. It is challenging to know when an increase will occur and services cannot expand if staff cannot be recruited to deliver those services.

The Director of Nursing and Governance suggested consideration is given to an overview of the pathway project and thought applied to what might be included.

The Chair highlighted particular interest in EPMA and the potential it has to improve quality but also recognises the challenges with prescribers. The Chair requested an update on how this will be resolved once the review of the whole process is completed. The Lead Clinical Director informed that EPMA is part of GDE process. GDE changes the way technology is considered and how it can be part of service transformation.

Action: Lead Clinical Director

The Chair referring to the Gosport report, asked how people are allocated to end of life care. The Director of Nursing and Governance explained that allocation is usually decided by acute trust or GPs rather than within our services. The Director of Nursing and Governance agreed to consider this further and bring back to the Committee.

Action: Director of Nursing and Governance

8.2 **Any Other Business**

There was no other business.

8.3 **Date of the Next Meeting**

20 November 2018 at 10am.

These minutes are an accurate record of the Quality Assurance Committee meeting held on 21 August 2018.

Signed:- _____

Date: 20 November 2018 _____

Berkshire Healthcare NHS
NHS Foundation Trust

Quality Assurance Committee Paper

Date	21 August 2018
Title	**Learning from Deaths Quarter 1 Report 2018/19**
Purpose	To provide assurance to the Trust Board that the trust is appropriately reviewing and learning from deaths
Business Area	Clinical Trust Wide
Authors	Head of Clinical Effectiveness and Audit, Medical Director
Relevant Strategic Objectives	1 – To provide accessible, safe and clinically effective services that improve patient experience and outcomes of care
Resource Impacts	None in this quarter
Legal Implications	None
Equality Diversity Implications	A national requirement is that deaths of patients with a learning disability are reviewed to promote accessibility to equitable care. This report provides positive assurance of learning from these deaths
SUMMARY	812 deaths were recorded on the clinical information system (RiO) during Q1 where a patient had been in contact with a trust service in the year before they died. Of these 73 met the criteria to be reviewed further. All 73 were reviewed by the executive mortality review group and the outcomes were as follows: • 39 were closed with no further action • 5 were classed as Serious Incident Requiring Investigation • 27 required further review using an initial findings review (IFR) • 2 currently open and further information required During Q1 the mortality review group reviewed the findings of 42 IFR reports (detailed on p8), 15 IFRs related to patients with a learning disability (these are cases reviewed in Q1 and will include cases reported in previous quarters). Of the 42 reports 3 related to complaints and 4 were second line reviews. **Lapse in care** One lapse of care has been identified and reported subsequently as an SI in May following review of the report by the TMRG: The death occurred in November 2017 and was reported initially as a Datix following a patient transfer, a post infection control review was requested to be completed by the Executive Mortality Review Group (EMRG) and in January 2018 a complaint was received regarding this patients care. Several themes and areas of learning are being implemented, key areas include: • Community Hospital inpatient wards recognising and treating patients when they have symptoms which require medical input and sometimes acute medical care. • Older Adults mental health services identified the importance of conducting and recording mental capacity assessments/best interest decisions to ensure

	the focus remains on meeting patient's needs whilst trying to maintain a positive working relationship with carer. • Prompt referral to eating disorder services (EDS) for patients with low BMI who may have an undiagnosed eating disorder (Learning from a Reading IFR has been applied to a current Slough patient with some similarities in presentation). • Mental health services continue to embed learning around families and carers communications and ensure that the physical health needs of patients are considered during management of their mental health condition. . New nursing posts in Inpatient and Community Mental Health services have been established for supporting physical healthcare in patients with severe mental illnesses. • Learning Disability services have reviewed assessment documents to ensure that there is additional guidance for consideration of people's dental needs and the impact of this may have on people's eating and drinking. Referral processes are also being reviewed with the pathways teams.
ACTION REQUIRED	The committee is asked to receive and note the Q1 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.

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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.

Definitions:

Review (IFR): A review is usually a proactive process, often without a 'problem', complaint or significant event. It is often undertaken to consider systems, policies and processes. A review is a broad overview of a sequence of events or processes. It can draw on the perceptions of a range of individuals and a range of sources. The resulting report does not make findings of fact, but it summarises the available information and makes general comments. A review may identify some areas of concern that require investigation e.g. if there is some evidence of poor practice, in which case the appropriate recommendation for an investigation should be made.

Investigation (RCA and SI): An Investigation generally occurs in response to a 'problem', complaint or significant event. An investigation is often initiated in relation to specific actions, activities or questions of conduct. It is a systematic analysis of what happened, how it happened and why. An investigation draws on evidence, including physical evidence, witness accounts, policies, procedures, guidance, good practice and observation - in order to identify the problems in care or service delivery that preceded the event to understand how and why it occurred and to reduce the risk of future occurrence of similar events.

4. Data

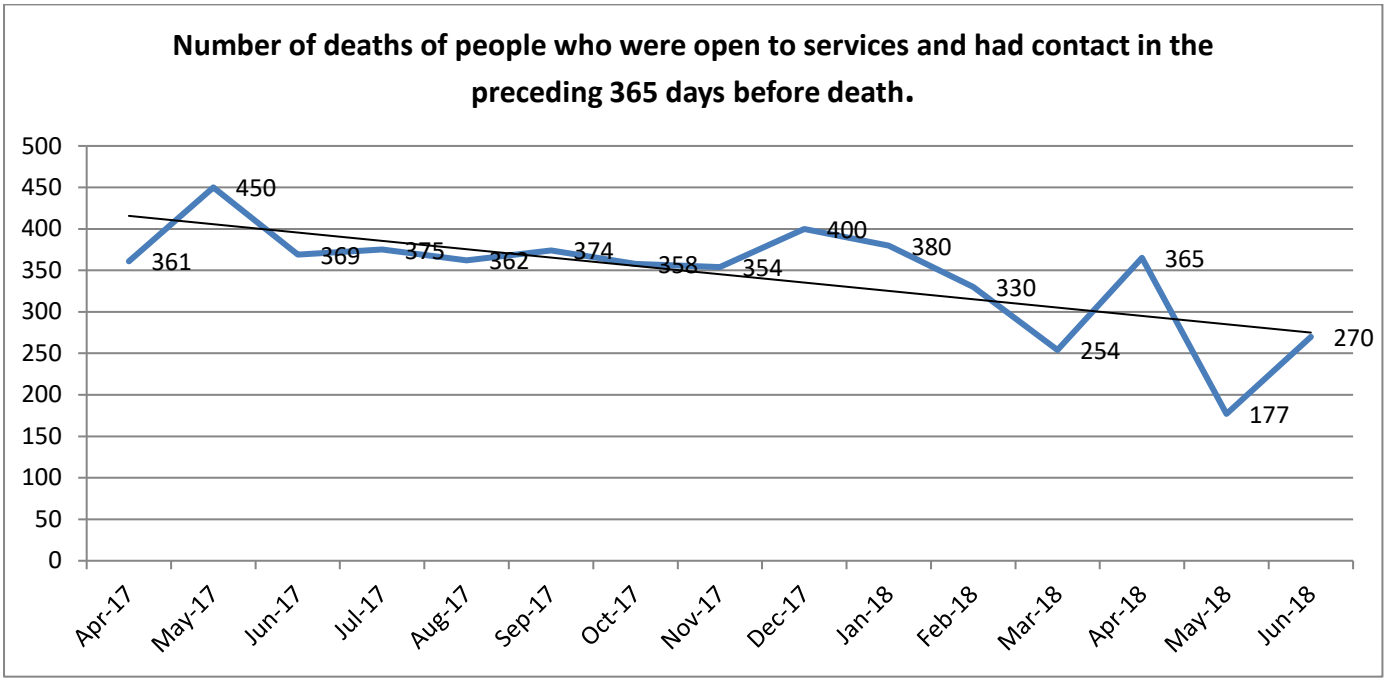
4.1 Total Number of deaths in Q1

The trust electronic patient record (RiO) is directly linked to the national spine which allows information regarding deaths to be shared amongst providers of health care. Figure 1 uses this information and is generated from our Rio system. It identifies all deaths where a patient had any contact 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 as recorded on RiO	April 2018	May 2018	June 2018	Grand Total
Nursing episode	160	92	138	390
Dietetics	38	24	24	86
Old age psychiatry	47	13	15	75
Community health services medical	25	13	19	57
Speech and language therapy	26	5	21	52
Podiatry	19	7	15	41
Palliative medicine	14	13	12	39
Adult mental illness	7	3	6	16
General medicine	7	1	4	12
Cardiology	8	1	2	11
Respiratory medicine	4	1	4	9
Rehabilitation	3	2	3	8
Clinical psychology		2	1	3
Physiotherapy	3			3
Learning disability			3	3
Geriatric medicine			2	2
Community paediatrics	2			2
Genito-urinary medicine	2			2
Intermediate care			1	1
	365	177	270	812

Figure 2 shows the numbers of deaths for April 2017 to June 2018



*** RiO: Note these figures are not absolute and due to a time lag in uploading from the spine may increase when reports are re run for recent months. Figures will be revised at the end of the fiscal year for the Quality Account and will increase as notifications from the national spine are updated.**

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.

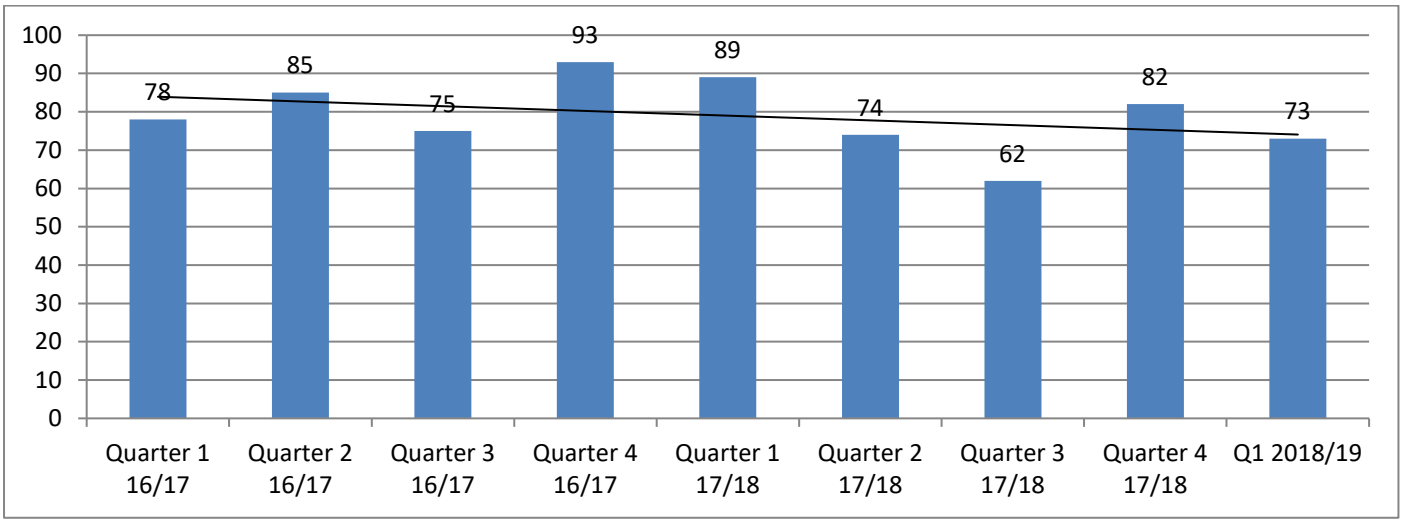
These are the last Specialty Teams seen before death	April 2018 to June 2018				
	A:0-17	B:18-65	C:66-75	D:Over 75	Grand Total
Nursing episode	3	44	57	286	390
Dietetics		13	21	52	86
Old age psychiatry		2	4	69	75
Community health services medical		3	9	45	57
Speech and language therapy		3	7	42	52
Podiatry		7	6	28	41
Palliative medicine		13	11	15	39
Adult mental illness		14	1	1	16
General medicine		3	2	7	12
Cardiology			2	9	11
Respiratory medicine		1	1	7	9
Rehabilitation		1	2	5	8
Clinical psychology		1	1	1	3
Physiotherapy				3	3
Learning disability		2	1		3
Geriatric medicine				2	2
Community paediatrics	2				2
Genito-urinary medicine			1	1	2
Intermediate care				1	1
	5	107	126	574	812

*** 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	April	May	June	Total
Community Hospital Inpatient	16 (4T)	13	8 (1T)	**37**
Community Mental Health	5	3	5	**13**
Community team for people with learning disabilities	3	5		**8**
Children's and young people's services	1	2	1	**4**
Common point of entry	1		2	**3**
District Nursing /Intermediate care			2	**2**
Community Mental Health Older Adults (CMHOA)	2			**2**
Mental Health psychological and liaison service	1		1	**2**
Mental Health inpatients		1		**1**
EIP	1			**1**
Total Datix				**73**

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.
1 CMHOA – died in Nov 2017 – notified through request for medical records in April

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 Q1

	Number
Datix closed no further action required	39
Classified as a Serious Incident (SI)	5
Initial findings report (IFR) requested	27*
Open further information required	2
Total	73

*1 IFR was subsequently reported as an SI following review at the MRG, giving a total of 6 SI in Q1 where a patient has died (see section below 4.3).

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 Q1

Service (Source Q4 Serious Incident Report)	Number
Wokingham Community Hospital (Transfer)	1*
Wokingham Community Mental Health	1
Reading Community Mental Health	1*
West Berkshire Community Mental health	1
Crisis Resolution and Home Treatment Team (CRHTT)	1
Slough CMHT	1
Total	**6**

4 suicides/suspected suicide and 2 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

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.

Telephone contact was made with all 6 families in Q1 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, 2 families accepted this opportunity, 4 families have declined to meet at present but will be contacted and invited again following the investigation.

5.2 For non SI deaths

Engagement and feedback with family members

The learning disability team make contact with the family following the reported death of a person with a learning disability. Telephone contact was made with family members of 7 of the individuals in order to offer support and condolences to those that the individual lived with, be they family or staff members. This action was completed by the local CTPLD team members who knew and had a relationship with those that supported the individual. Contact has not been made with the remaining persons Next Of Kin as the contact details are not known to the service.

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 includes details regarding the LeDeR programme. Of the 8 individuals who were reported, 7 NOK's were sent condolence cards and letters. Of the 7 cards sent there have been 3 responses from the NOK. All feedback from NOK was complimentary regarding the care that their family member had received from their care provider and acute Trust. There was no direct feedback regarding the care provided by BHFT.

6. Trust-wide 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 Trust-wide mortality review group (TMRG) meets monthly and is chaired by the Medical Director; the following reviews have been received as Initial Findings Reports (IFRs) and considered by the group in Q1.

Figure 8: Reviews Conducted in Q1

	Total Number	**Services**
April	13 new IFRs reviewed	Learning Disability – 7 cases Older Adults Mental Health -1 case Wokingham Inpatient Wards – 2 cases West Berkshire Inpatient Wards – 1 case East Berkshire Inpatient Wards – 1 case Common Point of Entry– 1 case
	1 complaint IFR	Older Adults Mental Health -1 case
May	8 new IFRs reviewed	Learning Disability –4 cases Henry Tudor Inpatients Ward – 1 Wokingham Inpatient Wards – 1 case Slough CMHT- 1 case Common Point of Entry (CPE) -1 case
	2 2nd line reviews of IFR	Wokingham Community Hospital – 2 cases
	1 Complaint IFR	Wokingham Community Hospital – 1 case directly linked to 2nd line review
June	14 New IFRs reviewed	Learning Disabilities – 4 cases Children's Services -2 cases Henry Tudor Inpatients Ward -2 cases CPE – 1 case Crisis resolution and home treatment team (CRHTT) – 1 case Bracknell CMHT -1 case WAM CMHT – 1 case Reading CMHT – 1 case Psychological Medicine Service – 1 case
	2 2nd line reviews of IFR	Henry Tudor Inpatient Wards – 2 cases
	1 Complaint IFR	West Berkshire Community Hospital -1 case

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

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

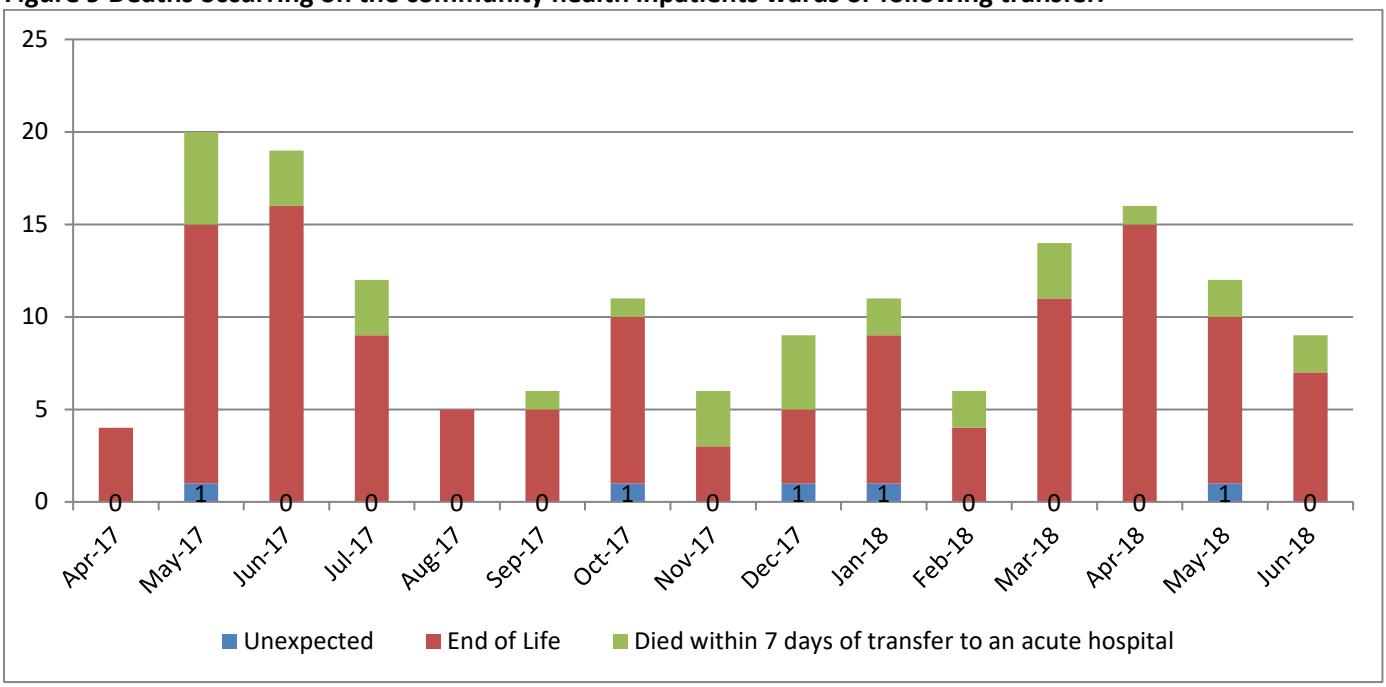
- Request further information from trust services or other providers
- Request a 2nd line review
- Agree to close the case and note any actions on the action log
- Agree to close and make recommendation for service level learning and improvements
- Identify a lapse in care and report for investigation through the SI process.

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

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

For community health inpatients we require all deaths to be reported on the Datix system including patients who are expected to die and receiving palliative care, figure 9 details those deaths.

Figure 9 Deaths occurring on the community health inpatients wards or following transfer.



In Q1 37 deaths in total were reported by the Community Inpatient Wards, of these 31 related to patients who were specifically receiving end of life care. 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.

5 deaths related to patients who were transferred from a community inpatient ward to an acute hospital following deterioration in health and died within 7 days of that transfer, IFR's have been requested for all 5.

1 death in Q1 was unexpected, this was reviewed by the EMRG and no further action was required following confirmation of natural cause of death.

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

An IFR was completed for two and reviewed at the June MRG, no further action was required. Both children were under the care of the acute hospital that provided end of life care. Two cases were closed at EMRG following as review of the information received.

2 further deaths were identified on the RiO system and are being reviewed.

6.4 Deaths of adults with a learning disability

In Q1 a total of 8 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. Of these all 8 have been reviewed by the Clinical Review Group (CRG) and 4 have been received and closed by the TMRG.

In total the TMRG reviewed 15 IFRs from patients who had died with a learning disability (relating to deaths reported at the end of Q4 and in Q1). Of the 15 deaths reviewed by TMRG, there were no identified lapses in care provided by BHFT services.

Demographics of adult patients with a learning disability who had their deaths reported in Q1

Gender:

Female	1
Male	7

Age: The age at time of death ranged from 53 to 84 years of age (median age: 61yrs)

Severity of Learning disability:

Mild	2
Moderate	1
Severe	1
Profound	0
Not known	4

Ethnicity:

White British	8
Other White	0
Asian Pakistani	0
Other Asian	0

National Learning Disability Mortality Review Process (LeDeR)

From the 1st September 2017 the Learning Disability Service has provided notification to LeDeR (national Learning Disability Mortality Review process) of all deaths of individuals with learning disabilities known to the Trust. Notifications have been made to LeDeR for each of the 8 people who died in the quarter. Locally in Berkshire, the CCGs are responsible for the coordination of the LeDeR process. The Trust participates in the Steering Groups in both East and West Berkshire, with a number of our staff supporting this process as trained LeDeR reviewers.

7. Additional Case Review

The National Audit of care at the End of Life (NACEL) is now live and the Trust is registered to participate in this. The audit relates to patients who die in our Community Hospitals and are identified as end of life. It comprises of three specific aspects:

1. An organisational audit, detailing how many patients died in our community inpatient and mental health inpatient settings in 2017/18, and the resource the trust has in place to manage these patients
2. A case note audit of community hospital inpatients that died between 1st April 2018 and 30th June 2018. Mental Health inpatients are excluded from this aspect of the audit
3. A quality survey for the 'nominated person'/ carer/ next of kin of all patients in the case note audit. Mental Health is excluded from this aspect of the audit.

Information for the organisational audit is being collated by the clinical lead for the audit. The sample period for the case note audit has now closed, and community ward staff across the trust is collecting data relating to the patients in the sample. For the Quality Survey, information on carers is being collated in preparation for sending them the survey in August 2018.

The final national deadline for submission of all data is 12th October 2018, and the Clinical Audit Team is managing this project to ensure that all relevant milestones are met.

8. Was a Lapse in care identified?

Of the 42 IFRS which have been reviewed in Q1, a Lapse in care has been identified for one death and this has been escalated and reported as a serious incident (SI).

The death occurred in November 2017 and was reported initially as a Datix and reviewed by the EMRG who requested a post infection control review. In January 2018 a complaint was received regarding the care provided to the patient. The family were contacted in line with duty of candour, and agreed an RCA would be conducted, this was received by the TMRG in May 2018 and concluded that a lapse in care had occurred.. The family have received a copy of the RCA report and offer of meeting, in line with duty of candour.

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 a lapse in care. The following section details updates on learning identified in 2017/18 and the new learning identified in Q1

9.1 Theme: Mentall Health

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 and further actions to improve include:

- Sharing of good examples of safety plans for discussion in supervision and other development opportunities on the mental health wards and in the community.
- Ongoing work is being undertaken as part of risk and suicide training for staff to focus on the importance of safety planning. A Service user is now helping to make a short film and a safety plan comic is being developed to aid staff in having difficult conversations.

Reviews have also highlighted joint learning for mental health and substance misuse services. In the East of Berkshire a harm reduction forum has been established which includes all of the east substance misuse services and mental health services, the Assistant Director of Nursing is now also attending these quarterly meetings to share learning. In the West of Berkshire a substance misuse death overview panel is in place and also attended by the Assistant Direcotor of Nursing to share relevant learning.

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

A significant development has been the creation and recruitment to a designated physical health role. 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 but also linking with the leads in West and PPH. This will be achieved through:

1. Provision of improved physical health monitoring and review
2. providing information and signposting to support physical health
3. support to enable service users to access interventions
4. physical health promotion
5. facilitating learning sessions with the common point of entry (CPE) to enable staff to learn from incidents
6. working on a shared care protocol

We have also had learning events to focus on the interface with GPs and especially following up on physical health check tests that we have requested.

9.3 Themes from our Physical Health Inpatient Wards

As a result of the MRG process, we have had the following changes in the community health inpatient wards specifcially in the west.

1. Process of escalation of NEWS scores in community inpatient wards has been reviewed on an ingoing basis and staff were supported to access NEWS training and discussions held in team meetings about the importance of NEWS score escalation. This has improved the ways NEWS scores is documented and escalated to relevant staff.

2. Process of transferring patients to acute hospital from community wards has become more streamlined and measures are in place to monitor the transfers and Datixes are completed when deteriorating patients are transferred to acute hospitals.
3. Process to review ceilings of care and how this will be implemented, this will be led through QMIS (Our quality improvement initiatite) and having a standard work plan.
4. Process of communciation between multidisciplinary teams on the wards, improvements in communication and documentation through the establishment of a senior overview meeting in Wokingham.
5. Record keeping and related assurance procedures are being reviewed across all physical health inpatient wards.

9.4 Theme Older Peoples Mental Health (OPMH)

For OPMH the establishment of a monthly Clinical Review Group (OPMH Service managers and lead) has had a really positive impact. Having a representative from each service involved in the review and evaluation of the standard of care provided to individual deceased patients typically leads to wider discussion of complex cases and group reflection and learning. Service Managers in turn take back the learning to their teams which help staff to understand the context for any resulting change to pathway/practice. The following actions and learning have been implemented:

1. The importance of conducting and recording mental capacity assessments/best interest decisions when a Carer declines support for a relative. (to ensure focus remains on meeting patient's needs whilst trying to maintain a positive working relationship with carer)
2. Prompt referral to EDS for patients with low BMI who may have an undiagnosed eating disorder (Learning from a Reading IFR has been applied to a current Slough patient with some similarities in presentation)

The group meet even if there is no IFR to discuss current developments/challenges. Service Managers have fed back that they value the regular opportunity for peer support and to learn from each other. The meetings also promote consistency of practice across OPMH Services.

9.5 Learning from deaths of patients with a learning disability

In Q1, there has been further learning identified on the recording of mental capacity assessment. Learning has been disseminated to the teams via the learning disability Patient Safety and quality meetings.

The nursing assessment document has been reviewed to ensure that there is additional guidance for consideration of people's dental needs and the impact of this may have on people's eating and drinking.

There was one individual where the referral had gone to Psychiatry, but not to the wider multi-disciplinary team (MDT). Whilst this did not impact on the care the person received as they were in hospital and the learning disability acute liaison nurse was involved, their care may have been further enhanced with wider CTPLD input. The learning from this will be shared at a learning event. In addition to this, there was one individual where there was a delay in care received in regards to a dementia assessment. This did not impact upon the person's delivery of care in regards to their death. Learning regarding the referral and team processes will be shared through the referral pathway/team process project and will inform the CTPLD referral and team processes.

The was evidence of good joint working between the community learning disability teams (CTPLD), Palliative Care and other providers of care. There was good consideration of the emotional support needed for people during end of life care and for their family and friends.

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.

9.6 Learning from LeDeR reviews

Representatives from the Trust attend the local LeDeR steering groups and reviewer groups in both the East and West of Berkshire. The quarterly reports received from the LeDeR programmes are shared through the Trust Mortality Review Group. In May 2018 LeDeR published a national report, the high level learning and relevant actions are being led by the steering groups, who we are supporting with local implementation. There are no specific actions currently for the Trust.

9.7 Learning from Complaints where the patient died

In Q1 the MRG reviewed 3 IFRs relating to complaints, of these one was identified as a lapse in care, learning has been identified within section 9.4 Themes from our Physical Health Inpatient Wards and further actions will be reviewed and monitored through the SI process.

10. National Guidance and Policy Review

National guidance on specific methodology for review of deaths of mental health patients (which are not declared as Serious Incidents) is still awaited. It is likely that the methodology recommended will be based on the Structured Judgement Review (SJR) methodology which has been piloted by Yorkshire and Humber through the AHSN Improvement Academy.

We have 8 number of our senior staff (including Clinical Directors) already trained to use the SJR for second line case record reviews. Our roll out plan is now in place, 2 training sessions will be conducted on 18th and 19th September led by the lead Clinical Director to ensure that we have enough staff trained in SJR methodology to complete first line case record reviews. We intend to start using the SJR methodology as soon as definitive guidance is published and not later than end of 2018; this will replace the current IFR methodology.

New national guidance was published in July on working with bereaved families and this is due to be reviewed by the TMRG in August and will approach to implementation will be reported in the Q2 report.

11. Conclusion

In Q1, of the 42 deaths concluded through the mortality review group, one lapse in care was identified and has been escalated as an SI in May. The death was initially reported as a death following transfer from a community hospital to an acute hospital, and subsequently via a complaint. On review it was identified as having a lapse in care, and was escalated and reported as a Serious Incident (SI) by the MRG.

Several themes and areas of learning from a review of the deaths are being implemented and the Q1 learning builds and supports the learning identified in 2017/18. In Q1 we identified a number of new areas for learning, which include:

- Community Hospital inpatient wards recognising and treating patients when they have symptoms which require medical input and sometimes acute medical care.
- Older Adults mental health services identified the importance of conducting and recording mental capacity assessments/best interest decisions to ensure the focus remains on meeting patient's needs whilst trying to maintain a positive working relationship with carer. Prompt referral to eating disorder services (EDS) for patients with low BMI who may have an undiagnosed eating disorder (Learning from a Reading IFR has been applied to a current Slough patient with some similarities in presentation).
- Mental health services continue to embed work and learning around families and carers communications and ensure that the physical health needs of patients are met with a specific post now in place.
- Learning Disability services have reviewed assessment documents to ensure that there is additional guidance for consideration of people's dental needs and the impact of this may have on people's eating and drinking. Referral processes are also being reviewed with the pathways teams.

Quality Assurance Committee	21 August 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 1 May 2018 to 31 July 2018
Business Area	Medical Director
Author	Dr James Jeffs, Dr Matthew Lowe, Ian Stephenson
Relevant Strategic Objectives	2 – 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. Since the last report to the Committee, there have been no exception reports.
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 1st May to the 31st July 2018

Executive summary

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

This report focusses on the period 1st May to the 31st July 2018. Since the last report to the Trust Board we have received no exception reports. Trainees will be reminded of their right to make exception reports, and the associated processes at the next Junior Doctors' Forum, during induction at the beginning of August.

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

Introduction

The current reporting period covers the second half of a six month CT and GPVTS rotation.

High level data

Number of doctors in training (total):	30 (FY1 – ST6)

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

Number of doctors in training on 2016 TCS (total):	30
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)**

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

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

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

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

In this period we have not had any further exception report. Exception reporting is a neutral action and is encouraged by the Guardians and DME. We have not been made aware of any evidence that trainees feel unable to submit exception reports, nor do we feel the systems are complex or cumbersome. It seems likely that there are no systemic concerns about working hours, within the definitions of the 2016 TCS.

b) 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

c) **Gaps**

(All data provided below for bookings (bank/agency/trainees) covers the period 1st May to the 31st July 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
	100	99	83	16	0	968	956	828	128	0

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	61	61	54	7	0	564	564	520	44	0
Sickness	39	38	32	6	0	404	392	336	56	0
Maternity	0	0	0	0	0	0	0	0	0	0
Total	100	99	86	13	0	968	956	856	100	0

The period 1st May to the 31st July 2018 covers the period from the end of the February rotation to date. We have had no long term sick and no maternity. Although we did have two doctors who were each off sick for approximately two weeks, as well as one-off incidents of sickness amongst the other trainees on the rota.

We did, however, have a number of gaps, both ongoing from the beginning of this rotation along with new gaps in this half of the rotation. Of the new gaps one was caused by a trainee resigning for family reasons and leaving at the very end of April, thus their slot for the whole of this period needed cover. Another set of shifts that needed covering resulted from a LAS doctor who finished a month early for work/life balance. We also had to move the

other LAS doctor off the rota in order to support the ward (Snowdrop) they were on at PPH, as the agency middle grade on that ward left to pursue other opportunities and we were unable to either recruit to this middle grade post or find an agency locum to replace them.

The MTI (medical training initiative) and WAST (widening access to specialty training) schemes are going ahead and will see us receive one doctor from each scheme in September and August respectively of this year. The slight delay in the MTI trainee starting is unavoidable as visa and GMC registration both need to be in place before the doctor can start. The Royal College of Psychiatrists has assured us that such delays are not uncommon with MTI trainees.

d) **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. However, the Guardians of Safe Working are reviewing the operation of the Forum as our small numbers of trainees, turnover of junior doctors, and geographic spread probably make the Forum less efficient than in larger trusts. No immediate patient safety concerns have been raised to the guardians 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 will 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 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.

Our exception report numbers remain low, and we remain mindful of the possibility of under-reporting, whilst having no evidence of this. Trainees are strongly encouraged to make reports.

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 Manager.

Appendix A: Glossary of frequently used terms and abbreviations

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

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

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

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

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

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

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

Berkshire Healthcare NHS
NHS Foundation Trust

TRUST BOARD

Quality Assurance Committee

Terms of Reference

Purpose

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

Document Control

Version	Date	Author	Comments
1.0	25.7.12	John Tonkin	Initial draft
2.0	31.7.12	John Tonkin	Amendments following Exec Discussion on 30 July 2012
3.0	20.8.12	John Tonkin	Amendments following Exec Discussion on 16 August 2012
4.0	11.9.12	John Tonkin	Post Board approval – 11 September 2012
5.0	5.4.14	John Tonkin	Post review with Director of Nursing & Governance
6.0	3.6.14	John Tonkin	For Board approval post QAC discussion 22 May 2014 APPROVED AT JUNE 2014 Board meeting
7.0	21.2.17	Julie Hill	Updated to include the Committee's new responsibilities in relation to receiving the Guardians of Safe Working reports and providing oversight of the Trust's mortality review process. Approved at July 2017 Trust Board meeting

This document is unrestricted.

Distribution:

No restriction.

Document References

Document Title	Date	Published By

Quality Assurance Committee - Terms of Reference

1. Constitution

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

2. Membership

The Committee's membership will comprise:

3 Non-Executive Directors
Chief Executive
Chief Operating Officer
Medical Director
Director of Nursing & Governance
The Lead Clinical Director will routinely attend Committee meetings and other directors and managers will attend meetings when requested by the Committee
The Clinical Lead(s) for the Clinical Audit(s) under discussion will be invited to attend the meeting.

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

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

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

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

3. Frequency of Meetings

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

4. Purpose

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

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

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

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

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

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

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

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

5. Reporting

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

The minutes of the Quality Assurance Committee's meetings will be received by the Trust Board along with the quarterly Learning from Deaths and Guardians of Safe Working Hours for Doctors and Dentists in training reports. The Committee will also refer the Quality Concerns report to the In Committee Trust Board meeting. ~~and t~~The Chair of the Committee will provide an oral report to the next convenient Trust Board after each Committee meeting. The Chair of the Committee shall draw to the attention of the Trust Board any issues that require disclosure to the full Board.

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

6. Duties

a. Governance, internal control and risk management

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

b. Audit

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

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

To receive summary reports of national clinical audits.

c. Quality and safety

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

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

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

To receive and consider reports from the Health Service Ombudsman.

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

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

To receive reports on national mandated clinical audits conducted ~~outcomes and on research and development activity~~ within the Trust.

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

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

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

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

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

To review the quarterly Guardians of Safe Working for Doctors and Dentist in Training reports.

7. Reporting to the Board

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

Version ~~7~~8 ~~July 2017~~ Approved by Trust Board For review:

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Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	11 September 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 11 September 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. Third of NHS Trusts have at least one vacant Executive Director Role

Just over one-third of trusts have at least one vacant executive director role due to pressures facing NHS provider organisations. In a new report released by NHS Providers and the King's Fund, severe "financial and austerity and performance" pressures facing management, alongside a blame culture of staff leadership, has left trusts struggling to recruit and retain senior leaders.

The pressurised climate has led to high turnover in health service boards: more than half (54%) of substantive executive directors were appointed in the past three years, with 18% employed in the last year alone.

The report also highlighted the 'inverse leadership law' as a particular area of concern. The King's Fund and NHS Providers found that the law— where trusts experiencing the most challenging levels of performance were also experiencing high vacancy rates and shortest leadership tenures— was "still very much in force," with those who conducted the report calling on a new approach to address the issue.

Length of tenure was a concern identified for all the executive director roles looked at, but the short tenure of chief operating officers was highlighted as a particular concern. The report suggests that this reflects the substantial pressure being placed on these positions during an unprecedented period of financial austerity and performance challenges for the NHS.

Executive Lead: Julian Emms, Chief Executive

3. Patient – Led Assessments of the Care Environment (PLACE)

PLACE scores with National average for 2018 are detailed at appendix 1. The Trust has exceeded the National Average in all 8 domains. We have dropped slightly again in the privacy, dignity and wellbeing domain. The privacy, dignity and wellbeing domain includes infrastructural and organisational aspects such as the provision of outdoor and recreational areas, changing and waiting facilities, and access to television, radio, internet and telephones. It also includes the practicality of male and

female services, for example, sleeping, bathroom and toilet facilities, bedside curtains sufficient in size to create a private space around beds and ensuring patients are appropriately dressed to protect their dignity.

A fundamental part of PLACE is the inclusion of patient assessors. All assessment teams must include a minimum of two patient assessors and no less than 50% of the team. This year again, we have seen an increase in patient assessors. Assessors were from all Berkshire Healthwatch groups and it is important to note that the assessors that score on the day have the final say in discussions with the Trust team supporting. PLACE scores are shared with the Care Quality Commission. An action plan is in development to maintain performance and improve privacy, dignity and wellbeing scores.

Performance of other Berkshire Trusts compared with Berkshire Healthcare Trust is attached at appendix 1.

Executive Lead: Helen Mackenzie, Director of Nursing and Governance

4. Workplace Race Equality Standard (WRES)

We are currently preparing our WRES submission to NHS England for 2018/19 which is due at the end of September. This will be considered by the Diversity Steering Group (DSG) and then shared with the Trust Board in line with guidance, prior to the submission date of 28 September 2018. This will give sufficient time for the final edits to be completed and approved by the DSG. We have a clear, Board approved action plan already in place, which has another two years to run through to the end of 2020.

Executive Lead: Bev Searle, Director of Corporate Affairs

Presented by: Julian Emms
Chief Executive
September 2018

Patient – Led Assessments of the Care Environment (PLACE) Results

	Organisation Code	Organisation Name	Commissioning Region	NHS or Independent Organisation	CLN Score %	Food Score %	Org Food Score %	Ward Food %	PDW Score %	CAM Score %	DEM Score %	DIS Score %
2018	RWX	BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST	SOUTH OF ENGLAND	NHS	99.87%	96.25%	90.71%	98.61%	94.37%	98.67%	98.83%	97.64%
2017					99.82%	96.69%	94.31%	98.64%	96.67%	98.91%	98.89%	98.72%
2016					98.95%	95.49%	93.96%	96.81%	98.05%	98.64%	98.58%	97.19%
National Average 2018					**98.47**	**90.17**	**89.97**	**90.52**	**84.16**	**94.33**	**78.89**	**84.19**

Performance of other Berkshire Trusts compared with Berkshire Healthcare Trust.

Organisation Code	Organisation Name	Commissioning Region	Organisation Type	NHS or Independent	CLN Score %	Food Score %	PDW Score %	CAM Score %	DEM Score %	DIS Score %
RDU	FRIMLEY HEALTH NHS FOUNDATION TRUST	SOUTH OF ENGLAND	ACUTE -MEDIUM	NHS	99.29%	92.89%	79.29%	94.23%	75.36%	79.79%
RHW	ROYAL BERKSHIRE NHS FOUNDATION TRUST	SOUTH OF ENGLAND	ACUTE -LARGE	NHS	99.32%	95.69%	93.97%	96.10%	87.41%	89.42%
RWX	BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST	SOUTH OF ENGLAND	MENTAL HEALTH AND LEARNING DISABILITY	NHS	99.87%	96.25%	94.37%	98.67%	98.83%	97.64%

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	11 September 2018
Title	Financial Summary Report – M4 2018/19
Purpose	To provide the Month 4 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 summary of the M4 2018/19 financial position.
ACTION REQUIRED	The Board is invited to note the following summary of financial performance and results for Month 4 2018/19 (July 2018): The trust reports to NHSi its 'Use of Resources' rating, which monitors risk monthly, 1 is the highest rating possible and 4 is the lowest. **YTD (Use of Resource) metric:** • Overall rating 1 (plan 1) o Capital Service Cover 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: £1.0m surplus • Variance: £0.5m better than plan. **YTD Cash** £23.8m vs Plan £21.8m - £2.0m better than plan due to earlier STF receipt than in plan and working capital timings. **YTD Capital expenditure:** £1.9m vs Plan £2.2m.

Berkshire Healthcare NHS
NHS Foundation Trust

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

Finance Report

Financial Year 2018/19

Month 4 (July 2018)

Purpose

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

Document Control

Version	*Date*	*Author*	*Comments*
1.0	09.08.18	Bharti Bhoja	1st Draft
2.0	10.08.18	Bharti Bhoja/Tom Stacey	2nd Draft
3.0	10.08.18	Tom Stacey	3rdDraft
4.0	13.08.18	Tom Stacey / Alex Gild	Final for Exec
5.0	31.08.18	Tom Stacey / Paul Gray	Final for Board

Distribution

All Directors

All staff needing to see this report.

Contents

1.0 Key Messages

Key Metric	YTD Actual £'m	YTD Plan £'m	Variance £'m	vs Last Mth	vs Prior Year
Surplus / (Deficit) for PSF	0.5	(0.1)	0.5	▼	▼
PSF - Trust	0.3	0.5	(0.2)	▲	▲
PSF - System	0.2	0.0	0.2		
Control Total Surplus / (Deficit)	**1.0**	**0.4**	**0.5**	▲	▲
Statutory Surplus / (Deficit)	1.6	0.4	1.1	▲	▲
CIP Delivery	0.7	0.7	0.0	▼	▲
Agency Spend	2.0	1.8	(0.2)	▼	▼
OAPs - Specialist Placements (incl LD)	2.6	2.7	0.1	▲	▼
OAPs - Overspill Beds	0.7	0.7	(0.1)	▼	▼
Capital Expenditure	1.9	2.2	0.3	▲	▲
Cash	23.8	21.8	2.0	▲	▲

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 breakeven position in July which was £0.1m below Control Total. However, YTD the Trust delivered a surplus of £1m which is £0.5m over Control Total.
- After accounting for PSF and recognising £0.4m of donated income, the Trust's statutory surplus stands at £0.4m in July and £1.6m YTD.
- Overall staff costs were £0.1m below plan this month, with AFC pay deal included and plan adjusted to reflect funding.
- Capital spend is £0.3m behind plan and Cash was £2m higher than anticipated.
- Use of Resources rating remains at a"1" overall.

Key Risks

- LD OAPS and Specialist placements YTD overspends vs prior year are £201k and £157k respectively
- CRHTT and Westcall may not achieve CIP targets as both areas are currently overspending against budget.
- The forecast made at Q1 remains in place at £4m surplus. A re-forecast is planned at end of Q2.

2.0 Income & Expenditure

Income Statement	In Month			YTD			FY	Prior Year YTD		
	Act £'m	Plan £'m	Var £'m	Act £'m	Plan £'m	Var £'m	Plan £'m	Act £'m	Var +/-	%
Operating Income	19.0	19.0	0.0	76.2	75.9	0.3	227.2	76.0	0.2	0.3%
DoH Pay Award	0.2	0.2	0.0	0.2	0.2	0.0	2.3	0.0	0.2	
Other Income	1.6	1.6	0.1	6.5	6.3	0.3	18.6	6.2	0.4	6.1%
Total Income	***20.8***	***20.7***	***0.1***	***82.9***	***82.3***	***0.6***	***248.1***	***82.1***	***0.8***	***1.0%***
Staff In Post	13.0	13.1	(0.2)	51.2	51.8	(0.6)	156.9	50.8	0.5	1.0%
Bank Spend	1.2	1.0	0.1	4.5	4.1	0.3	12.3	3.9	0.6	14.8%
Agency Spend	0.4	0.4	(0.1)	2.0	1.8	0.2	5.3	2.8	(0.8)	(29.4)%
Total Pay	***14.5***	***14.6***	***(0.1)***	***57.7***	***57.7***	***(0.0)***	***174.5***	***57.4***	***0.2***	***0.4%***
Purchase of Healthcare	1.4	1.2	0.2	5.6	5.0	0.7	13.7	5.3	0.3	5.3%
Drugs	0.6	0.4	0.1	1.9	1.7	0.2	5.0	1.6	0.3	20.0%
Premises	1.2	1.2	0.1	4.9	4.7	0.2	14.3	5.0	(0.1)	(2.0)%
Other Non Pay	1.8	1.9	(0.1)	7.0	7.9	(0.9)	23.4	7.2	(0.2)	(2.9)%
PFI Lease	0.5	0.5	0.0	2.1	2.1	(0.0)	6.3	2.1	0.1	2.5%
Total Non Pay	***5.6***	***5.3***	***0.3***	***21.5***	***21.3***	***0.2***	***62.7***	***21.2***	***0.3***	***1.6%***
Total Operating Costs	***20.1***	***19.9***	***0.2***	***79.2***	***79.1***	***0.2***	***237.3***	***78.7***	***0.6***	***0.7%***
EBITDA	***0.7***	***0.8***	***0.1***	***3.7***	***3.2***	***(0.5)***	***10.9***	***3.5***	***(0.2)***	***(6.7)%***
Interest (Net)	0.3	0.3	(0.0)	1.2	1.2	(0.0)	3.6	1.2	(0.0)	(0.2)%
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	0.5	(0.1)	1.5	1.6	(0.1)	5.6	1.8	(0.3)	(15.1)%
PDC	0.1	0.1	(0.0)	0.5	0.5	(0.0)	1.6	0.4	0.1	35.3%
Total Finanacing	***0.8***	***0.9***	***(0.1)***	***3.2***	***3.3***	***(0.1)***	***10.9***	***3.4***	***(0.1)***	***(3.8)%***
Surplus/ (Deficit) for PSF	***(0.1)***	***(0.1)***	***(0.1)***	***0.5***	***(0.1)***	***0.5***	***(0.0)***	***0.1***	***0.4***	***392.2%***
PSF - Trust	0.1	0.2	(0.1)	0.3	0.5	(0.2)	2.4	0.4	**0.2**	**40.6%**
PSF - System	0.1	0.0	0.1	0.2	0.0	0.2	0.0	0.0		
Surplus/ (Deficit) for CT	***0.0***	***0.1***	***(0.1)***	***1.0***	***0.4***	***0.5***	***2.4***	***0.5***	***0.5***	***109.6%***
Donated Income	0.4	0.0	0.4	0.6	0.0	0.6	0.0	0.0	0.5	1191.0%
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	***0.4***	***0.1***	***0.3***	***1.6***	***0.4***	***1.1***	***2.3***	***0.5***	***1.1***	***208.2%***

Key Messages

In July the trust delivered a breakeven position missing its control total by £0.1m due to continuing overspends on OAPS. However, YTD surplus stands at £1m which is £0.5m ahead of plan. This includes £0.5m of PSF funding.

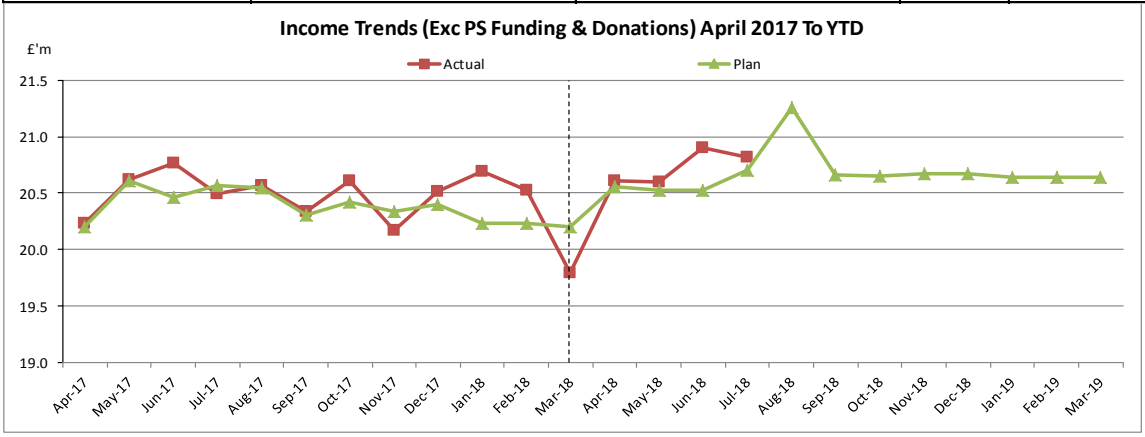
Overall staff costs in July were £0.1m lower than plan. Most areas still continue to remain within planning assumptions with the exception of CRHTT and WestCall. These services continue to overspend with the YTD overspends now standing at £219k and £200k respectively.

The pay award for July is now in the Trust's position. The additional funding from DOH for pay award of £2.3m and year to date pay accruals are sufficient to cover the increased pay award for 18/19.

Non Pay costs this month are overspent by £0.3m against plan due to higher OAPs costs than planned and pass through Pharmacy drugs which are being off-set by pass through income.

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	66.2	66.2	0.1	198.2	64.4	1.8	2.8%
Tariff Income	0.2	0.3	(0.1)	0.9	1.0	(0.1)	3.1	1.1	(0.2)	(15.8)%
Pass Through Income	0.3	0.3	0.1	1.2	1.0	0.2	3.0	1.0	0.2	22.5%
DoH Pay Award	0.2	0.2	0.0	0.2	0.2	0.0	2.3	0.0	0.2	
Other Income	3.6	3.5	0.1	14.4	13.9	0.5	41.5	15.7	(1.3)	(8.0)%
Total Operating Income	***20.8***	***20.7***	***0.1***	***82.9***	***82.3***	***0.6***	***248.1***	***82.1***	***0.8***	***1.0%***
PSF - Trust	0.1	0.2	(0.1)	0.3	0.5	(0.2)	2.4	0.4	0.2	40.6%
PSF - System	0.1	0.0	0.1	0.2	0.0	0.2	0.0			
Donated Income	0.4	0.0	0.4	0.6	0.0	0.6	0.0	0.0	0.5	1,191.0%
Total Reportable Income	***21.3***	***20.9***	***0.5***	***84.0***	***82.8***	***1.2***	***250.6***	***82.5***	***1.5***	***1.8%***



Income

YTD	£'m
2018/19	82.9
2017/18	82.1
▲	*1%*

Prior Yr	£'m
Jul-18	20.8
Jul-17	20.5
▲	*1%*

Key Messages

Income was £0.6m better than planned YTD. This was mainly due to £0.4m donated asset income for the Renal Unit build. Other increases in income this month were £82k Pharmacy community drugs, £28k Papist Way section 117 income accrual, £48k EDTS income from NHSPS, £49k year to date catch up of Junior Doctors' funding and accrual for family safeguarding pilot £27k. Please note extra Pharmacy and NHSPS income is offset by non-pay cost.

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

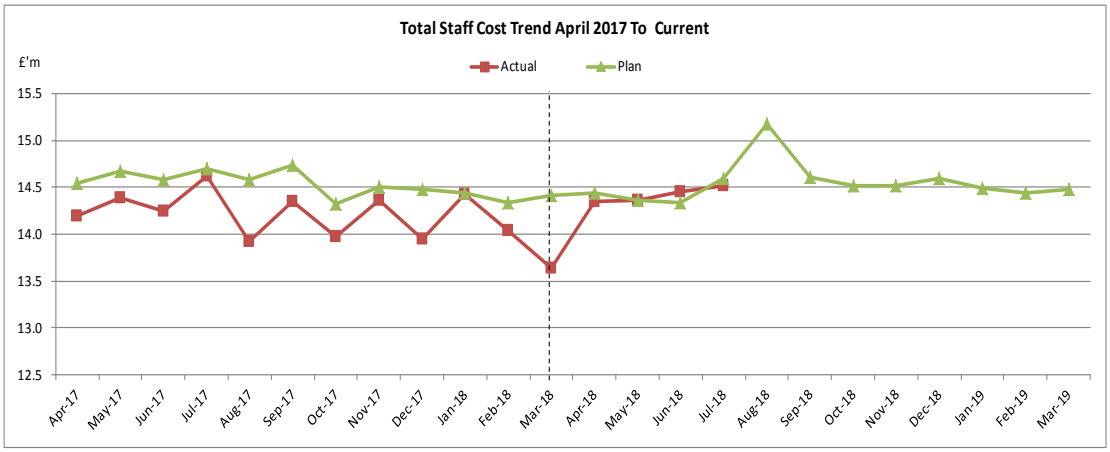
Commissioner Focus

The contracts for 18/19 are agreed with only a few minor contractual amendments remaining to be resolved.

System Focus

Q1 system control totals were met and are included in the figures YTD. At month 4 there is no indication that Q2 system control totals will not be met and they have been fully accrued. However, Frimley ICS is declaring risk to the year end achievement of control total.

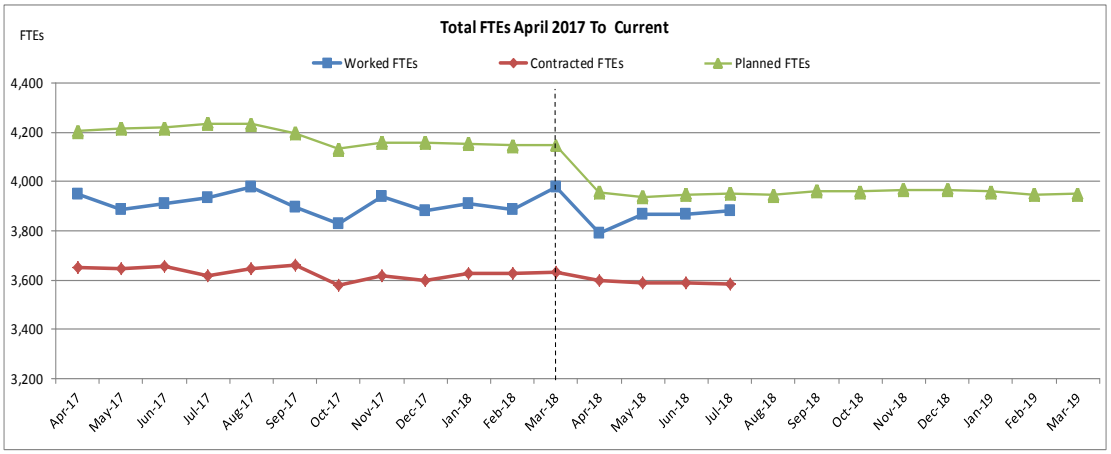
Workforce



Staff Costs

YTD	£'m
2018/19	57.7
2017/18	57.4
▲	0%

Prior Yr	£'m
Jul-18	14.5
Jul-17	14.6
▼	-1%



FTEs

Prior Yr	CFTE	WFTE
Jul-18	3,584	3,880
Jul-17	3,619	3,933
	1% ▼	1% ▼

Prior Mth	CFTE	WFTE
Jul-18	3,584	3,880
Jun-18	3,590	3,866
	0% ▼	0% ▲

Key Messages

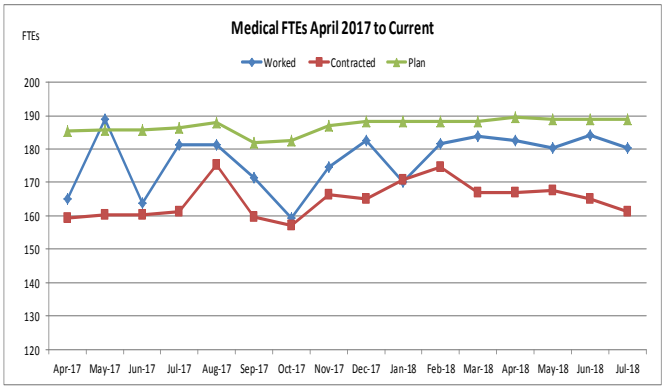
Overall staff costs in July were £0.1m lower than plan bringing the year to date cost in line with budget.

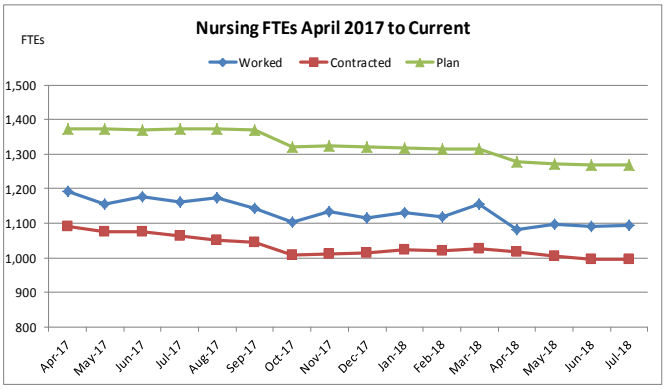
The YTD position now includes July pay award and accruals for year to date pay arrears. The additional pay award funding of £2.3m from DOH has now been received. The year to date pay accruals and the additional DOH funding are estimated to be sufficient to cover 18/19 pay award.

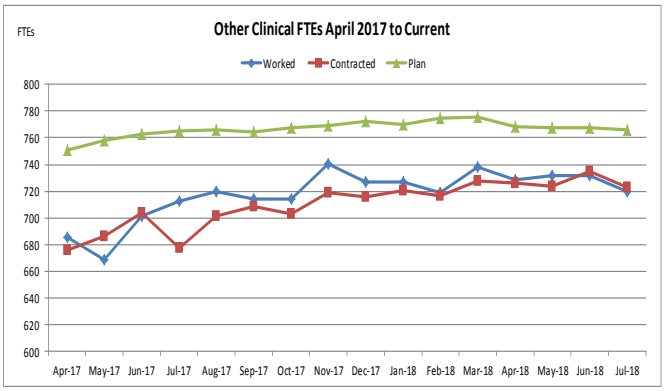
Most areas still continue to remain within planning assumptions with the exception of CRHTT and WestCall. YTD Pay overspends in these services were £209k and £174k respectively.

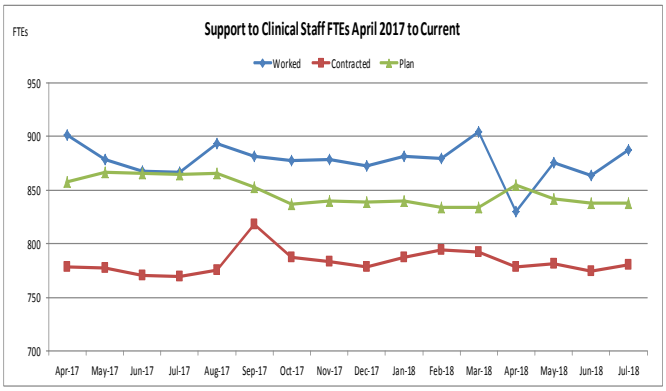
Substantive staffing costs are £0.2m below plan. YTD we are £0.6m below planning assumptions however this is being off-set by the use of bank and agency with both tracking ahead of plan by £0.3m and £0.2m YTD.

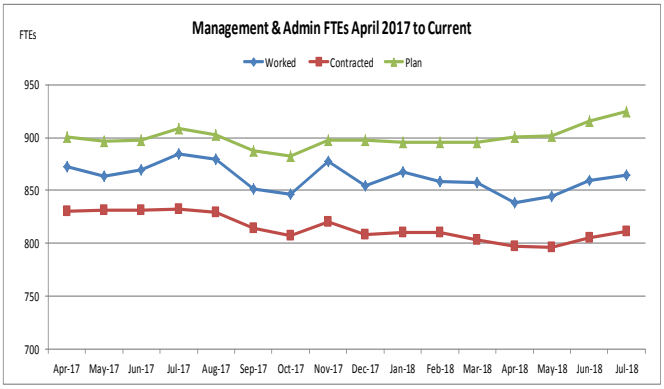
Workforce: Staff Groups

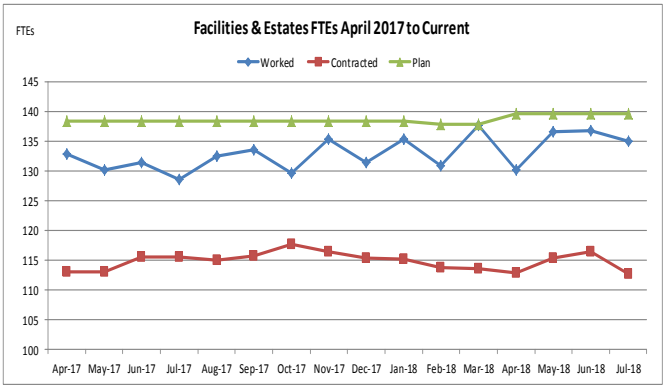












Key Messages

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.

Qualified Nursing staff increased slightly during July due to efforts to increase recruitment. There were notable increases in contracted qualified nursing staff within Adult Services and Specialist Mental Health.

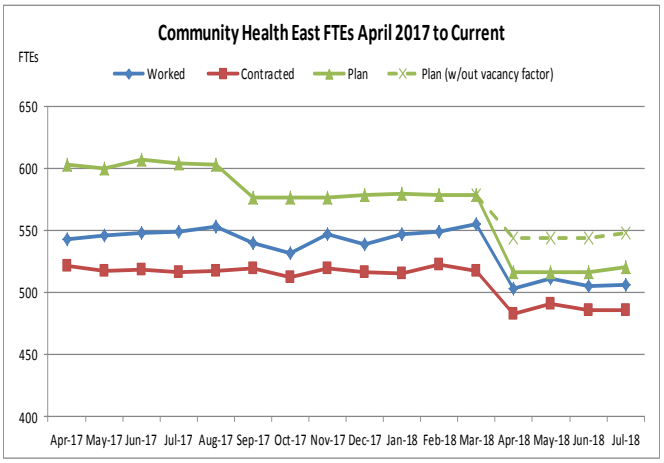
Other Clinical staff reduced during July; Talking Therapies seeing the biggest fall (3.5WTE).

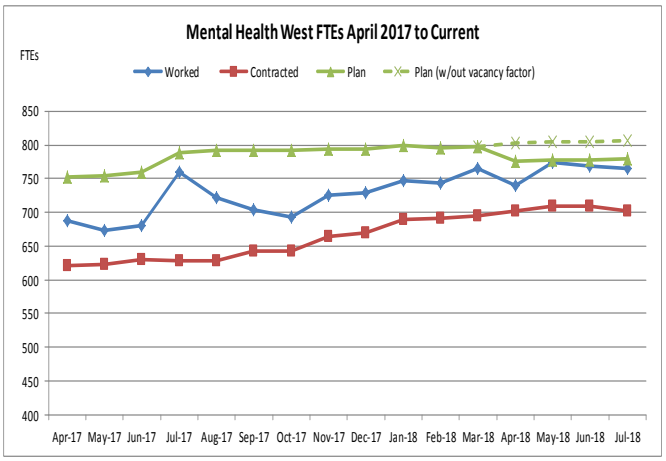
Medical staff reduced during July; with Junior Doctors seeing the biggest fall (3.8WTE).

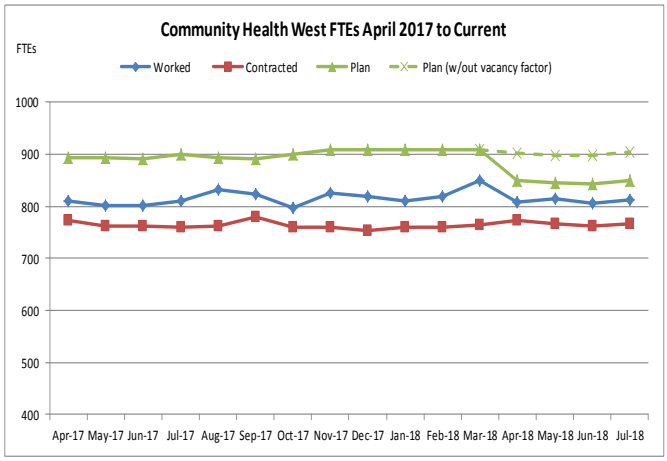
Management and Administrative contracted FTEs rose in July again due partly to non recurrent capitalisation of IM&T pay costs in prior months as well as management appointments in District Nursing.

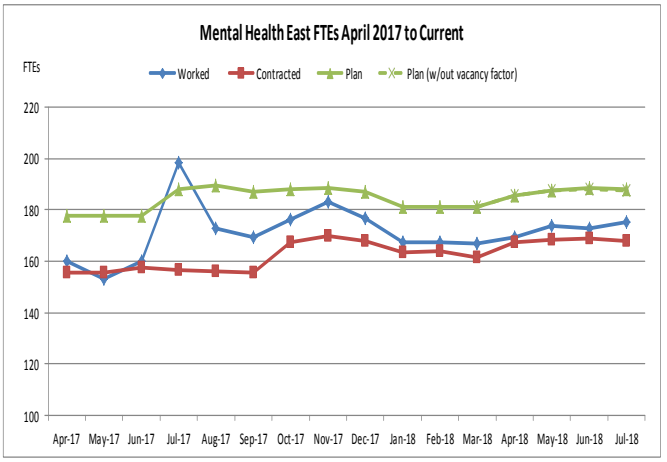
Facilities and Estates contracted staffing went down during July due to vacancies in Wokingham Domestic Catering which are being covered by bank and agency.

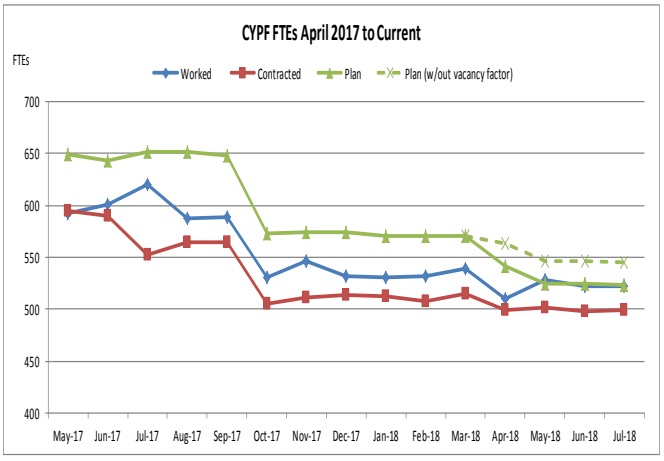
Workforce: Divisional

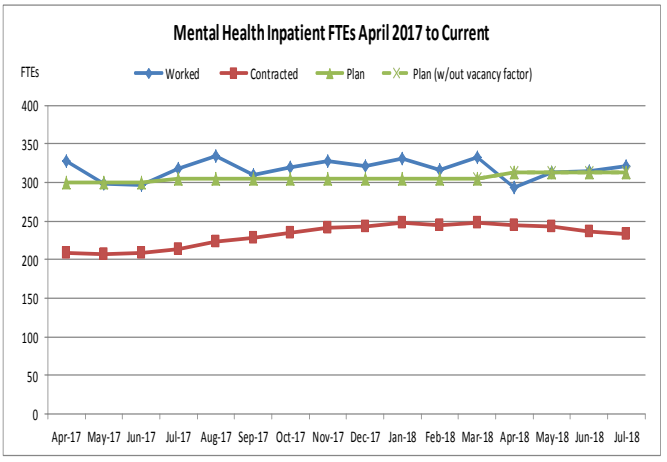


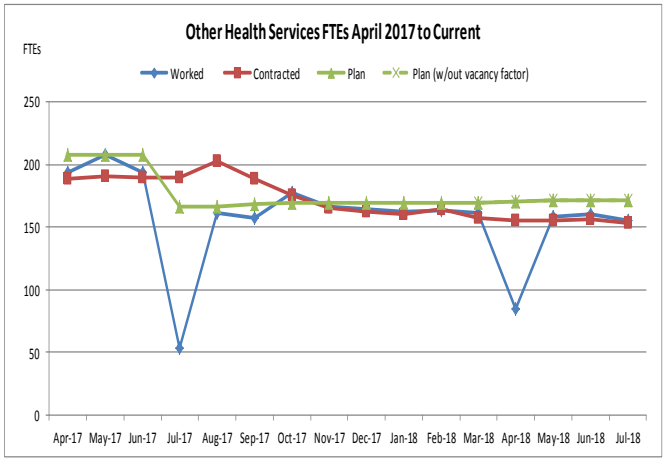


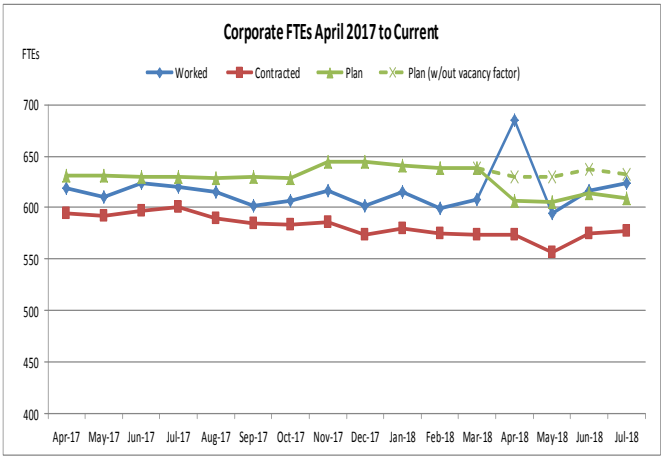




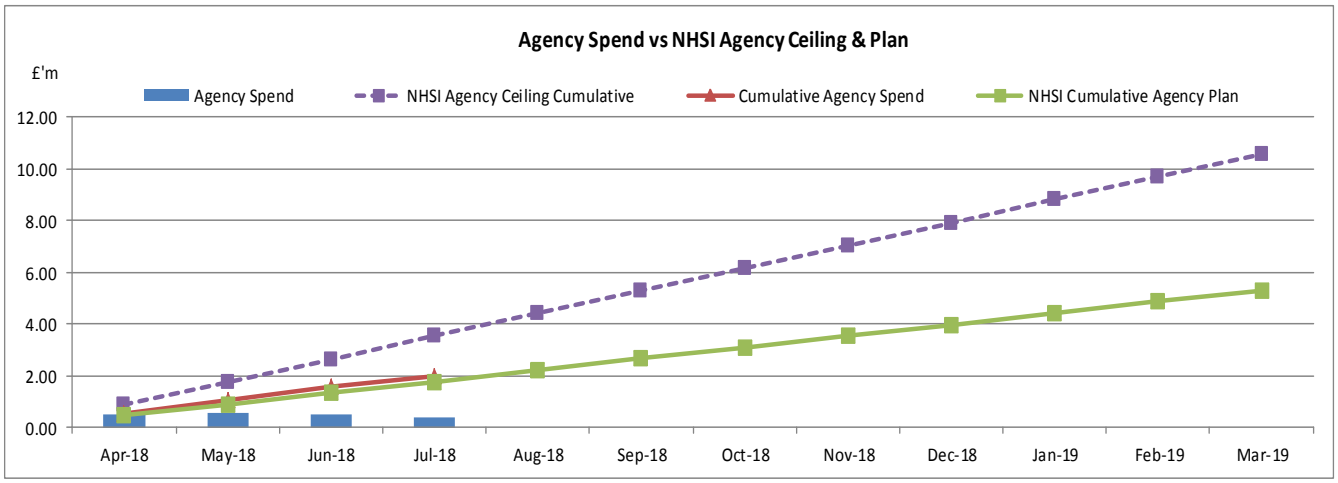


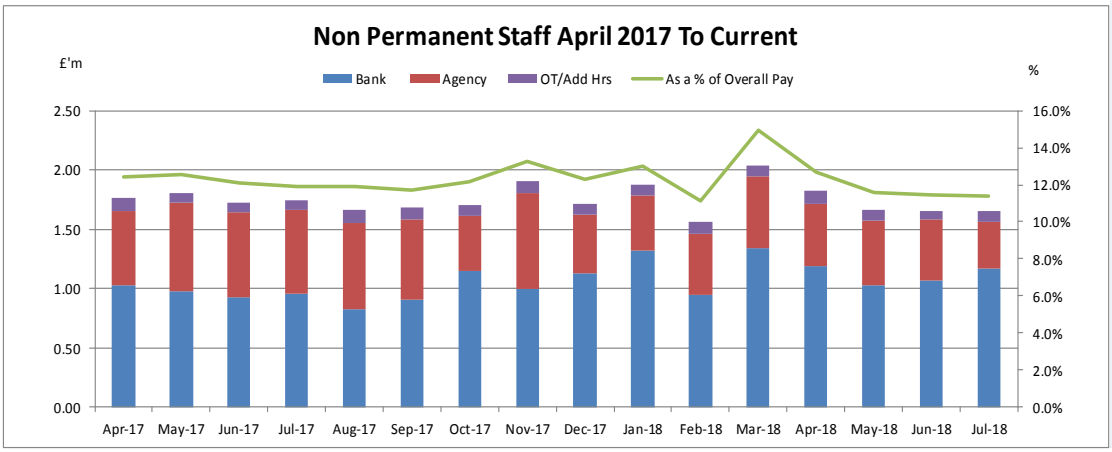






Non Permanent Pay

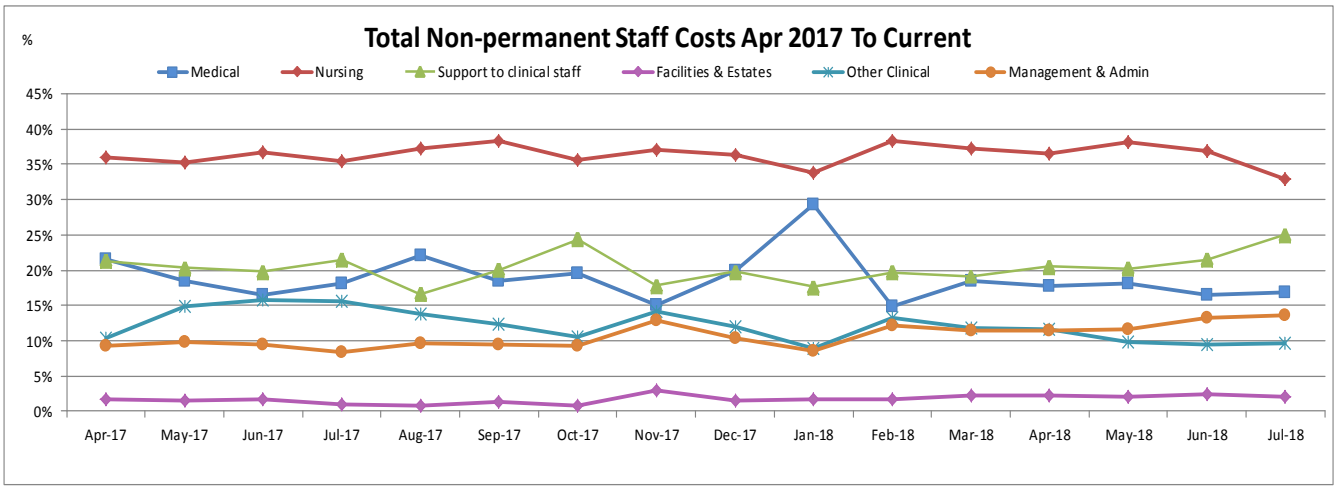




Non Permanent Pay

Prior Mth	Bank	Agency	OT/Add Hrs
Jul-18	1.2	0.4	0.1
Jul-17	1.0	0.7	0.1
	19% ▲	-82% ▼	8% ▲

Prior Mth	Bank	Agency	OT/Add Hrs
Jul-18	1.2	0.4	0.1
Jun-18	1.1	0.5	0.1
	9% ▲	-33% ▼	8% ▲



Key Messages

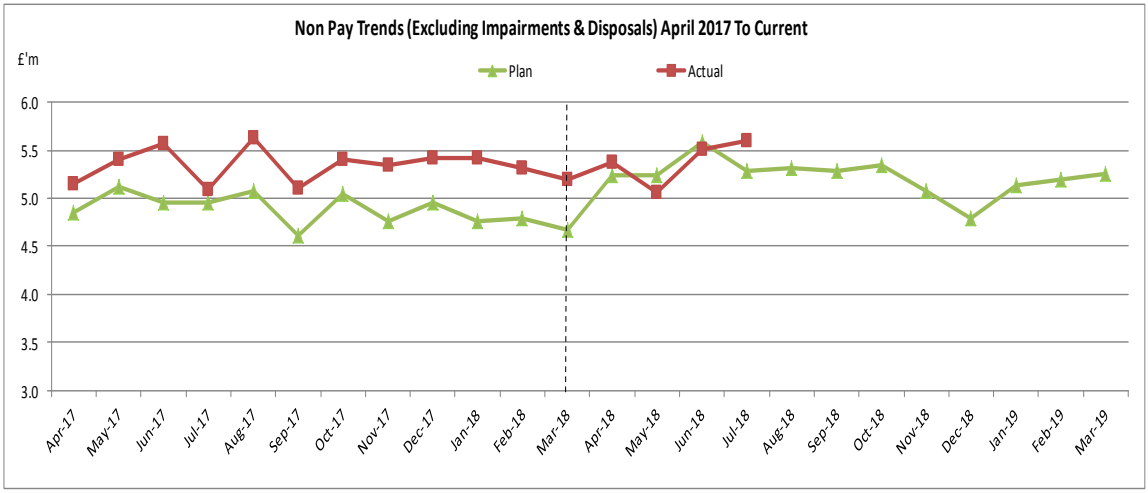
Non permanent staffing graph above now includes overtime and additional hours worked as well as bank and agency costs. July temporary staffing cost (excluding overtime and additional hours) was £1.6m, £0.1m higher than budgeted but in line with June and July 17/18.

Agency staffing costs in July were below plan and remain within NHSI celling.

YTD overall Non Permanent staffing spend (excluding additional hours and overtime) has risen to £6.4m, £253k lower than YTD 17/18.

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	1.2	0.2	5.6	5.0	0.7	13.7	5.3	0.3	5.3%
Drugs	0.6	0.4	0.1	1.9	1.7	0.2	5.0	1.6	0.3	20.0%
Premises	1.2	1.2	0.1	4.9	4.7	0.2	14.3	5.0	(0.1)	(2.0)%
Supplies and services – clinical	0.4	0.4	(0.0)	1.6	1.7	(0.1)	5.2	1.6	(0.0)	(1.1)%
Transport	0.2	0.3	(0.1)	1.0	1.3	(0.3)	3.9	1.0	0.1	8.9%
Establishment	0.3	0.3	0.0	1.2	1.0	0.2	3.1	1.7	(0.4)	(24.9)%
Other Non Pay	0.9	0.9	(0.0)	3.1	3.8	(0.7)	11.2	3.0	0.1	4.6%
PFI Lease	0.5	0.5	0.0	2.1	2.1	(0.0)	6.3	2.1	0.1	2.5%
Total Non Pay	**5.6**	**5.3**	**0.3**	**21.5**	**21.3**	**0.2**	**62.7**	**21.2**	**0.3**	**1.6%**



Non Pay

YTD	£'m
2018/19	21.5
2017/18	21.2
▲	***2%***

Prior Yr	£'m
Jul-18	5.6
Jul-17	5.1
▲	***10%***

Key Messages

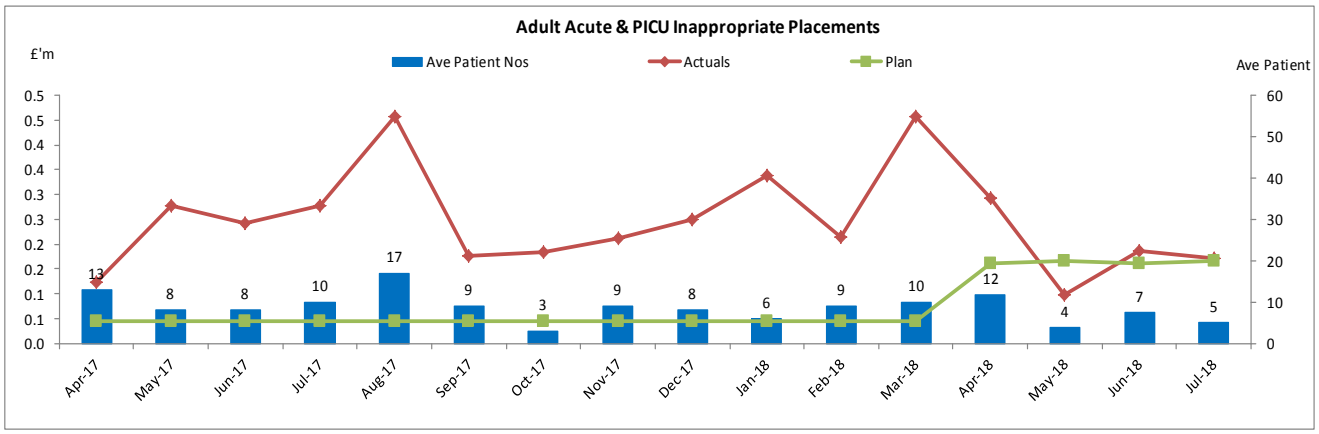
Non Pay expenditure was £0.3m higher than budget in July, bringing year to date overspend to £0.2m.

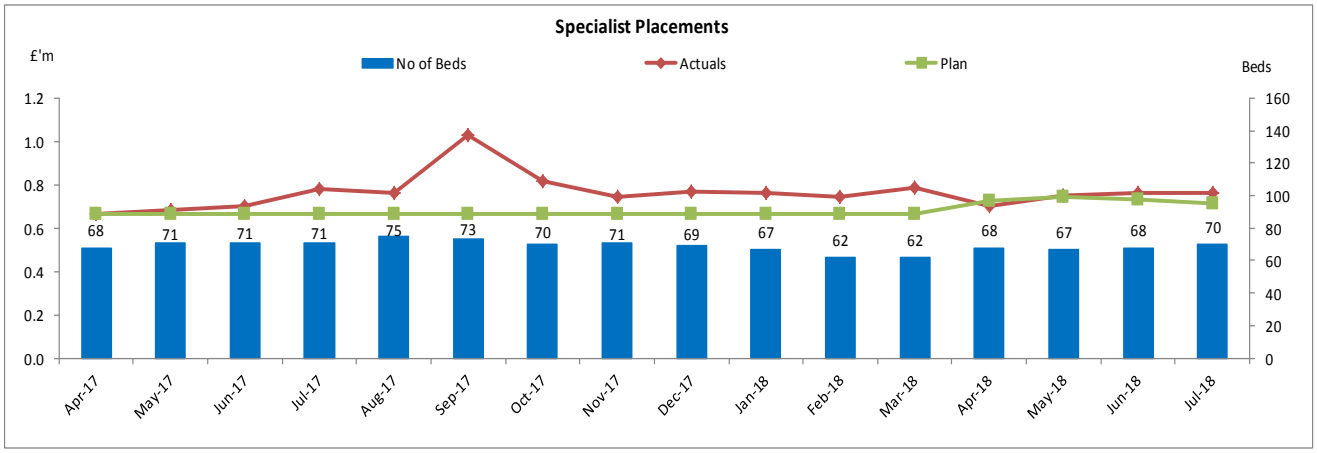
Overspends in July mainly relate to OAPS and pass through drugs.

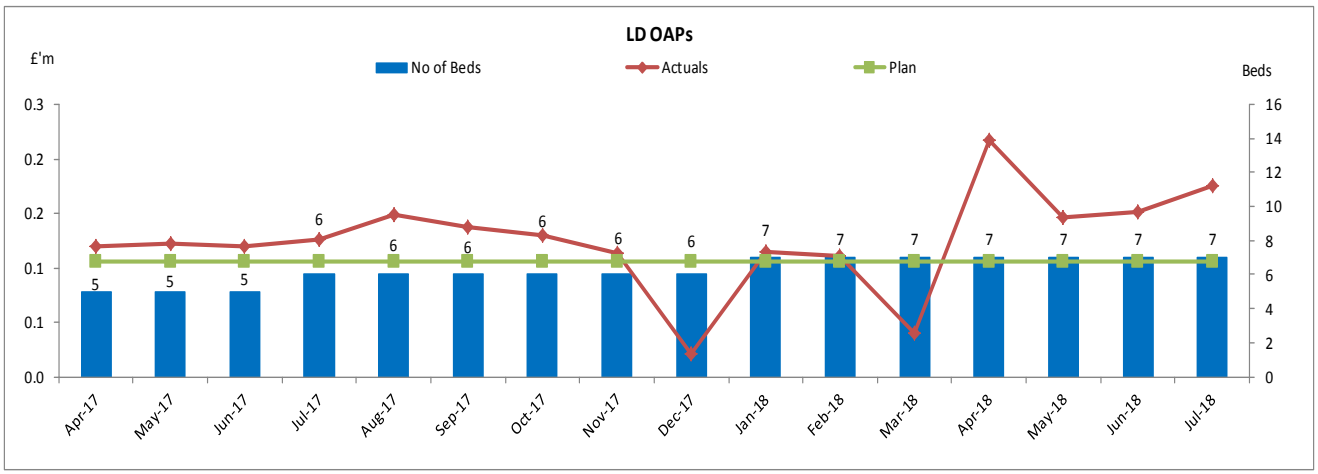
In month and YTD drugs expenditure overspend relates to pass through Pharmacy Community drugs. There is corresponding increase in pass through income which offsets the drugs over-spends.

During July overspend on OAPs, mainly driven by LD OAPs, was £129k and £438k YTD. Contract negotiations for OAPS specialist placements are continuing and are expected to secure savings.

Non Pay Expenditure - Focus on OAPs







Key Messages

Inappropriate Placements' spend in July was £6k higher than budget at £171k, £14k lower than June 18 and £72k lower than June 17.

Specialist Placements spend continues to remain in line with run rate.

LD OAPS costs continuing ahead of plan driven by continuing higher patient numbers than planned. July cost was £70k ahead of plan and YTD £267k.

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)	1.7	1.8	(0.1)	5.5	1.2	0.5	40.0%
Pay	2.9	2.9	(0.1)	11.4	11.6	(0.1)	35.4	11.1	0.3	2.7%
Non Pay	0.5	0.5	0.0	1.8	1.9	(0.0)	5.6	1.9	(0.0)	(1.6%)
Net Cost	***2.9***	***2.9***	***(0.0)***	***11.5***	***11.6***	***(0.1)***	***35.5***	***11.7***	***(0.2)***	***(1.9%)***
Mental Health West										
Income	0.2	0.3	(0.0)	1.0	1.0	(0.1)	3.0	1.0	0.0	2.7%
Pay	2.8	2.8	(0.0)	10.9	10.8	0.2	33.6	10.1	0.8	8.4%
Non Pay	0.6	0.5	0.1	2.5	2.0	0.5	5.1	2.3	0.2	6.5%
Net Cost	***3.1***	***3.1***	***0.1***	***12.4***	***11.7***	***0.7***	***35.7***	***11.4***	***1.0***	***8.5%***
Community Health East										
Income	0.252	0.273	(0.0)	1.1	1.1	0.0	3.3	2.4	(1.3)	(53.0)%
Pay	1.751	1.858	(0.1)	7.0	7.1	(0.2)	21.6	7.8	(0.8)	(10.1%)
Non Pay	0.563	0.568	(0.0)	2.2	2.3	(0.0)	6.8	2.2	0.0	0.1%
Net Cost	***2.061***	***2.153***	***0.1***	***8.1***	***8.3***	***(0.2)***	***25.2***	***7.6***	***0.5***	***6.2%***
Mental Health East										
Income	0.2	0.1	0.1	0.7	0.5	0.3	1.4	0.6	0.1	26.1%
Pay	0.7	0.7	(0.0)	2.5	2.6	(0.1)	8.0	2.4	0.1	4.1%
Non Pay	0.9	0.8	0.1	3.4	3.3	0.1	9.5	3.4	(0.0)	(1.3%)
Net Cost	***1.4***	***1.4***	***0.0***	***5.2***	***5.5***	***(0.3)***	***16.2***	***5.3***	***(0.1)***	***(1.8%)***
CYPF										
Income	0.2	0.2	0.0	1.1	0.9	0.1	2.7	1.1	(0.1)	(7.9)%
Pay	1.8	1.9	(0.0)	7.3	7.4	(0.1)	22.4	8.3	(1.1)	(13.1%)
Non Pay	0.2	0.1	0.1	0.6	0.5	0.1	1.6	0.6	0.0	2.7%
Net Cost	***1.8***	***1.8***	***0.0***	***6.8***	***7.0***	***(0.2)***	***21.3***	***7.8***	***(1.0)***	***(12.6%)***
Mental Health Inpatients										
Income	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	601.6%
Pay	1.0	0.9	0.0	3.7	3.6	0.1	11.1	3.6	0.1	3.7%
Non Pay	0.1	0.1	(0.0)	0.3	0.4	(0.0)	1.1	0.4	(0.0)	(11.9%)
Net Cost	***1.0***	***1.0***	***0.0***	***4.0***	***4.0***	***0.1***	***12.2***	***3.9***	***0.1***	***2.2%***
Other Health Services										
Income	0.2	0.1	0.1	0.6	0.4	0.2	1.2	0.4	0.2	47.8%
Pay	1.2	1.2	(0.0)	4.9	4.9	0.0	14.7	4.8	0.0	0.7%
Non Pay	0.1	0.0	0.1	0.3	0.1	0.2	0.3	0.1	0.2	210.6%
Net Cost	***1.1***	***1.1***	***(0.0)***	***4.5***	***4.6***	***(0.0)***	***13.7***	***4.5***	***0.0***	***0.6%***
Corporate										
Income	1.7	1.3	0.4	6.0	5.2	0.8	15.6	5.6	0.4	8.0%
Pay	2.4	2.3	0.2	10.0	9.8	(0.2)	27.7	9.3	(0.7)	8.0%
Non Pay	2.7	2.7	(0.0)	10.4	10.9	0.5	32.7	10.2	(0.3)	2.5%
Net Cost	***3.4***	***3.7***	***0.3***	***14.4***	***15.5***	***1.1***	***44.8***	***13.8***	***(0.6)***	***4.0%***
Corporate Income & Financing										
Income	18.1	18.1	(0.0)	71.7	71.9	(0.1)	217.9	70.2	1.5	2.2%
Financing	0.8	0.9	(0.1)	3.3	3.3	(0.1)	11.0	3.4	(0.1)	(3.8%)
Surplus/ (Deficit) Statutory	***0.4***	***0.1***	**0.3**	***1.6***	***0.4***	**1.1**	***2.3***	***0.7***	**0.8**	**116.9%**

Key Messages

All localities are on or below plan at the end of July with the exception of the following.

Mental Health West: Non pay overspent is due to LD OAPs £70k and Inappropriate Placements £6k.

Mental Health East: Income higher due to Family Safe Guarding £28k and OAPS £27k offset by non-pay over-spend of £32k on Papist Way, £30k on independents and £23k on CMHT drugs and security.

Corporate: £0.4m income variance relates to donated assets

4.0 Cost Improvement Programme

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

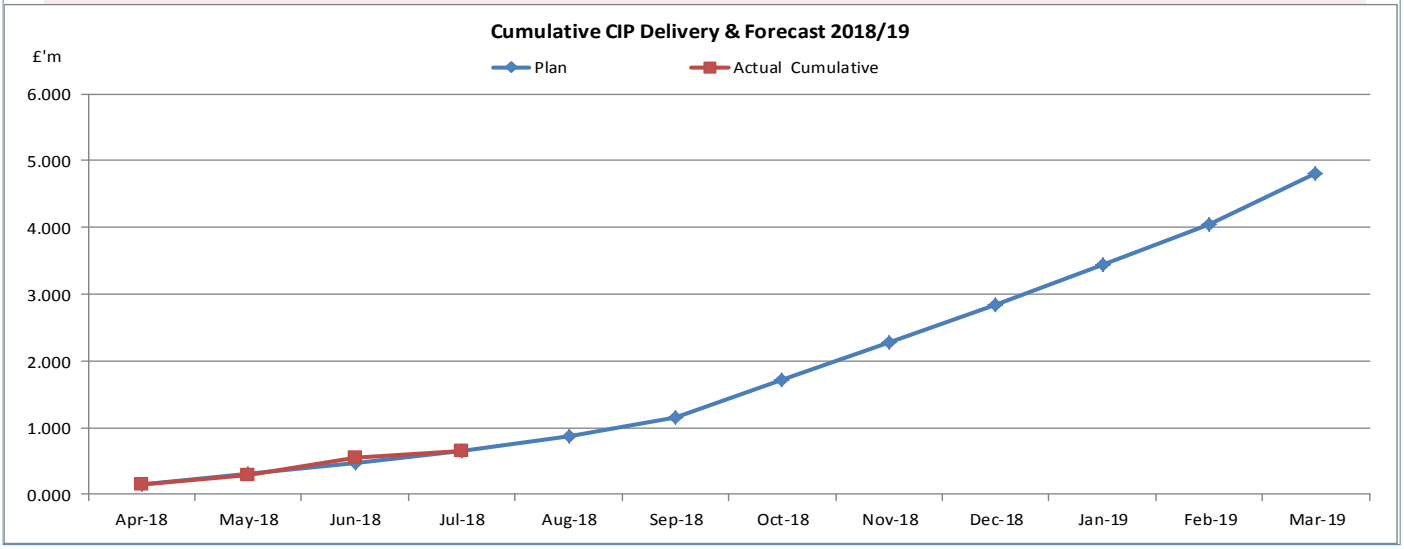
Scheme	In Month			YTD			Full Year		
	Act £'m	Plan £'m	Var £'m	Act £'m	Plan £'m	Var £'m	Forecast £'m	Plan £'m	Var £'m
OAPS Project									
Specialist Placements	0.01	0.03	(0.02)	0.22	0.12	0.11	0.59	0.59	0.00
Overspill Beds	0.00	0.02	(0.02)	0.00	0.10	(0.10)	1.73	1.82	(0.09)
Total OAPS Saving	***0.01***	***0.05***	***(0.05)***	***0.22***	***0.21***	***0.01***	***2.31***	***2.40***	***(0.09)***
Service Line Review									
WestCall	0.00	0.02	(0.02)	0.00	0.02	(0.02)	0.13	0.50	(0.38)
CRHTT	0.00	0.02	(0.02)	0.00	0.02	(0.02)	0.10	0.50	(0.40)
Total Service Line Savings	***0.00***	***0.03***	***(0.03)***	***0.00***	***0.03***	***(0.03)***	***0.23***	***1.00***	***(0.78)***
Procurement									
NHSP Contract	0.02	0.02	0.00	0.06	0.06	0.00	0.18	0.18	0.00
Procurement Spend	0.02	0.03	(0.00)	0.10	0.10	(0.00)	0.30	0.30	0.00
Total Procurement Savings	***0.04***	***0.04***	***(0.00)***	***0.16***	***0.16***	***(0.00)***	***0.48***	***0.48***	***0.00***
Other Schemes									
Community NCA	0.02	0.02	0.00	0.12	0.08	0.03	0.25	0.25	0.00
Liaison & Diversion Contract	0.02	0.02	0.00	0.08	0.08	0.00	0.25	0.25	0.00
Other Contracts	0.02	0.02	0.00	0.08	0.08	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***	***0.00***	***0.28***	***0.25***	***0.03***	***0.92***	***0.92***	***0.00***
Total CIP Delivery	***0.11***	***0.19***	***(0.08)***	***0.66***	***0.65***	***0.01***	***3.94***	***4.80***	***(0.87)***

Key Messages

The Trust delivered a £0.7m of savings YTD against a plan of £0.7m. Although CIP delivery remains on plan YTD, under delivery in month 4 has eroded the Q1 position where savings exceeding plan had been generated.

Savings from the service model reviews will not materialise until the latter part of the financial year. The mobilisation planning continues.

Contract negotiations for specialist OAPS placements continue and are expected to secure delivery of planned savings while demand for acute and PICU beds remains high. As a result associated OAPS cost remains ahead of plan by £0.1m.



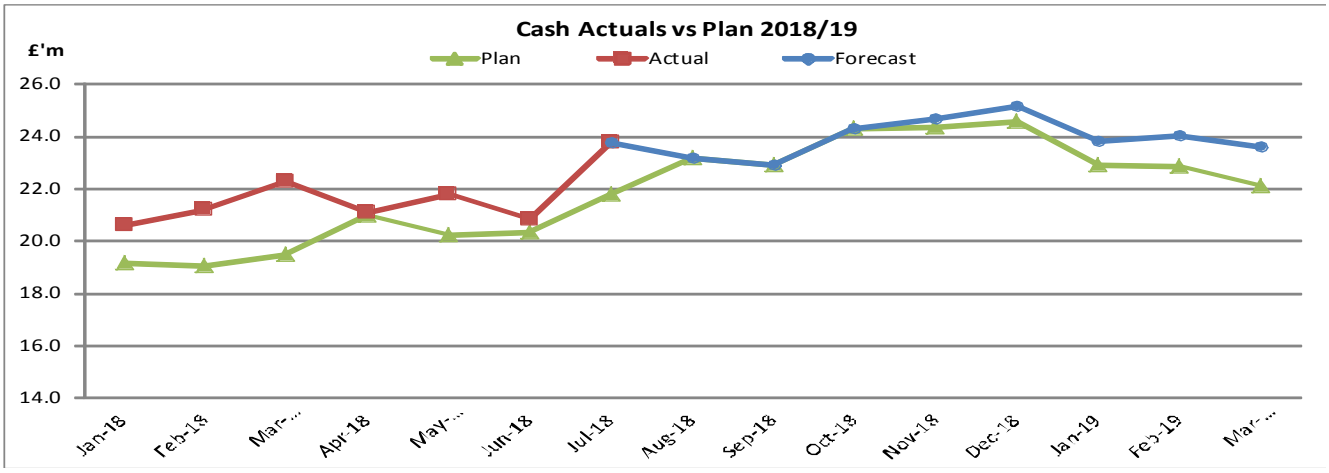
5.0 Balance Sheet & Cash

Balance Sheet		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	4.9	4.9	0.0	4.9	4.9	0.0	5.5
Property, Plant & Equipment (non PFI)		35.1	30.9	35.0	0.3	30.9	35.0	0.3	38.5
Property, Plant & Equipment (PFI)		55.6	59.7	55.4	(0.0)	59.7	55.4	(0.0)	55.6
Total Non Current Assets		**95.2**	**95.6**	**95.3**	***0.3***	**95.6**	**95.3**	***0.3***	**99.6**
Trade Receivables & Accruals		13.4	15.1	13.9	1.2	15.1	13.9	1.2	10.8
Other Receivables		0.3	0.2	1.3	(1.0)	0.2	1.3	(1.0)	1.3
Cash		22.3	23.8	21.8	2.0	23.8	21.8	2.0	22.1
Trade Payables & Accruals		(23.7)	(25.0)	(24.4)	(0.7)	(25.0)	(24.4)	(0.7)	(24.6)
Current PFI Finance Lease		(1.0)	(1.1)	(1.1)	(0.0)	(1.1)	(1.1)	(0.0)	(1.2)
Other Current Payables		(2.3)	(2.8)	(2.3)	(0.5)	(2.8)	(2.3)	(0.5)	(2.3)
Total Net Current Assets / (Liabilities)		**9.0**	**10.2**	**9.3**	***0.9***	**10.2**	**9.3**	***0.9***	**6.1**
Non Current PFI Finance Lease		(29.7)	(29.3)	(29.3)	0.0	(29.3)	(29.3)	0.0	(28.5)
Other Non Current Payables		(1.6)	(1.7)	(1.6)	(0.1)	(1.7)	(1.6)	(0.1)	(1.6)
Total Net Assets		***72.9***	***74.8***	***73.7***	***1.1***	***74.8***	***73.7***	***1.1***	***75.6***
Income & Expenditure Reserve		19.9	21.4	20.3	1.1	21.4	20.3	1.1	22.2
Public Dividend Capital Reserve		16.0	16.3	16.3	0.0	16.3	16.3	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***	***74.8***	***73.7***	***1.1***	***74.8***	***73.7***	***1.1***	***75.6***

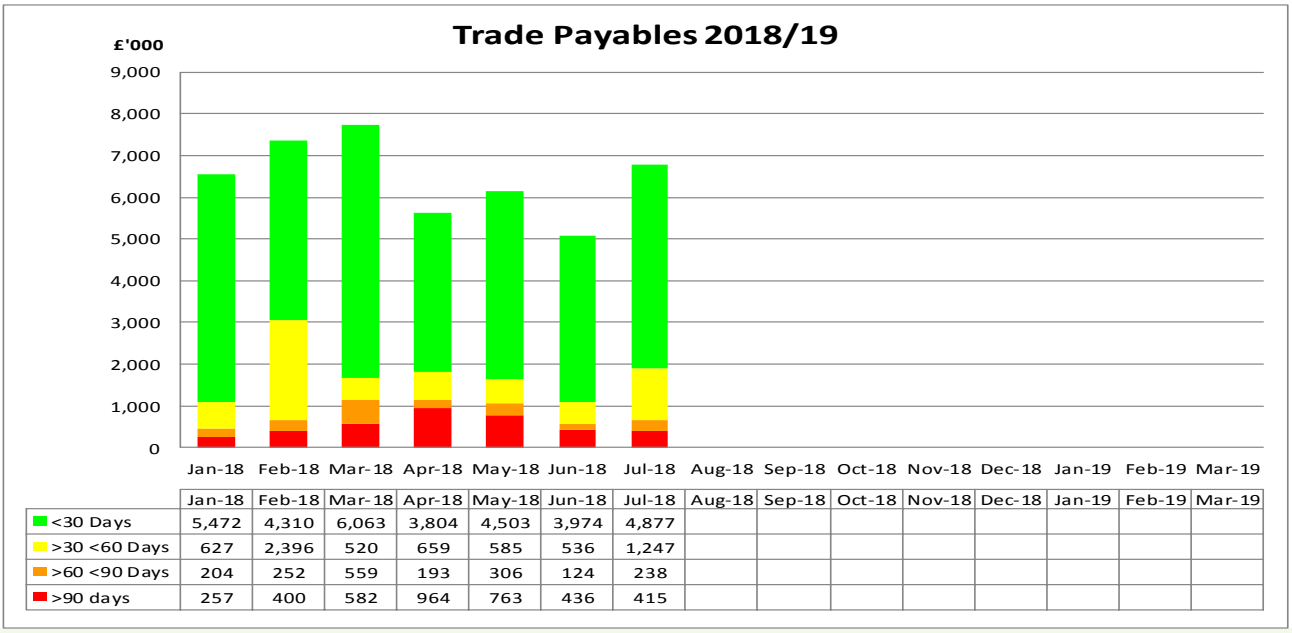
Cashflow		17/18 Actual £'m	Current Month Act £'m	Current Month Plan £'m	Current Month Var £'m	YTD Act £'m	YTD Plan £'m	YTD Var £'m	18/19 Plan £'m
Operating Surplus/(Deficit)	+/-	10.7	0.8	0.5	0.3	3.2	2.2	1.1	7.8
Depreciation and Impairments	+	5.4	0.3	0.5	(0.1)	1.5	1.6	(0.1)	5.7
Operating Cashflow		***16.1***	***1.1***	***1.0***	***0.1***	***4.7***	***3.8***	***1.0***	***13.4***
Net Working Capital Movements	***+/-***	***(2.1)***	***2.4***	***1.0***	***1.4***	***(0.9)***	***(2.5)***	***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)	(0.4)	(0.1)	(1.8)	(1.3)	(0.5)	(9.1)
Investments		***(10.2)***	***(0.5)***	***(0.4)***	***(0.1)***	***(1.0)***	***(0.5)***	***(0.5)***	***(7.5)***
PFI Finance Lease Repayment	-	(1.0)	(0.1)	(0.1)	0.0	(0.4)	(0.3)	(0.0)	(1.0)
Net Interest	+/-	(3.5)	(0.3)	(0.3)	(0.0)	(1.2)	(1.2)	0.0	(3.6)
PDC Revieved	+	1.8	0.3	0.3	0.0	0.3	0.3	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)***	***(0.1)***	***(0.1)***	***0.0***	***(1.2)***	***(1.2)***	***(0.0)***	***(6.1)***
Other Movements	+/-	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Net Cash In/ (Out) Flow		***1.6***	***3.0***	***1.4***	***1.6***	***1.5***	***(0.5)***	***2.0***	***(0.3)***
Opening Cash		20.7	20.8	20.4	0.4	22.3	22.3	0.0	22.3
Closing Cash		***22.3***	***23.8***	***21.8***	***2.0***	***23.8***	***21.8***	***2.0***	***22.0***

Key Messages

Closing cash balance for July above plan by £2m. Contributing factors was receipt of accrued STF bonus funding from 2017/18 received earlier than anticipated (£1.6m); YTD I&E surplus higher than plan (£1m); offset by outflow of cash against capital programme in respect of 18/19 programme and accruals from 17/18 (£0.5m).



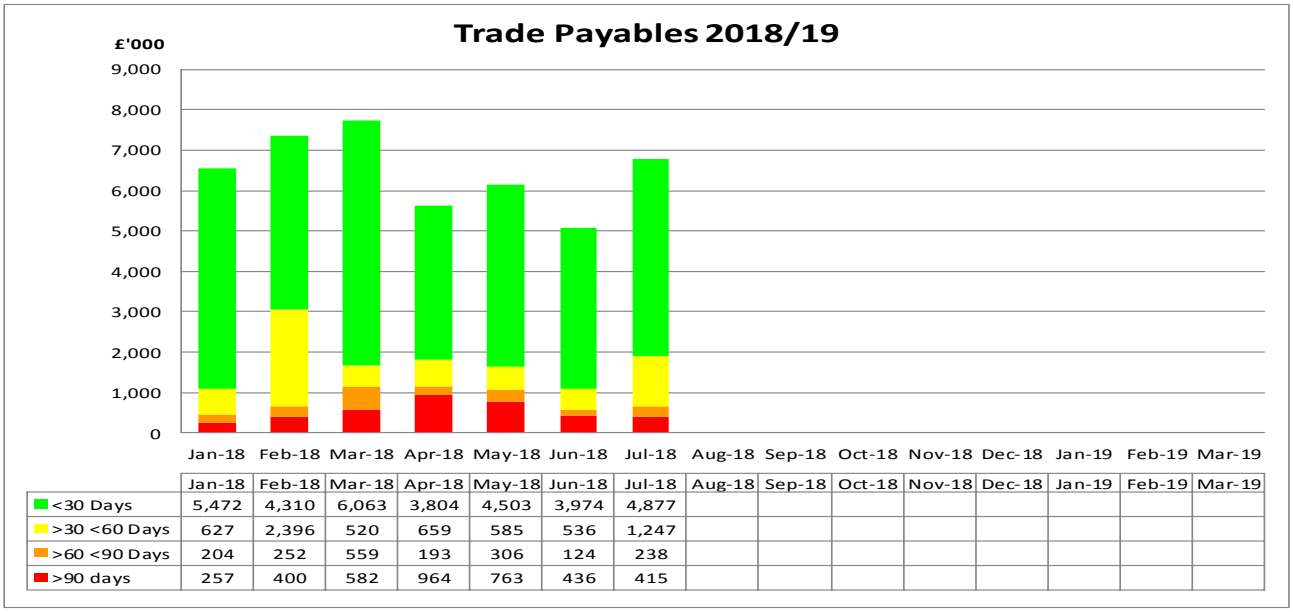
Cash Management



	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	5,472	4,310	6,063	3,804	4,503	3,974	4,877								
>30 <60 Days	627	2,396	520	659	585	536	1,247								
>60 <90 Days	204	252	559	193	306	124	238								
>90 days	257	400	582	964	763	436	415								

Key Message

Trade Receivables increased by £1.3m primary as a result of raising invoices to NHS Property Services for June and July SLA payments in anticipation of reaching agreement of payment of invoices for period April to July 2018. Total NHSPS debt at the end of M04 was £3m with £1.6m impacting over 60 and 90 aged debt. NHSPS have since settled £1.3m of this debt, albeit the most recent charges invoiced.



	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	3,974	4,877								
>30 <60 Days	627	2,396	520	659	585	536	1,247								
>60 <90 Days	204	252	559	193	306	124	238								
>90 days	257	400	582	964	763	436	415								

Key Message

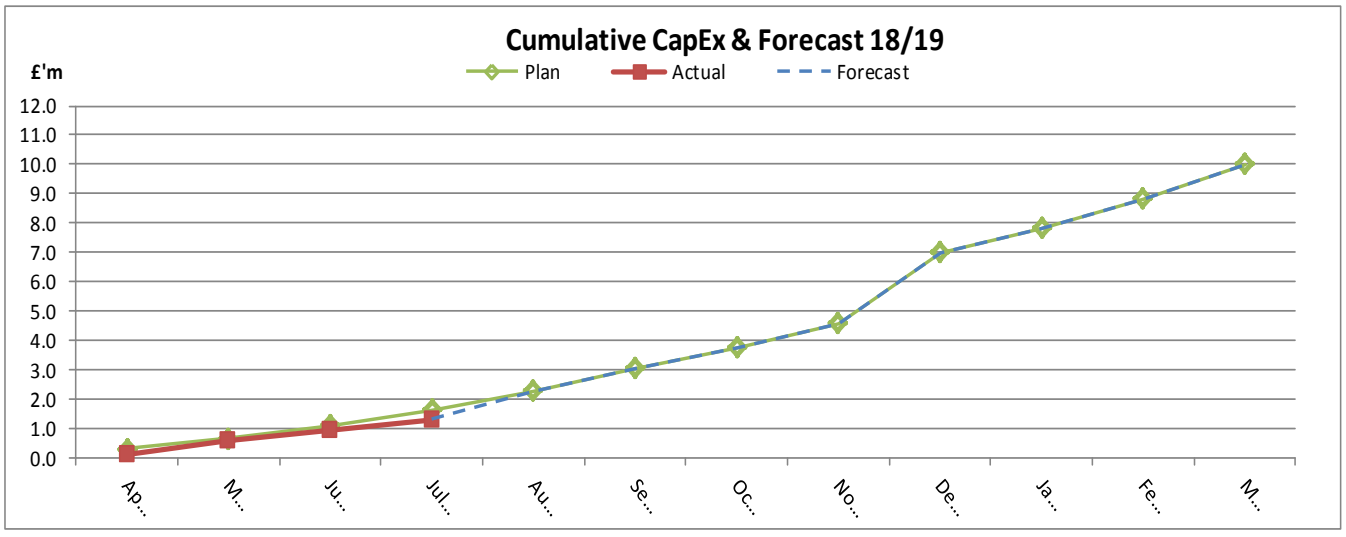
Trade Payables increased by £1.7m from receipt of Q2 invoices from NHS Property Services, although all Q1 charges have now been settled. Over 90 days aged debt includes balances due to Frimley Health for Pathology awaiting approval by operational management. Actions taken to try and get resolved for payment during August. YTD BPPC 90% (target 95%). Underperformance due to delays in approval of invoices and completing GRNs for Estates and IT capital spend.

6.0 Capital Programme

Schemes	Current Month			Year to Date			FY
	Actual £'000	Plan £'000	Variance £'000	Actual £'000	Plan £'000	Variance £'000	Plan £'000
Estates Maintenance & Replacement Expenditure							
Trust Owned Properties	13	118	(105)	70	193	(123)	755
Leased Non Commercial (NHSPS)	59	19	40	146	108	38	735
Leased Commercial	0	0	0	0	0	0	0
Statutory Compliance	63	10	53	96	23	73	448
Locality Consolidations	6	0	6	15	50	(35)	1,600
PFI	3	10	(7)	136	229	(92)	1,380
Subtotal Estates Maintenance & Replacement	**144**	**157**	**(13)**	**463**	**603**	**(140)**	**4,918**
IM&T Expenditure							
IM&T Refresh & Replacement	18	81	(63)	134	239	(105)	3,187
IM&T Business Intelligence and Reporting	0	10	(10)	2	55	(53)	130
IM&T System & Network Developments	0	0	0	(0)	0	(0)	0
IM&T Other	15	6	9	19	18	1	95
IM&T Locality Schemes	46	0	46	126	0	126	200
Subtotal IM&T Expenditure	**78**	**97**	**(19)**	**281**	**312**	**(31)**	**3,612**
GDE Expenditure							
GDE Trust Funded	153	261	(108)	173	344	(171)	1,985
GDE funded by NHS Digital	0	0	0	335	335	0	335
Subtotal GDE Expenditure	**153**	**261**	**(108)**	**508**	**679**	**(171)**	**2,320**
Other Locality Schemes	(38)	0	(38)	41	0	41	150
Subtotal Capital Expenditure	**337**	**515**	**(178)**	**1,293**	**1,594**	**(301)**	**11,000**
Assumed Slippage within NHSI Plan		0	0		0	0	(1,000)
Subtotal Capital Expenditure vs NHSI Plan	**337**	**515**	**(178)**	**1,293**	**1,594**	**(301)**	**10,000**
Donated Assets							
Renal Unit at WBCH	325	325	0	584	584	0	697
Subtotal Donated Assets	**325**	**325**	**0**	**584**	**584**	**0**	**697**
Total Capital Expenditure	**662**	**840**	**(178)**	**1,877**	**2,177**	**(301)**	**10,697**

Key Message

The Trust has submitted a £10m annual capital plan to NHSI. This plan is fully funded by the Trust except for £0.4m funding from NHS Digital, which has been drawdown 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.



Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	11th September 2018
Title	**Summary Board Performance Report M4 2018/19**
Purpose	To provide the Board with a performance summary dashboard, including narrative and KPI exception highlights.
Business Area	Trust-wide Performance
Author	Chief Financial Officer
Relevant Strategic Objectives	2 - To provide safe, clinically effective services that meet the assessed needs of patients, improve their experience and outcome of care and consistently meet or exceed the standards of CQC and other stakeholders.
CQC Registration/Patient Care Impacts	All relevant essential standards of care.
Resource Impacts	None.
Legal Implications	None.
Equality and Diversity Implications	None.
SUMMARY	The enclosed summary performance report provides information against the Trust's performance dashboard for July 2018. **Month 4** **2017/18 <u>EXCEPTIONS</u>** **The following Trust Performance Scorecard Summary indicator grouping is Red rated:** The "red" indicator grouping has been rated on an override basis, related to 1 specific indicator; • Service Efficiency and Effectiveness – RED **The following Trust Performance Scorecard Summary indicator groupings are Amber rated:** • People • NHS Improvement (non-financial) • Contractual Performance Further detail on the AMBER dashboard ratings is

	narrated within the section commentaries of the summary performance report (excluding contractual performance). **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-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-03** – Sickness **(People)** • DQMI – **NHS Improvement (non-financial)** • **SE-03** - Mental Health: Acute Average LOS (bed days) **(Service Efficiency & Effectiveness)** • **SE-03a** - Mental Health: Acute Average LOS Snapshot **(Service Efficiency & Effectiveness)** • **SE-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.

Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

Board Summary Performance Report

M4: 2018/19 July 2018

Performance Scorecard Summary: Month 4 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)	Amber	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; M4: July 2018:

- Mental Health 7 day follow up
- Mental Health new EIP cases seen within 2 weeks
- DM01 Diagnostics for Audiology – percentage of those waiting 6 weeks or more
- MHSDS – Data Quality Maturity Index
- A&E maximum waiting time of 4 hours, RTT Incomplete Pathways, IAPT 6 Weeks and 18 weeks, reduction in OAPS against agreed trajectory
- Failure against published thresholds for Infection Control rates for Clostridium Difficile, E-Coli, MSSA and MRSA.

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

Subjective

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

Exception report

Summary of Red Exceptions M4: 2018/19			
Indicator	**Indicator No**	**Comments**	**Section**
Mental Health Physical Assaults on Staff	US 01a	Decreased from 86 to 72	User Safety
Mental Health Physical Patient to Patient Assaults	US 02a	Decreased from 51 to 48	User Safety
Self-Harm incidents	US 05	Decreased from 317 to 263	User Safety
Absent Without Leave (AWOLS)	US 06	Increased from 26 to 30	User Safety
Prevention and Management of Violence and Aggression (PMVA)	US 18	Increased from 51 to 52	User Safety
Staff Turnover	PM 01	Decreased from 16.8% to 16.7%	People Management
Sickness	PM 03	Increased from 3.58% to 3.74%	People Management
Data Quality Maturity Index Score (DQMI)	NHSi	Decreased from 97.5 to 94.2	NHS i
Mental Health Acute Length of Stay	SE 03	Decreased from 40 days to 35 days	Service Efficiency
Mental Health Acute Snapshot Length of Stay	SE 03a	Decreased from 50 days to 53 days	Service Efficiency
Community Health Services Inpatient Occupancy	SE 05	Increased from 71% to 78%	Service Efficiency
Mental Health Acute Occupancy Rate by Locality and Ward	SE 06 a & b	Increased from 94% to 96%	Service Efficiency
New Birth Visits within 14 days	SE 08	Increased from 91% to 93%	Service Efficiency
Mental Health Clustering	SE 10	Increased from 84.4% to 86.4%	Service Efficiency

User Safety Commentary

There were 4 serious incidents in July 2018. These were; 1 suspected suicide (Common Point of Entry), 1 attempted suicide (Reading Care Pathways), and 2 unexpected deaths (1 each for Reading Care Pathways and 1 Wokingham Community Hospital).

The number of assaults on staff reduced to 72 in the rolling quarter to July 2018 and remains red rated. In the rolling quarter, Mental Health Inpatients reported 67 incidents (61 last month), 15 incidents were reported on Sorrel ward (22 last month), 6 on Daisy ward (same as last month), 7 incidents on Bluebell ward (5 last month), 12 on Snowdrop ward (13 last month), 9 on Rowan ward (8 last month), 11 incidents were reported on Rose ward (2 last month) and 2 incident was reported on Orchid ward (1 last month) and 9 on Rowan (0 last month). In addition 5 incidents took place in the place of safety. In the rolling quarter, 2 incidents were reported at Willow House (CAMHS) (21 last month). In the community there were 4 incidents reported; 1 each for Care Pathways, Criminal Justice and Liaison service, other and Mental Health Liaison services. All incidents which occurred in July 2018 were rated as low risk. This shows an increasing trend.

For Learning Disabilities there was a decrease in the number of assaults on staff from 52 in the rolling quarter to June 2018 to 49 in the rolling quarter to July 2018. 1 incident in July 2018 was rated as moderate and all other incidents in July 2018 were rated as low or minor risk. This shows an increasing trend.

Patient to Patient Assaults has decreased to 48 in the rolling quarter to July 2018 and remains red rated against a local target. 46 reported incidents were in Mental Health Inpatients in the rolling quarter and these occurred as follows; 9 incidents took place on Sorrel ward (13 last month), 11 on Rowan ward (7 last month), 3 on Daisy ward (same last month), 9 on Rose ward (6 last month), 2 on Bluebell ward (3 last month), 3 on Snowdrop ward (5 last month) and 2 occurred at Prospect Park. In the community 1 low risk incident was reported by Reading Care Pathways and another low risk by Reading Older Persons CMHT. At the time of reporting a total of 32 clients carried out assaults on other patients, including 1 client who carried out 6 assaults. This shows an increasing trend.

Learning Disability Patient to Patient Assaults increased to 11 (previously 26) in the rolling quarter to July 2018 and is now green rated. All incidents were rated as low or minor risk and the assaults were carried out by 3 clients, including 1 client responsible for 9 incidents. This shows a decreasing trend.

NRLS - the increase in the number of incidents reported per 1000 bed day was due to a backlog due to increase in reporting over the past year which has been cleared. The Patient Team held a Rapid Improvement Event to look at improving processes on 21st and 22nd June 2018 and 5th July 2018.

Slips Trips and falls –Orchid ward (19 falls) and Rowan ward (4 falls) are above target. Six wards (Donnington, Highclere, Henry Tudor, Rowan, Orchid and Oakwood) have chosen falls as a 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 by.

Self-Harm incidents have decreased to 263 in the rolling quarter to July 2018, and remains rated as red. In Willow House there were 106 incidents (134 last month) reported in the rolling quarter with 32 incidents for one patient and 23 incidents for another. All incidents at Willow House in the month of July 2018 were rated as low or minor risk. There were a total of 129 incidents reported in the rolling quarter to July 2018 by Mental Health Inpatients which is a reduction from 159 in the rolling quarter to June 2018. Of these, 14 incidents were reported on Rose ward (26 last month), 32 on Bluebell ward (38 last month), 27 on Daisy ward (42 last month) and 44 on Snowdrop ward (46 last month). There were also incidents reported as follows; 2 incidents Other/Unknown location, 3 at A&E, 5 in a public place/street and 1 in

the place of safety. At the time of reporting 19 inpatients self-harmed during the rolling quarter with one client responsible for 14 incidents. All incidents were rated as low or minor risk. In the community in the rolling quarter; 24 incidents reported by Mental Health West, 7 by Talking Therapies and 13 by Crisis team and 4 by Care Pathways. 4 incidents were reported by Mental Health East which were; 3 by Bracknell Care Pathways and 1 by Slough Care Pathways. This shows an increasing trend. For Mental Health inpatients including Willow House this is a Quality Improvement programme breakthrough objective.

Learning Disability Self-harm decreased to 1 in the rolling quarter to July 2018. This shows a decreasing trend.

Self-Harm incidents have decreased to 263 in the rolling quarter to July 2018 and remains rated as red. In Willow House there were 106 incidents (134 last month) reported in the rolling quarter with 32 incidents for one patient and 23 incidents for another. All incidents at Willow House in the month of July 2018 were rated as low or minor risk. There were a total of 129 incidents reported in the rolling quarter to July 2018 by Mental Health Inpatients; which is a reduction from 159 in the rolling quarter to June 2018. Of these, 14 incidents were reported on Rose ward (26 last month), 32 on Bluebell ward (38 last month), 27 on Daisy ward (42 last month) and 44 on Snowdrop ward (46 last month). There were also incidents reported as follows; 2 incidents Other/Unknown location, 3 at A&E, 5 in public place/street and 1 in the place of safety. At the time of reporting 19 inpatients self-harmed during the rolling quarter with one client responsible for 14 incidents. All incidents were rated as low or minor risk. In the community in the rolling quarter; 24 incidents reported by Mental Health West, 7 by Talking Therapies, 13 the Crisis team and 4 by Care Pathways. 4 Incidents were reported by Mental Health East which were 3 by Bracknell Care Pathways and 1 by Slough Care Pathways. This shows an increasing trend. For Mental Health inpatients including Willow House, this is a Quality Improvement programme breakthrough objective.

Learning Disability Self Harm – decreased to 1 in the rolling quarter to July 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. AWOLS (30) increased and Absconsions (14) decreased in the rolling quarter to July 2018. In July 2018 there were 12 AWOLS; these were 2 each for Bluebell ward, Daisy ward, Snowdrop ward, Rose ward and Prospect Park and 1 each for Sorrell ward and Orchid ward. There were 3 Absconsions s in July 2018, 2 from Daisy ward and 1 from Snowdrop ward. Both AWOLs and Absconsions show decreasing trends.

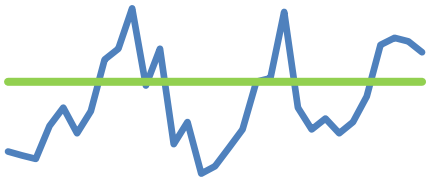
PMVA (Control and Restraint of Mental Health patients) – At the time of reporting, there were 52 uses of PMVA in July 2018. There were 3 incidents on Snowdrop, 11 incidents on Bluebell ward, 7 on Rose ward, 3 on Daisy, 1 on Rowan ward, 13 on Sorrel ward and 3 on Orchid ward. 6 incidents were reported at Willow House.

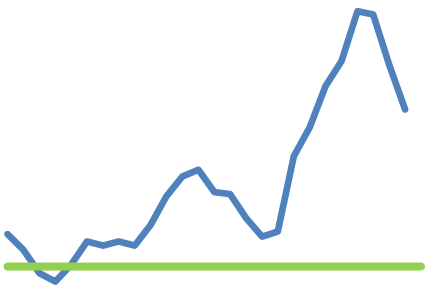
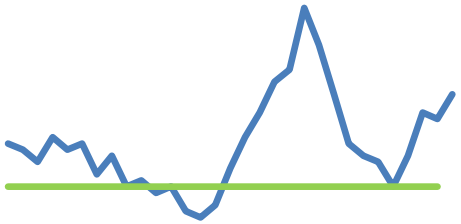
There were 3 incidents of prone restraint in July 2018, 1 each on Rose ward, Daisy ward and Prospect Park. The trend for the use of prone restraint is downwards, when measured over a 3-year period. A programme of work is in place to reduce the use of prone restraint on the wards by 90% by the end of 2018/19 and a Rapid Improvement event took place in July 2018.

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

Seclusion: In July 2018, in Mental Health Inpatients there were 14 incidents of seclusion with the longest incident lasting 68 hours and 40 minutes. There was 1 use of seclusion by Learning Disability Services which was for 3 hours and 15 minutes.

User Safety Exception Report Month 4: 2018/19

KPI	Target	Jul-18	Trend	Context/Reasons	Commentary of Trend
Mental Health Physical Assaults on Staff	<70	72		**Mental Health Physical Assaults on Staff show an increase in incidents reported in the rolling quarter in Older Person's Mental Health. This is measured against a local target.**	**In the 2016/17 Mental Health NHS Benchmarking exercise, this Trust was in the upper quartile of numbers of physical violence to staff at 867 incidents per 100,000 occupied bed days excluding leave.**
Mental Health Physical Patient to Patient Assaults	<40	48		**Physical Patient to Patient Assaults were carried out by 32 patients in the rolling quarter. 1 of which carried 6 assaults. This is measured against a local target.**	**In the 2016/17 Mental Health NHS Benchmarking exercise, this Trust was in the upper quartile of numbers of physical patient to patient assaults at 512 incidents per 100,000 occupied bed days excluding leave.**

KPI	Target	Jul-18	Trend	Context/Reasons	Commentary of Trend
Self-Harm incidents	<75	263		**Self-Harm incidents reduced in Adult Acute Mental Health Inpatients and CAMHS Inpatients. 1 individual was responsible for 32 incidents. This is measured against a local target.**	
AWOLs on MHA Section	<15	30		**AWOLS increased in the rolling quarter to July 2018. There was an 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.**

KPI	Target	Jul-18	Trend	Context/Reasons	Commentary of Trend
Preventing and Managing Violence and Aggression (PMVA)	**<41**	**52**		**This is the number of physical restraints of patients on our Mental Health Inpatient wards. This 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:

- AWOLs have worsened from 26 in the rolling quarter to June 2018 to 30 in the rolling quarter to July 2018.
- Prevention and Management of Violence and Aggression (PMVA) has worsened from 51 in the month of June 2018 to 52 in the month of July 2018.
- Prone Restraint has worsened from 2 uses in June 2018 to 3 uses in July 2018.
- Use of seclusion has worsened from 6 in June 2018 to 14 in July 2018.
- Learning Disability Strategy for Crisis Intervention and Prevention worsened from 7 uses in June 2018 to 8 uses in July 2018.

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

- Mental Health Physical Assaults on Staff improved from 86 in the rolling quarter to June 2018 to 72 in the rolling quarter to July 2018.
- Mental Health Patient to Patient Assaults improved from 51 in the rolling quarter to June 2018 to 48 in the rolling quarter to July 2018.
- Mental Health Self-Harm incidents have improved from 317 in the rolling quarter to June 2018 to 263 in the rolling quarter to July 2018.
- Learning Disability Physical Assaults on Staff has improved from 52 in the rolling quarter to June 2018 to 48 in the rolling quarter to July 2018.
- Learning Disability Patient to Patient Assaults has improved from 27 in the rolling quarter to June 2018 to 11 in the rolling quarter to July 2018.
- Learning Disability self-harm has improved from 6 incidents in the rolling quarter to June 2018 to 1 in the rolling quarter to July 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 Sickness rates for June 2018), 2 are amber (Fire training and Information Governance training), 3 are green (Gross Vacancies, Statutory training - Health and Safety and Manual Handling). The provisional sickness figure is no longer reported and the PDP target was for completion in May 2018.

Sickness Absence

• The final Trust-wide monthly sickness rate for June increased to 3.74%, from 3.54% in May with an increase in the number of working days lost to sickness. However, based on hourly rates, the cost of absence in June decreased to £357,945 (May was £362,575).

• There was a decrease in the short-term sickness rate in June which is attributed to a further decrease in absences due to cold/cough/flu, although absences for this reason continue to be higher than the same period last year.

• There has been a further increase in the long term sickness rate in June to 2.19%, from 2.07% in May. Analysis of the reasons for long-term sickness and associated trends indicates that this increase is attributed to the following:

o An increase in the long-term sickness rate due to musculoskeletal/back problems to 0.48%, from 0.44% in May. However, this rate is still showing a downward trend from 0.66% in December.

o A further increase in the long-term sickness rate due to anxiety/stress/depression to 0.78% (from 0.73% in April).

o An increase in the long-term sickness rate due to cancer; we will undertake further analysis to ensure that these cases are being sensitively yet effectively managed

• In addition to an increase in the long-term sickness rate; the total sickness rate attributed to anxiety/stress/depression has also increased in June to 1.03%, from 0.92% in May, with a clear upward trend evident in the last three months. Sickness for this reason accounted for 27.5% of all sickness in June. The number of WTE days lost due to anxiety/stress/depression absence in June increased to 1,121 although, based on hourly rates, the cost of absence for this reason decreased to £105,430. The HR Managers continue to work within their localities to identify and support the implementation of initiatives to address stress related sickness absence. Although the quantitative impact of these initiatives on the sickness data may not be evident for a further 2-3 months, the data will be kept under review and action plans adjusted as required.

• In order to better understand the increase in the level of stress related absence, the HR Managers will undertake some analysis of the data to be clearer about the

causes of stress and in particular whether it is work or non-work related.

Recruitment

• A number of local initiatives have been identified which are linked to, and aim to capitalise on, the national "We are the NHS" recruitment campaign. By the end of August, all nursing leavers in the last two years will receive a personalised letter encouraging them to consider re-employment with the Trust, and a dedicated text number will be advertised which, if contacted, will result in a prompt call back to discuss vacancies and opportunities for employment with the Trust.

• A number of other initiatives are planned to continue to address recruitment to hard to fill posts including:

o A review of the process for recruiting nursing students who have been on placement at the Trust, with a view to improving the transition from placement to employment.

o Development of a depository of recruitment documents on TeamNet to provide recruiting managers with templates for adverts, team profile information, etc.

o Development of an engagement plan to ensure regular communication with candidates from job offer to start date, to reduce the number of candidates who withdraw from a job offer during the pre-employment checking process.

Turnover

• The Trust-wide turnover rate in July has decreased to 16.68%, from 16.79% in June. The turnover rate in Oxford Health (May 2018) was 16.47%.

• The results of the 'stay survey' circulated to all community nursing staff in East and West adult services have been analysed and the key areas for action are: flexible working; flexible retirement; development and career planning to include coaching, mentoring and career clinics; mobile working and IT issues; and protected break times. A lead has been identified in both East and West to progress the more detailed action planning based on these themes. It is also anticipated that this work will have a positive impact on the level of stress related sickness absences in these teams.

• An HR Operations Manager has been recruited to work alongside the management team at Prospect Park Hospital, to provide dedicated HR expertise to the identification and implementation of strategies to improve recruitment, retention and engagement. This work will begin in September 2018.

Statutory and Mandatory Training

Statutory Training – Fire Training has reduced to 89% with all localities below target. Weekly reports are still being sent to Locality Directors and for Corporate staff detailing non-compliance. The Head of Training and Organisational Development has also been sending emails to staff who are non-compliant. Largest area of non-compliance are Estates and Facilities who are being offered training with a paper-based test. For Manual Handling - compliance in Mental Health Inpatients is 69%; there is work on-on-going between the locality and the lead for Manual Handling to ensure that staff have the correct level of training attributed to them on ESR.

Mandatory Training - Information Governance has decreased to 91% and is below target. Weekly reports are still being sent to Locality Directors for action. 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 are amongst the highest number of non-compliant staff. For the Information Governance Toolkit submission in March 2018, the Trust achieved the 95% target.

PDP - Target for May 2018 has now been achieved.

People Exception Report Month 4 2018/19

KPI	Target	Jul-18	Trend	Context/Reasons	Commentary of Trend
Staff Turnover (% YTD): Percent	**<15.2%**	**16.74%**		**Increase in turnover target from September 2016. This remains a challenging stretch target for the Trust. Turnover rates have reduced over the previous 12 months. This includes end of fixed-term contracts, retirements as well as voluntary resignations.**	**NHS Digital published data on The Stability Index for the period March 2017 to March 2018 published on 21st August 2018. The Trust is working to understand its position in relation to this new indicator.**

Sickness percent (June 2018)	**<3.5%**	**3.74%**		**The short-term sickness rate has reduced to 0.78%, and the long-term sickness has increased to 2.26%.**	**The most recently published NHS Staff Sickness Absence rates published on 26th July 2018 show that for March 2018 the NHS England overall sickness rate was at 4.51% and 4.08% for the Thames Valley.**

Other Key Performance Highlights for this Section

- Sickness has worsened from 3.58% in May 2018 to 3.74% in June 2018.
- Staff Turnover has improved from 16.8% in June 2018 to 16.7% in July 2018.
- Gross vacancies have worsened from 9.1% in June 2018 to 9.3% in July 2018.
- Statutory Training: Fire training has worsened from 90% in June 2018 to 89% in July 2018.
- Mandatory Training: Information Governance training has worsened from 92% in June 2018 to 91% to July 2018.

NHS Improvement Non-Financial and Financial Commentary

The Single Oversight Framework for 2018/19 - this section is amber rated due to below target DQMI score and the metrics are as follows:

In Quarter 4 -2017/18 the Trust were below the 99% target for DM01 diagnostic testing within 6 weeks for Audiology services, however the Trust recovered the position in Quarter 1 2018/19 and for July 2018 the Trust remains at 100%.

• Introduction of the Data Quality Maturity Index (DQMI) (MHSDS dataset score) – this will cover submissions of the following fields and published scores for Quarter 4 2017/18 are below:

- 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 (100%)

The Trust was given an overall data set a DQMI Score 94.2% for the Mental Health Services Data Set (MHSDS), against a target of 95% for the MHSDS. NHS Digital have included 3 additional fields which are not mentioned in the Single Oversight Framework. These are Primary Reason for Referral (Trust score 60%), Service or Team Type referred to (Trust score 100%), Mental Health Act Legal Status (Trust Score 100%). In this area DQMI scores were as follows Oxford Health at 94.1%, Surrey Borders 85.3% and Southern Health at 86.7% for the MHSDS. Only 12 Trusts were above 95% target for DQMI for MHSDS. A conference call took place on 23rd August 2018 between NHSi and the Trust's Senior Performance Manager to discuss the DQMI score with a further conference call with the Single Oversight Team to take place.

Inappropriate Out of Area placements, the Single Oversight Framework measures progress against the ICS trajectories for Frimley and Berkshire West. The guidance published by NHSi in their bulletin on 11th July 2018, states that "In the 2017 SOF update we added an indicator on reducing OAPs to the SOF to help us understand the progress being made to meet this ambition. From September 2018 onwards we will be monitoring providers' progress against the trajectories submitted to STPs in January. Substantial variation against a provider's trajectory will trigger a discussion to determine:

• whether support is required (if OAPs are substantially higher than predicted by the trajectory)
• whether quality and safety are being maintained (if OAPs are substantially lower than predicted by the trajectory, e.g. sudden reductions in OAPs can result in unintended consequences such as increased pressure on EDs).

In the period until September, discussions will be triggered if substantial increases or decreases in OAPs are noted from one month to another. We are committed to supporting providers to eliminate inappropriate OAPs by 2021 whilst ensuring safe care." For Quarter 2 2018/2019 the Trust was below target:

- Berkshire West CCG - 62 bed days against a Quarter 2 2018 target of 396 bed days.
- East Berkshire CCG - 113 bed days against a Quarter 2 2018 target of 380 bed days.

• Proportion of people completing treatment who move to recovery (from IAPT minimum dataset). For July 2018 the Trust achieved 57% with all CCGs above the 50% recovery threshold target. This is a reduction from 60% recovery rate in June 2018. The service has been taking on Trauma waiting lists and working with patients with Long Term Conditions.

In addition, Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI) will be included. Work in partnership with acute trusts/CCGs is on-going with organisations within Berkshire seeking to ensure a consistent approach to surveillance. A joint action plan was produced in September 2017; however no health economy target has been set however system targets apply. Methicillin-sensitive Staphylococcus aureus (MSSA) has also been added and the Head of Infection Control has contacted commissioners to ascertain whether there are targets for the Trust but there currently isn't. For July 2018, 2 Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI) were identified 1 on Donnington ward and 1 on Henry Tudor.

The Single Oversight Framework will continue to include an annual rating on the Cardio Metabolic CQUIN. The Trust rates for Q4 2017/18 show that we are above targets shown below:

- Inpatients – 97.86% compliance against 90% target
- Community – 100% compliance against 65% target
- EIP services - 93% compliant against 90% target

Service Efficiency And Effectiveness Commentary

There are 13 indicators within this category, 5 are rated as “Green” including DNA rates, CHS Length of Stay, Mental Health Readmissions and Mental Health Non-Acute Occupancy, and Crisis plans. None are rated as “Amber". 6 are rated “Red”; Mental Health Average and Snapshot Length of Stay, Mental Health Acute occupancy by ward and by locality, CHS Occupancy, Health Visiting and Mental Health Clustering and 1 of which does not have a target (place of safety).

The DNA rate increased from 4.85% in June 2018 to 4.88% in July 2018 and is rated as green. East Mental Health (7.28%) and West Mental Health (7.21%) and CYPF (7.47%) are above target. This indicator shows a decreasing trend.

In CPE, the DNA rate increased from 7.33% in June 2018 to 8.60% in June 2018.

In Children and Families Community Paediatrics at 8.97%, Health Visiting 7.49%, School Nursing 11% and CAMHS 9.33% are above the 6% target.

For Mental Health East; IMPACTT at 12.78%, East Adult CMHTs at 8.38% are above target. In West Mental Health, Clinical Health Psychology 15.47%, Adult Mental Health 8.11%, Trauma 14.29%, Neuropsychology 7.56% 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 onto RiO in the correct format. In July 2018 12,388 text messages were sent. As part of the GDE Digital Correspondence project patients have been sent details of their appointments digitally using a portal. A total of 1,428 first appointments and 12,600 reminders have been sent since go live on 29th May 2018, with a further tranche of services that went live on 10th and 11th July 2018.

Community Health Services Inpatient Average Length of Stay decreased to 23 days and is below target, with Slough and West Berkshire above target. Delayed transfers there have been some improvements in Slough 2.7% (last month 9.5%), Wokingham 9.2% (last month 10.7%), Reading 5.1% (last month 13%) and West Berkshire 4.3% (last month 4.8%). WAM worsened to 9.2% (last month 6.6%). A total of 38 patients’ discharges were delayed in July 2018; 22 of these are the responsibility of the NHS, and 6 are the responsibility of social care and 10 are joint health and social care responsibility. The most common reason for a delay was awaiting care package in own home (total 18; 8 for health, 3 social care, and 7 joint responsibility health and social care). 10 are awaiting care home placement, 5 are the responsibility of health, 3 are social care, and 2 are the responsibility of both.

Mental Health Acute Occupancy excluding home leave increased to 96% in July 2018.

The Average Length of Stay for Mental Health remained at 35 days in July 2018 and the acute snapshot length of stay increased to 53 days in July 2018 and continues to remain above target. Of the 200 clients discharged during May 2018 to July 2018, 64% (128 had lengths of stay below 30 days). 13 clients who were discharged in the period had lengths of stay above 90 days, including 10 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 8th August 2018 there were a total of 3 acute clients who were agreed delayed transfers of care (a decrease from 11 last month); by ward these are 2 on Snowdrop ward and 1 on Daisy ward. By locality, there are 2 for Wokingham clients, and 1 with a locality of Kingston.

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. All areas were above target except Bracknell.

As at the 14th August 2018, there were 2 Female PICU and 2 female acute adult mental health patients in out of area placements. For July 2018, a total of 5 patients were placed out of area, which included 1 acute patient and 4 PICU clients.

Older Adults Mental Health wards length of stay is 91 days for Rowan ward and 46 days Orchid ward for clients discharged.

Community Health Services Occupancy is below the 80% lower threshold at 78% and is therefore red rated. The CCGs 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 and then to QEG before submission to commissioners.

Mental Health Readmission rates remained at 8.3% in July 2018 which is below the 9% target; none of the localities are above target.

Community Services benchmarking – data collection for 2017/18 opened on 21st May 2018 and closes on 24th August 2018.

Mental Health Benchmarking – Collection has opened and a first submission has been sent and validation is underway a draft report is due in August 2018.

CAMHS Benchmarking 2017/18 has completed and has been submitted.

Mental Health Clustering has increased to 86.4% compliance but remains below the 95% target. There were issues with the clustering tool not working correctly for a period of 2 and half weeks from April to beginning of May which has 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 increased to 43 uses in July 2018, with 3 uses for minors. Of these 43 uses of the place of safety, 25 were admitted following assessment including 21 under Section 2 of the Mental Health Act. 10 clients waited over 8 hours for an assessment. None waited over 24 hours. The reasons for the delays in assessment include bed availability, patient intoxication, and availability of AMHP/assessing Doctor. 17 out of the 43 assessments were carried out by Berkshire Healthcare NHS Foundation Trust Section 12 Doctors. The most common time in July 2018 to be brought to the place of safety was between was 12 noon to 3pm followed by 3pm to 6pm. The most common days for detention in July 2018 were Tuesday with 9 detentions followed by 8 uses each on Wednesday and Thursday.

Crisis plans is above target at 96% with all areas above target when incomplete plans are included in the total.

Health Visiting is below target at 92.8%. Of the 34 cases not seen within 14 days 24% (8 each) were still in hospital or declined appointment, 21% (7) were due to lack of

staff capacity, 15% (5) no access, 6% (2 each) were due to late notification or no response from family. Of 34 cases not seen within target, 23 were outside of the control of the trust and it is not perceived as an issue with the number of breaches. The indicator has been overridden to Amber status as no quality or safety concerns were identified and the threshold will be reviewed by the Director of Nursing and Governance.

System Resilience – Frimley Health NHS Foundation Trust achieved 90.8% for Type 1 A&E attendances in July 2018.

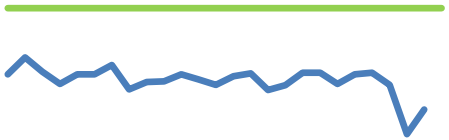
In the West – the A&E waiting times national return for July 2018 show the Royal Berkshire Hospital achieved 95.0% Tier 1 A&E attendances and 95.6% against Tier 1-3 attendances. Nationally only 83.5% of patients waiting at a Tier 1 A&E services met the target for the discharged, admitted transferred within 4 hours of arrival, and a national average 89.3% for all Tier 1-3 attendances during July 2018. The Trust's Minor Injury Unit achieved 99.67% 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 15th August 2018. In terms of Inpatients on 15th August 2018, there were a total of 12 community beds available at our community hospitals in Berkshire West including 5 male beds at Oakwood.

Service Efficiency And Effectiveness Exception Report Month 4: 2018/19

KPI	Target	Jul-18	Trend	Context/Reasons	Commentary of Trend
Mental Health: Acute Average Length of Stay: Number	**<30 Days**	**35**		**Bed optimisation project underway to look at alternatives to admission, productive stay and productive discharge. Length of stay is reducing.**	**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 at 30.8 days with an average length of stay of 38 days.**
Mental Health Acute Length of Stay Snapshot	**<30 Days**	**53**		**This is a decrease on the preceding month, but reflects the acuity of clients and the number of delayed transfers of care on the wards.**	

KPI	Target	Jul-18	Trend	Context/Reasons	Commentary of Trend
Mental Health Acute Occupancy rate (excluding Home Leave by Ward/ Locality)	< 90%	96%		Only Bracknell locality was below target. New bed management process including gatekeeping of clients has been introduced.	The cumulative total is a 70% increase in admissions of clients detained under the Mental Health Act since 2015/16. Quarter 1 2018/19 shows a further 1.5% increase in the number of detained patients.
Community Health Services Occupancy Rate	< 80%	78%		In July 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	Jul-18	Trend	Context/Reasons	Commentary of Trend
Health Visiting: New Birth Visits Within 14 days	**95%**	**92.8%**		**Of those not seen the reasons were 24% each mother or baby were still in hospital or family declined visit, 21% were due to lack of staff capacity, 15% due to no access, 6% each were due to late notification or contact from family.**	**The Trust is above the 88.5% England average in Quarter 4 2017/18, which is the latest data available on the Public Health England New Birth Visits, published on 26th July 2018.**
Clustering within target	**95%**	**86%**		**There are frequent reviews required for certain clusters which mean that it is difficult to achieve the target. At the end of April 2018, 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 Attends (DNA) rates have worsened from 4.85% in June 2018 to 4.88% in July 2018.
- Community Health Services Length of Stay has improved from 29 days in June 2018 to 23 days in July 2018.
- Mental Health Readmission rates remained at 8.3% in July 2018 (under the 9% target).
- Mental Health Acute occupancy has worsened from 94% in June 2018 to 96% in July 2018.
- Mental Health Non-Acute occupancy worsened from 65% in June 2018 to 71% in July 2018.
- New Birth Visits within 14 days has improved from 91% in June 2018 to 93% in July 2018.
- Clustering improved from 84.4% compliance in June 2018 to 86.4% compliance in July 2018.
- Prospect Park Place of Safety improved from 50 uses in June 2018 to 43 uses in July 2018.

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	11 September 2018
Title	Mental Health Bed Capacity Actions and Bed Optimisation programme update
Purpose	This document has been prepared to update the Board on the actions being taken following the recent mental health bed capacity modelling report and to update the board on the Bed Optimisation programme to address Out of Area Placement pressures.
Business Area	Operations
Author	David Townsend – Chief Operating Officer
Relevant Strategic Objectives	To provide good outcomes from treatment and care and to deliver services that efficient and financially sustainable
CQC Registration	n/a
Resource Impacts	Financial – impact of increased Mental Health bed numbers
Legal Implications	n/a
Equality and Diversity Implications	N/A
SUMMARY	The bed capacity actions are being delivered and the bed optimisation programme is progressing well on delivering the improvements and targets needed. This includes the Length of Stay reduction needed to mitigate an increase in bed numbers, the numbers of people being placed out of area and the system work to deliver on the Five Year Forward View targets for Out of Area Placements. There are programme resources and reporting structures which will continue to monitor the delivery of these targets and improvements.
ACTION REQUIRED	To note the report

Introduction

The board received a report in June, on the Berkshire mental health bed modelling work which provided an in-depth assessment of Berkshire's mental health inpatient bed requirements for the next 10 years.

There were 2 actions from the report findings –

1. Focus internal action on reducing disproportionately high lengths of stay in particular patient cluster groups, rather than reduce already low admission rates
2. Focus external action on engaging system partners to improve rates of delayed discharge.

This paper updates on these actions and provides an update on the bed optimisation programme which is the internal work to address the Average Length of Stay (ALOS)

Bed Optimisation Programme and Length of Stay

A presentation on this programme is attached.
This covers the bed optimisation programme and includes progress on the other 2 areas of work on OAPS – specialist placements and Learning Disability.

The bed optimisation programme was set up over 12 months ago to address the pressures we were experiencing on the high number of Out of Area Placements.

This had 3 workstreams looking at Alternatives to Admission, Productive Stay and Productive Discharge. We looked at best practise elsewhere and identified a number of 'lines of enquiry' to address this pressure.

A number of achievements and improvements were delivered from this but more work was needed to transform the processes and practises which would achieve greater and sustainable changes. Last year we undertook a root cause analysis to identify additional opportunities and these identified Access Pathways, Enhanced Offer of Care and Cluster 8 demand as the areas that would have the greatest impact. The cluster 8 demand is being managed as part of the EUPD Pathway project which has been separately reported to the board

Average Length of Stay and the usage of Acute overspill beds (beds needed out of area as we do not have capacity to admit to Prospect Park hospital) are the two key metrics which are used to measure the impact of the changes being tested.

A programme board monitors progress on a monthly basis, reporting to Business & Strategy Executive meeting and updates are provided to the FIP Board committee. Dedicated project resources are being used with Director SRO and Executive support

Engagement with the programme has been excellent across mental health services and good progress is being made on work programmes, with improvements being seen in both average length of stay and use of OAPs due to lack of capacity at PPH.

The majority of the acute overspill this year has come from the need for PICU placements, as Sorrel Ward has had reduced capacity due to the refurbishment works and we currently have high staff shortages on this ward.
Despite this we are meeting the targets in this year's plan.
This programme will continue to work on the current plan to improve average length of stay to increase capacity and reduce the need for OAPs.

External Engagement

There have been a number of updates provided to system partners on the OAPs pressures over the last year and a greater focus on delayed discharges, numbers of people in OAPs and development of local alternatives in the community.

OAPs is one of the priorities for the mental health Five Year Forward View so we are also working with partners in the 2 Integrated Care Systems and have joint targets to achieve with them, which are reported nationally.
We are providing monthly reports on OAPs to the CCGs as part this.

The bed modelling work has been presented to partners.

In the West it has been reviewed at the Unified Executive meeting and the A&E Delivery board will include the mental health delayed discharges and ALOS on their agenda.

In the East it was reviewed at the System Leaders meeting and a Local authority lead has agreed to discuss what they could do as Local authorities to assist. This is an action which will be reported on at system leaders in September to update what this assistance could look like.

We will continue to engage system partners on our work on OAPs as part of our joint working priorities and targets and to ensure support to new processes developed from the bed optimisation programme

Bed Optimisation Programme

NHS
Berkshire Healthcare
NHS Foundation Trust

Bed Optimisation
Impact & Update

Erif Newman

Previous Work...

Workstreams:

- Alternatives to Admission
- Productive Stay
- Productive Discharge

Achievements

- **Bed manager role** – advertised 3 times. 2/3 individuals to be interviewed end of January
- Gatekeeping - review being undertaken by CRHTT including psychiatrist and senior staff to provide recommendation on improvements and arrangements for on call over the weekends
- CRHTT Model – continued work on service design to increase Home Treatment and planned care
- Business cases for both cluster 8 and 11 produced for review and approval by end January
- Frequent Users Review – analysis being undertaken to identify numbers and options
- Nurse Prescriber – CRHTT to review existing trained staff and requirements for implementation of function in service out of hours
- Consultant Out of hours – pilot consultant review of all admission requests over 2 weekends in February to review gatekeeping process and identify alternatives needed to reduce admissions
- Admission criteria –template developed and being used by CRHTT.
- 72 hour assessment – pilot started 2 weeks ago on one ward.
- Dual diagnosis worker - Proceed to recruitment for– In-patients / Slough CMHT
- Discharge coordinator - funding approval needed for recruitment to post
- Funding process for OAPs – review complete on process used with CCG and LA's. Recommendation provided on improved process to reduce delayed discharges.

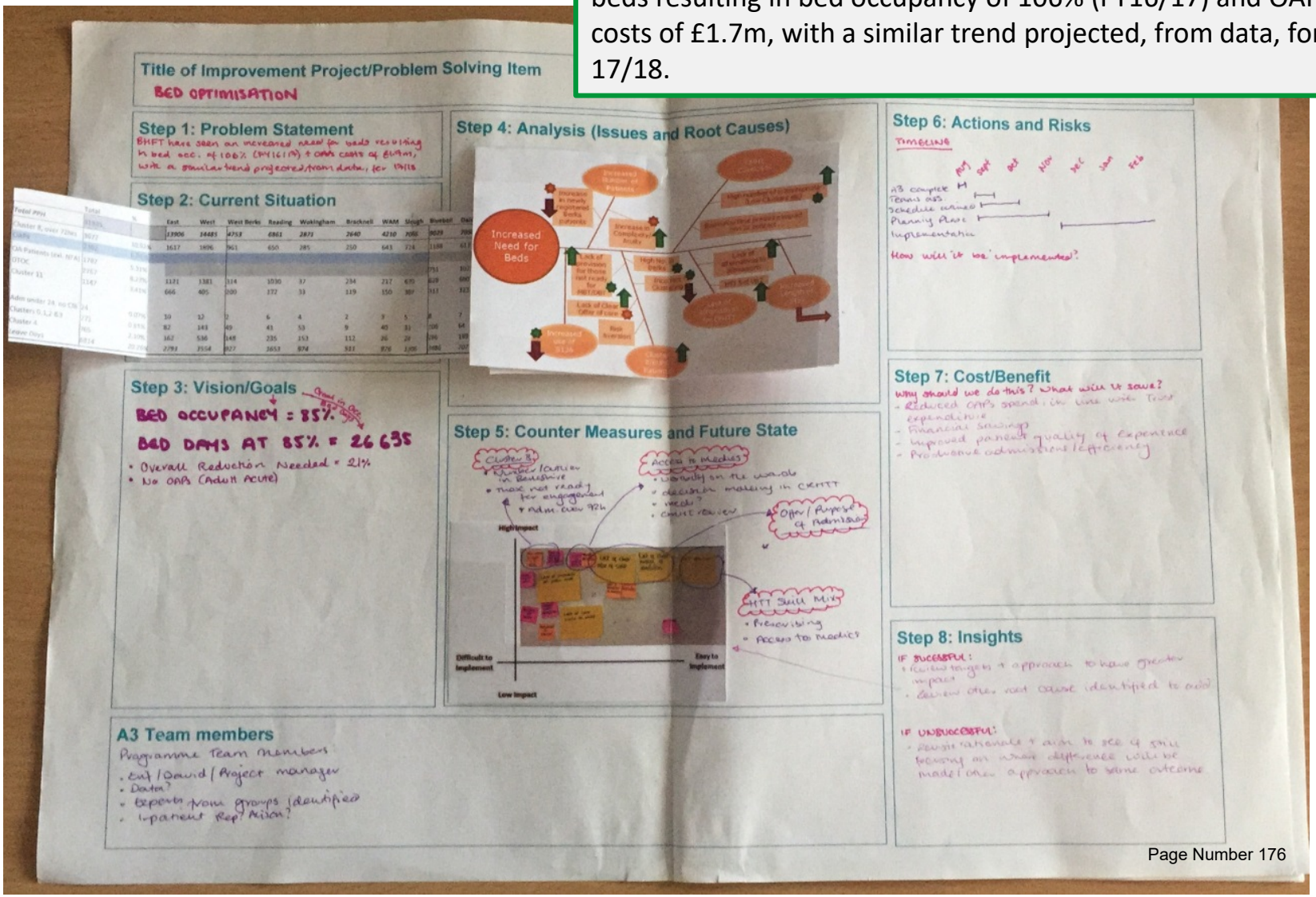
There are an additional two lines of enquiry added since the workshop

- Crisis beds review – Little House usage/ 3rd sector organisations.
- Length of Stay – initial review undertaken. Outlier in terms of leave. Review improvements to reduce LOS

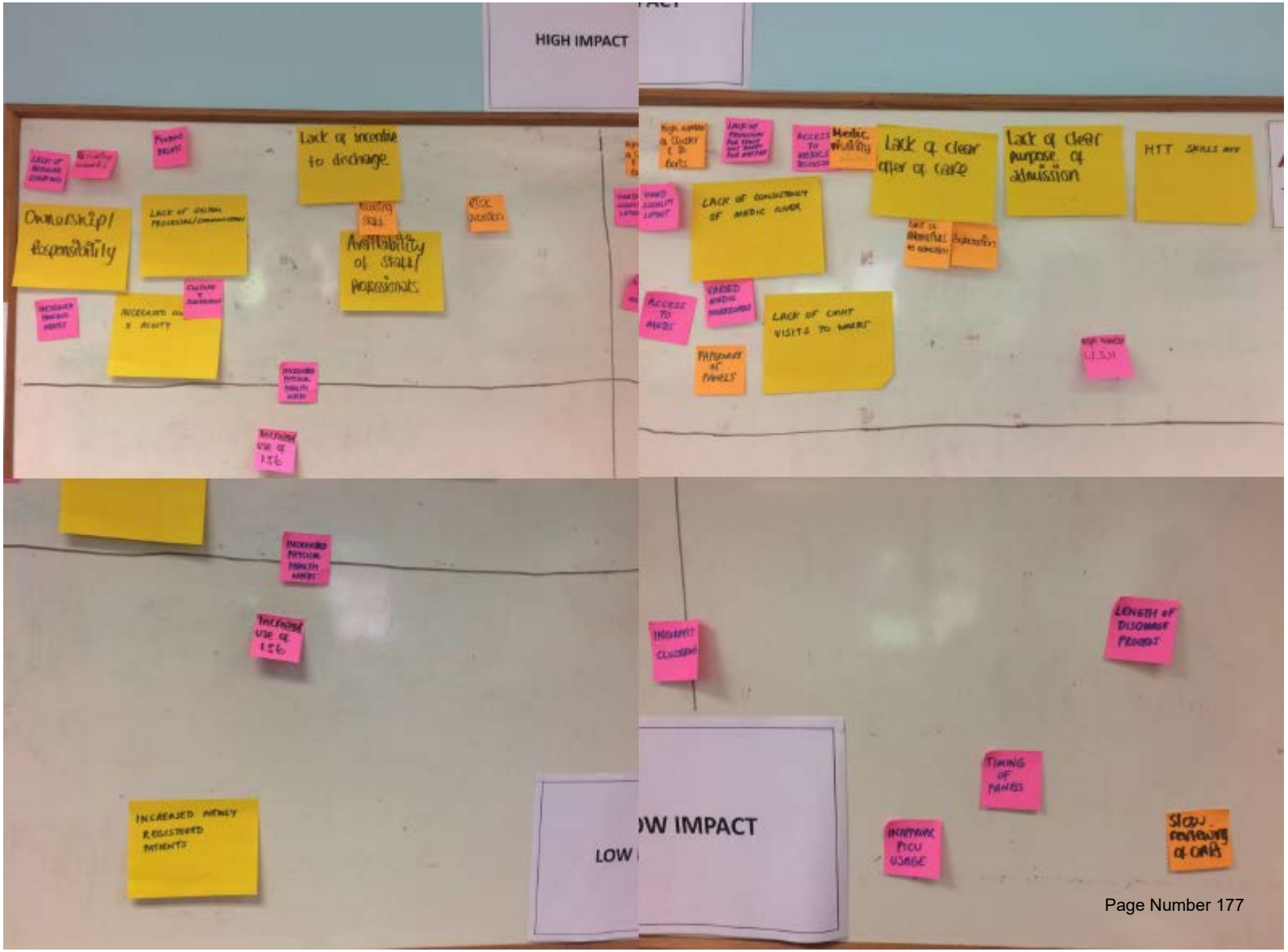
Line of Enquiry	Status	Priority
Alternatives to admission		
Bed manager	progress	1
Gatekeeping	progress	1
CRHTT model	progress	2
CMHT care plans & CPA policy	hold	3
First response team (Bradford)	hold	3
Crisis café	hold	3
Cluster 8 pathway design/Sheffield model	progress	2
Sanctuary (Bradford)	hold	3
Frequent users review	progress	2
Assessment lounge	hold	3
Nurse prescriber	progress	2
Consultants out of hours	progress	2
Productive stay		
Admission criteria	progress	1
72 hour assessment	progress	1
Dual diagnosis worker	progress	1
Ward treatment variability	hold	3
Productive discharge.		
Discharge co-ordinator	progress	1
Funding process for OAPs	progress	2
System visibility of delays	complete	2
Transfer protocol	hold	3

A3 Thinking

Problem Statement: BHFT have seen an increased need for beds resulting in bed occupancy of 106% (FY16/17) and OAPs costs of £1.7m, with a similar trend projected, from data, for 17/18.



Matrix Planning



Root causes originally identified,
mapped against current work streams

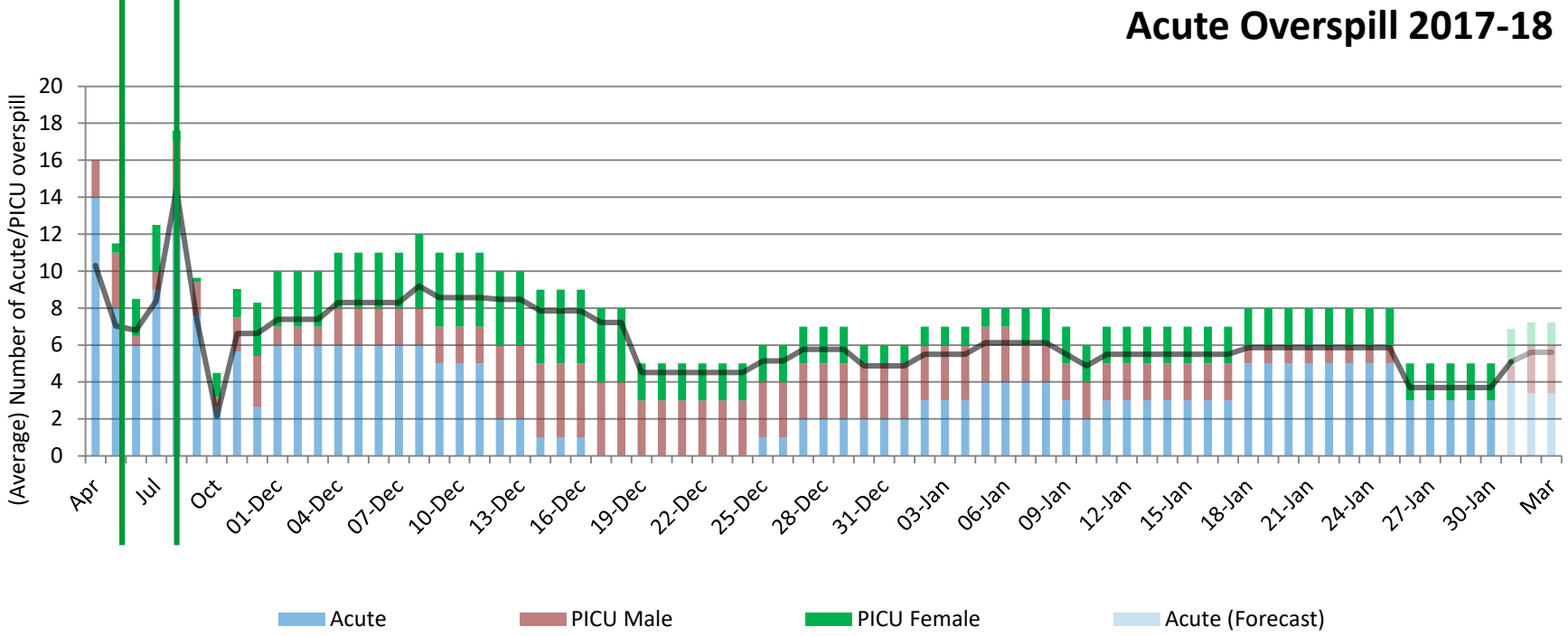
High Impact x High Feasibility	Where is this picked up?
High number of Cluster 8 in Berkshire	QI PD Work
Access to medics discussion	Post Admission Reviews
Medic visibility	Post Admission Reviews
Lack of clear offer of care	Post Admission Reviews
Lack of clear purpose of admission	Gatekeeping
HTT skill mix	*Not taken forward*
Ward locality layout	*Not taken forward*
Lack of consistency of medic cover	Other - Inpatient Work
Access to meds	CRHTT Review of Med Staffing
Lack of CMHT visits to Wards	Post Admission Reviews
Lack of Alternative to Admissions	*Not taken forward*
High Impact x Less Feasible	
Lack of incentive to discharge	Cultural approach to benefits of lower occupancy
Ownership / Responsibility	Daily Bed Meeting
Risk Aversion	Inpatient Positive Risk
Availability of nursing staff	Other - Staffing Project within PPH
Increased acuity	*Not taken forward*
Low Impact x Low Feasibility	
Increased use of 136	*Not taken forward*
Increased recently registered patients	Post Admission Reviews
Incorrect clustering	Other - MH Pathways work
Low Impact x High Feasibility	
Inappropriate PICU useage	*Not taken forward*
Slow reviewing of OAPs	Bed Manangement Function - Reviewing Officer
Timing of panels	Other - Out of panel approval in place
Length of D/C process	Other - Review as part of GDE programme

Acute Overspill 2017/18

Bed Optimisation Programme

Introduction of Bed Management Function

Change in Programme



Bed Optimisation Programme

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Berkshire Healthcare
NHS Foundation Trust

FY18/19

Programme Impact

	Work stream	Update	Ownership (Risk Level)
Access Pathways Project Lead: Theresa Wyles	Bed Management (inc OAPs)	Ongoing work for business case re resources needed and required processes.	CRHTT – Theresa Wyles. BAU at present
	Gate Keeping	LB to complete by 31/09.	CRHTT - Vishal Jugessur. Not embedded
	Creating Pull for Discharge (*TBC*)	On hold pending PAR review	
	Medical Staffing	Ongoing within CRHTT	CRHTT – Theresa Wyles
	Daily Bed Meeting	Amended and operationalised.	Currently JR to move to Inpatient. BAU at present
Enhanced Offer of Care Project Lead: Alison Durrands	Post-Admission Review	Trial June, continuing going forward with amendments, needing to embed	Current Bed Optimisation, needs to move to Inpatient
	7 Day CPA	On hold pending capacity at PPH	
	Inpatient Positive Risk Panel	Implemented and ongoing.	Sue McLaughlin
	Spring to Green	Completed and included within escalation criteria	Incorporated in Escalation Policy
	Red to Green Days	On hold, to be considered in line with GDE programme	
	Use of Leave	Sitting with Inpatient	Inpatient
Cluster 8 Project Lead: Nav Sodhi	To be merged with QI PD Project (TBC)	Being driven through operational phase of QI project	

Access Pathways

Project Lead: Theresa Wyles

Bed Optimisation Programme

Bed Management (including OAPs)

The Bed Management system is currently covering three main activities –

Duplicate gatekeeping: This is leading to a reduction in inappropriate admissions. This work will be absorbed by CRHTT through the Gate Keeping work stream, which aims to improve the understanding and quality of gatekeeping in the Crisis Teams. At which point duplicate gatekeeping will no longer be required.

Bed allocation: This function includes the daily monitoring of the bed status, the daily bed management meetings and communication, the allocation of beds to patients who require admission, the consideration of 'flipping' beds or transferring patients between wards, the prioritisation and planning of admissions, as well as the sourcing, monitoring and recording of Overspill beds when required. It also involves discussion around potential alternatives to admission and whether these have been considered.

Discharge facilitation: This function includes the identification of patients who may be suitable for leave, transfer or discharge, the following up on the actions required to achieve the aforementioned, and the support of discharge or leave plans such as approving and organising B&B stays. Going forward it would also look at those patients who have been in over an agreed number of days and consider escalation plans around this.
Due to the scope of activities detailed above and increasing pressures within PPH this means the current Patient Flow Co-Ordinator does not have the capacity to complete all the functions to the level needed to improve patient flow and there is no consistency in the cover of the above functions 24/7. Both Cycles 1 & 2, as well as the interim cycle, by necessity, view the above activities as additional tasks on top of existing roles within CRHTT and Inpatient staff.

Ongoing work:

- CURRENT MODEL: Cycle 3 of Bed Management now live, with 2 dedicated Bed Management roles in place. Business case being presented to cover the day time function in order to better understand the requirements over night.
- Monitoring of overspill use more robust, due to the creation of Virtual Wards on RiO
- Operational Ownership created and agreed to sit with Gerry Crawford within CRHTT, with separate reporting and cost centres now in place.
- OAPs Approval Process now sits with Exec On Call, with additional scrutiny process regarding need and consideration of alternatives in place.
- Final stages in approval of a Trust escalation procedure related to the hospital state, use of overspill beds and bed occupancy.

Access Pathways

Project Lead: Theresa Wyles

Bed Optimisation Programme

Daily Bed Meeting

The following changes to the Daily Bed Meeting have been implemented over the previous months:

- Community Invites – all community teams invited daily with specific locality allocated days to discuss locality patients
- Changes to format and information asked – now ran as a Status Exchange. Improved level of information asked for and received
- Change to Chair – now chaired by Regional Directors & Head of Inpatient Services. Improved attendance from inpatient staff and community representation

The next steps to enhance the running and impact of this meeting is to have Skype installed in the meeting room to enable better facilities for attendance across the Trust. When the bed occupancy is stable the chair of the meeting will be reset to Modern Matron/Service Manager level.

Since implementation there appears to be a correlation with the number of discharges from the wards, the highest number of discharges for 2018/19 has been w/c 25/06. It is thought that the improved patient information discussions and action setting is facilitating both planning and patient movement.

		Insert Locality	Bluebell	Daisy	Snowdrop	Rose	Sorrel	Orchid	Rowan	Crisis East	Crisis West
Patient Flow	How manys bed\patients do you currently have? (include OAPs & displaced adults) *Crisis: What is your current caseload?*									*Red\Amber\Green*	*Red\Amber\Green*
	Do you have any available beds?										YTL:
	Do you have any planned discharges today or tomorrow? Will these create beds?										
	Do you have any patients going on leave? Please state initials and length of leave.										
Patient Experience	How many DTOC patients do you have? What is the delay and what are the next steps?										
	Do you have any potential delays? What are their intials, what is the reason?										
	Do you have any patients who are post their IDD?										
Current State	Are there any assessments that we are not aware of? Is there any failed leave/AWOLs/Step-downs that we need to be aware of?										
	Is there anything else from your service/ward that we need to be made aware of?										
Actions											
1											
2											
3											
4											

Access Pathways

Project Lead: Theresa Wyles

Bed Optimisation Programme

Gatekeeping

Implementation of a consistent and high quality gate keeping process that will ensure that consistent completion of the gate keeping assessment takes place, with evidence that alternatives, purpose, benefit and risks of admission have been considered and documented. This process will enable CRHTT and Liaison clinicians to assume accountability for admissions, and result in no duplication occurring.

The current problems this aims to address include:

- Inconsistency in gate keeping quality: gate keeping contact not always completed, purpose and benefit of admission not always clear, consideration of all alternatives to admission not always evidenced.
- The only team able to request admission are CRHTT and Liaison services, not CMHTs.
- Lack of understanding of what constitutes a gate keeping contact and the circumstances where this is excluded
- Lack of clarity around where the responsibility of the gate keeping assessment sits

As a result, all admissions will have a clear purpose, which will inform the Post Admission Review process for inpatients and enable the ability to produce a Intended Discharge Date. There will be a reduction in average length of stay, as a result of the clear intention of admissions. The currently unfunded cost pressures for bed management will no longer be required.

Deliverables

Training of CRHTT and Liaison Services in gate keeping and accountability for admissions
Sustainable learning and improvement culture around benefits/risks of admissions
Understanding of patient journey's where admission has been requested but not facilitated by gate keeper
Revised gate keeping form and audited use of and quality of gate keeping form, with sustainable reporting in place for CRHTT

How

Value stream mapping to understand current state of gatekeeping process
Core Group / Working Group – Project A3, amendments to be made to gatekeeping form on RiO, developing deliverables

Enhanced Offer of Care

Project Lead: Alison Durrands

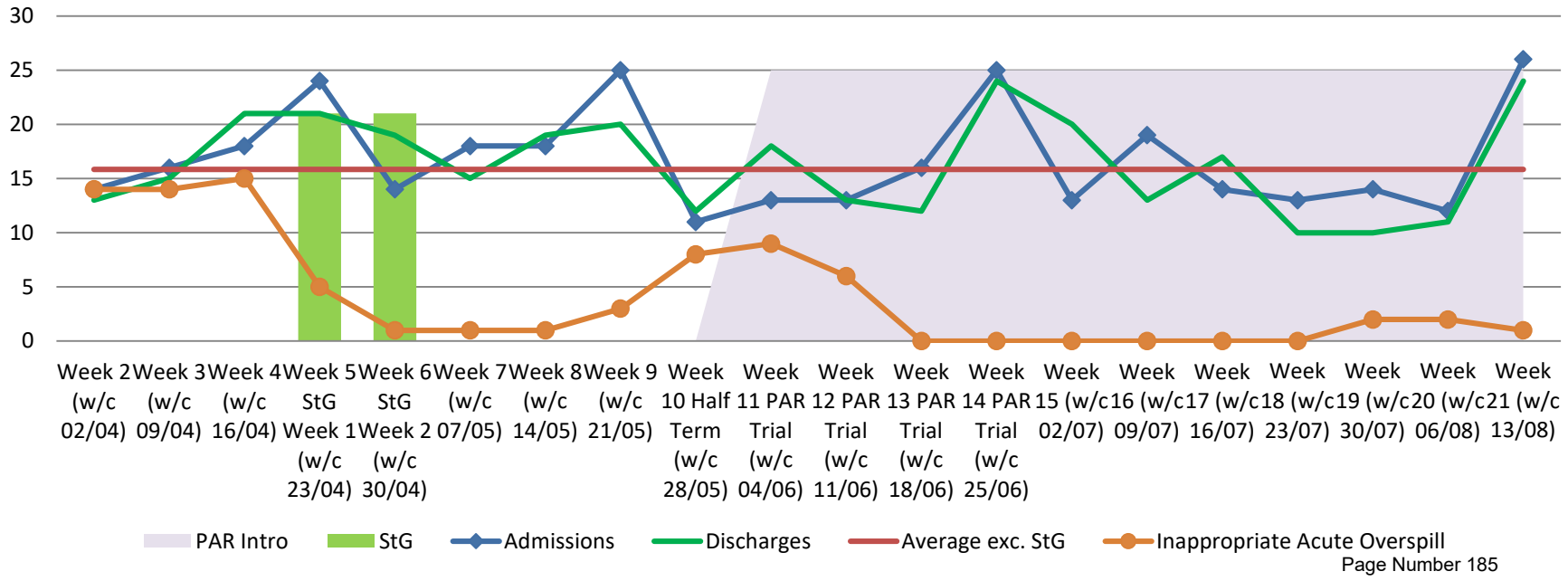
Bed Optimisation Programme

Post Admission Review

The original problem statement was defined as "Adult Patients in Prospect Park Hospital stay for 43 days, which is 13 days longer than national benchmarking, and as a result we cannot always provide the appropriate care, in the appropriate place." As part of improving the quality of care and experience for our patients needing inpatient care, this workstream is responsible for the introduction of the standardised compulsory review process. The goals this is aiming to achieve are;

- To have an estimated discharge date for all patients within approx. 72 hours of admission
- To have greater understanding and oversight of patients who are 'stranded' or staying longer than may be require
- To improve communication between the community and inpatient services.
- To begin to reduce the average length of stay

Following a staff coproduction event and trial period in June, the use of Post Admission Reviews is now ongoing, with learning from the trial period being implemented, and robust infrastructure being worked up (RiO Form, Skype facilities). Whilst it is very early in the use of Post Admission Reviews, the key metrics as shown below suggest positive impact of all work to date.



Enhanced Offer of Care

Project Lead: Alison Durrands

Bed Optimisation Programme

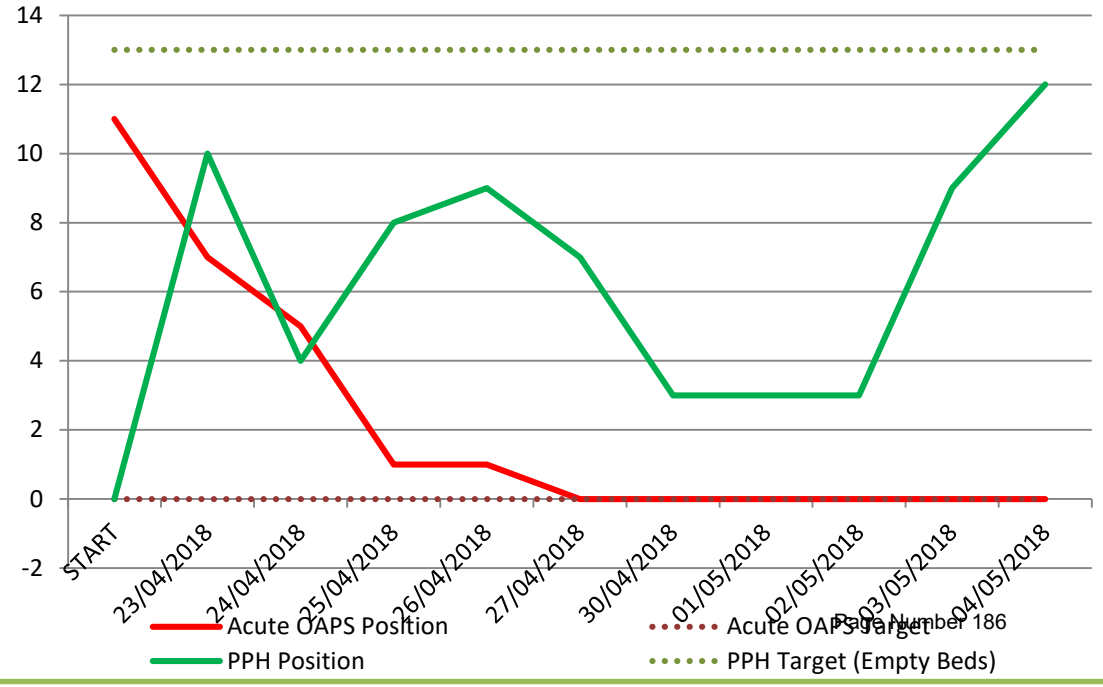
Spring to Green

Back in April BHFT is launched a 'Spring to Green' initiative for Prospect Park Hospital Mental Health Inpatients. The 'Spring to Green' initiative aimed to generate energy for change by doing things differently for the two weeks to support patient flow; and consequently improve patient experience, patient safety and staff morale. Through the hard work and collaboration of our mental health services, we managed to achieve the goal of no patients being treated outside of Berkshire who required acute admission to a mental health ward. We also managed to create 12 empty beds in Prospect Park, which created a calmer working environment for staff and a better patient experience for those on our wards, as well as reducing the number of patients who are formally delayed by 75%.

The initiative received positive feedback from those involved and whilst it is acknowledged that StG cannot be sustained, the following will be in place:

- Daily Bed Management Meeting; all wards expected to attend. Dedicated slot each day for locality patient discussion. This meeting aims to replicate those within to StG, albeit less frequently although CMHTs are welcome to join as and when.
- Acute Overspill Approval Processes
- Post Admission Reviews

Target	Achievement
0 Acute Overspill	0 Acute Overspill Achieved. The number of patients in PICU Overspill beds was up 1, to 5 in total, by the end of the initiative.
85% Bed Occupancy at PPH (13 Beds)	86% Bed Occupancy achieved (12 beds)
No DToC Target	75% Reduction in DToC, total DToCs were 4 by end of initiative.
No Readmission Target	No readmissions occurred within the period.



Enhanced Offer of Care

Project Lead: Alison Durrands

Bed Optimisation Programme

Positive Risk Panel

Following the introduction of the risk panel, amendments have been made to the format and approach in order to allow for greater input and in turn maximum impact. An audit of the use of the Risk Panel, including the uptake of recommendations and impact on subsequent patient journeys found that the recording of the panel and outcomes was poor prior to amendments being made. Impact since changes implemented is being audited.

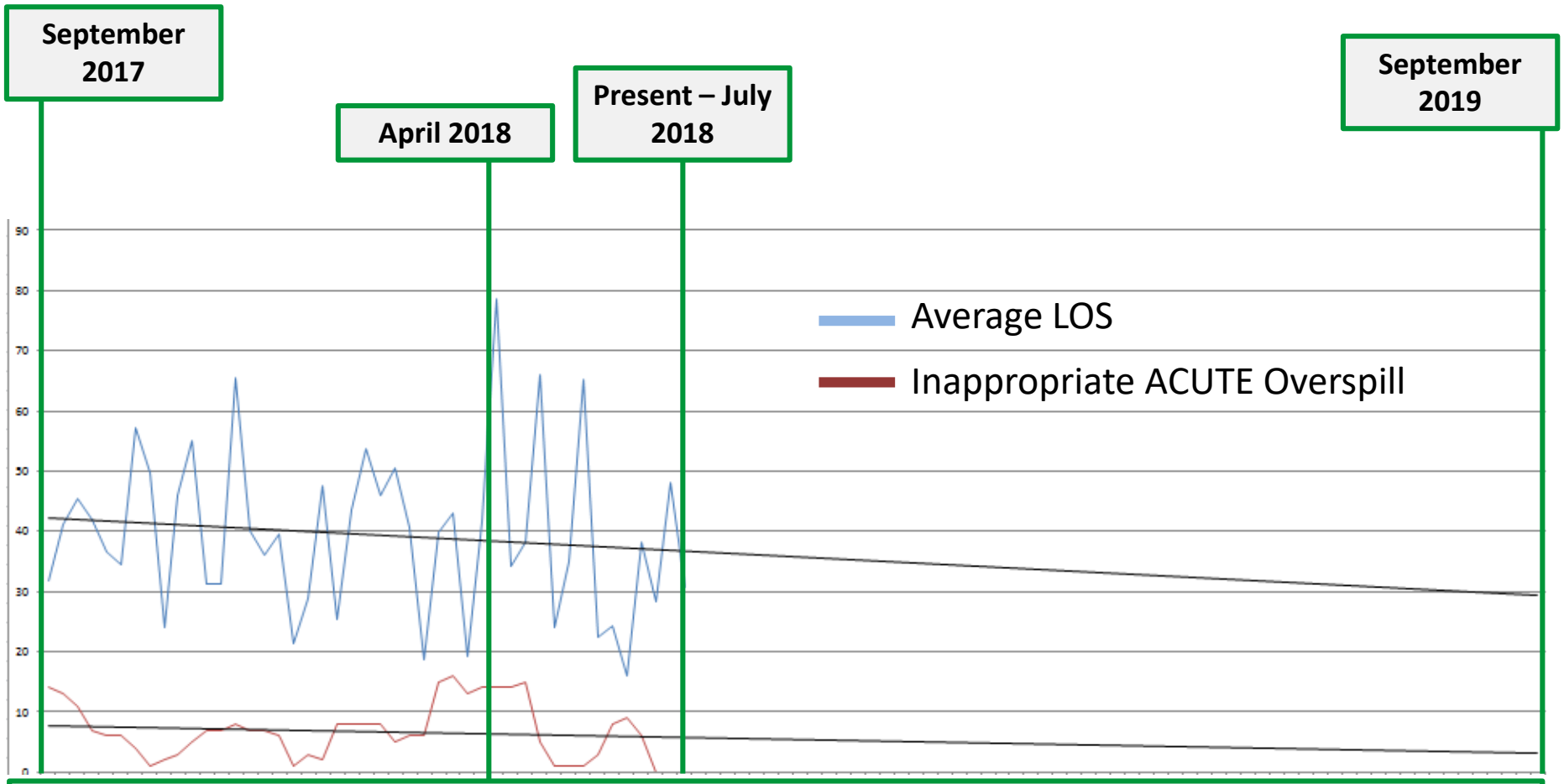
Red to Green Days

This work stream is on hold pending the introduction of the new electronic whiteboard development project, undertaken by BHFT as part of Global Digital Exemplar programme (Initiative of NHS England and NHS Digital). This is to replace the current physical whiteboard to an electronic whiteboard in the mental health wards with more live alerting on patient status and safety, to help the staff monitor their patients at real time. The use of a system similar to that of Red to Green will then be considered.

7 Day CPA

This work stream is on hold pending discussion regarding the impact of the Post Admission reviews, the need to implement this workstream and the capacity of PPH to undertake this change. Discussions taking place on 06/07/18.

Trends for Av. LOS and Overspill



The above graph shows the average LOS for PPH Acute wards, heading in a downward trend from 43 days in September 2017 when the programme commenced work programmes to a current position of 38 days. The trend line shows, at the current rate of improvement, the Av. LOS would hit the targeted 30 days by September 2019. It is hoped that the gradual uptake and cumulative impact of Post Admission Reviews will expedite this.

The inappropriate OAPS position shows a downtrend, that does not hit 0, although it is known that this trend line is skewed by the peak of overspill usage seen around Easter this year, with mitigation and planning now in place.

Optimising Rehab & Recovery

Bed Optimisation Programme

Contracts

- Review of current block arrangements –Cloisters/Papist Way & Rosebank
- Carramar – commencement of new project planned for July 2018.
- Model contract development with all other providers.
- Expansion of review team to accommodate new approach.
- Oversight and management of voids and potential associated costs.

Patient Trackers incl LD patients

- Development of Patient Tracker system to have oversight of progress against plans.
- Bi-monthly specialist OAPs meetings to ensure tacker actions are being taken forward.
- Ensure placements are appropriate and least restrictive option

S117 & S17

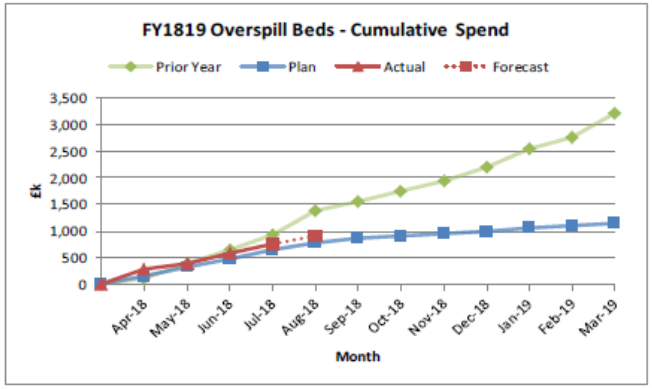
- Work, supported by legal team, to be undertaken with West LA's & CCG to ensure S117 placement costs are appropriately picked up.
- The above currently applies to 11 patients.
- Review of S17 leave as/protocol.

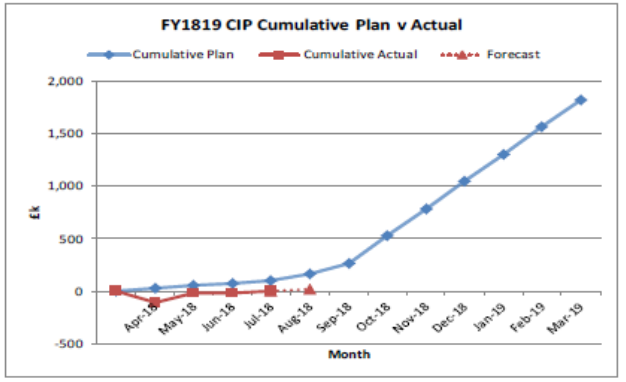
Jayne Reynolds

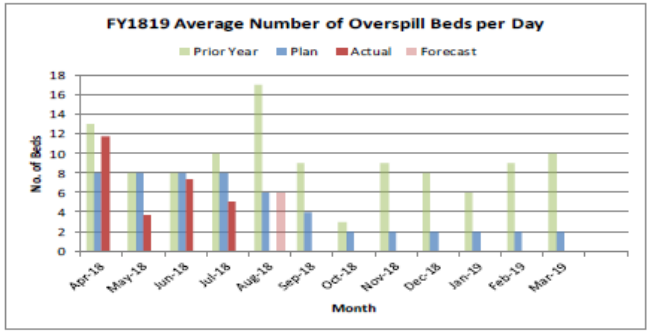
NHS
Berkshire Healthcare

MH Inpatient Overspill Beds

Reporting Month End	July18
Project	Overspill Beds/Bed Optimisation
Senior Responsible Officer	Gerry Crawford
Project Manager	Erif Newman
FY18/19 CIP Target	£1.815m







Action Plan

Action	Due Date	Rag Rating
Patient and placement detail recorded against virtual ward on RiO	Apr 18	Amber
Spring to Green	Apr 18	Green
Develop and implement Post Admission review process	Jul 18	Green
PICU works completed and 3 female PICU beds available	Jun 18	Green
Resolve staffing shortage on PICU to allow female beds to re-open	Jul 18	Red
Review and implement phase 1 patient flow structure (days)	Jul 18	Green
Review and implement phase 2 patient flow (nights)	Oct 18 (revised)	Green

Key Performance Indicators

KPI Measure	Month Snapshot	Variance (last month)	Variance (same month last year)
Bed Occupancy (target 85%)	tbc	tbc	tbc
Average No. of Acute Overspill Beds	1	▼	▼
Average No. of PICU Overspill Beds	4	▲	▲

Performance

	In Month			Year to Date		
Measure	Plan	Actual	Variance	Plan	Actual	Variance
Planned Spend (£k)	165	171	-6	650	747	-97
CIP Target (£k)	24	18	-6	96	-2	-98
	In Month			**Quarter to Date**		
Measure	-	Actual	-	Q2 Ceiling	Q2 Actual	Variance
Qtly Trajectory East (bed days)	-	25	-	380	25	355
Qtly Trajectory West (bed days)	-	109	-	396	109	287
Appropriate (bed days)	-	23	-	n/a	23	n/a

Commentary

Headline

Average beds in July was 5.1 of which PICU 4.2. This include approx. 1 appropriate acute bed. On 3rd August there are 3 Acute (1 being appropriate) and 3 PICU placements. YTD costs exceed plan by £97k.

Although PICU work now completed, PICU female beds remain unoccupied resulting from unavailability of staff qualified to work on PICU. The cost of 2 female PICU beds in July was £75k, year to date £275k of spend has resulted from unavailability of female PICU beds.

Forecast assumes bed use in August continues at an average 3 acute beds, 3 PICU beds.

Risks & Mitigation

There is a risk that the quarterly improvement trajectory will be missed if bed numbers do not reduce resulting in adverse Trust segmentation rating—currently 1. Target has been met in Q1, average bed occupancy would need to exceed 10 in Aug/Sept to exceed overall target for Q2, East/West split should be kept under review.

Summer leave risks further delay in discharge if discharge plans are not in place and delegated to other medical staff in absence of consultant—plans to be put in place to ensure appropriate cover and discharge processes (AD).

Data not being recorded/ reported correctly on RiO—further work with information team required. (TW, NP)

Unable to recruit and retain substantive or temporary staff to re-open PICU beds - mitigation plans to be explored. (AD, PG, CC)

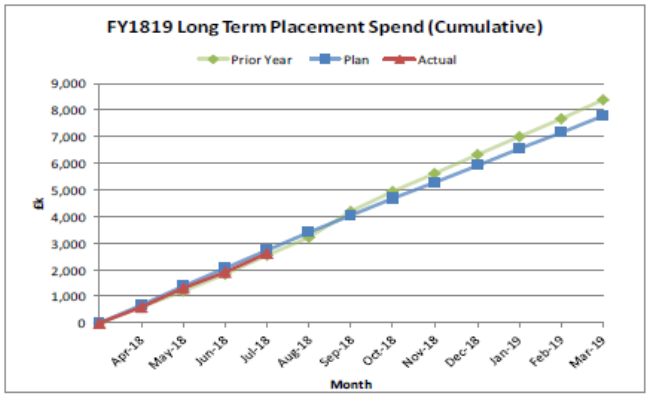
Bed Optimisation

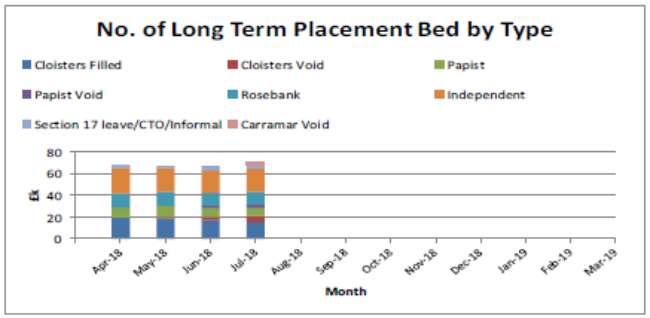
Long Term Placements (MH)

Reporting Month End	July 18
Project	Long Term Placements
Senior Responsible Officer	Jayne Reynolds
Project Lead	Susanna Yeoman
FY18/19 CIP Target	£588k

Action Plan

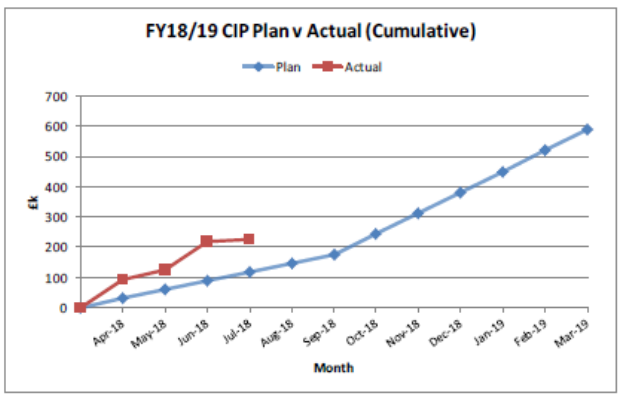
Action	Due Date	Rag Rating
Resolution of 117 dispute with RBC/ West CCG	Aug 18	Red
Section 117 or social Funding Agreements in place for 10 patients currently at Papist Way	Jun 18	Red
Section 117 funding agreements in place for transfer to Carramar of 6 patients when Carramar opens	Jul 18	Amber
Section 17 policy to give clear guidelines on length of leave that Trust will fund	Jun 18	Green
Options Appraisal for Cloisters completed.	May 18	Green
Future intention, requirement and provision agreed for Cloisters with Priory group.	Aug 18	Green
Transition of 7 patients from Cloisters to alternative placements.	Oct 18	Amber





Performance	In Month			Year to Date		
Measure	Plan	Actual	Variance	Plan	Actual	Variance
Planned Spend (£k)	665	689	-23	2,726	2,617	109
CIP Target (£k)	29	6	-23	116	225	109

Cost Incurred due to Delays and Voids (£k)			
Description	In Month	Var Prior Month	YTD
Papist - Social Care Applications	5	▶	20
Papist Empty Bed	4	▲	4
Rosebank - Await step down plan	18	▲	45
Independent - Informal, query responsibilit	10	▶	40
S17/CTO/Informal delayed application	25	▲	81
Cloisters Empty Bed	42	▲	68
Carramar Empty Bed	19	▲	19
Total	123	▲	277



Commentary

Headline

July position includes 4 Papist placements billed YTD to RBC which remain in dispute. Funding of 2 placements Apr—Jul by WB still outstanding.

4 patients stepped down to Carramar in July and have settled well. 2 further applications in progress with anticipated move August. Cost of empty beds in July £19k, risk in August £8k.

Cloisters options appraisal completed and engagement with Cloisters has taken place in June, response now received from Priory and BHFT to respond w/c 6th August. (TS/JR)

Void beds include 6 at Cloisters and 2 in Papist on 31st July.

Since April 2 placements have transferred to CCG for funding, 4 patients have step down into new placements, 1 of which is now funded by CCG. 3 new placements have been funded by BHFT.

Risks & Mitigation

Lack of Engagement with Reading CMHT and RBC with regards to S117 applications . Legal advice sought, letter sent from CFO. Unresolved in July, AG sent follow up letter in July and weekly update sought. (GC, AG)

Cloisters contract option mitigates cost of void beds, looking to commence new arrangements from 1st September. Transition plan for 7 patients to alternative placements must be followed to ensure full benefit by October.

S17 leave applications remain unresolved and patient continue to be funded by BHFT—applications must be progressed (2 patients).

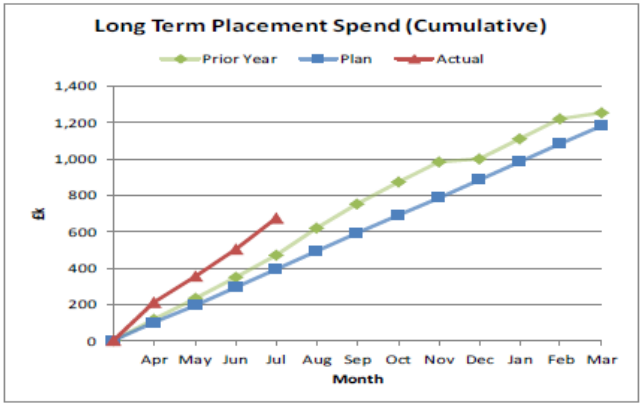
2 Independent placements informal but unresolved dispute with regards to CCG responsibility.—seeking legal advice.

Out of Area Learning Disability Placements

Reporting Month End	July 18
Service	LD placements
Regional Director	Gerry Crawford
Budget Manager	Colin Archer
FY18/19 CIP Target	£0

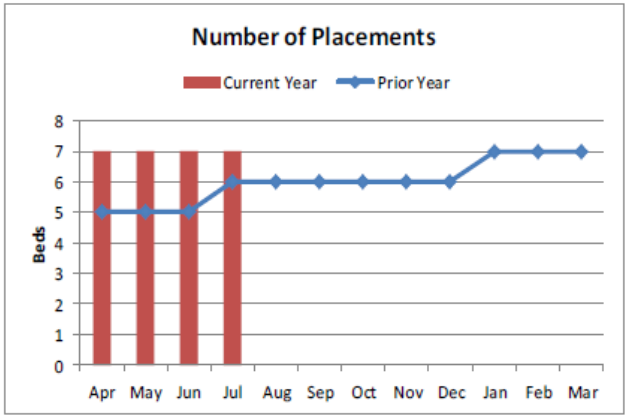
Action Plan

Action	Due Date	Rag Rating
Transfer of funding responsibility for 2 patients to CCG when no longer under section.	Jun 18	Red
Seek CCG funding for patient placed in community service and estimate date of transfer.	Jul 18	Green
Explore transfer back to Campion for 2 patients and estimate date of transfer if suitable.	Jul 18	Green



Performance

	In Month			Year to Date		
Measure	Plan	Actual	Variance	Plan	Actual	Variance
Planned Spend (£k)	98	171	-73	393	672	-279



Commentary

Headline
Average daily bed rate higher than plan resulting in adverse variance against plan. The no. of placements has not increased in April but includes an additional bed that was not known at budget planning.
Two patients not suitable for transfer back to campion, currently in suitable placements, discharge not anticipated before December 18.
Two patients being assessed for transfer back to campion when bed available, if not suitable would continue in current placement until discharge which is not
One patient in community placement—seeking funding from CCG.

Risks & Mitigation
Limited traction with CCG with regards to 2 patients placed in Gloucester. GC has raised again with CCG commissioning team.

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	11 September 2018
Title	Strategy Implementation Plan 2018/19 Summary Progress Report
Purpose	This paper provides a summary 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	N/A
Resource Impacts	None
Legal Implications	None
Equality and Diversity Implications	n/A
SUMMARY	The attached paper sets out the progress at the end of June 2018 to deliver the Trust's business strategy expressed as the 2018/19 Strategy Implementation Plan. The Director of Strategic Planning and Business Development is responsible for reviewing and updating the plan. Progress against the plan is reviewed monthly by the Business and Strategy Executive and a summary report is presented to the Board quarterly during the course of the year. The Strategy Implementation Plan Progress Report at the end of June 2018 shows that good progress is being made, with most the initiatives being delivered to the expected time frames or with minor slippage. There are no material risks to the delivery of the main elements of the plan. Where there are risks of significant delays these are

	primarily where we are introducing new ways of working to improve services, or to integrate services within local health systems. Additional time is being taken to learn and develop these initiatives, with full commitment to their overall success.
ACTION REQUIRED	The Board is asked to note the progress made against the plan, and revised target dates.

Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

Strategy Implementation Plan 2018/19

Progress Report to 30 June 2018

Author: Jenny Vaux, Director of Business Development and Strategic Planning

Director: Bev Searle, Director of Corporate Affairs

Date: 17 August 2018

Purpose

This document has been prepared to update the Trust Board on progress to deliver the Strategy Implementation Plan 2018/19 at the end of June 2018.

Members of the Trust Board are asked to review and note the report.

Document Control

Version	Date	Author	Comments
1	17.08.18	Jenny Vaux	Based on the combined projects and SIP monthly progress reports presented to the Business and Strategy Executive, and updates from programme leads.

Distribution:

All Trust Board Members

Document References

Document Title	Date	Published By
Strategy Implementation Plan 2017/18 presented to the Business and Strategy Executive	May 2018	Jenny Vaux
Business Development Strategy *Summary objectives updated to reflect current national policy and local system structures by TBG July 2018*	May 2016	Business & Strategy Exec Trust Business Group Finance Investment & Risk Committee
Monthly combined SIP and Projects Report	Monthly	Neil Murton, Director of Projects.

CONTENTS

INTRODUCTION

Background

1. The Strategy Implementation Plan 2018/19 captures the key activities required over this financial year and beyond to ensure successful implementation of our strategy, and operational plan. It is structured to reflect initiatives to deliver each True North goal. The attached summary report also provides references to our strategic projects filter which is used to prioritise all of our strategic projects.

2. In May 2018, the detailed Strategy Implementation Plan 2018/19 was approved by the Business and Strategy Executive, and the summary plan noted by the Board.

3. The Board receives a quarterly summary progress report on the delivery of the plan. Combined projects and strategy implementation plan progress reports are produced every month for review by the Business and Strategy Executive.

4. A 'Plan on a Page' was published in February 2018 to provide our staff and key stakeholders with an accessible version of the 2018/19 Strategy Implementation Plan and to support staff with their annual service and team plans, personal development plans and personal objectives.

Progress reports to the Board

5. This is the first quarterly progress report of the year presented to the Board; the quarter two report, to the end of September, will be presented to the November meeting.

6. This is the first summary report to include reference to our strategic filter, in the column headed "Class" (filter classification). The key to the symbols in this column are at the end of the table, however in broad terms those in **red** text (i.e. MC – Mission Critical; and IMP – Important) signify our highest priorities, and **green** text (i.e. COMP – completed; and BAU – business as usual) signify initiatives or workstreams which no longer need to be included in the strategic implementation plan.

Exception report approach

7. The summary exception report provides a RAG rated overview of initiatives to identify trends and highlight areas of risk. Initiatives are conservatively RAG rated in this paper. An initiative will only receive a green RAG rating if all workstreams and activity gateways are green rated in the detailed report. If there are ratings other than green, the initiative will be rated according to lowest RAG rating, to highlight areas of risk.

CHANGES TO INITIATIVES AND WORKSTREAMS

8. Initiatives which have been added to the plan since it's approval are shown in **blue** text:

    - Within True North Goal 3, Health and Social Care Systems, we have re-introduced the Connected Care initiative into the plan. This is in recognition we have significant resources deployed to support this major system-wide initiative and we are

considered leaders in some of the workstreams. Connected Care is a significant enabler in improving patient outcomes and experience, and service integration across multiple providers. It aims to securely share patient electronic records across organisations delivering health services, and provide easier access to patients to their own electronic records. This initiative commenced in 2017/18 and is expected to be fully implemented by 2020/21

- Within True North Goal 4, an additional workstream has been added to the Optimising the Use of Mental Health Inpatient Services initiative, to review the number of mental health beds in the county. The purpose is to consider whether Berkshire has sufficient inpatient capacity to effectively support the county's population. The report findings were presented to the Executive in June 2018, and actions agreed.

9. Initiatives which will be removed from the plan following this report are shown in **red** text:

    - Within True North Goal 4, the Renal/Cancer Care Unit at West Berkshire Community Hospital is now complete; and the Bank and Agency Project has moved to business as usual. These will be removed from the plan.

SUMMARY OF PROGRESS TO THE END OF JUNE 2018

Initiatives being delivered as planned

10. Good progress is being made in most areas of the plan at the end of the first quarter, some with very minor slippage on target dates. These include:

    - Zero Suicide
    - Development of Integrated Hubs in the Frimley Health and Care Integrated Care System
    - Mental Health Service Development
    - Improving Patient Experience
    - Development of the University of Reading as a Primary Trust Site
    - Learning Disability Service Development
    - Child and Adolescent Mental Health (CAMH) Service Development
    - Information Technology Roadmap (including our Global Digital Exemplar programme)
    - New Renal/Cancer Care Unit, West Berkshire Community Hospital (now completed)
    - Maintaining our NHS Improvement Use of Resources Rating of 1 (some slippage in Cost Improvement Plans)
    - Optimising the use of Mental Health Inpatient Services

Initiatives with minor slippage

11. Initiatives which are expected to be delivered but with delays to activity target dates (Amber rated) of more than 2 months include, within True North Goal 2:

    - delays of approximately 6 months in the Build our Strategic Workforce Planning capability in our Workforce Strategy, due to changes in key personnel and the complexity of the programme activity. Good progress is being made in the other Workforce Strategy initiatives

    - the roll out of our Quality Management Improvement System (QMIS) has been delayed, with Divisional QMIS Wave 2 starting 3 months later than originally planned, concluding in February 2019. The additional time has been used to assess the learning from Wave 1 to develop our approach to Wave 2. Similar delays are therefore expected to the start of Wave 3

    - the roll out of our Making It Right programme, part of our Equality and Inclusion Strategy, to Lesbian Gay Bisexual and Transsexual (LGBT) and disabled staff groups has been delayed by 6 months to January 2019. This will provide time to refine and further enhance this key staff development programme. Other workstreams to deliver our Equality and Inclusion Strategy are making good progress, including preparations for our submission to the Stonewall Workplace Equality Index at the end of August 2018.

12. There are also (Amber rated) delays of 3 months to explore Options for Trust Headquarters, within True North Goal 4. The current building is likely to remain available for longer than originally expected, and resources have been focussed on delivering higher priorities.

Initiatives with material risks of delivery or not continuing

13. There are three programmes in our strategy implementation plan with activities rated as Red and/or Purple, i.e. with significant risks of delivery, or will not be delivered. One is in True North Goal 1 and the other two True North Goal 3:

    - Within our Quality Improvement (QI) Programme, we have not made the progress expected with our Breakthrough Objectives to reduce falls and reduce self-harm. Our metrics show that we are not meeting planned trajectory of reductions in these areas. A review is underway into our process, its structures, and how information is communicated. Our other QI workstreams are making good progress.

    - Within our Health and Social Care Systems Initiatives, the programme led by the Berkshire West Integrated Care System (ICS) to integrate pathways and delivery of adult MSK/Physiotherapy services has been seriously delayed while the proposed prime contractor, the Royal Berkshire Hospital NHS Foundation Trust, negotiates with commissioners to address challenges in this complex transformation initiative. Agreement is not anticipated in this financial year, however some elements of the agreed new pathway are being progressed to implementation where it is practical to do so, and partners continue to work together to realise benefits to patients and the ICS.

- Also with our Health and Social Care Systems Initiatives, we have been active participants in the programme to integrate neurology services in the Frimley Health and Care ICS. We have concluded that the agreed integrated pathways would be more clinically effective if the small number of community based staff employed by Berkshire Healthcare transferred to Frimley Health NHS Foundation Trust. We will therefore not be a sub-contractor as expected, and will withdraw from the programme following the staff transfer.

CONCLUSION

14. The Strategy Implementation Plan Progress Report at the end of June 2018 shows that good progress is being made with most of the initiatives being delivered to the expected time frames or with minor slippage. There are no material risks to the delivery of the main elements of the plan.

15. We have one area of activity at risk of material slippage or will not be delivered relating to our Breakthrough Objectives, within our Quality Improvement Programme. This is a new initiative where we are reflecting and drawing on our learning to improve our approach. We also have a small number of system programmes experiencing significant delays. These are also programmes where we are learning with our system partners about the best ways of working together to integrate and improving services - and we all remain committed to their successful implementation.

ACTION

16. Members of the Trust Board are asked to:

    - review and note the report.

Berkshire Healthcare NHS
NHS Foundation Trust

2018/19 Strategy Implementation Plan Summary Report to end of June 2018

INITIATIVE	Class	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
True North Goal 1: To provide safe services, prevent self-harm and harm to others.													
QUALITY IMPROVEMENT (QI) PROGRAMME													
Strategy Deployment (overal programme delivery)	MC												
Improvement Projects (overall programme delivery)	MC												
Breakthrough Objectives (BO) - Reduction of falls	IMP												
BO - Reduction of self-harm	IMP												
BO - Reduction of harm to staff	IMP												
BO - overall programme delivery	MC												
Quality Improvement Business Intelligence (QIBI)	TBC												
Comments: The Breakthrough Objectives for the Reduction of Falls and Reduction of Self-Harm are both Red rated because our metrics show we are not meeting the planned trajectory of reductions in these areas. A review of the process, its structures, and how information is communicated, is underway.													
ZERO SUICIDE	IMP												
Comments:													
FRIMLEY INTEGRATED CARE SYSTEM: DEVELOPMENT OF INTEGRATED HUBS	IMP												
Comments: The ICDM programme is led and managed by the ICS; Berkshire Healthcare is a major delivery stakeholder, and we have considerable resource committed to its implementation. The programme is divided into the 3 local authority areas in the East, and all are Amber rated by the programme lead. This is due to slippage on project target dates, for example agreeing the final models of care, and how to organise the Single Point of Access.													
True North Goal 2: To strengthen our highly skilled and engaged workforce and provide a safe working environment.													
WORKFORCE STRATEGY													
Grow our own workforce	MC												
Develop and promote our employer brand	MC												
Align our workforce and service models	SI												
Plan and meet demand sustainably	SI												
Know our numbers	SI												
Build our strategic workforce planning capability	SI												
Achieving our workforce metrics	SI												
Comments: **Align our workforce and service models:** agreeing objectives for workforce digital competencies is delayed (due June 2018). The Strategic Workforce Steering Group is considering funding opportunities and types of training available. **Build our strategic workforce planning capability**: the workforce planning format and cycle of activity are delayed by 4 and 7 months respectively due to changes in personnel and the complexity of the programme.													
QUALITY MANAGEMENT IMPROVEMENT SYSTEM (QMIS) - programme delivery													
Comments: Divisional QMIS Wave 2 will be delayed for 3 months to enable more time to assess the learning from the experience of Wave 1.													
INTRANET	TBC												
Comments: *Awaiting completion and approval of business case.*													
DELIVERING OUR EQUALITY AND INCLUSION STRATEGY 2016-20													
Mandatory/Statutory requirements	NA												
Other priorities	NA												
Comments : Reviews of most of the **Locality Equality Plans for 2017/18** were completed. The roll out of the **Making It Right** training course to LGBT and disabled staff is delayed from June 2018 to January 2019.													
True North Goal 3: To provide good outcomes from treatment and care.													
MENTAL HEALTH SERVICE DEVELOPMENT													
Prospect Park Hospital Development Programme - Centre of Excellence	TBC												
Mental Health Pathways	Pause												
QI Improvement Project: Emotionally Unstable Personality Disorder Pathway	MC												
Comments: Mental Health Pathways delayed to redeploy resource to support Care Quality Commission inspections. This has now re-started (in July). **Emotionally Unstable Personality Disorder Pathway** - the implementation plan is being developed and is expected to be completed in September (delay of 3 months).													
IMPROVING PATIENT EXPERIENCE - PATIENT SATISFACTION	Wait												
Comments:													
DEVELOPMENT OF UNIVERSITY OF READING AS A PRIMARY TRUST SITE													
Phase 2 STC - Royal Berkshire Hospital NHS Foundation Trust services relocation	MC												
Phase 3 STC (final phase) - relocation of services to STC	MC												
Sale of Craven Road	BAU												
Erleigh Road - options appraisal for future use following transfer of services	TBC												
Comments:													
LEARNING DISABILITY SERVICE DEVELOPMENT													
Intensive Intervention Service	NA												
Move of Assessment & Treatment Unit from Campion to Jasmine Ward	MC												
Comments:													
CHILD AND ADOLESCENT MENTAL HEALTH SERVICE (CAMHS) DEVELOPMENT													
Integration of services into the Children Young People and Families Service	NA												
Tier 4 (Willow House) relocation to Prospect Park Hospital	IMP												
Comments: *Relocation of Willow House dependent on move of Campsion Unit to Jasmine Ward, and the approval of the business case. Capital bid for central funding support has been submitted.* **Consolidation of services onto Upton Hospital site** delayed for one month; will be implemented by October 2018.													
HEALTH AND SOCIAL CARE SYSTEMS INITIATIVES (not covered elsewhere)													
Berkshire West Integrated Care System (ICS) - Adult MSK/Physio services	BD												

INITIATIVE	Class	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Berkshire West ICS - System use of estates (part of BOB STP programme)	TBC												
Frimley Health and Care ICS - Integrated Neurology	BD												
BOB and Frimley STPs - Connected Care	IMP												
Berkshire wide initiative - Wellbeing Project	MC												
Comments: Berkshire West ICS Adult MSK/Physio service is delayed while the Royal Berkshire Hospital NHS Foundation Trust negotiates with commissioners on details around price and risk sharing, as the prime contractor. However elements of the pathway are being progressed to implementation although this will be delayed along with realisation of benefits. The **Frimley ICS Integrated Neurology** service may be delayed as final staffing and service model details are considered and agreed. There is agreement that community based staff will transfer to Frimley, as this provides a more clinically robust model of care. Dates of transfer to be confirmed. **Connected Care** has been brought back into the plan following clarification that it is separate from our GDE initiative. **The Wellbeing Project i**s being established, with project management provided by the East and West health system. Key milestones will be added to the SIP when agreed. Programme classified as Mission Critical.												
INFORMATION TECHNOLOGY ROADMAP													
Global Digital Exemplar (GDE) - Direct patient access and communication	MC												
GDE - Digital Wards and services	MC												
GDE - Digital workforce	MC												
GDE - Research and quality improvement	MC												
GDE - Payment milestones	NA												
Information Technology Architecture Strategy	MC												
Comments:													
True North Goal 4: To deliver services that are efficient and financially sustainable.													
NEW RENAL/CANCER CARE UNIT - WEST BERKSHIRE COMMUNITY HOSPITAL	COMP												
Comments: This initiative will be removed from the report following next presentation to the Board, as it has been completed.													
MAINTAINING OUR NHS IMPROVEMENT USE OF RESOURCE RATING OF 1													
Achieving our Control Total	NA												
Delivering our Cost Improvement Plan	NA												
Effective management of our staff vacancy factor	NA												
Comments: Delivering our CIP - Locality Directors and Finance leads are meeting to discuss opportunities which will identify additional savings to mitigate the current forecast shortfall and begin to shape the 2019/20 programme.													
OPTIONS FOR TRUST HEADQUARTERS	TBC												
Comments: The project has moved forward by 3 months, with the options paper now due in September 2018. This minor delay is due to focussing on higher priorities, as the current building is likely to remain available longer than originally expected.													
AGENCY AND BANK PROJECT	COMP												
Comments: This initiative will be removed from the report following next presentation to the Board, as it has moved to 'business as usual'.													
OPTIMISING THE USE OF MENTAL HEALTH INPATIENT SERVICES													
Eliminating overspill; optimising rehabilitation and recovery	MC												
Comments: This now includes a workstream reflecting the review of mental health inpatient bed capacity which has been completed; the recommendation is that we have sufficient bed capacity if we achieve our target Length of Stay. RAG has changed from Red to Amber following Spring to Green initiative. Although some significant progress has been made in reducing inappropriate out of area placements, some challenges remain.													

Class (Classification within Strategy Deployment Filter) Key:
BAU - Business As Usual; initiative is now embedded within normal operations
BD - the business development filter process applies for this initiative
COMP - initiative has been delivered/is completed
IMP - inititaive is Important
MC - inititiative is Mission Critical
NA - not applicable: this is an initiative/programme/activity which is a strategic priority where the filter process is not required
Pause - initiative underway but temporarily suspended
SI - True North Strategic Initiative: a strategic priority where the filter has not been required
TBC - to be classified (including initiatives planned for action in the future)
Wait - initiative is approved but not yet proceeding; this could be due to a dependency on other work concluding, or awaiting key decisions or availability of resources

RAG Key:	
P	Action will not be delivered
R	Significant risk that action will not be delivered or serious delays to project being delivered
A	Action delayed but delivered or will be delivered
G	Action either delivered or on schedule to be delivered within

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	11th September 2018
Title	**Berkshire West Integrated Care System Memorandum of Understanding (Local)**
Purpose	To provide the Memorandum of Understanding (MoU) for 2018/19 between Berkshire West ICS partners to note.
Business Area	Corporate
Author	Director of Corporate Affairs
Relevant Strategic Objectives	Supports all strategic objectives
CQC Registration/Patient Care Impacts	N/A
Resource Impacts	N/A
Legal Implications	The MoU represents an important agreement for partners to work as an Integrated Care System to achieve good quality care and treatment for local people, alongside effective use of our resources as a system.
Equality and Diversity Implications	Equality Impact Analysis is expected to take place at the level of specific projects within the ICS, rather than being part of the MoU.
SUMMARY	The following paper is the revised MoU for the Berkshire West Integrated Care System (ICS) for 2018/19. There are no material changes to the previous MoU, which has been updated to reflect some local changes: • The merger of the previous four CCGs in

	Berkshire West to form a single CCG • The inclusion of the GP Alliances, which are now formally part of the Unified Executive of the ICS and represent GPs in their provider role. The MOU also includes a summary of the Strategic Objectives of the ICS, and related projects and metrics. The MoU has been approved by both the Leaders Group and Berkshire West Unified Executive, which include: the Trust Chair and Chief Executive (the latter in both groups); Chief Financial Officer and Director of Strategy and Corporate Affairs respectively.
ACTION	For the Trust Board to note the 2018/19 local MoU.

DATE **JANUARY 2016**

1. **BERKSHIRE WEST CCG**
2. **ROYAL BERKSHIRE HOSPITAL FT**
3. **BERKSHIRE HEALTHCARE FT**
4. **WOKINGHAM GP ALLIANCE**
5. **NORTH & WEST READING GP ALLIANCE (NWRGPA)**
6. **READING PRIMARY CARE ALLIANCE (RPCA)**
7. **NEWBURY GP ALLIANCE (NGPA)**

MEMORANDUM OF UNDERSTANDING FOR THE DEVELOPMENT OF AN INTEGRATED CARE SYSTEM FOR THE BERKSHIRE WEST HEALTH ECONOMY

No	Date	Version Number	Author
1	30/12/15	1	RM
2	04/01/16	1.2	RM
3	12/01/16 * 14/01/16	1.32	RM

CONTENTS

Date: **January 2016**

This Memorandum of Understanding (**MoU**) is made between:

1. **NHS Berkshire West CLINICAL COMMISSIONING GROUP** of 57-59 Bath Road , Reading, Berkshire, RG30 2BA;
2. **ROYAL BERKSHIRE NHS FOUNDATIONTRUST** of Craven Road, Reading RG1 5AN (**RBFT**);
3. **BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST** of Fitzwilliam House, Skimped Hill Lane, Bracknell RG12 1BQ(**BHFT**);
4. **WOKINGHAM GP ALLIANCE** of xxxxxxxx, (**WGPA**)
5. **NORTH & WEST READING GP ALLIANCE (NWRGPA)**
6. **READING PRIMARY CARE ALLIANCE (RPCA)**
7. **NEWBURY GP ALLIANCE (NGPA)**

(together the "**Parties**").

RECITALS

1. The Five Year Forward View published in October 2014 (the "**Forward View**") sets out a clear goal that "the NHS will take decisive steps to break down the barriers in how care is provided between family doctors and hospitals, between physical and mental health, between health and social care."
2. In entering into and performing their obligations under this Agreement, the Parties are working towards the implementation of the integrated care models highlighted in the Forward View. In particular, this memorandum of understanding is intended to support the parties' ongoing work towards the establishment of an Integrated Care System.
3. This MoU is focussed on how the Parties may tackle a number of significant operational, clinical and financial challenges for patients in Berkshire West. These significant operational, clinical and financial challenges include: providers coming under increasing financial, performance and quality pressures, demand management programmes with variable levels of success, workforce issues in recruitment across health and social care, and commissioners facing significant affordability pressures given the current configuration of services.
4. The Parties as both providers and commissioners of healthcare in Berkshire West are challenged to ensure the provision of high quality care to an ageing and growing population, within its financial envelope. In accordance with the Forward View the Parties have identified three key system wide challenges, namely:
   - increasing the emphasis on primary prevention, health and wellbeing
   - improving quality of care through better outcomes and experience for patients and achieving constitutional standards; and
   - operating a financially sustainable system.
5. In response to these challenges the Parties have an emerging collective vision for a

clinically and financially sustainable health economy and have agreed with the other Parties to consider how this might be achieved for patients and the population of Berkshire West through the creation of an Integrated Care System (**ICS**).

OPERATIVE PROVISIONS

1. Definitions and interpretation

1.1 In this MoU, capitalised words and expressions shall have the meanings given to them in this MoU.

1.2 In this MoU, unless the context requires otherwise, the following rules of construction shall apply:

1.2.1 a reference to a "**Party**" is a reference to a party to this MoU and includes its personal representatives, successors or permitted assigns and a reference to "**Parties**" is a reference to all parties to this MoU;

1.2.2 a reference to a statute or statutory provision is a reference to such statute or provision as amended or re-enacted. A reference to a statute or statutory provision includes any subordinate legislation made under that statute or statutory provision, as amended or re-enacted;

1.2.3 any phrase introduced by the terms "**including**", "**include**", "**in particular**" or any similar expression shall be construed as illustrative and shall not limit the sense of the words preceding those terms; and

1.2.4 a reference to writing or written includes faxes and e-mails.

2. Purpose and effect of MoU

2.1 The Parties have agreed to work together on behalf of patients and the population to deliver the best possible experience and outcomes within the available resources for Berkshire West. The intention is for the Parties to organise themselves around the needs of their local populations rather than planning at an individual organisational level so as to deliver more integrated care for patients as detailed in Schedule 1 (the "**Integrated Care System**").

2.2 The Parties wish to record the basis on which they will collaborate with each other on the Integrated Care System in this MoU.

2.3 This MoU sets out:

2.3.1 the key objectives for the development of the Integrated Care System;

2.3.2 the principles of collaboration;

2.3.3 the governance structures the Parties will put in place; and

2.3.4 the respective roles and responsibilities the Parties will have during the development of the Integrated Care System.

2.4 The Parties agree that, notwithstanding the good faith consideration that each Party has afforded the terms set out in this MoU, save as provided in paragraph 2.5 below, this MoU shall not be legally binding.

2.5 Paragraphs 13, 15 and 16 shall come into force from the date hereof and shall give rise to legally binding commitments between the Parties.

2.6 In addition to this MoU the Parties will look to develop the following additional documents to manage the relationships and any sharing of information between them:

(i) a confidentiality agreement;

(ii) a protocol to manage conflicts of interest between the Parties; and/or

(iii) a protocol to manage the sharing of information in accordance with information governance principles and competition law requirements.

3. Key Objectives

3.1 The Parties shall undertake the development of the Integrated Care System to achieve the key objectives set out in Schedule 1 (the "**Key Objectives**").

3.2 The Parties acknowledge that the current position with regard to the Integrated Care System is set out in Schedule 1.

4. Principles of collaboration

4.1 The Parties agree to adopt the following principles when carrying out the development of the Integrated Care System (the "**Principles**"):

4.1.1 address the vision. In developing the Integrated Care System the Parties seek to address the triple aims of the Forward View: increasing the emphasis on primary prevention, health and wellbeing; improving quality of care by improving outcomes and experience for patients and achieving constitutional standards; delivering best value for the taxpayer and operating a financially sustainable system;

4.1.2 collaborate and co-operate. Establish and adhere to the governance structure set out in this MoU to ensure that activities are delivered and actions taken as required to deliver change collectively and in partnership with the three Berkshire West local authorities and the wider NHS ;

4.1.3 be accountable. Take on, manage and account to each other, the local authorities, the wider NHS and the Berkshire West population for performance of the respective roles and responsibilities set out in this MoU;

4.1.4 be open. Communicate openly about major concerns, issues or opportunities relating to the Integrated Care System and be transparent adopting an open book approach wherever possible (acknowledging the Parties requirements under paragraph 4.1.5 below);

4.1.5 adhere to statutory requirements and best practice. Comply with applicable laws and standards including procurement rules, competition law, data protection, information governance and freedom of information legislation;

4.1.6 act in a timely manner. Recognise the time-critical nature of the Integrated Care System and respond accordingly to requests for support;

4.1.7 manage stakeholders effectively with a clear intention to engage with all relevant stakeholders in the development of the Integrated Care System and to look towards the future inclusion of social care and the local authorities as parties to the arrangements;

4.1.8 adopt the principles of subsidiarity, noting that the ICS is a structure to be used for progressing work which cannot be done solely at an organisational level;

4.1.9 deploy appropriate resources. Ensure sufficient and appropriately qualified resources are available and authorised to fulfil the responsibilities set out in this MoU; and

4.1.10 act in good faith to support achievement of the Key Objectives and compliance with these Principles and to develop appropriate “Rules of Engagement” between stakeholders in the Integrated Care System.

5. Governance and reporting

5.1 The governance structure defined below provides a structure for the development and delivery of the Integrated Care System.

5.2 The governance arrangements will be

5.2.1 based on the principle. that the Parties respective boards and governance will remain in place and that any decisions will be taken by each relevant Party in accordance with their respective governance.

5.2.2 shaped by the Parties in accordance with existing accountability arrangements, whilst recognising that different ways of working will be required to deliver the transformational ambitions of the Integrated Care System. The Parties intend that there should be as far as permissible a single governance structure to help oversee the transformation to the

Integrated Care System and the delivery of the Key Objectives.

5.2.3 underpinned by the following principles:

(I) the Parties will remain subject to the NHS Constitution and Mandate and retain their statutory functions and their existing accountabilities for current resources and funding flows;

(II) clear agreements will be in place between the CCGs to underpin their governance arrangements where these are joint across the organisations;

(III) Berkshire West commissioners, providers, patients and public will shape the future of Berkshire West health and social care together;

5.3 The governance arrangements will be regularly reviewed to ensure that the Key Objectives are being delivered within the required timeline.

Leadership Team

5.4 The Leadership Team provides overall strategic oversight and direction to the development of the Integrated Care System. This group will initially consist of:

- The Chair and Chief Executive of RBFT
- The Chair and Chief Executive of BHFT
- The Accountable officer and Chair of the CCG
- The ICS Programme Director
- Primary Care Alliance representation
- An independent chair to be appointed by the Parties under a process to be agreed

5.5 The Leadership Team shall be managed in accordance with the agreed terms of reference which can be amended at any time with the consent of the parties.

Unified Executive

5.6 The Unified Executive will provide management at project and workstream level. It will provide assurance to the Leadership Team that the Key Objectives are being met and that the development of the Integrated Care System is within the boundaries set by the Leadership Team.

5.7 The Unified Executive consists of two representatives from each of the parties. The Unified Executive shall have responsibility for the execution of the programme plan and deliverables, and therefore it can draw technical, commercial, legal and communications resources as appropriate into the Unified Executive. The initial Unified Executive members are:

- Three nominated representatives for RBFT(including the Director of Finance and two other members of the executive team);
- Three nominated representatives for BHFT(including the Director of Finance and two other members of the executive team);
- Primary Care Alliance representation
- Two nominated representatives for the CCGs (including a CCG Director of Finance and another member of a CCG executive team); and
- The CCG Accountable Officer (also acting as Chair for the Unified Executive)

5.8 The Unified Executive shall be managed in accordance with the agreed terms of reference which can be amended at any time with the consent of the parties.

6. Roles and responsibilities

6.1 The parties shall undertake the roles and responsibilities set out in the Project Initiation Document for the Integrated Care System to help develop the Integrated Care System and meet the Key Objectives and will look to identify and remove areas of duplication with existing advisory groups for the Berkshire West area.

7. Escalation

7.1 If any Party has any issues, concerns or complaints about the development of the Integrated Care System, or any matter in this MoU, such Party shall notify the other Parties and the Parties acknowledge and confirm that they shall then seek to resolve the issue by a process of discussion.

7.2 If an issue identified in accordance with paragraph 7.1 above cannot be resolved within a reasonable period of time, the matter shall be escalated to the Unified Executive , which shall decide on the appropriate course of action to take.

7.3 If the matter cannot be resolved by the Unified Executive, within fifteen Operational Days (an "**Operational Day**" being a day other than a Saturday, Sunday or bank holiday in England), the matter may be escalated to the Leadership Team for resolution.

7.4 If any Party receives any formal inquiry, complaint, claim or threat of action from a third party (including, but not limited to, claims made by a supplier or requests for information made under the Freedom of Information Act 2000) in relation to the development of the Integrated Care System, the matter shall be promptly referred to the Leadership Team.

8. Conflicts of interest

The Parties agree that they will:

8.1 disclose to each other the full particulars of any real or apparent conflict of interest which arises or may arise in connection with this MoU or the development of the Integrated Care System, immediately upon becoming aware of the conflict of interest whether that conflict concerns the Parties or any person employed or retained by the Parties for or in connection with the development of the Integrated Care System; and

8.2 not allow themselves to be placed in a position of conflict of interest or duty in regard to any of their rights or obligations under this MoU (without the prior consent of the other Parties) before participating in any action in respect of that matter; and

8.3 comply with the terms of any agreed conflict of interest protocol in relation to the operation of the Integrated Care System.

9. Future involvement and addition of Parties

9.1 The Parties are the initial participating organisations in the development of the Integrated Care System but it is intended that other providers and commissioners to the Berkshire West population will also be key partners (including SCAS, GP Practices, independent sector providers and the local authorities (the "Partner Organisations")). Partner Organisations may where appropriate be invited to meetings of the Unified Executive or Leadership Team as observers or through an additional stakeholders forum. If appropriate to achieve the Key Objectives, the Parties may also agree to include additional party or parties to this MoU. If they agree on such a course the Parties will cooperate to enter into the necessary documentation.

10. Competition and Procurement compliance

10.1 The Parties recognise that it is the duty of the CCGs as commissioners, rather than the providers, to decide what services to procure and how best to secure them in the interests of patients. In addition, the Parties are aware of their competition compliance obligations, both under competition law and, in particular under the Monitor Provider Licence for providers, and shall take all necessary steps to ensure that they do not breach any of their obligations in this regard. Further, the Parties understand that in certain circumstances collaboration or joint working could trigger the merger rules and as such be notifiable to the Competition and Markets Authority and Monitor and will keep this position under review accordingly.

10.2 The Parties understand that no decision shall be made to make changes to the services in Berkshire West or the way in which they are delivered without prior consultation where appropriate in accordance with the Parties statutory and other obligations.

11. Term and Termination

11.1 This MoU shall commence on the date of signature by all the Parties, and shall continue until terminated by a Party in accordance with paragraph 11.2 below.

11.2 Any Party may terminate this MoU by giving at least *3* months' notice in writing to the other Parties.

12. Variation

12.1 This MoU, may only be varied by written agreement of the Parties and signed by, or on behalf of, each of the Parties.

13. Charges and liabilities

13.1 Except as otherwise provided, the Parties shall each bear their own costs and expenses incurred in complying with their obligations under this MoU including in respect of any losses or liabilities incurred due to their own or their employee's actions.

13.2 No Party intends that any other Party shall be liable for any loss it suffers as a result of this MoU.

14. No partnership

14.1 Nothing in this MoU is intended to, or shall be deemed to, establish any partnership or joint venture between the Parties, constitute either party as the agent of the other party, nor authorise either of the Parties to make or enter into any commitments for or on behalf of the other party.

15. Counterparts

15.1 This MoU may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this MoU, but all the counterparts shall together constitute the same agreement.

15.2 The expression “counterpart” shall include any executed copy of this Agreement transmitted by fax or scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e-mail attachment.

15.3 No counterpart shall be effective until each Party has executed at least one counterpart.

16. Governing law and jurisdiction

16.1 This MoU shall be governed by and construed in accordance with English law and, without affecting the escalation procedure set out in paragraph 7, each Party agrees to submit to the exclusive jurisdiction of the courts of England and Wales.

Signed by Berkshire Healthcare NHS Foundation Trust

Name:
Title:

Signed by Royal Berkshire Hospital NHS Foundation Trust

Name:
Title:

Signed by Berkshire West Clinical Commissioning Group

Name:
Title:

Signed by Wokingham GP Alliance

Name:
Title:

Signed by NW Reading GP Alliance

Name:
Title:

Signed by Reading Primary Care Alliance

Name:
Title:

Signed by Newbury Primary Care Alliance

Name:
Title:

Schedule 1

The ICS Strategic Objectives 18/19

NHS England MoU Domains	**Deliver the 5YFV four priorities: Progress urgent care, strengthen general practice, improve mental health and cancer** **Meet the system and organisation level financial control totals by delivering efficiencies and other improvements** **Develop integrated care pathways that build on a Population Health Management approach** **Act as a leadership cohort and contribute to the National ICS Programme of work**
ICS Objectives	**An improvement in the health and wellbeing of our population** **Enhancement of patient experience and outcomes** **Financial sustainability for all constituent organisations and the ICS**

18/19 Strategic Priorities

Develop a resilient urgent care system that meets the on the day need of patients and is consistent with our constitutional requirements		To redesign care pathways to improve patient experience, clinical outcomes and make the best use of clinical and digital resources		Progress a whole system approach to transforming primary care to deliver resilience, better patient outcomes and experience and efficiency	Develop the ICS supporting infrastructure to deliver better value for money and reduce duplication		Deliver the ICS financial control total agreed to by the Boards of the constituent statutory organisations

Key projects

ED streaming	Urgent Treatment Centre at WBCH	Outpatients Programme	iMSK	Deliver the enhanced access requirements set out by the FYFV and ICS MOU	Develop the ICS implementation plan	Work with Kings Fund to Agree the ICS Vision and Objectives	Credible financial recovery plan for 19/20 and 20/21
High Intensity User project	Demand & Capacity Model for bedded care	*Medicines utilisation*	*Cardiology*	Implement networks / neighbourhoods of practices each with a registered population of 30-50k covering the localities in Berkshire West	Progress the workforce projects identified by the ICS Workforce Group	Develop and implement a new contractual form	Progressing transparency of cost information at SLR level
Develop IUC & Launch 111 online	Wellbeing service CPE	*Respiratory*	*Long Term Conditions* (Care planning and Integrated Falls pathway)	Strengthen the workforce through better recruitment and retention to support sustainability and expansion of primary care	Agree and deliver ICS public engagement programme	Agree blueprint for PHM and implement a solution	
Produce a UEC Strategy for Berkshire West		*Ophthalmology*	*Phlebotomy*	Develop and work with provider Alliances to provide greater resilience and capacity in addition to enabling the implementation of new care models	Shared Corporate Services	Shared Estates project	

Benefits

• Patients being seen in the most appropriate setting • Services located where they are needed which provide care in a timely manner • Fewer patients needing to access on the day services from the acute hospital	• Patients to receive more of their care closer to home • Greater reliance on technology to free up clinical time for more complex tasks • Unlock estate capacity through fewer F2F appts • Services provided at a lower cost to the taxpayer	• Patients to be able to see a GP 7 days a week from 1st October 2018 • Greater resilience and capacity within the primary care sector • Development and deployment of new care models which are more integrated and delivered closer to patients' homes	• Increased public and patient involvement and understanding • New ways of working together to resolve issues • New payment mechanisms • Clear investment programmes based on objectives • Improved decision making to support health	• A system that is delivering its financial trajectory

Metrics

• 4 hour A&E standard performance against the agreed trajectory • Reduced growth in A&E Attendances • Reduced growth in NEL admissions • DTOC performance	• NEL and EL admissions per 100k • ALOS (MH, Community & Acute) • Aggregate £ savings from projects • Patient experience measure (to be defined) • Patient outcome measures (to be defined) • Reduction in Out of Area Placements	• Workforce bundle metrics (TBC) • Access to GP services including evenings and weekends for 100% population by 01/10/18 • Ensuring every practice implements at least 2 high impact "time to care" actions • Proportion of practices that are members of an alliance • Proportion of practices doing care planning through integrated teams	• Workforce bundle metrics (TBC) • Presence of a 3 year 'roadmap' that delivers the KPIs • Presence of a PHM blueprint • New contract form agreed and in place • Presence of an OD plan	• RBFT CT performance • BHFT CT performance • CCG CT performance • System CT performance • Agreed financial strategy in place for 19/20 and 20/21

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	11 September 2018
Title	**Audit Committee – 25 July 2018**
Purpose	To receive the unconfirmed minutes of the meeting of the Audit Committee of 25 July 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 Audit Committee reviewed the Board Assurance Framework and the Corporate Risk Register. The Committee agreed to recommend to the Trust Board that the risk relating to demand outstripping supply currently on the Corporate Risk Register should be transferred to the Board Assurance Framework in view rising demand for some services. The Audit Committee also agreed to recommend to the Trust Board the following additional changes to the Board Assurance Framework: • Risk 1 (workforce) – to be expanded to include the impact of workforce shortages on patient experience; • Risk 2 (clinician and service users involvement in the development of new pathways – to be closed because this was now integral to the Quality Improvement approach; • Risk 5 (regulatory standards) to be closed on the basis that workforce shortages presented the greatest risk to the Trust failing to meet the regulatory requirements and this was covered by risk 1.

	The Committee also made a couple of minor changes to its terms of reference as highlighted in red tracked changes.
ACTION REQUIRED	The Trust Board is asked: a) To receive the minutes and to seek any clarification on issues covered; b) To ratify the proposed changes to the Board Assurance Framework c) To ratify the proposed changes to the Audit Committee's Terms of Reference

Unconfirmed Draft Minutes

Minutes of the Audit Committee Meeting held on

Wednesday, 25 July 2018, Fitzwilliam House, Bracknell

Present:	Chris Fisher, Non-Executive Director, Committee Chair Naomi Coxwell, Non-Executive Director Mehmuda Mian, Non-Executive Director
In attendance:	Alex Gild, Chief Financial Officer Lorraine Bennett, Counter Fraud, TIAA Clive Makombera, Internal Auditors, RSM Amanda Mollett, Head of Clinical Effectiveness and Audit Minoo Irani, Medical Director Ben Sheriff, Deloitte, External Auditors Julie Hill, Company Secretary Paul Gray, Director of Finance David Townsend, Chief Operating Officer *(present for item 5)*

Item	Title	Action
1.A	**Chair's Welcome and Opening Remarks**	
	Chris Fisher, Chair welcomed everyone to the meeting.	
1.B	**Apologies for Absence**	
	Apologies were received from: Debbie Fulton, Deputy Director of Nursing, Debbie Kinch, TIAA and Laura Rogers, Deloitte	
2.	**Declaration of Interests**	
	There were no declarations of interest.	
3.	**Minutes of the Previous Meetings held on 25 April 2017 and 23 May 2018**	
	The Minutes of the meetings held on 25 April 2018 and 23 May 2018 were approved as a correct record after a minor correction was made to the minutes of the meeting held on 25 April 2018 as follows: Min no 13 – Internal Audit (top of page 9 to read: "The Chair asked whether RSM had awarded any level 1 ratings for 2017-18. Mr Makombera confirmed that **one** level 1 rating had been awarded".	
4.	**Action Log and Matters Arising**	
	The action log had been circulated. The following items were discussed further: **a) Agenda for Change Pay Award** The Chief Financial Officer reported that the Trust was still assessing the	

	financial impact of the Agenda for Change three year pay award and the GP and Doctors' pay award. **b) Clinical Audit Team** The Chair reported that he had raised the issue of the resourcing pressures associated with the increasing number of national clinical audits at the Trust Board meeting. The Head of Clinical Effectiveness and Audit reported that the team was currently out to advert for an additional Administrative Assistant. The Committee noted the Action Log.	
5	**Business Continuity Planning Process Report**	
	The Chair welcomed the Chief Operating Officer and invited him to present his report. The Chief Operating Officer reported that he was the Accountable Emergency Officer for the Trust and was the Trust Board lead for Emergency Preparedness. It was noted that all the Trust's services had completed a business impact analysis in order to determine their priority level as set out at page 29 of the agenda pack. This scale was an important part of business continuity planning as it indicated the order of priority in which services or activities within a service may be suspended and should be recovered in the event of a disruption to normal service delivery. The Chief Operating Officer reported that the Trust had two main emergency on call rotas: one for Directors and another one for Locality and Service leads. It was noted that the Trust participated in local, regional and national emergency preparedness exercises. In addition, over the years, there had been a number of emergencies affecting the Trust. These included the fatal fire on Daisy Ward, flooding at both Community Hospitals and recently a power outage for 3.5 hours at Prospect Park Hospital. It was noted that after every emergency, the Trust undertook a lessons learnt review to help with future incidents and to identify whether there needed to be any changes to estate maintenance regimes. Naomi Coxwell, Non-Executive Director referred to the power outage at Prospect Park Hospital and asked whether this had led to heightened anxiety amongst the patients. The Chief Operating Officer said that the power outage had occurred between 2.00am and 5.30am so most patients were asleep and were unaware of the loss of power. It was noted that staff had to work with only emergency lighting and that this had been challenging. The Chief Operating Officer said that one of the lessons learnt after the evacuation following the Daisy Ward fire was that evacuating mental health patients was challenging because some patients refused to leave their rooms and would not cooperate. The Chief Operating Officer reported that the Trust had produced an evacuation video to support staff fire evacuation training. The Chair referred to the Trust's compliance with the NHS Core Standards for Emergency Preparedness, Resilience and Response (EPRR) as set out at page 39 of the agenda pack and asked whether it was a cause for concern that	

	not all staff on the on-call rota had received training. The Chief Operating Officer reported that before a member of staff joined the on-call rota, they attended an induction training session and would be assigned a “buddy” to help them understand their role. The Chief Operating Officer said that the majority of the on-call directors had attended the Crisis Management training and pointed out that the role of the on-call directors was to be one step removed from the incident and to assess the situation, take remedial action and deal with the aftermath and that the most important prerequisite for the role was common sense. It was noted that the requirement for on-call directors to attend strategic crisis management training was part of the EPRR core standards. Mehmuda Mian, Non-Executive Director asked whether the Trust had taken steps in response to the continuing heat wave. The Chief Operating Officer confirmed that the Trust had implemented its summer resilience plan which included ensuring that patients were given additional hydration on the wards and that Community Nurses checked that patients were drinking sufficiently when they visited patients at home. The Chair thanked the Chief Operating Officer for his report and for attending the meeting. The Committee noted the report.	
6.A	**Board Assurance Framework**	
	The Chair reminded the meeting that at the last meeting, the Committee had requested that the Executive Team review the risks on the Board Assurance Framework to ensure that they continued to reflect the Trust’s key strategic risks. The full Board Assurance Framework had been circulated. Updates since the last Audit Committee were highlighted in red type. It was noted that following the Executive Review, it was proposed that risk 2 (co-production) and risk 5 (compliance with regulatory standards) be removed because the involvement of clinicians and co-production with service users was integral to the Quality Improvement Programme and the key risk to the Trust failing to meet regulatory standards was around work force shortages (risk 1). It was noted that that risk 1 had been expanded to include the impact of workforce shortages on patient experience. It was also noted that the Executive had proposed that the demand outstripping supply risk currently on the Corporate Risk Register be transferred to the Board Assurance Framework to reflect increased waiting times for some services and increasing demand. The Chair commented that he welcomed the approach taken by the Executive Team and fully supported the proposed changes to the risks on the Board Assurance Framework. The Chair requested a “deep dive” report into the new demand risk to help the Committee understand the issues and the actions which the Trust was putting	**DT/JH**

	in place to manage and mitigate the risk. The Chair also requested that the Executive Director risk owners review the risk scores of each of the risks for discussion at the next meeting. The Chair referred to risk 7 in relation to partnership working and queried why the risk score had reduced from severe to moderate. The Chief Financial Officer reminded the Non-Executive Directors that the Trust Board had received the outcome of the Stakeholder Reputational Survey which had provided assurance around how the Trust was regarded by partner organisations and as a consequence the risk score had been decreased. The Chief Financial Officer said that there remained a gap in assurance in relation to the lack of Non-Executive Director and Lay Member representation on both the Integrated Care Systems' governance arrangement. Naomi Cowell, Non-Executive Director commented that the Audit Committee reviewed the Board Assurance Framework on behalf of the Trust Board and asked about the governance process in relation to the Trust Board approving the changes to the risks on the Board Assurance Framework. The Chair explained that the minutes of the meeting would be presented to the September 2018 Trust Board meeting with a recommendation that the Trust Board approve the changes to the Board Assurance Framework. The Company Secretary reported that the Trust Board's Annual Strategic Planning Away Day on 9 October 2018 would be asked to review all the risks on the Board Assurance Framework in the light of their strategic discussions and that the November 2018 Trust Board In Committee meeting would receive the full Board Assurance Framework and Corporate Risk Register for review. The Committee agreed to recommend to the Trust Board that: a) Risk 1 (workforce) be expanded to include the impact of workforce shortages on patient experience; b) Risk 2 (co-production) and Risk 5 (regulatory standards) be removed from the Board Assurance Framework; and c) The demand outstripping risk currently included on the Corporate Risk Register be transferred to the Board Assurance Framework. The Committee noted the updates to each of the risks.	**JH** **JH**
6.B	**Corporate Risk Register**	
	The Corporate Risk Register had been circulated. It was noted that the Executive Director risk owners had reviewed the wording of each of the risk descriptions. The Chair referred to the absconsion risk and noted that the number of AWOLs and Absconsions in the rolling quarter to May 2018 had been lower than in the previous 12 months but there had been some increase in the last month and asked whether the Finance, Investment and Performance Committee had picked this up as part of their scrutiny of the Performance Assurance Framework report. Naomi Coxwell, Chair of the Finance, Investment and Performance Committee	

	said that the Committee had not discussed this particular performance indicator, but pointed out that as part of the Quality Improvement Programme, the Trust was currently reviewing its performance management reporting system. The Chair referred to the Cyber and Malware risk and requested that the Committee receive a further update to the January 2019 Committee. The Committee noted the report.	**AG/MD**
7.	**Single Waiver Tenders Report**	
	A paper setting out the single waivers approved from April 2018 to June 2018 had been circulated. The Chair commented that companies included on the national procurement frameworks would have to comply with a plethora of requirements and asked what steps the Trust took to ensure that non-framework companies met required standards, for example, in terms of resilience and security checks. The Chief Financial Officer agreed to find out and update the Committee. The Committee approved the single waivers as set out in the report.	**AG**
8.	**Information Assurance Framework Update Report**	
	The Chief Financial Officer presented the paper and highlighted the following points: • A total of five indicators were audited during quarter 1. Two indicators were rated with high assurance (green); two were rated with moderate assurance (amber); and one was rated with low assurance (red) in terms of data quality; • The red rated indicator - Mental Health Patient to Patient Assaults and was in relation to incorrect reporting onto the DATIX incident reporting system; the indicator was rated green for data assurance; • Of the six records DATIX patient assaults incidents audited, all were recorded incorrectly. All incidents were recorded as patient on staff assaults. • Action plans have been put in place to address the issues: • The data assurance for all indicators provided high levels of assurance. The Chief Financial Officer pointed out that reducing the incidence of patient to staff assaults was one of the Trust's Quality Improvement Programme Breakthrough objectives and therefore it was particularly important to ensure that the data was accurate. The Chair reported that the Director of Nursing and Governance had agreed to review Datix incident reporting and the outcome of which would be reported to the next meeting of the Audit Committee. Naomi Coxwell, Non-Executive Director said that the Quality Improvement Programme had exposed the need for more sophisticated data gathering and asked about the degree of confidence that this could be achieved.	**HM/DF**

	The Chief Financial Officer reported that the Trust would use the Quality Improvement methodology to undertake the review. The Chair commented that the chart on page 102 of the agenda pack highlighted that there was significantly higher performance in relation to data assurance than with data quality. The Committee noted the report.	
9.	**Losses and Special Payments Report**	
	There was no report this meeting.	
10.	**Clinical Audit Progress Report**	
	The Head of Clinical Audit and Effectiveness presented the report and highlighted the following points: • The Annual Clinical Audit Plan for 2018-19 was attached at appendix 1 of the report. • There were a total of 27 national quality audit reportable projects. • Two completed clinical audits would be submitted to the Quality Assurance Committee in August 2018 (prescribing Valproate for Bipolar Disorder and Early Intervention in Psychosis). The Chair asked in view of the additional administrative resource whether the Team was confident in delivering the clinical audit programme within the timescales. The Head of Clinical Audit and Effectiveness reported that it was particularly challenging this year because a number of the new audits had not been adequately tested and in some cases, the national systems were not working, resulting in data requirements being changed mid-way through the audits. It was also noted that the size of the audits and the number of data requirements was also increasing. Naomi Coxwell, Non-Executive Director asked whether the Trust should raise this issue with NHS Providers. The Medical Director proposed raising the concerns with the Mental Health Network. The Committee noted the report.	**MI**
11.	**Clinical Claims and Litigation Report Quarterly Report**	
	The Clinical Claims and Litigation Report for quarter 1 had been circulated. It was noted that there were three new claims received which was consistent with all quarters in 2017-18 (two related to employer liability and one related to patient care. The Chair commented that no claims had been closed this quarter and asked for an update on the open claims at the next meeting. The Committee noted the report.	**DF**
12.	**Internal Audit**	

	A) Internal Audit Progress Report Clive Makombera, Internal Auditors, RSM, presented the Internal Audit Progress Report and reported that: • Since the last Audit Committee meeting, three reports had been finalised: Key Financial Controls, Fit and Proper Person Test and Conflict of Interests. All three reviews had received "reasonable assurance". • Section 2 of the report provided information about the outstanding follow up of internal audit actions. • A copy of "Health Matters" and a benchmarking report on GDPR preparation had been circulated for information. The Chair requested an opportunity to review the scope of the Cost Improvement Programme Benefits Realisation review. Mr Makombera agreed to work with the Director of Finance to develop the review scope which would then be shared with the Chair. The Chair referred to the outstanding internal audit actions and requested that the Audit Committee receive an update on progress to implement the one high and four medium actions at the next meeting. Naomi Coxwell, Non-Executive Director pointed out that there may be reasons why management had decided not to implement the particular actions. Mr Makombera said that he and his team were happy to have a conversation with the relevant managers about whether alternative actions should be put in place. It was noted that in relation to the Procurement review, the Procurement Strategy would be presented to the Audit Committee in October 2018 and not in July 2018 as stated in the report. The Chair referred to page 124 of the agenda pack and asked whether there was any further information in relation to the January 2015 audit action in relation to Appraisers training. The Chief Financial Officer agreed to find out what progress had been made in terms of the take up of Appraisers training. The Chair referred to the Key Financial Controls review and asked whether the finding that 25% of controls in Payroll were non-compliant was a cause for concern. Clive Makombera confirmed that that the non-compliance was low level and related mainly to housekeeping issues and was therefore not a cause for concern. The Chair referred to the Fit and Proper Persons Test review and asked whether there were any Trust Board members who had not yet received an enhanced DBS check. The Company Secretary confirmed that all Trust Board members had a satisfactory enhanced DBS check in place. The Chair referred to the Conflicts of Interests review and asked whether the	**CM/PG** **PG** **AG/TS** **AG**

	issue of Board Members non-declaration of interests had been resolved. The Company Secretary reported that the Internal Auditors had identified a small number of historic interests in companies which had ceased to exist for a number of years and an interest in respect of an organisation which had no relevance to the Board members role (nevertheless this interest was now recorded on the Register of Directors' interests). Ben Sheriff, Deloitte pointed out that experience from other organisations was that staff sometimes did not appreciate the difference between declaring when they were a majority shareholder in a private company as opposed to a shareholder in a public company. Naomi Coxwell, Non-Executive Director referred to page 162 of the agenda pack and asked whether it would be exploring the GDPR software app. The Chief Financial Officer agreed to ask the Director of IM&T to review the app and report back. The Committee noted the report.	**AG/MD**
13.	**Counter Fraud**	
	A) Counter Fraud Annual Report 2017-18 Lorraine Bennett, Counter Fraud Service, TIAA presented the paper and highlighted the following points: • A risk-based counter fraud work plan was approved by the Trust's Counter Fraud Specialist (CFS) and was approved by the Audit Committee. • The Trust had self-assessed itself against the NHS Protect Standards for Providers: Fraud, Bribery and Corruption using the self-review tool. • The Trust's overall self-assessment rating was "green" with two 2 "amber" scores relating to the standard to have a fully implemented code of conduct which included reference to fraud, bribery and corruption and for the effectiveness of the code to be regularly test. • The other "amber" area required the Trust to review new and existing relevant policies and procedures using audit reports, investigation closure reports and the NHS Counter Fraud Authority guidance to ensure that appropriate counter fraud, bribery and corruption measures were included. The required changes to the Trust's policies were cosmetic. • To raise awareness and assist in the prevention of fraud and corruption, TIAA monitored emerging and current frauds and provided information, guidance and advice. • In the first six months of 2017-18, TIAA experienced a modest reduction in the overall level of fraud referrals entering the system and a subsequent impact on successful sanctions and redress. The NHS Counter Fraud Authority had confirmed that the TIAA data aligned with the national picture. • Working whilst on sick leave and issues relating to the completion of time sheets were the most common sources of fraud referrals. • Any completed investigations and proactive reviews included a matrix which highlighted any key system weaknesses identified and associated recommendations. During 2017-18 there was one red (high)	

	and six amber (medium) recommendations which had all been completed. The Chair asked whether there was a process in place to ensure that the completion of the self-review tool was reliable. Lorraine Bennett said that the NHS Counter Fraud Authority did undertake peer assessments only had a small team. The Chief Financial Officer said that he would consider asking the Internal Auditors to undertake a review of the Trust's self- assessment against the Counter Fraud standards. The Chair referred to page 203 of the agenda pack which asked the Audit Committee to consider whether the Trust's current level of resources put into fraud awareness raising was sufficient and targeted in the right areas and asked Ms Bennett for her view. Ms Bennett confirmed that she thought that the Trust devoted sufficient fraud awareness raising resources and that she was confident that the Trust would extend the number of days allocated to TIAA, if this was required in order for TIAA to complete their investigations. The Committee noted the report. **B) Counter Fraud Progress Report** Lorraine Bennett, Counter Fraud Service, TIAA presented the paper and reported that the progress report detailed activity carried out against the agreed Counter Fraud work plan since the April 2018 Audit Committee meeting. The Committee noted the report. **C) "Fraud Stop" Newsletter** TIAA's "Fraud Stop" Newsletter had been circulated for information. The Committee noted the report.	**AG**
14.	**External Audit Report**	
	Ben Sheriff, Deloitte, External Auditors presented the paper which highlighted the Department of Health and Social Care's changes to the Group Accounting Manual for 2018-19. The Chair reminded the meeting that the Audit Committee would be reviewing the impact of the changes at the October 2018 meeting. The Chair referred to the bottom of page 241 of the agenda pack which made reference to the Sustainability and Transformation Partnerships and commented that the lack of Non-Executive Director (other than the Trust Chair) and Lay Member involvement in the two Integrated Care Systems was a concern. The Chief Financial Officer reminded the meeting that this issue had been flagged on the Trust's Board Assurance Framework as a gap in assurance. The Committee noted the report.	**AG**

15.	**Minutes of the Finance, Investment and Performance Committee meetings held on 25 April 2018 and 27 June 2018**	
	The minutes of the Finance, Investment and Performance Committee meetings of 25 April 2018 and 27 June 2018 were received and noted. Naomi Coxwell, Chair of the Finance, Investment and Performance Committee reported that the Committee had met earlier today and discussed the following issues: • The Trust had delivered the first quarter financial plan; • The Trust was reviewing the delivery of the Cost Improvement Plan in relation to WestCall and the Crisis Resolution Home Treatment Team; • There was a reduction in the number of inappropriate Out of Area Placements which reflected the work being undertaken as part of the Bed Optimisation Programme. This included introducing a 72 hour review process after admission for new patients, reducing the length of stay and improving discharge processes. • The Royal Berkshire Hospital NHS Foundation Trust had moved off the payment by results funding mechanism to a block contract arrangement. The Chair said that it would be helpful to have an Out of Area Placement's dashboard to monitor the progress being made in relation to the Bed Optimisation Programme. Naomi Coxwell reported that the Trust was currently revising the Performance Assurance Framework.	
17.	**Minutes of the Quality Assurance Committee held on 15 May 2018**	
	The minutes of the Quality Assurance Committee meeting of 15 May 2018 were received and noted. The Chair reported that he had requested that the Clinical Directors of Mental Health West Locality and Mental Health Services East and Inpatients attend the Quality Assurance Committee and the Audit Committee to present on the Trust's work to improve the interfaces between the Common Point of Entry, Crisis Resolution Home Treatment Team and the Community Mental Health Team.	**GB/SM**
18.	**Minutes of the Quality Executive Committee held on 9 April 2018, 14 May 2018 and 11 June 2018**	
	The minutes of the Quality Executive meetings of 9 April 2018, 14 May 2018 and 11 June 2018 were received and noted.	
18.	**Annual Review of Effectiveness**	
	The Company Secretary reported that the responses to the Annual Review of the Committee's effectiveness had been very positive. The Chair asked Ben Sheriff, External Auditors if Deloitte could with providing professional development sessions for the Committee.	**BSh**

	The Committee reviewed the terms of reference and agreed to delete references to the Care Quality Commission standards as this was covered by the Quality Assurance Committee. The Committee noted the report.	
19.	**Annual Work Plan**	
	The Committee noted the work programme.	
20.	**Any Other Business**	
	Charitable Funds Account Audit Ben Sheriff, Deloitte reported that the Trust's Charitable Fund was small enough for it not to require an external audit. The Chief Financial Officer confirmed that he would review whether or not to ask Deloitte to externally audit the Charitable Funds Account.	**AG**
21.	**Date of Next Meeting**	
	31 October 2018	

These minutes are an accurate record of the Audit Committee meeting held on 25 July 2018.

Signed:- _____

Date: - 31 October 2018 _____

Berkshire Healthcare NHS
NHS Foundation Trust

Terms of Reference

Audit Committee

Purpose

This document contains the terms of reference for the Trust Audit Committee.

Document Control

Version	Date	Author	Comments
1.0	12 Mar 08	Garry Nixon	Initial Draft for Committee Chair
2.0	14 Mar 08	Garry Nixon	Updated following Committee Chair comments
3.0	1 May 08	Garry Nixon	Updated following Audit Committee consideration
4.0	22 May 09	John Tonkin	Revised per Internal Audit Report Recommendations on Integrated Governance – Ref: 080902
5.0	28 May 09	Clive Field	Minor amendments
6.0	12 August 2010	John Tonkin	Revision following Audit Committee review July 2010
7.0	14 Sept 2010	John Tonkin	Revision following Board consideration 14 Sept 2010
8.0	8 May 2012	John Tonkin	Revision following Board consideration 8 May 2012
9.0	12 April 2013	John Tonkin	General revision to reflect changes in past year
10.0	23 May 2013	John Tonkin	Revision following Board discussion on 14 May 2013
11.0	11 June 2013	John Tonkin	Board approved – 11 June 2013
12.0	13 May 2014	John Tonkin	Board approved - 13 May 2014
13.0	27 July 2016	Julie Hill	Revision following Audit Committee review – October 2016
14.0	08 November 2016	Julie Hill	Board approved – 08 November 2016
15.0	July 2018	Julie Hill	Revision following Audit Committee review – July 2018

Document References

Document Title	Date	Published By
NHS Audit Committee Handbook	2005	Department of Health & Healthcare
The NHS Foundation Trust Code of Governance	2006	NHS Improvement, Independent Regulator of NHS Foundation Trusts

Authority

1.1 The Audit 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 Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee.

1.3 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary.

Purpose

2.1 To conclude upon the adequacy and effective operation of the Trust's overall internal control system and independently review the framework of risks, controls and related assurances that underpin the delivery of the Trust's objectives.

2.2 To review the disclosure statements that flow from the Trust's assurance processes ahead of its presentation to the Trust Board, including:

a. Annual Governance Statement, included in the Annual Report and Accounts and the Annual Plan together with the external and internal auditors' opinions.

~~b. Care Quality Commission registration information.~~

~~c.~~b. Annual Plan declarations relating to the Assurance Framework.

2.3 ~~To approve the financial and self-certification quarterly returns to NHS Improvement on behalf of the Trust's Board of Directors.~~

Membership

3.1 The membership of the Committee shall comprise three Non-Executive Directors, at least one of whom shall have recent and relevant financial experience, plus, ex officio, the Chair of the Finance, Investment & Performance Committee. The Chair of the Quality Assurance Committee will attend as and when there are appropriate matters to discuss with the Audit Committee.

3.2 The Chair of the Trust and the Chief Executive shall **not** be members.

3.3 The Chair of the Committee will be a Non-Executive Director and will not be a member of any other standing Committee of the Board.

3.4 A quorum shall be two members.

In attendance at meetings

4.1 The Committee will be supported by the following in attendance:

~~• The Director of Finance, Performance and Information~~

- Chief Financial Officer
- Director of Finance
- The Company Secretary

4.2 The Committee can invite the Chairman and Chief Executive as well as other Trust Directors or Officers to attend to discuss specific issues as appropriate.

4.3 The Committee will be attended by representatives of the following:

- External Audit
- Internal Audit
- Counter Fraud
- Clinical Audit

4.4 The Committee will consider the need to meet privately, at least once a year, with both the internal and external auditors. The internal and external auditors may request a private meeting with the Committee at any time.

Frequency and Administration of Meetings

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

5.2 It will be supported by the Company Secretary who will agree the agenda for the meetings and the papers required, directly with the Chair.

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

Duties

Governance Risk Management and Internal Control

6.1 The Committee shall review the establishment and maintenance of an effective system of integrated Governance, risk management and internal control, across the Trust's clinical and non-clinical activities that support the achievement of its objectives.

6.2 The Committee shall ensure that the Board Assurance Framework is effective in enabling the monitoring, controlling and mitigation of risks to the Trust's strategic objectives.

6.3 In particular, the Committee will review the adequacy of the following:

a. All risk and control related disclosure statements, together with any accompanying Head of Internal Audit statement, external audit opinion or other independent assurances, prior to endorsement by the Board;

b. The underlying assurance processes that indicate the following:

- The degree of the achievement of corporate objectives
- The effectiveness of the management of principal risks
- The appropriateness of the disclosure statements

c. The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements.

6.4 The Committee shall request and review reports and positive assurances from Directors and managers on the overall arrangements for governance (including clinical audit and data quality), risk management and internal control.

Audit & Counter Fraud

6.5 The Committee shall ensure that there is an effective internal audit function and clinical audit function that provide appropriate independent assurance to the Audit Committee and includes the following:

a. Review the Internal Audit Plan, operational plan and programme of work and recommend this for acceptance by the Trust Board of Directors.

b. The review of the findings of internal audits and the management response.

c. Discussion and agreement with the External Audit of the nature and scope of the External Audit annual plan.

d. The review of all external audit reports, including the agreement of the annual audit letter before submission to the Board and any work completed outside the External Audit annual plan.

e. Review and approval of the Counter Fraud Plan and operational plans.

f. The review of the findings of the Counter Fraud plan and the management response.

6.6 Clinical Audit

The Committee shall ensure that there is an effective Clinical Audit process. This includes

~~g.~~ ~~R~~reviewing the annual clinical audit plan and receiving~~e~~ regular reports on both progress against plan and status of relevant action plans. ~~and key audit outcomes~~.

~~h) Review the audit findings from the annual audit of the mortality review process in the Trust.~~

~~6.6 The Committee shall ensure that there is an effective Clinical Audit process.~~

6.7 The Committee shall ensure that Internal Audit, External Audit and Clinical Audit recommendations are implemented promptly by management.

Financial Reporting

6.8 The Committee shall review the Annual Accounts and Financial Statements before submission to the Board.

6.9 It will ensure that the financial systems for financial reporting to the Board are subject to review as to completeness and accuracy of the information provided to the Board.

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6.10 It will review the annual accounts of the Charitable Trustees prior to submission.

Reporting

6.11 The Committee will routinely review the minutes of:

- Finance, Investment & Performance Committee
- Quality Assurance Committee
- Quality Executive Committee

and will review the work of other committees within the organisation whose work can provide relevant assurance to the Committee.

6.12 The Minutes of the Audit Committee will be formally submitted to the Trust Board.

6.13 The Chair of the Committee shall report to the Board any concerns and assurances relating to the Trust and the Committee's work.

6.14 It will report annually to the Trust Board through an 'Audit and Governance Report' which will include the following:

a. The fitness for purpose of the assurance framework.

b. The completeness and embeddedness of risk management.

c. The integration of Governance arrangements.

d. The Committee's self-assessment and any action required.

Other functions

6.15 The Committee will review and monitor compliance with Standing Orders and Standing Financial instructions.

6.16 It will review the following:

a. Schedules of losses & compensations and making recommendations to the Board

b. Any decision to suspend Standing Orders

c. Decision to waive the competitive tendering rules when requested by the Board

6.17 It will approve changes in accounting policies.

6.18 It will review the performance of the Audit Committee through self-assessment and independent review to be completed at least annually. It will also review the output from the annual self-assessment exercises conducted by other Board Committees.

6.19 It will provide oversight of the Trust's processes for ensuring robust data quality and will review periodic reports on data quality performance.

6.20 The Committee shall provide assurance on the quality checks of data used in the preparation of the Performance Assurance Framework.

6.21 The Committee will provide assurance on the system for identifying cost improvement plans, including the process for ensuring that there are no adverse impacts on quality.

6.22 ~~The Committee will provide assurance that the effective operation of the system surrounding compliance with CQC care standards.~~

6.23 The Committee shall encourage the sharing of, and learning from, lessons learnt across the Trust from serious incidents.

Amended: July 2018

Board approved:

Next review: July 2019

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	11 September 2018
Title	Change to the Membership of the Remuneration Committee
Purpose	To extend the membership of the Remuneration Committee to all Non-Executive Directors
Business Area	Corporate
Author	**Company Secretary**
Relevant Strategic Objectives	N/A
CQC Registration/Patient Care Impacts	N/A
Resource Impacts	None
Legal Implications	None
Equality and Diversity Implications	Extending the membership of the Remuneration Committee will provide gender balance
SUMMARY	At its last meeting in May 2018, the Remuneration Committee reviewed its membership which was currently all-male. The Trust Chair, the Remuneration Committee Chair and the Company Secretary met to discuss the options for achieving a better gender balance on the Committee. It was agreed to recommend to the Trust Board that the membership of the Committee should be extended to all Non-Executive Directors.
ACTION REQUIRED	The Board is asked to approve that the membership of the Remuneration Committee be extended to include all Non-Executive Directors.