Berkshire Healthcare
NHS Foundation Trust

**BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST**

**TRUST BOARD MEETING HELD IN PUBLIC**

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

## AGENDA

| No | Item | Presenter | Enc. |
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| | **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<br>i. Amendments to the Register<br>ii. Agenda Items | Martin Earwicker, Chair | Verbal |
| 5.1 | Minutes of Meeting held on 13 November 2018 | Martin Earwicker, Chair | Enc. |
| 5.2 | Action Log and Matters Arising | Martin Earwicker, Chair | Enc. |
| | **QUALITY** | | |
| 6.0 | Patient Story: Perinatal Service | Debbie Fulton, Acting Director of Nursing and Governance | Verbal |
| 6.1 | Freedom to Speak Up Guardian's Six Monthly Report | Elaine Williams, Freedom to Speak Up Guardian | Enc. |
| 6.2 | Quality Assurance Committee – 20 November 2018<br>a) Minutes of the Meeting<br>b) Learning from Deaths Quarterly Report<br>c) Guardians of Safe Working Quarterly Report | Ruth Lysons, Chair of the Quality Assurance Committee<br><br>Dr Minoo Irani, Medical Director | Enc. |
| 6.3 | Safe Staffing Six Monthly Report<br>*(NB the Finance, Investment and Performance Committee reviews the monthly Safe Staffing Reports)* | Debbie Fulton, Acting Director of Nursing and Governance | Enc. |
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| 7.0 | Executive Report | Julian Emms, Chief Executive | Enc. |
| | **PERFORMANCE** | | |
| 8.1 | Month 7 2018/19 Finance Report | Alex Gild, Chief Financial Officer | Enc. |
| 8.2 | Month 7 2018/19 Performance Report | Alex Gild, Chief Financial Officer | Enc. |

| No | Item | Presenter | Enc. |
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| 8.3 | Board Vision Metrics Report | Alex Gild, Chief Financial Officer | Enc. |
| 8.4 | Finance, Investment & Performance Committee | *(The Committee did not meet in November 2018)* | Verbal |
| **STRATEGY** | | | |
| **CORPORATE GOVERNANCE** | | | |
| 9.0 | Council of Governors Update | Martin Earwicker, Chair | Verbal |
| **Closing Business** | | | |
| 10. | Any Other Business | Martin Earwicker, Chair | Verbal |
| 11. | Date of the Next Public Trust Board Meeting – 12 February 2019 | Martin Earwicker, Chair | Verbal |
| 12. | **CONFIDENTIAL ISSUES:** To consider a resolution to exclude press and public from the remainder of the meeting, as publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted. | Martin Earwicker, Chair | Verbal |

Berkshire Healthcare NHS Foundation Trust

**AGENDA ITEM 5.1**

**Unconfirmed minutes**

# BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

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

## Boardroom, Fitzwilliam House

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| **Present:** | Martin Earwicker | Chair |
| | 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 |
| | Bev Searle | Director of Corporate Affairs |
| | David Townsend | Chief Operating Officer |
| **In attendance:** | Julie Hill | Company Secretary |
| | Lucy Cooke | Clinical Director for Children, Young People and Families *(present for agenda item 6.0)* |
| | Nolan Victory | Equality Human Resources Manager *(present for items 8.2 and 9.2)* |
| | Carol Carpenter | Director of People *(present for items 8.2 and 9.2)* |

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| **18/198** | **Welcome** (agenda item 1) |
| | Martin Earwicker, Chair welcomed everyone to the meeting, including the observers: Musha Hove, Trainee Doctor, Tom Lake, Public Governor and Guy Dakin, Staff Governor. |
| **18/199** | **Apologies** (agenda item 2) |
| | Apologies were received from: David Buckle, Non-Executive Director. |
| **18/200** | **Declaration of Any Other Business** (agenda item 3) |
| | There was no other business declared. |

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| **18/201** | **Declarations of Interest** (agenda item 4) |
| | **i. Amendments to Register –** none |
| | ii. **Agenda Items** – none |
| **18/202** | **Minutes of the previous meeting – 11 September 2018** (agenda item 5.1) |
| | The Minutes of the Trust Board meeting held in public on Tuesday 11 September 2018 were approved as a correct record of the meeting after a minor correction had been made to minute 18/174: 5th paragraph, 1st sentence – the word "and" was deleted. |
| **18/203** | **Action Log and Matters Arising** (agenda item 5.2) |
| | The schedule of actions had been circulated.<br><br>**The Trust Board**: noted the schedule of actions. |
| **18/204** | **Physical Health of Mental Health Patients Presentation** (agenda item 6.0) |
| | The Medical Director explained the context of the agenda item and said that the Quality Assurance Committee had originally requested an update on the Trust's work around managing the physical health of mental health patients, but it was decided that the presentation would be relevant to the whole Trust Board.<br><br>The Chair welcomed Lucy Cooke, Clinical Director for Children's Services and Lead for Improving the Physical Health of Mental Health Patients and invited her to give a presentation on the Trust's work in relation to the physical health of mental health patients.<br><br>During the presentation the Clinical Director highlighted the following points:<br><br>• Mental illness increased the risk of physical ill-health and physical health could be seriously impaired as a direct result of mental health problems;<br>• Nationally, people with severe mental illness were less likely to have their physical health needs met compared with the general population;<br>• Nationally, there was a lack of clarity around responsibilities in healthcare provision between primary and secondary care;<br>• There were gaps in training for primary and secondary mental health clinicians;<br>• The Mental Health Five Year Forward View set out NHS England's goal to improve access to physical health checks and follow up interventions and to improve the quality of those physical health checks and follow up interventions;<br>• The Trust had taken a number of actions to address the issue including: appointing a Physical Health Lead at Prospect Park Hospital; an e-observations project; training for all qualified staff from October 2018 and all Health Care Assistants from February 2019 in order to provide patients with a full physical health assessment and appropriate interventions and referrals; a monthly clinic run by a Consultant Endocrinologist and Diabetes Specialist Nurse for doctors to present and discuss their patients' management of Diabetes;<br>• A Physical Health Lead was working with the Community Mental Health East team.<br>• The Trust was participating in NHS Improvement's Closing the Gap Collaborative. |

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| | The Chief Executive said that it was important that improving the physical health for people with severe mental illness was incorporated into the Trust's strategic planning cycle.<br>**Action: Director of Corporate Affairs**<br><br>Mehmuda Mian, Non-Executive Director asked whether there was any good practice amongst any other Mental Health Trusts.<br><br>The Clinical Director said that the Trust had met with the other Mental Health Trusts who were participating in NHS Improvement's Closing the Gap Collaborative and other Trusts had done work around improving data collection, but had not yet embarked on a cultural change programme.<br><br>On behalf of the Board, the Chair thanked the Clinical Director of her presentation. |
| **18/205** | **Quality Board Visit: Older People's Mental Health Services, Prospect Park Hospital** (agenda item 6.1 |
| | Naomi Coxwell, Non-Executive Director presented the paper and said that her visit to the Older People's Mental Health Services (Hazelwood Unit) at Prospect Park Hospital had been very positive. Ms Coxwell said that she was very impressed by the team who had detailed knowledge of each service user and their family and carers.<br><br>Chris Fisher, Non-Executive Director reported that he had visited the Hazelwood Unit about 18 months ago and he echoed Ms Coxwell's comments about the professionalism of the team.<br><br>**The Trust Board:** noted the report. |
| **18/206** | **Patient Experience Report** (agenda item 6.2) |
| | The Director of Nursing and Governance presented the report and highlighted the following key points:<br><br>• The Trust had received 63 formal complaints during Quarter 2.<br>• The top reasons for complaints were: care and treatment and attitude of staff<br>• The response rate, including those within a timescale re-negotiated with complainants was 100% for the quarter which continued to be exceptional performance.<br>• 88.5% of patients had rated services as good or better in the Trust's internal patient satisfaction survey.<br>• For the first time during Quarter 2, the Trust's response rate to the Friends and Family Test had exceeded the target response rate of 15% for both Community and Mental Health Services. In September 2018, the Trust had achieved a combined response rate of 17.23%. In September 2018, 95% of patients would recommend the Trust's services for care and treatment.<br>• An action plan had been developed (attached at appendix 3 of the report) in response to the outcomes of the "Deep Dive" review into Reading Community Mental Health Team following an increase in the number of complaints.<br><br>The Chief Executive pointed out that the Trust discharged 38,000 service users each year and received a relatively small number of complaints. |

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| | The Chair referred to page 29 of the agenda pack and asked whether steps had been taken to provide cover when Care Co-ordinators were off sick for an extended period.<br><br>The Director of Nursing and Governance confirmed that there were now clear operating procedures in place to address the issue.<br><br>Chris Fisher, Non-Executive Director referred page 43 of the agenda pack and asked why there had been fewer responses from Podiatry and IPASS services to the Trust's Internal Patient Survey than in previous surveys. The Director of Nursing and Governance agreed to find out the reasons for the lower response rates.<br>**Action: Director of Nursing and Governance**<br><br>The Director of Nursing and Governance reported that a task and finish group had been set up to review the Trust's internal patient survey with a view to developing a survey which all services could use.<br><br>Ruth Lysons, Non-Executive Director, referred to page 41 of the agenda pack and commented that the number of responses in relation to the Friends and Family Test survey was similar in 2015/16 to 2018/19, but the percentage response rate was 6.60% in 2015/16 and had increased to 14.82% in 2018/19.<br><br>The Director of Nursing and Governance agreed to provide an explanation to the Board.<br>**Action: Director of Nursing and Governance**<br><br>Mehmuda Mian, Non-Executive Director asked whether the project to widen the use of SMS text messaging project had re-started.<br><br>The Director of Nursing and Governance confirmed that the Clinical Transformation Team would be re-starting the project.<br><br>**The Trust Board:** noted the report. |
| **18/207** | **Research and Development Annual Report** (agenda item 6.3) |
| | The Medical Director presented the paper and reported that the Trust had a small Research and Development Team who worked hard to attract research income.<br><br>The Medical Director reported that the Trust had a positive working relationship with the University of Reading.<br><br>Mehmuda Mian, Non-Executive Director asked how many research projects had resulted in benefits to clinicians, other staff or service users.<br><br>The Chief Executive informed the Board that Professor Cathy Creswell, University of Reading had been invited to attend the December 2018 Trust Board meeting to talk about her research into child anxiety which the Trust had supported and which had informed national policy.<br><br>Ruth Lysons, Non-Executive Director referred to the Equalities and Diversity section of the cover sheet and asked whether there was any progress made to track patient equality in terms of access to clinical trials. |

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| | The Medical Director agreed to find out more information.<br>**Action: Medical Director**<br><br>Naomi Coxwell, Non-Executive Director suggested that for future reports, it would be helpful to include a couple of examples where a research project had made a difference.<br>**Action: Medical Director**<br>**The Trust Board:** noted the report. |
| **18/208** | **Annual Information Governance and Caldicott Guardian Report** (agenda item 6.4) |
| | The Medical Director presented the paper and highlighted the following points:<br><br>• The Trust's Information Governance Toolkit score had increased from the previous year's score by 3%, taking the overall score to 82% (which was rated as: satisfactory with no improvement plan required);<br>• The Trust had received 471 Freedom of Information requests (a 7% increase on the previous year);<br>• Of the 823 subject access requests, the Trust had only 3 breaches in terms of meeting the 40-day timeframe for response;<br>• Of the 307 reported Information Governance incidents, 22 met the threshold for a reportable breach to the Information Commissioner's Office (any learning and actions from these incidents was included in the report);<br>• 7 Complaints relating to Information Governance were made and the key outcomes and learning were summarised in the report;<br>• The Trust had achieved the 95% requirement for Information Governance training across all staff (a statutory requirement).<br><br>The Medical Director reported that the Annual Report covered the financial year 2017-18. Since then the General Data Protection Regulations had come into effect and the Trust had undertaken a significant amount of work to ensure compliance with the requirements of the new regulations.<br><br>Mark Day, Non-Executive Director said that it was difficult to work out from the report how many incidents had directly impacted patient safety.<br><br>The Medical Director confirmed that if an incident had impacted on patient safety, it was likely that this would meet the threshold for a Serious Incident. It was noted that the Quality Assurance Committee received quarterly reports on all Serious Incidents and that Serious Incidents were also reported to the Trust Board.<br><br>Chris Fisher, Non-Executive Director reported that the most serious information governance incidents (level 4) would also be reported to the Audit Committee.<br><br>**The Trust Board:** noted the report. |
| **18/209** | **Executive Report (**agenda item 7.1) |
| | The Executive Report had been circulated. The following issues were discussed further:<br><br>**a) Waste Disposal**<br><br>The Chief Executive said that he wanted to assure the Board about the Trust's Clinical |

Waste Disposal contract following media stories about a Clinical Waste Disposal Company being stripped off its NHS Contracts following concerns over how it disposed of clinical waste.

**b) Fire Regulatory Notice**

The Chief Executive also drew attention to the section on the Fire Regulatory Notice and reported that the Trust had put in place a bespoke fire misting system at Prospect Park Hospital. It was noted that the misting system had had to be carefully designed in order not to create a ligature risk.

**c) Routes into Nurse Education**

The Chair referred to the section on Routes into Nurse Education and asked how many Nursing Apprenticeships the Trust had in place.

The Director of Nursing and Governance reported that the ambition was to have ten Nursing Apprenticeships. The Director of Nursing and Governance pointed out that under the current rules, staff undertaking the Nursing Apprenticeship training programme were treated as being “supernumerary” to the ward staffing.

The Chair reminded the Board that he had written to the Secretary of State to raise the issue.

**d) Care Quality Commission’s Inspection of WestCall GP Out of Hours Service**

Naomi Coxwell, Non-Executive Director referred to the section on WestCall and asked who was responsible for the delivery of the Care Quality Commission Compliance Action Plan.

The Director of Nursing and Governance confirmed that delivery of the action plan was the responsibility of the Head of Urgent Access Services and that the Quality Executive Committee would monitor its implementation and this would be overseen by the Quality Assurance Committee.

**e) Flu Vaccination**

Ruth Lysons, Non-Executive referred to the Flu Vaccination section and asked whether the Trust had experienced any supply issues following recent press stories about shortages of vaccines.

The Director of Nursing and Governance reported that there had been a two-week delay in obtaining vaccines at the start of the Flu Campaign, but since then the Trust had sufficient supplies of the vaccines.

The Director of Nursing and Governance pointed out that there were supply issues in obtaining the vaccine for people aged 65 and that the Trust was only offering the vaccine to staff under the age of 65. Staff over the age of 65 would be referred to their GP (or an alternative provider) for the flu vaccine.

**The Trust Board:** noted the report.

| 18/210 | **Month 06 2018-19 Finance Report** (agenda item 8.1) |
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The Chief Financial Officer presented the paper and highlighted the following points:

- The Trust had reported a surplus of £0.6m (which was £0.6m above the Control Total). Year to date, the surplus had risen to £1.8m, £1.3m better than the Control Total.
- Operating expenditure was £0.5m below plan with staff costs £0.3m and non-pay £0.2m below planned levels.
- Capital spend was £0.7m below plan and cash was £2.0m higher than anticipated, due to the higher year to date surplus and lower than planned capital expenditure.
- The Trust was forecasting a year end surplus of £4.2m (£1.5m ahead of the Control Total).
- The Trust had agreed with NHS Improvement and NHS England to offset £0.9m of the forecasted Control Total improvement with the Royal Berkshire NHS Foundation Trust. This reflected the Trust's commitment to closer system working and management of risk.
- The October 2018 Finance, Investment and Performance Committee received a detailed forecast review paper.

Chris Fisher, Non-Executive Director referred to the Cost Improvement Programme delivery (page 128 of the agenda pack) and asked for more information about the reasons why WestCall, the Crisis Resolution Home Treatment Team and the Out of Area project had not achieved their efficiency saving targets.

The Chief Financial Officer reported that the Finance, Investment and Performance Committee would be reviewing the areas which had under-performed in terms of their Cost Improvement Programme schemes at their meeting in December 2018.

**Action: Chief Financial Officer**

**The Trust Board noted:** the following financial summary of the financial performance and results for Month 6 2018-19:

**Year To Date (Use of Resource) metric:**

- Overall rating 1 (plan 1 – lowest risk rating)
    - Capital Service Cover rating 2
    - Liquidity days rating 1
    - Income and Expenditure Margin rating 1
    - Income and Expenditure Variance rating 1
    - Agency target rating 1

**Year To Date Income Statement** (including Provider Sustainability Funding):

- Plan: £0.5m surplus
- Actual: £1.8m surplus
- Variance: £1.3m better than plan

**Year to Date Cash:** £24.9m (Plan £22.9m) - £2.0m better than plan due to year to date surplus in excess of the financial plan and lower than planned capital expenditure.

**Year to Date Capital Expenditure**: £2.9m versus plan of £3.6m.

**Forecast against the Trust's Control Total:**

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| | The Finance, Investment and Performance Committee meeting in October 2018 reviewed the detailed Quarter 2 forecasts for 2018/19, confirming a ranged outlook to achieve the previously reported forecast of £1.5m surplus above our pre-Provider Sustainability Funding control total of breakeven. |
| **18/211** | **Month 6 2018-19 Performance Report** (agenda item 8.2) |
| | The Month 6 2018-19 Performance Summary Scorecard and detailed Trust Performance Report had been circulated.<br><br>It was noted that NHS Improvement (non-financial) and Service Efficiency were rated red for September 2018.<br><br>The Chief Financial Officer referred to the NHS Improvement (non-financial) section of the paper and reported that this section was RAG rated red because of a data governance issue in relation to the reporting of data in respect of the national access standards for audiology diagnostics.<br><br>The Chief Financial Officer confirmed that the issue had been flagged to NHS Improvement and that the Trust had re-submitted the correct data. The Chief Financial Officer also confirmed that there were no quality or safety impacts on patients.<br><br>It was noted that the Finance, Investment and Performance Committee in October 2018 had received a full report<br><br>The Chair referred to the People section of the paper and asked whether the Trust had a clear view why staff left the Trust.<br><br>The Director of People reported that all staff who were leaving the Trust were encouraged to complete an Exit Questionnaire.<br><br>The Director of People also reported that the Trust was introducing “Stay Surveys” for teams with high turnover to find out what more the Trust could do to encourage people to stay.<br><br>Chris Fisher, Non-Executive Director referred to the Contractual Performance section and asked what would happen to the building currently occupied by Willow House when the service was re-located to Prospect Park Hospital.<br><br>The Chief Operating Officer said that the Clinical Commissioning Group would be responsible for determining any future use of the building.<br><br>Mehmuda Mian, Non-Executive Director reported that the Mental Health Act Managers had recently received a report which had highlighted a 20% increase in the number of detained patients compared with the same period last year and asked about the reasons behind the increase.<br><br>The Medical Director reported that the increase in the number of detained patients was a national issue and suggested that this reflected the national decrease in the mental health in-patient beds base so that Clinicians tended only to admit the most seriously unwell patients.<br><br>**The Trust Board**: noted the report. |

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| **18/212** | **Finance, Investment and Performance Committee Meetings – 26 September 2018 and 31 October 2018** (agenda item 8.3) |
| | Naomi Coxwell, Chair of the Finance, Investment and Performance Committee reported that the Committee had reviewed the Trust's financial forecast for the year end and had been assured by the robustness of the process.<br><br>Ms Coxwell reported that the cash position was very positive. It was noted that there was slippage in relation to some capital schemes and that the Committee would be reviewing the Capital Programme at their next meeting in December 2018.<br><br>In terms of performance, Ms Coxwell reported that the Committee was very pleased by the reduction in the use of prone restraint. It was noted that the Committee acknowledged that further work was needed to reduce the number of patient falls, the incidence of self-harm and patient assaults and that this work was a key focus for the Quality Improvement Programme.<br><br>**The Trust Board:** thanked Ms Coxwell for her update. |
| **18/213** | **Mental Health Strategy Implementation – Update Report** (agenda item 9.0) |
| | The Director of Corporate Affairs reported that the paper set out the progress against the key priorities within the Mental Health Strategy agreed by the Board in December 2018. The paper also provided an overview of the developments in the national policy/local operating context since July 2018 when the last progress update was provided.<br><br>Chris Fisher, Non-Executive Director reported that a group of Non-Executive Directors had met with the Clinical Director, Reading, the Medical Director and the Director of Nursing and Governance before the Board meeting to discuss the Trust's work to improve the interface between the Crisis Resolution Home Treatment Team and the Community Mental Health Team services.<br><br>It was noted that the interface between the Trust's different mental health services was one of the Trust's "Quality Concerns" which reviewed by the Quality Assurance Committee.<br><br>**The Trust Board:** noted the report. |
| **18/214** | **Strategy Implementation Plan Update Report** (agenda item 9.1) |
| | The Director of Corporate Affairs reported that the Strategy Implementation Plan Progress Report as at the end of September 2018 showed that good progress was being made with most of the initiatives being delivered to the expected time frames or with minor slippage.<br><br>The Director of Corporate Affairs confirmed that there were no material risks to the delivery of the main elements of the plan, except for the aspiration to reduce staff vacancies to 10% by year end. The Trust had a range of initiatives underway to support staff retention and recruitment and this target was now expected to be delivered in 2019-20.<br><br>Chris Fisher, Non-Executive Director referred to page 185 of the agenda pack and asked |

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| | for further information in relation to the Fitzwilliam House lease.<br><br>The Chief Operating Officer explained that the Trust had signed another two-year lease for Fitzwilliam House. It was noted that during the two-year period, the landlord only had to give 12 months' notice to vacate the building.<br><br>**The Trust Board:** noted the report. |
| **18/215** | **Workforce Race Equality Standard Report** (agenda item 9.2) |
| | The Chair welcomed Nolan Victory, Human Resources Equality Manager and Carol Carpenter, Director of People.<br><br>The Director of Corporate Affairs reported that there had been some positive progress over the last year. It was particularly noteworthy that there had been a significant increase in the percentage of Black, Asian and Minority Ethnic (BAME) staff in Agenda for Change Band 7 roles from 12.2% in 2016 to 20% in 2018.<br><br>The Director of Corporate Affairs also highlighted that there had been an improvement in BAME staff accessing continuous professional development training and non-mandatory training.<br><br>The Director of Corporate Affairs pointed out that there was further work to do in relation to the relative likelihood of BAME staff being appointed from shortlisting across all posts.<br><br>The Human Resources Equality Manager presented the report and highlighted the following points:<br><br>• In 2017, the Trust achieved improvements in four out of the nine Workforce Race Equality Standard (WRES) indicators and in 2018, the Trust had achieved improvements in five out of the nine indicators.<br>• It was disappointing that the Trust's performance in relation to appointments from shortlisting for interviews had decreased compared with last year. Further work was being done to gain a better understanding of the reasons for the decrease in performance.<br>• The over representation of BAME staff reporting bullying and harassment remained an area of concern.<br>• The Trust's "Making it Right" Programme would be extended to other staff groups with protected characteristics this year;<br><br>The Human Resources Equality Manager thanked the Board for their continuing commitment and support for equalities and diversity and for their attendance at events such as the Diversity Road Shows and the BAME Conference held during Black History month.<br><br>The Chair reported that he had attended the BAME Conference and he was impressed by the attendees' ambition and commitment to improve the work experience of BAME staff.<br><br>The Chair thanked the Human Resources Equality Manager for his work and for attending the Board meeting.<br><br>**The Trust Board**: noted the report. |

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| **18/216** | **Audit Committee – Minutes of the Meeting held on 31 October 2018** (agenda item 10.1) |
| | Chris Fisher, Chair of the Audit Committee reported that the meeting on 31 October 2018 had discussed the following key items in addition to the Committee' standing items:<br><br>• **Charitable Funds Annual Accounts** – the Committee had reviewed the Charitable Funds Annual Report Accounts and had recommended that the Corporate Trustees approve the documents (a meeting of the Corporate Trustees would take place after the Trust Board meeting.<br>• **Private Meeting with the External Auditors** – the Non-Executive Director members of the Audit Committee held an annual private meeting with the External Auditors. The External Auditors raised no issues of concern and were very complimentary about the Trust.<br>• **NHS England's National Procurement Arrangements** – the Committee had discussed plans to have a national procurement arrangement which would involve top slicing budgets rather than a transaction fee for using the NHS Supply Chain.<br>• **Board Assurance Framework Risk 1 (workforce) –** the Committee had requested that the Director of People attends the next meeting to discuss her work around mitigating the workforce risk.<br><br>The Chief Financial Officer reported that NHS England was currently consulting on their proposals for a new National Procurement Strategy and agreed to keep the Trust Board updated about any developments.<br>**Action: Chief Financial Officer**<br><br>Ruth Lysons, Non-Executive Director commented that recent media reports had highlighted shortcomings in respect of external auditors who had failed to identify financial issues prior to big companies folding and asked whether the Trust needed to introduce more checks in the procurement process when seeking to appoint external auditors.<br><br>Chris Fisher pointed out that the Governors were responsible for appointing the Trust's External Auditors. Mr Fisher said that the Trust's procurement process included convening a Governor Panel oversee the appointment of external auditors supported by himself in his role as Chair of the Audit Committee and by the Chief Financial Officer.<br><br>The Chair thanked Mr Fisher for his update.<br><br>**The Trust Board:** noted the minutes of the last Audit Committee meeting. |
| **18/217** | **Trust Seal Report** (agenda item 10.2) |
| | A paper setting out the use of the Trust's Seal had been circulated.<br><br>**The Trust Board:** noted the report. |
| **18/218** | **Remuneration Committee Revised Terms of Reference** (agenda item 10.3) |
| | The Company Secretary reported that the Remuneration Committee's Terms of Reference had been updated to reflect the Committee's broader role in appointments and succession planning. It was proposed that the Committee's title be changed to: Appointments and Remuneration Committee. |

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| | **The Trust Board**: approved the revised Remuneration Committee's Terms of Reference and noted that the Committee would now be known as: The Appointments and Remuneration Committee. |
| **18/219** | **Council of Governors Update** (agenda item 10.4) |
| | Chair reported that the Council of Governors had agreed a new format for the Joint Board/Non-Executive Directors and Council of Governors meetings. This included a service presentation, feedback from the last Trust Board meeting and opportunity for table discussions with Non-Executive Directors as well as the other standing items: the Chief Executive's Strategic Update and Governor questions.<br>The Chair reported that the Berkshire West Integrated Care System Engagement Event on 29 October 2018 had been well attended and the feedback from delegates was very positive. The Chair thanked the Company Secretary and the Office Manager for organising the event.<br>**The Trust Board:** noted the update. |
| **18/220** | **Any Other Business** (agenda item 11) |
| | **Retirement of Helen Mackenzie, Director of Nursing and Governance**<br>The Chair reported that this would be Helen Mackenzie's last Trust Board meeting before she retired in December 2018. The Chair said that Ms Mackenzie was an impressive Director of Nursing and Governance and always put the patient at the heart of her work.<br>On behalf of the Board, the Chair thanked Ms Mackenzie for her contribution to the work of the Trust. |
| **18/221** | **Date of Next Meeting** (agenda item 12) |
| | Tuesday, 11 December 2018 |
| **18/222** | **CONFIDENTIAL ISSUES:** (agenda item 13) |
| | The Board resolved to exclude press and public from the remainder of the meeting on the basis that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted. |

I certify that this is a true, accurate and complete set of the Minutes of the business conducted at the Trust Board meeting held on 13 November 2018.

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

Berkshire Healthcare NHS Foundation Trust

**AGENDA ITEM 5.2**

**BOARD OF DIRECTORS MEETING: 13/11/2018**

**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 | Update | Status |
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| 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** | To be incorporated into the next Annual Health and Safety Report. | |
| 10.07.18 | 18/126 | Patient Story | The Trust Board to receive an update on the Peer Mentor Pilot Project | February 2019 | **DF** | The peer mentor pilot has commenced in Prospect Park Hospital. An update will be provided in February | |

| Meeting Date | Minute Number | Agenda Reference/Topic | Actions | Due Date | Lead | Update | Status |
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| | | | | | | 2019 | |
| 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 | **DF/NZ** | The Complaints Team will explore how this can be included in next year's Annual Complaints Report. | |
| 10.07.18 | 18/135 | Vision Metrics | Consideration to be given to including Quality Improvement Initiatives and timescales as part of the Vision Metrics reporting. | 11.12.18 | **AG** | The Strategy Implementation Plan updates to the Board include an overview of the Quality Improvement programme initiatives. This alongside the True North performance scorecard to be transitioned from the Performance Assurance Framework at the start of 2019/20 will provide the overview of improvement traction. | |
| 10.07.18 | 18/136 | Strategy Summary | The Trust's strategy to be distilled into three or four lines of text which would | May | **BS** | To be considered when the three year strategy | |

| Meeting Date | Minute Number | Agenda Reference/Topic | Actions | Due Date | Lead | Update | Status |
|---|---|---|---|---|---|---|---|
| | | Document 2018-21 | be discussed at the Board's Annual Strategic Planning Away Day in October 2018. | 2019 | | is refreshed in May 2019. | |
| 10.07.18 | 18/138 | Equality Strategy Annual Report | The Director of Corporate Affairs to include a section on gender pay equality when the Equality Strategy was refreshed. | TBC | **BS** | | |
| 11.09.18 | 18/168 | Patient Experience Report | The Director of Nursing and Governance to find out what measures the Trust was putting in place to meet the needs of deaf patients. | April 2019 | **HM** | The new Equality and Diversity Manager, reporting to the Corporate Lead for Patient Experience will take a lead in this area, with an update to be provided during April 2019. | |
| 13.11.18 | 18/204 | Physical Health of Mental Health Patients Presentation | Improving the physical health of people with severe mental health illness to be incorporated into the Trust's strategic planning cycle. | April 2019 | **BS** | To be incorporated into the 3 year Strategy Document refresh in April 2019. | |
| 13.11.18 | 18/206 | Patient Experience Report | The Director of Nursing and Governance to find out why the response rate to the Trust's internal patient survey from Podiatry and IPASS | 11.12.18 | **HM** | IPASS and Podiatry Services had switched from the tablets to the Friends and Family | |

| Meeting Date | Minute Number | Agenda Reference/Topic | Actions | Due Date | Lead | Update | Status |
|---|---|---|---|---|---|---|---|
| | | | services was lower than in previous surveys. | | | cards as this was more accessible for their patients. They had a 300% increase in response rate for FFT in Podiatry using the cards and continue to use the paper version of the patient survey and again get more responses than they did previously on the hand held devices. | |
| 13.11.18 | 18/206 | Patient Experience Report | The Director of Nursing and Governance to find out why the number of responses to the Friends and Family Test survey was similar in 201/16 to 2018/19 but the percentage response was 6.60% in 2015/16 compared with 14.82% in 2018/19. | 11.12.18 | **HM** | A review of the Unify reporting (national reporting of the FFT) shows that organisations differ in the way that they calculate the response rate; as the guidance for calculating the response rate leaves room for this.<br><br>We aligned with a | |

| Meeting Date | Minute Number | Agenda Reference/Topic | Actions | Due Date | Lead | Update | Status |
|---|---|---|---|---|---|---|---|
| | | | | | | number of Trusts, to change how we calculate this, as it was previously based on attendances and is now based on discharge figures (see appendix 1 attached) | |
| 13.11.18 | 18/207 | Research and Development Annual Report | The Medical Director to find out whether there was any progress made to track patient equality in terms of access to clinical trials. | 11.12.18 | **MI** | Response from the Research & Development Manager: The department do not routinely collect Equality and Diversity (E&D) data about research participants and do not have the capacity to do so. Some researchers (on project by project basis) collect E&D data about research participants through a demographic questionnaire. This data is not available | |

| Meeting Date | Minute Number | Agenda Reference/Topic | Actions | Due Date | Lead | Update | Status |
|---|---|---|---|---|---|---|---|
| | | | | | | routinely as published data; the department would have to trawl through demographic data from various research studies to determine research participant background. | |
| 13.11.18 | 18/207 | Research and Development Annual Report | A couple of examples where a research project had made a difference to patients or staff to be included in future annual reports. | Nov 2019 | **MI** | The 2018/19 Research and Development report will highlight studies which potentially benefit Berkshire patients. | |
| 13.11.18 | 18/210 | Month 6 Finance Report | The December 2018 Finance, Investment and Performance Committee to review the areas which had under-performed in terms of their Cost Improvement Programme schemes. | 21.12.18 | **AG** | The Finance Investment and Performance Committee to undertake a “deep dive” review of Cost Improvement Programme performance in the new year. December 2018 Finance, Investment | |

| Meeting Date | Minute Number | Agenda Reference/Topic | Actions | Due Date | Lead | Update | Status |
|---|---|---|---|---|---|---|---|
| | | | | | | and Performance Committee to consider the 2019/20 outline Cost Improvement Programme proposals. | |
| 13.11.18 | 18/216 | Audit Committee Minutes – October 2018 | The Board to be kept informed about the impact on the Trust of the new national Procurement Strategy. | 11.12.18 | **AG** | Future Trust Procurement Strategy updates will be reported via the Audit Committee, aligned to the Non-Executive Director lead for procurement (Chris Fisher, Chair of the Audit Committee). Updates will reference development of national procurement model. The Trust is awaiting December 2018 planning guidance to confirm whether NHS provider tariff funding will be topsliced to fund the new national supply | |

| Meeting Date | Minute Number | Agenda Reference/Topic | Actions | Due Date | Lead | Update | Status |
|---|---|---|---|---|---|---|---|
| | | | | | | chain co-ordinator body or whether a mark-up pay for use model will be applied. | |

**Appendix 1**

Friends and Family Test Response Rates

| | | | | | |
|---|---|---|---|---|---|
| 2018/19 | Q2 | 5443 | 14.82% | Discharges | 37306 *slight variation as this figure was taken off Tableau today |
| 2015/16 | Q2 | 6130 | 4.50% | Attendances | 134545 |

Berkshire Healthcare
NHS Foundation Trust

**Trust Board Paper**

| | |
|---|---|
| **Board Meeting Date** | 11 December 2018 |
| **Title** | **Executive Report** |
| **Purpose** | The purpose of the Report is to update the Trust Board on the work of the Freedom to Speak Up Guardian over the last 6 months. |
| **Business Area** | Corporate |
| **Author** | Freedom to Speak Up Guardian |
| **Relevant Strategic Objectives** | To strengthen our highly skilled and engaged workforce and provide a safe working environment |
| **CQC Registration/Patient Care Impacts** | The Care Quality Commission assesses Trust's Speaking Up Culture as part of its Well-Led Inspection |
| **Resource Impacts** | None |
| **Legal Implications** | NHS Provider organisations are required to appoint a Freedom to Speak Up Guardian |
| **Equality and Diversity Implications** | N/A |
| **SUMMARY** | The Freedom to Speak up Guardian is a newly established role in the NHS and was a recommendation of the Freedom to Speak up Review by Sir Robert Francis published in 2015.<br><br>The Freedom to Speak up Guardian (FTSUG) came into post in this Trust in March 2017. This is a report directly to the Trust Board for July 2018 – December 2018.<br><br>The Freedom to Speak up Guardian will be attending the Trust Board meeting to present the report. |
| **ACTION REQUIRED** | The Trust Board is asked:<br><br>a) to note the contents of this report by the Freedom To Speak Up Guardian; and<br>b) to provide assurance that the Board supports the Government's recommendations detailed in this report |

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

# Freedom to Speak up Guardian - Report for last 6 months (July 2018 – December 2018)

**For: Information**

## Executive Summary

A Freedom to Speak up Guardian (FTSUG) within every Trust was a key recommendation made by Sir Robert Francis QC in the Freedom to Speak Up review 2015. FTSU has also become part of the CQC Well Led inspection component since October 2016.

A standard integrated FTSU policy for the NHS issued in April 2016 is the basis of the Trust's Raising Concerns policy. The Trust policy is due for review in December 2018.

The National Guardian's office (NGO) was established in October 2016 at the same time as it became a contractual obligation for every NHS Trust to have appointed a FTSU Guardian.

## The Role of the Freedom to Speak Up Guardian

*"the Freedom to Speak Up Guardian will work alongside Trust leadership teams to support the organisation in becoming a more open and transparent place to work, where all are actively encouraged and enabled to speak up safely." (NGO 2018)*

The FTSUG is independent and impartial. The Guardian reports directly to the Chief Executive, and has access to anyone in the organisation. There are two main elements to the role.

- To give independent, confidential advice and support to members of staff who wish to speak up that have an impact on patient and staff safety or issues around malpractice, wrongdoing and fraud. This is not exclusive to permanent members of staff but extends to temporary or agency staff, trainees or students, volunteers and trust governors.

- To promote a culture where members of staff feel safe to raise concerns and do not fear adverse repercussions as a consequence.

Mark Day, Non-Executive Director has taken on the role of nominated Non-Executive Director for Freedom to Speak Up.

## Communication

It is crucial that the FTSU role is visible and accessible to all staff. The communications plan outlines how this is achieved.

The plan includes the following:

- Creating an animation (aim to start Jan 2019)

- Presentations and attendance to managers/team meetings
- FTSU month, focused promotion across the trust during October 2018
- Production and dissemination of posters, leaflets and cards
- FTSU Teamnet page
- Market stall at Induction
- Regular session as part of junior doctor induction
- Present at Essential Knowledge for New Managers training
- Present at student nurse induction
- Present at teams meetings

**Contribution to the Regional and National Agenda**

The Guardian is a member of the National Community, Mental Health and Learning Disability FTSU Network and the Thames Valley and Wessex Regional FTSU Network. The FTSUG has submitted a piece of work to the national network offering guidance for Guardians related to supporting staff with mental health problems

**Organisational response to staff speaking up**

Creating a culture where staffs are able to speak up and feel valued for doing so is dependent on the organisation showing it is listening and taking their concerns seriously. Giving feedback is one important way the Trust can demonstrate it values staff that speak up. The importance of this stage of the process is not always recognised by managers. Staffs speaking up to the FTSUG fear suffering detriment as a result and this can present a barrier.

**Quarterly submissions to the National Guardian's Office (NGO)**

The NGO requests and publishes quarterly speaking up data; there have been 28 contacts or cases of concerns raised in the last six months. Contacts are described as 'enquiries from colleagues that do not require any further support from the FTSUG'.

Cases are described as 'those concerns raised which require action from the FTSUG'. Of the 28 the themes have included elements of bullying and harassment; communication/relationship within teams; patient safety; asking for guidance; whistleblowing process. The concerns have been resolved through varying degrees of intervention depending on what the person who is speaking up wants. Examples include signposting, a listening ear, facilitating a conversation, requesting internal and external investigation. The post holder has been able to quickly obtain support from the exec team and the senior leadership team as required.

It's difficult to make comparisons with other similar organisations as the data available does not provide a narrative regarding how many guardians or champions there are, how many days a week they work and if they have recorded both cases and contacts. All cases and contacts at Berkshire Healthcare are reported.

| Location | Trust | Size | Type | No of Cases |
|---|---|---|---|---|
| London | Barnet Enfield and Haringey Mental Health NHS Trust | Small (up to 5000 staff) | Combined mental health / learning disability / community | 9 |
| Thames Valey | Berkshire Healthcare NHS Foundation Trust | Small (up to 5000 staff) | Combined mental health / learning disability / community | 17 |
| East of England | Cambridgeshire and Peterborough NHS Foundation Trust | Small (up to 5000 staff) | Combined mental health / learning disability / community | 16 |
| North West | Cheshire and Wirral Partnership NHS Foundation Trust | Small (up to 5000 staff) | Combined mental health / learning disability / community | 8 |
| West Midlands | Coventry and Warwickshire Partnership NHS Trust | Small (up to 5000 staff) | Combined mental health / learning disability / community | 8 |
| East Midlands | Derbyshire Healthcare NHS Foundation Trust | Small (up to 5000 staff) | Combined mental health / learning disability / community | 21 |

The post holder meets with the Chief Executive on a monthly basis to reflect on concerns raised, support received and to discuss themes. The Director of Nursing and Governance and Director for Corporate Affairs have been invited to join this monthly meeting from September 2018. It was felt that this may help triangulate knowledge and maybe able to support teams where it appears there are difficulties.

Learning from the National Guardians Office is shared via Teamnet and during presentations to teams.

On 21st November 2018, the Department for Health and Social Care published the Governments response to the report of the Gosport Independent Panel. *"The Gosport Independent Panel has made us see with great clarity a terrible and shameful episode in our history. To read the Panel's report is to understand how doctors, nurses, and leaders in healthcare - those we most want and need to trust - can fall away from acceptable standards of practice, with awful consequences for patients."*

Creating an open culture where workers can speak up, without fear of retribution, is the primary function of Freedom to Speak Up. It is only then that lapses in the quality of care can be prevented, and the welfare of staff can be properly protected. The story of Gosport is a reminder of what can happen when workers are not free to speak up.

The report includes some important recommendations for the National Guardian's Office (NGO), and guardians, including:

- The Government will consider how best to strengthen protection for whistleblowers within the NHS in order to support patients, families and staff to raise concerns.
- The Government is committed to ensuring that where staff speak up their concerns are investigated; and to making it more transparent in the way individual NHS trusts manage these cases. The Government will legislate, subject to Parliamentary time, to make all NHS trusts in England publish annual reports on concerns of this type.
- The National Guardian will continue to champion those who speak up through the network of Freedom to Speak Up Guardians, and will publish an independent annual report to be laid before Parliament to showcase best practice, hold the Government and the system to account and advocate for change.

- The National Guardian has started to take a more active approach in looking at how organisations handle concerns raised by staff that speak up and will continue to implement its approach for staff in NHS trusts.
- The Government will place listening to and learning from feedback at the heart of care and improving care with a new strategy to be published this year.

**Recommendation**

The Trust Board is asked to note the contents of this report by the FTSUG and to provide assurance that the Board supports the Government recommendations detailed

**Author and Title:**

Elaine Williams, Freedom to Speak Up Guardian

November 2018

Berkshire Healthcare
NHS Foundation Trust

# Trust Board Paper

| | |
|---|---|
| **Board Meeting Date** | 11 December 2018 |
| **Title** | **Quality Assurance Committee – 20 November 2018** |
| **Purpose** | To receive the unconfirmed minutes of the meeting of the Quality Assurance Committee of 20 November 2018 |
| **Business Area** | Corporate |
| **Author** | **Office Manager and Assistant Company Secretary**<br>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 20 November 2018 are provided for information.<br><br>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:<br><br>• Learning from Deaths Quarterly Report<br>• Guardians of Safe Working Hours Quarterly Report |
| **ACTION REQUIRED** | The Trust Board is requested to receive the minutes and the quarterly Guardians of Safe Working Hours and Learning from Deaths Reports and to seek any clarification on issues covered. |

Berkshire Healthcare NHS
NHS Foundation Trust

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

| | |
|---|---|
| Present: | Ruth Lysons, Non-Executive Director (Chair<br>Mehmuda Mian, Non-Executive Director<br>Dr Minoo Irani, Medical Director<br>Dr Guy Northover, Lead Clinical Director<br>Helen Mackenzie, Director of Nursing and Governance<br>Amanda Mollett, Head of Clinical Effectiveness and Audit<br>David Townsend, Chief Operating Officer |
| In attendance: | Julie Hill, Company Secretary<br>Debbie Fulton, Deputy Director of Nursing<br>Jagjit Sethi, Clinical Director for East Physical Health Locality<br>Sue McLoughlin, Clinical Director for Mental Health East Locality and Inpatients |

## 1 Apologies for absence and welcome

The Chair welcomed everyone to the meeting.

Apologies had been received from: Julian Emms, Chief Executive and David Buckle, Non-Executive Director.

## 2. Declaration of Any Other Business

There were no items of Any Other Business.

## 3. Declarations of Interest

There were no declarations of interest.

## 4.1 Minutes of the Meeting held on 21 August 2018

The minutes of the meeting held on 21 August 2018 were confirmed as an accurate record after a correction had been made to min 5.4 (Serious Incident Report), the 2nd bullet point, 2nd sentence was amended to read:

“Not all the men had been in contact with mental health services”.

## 4.2 Matters Arising Log

The Matters Arising Log had been circulated. The following actions were considered further:

### a) Caring for Carers Report

The Chief Operating Officer reported that the Carers Strategy Group met quarterly and reviewed the Triangle of Care self-assessments and currently the Group did not report into the Quality Assurance Committee.

The Director of Nursing and Governance said that the Board and the Governors were interested in the Trust's work around supporting Carers and suggested that the Committee receive a short summary report every six-nine months (the timing would depend upon the Carers Strategy Group meeting schedule) setting out the key headlines of the Trust's Carers work over the course of the reporting period.

**Action: Chief Operating Officer**

**b) Prescribing Valproate to Women of Child Bearing Age**

The Chair reported that David Buckle, Non-Executive Director had confirmed to her that following his meeting with the Medical Director, Chief Pharmacist, Clinical Director and the Head of Clinical Effectiveness and Audit, he had been assured that the Trust was mitigating the risks around prescribing Valproate to women of child bearing age.

The Committee noted the schedule of actions.

## 5. Patient Safety and Experience

### 5.1 Quality Concerns Status Report

The Director of Nursing and Governance presented the paper and reported that there had been no new quality concerns added since the last meeting.

The Director of Nursing and Governance reported that the new Director of People was engaging closely with staff and was developing plans to mitigate the associated risks posed by workforce shortages.

The Director of Nursing and Governance reported that the Sorrell Ward risks were reducing in terms of their quality impacts and it was hoped that the female wing on the Psychiatric Intensive Care Unit would re-open in January 2019. It was noted that a new Ward Manager had been appointed for Sorrell Ward and a recruitment and retention premium had been agreed for staff working on Sorrell Ward.

In relation to the risks around the interface between the Trust's mental health services, the Director of Nursing and Governance reported that a group of Non-Executive Directors had met with the Clinical Director, Reading, the Medical Director and herself prior to the November 2018 Trust Board meeting to discuss the interface between the Crisis Resolution Home Treatment Team and Community Mental Health Team services.

The Director of Nursing and Governance invited the Clinical Director for Mental Health East Locality and Inpatients to report on the work being undertaken to improve the administration of the Mental Health Act.

The Clinical Director reported that the Mental Health Act Improvement Manager was providing additional support to the Ward Managers and had developed a comprehensive action plan to address any gaps. The Clinical Director also reported that recent audits had provided assurance that although further work was required, improvements had been made.

It was noted that bed occupancy was currently high and that the Trust had a number of Out of Area Placements.

The Director of Nursing and Governance reported that the risk around Reading Community Mental Health Team was reducing and that there was a new Head of Service in post. It was noted that the Trust Board had received a presentation on the Trust's work to improve access to physical health checks and treatment for people with severe mental illness.

The Director of Nursing and Governance stated that improving the quality of record keeping remained a key challenge, especially as the recording requirements were constantly being increased. The Lead Clinical Director pointed out that the importance of record keeping was not included in Clinicians training programmes and therefore the Trust was providing training and guidance to staff.

Mehmuda Mian, Non-Executive Director asked whether staff found it easy to use the online patient record system. The Lead Clinical Director said that the RiO patient record system was one of the best systems on the market. It was noted that the IT Department was constantly looking for ways of making the system easier to use. The Lead Clinical Director said that finding time to input into the system was a greater challenge for staff.

The Chair referred to the reduction in the use of prone restraint and asked whether staff were still enthusiastic about the Quality Improvement Programme.

The Clinical Director said that reporting on the Quality Improvement Programme work was now part of the monthly Patient Safety and Quality meetings. This meant that Ward Managers were able to feedback on progress and share counter measures and that this had reinvigorated the Quality Improvement Programme work.

The Chair asked whether the Quality Improvement Programme was now embedded across the Trust. The Clinical Director said that staff were working hard to use the Quality Improvement methodology and tools, but there was further work to be done to fully embed the systems and processes.

The Committee noted the report.

**5.2 Serious Incidents Report – Quarterly Report**

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

- There were initially 18 Serious Incidents reported in Quarter 2 with none currently downgraded.
- Three of the unexpected deaths reported in Quarter 2 were retrospectively reported having been identified as Serious Incidents following the Mortality Review process.
- The Trust had received a Preventing Future Deaths Notice (Regulation 28) from the Coroner in respect of a death by choking on Bluebell Ward. The Trust was currently drafting a response to the Coroner.
- The main themes from this quarter's Serious Incidents were: issues around the robustness and completeness of documenting what was discussed and planned at multi-disciplinary team meetings; not returning telephone calls; not using all the information available to assist in gaining a better understanding of a patient's risk; and positive identification of patients prior to medication administration.

The Chair referred to the issue of not returning telephone calls and asked whether there was a telephone answering procedure in place.

The Deputy Director of Nursing explained that the issue was around the volume and nature of the calls. It was noted that a high volume of calls related to patients wanting to change their appointment times.

The Lead Clinical Director said that the key issue was around ensuring that the escalation process operating effectively.

Mehmuda Mian, Non-Executive Director asked whether there was a specific reason why the Mental Health West team had significantly more Serious Incidents during Quarter 2 than the other teams.

The Deputy Director of Nursing explained that the Mental Health West team were responsible for Trust wide services, for example, IAPT, Common Point of Entry and Crisis Resolution Home Treatment Team services.

The Committee noted the report.

**5.3 Learning from Deaths Quarterly Report**

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

- 788 deaths were recorded on the clinical information system (RiO) during Quarter 2 where a patient had been in contact with a Trust service in the year before they died. Of these, 77 deaths met the criteria to be reviewed further.
- All 77 deaths were reviewed by the Executive Mortality Review Group and the outcomes were as follows: 42 were closed with no further action; 11 were classed as Serious Incidents requiring investigation; 24 required further review using the initial findings review process.
- 7 initial findings reviews related to patients with a learning disability.
- 3 initial findings reviews were escalated as potential lapses in care for root cause analysis through the Serious Incident process. The outcomes of these will be detailed when the Serious Incident process was completed during Quarter 3 or 4.
- Of the Serious Incidents which have been completed during Quarter 2 and finalised, there were no lapses in care.
- During Quarter 2 several new areas for learning had been identified.
- New national guidance had been published in July 2018 with regards to the information we provide to bereaved families where a patient in the Trust's care had died. The documentation and process to support this were currently being developed and would be approved for use and implementation at the November 2018 Trust Mortality Review Group.
- In preparation for the national requirement to use structured judgement review as the main methodology for case reviews, the Trust had trained over 30 staff in Quarter 2 and had started using structured judgement reviews as the main case review tool from October 2018.

Mehmuda Mian, Non-Executive Director referred to page 45 of the agenda pack and asked whether the national information leaflet and the Trust's letter

sent to bereaved families and carers had been reviewed by families and carers to ensure that the tone and content was appropriate.
The Medical Director confirmed that the national leaflet had been co-produced with families and carers.

The Chair asked whether the structured judgement review process was better than the initial findings review process.

The Medical Director said that the structured judgement review process had been used by the acute hospital sector for several years and said that one of the key advantages was that it was a validated tool. The Medical Director reported that the Head of Clinical Effectiveness and Audit had worked with the Academic Health Science Network to adapt the process for a Community and Mental Health setting.

The Chair said that it was an informative report and thanked the Medical Director and his team for developing a robust mortality review process.

The Committee noted the report.

**5.4 Bluebell Ward Serious Incident Action Plan**

The completed Bluebell Ward Serious Incident Action Plan had been circulated.

The Committee noted that report.

**5.5 WestCall Care Quality Commission Compliance Report**

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

- WestCall GP Out of Hours Service had been rated overall as “requires improvement” by the Care Quality Commission. The Safe, Effective and Well Led domains were rated as “Requires Improvement” with Caring and Responsive domains rated as “Good”.
- WestCall was not a core service for the Trust and therefore the rating did not affect the Trust’s overall Care Quality Commission rating of “good”.
- WestCall had developed a comprehensive action plan to address the areas highlighted for improvement by the Care Quality Commission.

Mehmuda Mian, Non-Executive Director asked whether WestCall had the resources to deliver the action plan.

The Director of Nursing and Governance said that the overall patient experience was very good and the areas for improvement mainly related to governance systems and processes. The Director of Nursing and Governance confirmed that in her opinion, WestCall had the necessary resources and that they were receiving corporate support to deliver the action plan.

It was noted that an updated action plan would be presented to the next meeting of the Committee.

**Action: Acting Director of Nursing and Governance**

The Committee noted the report.

**5.6 Board Assurance Framework (Risk 1 Workforce)**

The Committee's updated Board Assurance Framework Risk 1 had been circulated. The Committee noted that there were a number of actions being taken by the Trust to mitigate workforce shortages.

The Committee noted the report.

**Clinical Effectiveness and Outcomes**

**6.1 Quality Accounts Report 2018-19 Quarter 2 Report**

The Medical Director and Head of Clinical Effectiveness and Audit presented the paper and reported that the Quality Accounts Report 2018-19 had been updated to reflect the comments made by the Committee at the last meeting.

The Director of Nursing and Governance said that the report was easy to read, and she particularly liked the use of the blue highlighted boxes.

The Head of Clinical Effectiveness and Audit reported that the Council of Governors would be asked to select their indicator for external audit at the December 2018 meeting.

It was noted that the Quality Accounts 2018-19 Quarter 3 report would be presented to the Governors' Quality Assurance Group for comment and would be shared with the Trust's key stakeholders.

The Chief Operating Officer queried whether the section of delayed transfers of care should be moved to the patient experience section.

**Action: Head of Clinical Audit and Effectiveness**

The Head of Clinical and Effectiveness said that the next version of the Quality Accounts (Quarter 3) would be the almost final version and therefore it members of the Committee had any comments, they should make them on the Quarter 3 version, so they could be incorporated into the final document.

The Committee noted the report.

**6.2 Clinical Audit Reports**

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

The Chair also thanked the Clinical Directors, Jagjit Sethi and Sue McLoughlin for attending the meeting and presenting the findings of the Clinical Audit Reports.

It was noted that three national audits were received by the Clinical Effectiveness Group in September 2018:

a) National Clinical Audit of Psychosis;
b) National Diabetes Audit and National Diabetes Insulin Pump Audit; and
c) National Diabetes Secondary Care Foot Care Audit*.

*The Medical Director pointed out that responsibility for the National Diabetes Secondary Care Foot Care Audit sat with the Royal Berkshire NHS Foundation Trust and that the Trust only provided an element of Podiatry input into their Foot Care team.

**National Clinical Audit of Psychosis**

The Clinical Director for Mental Health East Locality and Inpatient Services reported that the audit was a large project which reviewed core aspects of care across the whole of community mental health.

It was noted that overall the Trust's results were positive. The following areas identified for further review of the Clinical Effectiveness Group:

- Intervention for glucose and lipid abnormalities;
- Number of patients on Care Planning Approach (CPA). The Trust had the lowest proportion of patients on CPA when benchmarked with other organisations;
- Number of patients on Community Treatment Orders (CTO). The Trust had a low proportion of patients on CTO when benchmarked with other organisations;
- Assessment of Carers' Needs; and
- Employment status

The Clinical Director reported that the Trust had on-going work in place to improve these aspects of care.

The Chair asked whether the support the Trust provided through the Individual Placement Support service covered volunteering as well as paid work. The Clinical Director confirmed that the Individual Placement Support service only covered paid employment, but said that the Trust would provide help and advice on appropriate steps to employment and that this may include volunteering opportunities.

The Chair said that Mehmuda Mian, Non-Executive Director and herself were Mental Health Act Managers and commented that as long as there was appropriate care package in place, Community Treatment Orders were a less restrictive option than an in-patient stay. The Medical Director pointed out that only a small proportion of detained patients were suitable for Community Treatment Orders.

**National Diabetes Secondary Care Audit and National Diabetes Insulin Pump Audit**

The Clinical Director for East Physical Health Locality reported that in East Berkshire, the Trust was commissioned to provide a small proportion of the Secondary Care Diabetes Service which supported both people with Diabetes and Primary Care in the management of the condition.

It was noted that the results of the two audits related to 2016-17 data and that the Trust had completed a number of improvements and investments since 2016-17.

The Clinical Director reported that the data submission for the 2017-18 national Diabetes audit and national Diabetes insulin pump audit and it was anticipated that the results would be published in March 2019.

The Clinical Director pointed out that the audits had highlighted data quality issues and it was noted that the audits were dependent upon data from a range of primary and secondary care organisations. Whilst work was on-going to improve data collection and reporting for 2018-19 submissions, the 2017-18 submission will still have the old reporting style data and hence it was anticipated would highlight similar issues to those reported in the 2016-17 audits.

It was noted that the Frimley Health and Care Integrated Care Systems (ICS) was reviewing how best to engage people with Diabetes to improve the uptake of the available services.

**Prescribing Valproate**

The Medical Director reported that the August 2018 meeting had requested a local re-audit be completed in Quarter 3 to give further assurance in respect of prescribing Valproate to women of child bearing age.

The Medical Director said that it was not practical to undertake a local audit which covered the scope of the national audit before the next national audit and as previously reported (see minute 4.2b) he had convened a meeting with David Buckle, Non-Executive Director to discuss the issue and to provide the necessary assurance. The proposal for a local audit limited to the use of Valproate on inpatient wards at Prospect Park Hospital was noted.

**Action: Medical Director/Head of Clinical Effectiveness and Audit**

The Chair thanked the Medical Director and re-iterated that Dr Buckle had confirmed to her that he was assured by the Trust's approach to managing the risks around the prescribing of Valproate to women of child bearing age.

The Committee noted the report.

**Update Items for Information**

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

The Medical Director presented the paper which had been written by the Trust's Guardians of Safe Working Hours.

The Medical Director reported that there had been nine exception reports in Quarter 2 and pointed out that the Trust encouraged Junior Doctors to report all incidences over and above the trainees' work schedules. It was noted that the total number of additional hours worked was 11.5 hours. Eight exception reports were upheld, and the trainee doctors were offered time off in lieu.

The Medical Director reported that the Guardians of Safe Working Hours had confirmed that all work schedules were currently compliant with the Contract Terms and Conditions of Service, but the Core Psychiatric Rota was being reviewed to better suit trainee and service need.

The Medical Director said that the Guardians had given assurance to the Board that no unsafe working hours had been identified and no other patient safety issues requiring escalation had been identified.

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

The Committee noted the report.

**7.2 Quality Executive Committee Minutes**

The minutes of the Quality Executive Committee meetings held on: 13 August 2018, 10 September 2018 and 8 October 2018 were noted.

Mehmuda Mian, Non-Executive Director asked for more information about the Trust's policy on the use of e-cigarettes.

The Director of Nursing and Governance explained that e-cigarettes were currently included in the Trust's "no smoking" ban but reported that the Trust was currently reviewing the policy and was looking at the pros and cons of allowing in-patients to use e-cigarettes on the wards.

**Closing Business**

**8.1 Standing Item – Horizon Scanning**

The Chair asked members of the Committee to forward suggestions for future agenda items to the Company Secretary.

**8.2. Any Other Business**

Retirement of Helen Mackenzie, Director of Nursing and Governance

The Chair reported that this would be the Director of Nursing and Governance's last Quality Assurance Committee meeting before she retired from the Trust in December 2018.

On behalf of the Committee, the Chair thanked the Director of Nursing and Governance for her contribution to the work of the Trust. The Chair said that it had been a privilege to work with Ms Mackenzie and wished her all the very best for the future.

**8.3. Date of the Next Meeting**

19 February 2019 at 10.00

These minutes are an accurate record of the Quality Assurance Committee meeting held on 20 November 2018.

**Signed:-**_____

**Date: - 19 February 2019**_____

| | |
|---|---|
| **QEG / QAC/ Trust Board** | November 2018 |
| **Title** | **Learning from Deaths Quarter 2 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** | 788 deaths were recorded on the clinical information system (RiO) during Q2 where a patient had been in contact with a trust service in the year before they died. Of these 77 met the criteria to be reviewed further. All 77 were reviewed by the executive mortality review group and the outcomes were as follows:<br>• 42 were closed with no further action<br>• 11 were classed as Serious Incident Requiring Investigation<br>• 24 required further review using an initial findings review (IFR)<br>During Q2 the mortality review group reviewed the findings of 25 IFR reports (detailed on p8), 7 IFRs related to patients with a learning disability (these are cases reviewed in Q2 and will include cases reported in previous quarters).<br><br>**Potential Lapse in Care**<br>Of the 25 case reviews, 3 were escalated as potential lapses in care for root cause analysis through the Serious Incident (SI) process. The outcomes of these will be detailed when the SI process is completed in Q3/Q4.<br><br>Of the SI which have been completed in Q2 and finalised there were no lapses of care.<br><br>Several themes and areas of learning from a review of the deaths are being implemented, and the Q2 learning builds and supports the learning identified in Q1. In Q2 we identified a number of new areas for learning, as well as areas we continue to embed which include:<br>• Learning disabilities: The referral pathway project will inform the revision of our community learning disability referral and team processes. This will also include following up on actions regarding referrals via the Hub/Adult Speech and Language Therapy – and the urgency of dysphagia referrals for people with a learning disability<br>• Importance of completing stool charts and bowel management was highlighted and is now included in the Daily Ward Rounds so as to further embed the process. The guidelines also include the required medical assessments for these patients.<br>• Learning and video on Male catheter insertion shared through the Clinical Development Group (Berkshire wide) and then through district nurse forums.<br>• Review of guidance for staff on catheterisation is being undertaken<br>• Share with call handlers the urgency of the situation regarding supra pubic catheters and |

| | |
|---|---|
| | ensure that appropriate advice is available<br>• Process for review and ordering continence supplies to be reviewed to ensure that patients have the correct equipment<br>• Multidisciplinary Team Meetings: the robustness and completeness of documenting what is discussed and planned in Multidisciplinary Team meetings has been highlighted as a recommendation in a number of SI's relating to mental health patients. An aide memoir/process sheet is being put together to assist staff on what to focus on in the Inpatient discharge MDT and also the first follow up visit. CRHTT are working with the Clinical Transformation team to develop a standardised MDT form.<br>• Returning calls: Not returning calls has been identified in a number of mental health SIs (making a plan to call back, not carrying through with this plan and no follow up/handover) This has been shared with Clinical Directors and will be included in learning events to identify what will assist services with ensuring all calls are returned and within work being undertaken to improve interface challenges between mental health services.<br>• Using all information available to assist in better understanding a patient's risk: Investigations have been identifying that staff are not always using information available from wider sources including other agencies and family members. This learning is included within the risk and suicide training and support materials provided across the trust.<br><br>New national guidance has been published (July 18) with regards to the information we provide to bereaved families where a patient in our care has died, the documentation and process to support this are currently being created and will be approved for use and implementation at the November Trust Mortality Review Group (TMRG).<br><br>In preparation for the national requirement to use structured judgement review (SJR) as our main methodology for case review, we have trained over 30 staff in Q2 and have started using SJR as our main case review tool as of October. |
| **ACTION REQUIRED** | The committee is asked to receive and note the Q2 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. First line review is through weekly review of Datix reported deaths by the Executive Mortality Review Group. Second line reviews (using IFR/SJR) are discussed at the monthly Trust Mortality Review Group where learning is identified and service improvement actions are followed through.

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 suspected 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

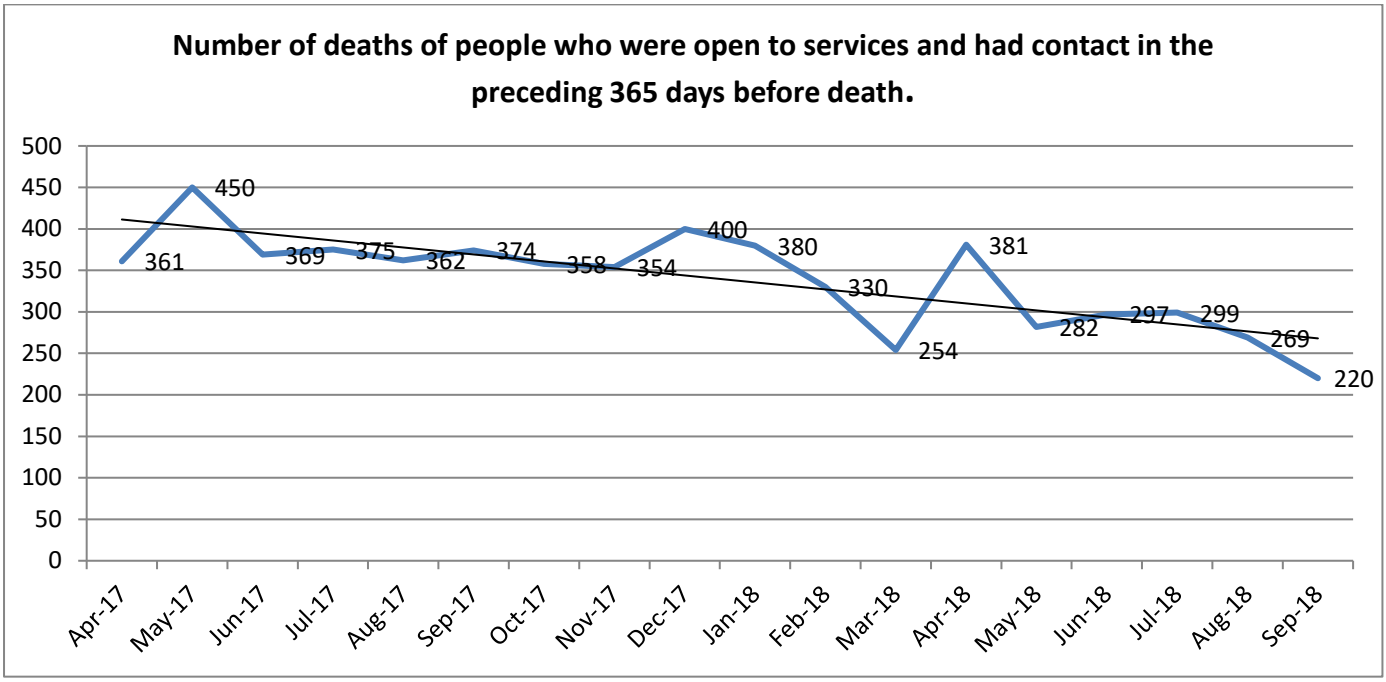
## 4.1 Total Number of deaths in Q2

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 | July 18 | August 18 | September 18 | Total Q2 |
|---|---|---|---|---|
| Nursing episode | 126 | 130 | 109 | 365 |
| Dietetics | 42 | 40 | 33 | 115 |
| Community health services medical | 19 | 19 | 20 | 58 |
| Old age psychiatry | 28 | 18 | 12 | 58 |
| Podiatry | 25 | 10 | 4 | 39 |
| Palliative medicine | 14 | 12 | 11 | 37 |
| Speech and language therapy | 17 | 10 | 9 | 36 |
| Adult mental illness | 5 | 5 | 6 | 16 |
| General medicine | 6 | 5 | 4 | 15 |
| Cardiology | 4 | 4 | 5 | 13 |
| Rehabilitation | 3 | 5 | 1 | 9 |
| Physiotherapy | 3 | 3 | | 6 |
| Respiratory medicine | 4 | 2 | | 6 |
| Genito-urinary medicine | | 2 | 3 | 5 |
| Geriatric medicine | 2 | | 1 | 3 |
| Clinical psychology | | 1 | 2 | 3 |
| Learning disability | 1 | 1 | | 2 |
| Child and Adolescent Psychiatry | | 1 | | 1 |
| Paediatrics | | 1 | | 1 |
| Grand total | 299 | 269 | 220 | 788 |

**Figure 2 shows the numbers of deaths for April 2017 to September 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.

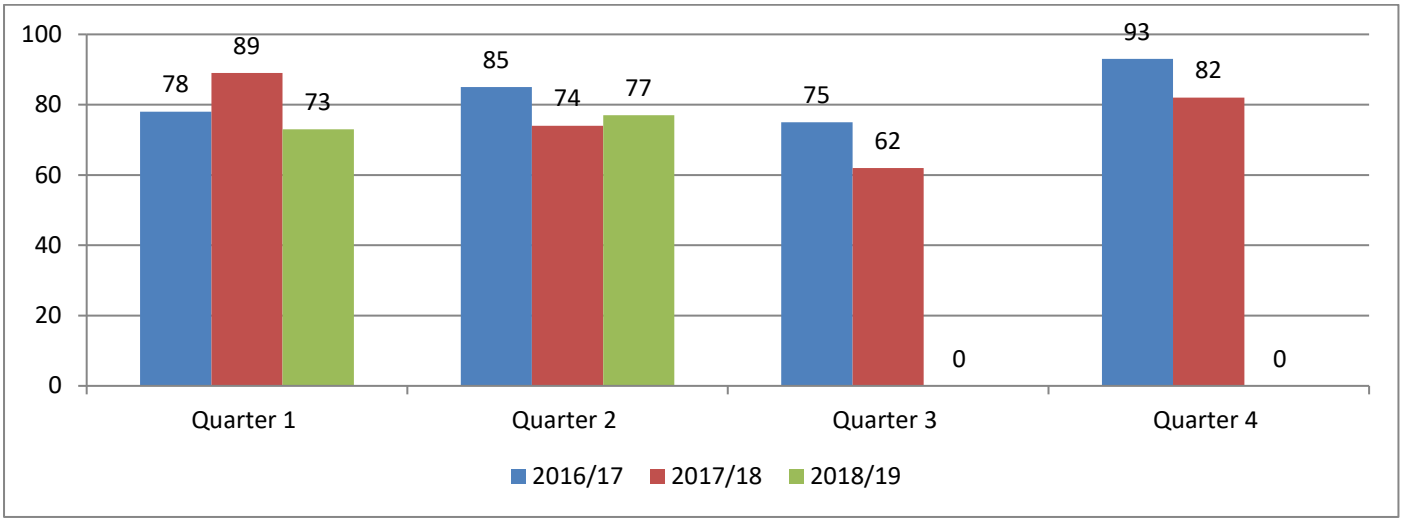
| These are the last Specialty Teams seen before death | July 2018 to September 2018 | | | | |
|---|---|---|---|---|---|
| | A:0-17 | B:18-65 | C:66-75 | D:Over 75 | Grand Total |
| Nursing episode | 2 | 42 | 67 | 254 | 365 |
| Dietetics | 2 | 23 | 27 | 63 | 115 |
| Community health services medical | | 7 | 8 | 43 | 58 |
| Old age psychiatry | | 2 | 7 | 49 | 58 |
| Podiatry | | 2 | 6 | 31 | 39 |
| Palliative medicine | | 13 | 11 | 13 | 37 |
| Speech and language therapy | | 3 | 3 | 30 | 36 |
| Adult mental illness | | 12 | 2 | 2 | 16 |
| General medicine | | 3 | 5 | 7 | 15 |
| Cardiology | | 1 | 3 | 9 | 13 |
| Rehabilitation | | 1 | 1 | 7 | 9 |
| Physiotherapy | | | 1 | 5 | 6 |
| Respiratory medicine | | 2 | | 4 | 6 |
| Genito-urinary medicine | | | | 5 | 5 |
| Geriatric medicine | | | | 3 | 3 |
| Clinical psychology | | 1 | 2 | | 3 |
| Learning disability | | 2 | | | 2 |
| Child and Adolescent Psychiatry | 1 | | | | 1 |
| Paediatrics | | 1 | | | 1 |
| Grand total | 5 | 115 | 143 | 525 | 788 |

*** 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 | July | August | September | Total |
|---|---|---|---|---|
| Child and Adolescent Mental health (CAMHS) | | 1 | | 1 |
| Community Matron | 1 | | | 1 |
| Criminal Justice Liaison and Diversion | 1 | | | 1 |
| District Nursing - Bracknell | 1 | | | 1 |
| Eating Disorders Service | 1 | | | 1 |
| Out of Hours GP | | | 1 | 1 |
| Specialist children services | | | 1 | 1 |
| Talking Therapies | 1 | | 1 | 2 |
| Criminal justice and liaison service | 1 | 1 | 1 | 3 |
| Common Point of Entry | 1 | | 2 | 3 |
| Crisis Resolution and Home treatment team | | 2 | 2 | 4 |
| Older People's Mental Health | 2 | 2 | 1 | 5 |
| Health Visiting | | 1 | 4 | 5 |
| Learning Disability | 3 | 1 | 3 | 7 |
| Community Mental Health | 3 | 1 | 6 | 10 |
| Community Hospital Inpatient | 10 (T1) | 14 (T5) | 7 (T2) | 31 |
| **Total Datix** | **25** | **23** | **29** | **77** |

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

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

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

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

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

**Figure 6. Outcome following review at EMRG in Q2**

| | Number |
|---|---|
| Datix closed no further action required | 42 |
| Classified as a Serious Incident (SI) | 11 |
| Initial findings report (IFR) requested | 24 |
| Total | 77 |

## 5. Trust-wide Mortality Review Group

### 5.1 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; 25 reviews have been received as Initial Findings Reports (IFRs) or Infection Control Reviews and considered by the group in Q2.

**Figure 8: Reviews Conducted in Q2**

| | **Total Number** | **Services** |
|---|---|---|
| **July** | 7 new IFRs reviewed<br><br><br><br>1 Infection Control Review | Learning Disability – 4 cases<br>Older Adults Mental Health -1 case<br>Wokingham Inpatient Wards – 1 cases<br>WAM Community Mental Health – 1 case<br>West Berkshire Community Hospital – 1 case |
| **August** | 11 new IFRs reviewed | Berkshire Eating Disorder Service – 1 case<br>Wokingham Inpatient Wards – 2 cases<br>Reading CMHT – 1 case<br>Court Liaison and Divert Service – 1 case<br>Upton Community Hospital – 1 case<br>Talking therapies – 1 case<br>Common Point of Entry – 1 case<br>Crisis resolution and home treatment team – 2 cases<br>Children's Services – 1 case |
| **September** | 6 New IFRs reviewed | Learning Disabilities – 3 cases<br>Older Adults Mental Health -2 case<br>Slough CMHT – 1 case |

***Note: these are cases reviewed in Q2 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
- 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 potential or 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 Q2.

## 5.2 Potential Lapse in care

Of the 25 IFRS which have been reviewed in Q2 by the TMRG, 3 were identified as a potential lapse in care and have been escalated and declared as a serious incident (SI). These are identified in the table below. Following completion of the SI process any lapse in care (root cause) and learning will be included in the Q3 learning from deaths report. One further case from April was retrospectively declared as an SI and is also identified in the table below.

### 5.3 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 Q2**

| Service (Source Q2 Serious Incident Report) | Number |
|---|---|
| CPE (S) | 2 |
| CAMHS (S) | 1 |
| CRHTT/MHIP (S) | 1 |
| Talking Therapies (S) | 1 |
| Slough CMHT (S) | 1 |
| West Berkshire CMHT (S) | 1 |
| *Wokingham Community Hospital Transfer | 1 |
| *West Berkshire Community Hospital Transfer | 1 |
| *Westcall (Death 2 days after Assessment) | 1 |
| Reading CMHT | 1 |
| Wokingham CMHTOA | 1 |
| West Berkshire CMHT | 1 |
| *Mental Health Inpatients Transfer (reported initially in April 17) | 1 |
| **Total** | **14** |

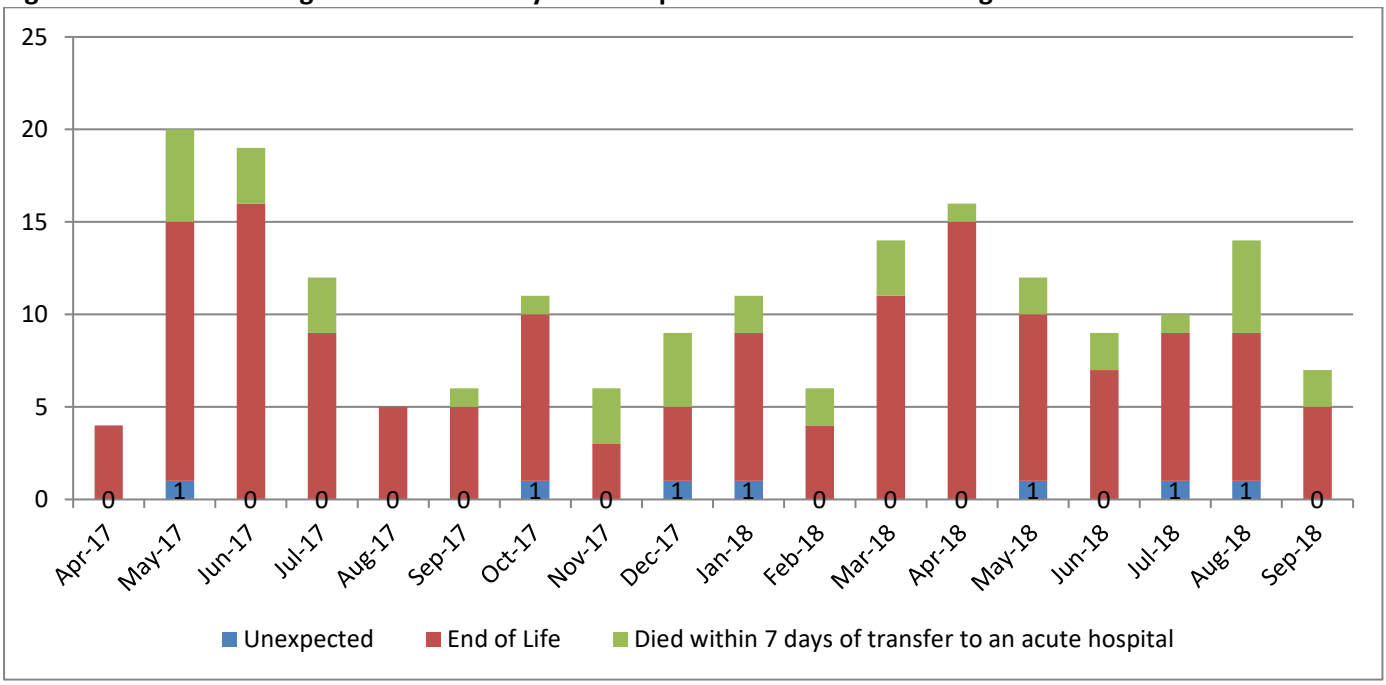
**4 deaths escalated for SI investigation following review and further information.*
(S) Suspected suicide all others unexpected deaths.

### 5.4 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 Q2 31 (Q1 37) deaths in total were reported by the Community Inpatient Wards, of these 21 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.

8 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 8.

2 deaths in Q2 were unexpected, this was reviewed by the EMRG and no further action was required following confirmation of natural cause of death.

**5.5 Deaths of Children and Young People**

7 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.

1. One reported as an SI (CAMHS)
2. One IFR reviewed and closed at the October TMRG
3. Five were reviewed by the EMRG and were closed with no further action required, 4 were in relation to babies born before 26 weeks and one related to a baby with complex health needs.

**5.6 Deaths of adults with a learning disability**

In Q2 there are a total of 5 deaths of adults with learning disabilities who were known/open to the learning disability services in the 12 months prior to their death. In addition there have been 2 additional deaths of adults with a learning disability who were not known/open to the specialist learning disability services during this time.

In total the TMRG reviewed 7 IFRs from patients who had died with a learning disability (relating to deaths reported at the end of Q1 and in Q2). Of these 7 deaths reviewed by TMRG, there were no identified lapses in care provided by BHFT services.

**The deaths were attributed to the following causes:**

3 - Diseases of the Respiratory System
2 - Infections
1 - Heart and Circulatory System
1 - Awaiting confirmation by GP

**Demographics of adult patients with a learning disability**

**Gender:**

| | |
|---|---|
| Female | 2 |
| Male | 5 |

**Age:**

The age at time of death ranged from 33 to 78 years of age (median age: 54yrs)

**Severity of Learning disability:**

| | |
|---|---|
| Mild | 3 |
| Severe | 3 |
| Not known | 1 |

**Ethnicity:**

| | |
|---|---|
| White British | 6 |
| Other White | 1 |

**National Learning Disability Mortality Review Process (LeDeR)**

From the 1st September 2017 the Learning Disability Service has provided notification to LeDeR (national Learning Disability Mortality Review process) of all deaths of individuals with learning disabilities known to the Trust. Locally in Berkshire, the CCGs are responsible for the coordination of the LeDeR process. BHFT participate in the Steering Groups in both East and West Berkshire and support the LeDeR process practically with staff trained as LeDeR reviewers (and these staff attend LeDeR Reviewer Forums).

**LeDeR Notifications**

Notifications have been made to LeDeR for each of the 7 people who died in the Q2.

## 6. Additional Case Review

Data collection for the National Audit of care at the End of Life (NACEL) has been completed and all required Trust information has been successfully submitted to The NHS Benchmarking Network (the national team running the audit). This national team will now collate the data from all participating trusts across the country, with a national report being published in May 2019. This report is likely to benchmark our trust findings against other trusts across the country.

In June 2018, a report into deaths at the Gosport War Memorial Hospital was published; in order to support the Trust review of the Gosport Report, the Clinical Effectiveness Team have analysed the EOL data internally which has been submitted to the National Audit . This draft report represents an in-house, interim analysis of trust findings from the case note audit against best practice as defined in "One Chance to get it Right" (2014) and NICE Quality Standard 144 -Care of Dying Adults in the Last Days of Life (2017). The report is due to be presented to the TMRG in December 2018.

## 7. Involvement of families and carers in reviews and investigations

There are established processes to involve all families and carers where a death is reported as an SI or a death relates to an individual with a learning disability and these are detailed below with regards to the level of involvement for those deaths reported in Q2.

In July 2018, NHS England published guidance on information for families following bereavement, a template information leaflet for trusts was provided. The leaflet gives families the opportunity to raise any concerns and gives details on reviews of deaths in our care and investigations which may occur, it also gives local information for advocacy and support.
The leaflet has been updated by the TMRG to include the relevant contacts and specific local information the template requires, in addition to this we are in the process of drafting and agreeing the template letters which will accompany the leaflet. It is proposed that there will be a generic letter for services to use alongside specific letters for families of patients with a learning disability, families of children and families where the patient was receiving End of Life Care. The process for this and how it will work alongside (but distinct from) duty of candour, are due to be discussed and agreed at the November TMRG.

### 7.1 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 12 families in Q2 and this was followed up with a written request for a meeting (in 1 additional case neither the service nor coroner have been unable to make contact). All families/ carers were offered the opportunity for a face to face meeting, 1 family accepted this opportunity initially with 2 further families

subsequently accepting the offer, 9 families have declined to meet at present but will be contacted and invited again as part of the investigation process and also following the investigation completion

**7.2 For non SI deaths**

**Engagement and feedback with family members**

The learning disability team make contact with the family or carer, following the reported death of a person with a learning disability. Telephone contact was made for the 5 individuals who were known to the learning disability services in order to offer support and condolences to those that the individual lived with, be they family or carers (staff members from a care home/supported accommodation). This action was completed by the local CTPLD team members who knew and had a relationship with those that supported the individual. Phone contact had not been made by the learning disability service for the remaining persons as they were not known directly 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 7 individuals whose deaths were reported, 3 next of kin (NOK's) were sent condolence cards with 1 one due to be sent imminently following provision of the NOK details. Contact had not been made for the remaining 3 persons as 1 had no known family and the NOK details for the remaining 2 people has not been possible to be obtained. Of the 3 cards sent, there have been no responses from the NOK to date.

## 8. 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 Q2

**8.1 Themes and learning from serious incidents (SI)**

**Multidisciplinary Team Meetings**: the robustness and completeness of documenting what is discussed and planned in Multidisciplinary Team meetings has been highlighted as a recommendation in a number of SI's relating to mental health patients. An aide memoir/process sheet is being put together to assist staff on what to focus on in the Inpatient discharge MDT and also the first follow up visit. CRHTT are working with the Clinical Transformation team to develop a standardised MDT form.

**Returning calls**: Not returning calls has been identified in a number of mental health SIs (making a plan to call back, not carrying through with this plan and no follow up/handover) This has been shared with Clinical Directors and will be included in learning events to identify what will assist services with ensuring all calls are returned and within work being undertaken to improve interface challenges between mental health services.

**Using all information available to assist in better understanding a patient's risk:** Investigations have been identifying that staff are not always using information available from wider sources including other agencies and family members. This learning is included within the risk and suicide training and support materials provided across the trust.

**Learning for community nursing and call handlers with regards to catheter care**:

- Learning and video on Male catheter insertion shared through the Clinical Development Group (Berkshire wide) and then down through district nurse forums.
- Review of guidance for staff on catheterisation is being undertaken
- Share with call handlers the urgency of the situation regarding problems with supra pubic catheters and ensure that appropriate advice is available
- Process for review and ordering continence supplies to be reviewed to ensure that patients have the correct equipment.

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

All deaths reported in Q2 have been discussed in patient saftey and quality meetings, in particular to continue to

highlight the importance of physical health monitoring. At Prospect Park Hospital, we have revised the physical health monitoring policy so that expectations are clearly set out. A programme of training for cardio metabolic screening is now part of essential training, this starts in Novemeber for staff at prospect park hospital and January 2019 for community mental health teams. The physical health lead has also been providing individual sessions for staff around physical health screening.

**8.3 Theme Older Peoples Mental Health (OPMH)**
Most OPMH deaths in Q2 did not require an IFR, however the service has noted a potential theme of other agencies attributing sudden deterioration/changes in behaviour to dementia rather than to a physical health cause e.g. delirium due to infection, poly-pharmacy or pain. The service will monitor reviews for further examples and flag at TMRG if it appears to be something we need to raise with GPs/Acute Hospitals.

**8.4 Learning from deaths of patients with a learning disability (LD)**
Actions and learning identified during the previous quarter have been completed / shared. In Q2, learning has been identified regarding the team processes and the need to ensure there is multi-disciplinary team (MDT) discussion and awareness of plans to close referrals. This work is already being undertaken through the referral pathway/team process project and will inform the CTPLD referral and team processes.

There was one individual where there was a delay in care received in regards to a referral to Speech and Language Therapy (SLT) to support swallow difficulties in March 2018. While this did not contribute to their death, there was learning regarding the referral and team processes which has been shared through the referral pathway project and will inform the revision of CTPLD referral and team processes. This will also include following up on actions regarding referrals via the Hub/Adult SLT – and the urgency of dysphagia referrals for people with a learning disability

In Q2, there was also evidence of good practice through the effective joint working practice demonstrated between the CTPLD, Palliative Care services and support providers. There was good consideration of the emotional support needed for people during end of life care and for their family and friends (including people with learning disabilities living in the same home).

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.

**8.5 Learning from LeDeR reviews**
The CTPLD Clinical Review Group shares the Initial Findings Report with the LeDeR programme and this includes any areas recommended for further review which are beyond the scope of BHFT. Representatives from BHFT attend the LeDeR steering groups and reviewers groups in both the East and West of Berkshire. There have been no further individual review reports formally shared from the local LeDeR arrangements with BHFT. The quarterly reports from the LeDeR programmes in Berkshire, and learning from the national programme are shared via the Learning Disability Service Patient Safety Quality and Governance meeting and Trust Mortality Review Group.

**8.6 Learning from Community Health**
Two recent deaths post transfer to acute hospital, noted a related cause of death to bowel obstruction/impaction, and whilst no lapse care was identified, actions were taken to provide assurance that the community wards are clear on policy and actions related to bowel obstruction/impaction in elderly patients.

Prior to the two deaths related to bowel obstruction, nurses were already completing stool charts and following bowel actions included in the HCAs hand over. This is now included in the Daily Board Rounds so as to further embed the process. The guidelines the also include the required medical assessments for these patients.

Community Hospital inpatient wards recognising and treating patients when they have symptoms which require medical input and sometimes acute medical care, this was highlighted in Q1 and continues to be a theme in Q2 and area for learning.

## 9. National Guidance and Policy Review

Royal College of Psychiatry guidance on specific methodology for review of deaths of patients in mental health & community health trusts (which are not declared as Serious Incidents) was published on 27 November. The methodology recommended is based on the Structured Judgement Review (SJR) which has been piloted by Yorkshire and Humber through the AHSN Improvement Academy and adapted in Berkshire Healthcare.

Staff have been trained in SJR methodology to complete case record reviews and this is replacing the current IFR methodology, in a phased approach, from October 2018. We held 2 training sessions on 18th and 19th September one for mental health staff and one for community health staff which were led by the lead Clinical Director, in addition we held training sessions for learning disabilities staff led by the Consultant Nurse. In total we have over 30 staff from across the trust trained in the SJR methodology.

## 10. Conclusion

In Q2, of the 25 deaths concluded through the trust mortality review group, 3 reviews received in Q2 have been escalated to SI following review by the TMRG.

Several themes and areas of learning from a review of the deaths are being implemented and the Q2 learning builds and supports the learning identified in Q1. In Q2 we identified a number of new areas for learning, which include:

- Learning disabilities: The referral pathway project will inform the revision of our community learning disability referral and team processes. This will also include following up on actions regarding referrals via the Hub/Adult SLT – and the urgency of dysphagia referrals for people with a learning disability
- Importance of completing stool charts and following bowel actions was highlighted and is now included in the Daily Board Rounds so as to further embed the process. The guidelines also include the required medical assessments for these patients.
- Learning and video on Male catheter insertion shared through the Clinical Development Group (Berkshire wide) and then down through district nurse forums.
- Share with call handlers the urgency of the situation regarding supra pubic catheters and ensure that appropriate advice is available
- Process for review and ordering continence supplies to be reviewed to ensure that patients have the correct equipment.

SJR will be increasingly used for case record reviews of non-SI deaths from October. The trust services will support bereaved families and carers in line with the national guidance published in July.

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

**This report covers the period 1st Aug to the 30th Oct 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 Aug to the 30th Oct 2018. Since the last report to the Trust Board we have received 9 exception reports. This remains a low number of reports compared to other trusts locally and we feel represents a success of encouragement to the trainees to report when they work extra hours.

The core psychiatry out of hour's rota is being redesigned as the current pattern is very heavy and one week in particular has been identified as representing a higher than desirable number of hours worked, although this week is still within the hours allowed by the contract. Equally the redesign is being embarked upon to allow the trainees to more spend time in their specialty and improve their work/life balance. The redesign is being carried out with the input of junior doctors, Consultants in educational roles and medical staffing.

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): | 33 (FY1 – ST6) |

Included in that figure is 1 LAS (Locum Appointment for Service), 1 WAST (Widening Access to Specialty Training programme) and 1 MTI (Medical Training Initiative).

| | |
|---|---|
| Number of doctors in training on 2016 TCS (total): | 33 |
| 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 | 9 | 9 | 0 |
| Dentistry | 0 | 0 | 0 | 0 |
| Sexual Health | 0 | 0 | 0 | 0 |
| Total | 0 | 9 | 9 | 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 | 8 | 8 | 0 |
| ST 4-6 | 0 | 1 | 1 | 0 |
| Total | 0 | 9 | 9 | 0 |

| Exception reports by rota | | | | |
|---|---|---|---|---|
| Specialty | No. exceptions carried over from last report | No. exceptions raised | No. exceptions closed | No. exceptions outstanding |
| Psychiatry | 0 | 9 | 9 | 0 |
| Dental | 0 | 0 | 0 | 0 |
| Total | 0 | 9 | 9 | 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 | 2 | 0 | 6 | 0 |
| ST4-6 | 0 | 0 | 1 | 0 |
| Total | 2 | 0 | 7 | 0 |

In this period we have received 9 exception reports totaling an extra 11.5 hours worked over and above the trainees' work schedules. This is an increase compared to previous reports. Exception reporting is a neutral action and is encouraged by the Guardians and Director of Medical Education (DME). We feel that the increase in number of exception reports is a positive sign suggesting that trainees are now more willing to complete a report when extra hours are worked. 9 is still a low number of reports in comparison to other local trusts and suggests that most of the time trainees are working within their work schedules.

8 exception reports were upheld and the trainees offered time off in lieu. These related to unusual work pressures on specific days and the trainees did not feel there was any broader issue. 1 exception report was not upheld. The trainee noticed that they worked 74 hours in one week, however according to the contract they had worked those

hours over 8 calendar days not 7 and as such had not exceeded their work schedule. However as this raised an issue with a particular week having a higher workload than others the decision was taken to remove one evening shift off that week for the remainder of the rota. These shifts were instead, and will continue to be until February 2019, covered by the Trust bank of doctors. From February a new rota will be in place. The details of which are currently being negotiated between Junior Doctor representatives and Medical Staffing.

The slow completion of reports is consistent with the emails and conversations we have had with Clinical Supervisors and Supervisees that they are not familiar with the DRS reporting system and as such need advice and support each time they complete an exception report.

There have been 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 August to the 31st October 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 |
| | 52 | 52 | 45 | 7 | 0 | 376 | 376 | 324 | 52 | 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** | 41 | 41 | 34 | 7 | 0 | 260 | 260 | 324 | 52 | 0 |
| **Sickness** | 11 | 11 | 11 | 0 | 0 | 116 | 116 | 116 | 0 | 0 |
| **Maternity** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total** | 52 | 52 | 45 | 7 | 0 | 376 | 376 | 324 | 52 | 0 |

The period 1st August to the 31st October 2018 covers the period from the start of the August rotation of Trainee Doctors. We have had no one on long term sick, but have had a small number of one-off incidents of sickness amongst trainees. One trainee was already on maternity leave on 1st August, and returned on 30th October 2018.

We did have a number of gaps at the start of the August Rotation, and further gaps were created in October when the rota was reorganized as discussed above in section a).

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. 4 trainees, under the supervision of Dr Lowe, are undertaking a Quality Improvement Project looking at the working of the Junior Doctor Forum. The initial data on trainee satisfaction and views on the current JDF format have been gathered and discussed. A provisional action plan was discussed at the last Junior Doctor Forum and will be implemented for the next JDF when further data will be gathered to guide the next steps in the improvement cycle.

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 HETV (Health Education Thames Valley) 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 (Medical Staffing Committee) 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.

**Summary**

All work schedules are currently compliant with the Contract Terms and Conditions of Service but the Core Psychiatry Rota is being reviewed to better suit trainee and service needs.

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 Manage.*

**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 Foundation Trust

# Trust Board Paper

| | |
|---|---|
| **Board Meeting Date** | 11 December 2018 |
| **Title** | Six Monthly Safe Staffing Review |
| **Purpose** | The purpose of this report is to provide the Board with information and a review of staffing within inpatient wards |
| **Business Area** | Nursing and Governance |
| **Author** | Heidi Ilsley, Deputy Director of Nursing |
| **Relevant Strategic Objectives** | 1 – To provide safe services, prevent self-harm and harm to others |
| **CQC Registration/Patient Care Impacts** | Supports maintenance of CQC registration and supports maintaining good patient experience |
| **Resource Impacts** | N/A |
| **Legal Implications** | N/A |
| **Equality and Diversity Implications** | None associated with this paper |
| **SUMMARY** | This report reviews staffing on the inpatient wards between 1st April and 30th September 2018.<br><br>The acute working age adult mental health wards and Orchid ward uplifted their staffing by one additional member of staff per shift from May 2018 as a result of a review and recommendations presented in December 2017 and March 2018.<br><br>For community and learning disability inpatient wards staffing levels remain appropriate.<br><br>West Berkshire Community Hospital continues to suspend ten beds.<br><br>Vacancy of Band 5 registered nursing staff remain high across some of our and the number of shifts where there was only 1 registered nurse instead of the expected 2 registered staff has been significantly higher at Prospect Park Hospital than in previous reporting periods<br><br>The use of temporary staff (registered and unregistered) to maintain safe staffing levels across the wards continues to be high. |
| **ACTION** | The Board is asked to note the report. |

# Six Monthly Safe Staffing Review
# April 2018-September 2018

## Executive Summary

In line with the National Quality Board requirement to review the staffing across inpatient wards at least annually, this board report details the staffing position for all of the inpatient wards within Berkshire Healthcare Trust between April 2018 and September 2018.

During this reporting period ten beds have remained closed at West Berkshire Community Hospital (WBCH), this is in order to maintain safe staffing levels and reduce any potential risks on patient safety and quality. All other wards have remained the same in terms of capacity.

Three of the acute working age adult mental health wards (Rose, Snowdrop and Daisy) and Orchid ward uplifted their staffing by one additional member of staff per shift from May 2018, this has brought all 4 acute wards and Orchid ward in line and is as a result of a review and recommendations presented in December 2017 and March 2018.

The number of shifts reported with less than two registered nurses has significantly increased since the last six month report where 188 shifts were reported compared to 561 within this reporting period (table 7). The majority of these have been at Prospect Park Hospital (PPH).

There have been times when due to high patient acuity to maintain safety the fill rate has been above agreed Trust staffing levels. Achievement of this relies on use of temporary staffing.

During this reporting period, a staffing report was introduced for community nursing services; this is in recognition that alongside the mental health and community inpatient wards this is the service which has most significant staffing concerns.

In October 2018, NHSi published “An overview of developing workforce safeguards, supporting providers to deliver high quality care through safe and effective staffing.” The guidance from this report will be embedded in the second half of 2018/19.

### Prospect Park Hospital (PPH)

As this report demonstrates PPH continues to experience challenges with high bed occupancy, patient acuity and vacancy rates. Bed occupancy on the acute wards has remained above 93% (table 3).

The current vacancy rate (registered and unregistered) is 53.85wte. This is reduced to 30.85 wte once posts that have been offered are included. The majority of registered vacancies that have been recruited to have been filled by newly qualified staff and they will require additional support from senior staff through preceptorship.
The number of reported shifts with less than two registered nurses has increased significantly during this reporting period and there was also 27 occasions when a shift for a ward had no registered staff rostered. The wards with most shifts not covered by 2 registered

nurses was Sorrel ward and Daisy ward (table 7). Senior registered nursing staff stepped in to cover these shifts and staff were moved around the hospital to maintain safety. There is an increased focus on the Duty Senior Nurse (DSN) role in monitoring staff across wards and moving staff when necessary has assisted wards in maintaining registered nurses per shift. In addition long term placements of agency registered nurses have been used to support the registered nursing levels although it has proved challenging in securing these long term placements.

This vacancy rate combined with the additional staffing required to maintain safe staffing and high levels of observations levels means that a high number of temporary staff have been used during this period and temporary staff requested at PPH has increased each month from 1471 in April to 1971 in September.

There was a period of time when PPH stopped using Match Options agency because they were not compliant with the NHS agency framework requirements (April). This resulted in an increased number of unfilled shifts (particularly registered nurses) and in June following a review of this decision due to the impact on safety and quality, the agency programme board recommenced using Match Options agency off framework with regular monitoring.

The bed occupancy on the older adults wards have fluctuated more than the adult wards, Rowan in particular, although both Rowan and Orchid ward have seen an increase each month from April to September 2018 (table 3). These wards are caring for patients with more complex physical health needs, combined with mental health illness. The continued increase in patient acuity shows the challenges staff experience in caring for patients with both mental and physical health conditions. PPH now have a physical health lead who is working with staff to support and develop competencies in caring for physical health conditions with challenging mental health diagnosis.

From May, the wards commenced their new adjusted safer staffing numbers of (6, 6, 5 for the acute wards and Orchid, 7,7,5 for Rowan ward). At this time the Modern Matron role was also introduced into the hospital to provide more focused support for wards.

Sickness rates have been mostly above the Trust's agreed 3.5 % throughout this period except for Bluebell ward which was below 3.5% until September. Snowdrop's sickness rate has reduced and from July has been below the Trust target.

**Willow House**

The average bed occupancy in the period from April to September was 55%. Although this is low, patent acuity has been high, resulting in additional temporary staffing requirements to support 1:1 observations.

Temporary staffing requests have varied from its lowest in June (143) to its highest in September (221). The Unit has struggled to fill temporary shifts, more on week days than weekends and as with other units, registered nurse requests have been the most difficult to fill. Closer alliance with PPH supports the unit via the DSN role, alongside robust systems to support staff by the senior management on the unit. In September, the unit went off of the agency framework to secure the necessary staff.

Vacancy rates have increased throughout this reporting period, from 4.49 wte to 10.75 wte in September. Sickness has improved and between May and August was below the trust target of 3.5%. This rose to 4.49% in September.

**Campion**

Campion's staff team has become more stable over this reporting period with strong leadership, the unit is currently fully established. The average bed occupancy was 88.71%. The sickness rate has been above the Trust target spiking in July at 10.91 %, although this reduced in August and September (graph 4).

Patient acuity has been high with very complex patients often requiring 2:1 observational levels which have meant the unit have needed to use high numbers of temporary staffing to support this.

**Community Wards**

The community wards have had lower than expected bed occupancy during this reporting period (average 74.26%). WBCH have ten beds which remain closed in order to maintain safe staffing levels on the ward.

Registered nurse vacancy rates are still difficult to recruit to, WBCH have the most challenges although they have secured new registered nurses to their vacant posts in the last two months.

All wards now have Advanced Nurse Practitioners to support the wards. The band 4 health care assistant roles continues to develop to maximise the contribution of the unregistered nurses by providing additional training, competency assessment and supervision which enables them to provide enhanced levels of nursing care alongside registered nurses. Community health wards are reviewing staffing models due to their continued challenges in securing permanent registered nurses, and the role of the nursing associate is being developed and rolled out.

Sickness rates have been consistently high across the CHS wards throughout this period.

## Main Report

### Background

In July 2016 the National Quality Board (NQB) published 'Supporting providers to deliver the right staff with the right skills in the right place at the right time: safe sustainable and Productive staffing', this was a refresh of the original document published in 2013 and was aimed at setting context and offering support to local decision making around an agreed workforce that is able to continue to provide high-quality and financially sustainable services

Detailed within the NQB report was a commitment to the development of additional resources to support NHS provider trusts with making staffing decisions that will deliver safe, effective, caring, responsive and well-led care. The improvement resources of relevance to Berkshire Healthcare are for learning Disability, Community Nursing, Adult Inpatients and mental Health. All of these resources were published on 30th January 2018.

These resource guides continue to advocate the use of the Keith Hurst tools (which were updated in October 17) for supporting safe staffing calculations on inpatient wards; this has always been the tool used within the trust to support safe staffing decisions and therefore alongside clinical judgement and benchmarking will continue to be the tool used. The work to address the registered nursing shortfall across our wards continues with a richer skill-mix of unregistered staff including band 4 being recruited to whilst maintaining the nationally recognised minimum of 2 registered staff on each shift remains. Support around recruitment and retention is also underway across Community Mental Health and Community nursing Teams who are also challenged in terms of recruiting to registered practitioner vacancies.

To agree planned staffing establishment for each ward a combination of the Keith Hurst modelling tools which include patient dependency toolkit, professional judgement and benchmarking across other similar wards is used. The updated toolkits from April 2018 have been used for the staffing establishments reviews discussed in this report.

Berkshire Healthcare continues to report their planned and actual staffing levels each month. This is published on NHS choices with a link to the BHFT website for further explanation on what the information means and reasons for differences between the planned and actual staffing numbers.

The national minimum staffing expectation of at least two registered staff on each ward every shift remains a requirement, however, vacancies across all of the wards means that at times this has been challenging to maintain. The number of shifts where there is less than two registered staff on duty is monitored on a monthly basis at executive and board meetings. The exception to this minimum is on Campion Unit where it was agreed that a skill-mix of one registered with three support workers was best able to meet with patient need at night, this position has not been altered.

### 1. Current Situation

Berkshire Healthcare Trust has a total of 14 wards:

- 1 learning disability unit
- 5 community hospital units
- 7 mental health wards.
- 1 Adolescent Unit

All of the wards have a staffing establishment that includes an allowance of 24% for planned and unplanned leave (training, annual leave, sickness absence). Table 1 sets out the actual and agreed staffing level on each shift.

**Table1: Current Staffing establishment, bed numbers and shift patterns**

| | Beds | FTE Establishment in budget 18/19 | Professional judgement<br><br>FTE | Planned shift pattern<br><br>(Early-late-night) |
|---|---|---|---|---|
| **WBCH** | **59** (10 closed Highclere) | 73.1 | 58.6 +ward matrons and 0.6 staff development lead (based on reduced beds) =61.2 | Donnington 9-6-6 Highclere 8-6-5 (currently 6-5-4 due to closure of 10 beds) |
| **Oakwood** | **24** | 38.26 | 33 + 1 ward manager and 1 deputy ward manager matron = 35 | 9-7-4 |
| **Wokingham** | **46** | 55.73 | 57.8+ 1 ward manager + 0.8 matron = 59.6 | 14-10-7 |
| **Henry Tudor** | **24** | 31.80 | 30.8+ 1 ward manager = 31.8 | 7-5-4 |
| **Jubilee** | **22** | 31.52 | 30.8 + 1 ward manager = 31.8 | 7-5-4 |
| **Campion** | **9** | 30.44 | 30.8 + 1 ward manager = 31.8 | 9-6-4 |
| **Sorrel** | **14** | 36.00 | 27.3 + 1 ward manager + 1 CDL+ 0.5 DSN = 29.8 | 6-6-5 |
| **Rose** | **22** | 31.00 | 27.3 + 1 ward manager + 0.5 DSN + 1 CDL = 29.8 | 6-6-5 |
| **Snowdrop** | **22** | 31.00 | 27.3 + 1 ward manager + 1 CDL+ 0.5 DSN = 29.8 | 6-6-5 |
| **Rowan** | **20** | 38.50 | 29 + 1 ward manager + 1 CDL+ 0.5 DSN = 31.5 | 7-7-5 |

| | Beds | FTE Establishment in budget 18/19 | Professional judgement<br><br>FTE | Planned shift pattern<br><br>(Early-late-night) |
|---|---|---|---|---|
| **Orchid** | **20** | 31.00 | 27.4 + 1 ward manager + 0.5 DSN + 1 CDL = 29.9 | 6-6-5 |
| **Bluebell** | **27** | 31.53 | 33.3 + 1 ward manager + 1 CDL+ 0.5 DSN = 35.8 | 6-6-5 |
| **Daisy** | **23** | 32.00 | 28.8 + 1 ward manager + 1 CDL + 0.5 DSN =31.3 | 6-6-5 |
| **Willow House** | **7 (9)** | 23.02 | 24+1 ward Manager =25 | Work shift pattern of long days with 4 on during day and 3 at night |

*Sorrel & Rowan establishments include additional unregistered staff for observations across the hospital. **Reflects the increase in establishment for the mental health wards.

At times across a month, wards may require additional staff above what is planned within the establishment. This is to meet patient need and is because of the increased dependency of the patients. The staffing levels are reviewed daily and also monthly alongside a range of quality and workforce indicators to monitor the impact and experience for patients.

**2.1 Assessment of current establishment**

Dependency is measured by taking into account the level of nursing input (registered and care worker) required to meet the needs of the patient.

When workforce modelling is undertaken for the wards, the Keith Hurst dependency modelling tool is used to assist in the triangulation of data. However, it is recognised that this modelling tool uses a snapshot of dependency of patients on a given day. Dependency can fluctuate and therefore the collation of this data over a period of time is required in order to understand the average dependency for each ward. Where dependency is increased, staff use clinical judgement in negotiation with their managers to agree additional staffing, which is assessed on a shift by shift basis.

Table 2 below shows the dependency scoring for each ward from April-September 2018. These scores are used to monitor patient workload on the wards and help identify when reviews are needed to maintain safe staffing levels across the Trust.

The data in the table below is highlighted red where the dependency of the patients on the ward at the time is greater than the ward establishment is able to meet (all of the tools allow a 10% margin and therefore only the times when need is identified to be greater than 10% over the current establishment is highlighted). Additional temporary staff are used on the wards to help meet patient need.

**Table 2 - WTE requirements using the Keith Hurst dependency tool**

| Ward | Beds | Budget Est. 2018/19 | Apr 2018 | May 2018 | Jun 2018 | Jul 2018 | Aug 2018 | Sep 2018 |
|---|---|---|---|---|---|---|---|---|
| **WBCH** | 59 (10 closed Highclere) | 73.13 | 42.1 (36) | 49.2 (42) | 44.1 (38) | 43.8 (37) | 49.0 (43) | 42.1 (35) |
| **Oakwood Community Ward** | 24 | 38.26 | 30.9 (22) | 16.9 (12) | 17.2 (13) | 21.1 (19) | 26.8 (19) | 17.9 (18) |
| **Wokingham Community Ward** | 46 | 55.73 | 41.7 (40) | 40.5 (35) | | 32.9 (33) | | 28.7 (26) |
| **Henry Tudor Community Ward** | 24 | 31.80 | 24.6 (19) | 20.5 (19) | 21.6 (18) | 18.8 (15) | | |
| **Jubilee Community Ward** | 22 | 31.52 | 25.7 (21) | 24.5 (20) | 24.5 (20) | 20.4 (16) | 21.0 (17) | 22.4 (18) |
| **Campion Learning Disability Unit** | 9 | 30.44 | 20.2 (7) | 35.9 (7) | 35.9 (7) | 37.6 (8) | 47.3 (9) | 47.3 (9) |
| **Sorrel Adult Mental Health Intensive Care Unit** | 14 | 36.00 | 41.6 (8) | 29.1 (6) | | 24.4 (7) | | |
| **Rose Ward Acute Adult Mental Health** | 22 | 31.00 | 28.8 (20) | 38.7 (18) | 49.0 (22) | 39.4 (22) | 42.2 (22) | 36.1 (22) |
| **Snowdrop Ward Acute Adult Mental Health** | 22 | 31.00 | 42.3 (21) | 45.3 (19) | 39.1 (22) | 45.3 (22) | 47.6 (21) | 55.0 (22) |
| **Rowan Ward Older Peoples Mental Health** | 20 | 38.50 | 21.7 (7) | 31.5 (10) | 27.5 (11) | 32.0 (11) | 39.4 (14) | 40.4 (14) |
| **Orchid Ward Older Peoples Mental Health** | 20 | 31.00 | 39.5 (16) | 28.4 (11) | 31.0 (13) | 32.0 (11) | 39.4 (16) | 50.4 (20) |
| **Bluebell Ward Acute Adult Mental Health** | 27 | 31.53 | 24.9 (21) | 35.1 (22) | 40.4 (22) | 41.7 (22) | 39.1 (22) | 32.2 (22) |
| **Daisy Ward Acute Adult Mental Health** | 23 | 32.00 | 46.8 (22) | 48.0 (21) | 53.4 (22) | 41.9 (20) | 42.9 (19) | 40.2 (19) |
| **Willow House** | 7 ( 9) | 23.02 | 22.5 (6) | 14.8 (5) | 6.9 (5) | | 15.3 (6) | |

### 2.2 Review of staffing establishment

There is an expectation set out within the NQB documents that all ward staffing levels are reviewed on an annual basis. The annual staffing review for the trust is planned for November 2018.

### 2.2 Bed occupancy

Table 3 below details monthly bed occupancy over the reporting period, the data highlighted in red is where bed occupancy has exceeded 90%. The areas that have consistently experienced bed occupancy in excess of 90% are the Acute Adult Mental Health Wards.

**Table 3: Bed Occupancy**

| | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Average |
|---|---|---|---|---|---|---|---|
| **Donnington** | 83.56% | 78.60% | 71.22% | 80.22% | 78.88% | 91.84% | 80.72% |
| **Highclere** | 57.70% | 54.84% | 55.52% | 52.50% | 53.62% | 51.89% | 54.35% |
| **Oakwood** | 79.26% | 60.88% | 65.55% | 84.27% | 75.94% | 88.49% | 75.73% |
| **Wokingham** | 81.46% | 83% | 74.54% | 81% | 65% | 81% | 71.96% |
| **Henry Tudor** | 83.75% | 81.05% | 72.22% | 83% | 81.05% | 84.13% | 78.84% |
| **Jubilee** | 85.61% | 87.54% | 85.15% | 77.13% | 76.83% | 86% | 83.97% |
| **Campion** | 91.11% | 85.66% | 81.11% | 83.87% | 91.04% | 99.47% | 88.71% |
| **Sorrel** | 97.88% | 68.06% | 77.67% | 75.08% | 80.97% | 86.19% | 80.98% |
| **Rose** | 94.55% | 93.40% | 91.67% | 97.51% | 98.39% | 98% | 97.18% |
| **Snowdrop** | 97.88% | 93.40% | 96.36% | 97.36% | 95.75% | 98% | 97.95% |
| **Rowan** | 43.50% | 51.29% | 52.67% | 64.68% | 72.10% | 76.19% | 60.07% |
| **Orchid** | 72.61% | 74.68% | 66.67% | 73.71% | 84.03% | 91% | 78.18% |
| **Bluebell** | 98.18% | 96.19% | 93.94% | 94.43% | 95.60% | 99% | 97.76% |
| **Daisy** | 94% | 95% | 95% | 95.92% | 95.81% | 96% | 94.73% |
| **Willow House** | 61.11% | 39.78% | 61.85% | 63.08% | 65.95% | 38.62% | 55.07% |

## 3. Workforce data

A number of factors have the potential to impact on the wards ability to achieve the agreed staffing levels on every shift; these include vacancies and sickness absence. The position over the period April - September 2018 in relation to these two indicators is detailed below.

### 3.1 Vacancies

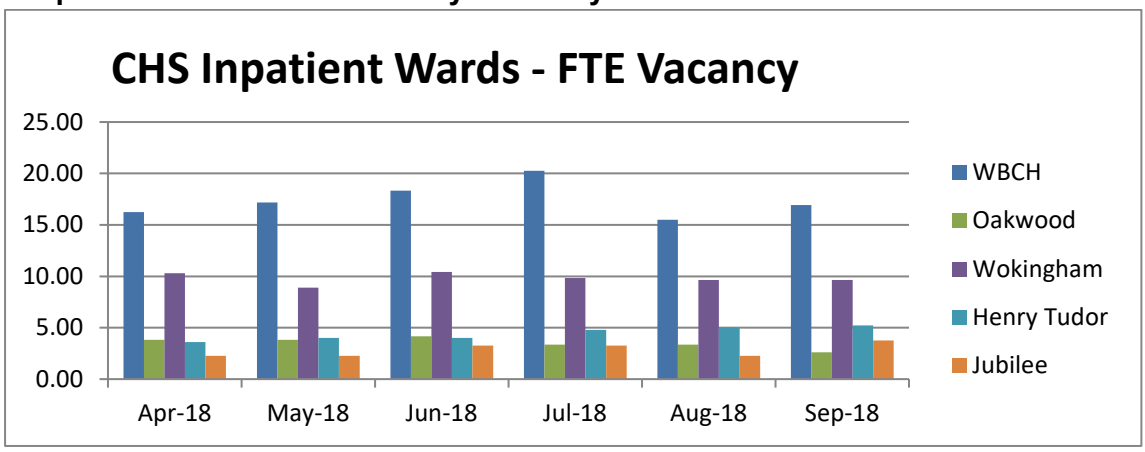
Table 4 below shows the combined WTE vacancy rate of registered nursing and care staff for each ward according to finance data over the last six months. All wards continue to struggle with recruitment, particularly registered nurses.

**Table 4 – Whole Time Equivalent (WTE) vacancy of registered nursing and care worker combined**

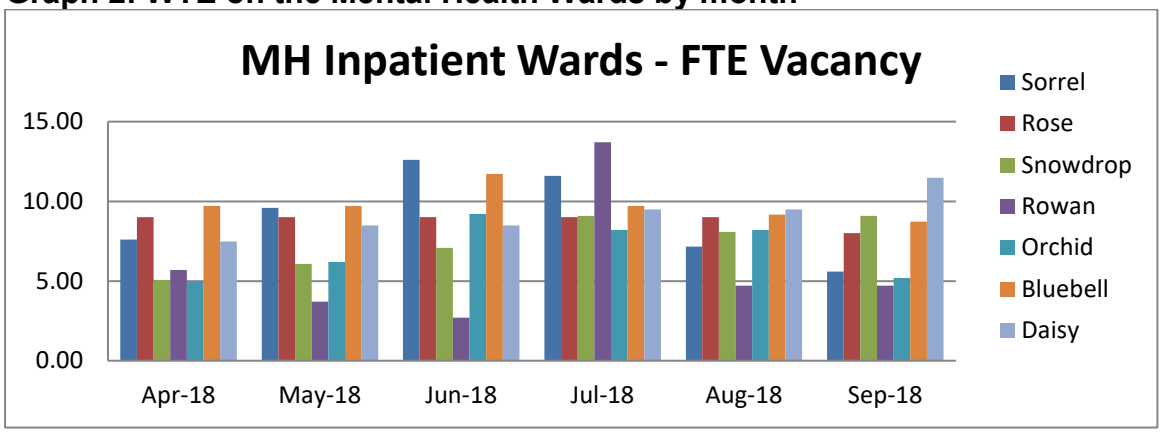
| | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Current vacancy as approximate % total nursing staffing (registered and unregistered) |
|---|---|---|---|---|---|---|---|
| Prospect Park Hospital wards | 49.58 | 52.78 | 60.78 | 70.78 | 55.78 | 52.78 | 33.93%(24.28% once posts offered in post) |
| Community Health wards | 36.22 | 36.15 | 40.17 | 41.50 | 35.74 | 38.17 | 15.5% |
| Campion | 5.04 | 5.41 | 5.41 | 4.41 | 4.41 | 1.74 | 0% |
| Willow House | 4.49 | 5.82 | 6.82 | 6.43 | 7.43 | 10.75 | 30% |

Graphs 1 and 2 below detail the split of vacancy across the wards and demonstrate variation in level of vacancy that each ward is experiencing.

**Graph 1: WTE on the Community Wards by month**




**Graph 2: WTE on the Mental Health Wards by month**

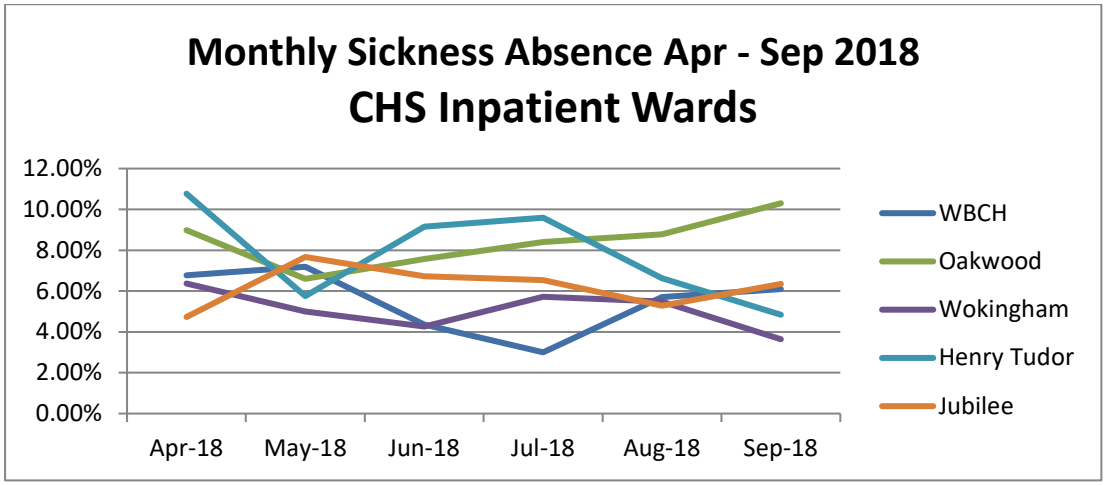


### 3.2 Sickness absence

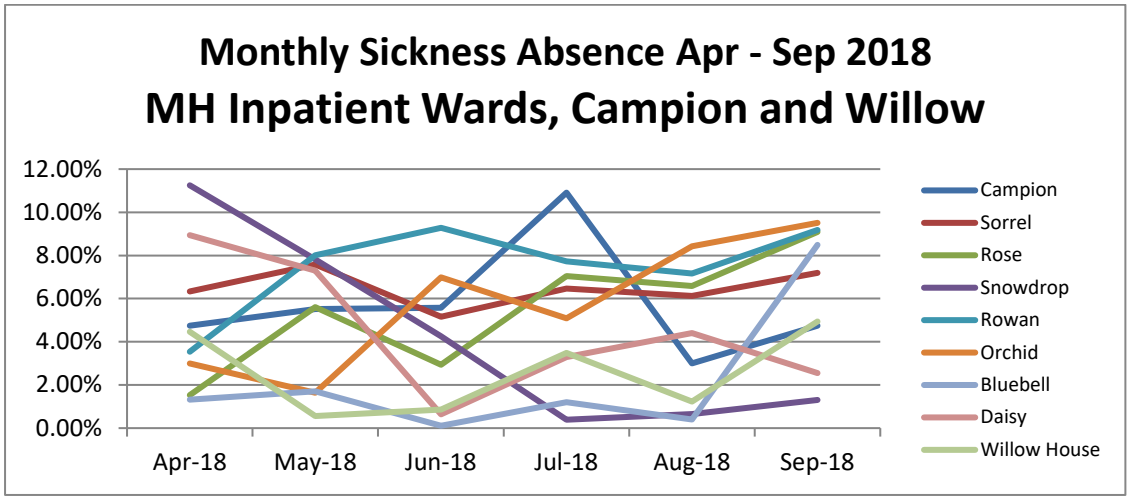
Graph 3 and 4 detail the sickness absence as a percentage of the total registered nursing and care staff workforce for each ward. The sickness absence includes long and short term sickness.

The trust sickness absence target is 3.5%, therefore the majority of wards are exceeding this. The Trust has a sickness absence policy which with support from the Human Resources department, ensures that appropriate action is taken to support staff and their managers with sickness related absenteeism. There are a number of wards with a high sickness absence factor due to a combination of both long and short term sickness. These wards are working closely with Human Resources and Occupational Health providers to ensure that appropriate actions are being taken.

**Graph 3 - Sickness absence for wards as a percentage of total ward staffing (Community Wards)**



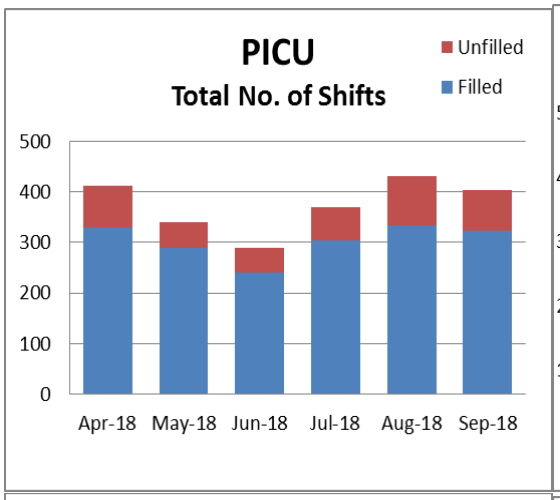

**Graph 4 - Sickness absence for wards as a percentage of total ward staffing (Mental Health, Learning Disability and CAMHs Wards)**

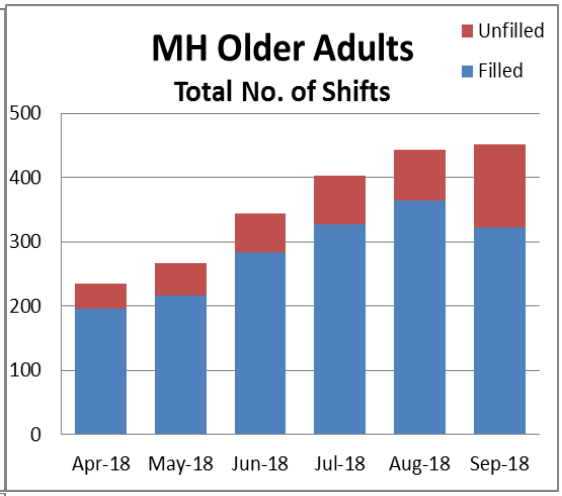


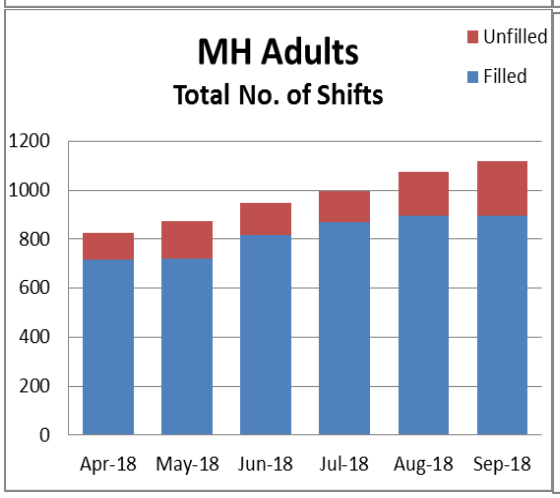
### 3.3 Temporary staffing

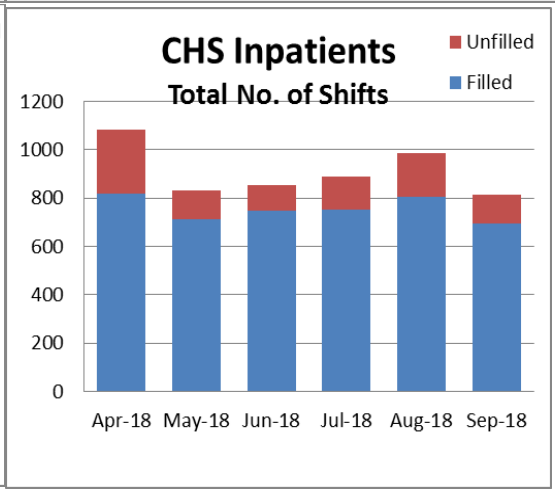
When the wards have vacancies/sickness within their nursing staff establishment they use temporary staffing (agency / bank or additional shifts by their own staff) to ensure that safe staffing levels are maintained. Temporary staffing is also used where patient need means that additional staff are required. It is recognised that increased numbers of agency and bank staff have the potential to impact on quality and therefore the wards continue to work hard with the support of the recruitment team to fill vacancies and so reduce the reliance on temporary staffing.

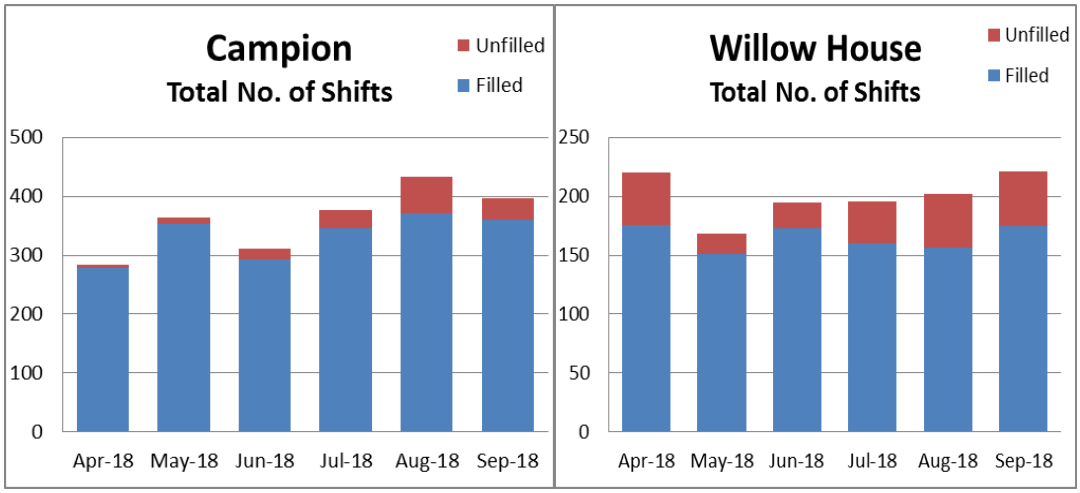
The graphs below show the total number of shifts required to be filled for each area as well as number of these that were filled/ unfilled. As it demonstrates mental health wards have had the most difficulty in filling their required shifts, whilst Campion has the lowest unfilled rate.






**4. Displaying planned and actual registered and care staff on the wards**

All of the wards within the trust have a display board which shows the number of staff that the ward had planned to have on the shift and the number of staff actually on the shift. This allows visitors to the ward to be clear about the number of registered nurses and care staff on the ward at the time. The boards also show who the nurse in charge is so that visitors know who to contact if they have a concern or would like to speak to the nurse in charge about anything. These boards are monitored during visits to individual wards throughout the year by senior managers.

**5. Capability and safety on our wards**

Having the right capacity of registered nurse and care staff on each ward allows for staff to have the best chance of achieving safe care. However, it is just as important to have the appropriate staff capability to ensure that they can deliver a safe and quality service to all patients. This section of the report details how the Trust currently measures and monitors capability.

**5.1 Quality indicators**

To monitor safety of care delivered on the wards the Director of Nursing and Governance reviews a range of quality indicators on a monthly basis alongside the daily staffing levels. These indicators are:

<u>Community wards</u>

- Falls where the patient is found on the floor ( an unobserved fall);
- Developed pressure sores;
- Medication related incidents.

<u>Mental health wards</u>

- AWOL (Absent without leave) and absconsion;
- Falls where the patient is found on the floor ( an unobserved fall);
- Patient on patient physical assaults;
- Seclusion of patients;
- Use of prone restraint on patients;

Monthly teleconferences are held with senior staff from each of the ward areas to discuss the staffing data along with these indicators, any concerns are highlighted in the monthly safer staffing board report and are able to inform the safe staffing declaration provided by the Director of Nursing and Governance.

**Table 5: Quality metric for mental health inpatient wards (April to September 2018)**

| Ward | AWOL | Falls | Patient on Patient Assaults | Patient on Staff Assaults | Prone Restraint | Seclusion | Self-harm |
|---|---|---|---|---|---|---|---|
| **Bluebell** | 28 | 5 | 3 | 11 | 6 | 5 | 99 |
| **Campion** | 0 | 0 | 45 | 72 | 0 | 4 | 9 |
| **Daisy** | 27 | 6 | 12 | 10 | 7 | 3 | 44 |
| **Orchid** | 1 | 37 | 12 | 2 | 0 | 0 | 0 |
| **Rose** | 16 | 0 | 10 | 11 | 2 | 1 | 35 |
| **Rowan** | 0 | 7 | 25 | 15 | 0 | 0 | 0 |
| **Snowdrop** | 9 | 2 | 8 | 18 | 5 | 2 | 70 |
| **Sorrel** | 7 | 0 | 23 | 27 | 8 | 53 | 1 |
| **Willow House** | 1 | 0 | 3 | 9 | 0 | 1 | 213 |
| **Total** | **89** | **57** | **141** | **175** | **28** | **69** | **471** |

* correct at time of report (October 2018)

The number of incidents reported for self-harm, patient on staff assaults and patient on patients assaults have increased since the last report and are part of the quality improvement (QI) work within the Trust.

**Table 6: Quality metric for community physical health inpatient wards (April to September 2018)**

| Ward | Drugs | Falls | Pressure Ulcers | Patient on Staff Assaults |
|---|---|---|---|---|
| Donnington | 19 | 22 | 4 | 2 |
| Highclere | 8 | 9 | 2 | 2 |
| Oakwood | 18 | 18 | 2 | 1 |
| Jubilee | 7 | 4 | 0 | 0 |
| Henry Tudor | 11 | 11 | 1 | 0 |
| Wokingham | 28 | 16 | 8 | 1 |
| **Total** | **91** | **80** | **17** | **6** |

* correct at time of report (October 2018)

There has been a reduction in the number of drugs incidents reported, whilst falls have remained similar and pressure ulcers increased by 70%. These areas are included in the QI projects on the wards.

The ability to achieve a position of at least two registered staff on duty is also perceived as a metric of quality, Nice guidance (2014) on safe staffing, identified that a shift with less than two registered staff on duty should be perceived as a red flag (incident).

Table 7 below shows the number of occasions by ward and month where there was less than two registered staff on a shift. The highlighted data in the table demonstrates the wards with the highest numbers of breaches each month. Sorrel ward has the most breaches with 141 in total over the six months; Daisy ward had the second highest number with 103 and all acute mental health wards over 55 breeches during this reporting time.

For all of the wards where there are less than two registered staff, senior staff and ward managers (who are supernumerary to the safe staffing numbers) as well as other clinical staff such as Physiotherapy and Occupational Therapy support when available. For wards at Prospect Park Hospital the Duty Senior Nurse is also available and is able to take an overview of the wards and redeploy staff to areas of most need.

**Table 7: wards and number of occasions where there was less than 2 registered staff on duty (excluding Ward Manager)**

| | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Total for ward |
|---|---|---|---|---|---|---|---|
| **Donnington** | 5 | 0 | 3 | 3 | 6 | 0 | 17 |
| **Highclere** | 3 | 5 | 5 | 5 | 19 | 21 | 58 |
| **Oakwood** | 2 | 0 | 0 | 0 | 2 | 1 | 5 |
| **Wokingham** | 1 | 0 | 0 | 4 | 0 | 1 | 6 |
| **Henry Tudor** | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Jubilee** | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Campion** | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Sorrel** | 31 | 18 | 7 | 19 | 39 | 27 | 141 |
| **Rose** | 13 | 20 | 4 | 6 | 7 | 13 | 63 |
| **Snowdrop** | 11 | 17 | 7 | 1 | 22 | 8 | 66 |
| **Rowan** | 0 | 1 | 3 | 2 | 5 | 11 | 22 |
| **Orchid** | 5 | 4 | 2 | 11 | 4 | 11 | 37 |
| **Bluebell** | 0 | 1 | 0 | 0 | 0 | 1 | 2 |
| **Daisy** | 19 | 9 | 10 | 22 | 20 | 23 | 103 |
| **Willow House** | 9 | 4 | 4 | 6 | 4 | 14 | 41 |
| **Total for month** | 99 | 79 | 45 | 79 | 128 | 131 | |

### 5.2 Safe staffing declaration

Each month the Director of Nursing and Governance is required to make a declaration regarding safe staffing based on the available information.

As with the last six month report, the acute and Sorrel wards, Prospect Park Hospital, throughout the reporting period have been declared as causing concern because of the high number of temporary staff and care potentially not being optimal. This declaration has also been in place for Orchid ward since July.

For all months, there has been no direct correlation between clinical incidents reviewed and staffing.

In May, Campion declaration altered their status to no identified impact on quality and safety of care provided as a result of staffing issues and continued to report this throughout this reporting period.

In May, Willow House's declaration altered to no identified impact on quality and safety of care provided as a result of staffing issues.

For all other wards current reporting is that there are no identified impact on quality and safety of care provided as a result of staffing issues was declared each month.

The overarching monthly declaration has been that the wards have had sufficient numbers of staff however this has required a high use of temporary staff over a significant period of time to achieve this position. The impact of this sustained high use of temporary staff is that there is increasing concern in relation to clinical risk and safety and as a result there is a limited ability to provide assurance that the care provided was good at all times on all wards. Although safety was maintained, it is possible that patient experience was compromised.

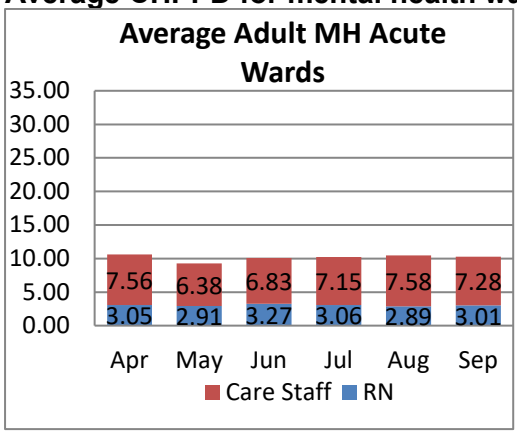
**5.3 Care Hour per Patient Day (CHPPD) Data Collection**

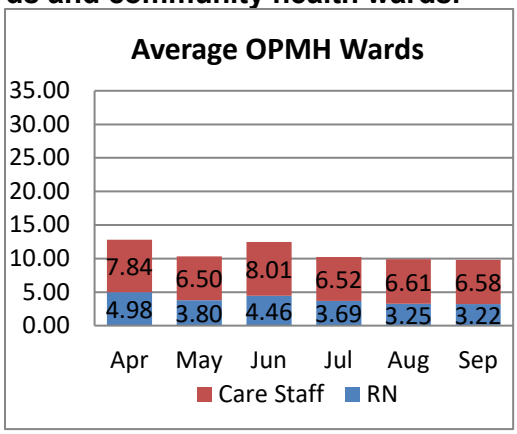
The publication of Lord Carter's review, 'Operational productivity and performance in English acute hospitals: Unwarranted variations', in February 2016 highlighted the importance of the non-acute sectors to ensure efficiency and quality across the whole NHS health economy. One of the obstacles identified to eliminating unwarranted variation in clinical staff distribution across and within the NHS provider sector has been the absence of a single means of consistently recording, reporting and monitoring staff deployment. CHPPD provides this measure.

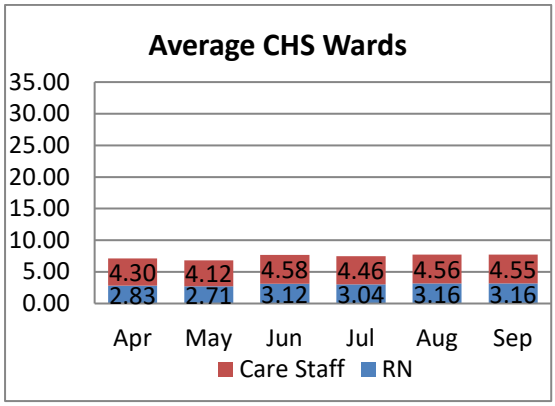
The CHPPD is calculated by taking the actual hours worked (split into registered nurses and healthcare support workers) divided by the number of patients occupying beds on the ward at midnight.it should be noted that CHPPD does not take into account patient acuity, ward environmental issues, patient turn over or movement of staff for short periods.

This is the first reporting period when CHPPD have been consistently collected. The tables below show average CHPPD for the mental health wards and community wards. Campion and Willow House are total CHPPD.

**Average CHPPD for mental health wards and community health wards.**

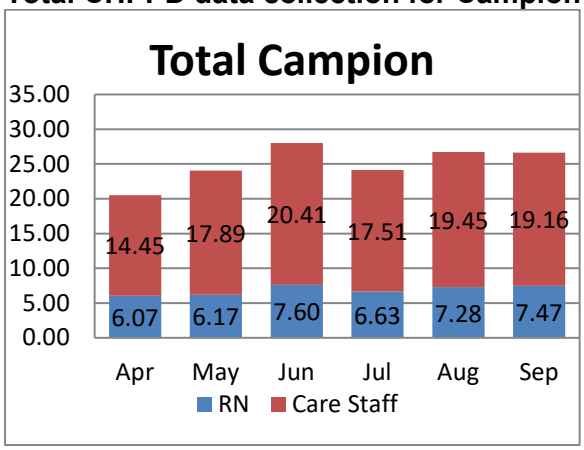


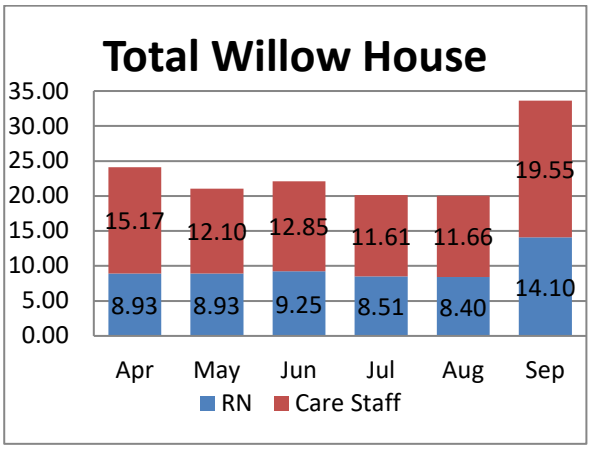




From these tables the CHPPD metric within this reporting period appears to be static and reflects the high patient acuity on the wards at PPH. For Campion and Willow House there is slightly more variation.

**Total CHPPD data collection for Campion and Willows**




## 6. Community Caseloads

Work has been introduced around recruitment and retention for the community nursing teams led by the Chief Operating Officer. There have been a high number of vacancies in community nursing during the period April to September 2018, particularly in Wokingham

and Slough. Recruitment hubs were introduced as part of the recruitment and retention strategy. Whilst there is support from NHSP for community nursing, appropriately skilled nurses for this area are few.

A new staffing report for community nursing has been introduced to monitor staffing and vacancies.. Across Berkshire, community nursing services use an Internal Escalation Triggers tool, where community nursing teams undertake a daily capacity assessment with results collated to allow an escalation process to take place where services are unable to meet their commissioned service. Following the RAG rating being completed, teams can move staffing resources accordingly.

**The escalation tool:**

| | |
|---|---|
| Green | less than 25% reduction in staffing. |
| Amber | 26-35% reduction in staffing. Professional judgement of dependency of patients to be taken into account as well as levels of staffing. |
| Red | 36-45% reduction in staffing. Amber staffing status moves to red once continuous for over 1 week period. Professional judgement of dependency of patients to be taken into account as well as levels of staffing. |
| Dark red | 46-60% reduction in staffing. Red staffing status moves to dark red once continuous for over 1 week period. Professional judgement of dependency of patients to be taken into account as well as levels of staffing. |
| Black | 61% plus reduction in staffing. Capacity in all teams not sufficient to meet demand.<br><br>Unable to accept any new referrals. |

Below is the October safe staffing table for community nursing:

| Locality | Budgeted staff wte | Staff in post (includes mat leave and sick leave) | Vacancy | Additional shortfall due to absence e.g. Sickness and Maternity leave | Number of agency staff used | Total available workforce | RAG rating |
|---|---|---|---|---|---|---|---|
| West Berks | 41.57 | 34.49 | 7.08 | 2.2 mat leave<br>2.0 sick<br>0.8 Long term unpaid leave | 1.0 | 30.49wte<br>73.3% | |
| Reading | 60.89 | 53.32 | 7.57 | 10.47 | 0 | 42.85wte<br>70.3% | |
| Wokingham | 58.2 | 40.01 | 18.19 | 3.0 Mat leave<br>5.0 Long term sick | 3.95 | 35.96wte<br>61.7% | |
| Bracknell | 44.17 | 37.40 | 6.77 | 1.0 mat leave | 2.56 | 38.96wte<br>88.2% | |
| Windsor & Maidenhead | 47.78 | 43.69 | 4.09 | 4.0 mat leave<br>1.3 sick leave | 0 | 38.39wte<br>80.3% | |
| Slough | 43.37 | 31.08 | 12.29 | 2.8 sick leave | 1.78 | 30.06wte<br>69.3% | |

## 7. Conclusion

The last six months have been very challenging for both the inpatient wards and the community nursing service as detailed, particularly Prospect Park Hospital (PPH). This is due to challenges with the recruitment of registered nursing staff and the reliance on temporary staffing.

Bed occupancy and patient acuity have remained high in PPH throughout this reporting period.

A safe staffing review will be undertaken in November using the new acuity and dependency tools MHOST and LDOST which will be available to the Trust on 9th November from NHS Improvement.

Berkshire Healthcare
NHS Foundation Trust

# Trust Board Paper

| | |
|---|---|
| **Board Meeting Date** | 11 December 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 December 2018**

**EXECUTIVE REPORT**

## 1. Never Events

Directors are advised that no 'never events' have occurred since the last meeting of the Board.

**Executive Lead:** Debbie Fulton, Acting Director of Nursing and Governance

## 2. "Listening into Action"

Approximately every 18 months, I hold a series of "Big Conversations" with a random sample of around 10% of the workforce. This year we held five events across the county with between 50-80 people in attendance. The two-hour sessions involved a simple, but structured process and ask just two questions:

- What are the main things that get in the way of you delivering the very best care for our patients and their families?
- Being specific, what practical steps should we take together to address the top 3 issues you have identified?

Over the coming months, at different intervals, I shall be writing out to every member of staff to explain what we intend to do. In the meantime, I thought it would be helpful if Board members were given early sight of the main issues that were surfaced.

**IM&T**

- **Helpdesk –** Too long to get help and support to fix problems. It would be helpful to have some expertise physically present at the bigger sites;
- **Connectivity** – Some parts of Berkshire have no 3G or 4G signal or the signal drops out. This results in lost work or sub optimal mobile working. Some of the smaller buildings have poor Wi-Fi;
- **IT equipment** – the Trust has lots of out of date 'not fit for purpose' kit, especially old mobile phones in Community Services and old PC docking stations are still present in some areas;
- **Inter-operability between partners** - Staff were positive about Connected Care, but not all partners are on it yet resulting in duplication for staff and patients;

- **Intuitive electronic filing system on RiO** (electronic patient record) – for example it would be helpful to have all test results in one place etc and standardised labelling of documents;

- **Agile working** areas do not always have the right kit (docking stations/electric sockets) available or the kit in the agile working space is not working or is missing; there was also an issue around accessibility, for example, how do you get into an agile working space?

**Estates and Facilities**

- **Parking** – parking at West Berkshire Community Hospital was under pressure following the new build. Parking at Wokingham Hospital had been very difficult for some time. The lack of staff car parking particularly impacted on mobile workers who return to their base but cannot find a car park space;

- **Breaks** – currently there is a mixed picture with not all facilities to have a decent space away from desks to have lunch or a break;

- **Well-being** - Some staff mentioned agile working not being great for well-being.

- **Flexible working** (impacts on parking and recruitment and retention)

- **Working from home** – the Trust needed to communicate a clear commitment on Berkshire Healthcare's stance on this issue – there were a number of locally generated myths and rules about working from home and an inconsistent approach from managers

**Recruitment and retention**

- **Improve recruitment and retention**!

- **NHS Professionals** - there was a view that NHS Professionals were not good for recruitment of administrative staff - if someone comes from NHS Professionals to a clinical area they MUST arrive with the right training to start the job straight away. The relevant staff should also have access to the RiO system when they started work.

- **Admin #1** - there were concerns around administrative staff not being replaced; some clinicians reporting that they feel like they are doing more administration; this was impacting on quality and reducing clinicians' time for patient care as well as administrative tasks taking longer to complete.

- **Admin #2** - career progression, opportunities for administrative staff less clear than for clinical colleagues

**Managers** – the feedback was inconsistent with some managers reporting very positive experiences and some less so. Micro-management was identified as the biggest frustration.

**Volunteers** – there was a suggestion that the Trust should recruit more volunteers and increase communication about this service

**Communication**

- **Team Brief -** Staff thought Friday afternoon was the wrong time for Team Brief to be circulated;

- **Teamnet -** Staff wanted Teamnet to be improved so that staff across the organisation can connect better. Staff also reported issues and delays with Marcomms getting information out and information about teams not being correct.

**Meetings –** Staff wanted more Skype facilities to prevent travel time to meetings and staff also wanted the reliability of Skype to be improved.

**Increasing demand on services**

- **Patients** – improved information about what the offer is from a service so there is a clearer expectation from the outset;

- **Stakeholders –** ensure Commissioners are aware of high vacancies and increased activity. Shift commissioner focus from process key performance indicators and targets to patient centred care outcomes

**Finance -** there was a request to allocate a budget for small pieces of specialist equipment; more money available for external training to in order for staff to develop professionally; and team development days

**Diversity and Inclusion -** new translation service was not always reliable

**Children, young people and families -** Staff felt that they had undergone too many consultations over the last 5 years

**Executive Lead:** Julian Emms, Chief Executive

## 3. National Staff Survey

The National Staff Survey was scheduled to go live this year on 8 October 2018, and all necessary preparation was completed in good time. Unfortunately, it became clear in the afternoon of 8 October that a number of emails had not been received by staff. It transpired that the emails had been sent by Picker, who run our survey for us and a number of other Trusts throughout the country, but were not received by Berkshire Healthcare IT systems.

Picker has subsequently explained that their emails went via Microsoft who labelled them as 'junk' and they deleted them. It took Picker a long time to establish a reason and find a remedy because the delivery of emails to different Trusts and people within the Trusts was not consistent. All staff who should have received an email link did receive one, and paper surveys were provided to staff groups for whom this was more convenient.

The average response rate for the survey at Berkshire Healthcare is 40-46% and this year we had planned to improve this to over 50% by working with managers and staff to explain that their opinion counts and provide supporting material. Despite the problems with the email surveys, we had achieved a response rate of 44.2% as at 26 November 2018, with the survey due to end on 30 November 2018.

Our experience of the problems with the staff survey this year has given rise to a number of concerns which have been addressed with Picker, as we seek to ensure that:

- There is a system in place to identify any concerns relating to the safe delivery of emails to staff, and effective communication with customers
- There is a contingency plan for delivery via another IT system or paper following the error

The issues that have been experienced with the survey have been raised via a survey advisory group and with NHS Employers and NHS England. Our contract with NHS England is managed by NHSE and we have a multi-year agreement with Picker to run our survey from 2017–2019.

We are seeking appropriate assurances in response to our concerns as we plan for next year's survey, and have established a working group to ensure that our own preparation and use of the valuable insights that the survey gives us continues to develop well.

**Executive Lead:** Bev Searle, Director of Corporate Affairs

## 4. Pulse Check Results

Each year, in the first quarter of the financial year, we ask our staff a set of locally determined questions alongside the national "Friends and Family" questions. This is done through Picker, so the answers are confidential. The results for 2018 are as follows:

- Likely to recommend organisation to friends and family for care/treatment – 86% (82% in 2017)
- Likely to recommend organisation to friends and family as a place to work – 74% (71% in 2017)

| | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 |
|---|---|---|---|---|---|---|---|
| I feel happy and supported working in my team/department/service | 58% | 60% | 61% | 66% | 69% | 68% | **69%** |
| Our Organisation culture encourages me to contribute to changes that affect my team/department/service | 36% | 46% | 51% | 56% | 61% | 59% | **63%** |
| Managers and leaders seek my views about how we can improve our services | 39% | 46% | 49% | 52% | 55% | 55% | **59%** |
| Day-to-day issues and frustrations that get in our way are quickly identified and resolved | 21% | 24% | 31% | 35% | 38% | 38% | **39%** |

| | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 |
|---|---|---|---|---|---|---|---|
| I feel that our organisation communicates clearly with the staff about its priorities and goals | 31% | 40% | 47% | 52% | 60% | 58% | **59%** |
| I believe we are providing high quality services to our patients/service users | 43% | 66% | 72% | 73% | 77% | 72% | **78%** |
| I feel valued for the contribution I make and the work I do | 24% | 45% | 49% | 54% | 59% | 59% | **62%** |
| I understand how my role contributes to the wider organisational vision | 44% | 57% | 63% | 68% | 72% | 70% | **74%** |
| I feel that the quality and safety of patient care is our organisation's top priority | - | 60% | 65% | 68% | 76% | 73% | **78%** |
| I feel able to prioritise patient care over other work | - | 46% | 52% | 53% | 61% | 61% | **66%** |
| Communication between senior management and staff is effective | 25% | 33% | 28% | 43% | 48% | 46% | **49%** |

Although the results were issued later than usual this year, they have been shared with staff and used to inform the analysis prepared for our Board Planning Day in October. It is very encouraging to see the continued, year on year, improvement in the majority of questions, and a very significant improvement since 2012.

The results will continue to be used to understand variances between services, alongside other information such as sickness levels to enable us to target our efforts more precisely.

**Executive Lead:** Bev Searle, Director of Corporate Affairs

## 5. Staff Flu Vaccination Campaign

### Introduction

Influenza can cause a spectrum of illness, ranging from mild to severe, even among people who were previously well. Seasonal flu typically causes 8,000 deaths a year in the United Kingdom with up to a third of deaths from influenza in people considered healthy. The strains of influenza circulating in the community may change each year, therefore annual vaccination is required to provide maximum protection.

Staff vaccination is about protecting staff, patients, colleagues, and their families. Up to one in four healthcare workers become infected in a mild influenza season, which is much higher than in the general population.

**What is new for 2018-19?**

NHS Improvement have stated that trusts need to work towards 100% ambition in 'high risk' clinical environments, to include haematology, oncology, bone marrow transplant, neonatal intensive care and special care baby units. Additional areas are to be identified and determined locally.

Berkshire Healthcare has identified Children's Respite and Campion Units as high risk due to the adverse outcomes flu could have on these patient groups. In addition community nurse managers have been requested to plan care allocation so that unvaccinated community staff are not allocated to visit patients who are receiving chemotherapy. Trust Boards are required to record commitment to achieving the ambition of 100% of front line healthcare workers being vaccinated.

Trusts are required to report the number of healthcare workers with direct patient contact that have been offered the vaccine and opted-out. Berkshire Healthcare has made a decision not to offer opt-out until December when all staff who have not had the vaccine will be contacted and requested to complete a survey monkey with the required questions included.

By February 2019, Trusts to include in their public board papers their performance on overall vaccination uptake rates and numbers of staff declining the vaccinations including details of rates within each of the areas designated as 'higher-risk'. This report should include actions undertaken to deliver the 100% ambition.

Trusts will be required to give a breakdown of the number of staff opting out against each of the reasons listed (I don't like needles, I don't think I'll get the flu, I don't believe the evidence, I'm concerned about side effects, I don't know how or where to get vaccinated, it was too inconvenient to get to a venue to be vaccinated, the times weren't convenient, other-please state). NHSI will collate this information nationally.

**The Board is asked to:**

Receive their vaccinations and commit to continue to promote the flu vaccination over the final month of the campaign

As in 2017-18, the Denominator data will need to be updated each month prior to submission to reflect the dynamic nature of the workforce being vaccinated. This will need to be undertaken manually as there is currently no field in ESR to record flu vaccination. As a result the Trusts percentage compliance could fluctuate going down as well as up over the period of the campaign.

**Progress to date**

Monthly flu campaign strategy meetings continue and involve key stakeholders; communications are being managed by the Marketing and Communication Team. The campaign continues to be delivered through a mix of peer vaccination in services, vouchers and recording of staff who report that they have had their vaccination at their GP practice, previous employer etc. The formal clinics have been

completed. This year we have 26 peer vaccinators to support delivery of the campaign.

As of 30th November 2018, 2,269 vaccines had been given. Table 1 shows the break down by locality and Table 2 by clinical staff group.

| Table 1 | Children YPF | Community Health East | Community Health West | Corporate | Inpatients PPH | Mental Health East | Mental Health West | Other Health Services | Berkshire Healthcare |
|---|---|---|---|---|---|---|---|---|---|
| ***Overall Baseline*** | *582* | *549* | *851* | *548* | *236* | *181* | *784* | *200* | *3931* |
| ***Clinical Baseline*** | *484* | *479* | *695* | *106* | *219* | *135* | *667* | *172* | *2957* |
| **Clinical Actual** | 292 | 249 | 415 | 60 | 112 | 74 | 333 | 108 | 1643 |
| **Clinical Percentage** | **60.33%** | **51.98%** | **59.71%** | **56.60%** | **51.14%** | **54.81%** | **49.93%** | **62.79%** | **55.56%** |
| ***Non Clinical Baseline*** | *98* | *70* | *156* | *442* | *17* | *46* | *118* | *28* | *975* |
| **Non Clinical Actual** | 68 | 41 | 81 | 217 | 10 | 32 | 73 | 21 | 543 |
| **Non Clinical Percentage** | **69.39%** | **58.57%** | **51.92%** | **49.10%** | **58.82%** | **69.57%** | **61.86%** | **75.00%** | **55.69%** |
| **Locality Actual Total** | 360 | 290 | 496 | 277 | 122 | 106 | 406 | 129 | 2186 |
| **Overall Actual Percentage** | **61.86%** | **52.82%** | **58.28%** | **50.55%** | **51.69%** | **58.56%** | **51.79%** | **64.50%** | **55.61%** |

| Table 2 | Doctors & Dentists | Nurses | AHP/ST&T | Clinical Support |
|---|---|---|---|---|
| **Baseline** | 181 | 1033 | 787 | 956 |
| **Number vaccinated** | 104 | 596 | 471 | 472 |
| **Percentage** | 57.46% | 57.70% | 59.85% | 49.37% |

**Executive Lead:** Debbie Fulton, Acting Director of Nursing and Governance

Presented by: Julian Emms
Chief Executive
December 2018

Berkshire Healthcare
NHS Foundation Trust

# Trust Board Paper

| | |
|---|---|
| **Board Meeting Date** | 11 December 2018 |
| **Title** | Financial Summary Report – M7 2018/19 |
| **Purpose** | To provide the Month 7 2018/19 financial position to the Trust Board |
| **Business Area** | Finance |
| **Author** | Chief Financial Officer |
| **Relevant Strategic Objectives** | 3. - Strategic Goal: To deliver financially sustainable services through efficient provision of clinical & non-clinical services |
| **CQC Registration/Patient Care Impacts** | N/A |
| **Resource Impacts** | None |
| **Legal Implications** | Meeting regulatory requirements |
| **SUMMARY** | The Financial Summary Report provides the Board with summary of the M7 2018/19 financial position. |
| **ACTION REQUIRED** | The Board is invited to note the following summary of financial performance and results for Month 7 2018/19 (October 2018):<br><br>The trust reports to NHSi its 'Use of Resources' rating, which monitors risk monthly, 1 is the lowest risk rating possible and 4 is the highest.<br><br>**YTD (Use of Resource) metric:**<br>• Overall rating 1 (plan 1)<br>  ○ Capital Service Cover rating 2<br>  ○ Liquidity days rating 1<br>  ○ I&E Margin rating 1<br>  ○ I&E Variance rating 1<br>  ○ Agency target rating 1 |

| | |
|---|---|
| | **YTD Income Statement (including PSF Funding; excluding donations):**<br>• Plan: £0.6m surplus<br>• Actual: £2.3m surplus<br>• Variance: £1.7m better than plan.<br><br>**YTD Cash** £24.5m vs Plan £24.3m.<br><br>**YTD Capital expenditure:** £3.8m vs Plan £4.7m. |

Berkshire Healthcare NHS
NHS Foundation Trust

# *BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST*

# Finance Report

# Financial Year 2018/19

# Month 7 (October 2018)

## *Purpose*

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

## *Document Control*

| *Version* | *Date* | *Author* | *Comments* |
|---|---|---|---|
| 1.0 | 09.11.18 | Bharti Bhoja | 1st Draft |
| 2.0 | 12.11.18 | Tom Stacey | 2nd Draft |
| 3.0 | 15.11.18 | Paul Gray | Final |

## *Distribution*

All Directors

All staff needing to see this report.

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# 1.0 Key Messages

| Key Metric | YTD Actual £'m | YTD Plan £'m | Variance £'m | vs Last Mth | vs Prior Year |
|---|---|---|---|---|---|
| Surplus / (Deficit) for PSF | 1.2 | (0.5) | 1.7 | ▼ | ▲ |
| PSF - Trust | 0.7 | 0.7 | 0.0 | | |
| PSF - System | 0.4 | 0.4 | 0.0 | ▲ | ▲ |
| **Control Total Surplus / (Deficit)** | **2.3** | **0.6** | **1.7** | ▲ | ▲ |
| Statutory Surplus / (Deficit) | 2.8 | 0.6 | 2.3 | ▼ | ▲ |
| CIP Delivery | 1.4 | 1.7 | (0.3) | ▲ | ▲ |
| Agency Spend | 3.3 | 3.1 | 0.2 | ▲ | ▲ |
| OAPs - Specialist Placements (incl LD) | 5.9 | 5.4 | 0.5 | ▲ | ▲ |
| OAPs - Overspill Beds | 1.3 | 0.9 | 0.4 | ▼ | ▼ |
| Capital Expenditure | 3.8 | 4.7 | 0.9 | ▲ | ▼ |
| Cash | 24.5 | 24.3 | 0.2 | ▲ | ▲ |

| ***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 reported a surplus of £0.5m, £0.4m above Control Total. YTD the surplus has risen to £2.3m, £1.7m better than Control Total. Our YTD statutory surplus is now £2.8m, including £0.6m of Donations.
- Pay costs increased in month, but due to lower than planned Non Pay spend, and higher income, our EBITDA was £0.3m better than plan overall.
- Capital spend is £0.95m below plan and Cash £0.2m higher than anticipated; the latter due to the higher YTD surplus and lower than planned capital expenditure, partly offset by reduction in payables. Use of Resources rating remains at a"1" overall.
- We are forecasting a YE surplus of £4.4m, £1.5m ahead of our Control Total. We have agreed with NHSI/NHSE to offset £0.9m of our forecast Control Total improvement with the Royal Berkshire Hospital, continuing our approach to closer system working . Whilst this does not move our Control Total, it does require us to deliver our forecast to ensure receipt of PSF.

### *Key Risks*

- Whilst we are forecasting a better than Control Total YE, we must ensure that we do not become complacent and assume this is delivered. We must continue our focus on controlling costs over the remainder of the year to ensure we hit our revised target and gain our final tranches of PSF.
- LD OAPs (£468k), CRHTT (£335k), LD inpatients (£389k) and Acute & PICU Beds (£382k) are the highest overspending services YTD and represent the highest financial risk going forwards.

# 2.0 Income & Expenditure

| Income Statement | In Month | | | YTD | | | FY | | | Prior Year YTD | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Act | Plan | Var | Act | Plan | Var | Plan | Forecast | Forecast Var | Act | Var | |
| | £'m | £'m | £'m | £'m | £'m | £'m | £'m | £'m | £'m | £'m | +/- | % |
| Operating Income | 19.1 | 18.9 | 0.2 | 133.2 | 132.5 | 0.7 | 227.1 | 228.7 | 1.6 | 132.5 | 0.7 | 0.5% |
| DoH Pay Award | 0.2 | 0.2 | 0.0 | 1.4 | 1.4 | 0.0 | 2.3 | 2.4 | 0.1 | 0.0 | 1.4 | |
| Other Income | 1.6 | 1.5 | 0.0 | 11.2 | 10.9 | 0.3 | 18.6 | 19.0 | 0.3 | 11.1 | 0.1 | 0.9% |
| ***Total Income*** | ***20.9*** | ***20.6*** | ***0.2*** | ***145.8*** | ***144.8*** | ***1.0*** | ***248.1*** | ***250.0*** | ***2.0*** | ***143.6*** | ***2.2*** | ***1.5%*** |
| Staff In Post | 13.0 | 13.0 | (0.0) | 90.1 | 91.7 | (1.6) | 156.9 | 155.4 | (1.5) | 88.2 | 1.9 | 2.1% |
| Bank Spend | 1.1 | 1.0 | 0.1 | 8.0 | 7.2 | 0.9 | 12.3 | 13.3 | 1.0 | 6.8 | 1.3 | 18.9% |
| Agency Spend | 0.5 | 0.4 | 0.0 | 3.3 | 3.1 | 0.2 | 5.3 | 5.5 | 0.2 | 4.7 | (1.4) | (29.6)% |
| ***Total Pay*** | ***14.6*** | ***14.5*** | ***0.1*** | ***101.5*** | ***102.0*** | ***(0.6)*** | ***174.5*** | ***174.2*** | ***(0.3)*** | ***99.7*** | ***1.8*** | ***1.8%*** |
| Purchase of Healthcare | 1.3 | 1.1 | 0.2 | 9.8 | 8.4 | 1.4 | 13.7 | 16.5 | 2.8 | 9.8 | (0.0) | (0.4)% |
| Drugs | 0.5 | 0.4 | 0.1 | 3.4 | 2.9 | 0.5 | 5.0 | 5.9 | 0.9 | 2.9 | 0.5 | 17.5% |
| Premises | 1.2 | 1.2 | 0.1 | 8.5 | 8.2 | 0.3 | 14.3 | 14.8 | 0.5 | 8.7 | (0.2) | (2.4)% |
| Other Non Pay | 1.6 | 2.1 | (0.5) | 12.0 | 14.0 | (2.1) | 23.3 | 20.6 | (2.7) | 12.3 | (0.4) | (3.0)% |
| PFI Lease | 0.5 | 0.5 | 0.0 | 3.7 | 3.7 | 0.0 | 6.3 | 6.4 | 0.0 | 3.6 | 0.1 | 3.1% |
| ***Total Non Pay*** | ***5.2*** | ***5.3*** | ***(0.2)*** | ***37.4*** | ***37.3*** | ***0.2*** | ***62.7*** | ***64.2*** | ***1.5*** | ***37.4*** | ***(0.0)*** | ***(0.0)%*** |
| ***Total Operating Costs*** | ***19.8*** | ***19.8*** | ***(0.1)*** | ***138.9*** | ***139.3*** | ***(0.4)*** | ***237.2*** | ***238.4*** | ***1.2*** | ***137.1*** | ***1.8*** | ***1.3%*** |
| ***EBITDA*** | ***1.1*** | ***0.8*** | ***(0.3)*** | ***6.9*** | ***5.6*** | ***(1.3)*** | ***10.9*** | ***11.6*** | ***(0.7)*** | ***6.5*** | ***(0.4)*** | ***(6.3)%*** |
| Interest (Net) | 0.3 | 0.3 | (0.0) | 2.1 | 2.1 | (0.1) | 3.6 | 3.5 | (0.1) | 2.1 | (0.0) | (0.9)% |
| Impairments | 0.0 | 0.0 | (0.0) | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.1 | (0.1) | (76.1)% |
| Disposals | 0.0 | 0.0 | (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) | 2.7 | 3.0 | (0.3) | 5.6 | 4.9 | (0.7) | 3.1 | (0.4) | (12.5)% |
| PDC | 0.1 | 0.1 | (0.0) | 1.0 | 1.0 | (0.0) | 1.6 | 1.6 | (0.0) | 0.9 | 0.1 | 5.7% |
| ***Total Finanacing*** | ***0.8*** | ***0.9*** | ***(0.1)*** | ***5.7*** | ***6.0*** | ***(0.3)*** | ***10.9*** | ***10.1*** | ***(0.8)*** | ***6.2*** | ***(0.4)*** | ***(6.8)%*** |
| ***Surplus/ (Deficit) for PSF*** | ***0.3*** | ***(0.1)*** | ***0.4*** | ***1.2*** | ***(0.5)*** | ***1.7*** | ***(0.0)*** | ***1.5*** | ***1.5*** | ***0.3*** | ***0.8*** | ***240.5%*** |
| PSF - Trust | 0.1 | 0.1 | 0.0 | 0.7 | 0.7 | 0.0 | 1.4 | 1.5 | 0.0 | 0.8 | **0.3** | **41.1%** |
| PSF - System | 0.1 | 0.1 | 0.0 | 0.4 | 0.4 | 0.0 | 1.0 | 0.7 | (0.3) | 0.0 | | |
| ***Surplus/ (Deficit) for CT*** | ***0.5*** | ***0.1*** | ***0.4*** | ***2.3*** | ***0.6*** | ***1.7*** | ***2.4*** | ***3.7*** | ***1.3*** | ***1.1*** | ***1.1*** | ***102.1%*** |
| Donated Income | 0.0 | 0.0 | 0.0 | 0.6 | 0.0 | 0.6 | 0.0 | 0.6 | 0.6 | 0.9 | (0.3) | (33.1)% |
| Donated Depreciation | (0.0) | (0.0) | 0.0 | (0.0) | (0.0) | 0.0 | (0.1) | (0.0) | 0.0 | (0.0) | (0.0) | 70.8% |
| ***Surplus/ (Deficit) Statutory*** | ***0.5*** | ***0.1*** | ***0.4*** | ***2.8*** | ***0.6*** | ***2.3*** | ***2.3*** | ***4.2*** | ***1.9*** | ***2.0*** | ***0.8*** | ***42.0%*** |

## *Key Messages*

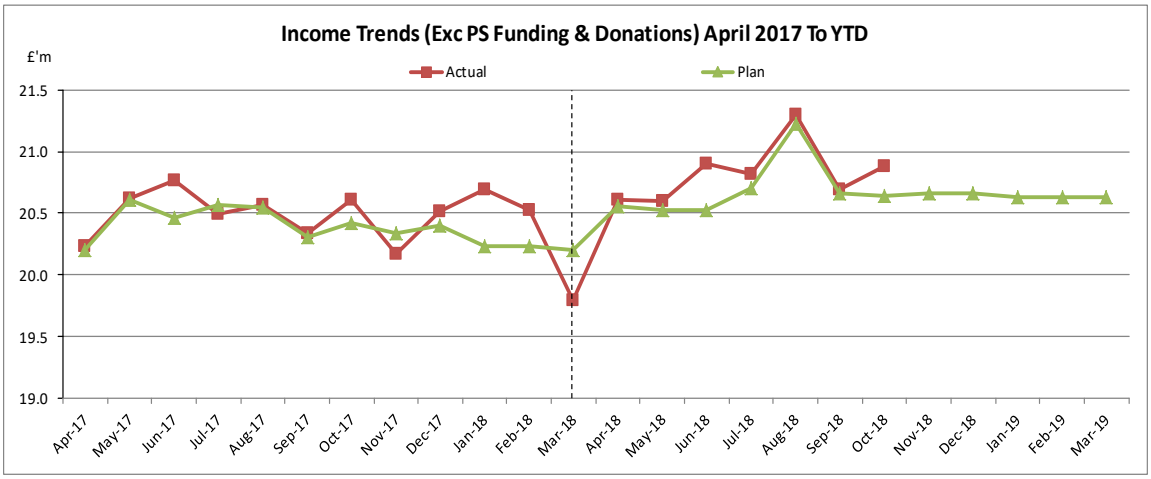
Our YTD, pre PSF, surplus has increased by £0.3m to £1.2m, £1.7m ahead of plan. After incorporating £1.1m of PSF and donations, our reported surplus is £2.8m, £2.3m better than planned.

Our Pay costs rose in month due to a number of factors including arrears payment relating to CEA Awards, R&R arrears and incremental increases. YTD we are £1.6m below our permanent plan, and even after offsetting non permanent costs, we are £0.6m below our overall Pay plan. This indicates that we are still running with vacancies in excess of our initial £6m estimate for the year.

The continuing cost of higher than planned out of area placements continues to dominating Non Pay. YTD spend is now £1.4m higher than planned, with unbudgeted LD placements and un-patriated PICU patients continuing to be the key driver of costs. Unallocated contingency continues to be released to offset these costs, mitigating the over-all impact to a £0.2m overspend.

# Income & Contracts

| Income Statement | In Month | | | YTD | | | FY | | | Prior YTD | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Act | Plan | Var | Act | Plan | Var | Plan | Forecast | Forecast Var | Act | Var | |
| | £'m | £'m | £'m | £'m | £'m | £'m | £'m | £'m | £'m | £'m | +/- | % |
| Block Income | 16.7 | 16.5 | 0.2 | 115.9 | 115.6 | 0.3 | 198.1 | 198.8 | 0.7 | 113.3 | 2.6 | 2.3% |
| Tariff Income | 0.3 | 0.3 | (0.0) | 1.6 | 1.8 | (0.2) | 3.1 | 2.7 | (0.4) | 1.8 | (0.3) | (15.1)% |
| Pass Through Income | 0.4 | 0.3 | 0.1 | 2.3 | 1.8 | 0.5 | 3.0 | 3.9 | 0.8 | 1.8 | 0.5 | 26.0% |
| DoH Pay Award | 0.2 | 0.2 | 0.0 | 1.4 | 1.4 | 0.0 | 2.3 | 2.4 | 0.1 | 0.0 | 1.4 | |
| Other Income | 3.4 | 3.4 | (0.0) | 24.7 | 24.3 | 0.4 | 41.5 | 42.3 | 0.8 | 26.7 | (2.0) | (7.6)% |
| ***Total Operating Income*** | ***20.9*** | ***20.6*** | ***0.2*** | ***145.8*** | ***144.8*** | ***1.0*** | ***248.1*** | ***250.0*** | ***2.0*** | ***143.6*** | ***2.2*** | ***1.5%*** |
| PSF - Trust | 0.1 | 0.2 | (0.1) | 0.7 | 1.1 | (0.4) | 1.4 | 1.5 | 0.1 | 0.8 | 0.3 | (15.9)% |
| PSF - System | 0.1 | 0.0 | 0.1 | 0.4 | 0.0 | 0.4 | 1.0 | 0.7 | (0.3) | | | |
| Donated Income | 0.0 | 0.0 | 0.0 | 0.6 | 0.0 | 0.6 | 0.0 | 0.6 | 0.6 | 0.9 | (0.3) | (33.1)% |
| ***Total Reportable Income*** | ***21.1*** | ***20.9*** | ***0.3*** | ***147.5*** | ***145.9*** | ***1.6*** | ***250.5*** | ***252.8*** | ***2.4*** | ***145.3*** | ***2.2*** | ***1.5%*** |




**Income**

| YTD | £'m |
|---|---|
| 2018/19 | 145.8 |
| 2017/18 | 143.6 |
| ▲ | *2%* |

| Prior Yr | £'m |
|---|---|
| Oct-18 | 20.9 |
| Oct-17 | 20.6 |
| ▲ | *2%* |

## *Key Messages*

Operating Income was £0.2m ahead of plan in month, £1.0m YTD. Our block increased by £0.1m due to the impact of CV40 which included Lower limb pilot, MSK Acute Triage and continuation of AIRs Pilot. Other movements seen in month include EDTS charges for RBH work £40k, and NHSE Waiting List & DNA Reduction funding of £48k for Dental.

## *Commissioner Focus*

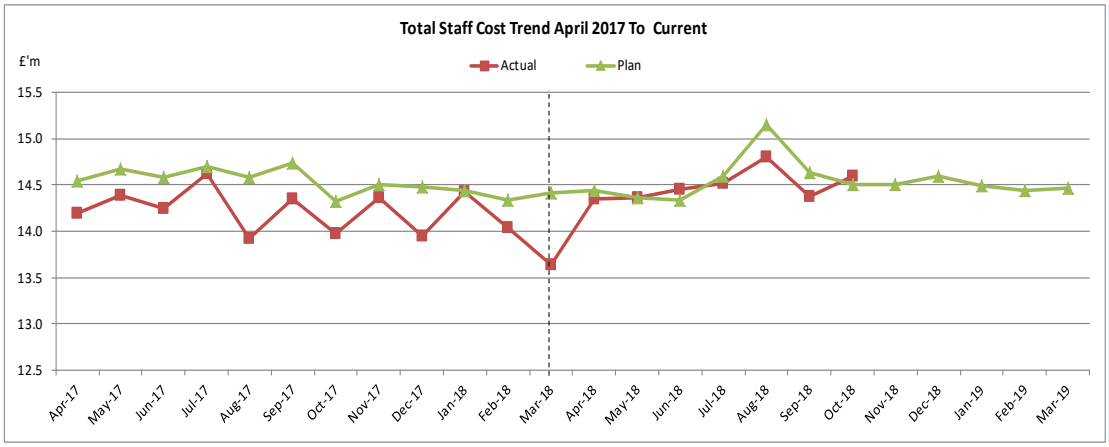
The Q2 contract variation has been agreed and includes clarification of funding arrangements for MSK Physio Service and AIRS Pilot extension, reflected in this months financials. Conversations have begun to turn towards 19/20 and we have begun to articulate our funding priorities for this years contract discussions with CCGs.

## *System Focus*

At a system level, Control Totals have been met, and we have accrued both Trust and System PSF to plan. There remains a level of risk of overall system. The full year forecast reflects the Frimley ICS financial risk and assumes that Q4 is not met, resulting in loss of system PSF.

Of our £1.5m better than Control Total performance, £0.9m is now being utilised by RBH to 'Offset' their performance and enable them to meet their Control Total. The remainder is contributing to Frimley ICS overall delivery.

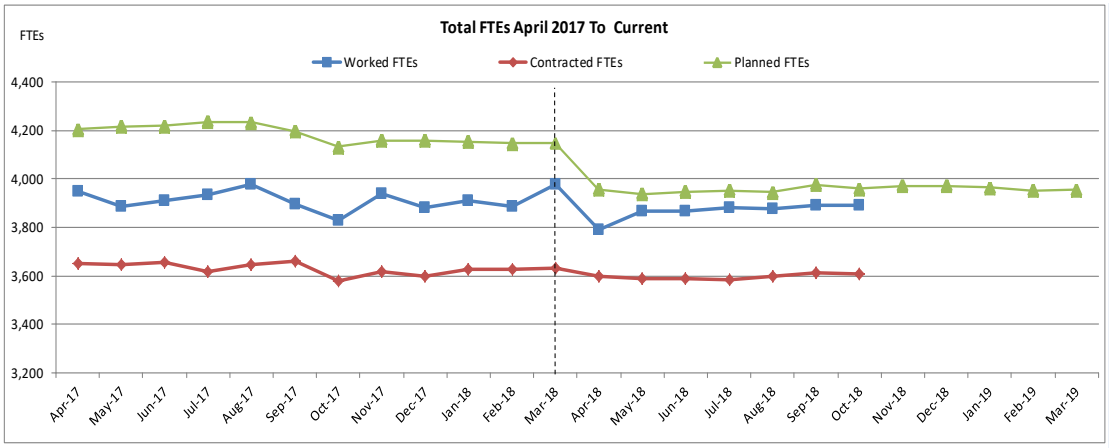
# Workforce




**Staff Costs**

| YTD | £'m |
|---|---|
| 2018/19 | 101.5 |
| 2017/18 | 99.7 |
| ▲ | 2% |

| Prior Yr | £'m |
|---|---|
| Oct-18 | 14.6 |
| Oct-17 | 14.0 |
| ▲ | 5% |




**FTEs**

| Prior Yr | CFTE | WFTE |
|---|---|---|
| Oct-18 | 3,607 | 3,892 |
| Oct-17 | 3,580 | 3,831 |
| | -1% ▲ | -2% ▲ |

| Prior Mth | CFTE | WFTE |
|---|---|---|
| Oct-18 | 3,607 | 3,892 |
| Sep-18 | 3,613 | 3,891 |
| | 0% ▼ | 0% ▲ |

## *Key Messages*

Overall staff costs in October were £0.1m higher than planned reducing the YTD variance to £0.6m.

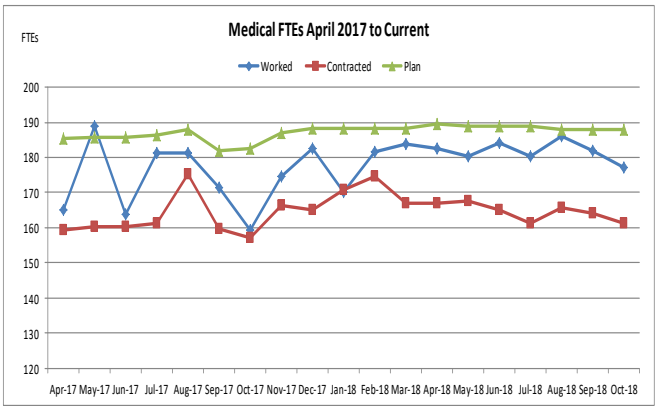
The costs seen in month reflected payments to existing staff, opposed to an increase in overall headcount. This accounts for the rise in costs and static FTE position. Looking ahead, indications from starter and leaver information, suggests a net increase to the end of September, which will likely be reflected fully in next months accounts.

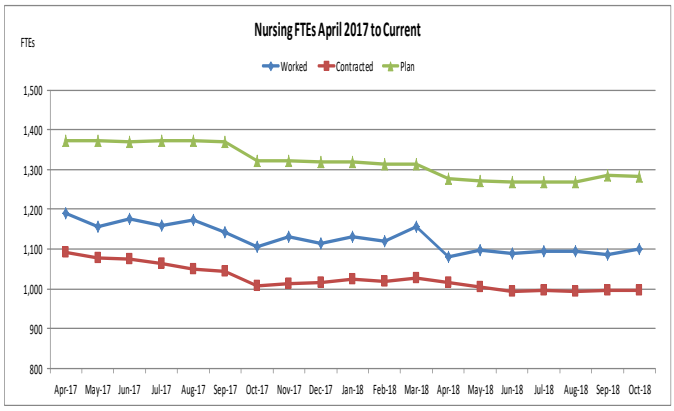
YTD costs include the full impact of the 18/19 Agenda For Change Pay Award, Medics Clinical Excellence Awards payments , doctors' pay award and YTD recruitment and retention premium for Sorrell Ward.

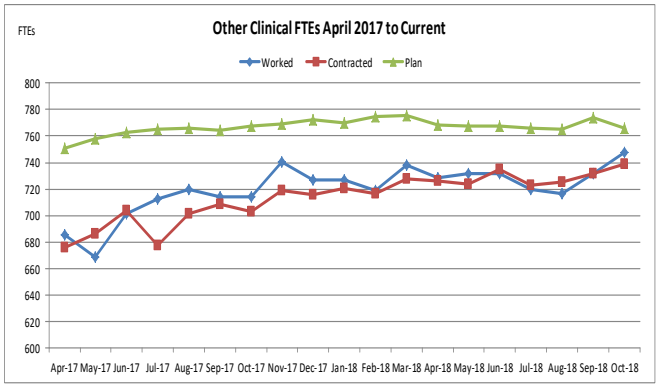
We are still £1.6m below our estimated permanent staffing spend, whilst having spent £11.3m on non permanent cover.

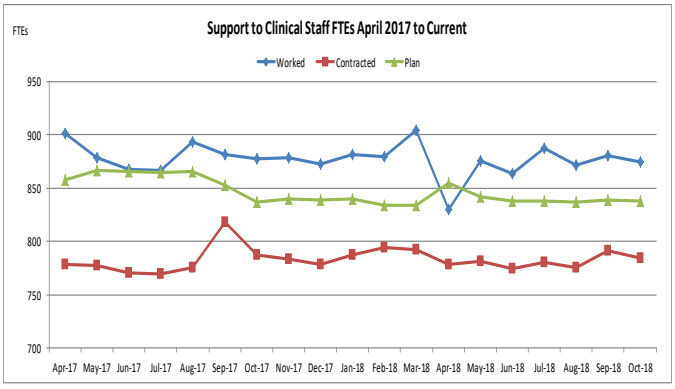
Despite our staffing costs being contained within our planning assumptions, there remain the continuing pressures in CRHTT and WestCall, neither of which will revert back to plan by the end of the current year. Campion Unit observation costs also continue to overspend and YTD overspend at the end of October was £389k.

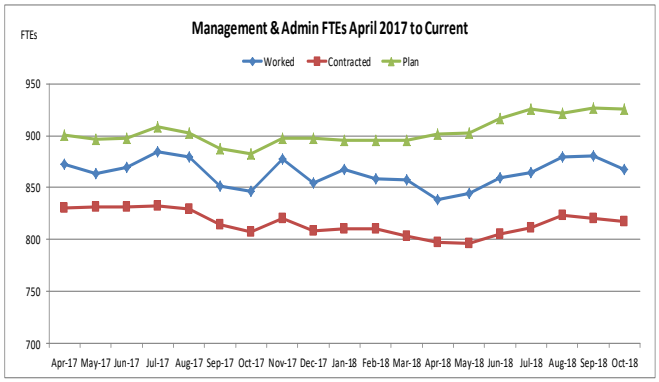
# Workforce: Staff Groups

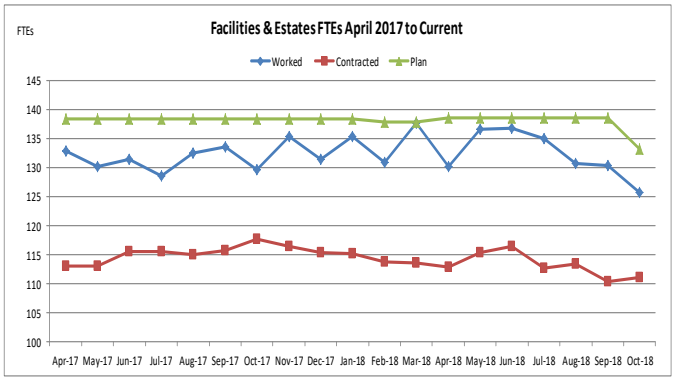



## *Key Messages*

The charts clearly indicate that 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.

This month there was an increase in Other Clinical staffing group with CAMHS increasing by 3 FTE, Intermediate Care by 3 FTE and Physiotherapy by 2 FTE.

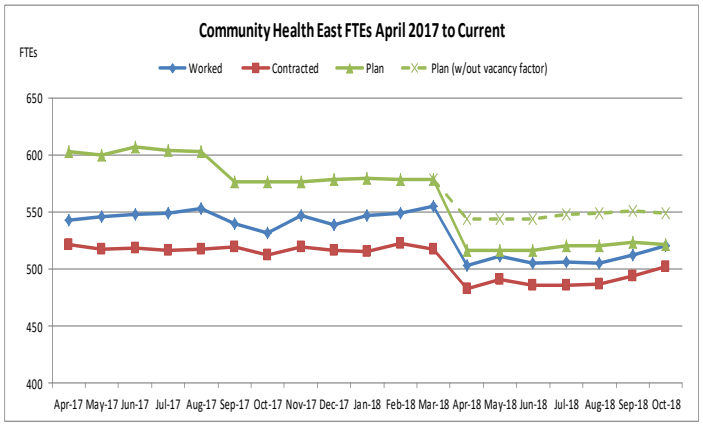
Clinical Support staff FTE reduced this month in CRHTT 2 FTE, District Nursing 2 FTE, Phlebotomy 3 FTE, and Workforce Development 2 FTE while Talking Therapies and Nursery staff increased by 2 FTE and 5 FTE respectively.

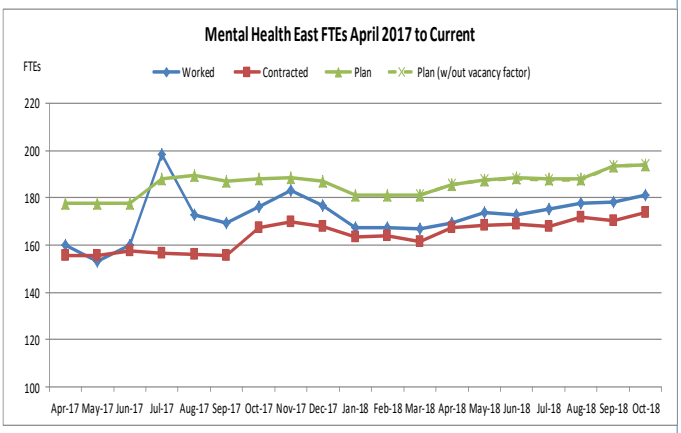
Within Facilities and Estates reductions in worked FTE and planned FTE due to removal of catering staff based at Duchess of Kent for Sue Ryder, which is also reflected in plans.

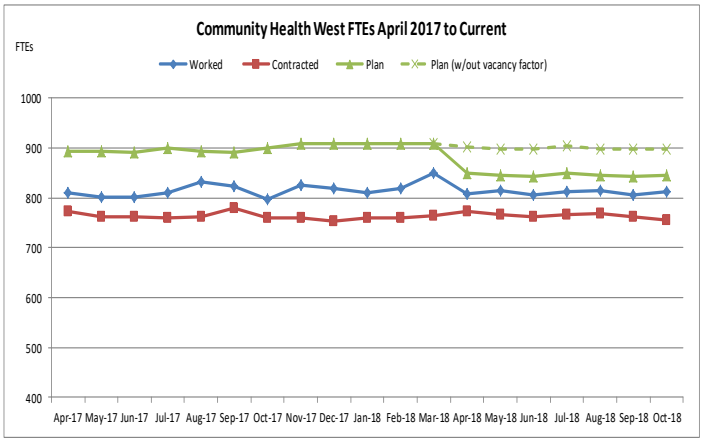
The reduction in Medical WTE is due to month on month fluctuations in demand within Westcall.

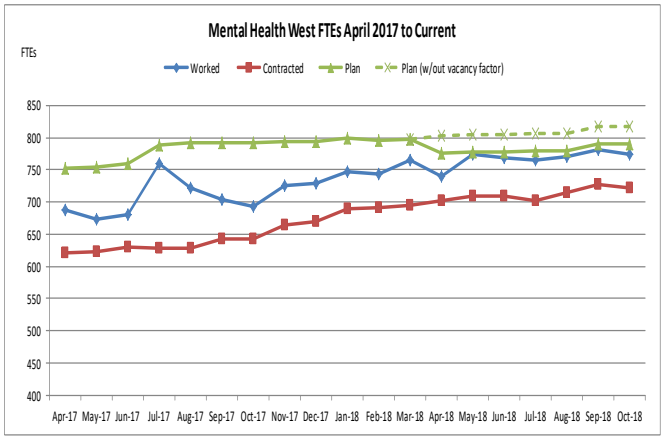
The use of Support staff over and above plan continues, offsetting the challenges to recruit and retain qualified staff. Qualified Nursing numbers, despite efforts, still remain stubbornly static, and well below planned levels. Even after factoring in non-permanent usage, the gap to planned levels remains c200 FTE.

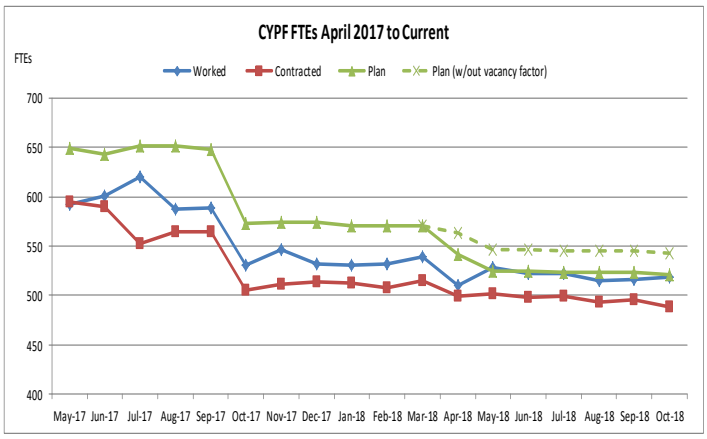
# Workforce: Divisional

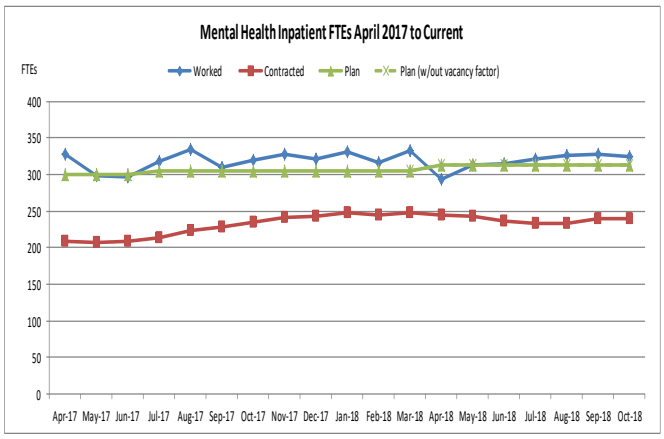


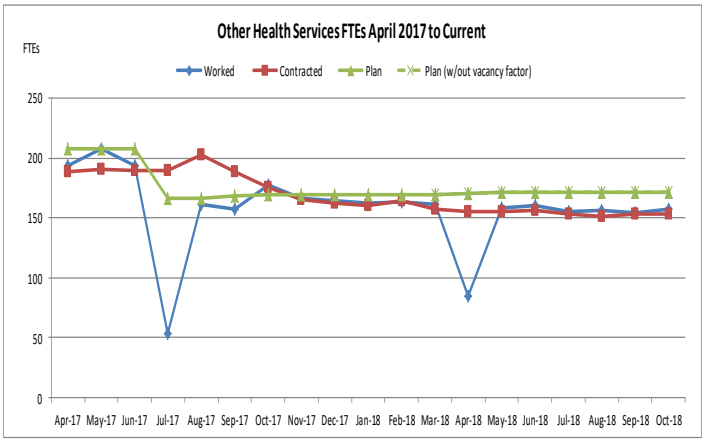



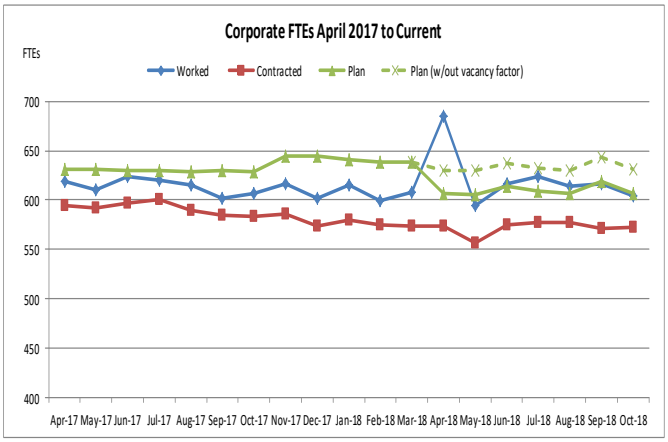



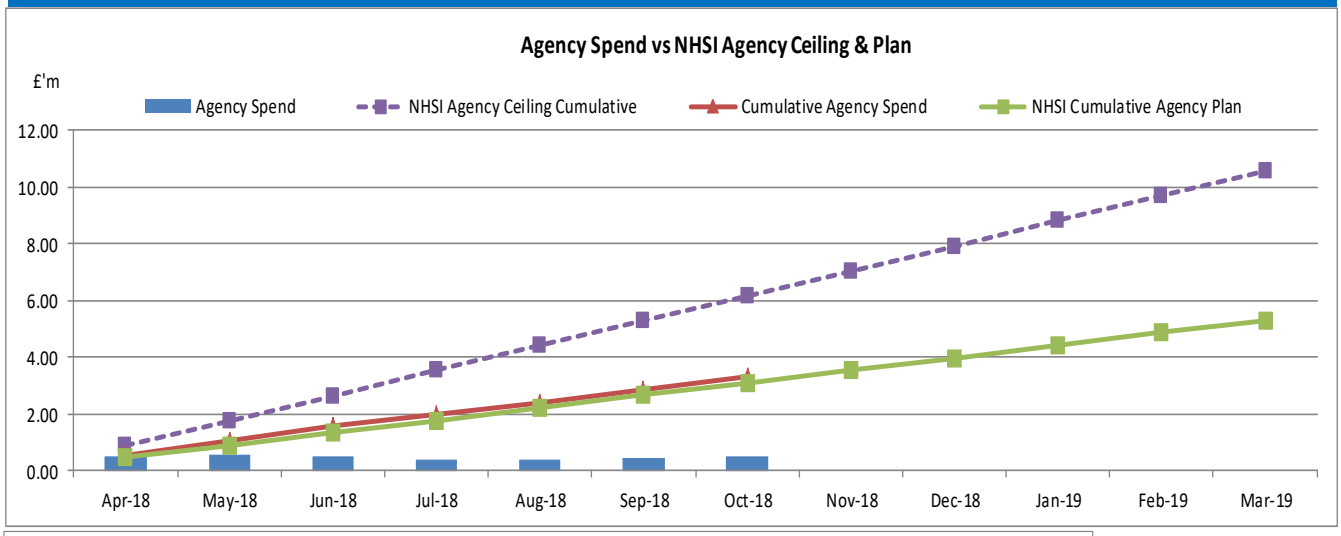



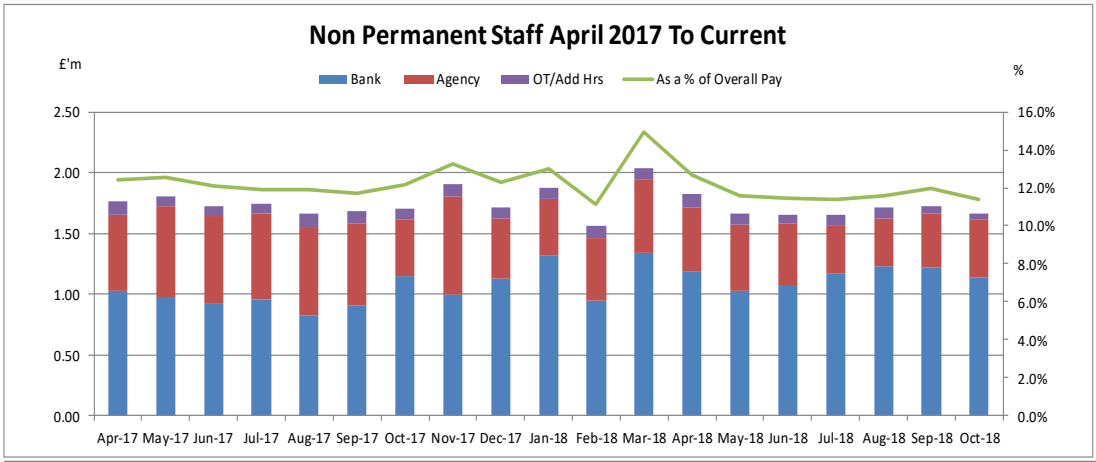



# Non Permanent Pay

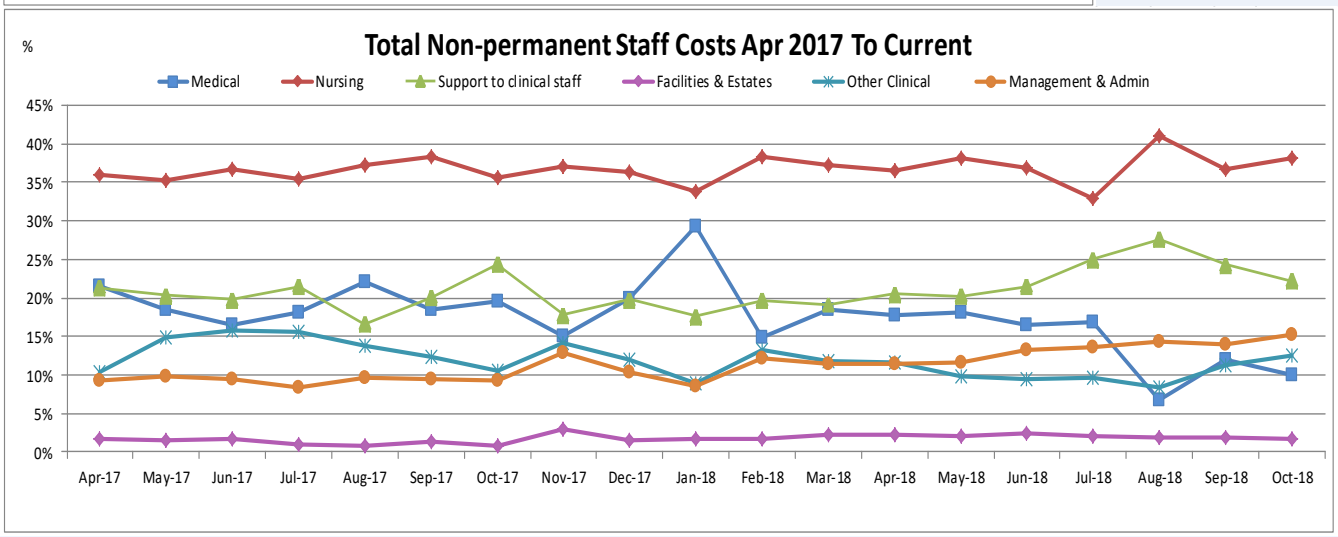



**Non Permanent Pay**

| YTD | Bank | Agency | OT/Add Hrs |
|---|---|---|---|
| 2018/19 | 8.0 | 3.3 | 0.6 |
| 2017/18 | 6.8 | 4.7 | 0.6 |
| | 16% ▲ | -42% ▼ | -14% ▼ |

| Prior Yr | Bank | Agency | OT/Add Hrs |
|---|---|---|---|
| Oct-18 | 1.1 | 0.5 | 0.1 |
| Oct-17 | 1.2 | 0.4 | 0.1 |
| | -7% ▼ | 4% ▲ | -54% ▼ |



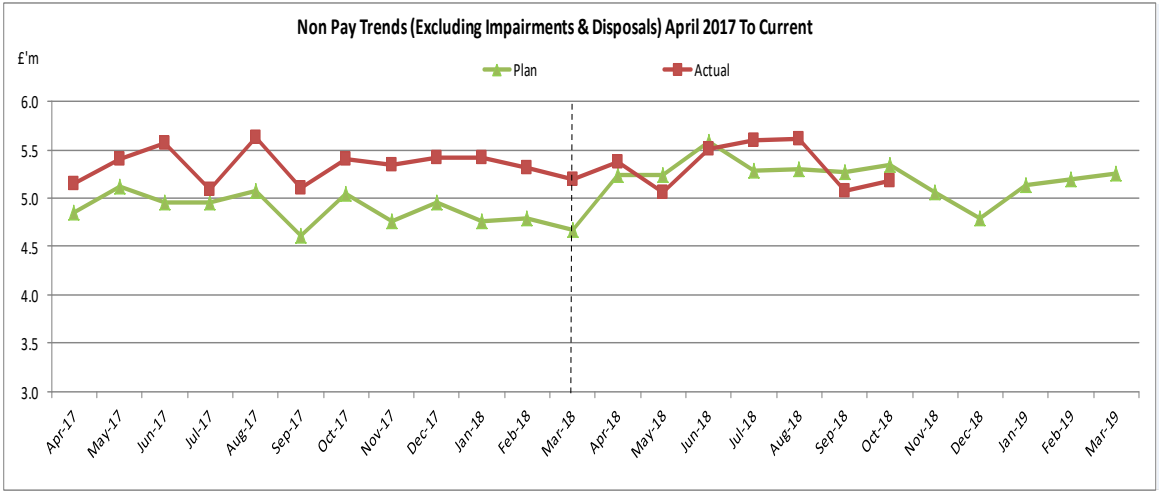

## *Key Messages*

Non permanent staffing graph above includes overtime and additional hours worked as well as bank and agency costs. Costs in October (excluding overtime and additional hours) were £1.6m. There was a drop of £54k in overall temporary staffing costs although agency rose for a 3rd straight month. NHSI have requested specific information on Mangement and Admin agency costs, suggesting a future area of focus for them into 19/20.

Overall Bank and Agency spend is tracking £0.2m below last year, with agency spend down £1.4m, offset by a £1.2m increase in bank spend, illustrating the movement of staff to the bank.

# Non Pay Expenditure

| Non Pay | In Month | | | YTD | | | FY | | | Prior YTD | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Act | Plan | Var | Act | Plan | Var | Plan | Forecast | Forecast Var | Act | Var | |
| | £'m | £'m | £'m | £'m | £'m | £'m | £'m | £'m | £'m | £'m | +/- | % |
| Purchase of Healthcare | 1.3 | 1.1 | 0.2 | 9.8 | 8.4 | 1.4 | 13.7 | 16.5 | 2.8 | 9.8 | (0.0) | (0.4)% |
| Drugs | 0.5 | 0.4 | 0.1 | 3.4 | 2.9 | 0.5 | 5.0 | 5.9 | 0.9 | 2.9 | 0.5 | 17.5% |
| Premises | 1.2 | 1.2 | 0.1 | 8.5 | 8.2 | 0.3 | 14.3 | 14.8 | 0.5 | 8.7 | (0.2) | (2.4)% |
| Supplies and services – clinical | 0.4 | 0.4 | (0.0) | 2.7 | 3.0 | (0.3) | 5.2 | 4.7 | (0.5) | 2.8 | (0.1) | (3.0)% |
| Transport | 0.2 | 0.3 | (0.1) | 1.8 | 2.3 | (0.5) | 3.9 | 3.1 | (0.8) | 1.8 | (0.1) | (3.3)% |
| Establishment | 0.4 | 0.3 | 0.1 | 2.2 | 1.8 | 0.4 | 3.1 | 3.7 | 0.6 | 2.9 | (0.7) | (24.6)% |
| Other Non Pay | 0.6 | 1.1 | (0.5) | 5.2 | 6.9 | (1.7) | 11.2 | 0.0 | (11.2) | 4.7 | 0.5 | 10.4% |
| PFI Lease | 0.5 | 0.5 | 0.0 | 3.7 | 3.7 | 0.0 | 6.3 | 6.4 | 0.0 | 3.6 | 0.1 | 3.1% |
| ***Total Non Pay*** | **5.2** | **5.3** | **(0.2)** | **37.4** | **37.3** | **0.2** | **62.7** | **55.1** | **(7.6)** | **37.4** | **(0.0)** | **(0.0)%** |




**Non Pay**

| YTD | £'m |
|---|---|
| 2018/19 | 37.4 |
| 2017/18 | 37.3 |
| ▲ | *0%* |

| Prior Yr | £'m |
|---|---|
| Oct-18 | 5.2 |
| Oct-17 | 5.4 |
| ▼ | *-4%* |

## *Key Messages*

Overall non pay expenditure in October was £0.2m lower than planned, £0.1m lower than last month and £0.2m lower than October 17. The overall YTD overspend has reduced to £0.2m.

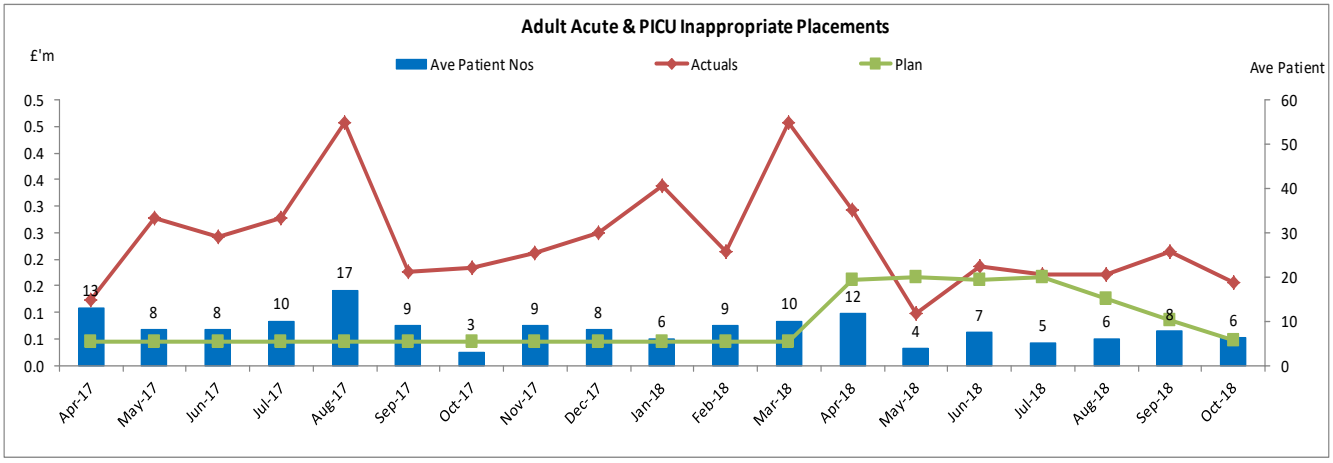
Non-pay reserves continue to cover higher than planned OAP costs. OAPS and Drug costs continue above plan, the latter directly recovered by income.

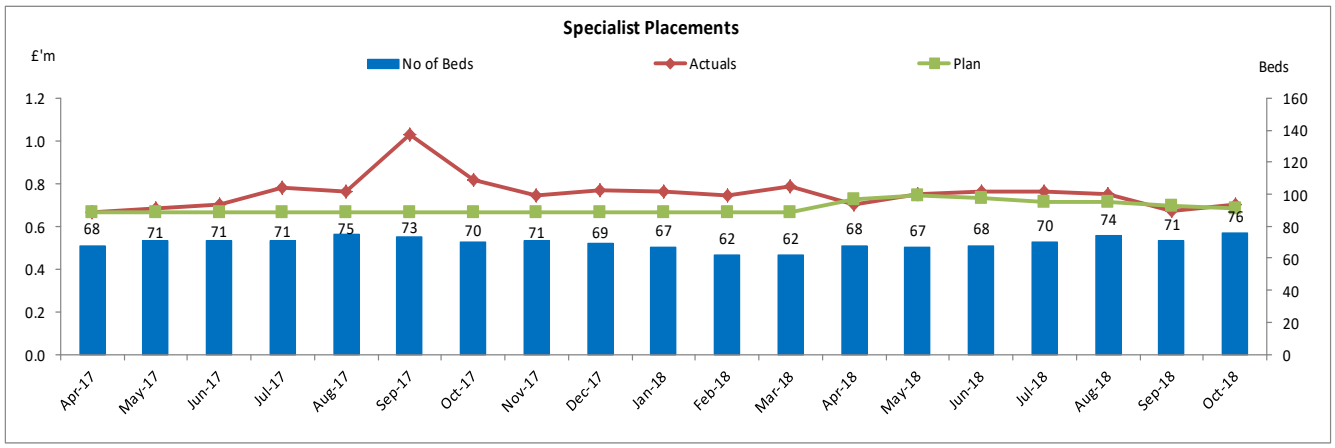
Purchase of Healthcare overspend has risen to £1.4m YTD; this includes OAPs overspend and services which we contract from other providers.

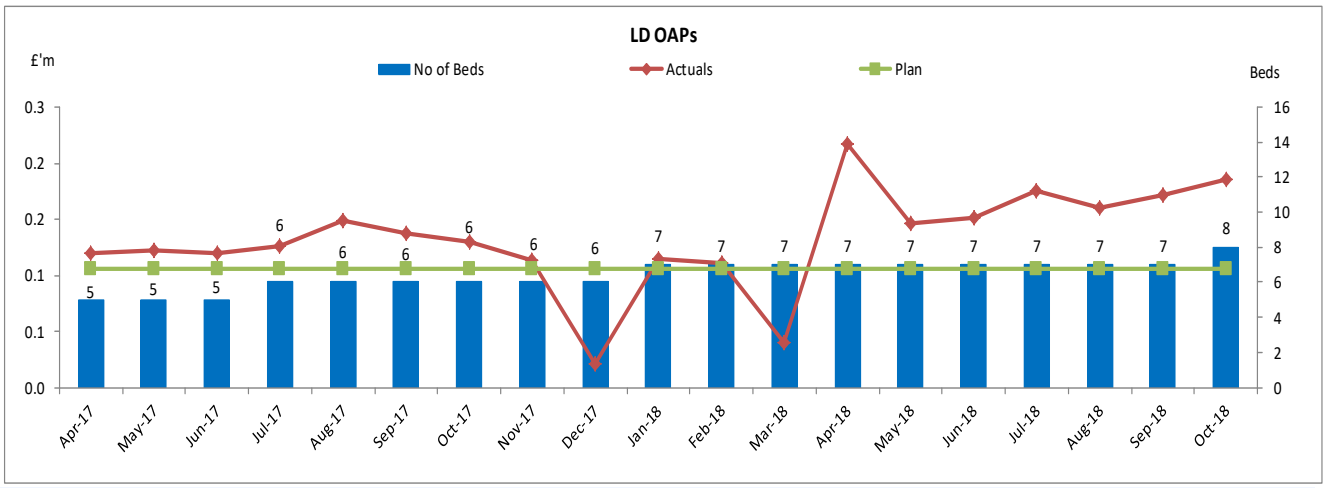
OAPs expenditure overall remains ahead of plan, with the potential to rise given the pressure on beds being experiences currently. LD OAPs cost was the highest this month since April 18 at £186k, increasing the over-spend by £80k. Inappropriate/PICU Placements overspend rose by £108k and Specialist Placement overspend by £21k. However, Specialist placements costs are £116k lower than October 17. YTD overall OAPs over-spend is £1.0m with LD contributing £468k, Inappropriate Placements £382k and Specialist Placements by £108k.

We are still awaiting a formal agreement with the Reading Borough Council relating to the funding of patients in Papist Way from September. Negotiations are close to completion on a revised Cloisters contract, which is expected to be implemented from imminently.

# Non Pay Expenditure - Focus on OAPs




## *Key Messages*

**Inappropriate Placements'** costs in October were £108k higher than plan but £21k lower than October 17. Although YTD cost are £382k higher than expected they are £446k lower than last year.

**Specialist Placements** spend was £21k overspent in October but continues to be in line with the run rate. Again spend is down notably on last year, £331k.

**LD OAPS** YTD costs are £468k overspent against plan and £303k higher than 17/18 with a higher number of beds in use.

# 3.0 Divisional Summary

| Income Statement | In Month | | | YTD | | | Full Year | Full Year | Full Year | Prior YTD | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Act | Plan | Var | Act | Plan | Var | Plan | Forecast | Forecast Var | Act | | Var |
| | £'m | £'m | £'m | £'m | £'m | £'m | £'m | £'m | £'m | £'m | +/- | % |
| **Community Health West** | | | | | | | | | | | | |
| Income | 0.5 | 0.5 | 0.0 | 3.0 | 3.2 | (0.2) | 5.5 | 4.9 | (0.6) | 2.3 | 0.7 | 30.2% |
| Pay | 2.9 | 2.9 | (0.1) | 20.1 | 20.6 | (0.5) | 35.4 | 34.7 | (0.7) | 19.5 | 0.7 | 3.4% |
| Non Pay | 0.4 | 0.5 | (0.0) | 3.2 | 3.3 | (0.0) | 5.6 | 5.5 | (0.1) | 3.0 | 0.2 | 6.0% |
| ***Net Cost*** | ***2.8*** | ***3.0*** | ***(0.1)*** | ***20.4*** | ***20.7*** | ***(0.3)*** | ***35.5*** | ***35.2*** | ***(0.3)*** | ***20.3*** | ***0.2*** | ***0.7%*** |
| **Mental Health West** | | | | | | | | | | | | |
| Income | 0.2 | 0.3 | (0.1) | 1.8 | 1.8 | (0.0) | 3.0 | 2.7 | (0.3) | 1.7 | 0.1 | 5.0% |
| Pay | 2.8 | 2.8 | 0.0 | 19.6 | 19.6 | 0.1 | 33.8 | 33.7 | (0.1) | 17.6 | 2.0 | 11.4% |
| Non Pay | 0.6 | 0.4 | 0.2 | 4.3 | 3.2 | 1.1 | 5.1 | 7.4 | 2.3 | 4.1 | 0.2 | 4.9% |
| ***Net Cost*** | ***3.2*** | ***3.0*** | ***0.3*** | ***22.2*** | ***21.0*** | ***1.2*** | ***35.9*** | ***38.4*** | ***2.5*** | ***20.1*** | ***2.1*** | ***10.6%*** |
| **Community Health East** | | | | | | | | | | | | |
| Income | 0.2 | 0.3 | (0.0) | 1.7 | 1.9 | (0.2) | 3.3 | 3.5 | 0.2 | 3.8 | (2.1) | (55.1)% |
| Pay | 1.8 | 1.8 | (0.0) | 12.4 | 12.8 | (0.3) | 22.0 | 21.6 | (0.4) | 13.4 | (1.0) | (7.5%) |
| Non Pay | 0.5 | 0.6 | (0.0) | 3.7 | 4.0 | (0.3) | 6.9 | 6.5 | (0.3) | 4.0 | (0.3) | (6.7%) |
| ***Net Cost*** | ***2.1*** | ***2.1*** | ***(0.0)*** | ***14.4*** | ***14.8*** | ***(0.4)*** | ***25.6*** | ***24.6*** | ***(1.0)*** | ***13.6*** | ***0.8*** | ***6.2%*** |
| **Mental Health East** | | | | | | | | | | | | |
| Income | 0.0 | 0.1 | (0.1) | 0.9 | 0.8 | 0.1 | 1.4 | 1.5 | 0.2 | 1.0 | (0.0) | (0.7)% |
| Pay | 0.7 | 0.7 | (0.0) | 4.6 | 4.8 | (0.2) | 8.3 | 8.0 | (0.3) | 4.3 | 0.3 | 7.0% |
| Non Pay | 0.8 | 0.8 | (0.0) | 5.8 | 5.7 | 0.1 | 9.5 | 9.6 | 0.1 | 6.1 | (0.3) | (5.5%) |
| ***Net Cost*** | ***1.4*** | ***1.4*** | ***0.1*** | ***9.4*** | ***9.7*** | ***(0.3)*** | ***16.5*** | ***16.1*** | ***(0.4)*** | ***9.5*** | ***(0.0)*** | ***(0.2%)*** |
| **CYPF** | | | | | | | | | | | | |
| Income | 0.2 | 0.2 | 0.0 | 1.8 | 1.6 | 0.2 | 2.7 | 3.1 | 0.4 | 1.9 | (0.1) | (6.8)% |
| Pay | 1.8 | 1.8 | (0.0) | 12.8 | 13.1 | (0.2) | 22.3 | 22.1 | (0.1) | 14.2 | (1.4) | (9.6%) |
| Non Pay | 0.1 | 0.1 | (0.0) | 1.0 | 0.9 | 0.1 | 1.6 | 1.6 | 0.1 | 0.9 | 0.1 | 8.1% |
| ***Net Cost*** | ***1.7*** | ***1.8*** | ***(0.0)*** | ***12.0*** | ***12.4*** | ***(0.4)*** | ***21.2*** | ***20.7*** | ***(0.5)*** | ***13.2*** | ***(1.2)*** | ***(8.8%)*** |
| **Mental Health Inpatients** | | | | | | | | | | | | |
| Income | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 60.9% |
| Pay | 1.0 | 0.9 | 0.1 | 6.7 | 6.5 | 0.3 | 11.1 | 11.4 | 0.3 | 6.2 | 0.5 | 8.4% |
| Non Pay | 0.1 | 0.1 | (0.0) | 0.5 | 0.6 | (0.1) | 1.1 | 0.9 | (0.2) | 0.6 | (0.1) | (13.6%) |
| ***Net Cost*** | ***1.1*** | ***1.0*** | ***0.1*** | ***7.3*** | ***7.1*** | ***0.2*** | ***12.2*** | ***12.3*** | ***0.1*** | ***6.9*** | ***0.4*** | ***6.4%*** |
| **Other Health Services** | | | | | | | | | | | | |
| Income | 0.3 | 0.1 | 0.2 | 1.4 | 0.7 | 0.7 | 1.2 | 2.3 | 1.1 | 0.8 | 0.6 | 78.4% |
| Pay | 1.3 | 1.2 | 0.1 | 8.6 | 8.6 | 0.1 | 14.7 | 14.9 | 0.1 | 8.6 | 0.1 | 0.8% |
| Non Pay | 0.2 | 0.0 | 0.1 | 0.8 | 0.2 | 0.6 | 0.3 | 1.3 | 1.1 | 0.2 | 0.6 | 315.2% |
| ***Net Cost*** | ***1.2*** | ***1.2*** | ***0.1*** | ***8.0*** | ***8.0*** | ***(0.0)*** | ***13.8*** | ***13.9*** | ***0.0*** | ***8.0*** | ***0.0*** | ***0.6%*** |
| **Corporate** | | | | | | | | | | | | |
| Income | 1.4 | 1.1 | 0.2 | 10.0 | 8.9 | 1.1 | 15.0 | 16.7 | 1.7 | 10.8 | (0.8) | (7.4)% |
| Pay | 2.2 | 2.2 | 0.0 | 16.4 | 16.1 | 0.4 | 26.9 | 27.8 | 1.0 | 15.8 | (0.6) | 3.7% |
| Non Pay | 2.5 | 2.9 | (0.4) | 18.1 | 19.3 | (1.2) | 32.6 | 31.1 | (1.5) | 18.4 | 0.3 | (1.7%) |
| ***Net Cost*** | ***3.368*** | ***3.952*** | **0.6** | ***24.492*** | ***26.5115*** | **2.0193** | ***44.5*** | ***42.3*** | ***(2.3)*** | ***23.4*** | **(1.1)** | **4.6%** |
| ***Corporate Income & Financing*** | | | | | | | | | | | | |
| Income | 18.3 | 18.3 | 0.0 | 126.9 | 127.0 | (0.1) | 218.5 | 218.1 | (0.5) | 123.0 | 3.9 | 3.1% |
| Financing | 0.840 | 0.935 | (0.1) | 5.740 | 6.0737 | (0.333) | 11.0 | 10.1 | (0.8) | 6.2 | (0.4) | (7.0%) |
| ***Surplus/ (Deficit) Statutory*** | ***0.5*** | ***0.1*** | **0.4** | ***2.8*** | ***0.6*** | **2.3** | ***2.3*** | ***4.4*** | ***2.1*** | ***2.1*** | **0.8** | **38.5%** |

## *Key Messages*

All localities continue to be on or below plan with the exception of the following.

Mental Health West: Non pay overspend of £0.2m is entirely due to OAP costs.

Mental Health East: Income reduced to reflect likely agreement with RBC for S117 funding to begin from September. This is off-set by a release of bad debt provision in Corporate, so there is no overall impact on our YTD surplus.

Other Health: Income and non-pay relate to Pharmacy pass through drugs and pay overspend relates to a pay accrual for trainee registrars.

# 4.0 Cost Improvement Programme

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

| 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 | (0.05) | 0.07 | (0.12) | 0.05 | 0.24 | (0.20) | 0.74 | 0.59 | 0.15 |
| Overspill Beds | 0.20 | 0.26 | (0.06) | 0.50 | 0.52 | (0.02) | 1.26 | 1.82 | (0.56) |
| ***Total OAPS Saving*** | ***0.15*** | ***0.33*** | ***(0.18)*** | ***0.55*** | ***0.76*** | ***(0.22)*** | ***2.00*** | ***2.40*** | ***(0.41)*** |
| ***Service Line Review*** | | | | | | | | | |
| WestCall | 0.00 | 0.07 | (0.07) | 0.00 | 0.12 | (0.12) | 0.00 | 0.50 | (0.50) |
| CRHTT | 0.00 | 0.07 | (0.07) | 0.00 | 0.12 | (0.12) | 0.00 | 0.50 | (0.50) |
| ***Total Service Line Savings*** | ***0.00*** | ***0.13*** | ***(0.13)*** | ***0.00*** | ***0.23*** | ***(0.23)*** | ***0.00*** | ***1.00*** | ***(1.00)*** |
| ***Procurement*** | | | | | | | | | |
| NHSP Contract | 0.02 | 0.02 | 0.00 | 0.11 | 0.11 | 0.00 | 0.18 | 0.18 | 0.00 |
| Procurement Spend | 0.03 | 0.03 | 0.00 | 0.20 | 0.18 | 0.03 | 0.40 | 0.30 | 0.10 |
| ***Total Procurement Savings*** | ***0.04*** | ***0.04*** | ***0.00*** | ***0.31*** | ***0.28*** | ***0.03*** | ***0.58*** | ***0.48*** | ***0.10*** |
| ***Other Schemes*** | | | | | | | | | |
| Community NCA | 0.02 | 0.02 | 0.00 | 0.17 | 0.15 | 0.03 | 0.25 | 0.25 | 0.00 |
| Liaison & Diversion Contract | 0.02 | 0.02 | 0.00 | 0.15 | 0.15 | 0.00 | 0.25 | 0.25 | 0.00 |
| Other Contracts | 0.02 | 0.02 | 0.00 | 0.15 | 0.15 | 0.00 | 0.25 | 0.25 | 0.00 |
| Scheme to be Identified | 0.07 | 0.00 | 0.07 | 0.07 | 0.00 | 0.07 | 0.17 | 0.17 | 0.00 |
| ***Total Other Savings*** | ***0.14*** | ***0.06*** | ***0.07*** | ***0.54*** | ***0.44*** | ***0.10*** | ***0.92*** | ***0.92*** | ***0.00*** |
| **Total CIP Delivery** | ***0.33*** | ***0.56*** | ***(0.23)*** | ***1.39*** | ***1.71*** | ***(0.32)*** | ***3.50*** | ***4.80*** | ***(1.31)*** |

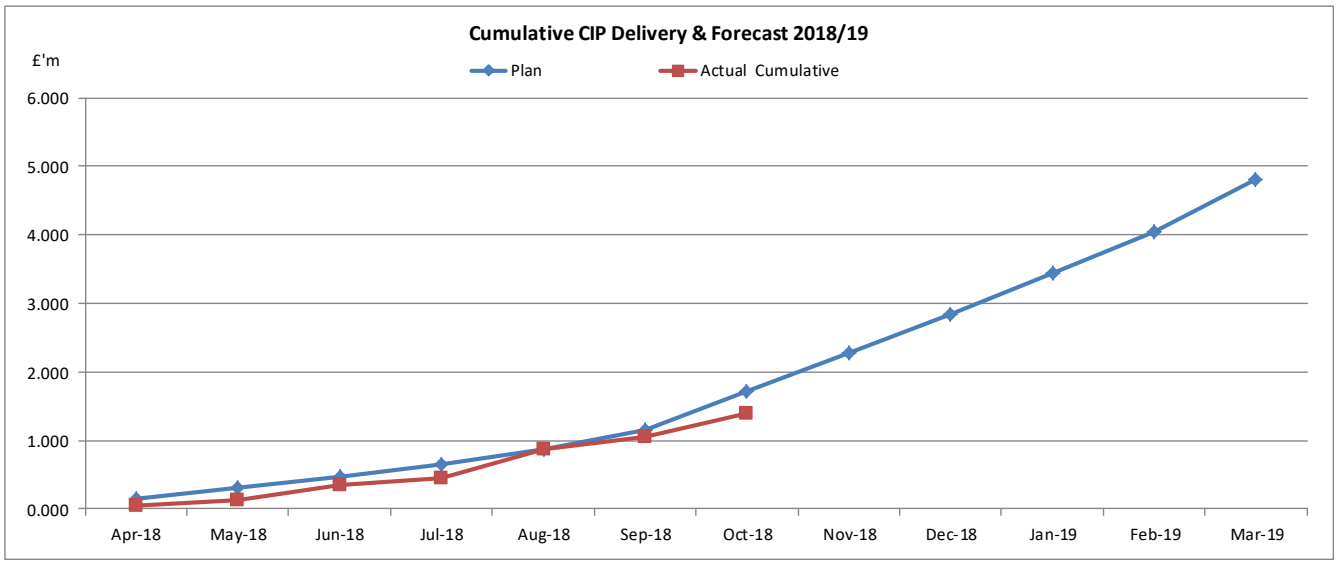
## *Key Messages*

The Trust delivered a £1.4m of savings YTD against a plan of £1.7m. Forecast savings are expected to be £3.5m with service model reviews savings unlikely to materialise this year.

Contract negotiations for specialist OAPs placements continue and are expected to secure delivery of planned savings and cost mitigation into 19/20.

The demand for acute and PICU beds remains high and associated OAPs cost remains ahead of plan by £0.4m inclusive of female PICU beds.

Procurement has delivered savings of £0.2m YTD against a plan of £0.18m. A YTD cost reduction of £0.06m resulting from Children's Services Management Review is recognised this month.



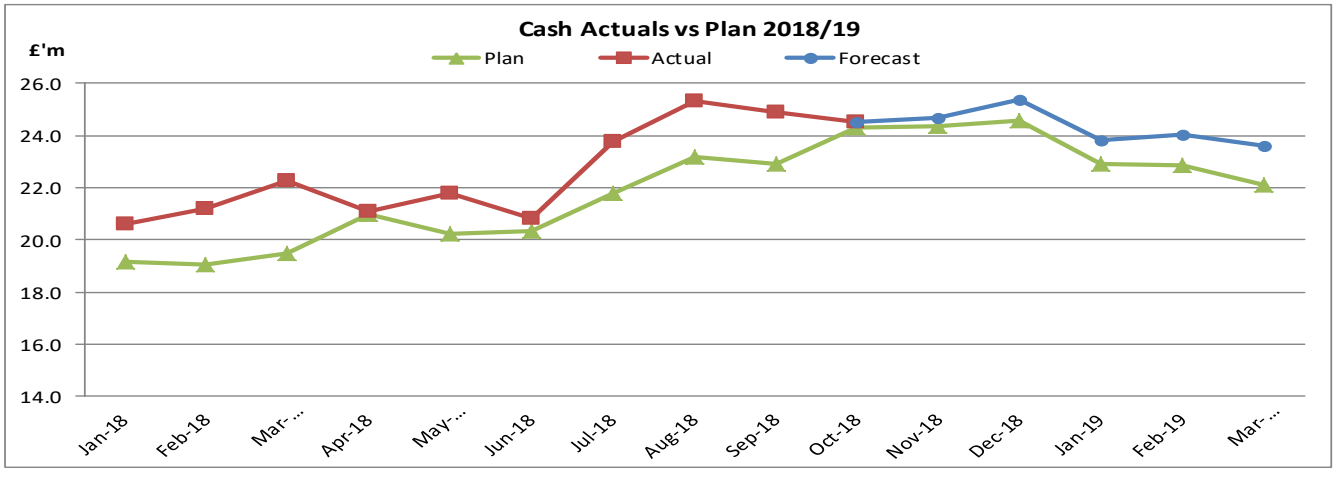
# 5.0 Balance Sheet & Cash

| 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 | 4.4 | 5.3 | (0.9) | 4.4 | 5.3 | (0.9) | 5.5 |
| Property, Plant & Equipment (non PFI) | | 35.1 | 32.8 | 31.1 | 1.7 | 32.8 | 31.1 | 1.7 | 38.5 |
| Property, Plant & Equipment (PFI) | | 55.6 | 59.1 | 59.6 | (0.5) | 59.1 | 59.6 | (0.5) | 55.6 |
| **Total Non Current Assets** | | **95.2** | **96.3** | **96.0** | ***0.3*** | **96.3** | **96.0** | ***0.3*** | **99.6** |
| Trade Receivables & Accruals | | 13.4 | 15.3 | 10.8 | 4.5 | 15.3 | 10.8 | 4.5 | 10.8 |
| Other Receivables | | 0.3 | 0.2 | 1.3 | (1.1) | 0.2 | 1.3 | (1.1) | 1.3 |
| Cash | | 22.3 | 24.5 | 24.3 | 0.2 | 24.5 | 24.3 | 0.2 | 22.1 |
| Trade Payables & Accruals | | (23.7) | (25.7) | (24.5) | (1.2) | (25.7) | (24.5) | (1.2) | (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) | (2.6) | (2.3) | (0.3) | (2.6) | (2.3) | (0.3) | (2.3) |
| **Total Net Current Assets / (Liabilities)** | | **9.0** | **10.5** | **8.4** | ***2.1*** | **10.5** | **8.4** | ***2.1*** | **6.1** |
| Non Current PFI Finance Lease | | (29.7) | (29.0) | (29.0) | (0.0) | (29.0) | (29.0) | (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*** | ***76.1*** | ***73.8*** | ***2.2*** | ***76.1*** | ***73.8*** | ***2.2*** | ***75.6*** |
| Income & Expenditure Reserve | | 19.9 | 22.7 | 20.5 | 2.3 | 22.7 | 20.5 | 2.3 | 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*** | ***76.1*** | ***73.8*** | ***2.3*** | ***76.1*** | ***73.8*** | ***2.3*** | ***75.6*** |

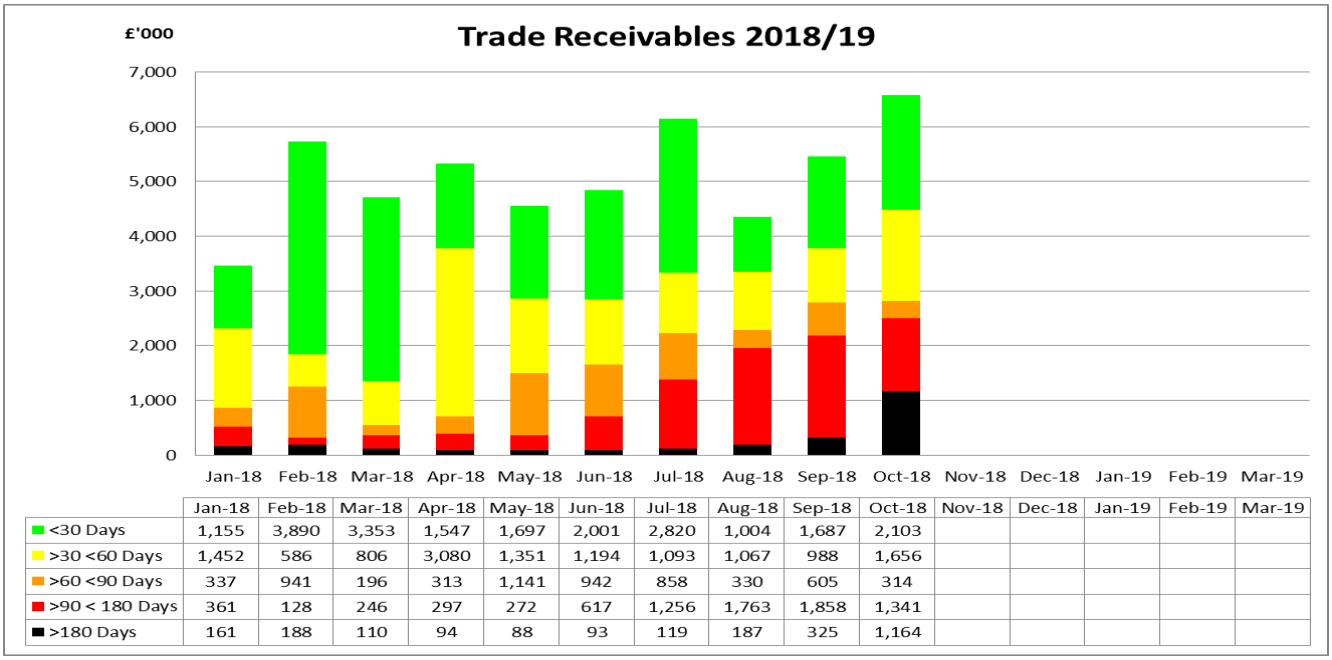
| Cashflow | | 17/18 Actual £'m | Current Month Act £'m | Current Month Plan £'m | Current Month Var £'m | YTD Act £'m | YTD Plan £'m | YTD Var £'m | 18/19 Plan £'m |
|---|---|---|---|---|---|---|---|---|---|
| Operating Surplus/(Deficit) | +/- | 10.7 | 0.9 | 0.5 | 0.4 | 5.8 | 3.7 | 2.2 | 7.8 |
| Depreciation and Impairments | + | 5.4 | 0.4 | 0.5 | (0.1) | 2.7 | 3.0 | (0.3) | 5.7 |
| ***Operating Cashflow*** | | ***16.1*** | ***1.3*** | ***1.0*** | ***0.2*** | ***8.5*** | ***6.7*** | ***1.8*** | ***13.4*** |
| ***Net Working Capital Movements*** | ***+/-*** | ***(2.1)*** | ***(0.4)*** | ***1.5*** | ***(1.9)*** | ***(0.1)*** | ***1.2*** | ***(1.3)*** | ***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) | (1.0) | (0.7) | (0.3) | (3.7) | (3.3) | (0.4) | (9.1) |
| ***Investments*** | | ***(10.2)*** | ***(1.0)*** | ***(0.7)*** | ***(0.3)*** | ***(2.9)*** | ***(2.5)*** | ***(0.4)*** | ***(7.5)*** |
| PFI Finance Lease Repayment | - | (1.0) | (0.1) | (0.1) | (0.0) | (0.6) | (0.6) | (0.0) | (1.0) |
| Net Interest | +/- | (3.5) | (0.3) | (0.3) | 0.0 | (2.1) | (2.1) | 0.1 | (3.6) |
| PDC Revieved | + | 1.8 | 0.0 | 0.0 | 0.0 | 0.3 | 0.3 | 0.0 | 0.3 |
| PDC Dividends Paid | - | (1.6) | (0.0) | 0.0 | (0.0) | (0.9) | (0.9) | 0.0 | (1.7) |
| ***Financing Costs*** | | ***(4.3)*** | ***(0.4)*** | ***(0.4)*** | ***(0.0)*** | ***(3.3)*** | ***(3.3)*** | ***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*** | ***(0.5)*** | ***1.4*** | ***(1.9)*** | ***2.2*** | ***2.0*** | ***0.2*** | ***(0.3)*** |
| Opening Cash | | 20.7 | 25.0 | 22.9 | 2.1 | 22.3 | 22.3 | 0.0 | 22.3 |
| ***Closing Cash*** | | ***22.3*** | ***24.5*** | ***24.3*** | ***0.2*** | ***24.5*** | ***24.3*** | ***0.2*** | ***22.0*** |

## *Key Messages*

Closing cash balance for October was £24.5m, which was £0.2m above plan. Despite the Trust benefitting from a higher YTD surplus and lower than planned capital expenditure, issues working capital issues with NHSPS and CCG are reducing what should be a higher cash balance. Given the improvement in our YE forecast, we are expecting that this will flow through into our cash balance by the end of the year.



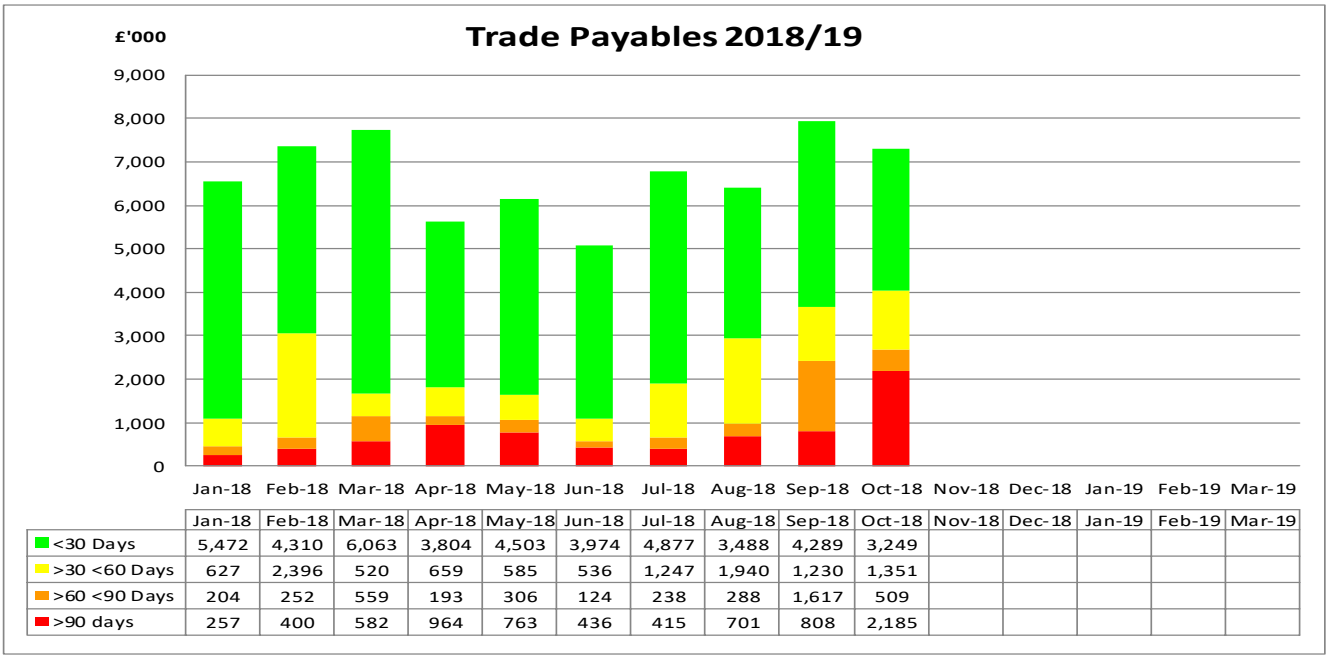
# Cash Management




| | Jan-18 | Feb-18 | Mar-18 | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| <30 Days | 1,155 | 3,890 | 3,353 | 1,547 | 1,697 | 2,001 | 2,820 | 1,004 | 1,687 | 2,103 | | | | | |
| >30 <60 Days | 1,452 | 586 | 806 | 3,080 | 1,351 | 1,194 | 1,093 | 1,067 | 988 | 1,656 | | | | | |
| >60 <90 Days | 337 | 941 | 196 | 313 | 1,141 | 942 | 858 | 330 | 605 | 314 | | | | | |
| >90 < 180 Days | 361 | 128 | 246 | 297 | 272 | 617 | 1,256 | 1,763 | 1,858 | 1,341 | | | | | |
| >180 Days | 161 | 188 | 110 | 94 | 88 | 93 | 119 | 187 | 325 | 1,164 | | | | | |

***Key Message***

The table above shows that Trade Receivables as at the end of October increased by £1.1m with unpaid invoices by NHS PS the main driver. Since month end, NHSPS have paid their oldest invoices and we have resolved a number of outstanding payments due from CCGs. The net impact is that debts over 90 days are currently £0.7m, opposed to the £2.5m illustrated above.




| | 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 | 3,488 | 4,289 | 3,249 | | | | | |
| >30 <60 Days | 627 | 2,396 | 520 | 659 | 585 | 536 | 1,247 | 1,940 | 1,230 | 1,351 | | | | | |
| >60 <90 Days | 204 | 252 | 559 | 193 | 306 | 124 | 238 | 288 | 1,617 | 509 | | | | | |
| >90 days | 257 | 400 | 582 | 964 | 763 | 436 | 415 | 701 | 808 | 2,185 | | | | | |

***Key Message***

Trade Payables decreased by £0.7m overall in the month. Of the £2.2m of debt that has moved to over 90 days, £1.4m due to NHS PS has now being paid in response to the payment of our aged invoices.

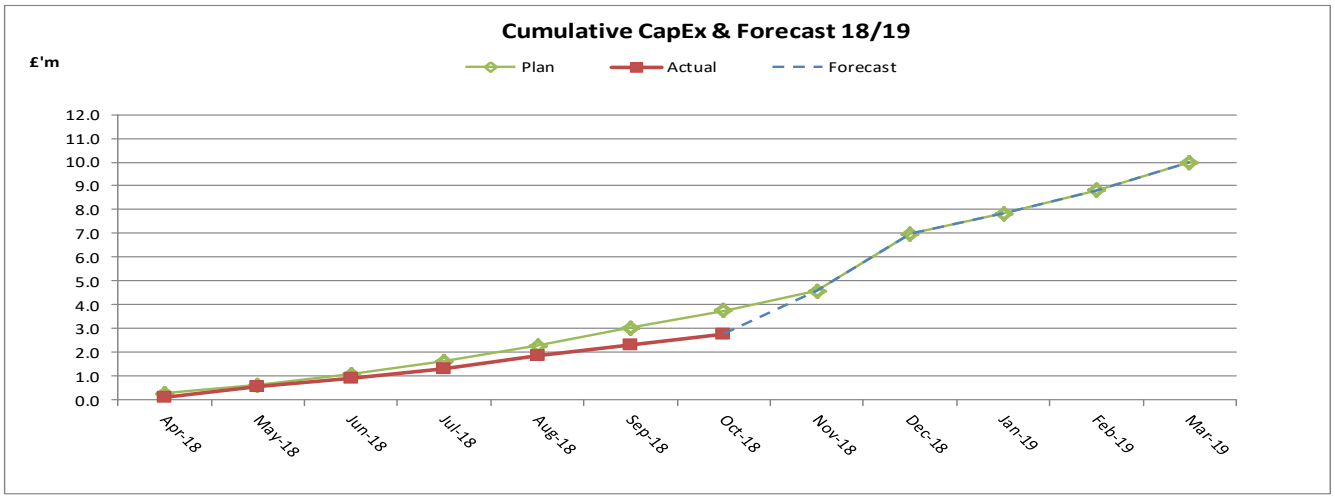
# 6.0 Capital Programme

| 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 | 6 | 70 | (64) | 93 | 454 | (361) | 755 |
| Leased Non Commercial (NHSPS) | 32 | 54 | (21) | 507 | 424 | 83 | 735 |
| Leased Commercial | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Statutory Compliance | 5 | 8 | (3) | 105 | 79 | 26 | 448 |
| Locality Consolidations | 6 | 200 | (194) | 43 | 250 | (207) | 1,600 |
| PFI | 82 | 64 | 18 | 327 | 491 | (163) | 1,380 |
| **Subtotal Estates Maintenance & Replacement** | **131** | **396** | **(265)** | **1,077** | **1,698** | **(621)** | **4,918** |
| ***IM&T Expenditure*** | | | | | | | |
| IM&T Refresh & Replacement | 53 | 65 | (12) | 336 | 471 | (135) | 3,187 |
| IM&T Business Intelligence and Reporting | 53 | 10 | 43 | 55 | 85 | (30) | 130 |
| IM&T System & Network Developments | (0) | 0 | (0) | (3) | 0 | (3) | 0 |
| IM&T Other | 7 | 5 | 2 | 48 | 35 | 13 | 95 |
| IM&T Locality Schemes | 23 | 0 | 23 | 265 | 0 | 265 | 200 |
| **Subtotal IM&T Expenditure** | **136** | **80** | **56** | **701** | **591** | **110** | **3,612** |
| ***GDE Expenditure*** | | | | | | | |
| GDE Trust Funded | 197 | 242 | (45) | 593 | 1,108 | (515) | 1,985 |
| GDE funded by NHS Digital | 0 | 0 | 0 | 335 | 335 | 0 | 335 |
| **Subtotal GDE Expenditure** | **197** | **242** | **(45)** | **928** | **1,443** | **(515)** | **2,320** |
| Other Locality Schemes | (0) | 0 | (0) | 71 | 0 | 71 | 150 |
| **Subtotal Capital Expenditure** | **463** | **718** | **(255)** | **2,777** | **3,732** | **(955)** | **11,000** |
| Assumed Slippage within NHSI Plan | | 0 | 0 | | 0 | 0 | (1,000) |
| **Subtotal Capital Expenditure vs NHSI Plan** | **463** | **718** | **(255)** | **2,777** | **3,732** | **(955)** | **10,000** |
| ***Donated Assets*** | | | | | | | |
| Renal Unit at WBCH | 416 | 416 | 0 | 996 | 996 | 0 | 697 |
| **Subtotal Donated Assets** | **416** | **416** | **0** | **996** | **996** | **0** | **697** |
| **Total Capital Expenditure** | **879** | **1,133** | **(255)** | **3,773** | **4,728** | **(955)** | **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 was drawdown in July.

YTD spend is £1.0m behind plan with slippage against our Estates and IM&T programmes. The latest view of spend is that it will come in close to the £10m NHSI plan, assuming schemes deliver to their current revised trajectories. We will continue to monitor to ensure we accurately reflect slippage into 19/20.



Berkshire Healthcare
NHS Foundation Trust

**Trust Board Paper**

| | |
|---|---|
| **Board Meeting Date** | 11th December 2018 |
| **Title** | **Summary Board Performance Report M7 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 October 2018.<br><br>**Month 7**<br><br>**2018/19 EXCEPTIONS**<br><br>**The following Trust Performance Scorecard Summary indicator grouping is Red rated:**<br><br>The "red" indicator grouping has been rated on an override basis, related to 1 specific indicator;<br><br>• Service Efficiency and Effectiveness – RED<br><br>**The following Trust Performance Scorecard Summary indicator groupings are Amber rated:**<br><br>• People - AMBER<br><br>Further detail on the AMBER dashboard ratings is narrated within the section commentaries of the |

| | |
|---|---|
| | summary performance report.<br><br>**The following individual performance indicators are highlighted by exception as RED with their link to the Trust Performance Dashboard Summary identified in brackets:**<br><br>• **US-01a -** Mental Health Physical Assaults on Staff **(User Safety)**<br>• **US-02a -** Mental Health Physical Patient to Patient Assaults **(User Safety)**<br>• **US-05 -** Self-harm incidents: Number **(User Safety)**<br>• **US-18** – Prevention and Management of Violence and Aggression (PMVA) **(User Safety)**<br>• **US-19** – Use of Prone Restraint **(User Safety)**<br>• **PM-01** - Staff Turnover **(People)**<br>• **PM-03** – Sickness **(People)**<br>• **SE-03** - Mental Health: Acute Average LOS (bed days) **(Service Efficiency & Effectiveness)**<br>• **SE-03a** - Mental Health: Acute Average LOS Snapshot **(Service Efficiency & Effectiveness)**<br>• **SE-05 –** Community Health Services Occupancy Rate **(Service Efficiency & Effectiveness)**<br>• **SE-06a** - Mental Health: Acute Occupancy rate (Ex HL) **(Service Efficiency & Effectiveness)**<br>• **SE-06b -** Mental Health: Acute Occupancy rate by Locality (Ex HL) **(Service Efficiency & Effectiveness)**<br>• **SE-07** - Mental Health Non-Acute Occupancy Rate **(Service Efficiency & Effectiveness)**<br>• **SE-08** – New Birth Visits Within 14 days (**Service Efficiency & Effectiveness)**<br>• **SE-10** - Mental Health Clustering within target **(Service Efficiency & Effectiveness)**<br><br>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

## M7: 2018/19 October 2018

# Performance Scorecard Summary: Month 7 2018/19

Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

## Board Summary

| Ref | Mapped indicators | Indicators | Overall Performance | Over ride | Subjective |
|---|---|---|---|---|---|
| US | US-01 to US-20 | User Safety | Green | No | N/A |
| P | PM-01 to PM-08 | People | Amber | No | Yes |
| SOF | SOF 01-05 & SOF 07-10 | NHS Improvement (non-financial) | Green | No | N/A |
| | SOF-06 | NHS Improvement (financial) | Green | No | N/A |
| SE | SE-01 to SE-11 | Service Efficiency & Effectiveness | Red | No | No |
| CP | CP-01 | Contractual Performance | Green | 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; M7: October 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 (DQMI)
- 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 M7: 2018/19 | | | |
|---|---|---|---|
| **Indicator** | **Indicator No** | **Comments** | **Section** |
| Mental Health Physical Assaults on Staff | US 01a | Increased from 67 to 77 | User Safety |
| Mental Health Physical Patient to Patient Assaults | US 02a | Decreased from 55 to 52 | User Safety |
| Self-Harm incidents | US 05 | Decreased from 234 to 262 | User Safety |
| Prevention and Management of Violence and Aggression (PMVA) | US 18 | Increased from 53 to 62 | User Safety |
| Use of Prone Restraint | US 19 | Decreased from 7 to 4 | User Safety |
| Staff Turnover | PM 01 | Increased from 16.6% to 16.9% | People Management |
| Sickness | PM 03 | Increased from 3.84% to 4.07% | People Management |
| Mental Health Acute Average Length of Stay | SE 03 | Increased from 45 days to 48 days | Service Efficiency |
| Mental Health Acute Snapshot Length of Stay | SE 03a | Decreased from 56 days to 49 days | Service Efficiency |
| Community Health Service Occupancy | SE 05 | Decreased from 78% to 75% | Service Efficiency |
| Mental Health Acute Occupancy Rate by Locality and Ward | SE 06 a & b | Remains at 98% | Service Efficiency |
| Mental Health Non-Acute Occupancy Rate | SE 07 | Decreased from 80% to 69% | Service Efficiency |
| New Birth Visits within 14 days | SE 08 | Decreased from 94% to 91% | Service Efficiency |
| Mental Health Clustering | SE 10 | Decreased from 84.6% to 82.2% | Service Efficiency |

## User Safety Commentary

There were 9 serious incidents in October 2018. These were; 3 suspected suicides (1 on Bluebell ward, 1 in Neuropsychology and 1 at West Berkshire), 3 unexpected deaths (1 Reading CMHT, 1 Reading CMHT/Daisy Ward and 1 Slough CMHT) and 2 falls with harm; 1 each on Highclere ward and Oakwood ward and 1 assault by another patient resulting in a fall with harm (Rowan Ward).

The number of assaults on staff increased to 77 in the rolling quarter to October 2018 and is now red rated. In the rolling quarter; Mental Health Inpatients reported 73 incidents (same as last month), 13 incidents were reported on Sorrel ward (12 last month), 6 on Daisy ward (same as last month), 8 incidents on Bluebell ward (6 last month), 12 on Snowdrop ward (10 last month), 18 on Rowan ward (13 last month), 11 incidents were reported on Rose ward (12 last month) and 1 incident was reported on Orchid ward (same as last month). In addition, 1 incident each took place at the place of safety (POS), 1 at Prospect Park Hospital (no specific location), A&E and other or unknown location. In the rolling quarter, 2 incidents were reported at Willow House (CAMHS 1 last month). One incident was reported by Pharmacy in the rolling quarter. All incidents which occurred in October 2018 were rated as low risk. This shows an increasing trend.

For Learning Disabilities there was an increase in the number of assaults on staff from 50 in the rolling quarter to September 2018 to 65 in the rolling quarter to October 2018. All incidents in October 2018 were rated as low risk. This shows an increasing trend.

Patient to Patient Assaults - this has decreased to 52 in the rolling quarter to October 2018 and remains red rated against a local target. 47 incidents occurred in Mental Health Inpatients in the rolling quarter and these were as follows; 13 incidents took place on Sorrel ward (8 last month), 14 on Rowan ward (19 last month), 2 on Daisy ward (5 last month), 5 on Rose ward (same as last month), 0 on Bluebell ward (same as last month), 7 on Snowdrop ward (2 last month) and 2 on Orchid ward (5 last month), 2 each occurred at Prospect Park Hospital (no specific location) and  place of safety. In the rolling quarter, 1 incident was reported at Willow House. In the community in the rolling quarter 3 incidents were reported in the community; 1 each for WAM Care pathways, Crisis team and Reading Older Persons services. One incident has been rated as moderate in October 2018, which occurred on Rowan ward as is outlined in the serious incident narrative above. All other incidents in October 2018 were rated as low or minor risk. At the time of reporting a total of 30 clients carried out assaults on other patients including 1 client who has carried out 5 assaults. This shows an increasing trend.

Learning Disability Patient to Patient Assaults increased to 20 (previously 16) in the rolling quarter to October 2018 and is now rated as amber against a local target.  All incidents were rated as low or minor risk and the assaults were carried out by 6 clients including 2 who carried out 5 incidents each. This shows a decreasing trend.

Slips Trips and falls - Orchid ward (6 falls) and Rowan ward (3 falls) are above target. Trust are trialling a new falls assessment and care plan on the community and older adult wards otherwise the counter measures remain unchanged. 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 234 in the rolling quarter to October 2018, and remains rated as red. In Willow House there were 72 incidents (99 last month) reported in the rolling quarter. There was a total of 108 incidents reported in the rolling quarter to October 2018 by Mental Health Inpatients, which is reduced from 111 in the rolling quarter to September 2018. Of these, 12 incidents were reported on Rose ward (9 last month), 59 on Bluebell ward (66 last month), 3 on Daisy ward (2 last

month) and 25 on Snowdrop ward (same as last month). There were also incidents reported as follows; 1 POS, 3 Prospect Park Hospital (no specific location), 1 Mental Health Reception and 3 other or unknown locations. In the community in the rolling quarter; 43 incidents reported by Mental Health West; 3 by Talking Therapies and 30 by Crisis, 2 by Traumatic Stress service, 1 each Mental Health Liaison and Criminal Justice and Liaison services and 1 by Care Pathways Reading. 1 was reported by the Eating Disorders service, 11 Incidents were reported by Mental Health East which were 3 by Bracknell Care Pathways and 2 by Bracknell COAMHS, 5 by IMPACTT and 1 by WAM 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 increased to 7 in the rolling quarter to October 2018. This shows a decreasing trend.

AWOLS and Absconsions - this data covers only those clients detained on a Mental Health Act Section and is measured against a local target. Both AWOLS (27 to 19) and Absconsions (21 to 20) decreased in the rolling quarter to October 2018. In October 2018, there were a total of 5 AWOLs reported; 3 from Snowdrop ward and 2 from Daisy ward. All incidents in October 2018 were rated as low risk. In October 2018, there were 3 absconsions; 2 from Bluebell ward, Rose ward and Snowdrop ward. Both AWOLs and Absconsions show decreasing trends.

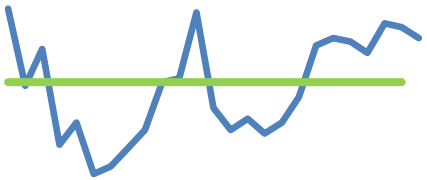
PMVA (Control and Restraint of Mental Health patients) – at the time of reporting there were 62 uses of PMVA in October 2018. There were 19 incidents on Bluebell ward, 12 incidents on Sorrel ward, 8 on Rose ward, 3 on Daisy ward and 6 each on Rowan ward and Snowdrop ward. 1 from Car Park, 2 from Prospect Park (no specific location) and 1 other or unknown location and RBH. In addition, 1 use was reported at CYPF and 1 other.

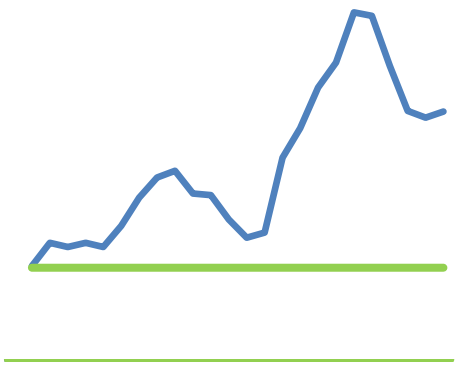
There were 4 incidents of prone restraint in October 2018, 1 each on Bluebell ward, 1 Rose ward, 1 on POS, and 1 other. The trend for use of prone restraint is downwards when measured over a 3-year period. A programme of work is in place to reduce the use of prone restraint on the wards by 90% by the end of 2018/19 with a Rapid Improvement Event that took place in July 2018. Target is less than 2 per month from September 2018.

There were 6 uses of Strategy for Crisis Intervention and Prevention in October 2018.

Seclusion in October 2018 in Mental Health Inpatients - Currently waiting for data for October 2018. There were 2 uses of seclusion in the Learning Disability Service, both for the same client, with the longest incident 5 hours and 55 minutes.

## User Safety Exception Report Month 7: 2018/19

| KPI | Target | Oct-18 | Trend | Context/Reasons | Commentary of Trend |
|---|---|---|---|---|---|
| Mental Health Physical Assaults on Staff | <70 | 77 |  | **Mental Health Physical Assaults on Staff show an increase in incidents reported in the rolling quarter by in Older Person's Mental Health. This is measured against a local target.** | **In 2017/18 Mental Health NHS Benchmarking exercise, this Trust was above the mean of incidents of physical violence to staff at 507 incidents per 100,000 occupied bed days excluding leave.** |
| Mental Health Physical Patient to Patient Assaults | <40 | 52 |  | **Physical Patient to Patient Assaults were carried out by 30 patients in the rolling quarter. 1 of which carried 5 assaults. This is measured against a local target.** | **In 2017/18 Mental Health NHS Benchmarking exercise, this Trust was above the mean and median but at 311 incidents per 100,000 occupied bed days excluding leave.** |

| KPI | Target | Oct-18 | Trend | Context/Reasons | Commentary of Trend |
|---|---|---|---|---|---|
| Self-Harm incidents | **<75** | **234** |  | **Self-harm incidents reduced in Adult Acute Mental Health Inpatients and CAMHS Inpatients.** | |
| Preventing and Managing Violence and Aggression (PMVA) in Mental Health | **<41** | **62** |  | **This is the number of physical restraints of patients on our Mental Health Inpatient wards. This shows an increase driven by an increase on Bluebell ward. This is measured against a local target.** | **In the 2017/18 NHS Benchmarking exercise, the Trust was above the mean of users of restraint at 309 uses per 100,000 bed days excluding leave.** |

| KPI | Target | Oct-18 | Trend | Context/Reasons | Commentary of Trend |
|---|---|---|---|---|---|
| Use of Prone Restraint | <2 | 4 |  | **The Trust target reduced to 2 from September 2018. One incident each occurred in Place Of Safety, Bluebell ward, Rose ward and other location.** | |

**Other Key Performance Highlights for this Section**

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

- Mental Health Physical Assaults on Staff worsened from 67 in the rolling quarter to September 2018 to 77 in the rolling quarter to October 2018.
- Mental Health: Preventing and Managing Violence and Aggression worsened from 50 in the rolling quarter to September 2018 to 62 in the rolling quarter to October 2018.
- Learning Disability Physical Assaults on Staff worsened from 50 in the rolling quarter to September 2018 to 65 in the rolling quarter to October 2018.
- Learning Disability self-harm has worsened from 4 incidents in the rolling quarter to September 2018 to 7 in the rolling quarter to October 2018.
- Learning Disability Physical Patient to Patient Assault worsened from 16 in the rolling quarter to September 2018 to 20 in the rolling quarter to October 2018.
- Learning Disability Strategy for Crisis Intervention & Prevention (SCIP) worsened from 5 uses in the rolling quarter September 2018 to 6 in the rolling quarter to October 2018.

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

- Mental Health Patient to Patient Assaults improved from 55 in the rolling quarter to September 2018 to 52 in the rolling quarter to October 2018.
- Mental Health: Absconsions improved from 21 in the rolling quarter to September 2018 to 20 in the rolling quarter in October 2018.
- Mental Health Self-Harm incidents have improved from 262 in the rolling quarter to September 2018 to 234 in the rolling quarter to October 2018.
- Use of Prone Restraint has improved from 7 uses in September 2018 to 4 uses in October 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 Personal Development Plan (PDP) is a local target. Of the 8 indicators, 2 are red (Staff turnover, Sickness rates for September 2018) 2 are amber (Fire 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 September increased to 4.07%, from 3.84% in August. Based on hourly rates, there was an associated increase in the cost of absence in September to £384,159 (the final cost for August was £373,718).

• There was an increase in the short-term sickness rate in September to 0.88%, from 0.77% in August. This is attributed to an increase in absences due to cold/cough/flu, with the total sickness rate for this reason increasing to 0.29% in September (from 0.14% in August). Whilst this is an increase, this rate is currently lower than the same period last year (September 2017 was 0.36%).

• There has been a decrease in the long-term sickness rate in September to 2.04%, from 2.32% in August, and the rate is now at its lowest level since April. Following the recent upward trend seen in this rate, this reduction is encouraging and follows focused work in the localities to ensure that individual cases are being effectively managed.

• The total sickness rate attributed to anxiety/stress/depression increased further in September to 1.24% (from 1.13% in August) and is showing an upward trend over the last three months. Sickness for this reason accounted for 31% of all sickness in September, a proportional increase from 29.6% in August. Whilst the long-term sickness rate attributed to stress related absence has decreased, the medium-term sickness rate (i.e. absences of 8-27 days in duration) has increased in September to 0.34%, compared to an average of 0.17% over the previous six months. This data, in addition to some initial analysis of the closed sickness cases, may indicate a reduction in the duration of stress related sickness cases i.e. there is some evidence of a decrease in the average number of days lost per episode of sickness. The data will be analysed further over the next 2-3 months to identify any trends.

• There has been an increase in the number of return to work interviews recorded via Health Roster following a decline in the previous few months. The guidance for logging both return to work interviews and occupational health referrals has been re-circulated. In addition, it is anticipated that the introduction of the online portal for making management referrals to occupational health will improve the visibility of progress with each referral, thereby minimising delays and enabling more effective management of individual cases.

**Recruitment**

• A two-day workshop took place in October to identify and prioritise ideas for initiatives to support the recruitment and retention of difficult to fill posts. The specific actions resulting from this workshop will be shared widely over the coming months.

• Following the introduction of the 10% retention allowance on Sorrell ward at Prospect Park Hospital, three staff have transferred internally to Sorrell ward. In addition, six job offers have been made (4 external and 2 internal) with the candidates currently undergoing pre-employment checks. Consequently, the number of vacancies has reduced to one Band 5 vacancy and one Band 2 vacancy.

**Turnover**

• The Trust-wide turnover rate in October has increased to 16.88%, from 16.63% in September.

• Work is underway to improve the response rate to the leaver's questionnaire to enable more meaningful analysis of the feedback data. The response rate in October was 62%, the highest response rate in over 12 months and compares with an average response rate over the previous six months of 54%. Initiatives to increase the response rate and quality of feedback include:

- In the East District Nursing service, a designated manager has been identified to undertake exit interviews with all leavers. However, there is a need to ensure that any exit interview feedback, in this or other services, is entered into survey monkey, in order that the feedback can be included in any analysis of trends.
- The HR Operations Manager at Prospect Park Hospital is working with ward managers to arrange exit interviews on receipt of a resignation. The average response rate to the leaver's questionnaire for Prospect Park in the period April-September 2018 was 21%. The response rate in September was 44%, which may be an early indication of the effectiveness of this approach.
- From November, a revised process will be piloted in Estates and Facilities whereby leavers will receive a phone call from the HR team during their final week of employment, rather than an email, with a view to improving the quantity and quality of feedback received. This approach will be evaluated and if effective, the scope will be extended to other areas of the Trust with a low response rate.

**Statutory and Mandatory Training**

Statutory Training – Fire Training - This increased to 90% with only Community Health Services East above target Weekly reports are still being sent to Locality Directors and for Corporate staff reports on non-compliance have been sent to the relevant Heads of Service/Directors. 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 66%; however 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 increased 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 7 - 2018/19

| KPI | Target | Oct-18 | Trend | Context/Reasons | Commentary of Trend |
|---|---|---|---|---|---|
| Staff Turnover (% YTD): Percept | **<15.2%** | **16.88%** |  | **Increase in turnover target from September 2016. This remains a challenging stretch target for the Trust. Turnover rates have reduced over 12 months. This includes end of fixed-term contracts, retirements as well as voluntary resignations.** | **NHS Digital published data on The Stability Index. This is the percentage of staff there at the start of the period that do not leave the specified group (e.g. organisation, staff group or the NHS in England) during period in question. The Trust score of 81.62% is lower than an England average of 88.38%. Locally Oxford Health scored 78.85%, Surrey and Borders Partnership 77.02%, and Southern Health at 80.22%.** |

| | | | | | |
|---|---|---|---|---|---|
| Sickness | **<3.5%** | **4.07%** |  | **The short-term sickness has increased to 0.88%, and the long-term sickness has increased to 2.47%.** | **The most recently published NHS Staff Sickness Absence rates published on 27th September 2018 show that for May 2018 the NHS England overall sickness rate at 3.79% and 3.45% for the Thames Valley.** |

**Other Key Performance Highlights for this Section**

- Sickness has worsened from 3.84% in August 2018 to 4.07% in September 2018
- Staff Turnover has worsened from 16.6 % in September 2018 to 16.88% in October 2018
- Gross vacancies have improved from 9.2 % in September 2018 to 9.0% in October 2018.
- Mandatory Training: Information Governance training has improved from 91% in September 2018 to 93% in October 2018.

## NHS Improvement Non-Financial and Financial Commentary

The Single Oversight Framework for 2018/19 - this section is green as all areas are above target.

DM01 - 6-week compliance for Audiology Diagnostics was recalculated and resubmitted following an internal review and was 99.4% for September 2018 (496/499) and October 2018 99.8% (500/501).

The Trust was given an overall data set a Data Quality Maturity Index (DQMI) Score 99.8% for the Mental Health Service Data Set (MHSDS), against a target of 95% for the MHSDS according to the most recent data published on 6th November 2018. NHS Digital published guidance which stated that there will be a new approach to adding indicators which will allow Trust's time to take corrective action prior to publication, and so the score published in November 2018 has reverted to the original 6 fields and achieved the target.

• Inappropriate Out of Area Placements (OAP), the Single Oversight Framework (SOF) measures progress against the Integrated Care System (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 3 2018/2019 - quarter to date the Trust were below target:

- Berkshire West CCG - 117 inappropriate OAP bed days against a Quarter 3 2018 target of 356 bed days.
- East Berkshire CCG - 46 inappropriate OAP bed days against a Quarter 3 2018 target of 342 bed days.

• Proportion of people completing treatment who move to recovery (from IAPT minimum dataset). For October 2018 the Trust achieved 55% with all CCGs above the 50% recovery threshold target.

In addition, Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI) and Methicillin-sensitive Staphylococcus aureus (MSSA) 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 as there is a system target to achieve. Trusts are required to report all E coli, Pseudomonas, Klebsiella, MRSA, MSSA, and GRE bacteraemia. For October 2018 - 1 case of Escherichia coli (E. coli) bacteraemia bloodstream infection occurred on Henry Tudor ward.

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, 4 are rated as “Green” including Did Not Attend (DNA) rates, Community Health Services Length of Stay, Mental Health Readmissions and Crisis plans. None are rated as “Amber”, 7 are rated “Red”; Mental Health Average and Snapshot Length of Stay, Mental Health Acute occupancy by ward and by locality, Mental Health Non-Acute Occupancy, Community Health Services Occupancy, Mental Health Clustering and Health Visiting, and 1 of which does not have a target (place of safety).

The DNA rate increased from 4.66% in September 2018 to 4.87% in October 2018 and remains green. East Mental Health (8.60%) and West Mental Health (6.15%) and Children, Young People and Families (CYPF) (7.89%) are above target. This indicator shows a decreasing trend.

In Common Point of Entry (CPE), the DNA rate decreased from 7.54% in September 2018 to 6.16% in October 2018.

Children and Families; Community Paediatrics at 12.67%, Health Visiting 9.17%, School Nursing 5.82% and CAMHS 8.81% were above the 6% target.

For Mental Health East; Intensive Management of Personality Disorders and Clinical Therapies Team (IMPACTT) at 12.53%, East Adult Community Mental Health Teams (CMHT) at 8.60% are above target. In West Mental Health; Clinical Health Psychology 21.32%, Adult Mental Health 7.07%, Trauma 8.64%, Neuropsychology 7.52% are above target. The portal, interactive voice message and SMS text messaging service can be used for reminders for appointments which take place in clinics provided that a mobile number is collected and entered into RiO in the correct format. In October 2018, 24,909 messages were sent.

Community Health Services Inpatient Average Length of Stay reduced to 21 days and is below target, with West Berkshire above target. Delayed transfers of care have had some improvements; Wokingham 1.8% (last month 3.5%), Slough 2.3% (4.4% last month) and WAM 6.2% (last month 4.0%), Reading 4.05% (last month 14.3%), but West Berkshire 15.3% at (last month 7.9%) worsened. A total of 35 patients’ discharges were delayed in October 2018. 17 of these are the responsibility of the NHS, and 9 are the responsibility of Social Care and 9 are joint Health and Social Care responsibility. The most common reason for a delay was awaiting care package in own home (total 16, 5 for Health, 5 Social Care, and 6 joint responsibility Health and Social Care). 8 are awaiting care home or nursing home placement, 4 Social Care, 1 Health and 3 joint responsibility.

Mental Health Acute Occupancy excluding home leave remained at 98% in October 2018.

The Average Length of Stay for Mental Health increased to 48 days in October 2018 and the acute snapshot length of stay reduced to 49 days in October 2018 and continues to remain above target. Of the 189 clients discharged during August 2018 to October 2018, the median length of stay was 26 days. 26 clients who were discharged in the period had lengths of stay above 90 days, including 22 above 100 days and 1 at 390 days and 1 at 707 days. There are several clients who have accommodation needs for which funding must be obtained and placements sought before they can be discharged from the ward. As at 14th November 2018 there were a total of 3 acute clients who were agreed delayed transfers of care (a decrease from 8 last month); 2 on Bluebell ward and 1 on Rose ward. By locality, there are 2 for West Berkshire and 1 for Reading.

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

As at the 13th November 2018, there were 2 female PICU and 6 acute adult mental health patients in out of area placements.

Older Adults Mental Health wards length of stay is 68 days for Rowan ward and 65 for Orchid ward for clients discharged.

Community Health Services Occupancy is below the 80% lower threshold at 69% 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 and has been submitted to commissioners, no change has been made to the contract yet.

Mental Health Readmission rates are at 4.9% in October 2018 which is below the 9% target, with only Wokingham above target.

Mental Health Benchmarking reports have been sent, however the Trust is awaiting a final toolkit.

CAMHS Benchmarking reports have been sent, however the Trust is awaiting a final toolkit.

Mental Health Clustering has decreased to 82.2% compliance and remains below the 95% target.

Place Of Safety decreased to 40 uses in October 2018, but 2 uses for Minors. Of these 40 uses of the place of safety, 22 were admitted following assessment including 20 under Section 2. Eight clients waited over 8 hours for an assessment including 2 over 24 hours. The reasons for the delays in assessment include bed availability, patient intoxication, and availability of AMHP/assessing Doctor. Six out of the 40 assessments were carried out by Berkshire Healthcare NHS Foundation Trust Section 12 Doctors. The most common time in October 2018 to be brought to the place of safety was between 9pm and midnight followed by midnight to 3am. The most common days for detention in October 2018 were Wednesday with 8 detentions followed by 6 uses each on Tuesday, Thursday and Friday.

Crisis plans are above target at 96% when incomplete plans are included in the total.

New Birth Visits within 14 days for Health Visiting is below target at 90.8% however this compares favourably from the most recently published data which shows that in Quarter 4 2017/18 only 88.5% of New Birth Visits took place within 14 days. Of the 48 cases not seen within 14 days 27% (13) were due to staff capacity, 25% (12) were still in hospital, 17% (8) declined the appointment, and 15% (7) were due to no access, 6% (3) no response from family and 4% (2) were due to late notification.

System Resilience – Frimley Health NHS Foundation Trust achieved 89.1% for Type 1 A&E attendances in October 2018.

In the West – the A&E waiting times national return for October 2018 show the Royal Berkshire Hospital achieved 85.6% Tier 1 A&E attendances and 87.9% against Tier 1-3 attendances. Nationally only 83.2% 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 89.1% for all Tier 1-3 attendances during October 2018. The Trust's Minor Injury Unit achieved 100% for discharged, admitted transferred within 4 hours of arrival.

The system wide report showed West Berkshire, Reading and Wokingham Rapid Access teams had capacity on 13th November 2018. In terms of Inpatients on 14th November 2018, there were a total of 24 community beds available at our community hospitals in the Berkshire West area including 11 at Wokingham Community Hospital.

## Service Efficiency And Effectiveness Exception Report Month 7: 2018/19

| KPI | Target | Oct-18 | Trend | Context/Reasons | Commentary of Trend |
|---|---|---|---|---|---|
| Mental Health: Acute Average Length of Stay: Number | **<30 Days** | **48** |  | **Bed optimisation project underway to look at alternatives to admission, productive stay and productive discharge. Median Length of stay was 26 days. As an outlier, one client was discharged after 707 days (excluding leave).** | **Delayed transfers of care and a lack of onward accommodation have impacted on this metric. In the 2017/18 NHS Benchmarking Exercise the Trust was above the national mean of 31.3 days with an average length of stay of 38 days.** |
| Mental Health Acute Length of Stay Snapshot | **<30 Days** | **49** |  | **This is a decrease on the preceding month and reflects the acuity of clients and number of delayed transfers of care and decrease in long stayers.** | |

| KPI | Target | Oct-18 | Trend | Context/Reasons | Commentary of Trend |
|---|---|---|---|---|---|
| Mental Health Acute Occupancy rate (excluding Home Leave - by Ward / Locality) | < 90% | 98% |  | All localities are above target. New bed management process including gatekeeping of clients introduced, but significant pressures remain. | Increase in the number of patients admitted whilst detained under the Mental Health Act. For 2016/17 there was a 41% increase in detained patients in comparison with 2015/16. In 2017/18 it shows a further 20% increase. There has been a cumulative increase of 70% of our admitted clients being detained under the Mental Health Act since 2015/16. The 2018/19 data shows further increases. |
| Community Health Services Occupancy Rate | < 80% | 75% |  | In October 2018, Wokingham and West Berkshire Community Hospital were below target. 10 beds on Highclere ward are proposed to be 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 | Oct-18 | Trend | Context/Reasons | Commentary of Trend |
|---|---|---|---|---|---|
| Health Visiting: New Birth Visits Within 14 days | **95%** | **90.8%** |  | **Of those not seen in October the reasons were; 27% due to staff capacity, 25% were still in hospital, 17% declined appointment, 15% were due to no access for the visit, 6% no response from family and 4% were due to late notification.** | **The Trust is above the 87.7% England average in 2017/18, which is the latest data available from Public Health England on New Birth Visits, published on 24th October 2018.** |
| Mental Health Clustering | **95%** | **82%** |  | **There are frequent reviews required for certain clusters which mean that it is a challenging target to achieve.** | **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 4.66% in September 2018 to 4.87% in October 2018.
- Mental Health Readmission rates have improved from 6.2% in September 2018 to 4.9% in October 2018.
- Mental Health Acute Average Length of Stay has worsened from 45 days in September 2018 to 48 in October 2018.
- Mental Health Acute Snapshot Length of Stay has improved from 56 days in September 2018 to 49 days in October 2018.
- Mental Health Acute occupancy remains at 98% in October 2018.
- Mental Health Non-Acute occupancy improved from 80% in September 2018 to 69% in October 2018.
- New Birth Visits within 14 days has worsened from 94% in September 2018 to 91% in October 2018.
- Mental Health Clustering worsened from 84.6% compliance in September 2018 to 82.2% compliance in October 2018.
- Prospect Park Place of Safety improved from 41 uses in September 2018 to 40 uses in October 2018.

## Contractual Performance Commentary

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

| Commissioner | Contract | Total Contract Value | Sub-Contract | Sub-Contract Element | Risk | Commentary |
|---|---|---|---|---|---|---|
| CCG | Main Block Contract | £187.4m | Overall | | | All Long stop issues are on track .We have asked for an updated on MSK beyond Sept 18. We have flagged with commissioners pressure in CHS – Heart Failure, Falls, MH – CAMHS , ASD/ADHD, IPS ongoing funding. |
| NHSE | Main Block Contract | £6.95m | Overall | | | Content of CV for 18/19 agreed |
| | | | CAMHS T4 | £2,290k | | Agreement has been given to restore original funding for 17/18 and 18/19 with a view to new contract negotiations for 19/20 along with plans to move to PPH 12 bed unit. Meeting took place on 9th July , NHSE will work with BHFT to fully utilise the beds within the current building constraints. Positive support for STP bid for Unit at PPH. NHSE modify offer – incorrect positioning of CQUIN in heads Circa £53K. Agreed and accepted by BHFT. |
| | | | HIV Drugs | £2,934k | | Pass through costs |
| Reading BC | Public Health Nursing 0-19 Service | £3.2m | Overall | | | Reading Borough Council are looking for significant reduction in contract value and discussions are underway. BHFT cannot meet their ultimate goal and deliver a sustainable and safe service . |
| NHSE | Dental | £2.75m | Overall | | | Contract signed. NHSE to ask Trust to consider a contract extension for up to 2 years. Support in principle subject to funding. |
| | | | General Anaesthetic | £588k | | Contract expires 31st March 2019 |
| | | | Special Care | £1,865k | | Contract expires 31st March 2019 |
| | | | Access Centres | £294k | | Contract expires 31st March 2019 |
| Berkshire CCGs | AQP | Variable | Podiatry | | | Contract with CCG for signing |
| East Berks CCG | AQP | Variable | Audiology | | | The Trust is unable to reconcile its costs with the available income from a revised tariff and pathway , discussions underway with CCG |
| RBH | Inter Provider Contract | £2,087k | Overall | | | |
| Frimley | Inter Provider Contract | £323k | Overall | | | |

Berkshire Healthcare
NHS Foundation Trust

# Trust Board Paper – public

| | |
|---|---|
| **Board Meeting Date** | 11th December 2018 |
| **Title** | **Board vision metrics performance update** |
| **Purpose** | To update the Board on performance against our agreed vision metrics |
| **Business Area** | Trust-wide Performance |
| **Author** | Alex Gild – 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** | This paper updates the Board on performance against Trust vision metrics YTD to end October 2018.<br><br>Benchmarking and Trust performance shows we have improved in the following areas:<br><br>• Mental Health Patient on Patient Physical Assaults from 51st to 19th out of 55 English Mental Health Trusts for 2017/18.<br>• Mental Health Patient on Staff Assaults from 44th to 24th out of 55 English Mental Health Trusts.<br>• Stable benchmark positon on Mental Health Use of Restraint moving from 19th to 20th out of 55 English Mental Health Trusts for 2017/18, and with significant improvement from reduction in use of restraint noted in trend at the Trust.<br>• Latest National Confidential Inquiry data on suicide rates per 10,000 in mental health services (4.3 from 7, below 8.2 target).<br>• Staff engagement score: Trust maintained the second highest scoring in cohort of 32 |

| | |
|---|---|
| | combined trusts.<br>• During May to July 2018 the Trust was inspected and maintained its “Good” overall CQC rating from last comprehensive inspection in 2015, and achieved an “Outstanding” rating for the well led domain.<br>• Stakeholder survey completed with very positive responses. Indicator changed to green whilst target agreed.<br>• Patient Friends and Family Test Response Rate above the 15% target at 15.19% from 13.10%.<br><br>Deteriorating performance or exception notes as follows:<br><br>• Mental health inpatient death from self-harm occurring on Bluebell ward in October 2018.<br>• Falls due to lapse in care appear to be trending higher than 2017/18, although very low numbers.<br>• Acquired pressure ulcers continue to feature in line with last year’s trend. |
| **ACTION** | The Board is asked to note current performance against the vision metrics. |

# Board Vision Metrics: Performance Update to end October 2018

## Supporting Delivery of the Trust's Vision

## Trust Board – Public Meeting

Alex Gild, Chief Financial Officer
11th December 2018

*BHFT staff only*

## *Purpose*

Update the Trust Board on Vision Metrics.

## *Document* control

| *Version* | *Date* | *Author* | *Comments* |
|---|---|---|---|
| 0.1 | 29/11/2018 | I Hayward & C Magee | |
| 1.0 | 29/11/2018 | I Hayward & C Magee | Updates from I Hayward |
| 1.1 | 29/11/2018 | I Hayward & C Magee | Updates from I Hayward |
| 1.2 | 03/12/2018 | I Hayward & C Magee | Updates from A Gild |

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

## *Distribution*

Trust Board

## *Document references*

| *Document title* | *Date* | *Published by* |
|---|---|---|
| | | |

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# 1. Introduction

## Background

1.1. Our vision is:

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

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

- Quality
- Safety
- Engagement
- Regulatory Compliance

1.3. These sections cover the key indicators to assure the Trust on its progress towards the vision.

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

1.5. The national benchmarking network has expanded participants in the Mental Health project to include providers from Wales, Northern Ireland, the Channel Islands and Scotland. The data here shows the rankings against the 55 English Mental Health providers and the 32 Combined Mental Health and Community Trust respondents, now updated for 2017/18 benchmarks. Indicator performance has been updated to the latest available.

# 2. Rationale for Metric Inclusion

## Sections

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

## Quality

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

2.3. A long-term stretch performance measure is maintained in the dashboard to achieve top 3 ranking of all Mental Health service providers in the national benchmarking cohort, however, where data is available we have shown how we compare to the combined community and mental health trust cohort in the descriptions below. The 2017/18 benchmarking results have been updated to the dashboard as follows:

- **Mental Health Patient on Patient Physical Assaults** – The benchmark position target shown here is a long-term stretch target. The Trust was below the mean for 2017/18 but above the median per 100,000 occupied bed days excluding leave and is ranked 19th out of 55 English Mental Health respondents. The Trust ranks 11th out of 32 combined Mental Health & Community Health Trust respondents. This is an improvement in our performance from our 2016/17 position, where the Trust was ranked 51st out of 55 Mental Health trusts and 28th out of 32 combined Mental Health and Community Health Trusts.

- **Mental Health Patient on Staff Assaults** – The benchmark position target shown here is a long-term stretch target. The Trust was below the mean for 2017/18 and is in the upper quartile per 100,000 occupied bed days, excluding leave. The Trust is ranked 24th out of 55 English Mental Health benchmarking respondents. The Trust ranks 15th out of 32 combined Mental Health & Community Trust respondents. This is an improvement in our performance from our 2016/17 position, where the Trust was ranked 44th out of 55 Mental Health trusts and 23rd out of 32 combined Mental Health and Community Health Trusts. Absolute and benchmark improvement in this area is a driver metric (seeking "breakthrough" improvement) within our Quality Improvement (QI) programme.

- **Mental Health Use of Restraint** – The benchmark position target shown here is a long-term stretch target. The Trust was below the mean for 2017/18 and the Trust is ranked 20th out of 55 English benchmarking respondents, which shows a slight worsening in our position by 1 place from 19th in 2016/17. The Trust ranks 12th out of 32 combined Mental Health & Community respondents and this was an improvement from 13th in 2016/17. Absolute and benchmark improvement in this area is a driver metric (seeking "breakthrough" improvement) within our QI programme. Encouragingly with improvement focus the Trust is seeing numbers of restraint use falling significantly.

## Safety

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

- **Falls –** where the fall results in significant harm due to a lapse in care. The process for identifying where falls with significant harm have been the result of a lapse in care was developed and approved by the Safety Experience and Clinical Effectiveness Group in April 2017. In the financial year 2017/18, 2 relevant incidents occurred in the year, and there have been 2 incidents so far in 2018/19. Reduction in falling is a focus for a QI programme breakthrough objective.

- **Mental Health Inpatient Deaths as a consequence of self-harm –** the metric has been updated to zero mental health inpatient deaths resulting from self-harm within a 12-month period. The last incident of an inpatient death from self-harm in the year to date was in October 2018 on Bluebell ward. The metric requires further consideration to confirm inclusion and definition of inpatient deaths from lapse in care, and whether this covers patients who were expected to be on a ward at the time of death. Reduction of all self-harm is a QI programme driver objective.

- **Mental Health Bed occupancy** – for mental health acute beds. The figure shown here were occupancy rates in May 2018 and shows 95% against a target of 85%. This has worsened in October 2018 at 98%.

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

- **Pressure Ulcers -** Reduction in the level of developed category 3 and 4 pressure ulcers due to lapse in care in our community health services. The cumulative total is 18 incidents in the period 1st April 2017 to 31st March 2018, and we have reported 9 so far in 2018/19. Pressure ulcers are an improvement focus under the QI programme's Harm Free Care domain.

- **Suicide Rate -** By 2020/21, the Five Year Forward View for Mental Health set the ambition that the number of people taking their own lives will be reduced by 10% nationally compared to 2015/16 levels. The Trust's suicide rate reduced to 4.3 per 10,000 under mental health care in 2017/18. This local target was based on a 10% reduction on the 2015/16 suicide level of 9.2 per 10,000 people under mental health care. The next update will be in Quarter 4 2019/20. Our zero-suicide initiative and QI programme self-harm focus provide complementary improvement activity in this critical safety area.

## Engagement

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

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

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

- **Patient Friends and Family Test Response Rate –** 15.19% in October 2018 against the target of 15% is an improvement from May 2018 (13.10%). This is a QI driver metric.

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

### Regulatory Compliance

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

- **Care Quality Commission Rating –** overall "Good" rating maintained in summer 2018 core service and well led inspections (last comprehensive inspection was in December 2015). The Trust was rated "Outstanding" for the well led domain.

- **NHSI Segmentation -** maintained segment 1 of the Single Oversight Framework in latest assessment. Highest autonomy, with no NHSI support required. Also maintaining NHSI Use of Resources rating of 1 (lowest financial risk rating available on scale of 1 to 4).

- **Number of CQC Compliance Actions –** there are four compliance actions; 1 for Willow House, which forms part of our core services and 3 for WestCall which does not form part of our core services. Review of these compliances issues are subject to the outcome of the current CQC core services inspection.

## 3. Quality Improvement (QI) Programme: supporting delivery of our vision

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

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

3.3. The QI programme consists of four work streams:

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

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

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

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

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

3.5. True North:

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

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

3.5.3. To improve the patient experience, evidenced by an increase in the number of returned Friends and Family Tests and improve results

3.5.4. To support financial sustainability across the organisation, by improving net surplus performance.

3.6. As the QI programme develops during 2018/19, the underpinning driver and tracker metrics aggregating to the performance view of True North delivery will be integrated into the Trust Board's summary performance reporting from beginning of 2019/20, supported by review at Finance Investment and Performance (FIP) committee and Finance Performance and Risk Executive (FPR).

It is not surprising that a number of our QI / True North metrics align with the Trust's vison metrics in Appendix 1, given True North's purpose is to align quality improvement activity to delivery of our vision.

## Appendix 1 – Board Vision Metrics

# Trust Board Vision Metrics

As at: October 2018

| | | Quality | | | Safety | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Target | | Mental Health Patient on Patient Assaults<br>Top 3 | Mental Health Patient on Staff Assaults<br>Top 3 | Mental Health Use of Restraint<br>Top 3 | Falls Due to Lapse in Care<br>0 | Mental Health Inpatient Deaths from Self Harm<br>0 | Mental Health Bed Occupancy<br>85% | Never Events<br>0 | Pressure Ulcers<br>Better than Last Year | Suicide Rate per 10,000 under Mental Health care<br>10% Reduction Target 8.2 |
| | Performance trend since last report (May 2018) | ↑ | ↑ | ↓ | ↓ | ↓ | ↓ | ↔ | ↔ | ↑ |
| Actual | All English NHS Mental Health Providers (out of 55) | 19th | 24th | 20th | 2 | 1 | 98% | 0 | 9 | 4.3 |
| | Joint English Mental Health and Community Trusts (out of 32) | 11th | 15th | 12th | | | | | | |
| | Map to True North goals/metrics (draft) | Harm-free care, Watch metric | Supporting our staff, Drive metric | Harm-free care, Watch metric | Harm-free care, Drive metric | Harm-free care | Money Matters, Watch metric | Harm-free care | Harm-free care, Watch metric | Harm-free care, Drive metric |

| | | Engagement | | | Regulatory Compliance | | |
|---|---|---|---|---|---|---|---|
| Target | | CCG Net Investment<br>Green | CCG Satisfaction Survey<br>To be defined | Patient FFT Response Rate<br>15% | Staff Survey Engagement Rating (out of 32)<br>3rd | CQC Rating<br>Outstanding | CQC Compliance Actions<br>0 | NHSi<br>Segment 1 |
| | | ↔ | - | ↑ | ↑ | ↔ | ↑ | ↔ |
| Actual | | ✓ | ✓ | 15.19% | 2nd | Good | 4 | ✓ |
| | | - | - | Patient Experience, Drive Metric | Supporting our staff, Drive Metric | - | - | |