Berkshire Healthcare
NHS Foundation Trust

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

TRUST BOARD MEETING HELD IN PUBLIC

10:00am on Tuesday 09 April 2019
Boardroom, Fitzwilliam House,
Skimped Hill Lane, Bracknell, RG12 1BQ

AGENDA

No	Item	Presenter	Enc.
	OPENING BUSINESS		
1.	Chairman's Welcome	Martin Earwicker, Chair	Verbal
2.	Apologies	Martin Earwicker, Chair	Verbal
3.	Declaration of Any Other Business	Martin Earwicker, Chair	Verbal
4.	Declarations of Interest i. Amendments to the Register ii. Agenda Items	Martin Earwicker, Chair	Verbal
5.1	Minutes of Meeting held on 12 February 2019	Martin Earwicker, Chair	Enc.
5.2	Action Log and Matters Arising	Martin Earwicker, Chair	Enc.
	QUALITY		
6.0	Board Visit Report – West Berkshire Community Nursing Team	Debbie Fulton, Acting Director of Nursing and Governance	Enc.
6.1	Quality Assurance Committee a) Minutes of the meeting held on 19 February 2019 b) Learning from Deaths Quarterly Report c) Guardians of Safe Working Quarterly Report	Ruth Lysons, Chair of the Quality Assurance Committee Dr Minoo Irani, Medical Director	Enc.
6.2	Quality Impact Assessment Annual Report	Debbie Fulton, Acting Director of Nursing and Governance	Enc.
7.0	Executive Report	Julian Emms, Chief Executive	Enc.
7.1	Gender Pay Gap Report	Bev Searle, Director of Strategy and Corporate Affairs	Enc.
	PERFORMANCE		
8.0	Month 11 2018/19 Finance Report*	Alex Gild, Chief Financial Officer	Enc.
8.1	Financial Plan 2019-20 Report*	Alex Gild, Chief Financial Officer	Enc.
8.2	Month 11 2018/19 Performance Report*	Alex Gild, Chief Financial Officer	Enc.

No	Item	Presenter	Enc.
8.3	Board Vision Metrics Report	Alex Gild, Chief Financial Officer	Enc.
8.4	Finance, Investment & Performance Committee meeting on 22 February 2019 and 26 March 2019 * *These Reports were reviewed by the Finance, Investment and Performance Committee*	Naomi Coxwell, Chair of the Finance, Investment & Performance Committee	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 – 14 May 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 12 February 2019

Boardroom, Fitzwilliam House

Present:	Martin Earwicker	Chair
	Naomi Coxwell	Non-Executive Director
	Mark Day	Non-Executive Director
	Julian Emms	Chief Executive *(present from 10.10)*
	Chris Fisher	Non-Executive Director
	Alex Gild	Chief Financial Officer
	Dr Minoo Irani	Medical Director
	Ruth Lysons	Non-Executive Director
	Debbie Fulton	Acting 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

19/001	**Welcome** (agenda item 1)
	Martin Earwicker, Chair welcomed everyone to the meeting, including the observers: Cath Darby, Lead for Community Cardiac and Respiratory Specialist Service, Ian Greggor, Director of Estates and Susana Carvalho, Public Governor.
19/002	**Apologies** (agenda item 2)
	Apologies were received from: David Buckle, Non-Executive Director Apologies for lateness: Julian Emms, Chief Executive
19/003	**Declaration of Any Other Business** (agenda item 3)
	There was no other business declared.
19/004	**Declarations of Interest** (agenda item 4)
	i. Amendments to Register – none

	ii. **Agenda Items** – none
19/005	**Minutes of the previous meeting – 11 December 2018** (agenda item 5.1)
	The Minutes of the Trust Board meeting held in public on Tuesday 11 December 2018 were approved as a correct record of the meeting.
19/006	**Action Log and Matters Arising** (agenda item 5.2)
	The schedule of actions had been circulated. The following actions were discussed further: **a) West Berkshire Hospital Community Beds** Ruth Lysons, Non-Executive Director asked whether the ten general beds at West Berkshire Community Hospital were now permanently closed. The Chief Operating Officer confirmed that the Commissioners had agreed that the beds would be permanently closed. The Commissioners had agreed to use the money saved to pay for six additional Therapy posts. Ms Lysons asked whether it would be possible to recruit to the new Therapy posts. The Director of Corporate Affairs said that it was easier to recruit suitably qualified Therapy staff than Registered Nurses. **b) Peer Mentors** Mehmuda Mian, Non-Executive Director asked about the next steps for the Peer Mentor Programme. The Acting Director of Nursing and Governance said that the next step was to roll out the Peer Mentor Programme across all wards. Chris Fisher, Non-Executive Director asked whether Peer Mentors were service users. The Acting Director of Nursing and Governance confirmed that the Peer Mentors were service users who had been fully discharged from the Trust's services. Mark Day, Non-Executive Director suggested extending the evaluation of the Peer Mentor Programme to cover the impact on the Peer Mentors themselves, in addition to Programme's impact on patients, **Action: Acting Director of Nursing and Governance** **The Trust Board**: noted the schedule of actions.
19/007	**Service User Story Video – A Criminal Justice Liaison and Diversion Service Story** (agenda item 6.0)
	The Acting Director of Nursing and Governance played a video which concerned a young man who was known to the Criminal Justice system and his mother. The story highlighted how the Trust's Criminal Justice Liaison and Diversion Service addressed the young man's substance abuse and mental health needs as well as providing mental health and practical support to his mother. This included referring her to

	the Talking Therapies Service and helping her to access benefits. Both the young man and his mother were highly complimentary about the support they had received from the Trust which had resulted in the young man turning his life around and finding employment. Naomi Coxwell, Non-Executive Director asked about the interface between the Trust's Criminal Justice Liaison and Diversion Service and the Voluntary Sector. The Chief Executive said Voluntary Services, such as NACRO provided support to people in the Criminal Justice System, but the Trust's expertise was around supporting people with mental health issues. The Acting Director of Nursing and Governance said that the service was able to tap into other non-Trust services, including the Voluntary Sector, depending on the needs of the individual. The Chair asked whether as a local health system there was more to do to support people with long term mental health needs by signposting them to the services that were available to them. The Acting Director of Nursing and Governance reported that signposting to other sources of support was one of the key roles of the Community Mental Health Teams. The Chief Executive pointed out that the services were not consistently replicated across Berkshire, and in particular, funding for Substance Misuse Services had been cut over recent years. The Chair thanked the Acting Director of Nursing and Governance for sharing the Service User's Story.
19/008	**Patient Experience Report Quarter 3 Report** (agenda item 6.1)
	The Acting Director of Nursing and Governance presented the paper and highlighted the following points: • In Quarter 3, the Trust received 57 formal complaints; • Care and treatment and attitude of staff continued to be the top reasons for complaints; • The formal complaint response rate, including those within a timescale re-negotiated with complainants was 100% for the Quarter which continued to be exceptional performance; • In December 2018, the Trust's Friends and Family Test response rate was 18%. For Quarter 3, the combined Mental and Physical Health Friends and Family Test scores demonstrated an overall positive Trust score of 95%. • Collection of ethnicity data associated with complaints commenced last Quarter and has risen from 48% in Quarter 2 to 80% in Quarter 3. The Chair referred to page 37 of the agenda pack and commented that it was impressive that 100% of Sorrel Ward patients said that they would recommend the service to friends and family. The Chief Executive said that the Trust was hoping to develop a more meaningful patient experience indicator than the Friends and Family Test.

	Naomi Coxwell, Non-Executive Director asked for more information about the complaint process. The Acting Director of Nursing and Governance explained that all complaints were acknowledged within three days of receipt and were reviewed straightaway to see whether they needed to be escalated as Serious Incidents. It was noted that the relevant Clinical Director approved the complaint response letters which were then referred to the Chief Executive for final review and sign off. The Medical Director reported that if there were complaints relating to Doctors, the complaint would be forwarded to him for review. The Medical Director also reported that the Mortality Review Group looked at complaints as part of their work. Ruth Lysons, Non-Executive Director pointed out that the number of complaints relating to the WestCall Out of Hours GP Service had increased. The Chief Executive pointed out that there were no significant emerging clinical concerns in relation to the quality of care delivered by the WestCall service and that in the main, the complaints related to wait times, disputes about clinical care and the attitude of staff. It was noted that not all complaints were upheld. Ms Lysons asked whether the Trust picked up issues raised via the NHS Choices website. The Acting Director of Nursing and Governance confirmed that all feedback received via NHS Choices was referred to the relevant service and was escalated as appropriate. Chris Fisher, Non-Executive Director pointed out that one of the key reasons why the Board reviewed complaints was to identify trends and said that it would be helpful if either the Quarterly Reports or the Annual Complaints Report included some narrative which explained the reasons behind any trends, together with the actions that were being taken to address the issues. **Action: Acting Director of Nursing and Governance** The Chief Executive said that the three services which were receiving the highest number of complaints were: CAMHs waiting times; WestCall and the Crisis Services. The Chief Executive pointed out that the NHS Ten Year Plan pledged additional resources to address these issues, but it would take a number of years before there were any significant improvements in provision. **The Trust Board:** noted the report.
19/009	**Annual Community Health Survey Report** (agenda item 6.2)
	The Acting Director of Nursing and Governance presented the paper and highlighted the following points: • The response rate to the survey had increased this year to 33% from 29% in 2017 and compared favourably to the national response rate of 28%; • Regional comparison demonstrated that for all areas, the Trust was rated as about the same as others (there were no areas where the Trust scored either “much better” or “much worse” than other organisations); • The areas identified for further focus to achieve improvements were: ensuring that patients know who to contact if they had a concern about the their care; minimising the impact on patients experiencing a change in their Healthcare Worker; not being

	seen often enough by services to meet their needs; and support and wellbeing in relation to work, access to benefits and physical healthcare. The Chair commented that it was disappointing that the Trust's scores were about the same as for other organisations. The Acting Director of Nursing and Governance pointed out that a relatively small number of people completed the survey. Chris Fisher, Non-Executive Director referred to appendix 3 of the report and pointed out that the 2gether NHS Foundation Trust's scores were more positive than the Trust and suggested contacting the 2gether Trust to find out whether there was any learning. **Action: Acting Director of Nursing and Governance** Ruth Lysons, Non-Executive Director asked whether it was concerning that a number of respondents did not know who to contact if they had a concern about their care. The Acting Director of Nursing and Governance said that the Trust's work around safety planning aimed at helping patients to understand who to contact if there was a problem and that the survey had highlighted that more effective means of communication were required. The Chief Executive pointed out that the Trust's Internal Auditors had reviewed the safety planning process and had identified an improvement. It was also noted that in the last Inspection, the Care Quality Commission had identified a high level of compliance with safety planning. **The Trust Board:** noted the report.
19/010	**Executive Report (**agenda item 7.0)
	The Executive Report had been circulated. The following issues were discussed further: **A) NHS Ten Year Plan** The Chief Executive reported that the King's Fund had published a very good summary of the NHS Ten Year Plan (attached as an Appendix to the Executive report). It was noted that since 2000, there had been seven long term NHS Plans. The Chief Executive said that it was likely that the early years of the implementation plan, which was yet to be published, would focus on Provider Sustainability and that areas such as health prevention would feature in the later years of the plan. The Chief Executive highlighted that the proposed changes to the GP Contract were significant and would change the way Primary Care was delivered. This included Paramedics, Pharmacists, Physiotherapists and Practice Nurses working alongside GPs to meet the Primary Care needs of patients. Mark Day, Non-Executive Director pointed out a potential barrier to the success of using non-GPs would be public perception and that the key to the success of new ways of working in Primary Care would be the quality of triage system. The Chief Executive said that some of the larger GP Practices in Berkshire deployed a GP to triage calls and ensure that patients were seen by the most appropriate health care

	professional and that this system was working well. **The Trust Board:** noted the report.
19/011	**Month 09 2018-19 Finance Report** (agenda item 8.1)

	The Chief Financial Officer presented the paper and highlighted the following points:
	
	• The Trust was tracking in line with the Financial Plan. The Trust had broken even pre-Provider Sustainability Funding and was £0.3m below Plan.
	• Year to date, the surplus remained at £1.2m, £1.2m ahead of the Control Total. After accounting for Provider Sustainability Funding and donations, the Trust's statutory surplus was £3.3m.
	• The Trust had reviewed the forecast and were holding it at a £1.5m surplus, pre-Provider Sustainability Funding and donations. This required the surplus position to improve by £0.3m over the remainder of the financial year.
	• Pay costs were in line with last month and were in line with the Plan.
	• Capital spend was £0.8m below plan and cash was £0.4m below the anticipated level.
	• Berkshire West Integrated Care System was forecasting missing the System Control Total which would put £0.1m of Provider Sustainability Funding at risk. Frimley Health and Care Integrated Care System was forecasting Control total delivery, although this now included an agreed £600k "offset" against the Trust's forecast.
	
	The Chair commented that the Trust had under delivered in relation to the Cost Improvement Programme. The Chief Financial Officer pointed out that the Cost Improvement Programme performance was in line with the revised financial forecast.
	
	The Trust Board noted: the following financial summary of the financial performance and results for Month 9 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: £1.6m surplus
	• Actual: £2.8m surplus
	• Variance: £1.2m better than plan
	
	Year to Date Cash: £24.1m (Plan £24.5m)
	
	Year to Date Capital Expenditure: £7.1m versus plan of £8.0m.

19/012	**Month 9 2018-19 Performance Report** (agenda item 8.2)
	The Month 9 2018-19 Performance Summary Scorecard and detailed Trust Performance Report had been circulated. The Chair noted that the incidence of self-harm had reduced. The Chief Financial Officer pointed out that it was important to review performance over the space of a Quarter. Mehmuda Mian, Non-Executive Director referred to page 127 of the agenda pack and asked about the trial of the new falls assessment and care plan on the Community and Older Adult Wards. The Acting Director of Nursing and Governance reported that the trial of the new falls assessment and care plan had only just begun so it was too early to assess its impact. It was noted that the trial was being undertaken in conjunction with the new falls technology system. Chris Fisher, Non-Executive Director referred to the 11 uses of prone restraint and commented that this was disappointing in view of the Trust's Quality Improvement Programme work on reducing the use of prone restraint. The Acting Director of Nursing and Governance explained that the Trust had successfully reduced the use of prone restraints at Prospect Park Hospital, but further work was needed to reduce its use at Willow House. The Acting Director of Nursing and Governance pointed out that the 6 uses of prone restraint at Willow House related to one individual. **The Trust Board**: noted the report.
19/013	**Finance, Investment and Performance Committee Meeting** (agenda item 8.3)
	Naomi Coxwell, Chair of the Finance, Investment and Performance Committee reported that the Trust's financial management was sound and there had been no unexpected fluctuations during the year. Ms Coxwell also reported that the Trust's capital expenditure was much more in line with the Financial Plan than in previous years. It was noted that the number of Out of Area Placements had reduced as a result of the Trust's Bed Optimisation Programme. The Chair thanked Ms Coxwell for her update.
19/014	**Strategy Implementation Plan 2018-19 Update Report** (agenda item 9.1)
	The Strategy Implementation Plan 2018-19 Update Report had been circulated. **The Trust Board**: noted the paper.
19/015	**Equality, Diversity and Inclusion Strategy Update Report** (agenda item 9.2)
	The Director of Corporate Affairs presented the paper and highlighted the following points:

	• The paper summarised progress against the Trust's Equality Strategy objectives; • There was an improving trend in the following areas: the number of BAME staff employed in Agenda for Change Bands 7-8A; improved perceptions about access to career development; and a reduction in the incidence of bullying and harassment. • Further focussed work was required to address stress related sickness in relation to staff with a disability; regaining a place in the Stonewall Workplace Equality Index; engaging effectively with community groups; and improving the Trust's approach to making reasonable adjustments. • The Trust was also working with service users to improve the accessibility of information. The Chair commented that the Trust's performance as an employer in relation to BAME staff had improved, but it was important to recognise that further work was required. The Chair noted that the number of BAME staff employed in Agenda for Change Bands 7-8A had increased, but asked what more could be done to increase the number of BAME staff in Clinical posts. The Chief Executive said that the national Equality and Diversity reporting concerned staff covered by Agenda for Change and pointed out that senior clinical positions filled by Doctors were not were not covered by Agenda for Change and were therefore BAME staff in these positions were not reported. The Director of Corporate Services agreed to include information about BAME staff in senior clinical roles in future reports. **Action: Director of Corporate Affairs** Mehmuda Mian, Non–Executive Director commented that it was clear that the Trust's focussed work around BAME staff was having a positive impact, but pointed out that stress and anxiety related sickness was disproportionately higher amongst disabled staff. Ms Mian asked what the Trust was doing to meet the requirements of disabled staff. The Chief Financial Officer said that the newly formed "Purple Network" for disabled staff was helping the Trust to establish the priority areas for further focussed work. It was noted that disabled staff had recently completed a survey which had provided rich feedback about their experiences of working at the Trust. Ruth Lysons, Non-Executive Director commented that it was disappointing that the Trust had not been successful in regaining a place in the top 100 Stonewall Equality Index and asked whether there was any feedback about the areas which the Trust needed to address. The Director of Corporate Affairs agreed that it was disappointing and reported that the Trust had a meeting with Stonewall to discuss what further actions the Trust could take to improve its ranking in the future. The Director of Corporate Affairs pointed out that although the Trust had made improvements compared with last year, the bar was higher every year. The Chief Executive said that the Stonewall Equality Index was a respected benchmark and provided an opportunity for the Trust to learn from other organisations but pointed out that the ranking was less important than focusing on the things which mattered to the Trust's staff.

	Naomi Coxwell, Non-Executive Director said that it would be helpful if future reports included the percentage of BAME staff in Agenda for Change bands 2-6 in order for the Board to gain an insight into the retention of BAME staff. **Action: Director of Corporate Affairs** **The Trust Board:** noted the paper.
19/016	**Annual Health and Safety Report** (agenda item 10.0)
	The Chief Operating Officer presented the paper and highlighted the following points: • The report reviewed the Trust's performance on a range of health and safety indicators and compared results to the previous year and provided national benchmarking data; • The Trust had received one Enforcement Notice from the Royal Berkshire Fire and Rescue Service following a fire at Prospect Park Hospital. This was then withdrawn later in the year. • There were 14 incidents reported under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) during 2018. As in previous years, these mostly related to slips, trips and falls. • 12 fires were reported during 2018 of which 7 related to Prospect Park Hospital. Six were minor incidents and one required ward evacuation and led to the Enforcement Notice. • During 2018, the Trust had reported 641 physical assaults against staff. • There had been an increase in the number of days lost through sickness (14.6 days per full time equivalent in 2018 compared with 13.5 days per full time equivalent in 2017. Mehmuda Mian, Non-Executive Director referred to the increase in the number of physical assaults relating to the Learning Disability Unit (Campion Unit) and asked whether there were any underlying factors. The Chief Operating Officer reminded the meeting that reducing the number of physical assaults on the Campion Unit was one of the Quality Improvement Programme "break through objectives". As part of the Quality Improvement Programme work, the Campion Unit had reviewed the way staff reported incidents to ensure that there was a consistent approach and this had led to an increase in reporting. The high levels of acuity amongst the patient cohort had also led to an increase in the number of reported physical assaults on staff. The Chief Executive proposed inviting Campion Unit staff to give a presentation to a future Trust Board meeting on their Quality Improvement Programme work on reducing the number of physical assaults on staff. **Action: Chief Operating Officer** Ruth Lysons, Non-Executive Director referred to page 180 of the agenda pack and asked why only 23% of the Lone Worker devices were used within any one month. The Chief Operating Officer reported that Lone Worker devices were one element of Lone Worker Risk Management Policy. Staff conducted risk assessments before conducting home visits and would visit in pairs if necessary. The Chief Executive said that the next wave of Lone Worker devices would be easier to use and that this was likely to increase the take up.

	Naomi Coxwell, Non-Executive Director asked whether the Trust pursued criminal prosecutions following physical assaults on staff. The Chief Operating Officer said that the Trust supported and encouraged staff to take legal action but many staff did not want to pursue a prosecution. The Chief Operating Officer said that the introduction of CCTV cameras would be helpful in providing evidence for future criminal prosecutions. **The Trust Board:** noted the paper.
19/017	**Use of the Trust Seal** (agenda item 10.1)
	It was noted that the Trust's Seal had been affixed to the following documents: • A lease in relation to the Science and Technology Centre, University of Reading, Whiteknights • A deed of variation in relation to Old Forge House Lease, Wokingham **The Trust Board**: noted the paper.
19/018	**Audit Committee Minutes – 30 January 2019** (agenda item 10.2)
	The unconfirmed minutes of the Audit Committee meeting held on 30 January 2019 had been circulated. Chris Fisher, Chair of the Audit Committee reported that in addition to the standard items, the Committee had: • Discussed the Annual Cyber Security Report; • Approved minor changes to the Trust's Standing Financial Instructions; • Approved the critical accounting estimates and judgments for the year end accounts; and • Discussed "deep dive" risk reports on: demand outstripping capacity (Board Assurance Framework Risk) and Ligature and "Near Miss" reporting (both risks on the Corporate Risk Register). The Chair referred to the "Any Other Business" section of the minutes which covered his recent Board Visit to Health Visiting Services. The Chair reported that the metal roof of Southcote Clinic had peeled off and was secured by a tarpaulin. The Chair thanked the Chief Operating Officer for confirming that NHS Property Services (who owned the building) would shortly be repairing the roof. Ruth Lysons, Non-Executive Director referred to page 188 of the agenda pack asked when the Trust Board would receive the paper setting out the various workstreams, actions and timescales in relation to managing the interface between the Crisis Resolution Home Treatment Team and Community Mental Health Team services. The Company Secretary confirmed that the report had been scheduled for the April 2019 Trust Board meeting. **Action: Chief Operating Officer/Company Secretary** The Chair thanked Mr Fisher for his update.

19/020	**Annual Declarations of Interest and Fit and Proper Persons Test Report** (agenda item 10.3)
	The Company Secretary presented the paper and highlighted the following points: • The purpose of the report was to receive the Trust Board members' individual declarations of interest; • The report also set out what steps the Trust had taken to ensure on going compliance with the requirements of the Fit and Proper Persons Test; • In July 2018, Stephen Barclay, MP, former Minister of State for Health commissioned Tom Kark QC to review the operation of the Fit and Proper Persons Test. The outcome of the review was published on 6 February 2019. • The Kark Review had identified a number of issues and had made seven recommendations. The Government had immediately accepted two of the recommendations, namely that all Directors (including Non-Executive Directors) should meet specified standards of competence to sit on NHS Boards and that there should be a centralised database holding relevant information about qualifications and employment history about each Executive and Non-Executive Director. • A summary of the Kark Review together with changes to the Trust's Fit and Proper Person Test Policy in the light of the Kark Review would be presented to the next Public Trust Board meeting. **Action: Company Secretary** The Chair commented that the Kark review included some sensible suggestions, but some of the recommendations would be challenging to implement. The Chief Executive explained that Dr Bill Kirkup in his report into leadership and governance failures at Liverpool Community Health Trust in February 2018 had recommended that the effectiveness of the Fit and Proper Persons Test in preventing unsuitable staff from being redeployed or re-employed into similar positions in NHS be reviewed. **The Trust Board:** a) Noted the Register of Individual Directors' Interests; b) Noted that assurance provided that all Directors (and staff on Very Senior Manager contracts) were and remained Fit and Proper Persons as identified in Regulation 5 of the Health and Social Care Act 2014 and did not meet the grounds of unfitness as specified in Part 1 of Schedule 4 of the Registered Activities Regulations;
19/021	**Annual Trust Board Meeting Planner** (agenda item 10.4)
	The Annual Trust Board Meeting Planner for 2019 had been circulated. The Chair requested that future Planners included the Discursive Board meetings. **Action: Company Secretary**
19/022	**Council of Governors Update** (agenda item 10.5)
	The Chair reported that the Joint Non-Executive Directors and Council of Governors meeting held on 6 February 2019 had included presentations on the NHS Ten Year Plan, the Annual Planning process and the new GP contract.

	The Chair reported that it was disappointing that a number of Governors had not attended the meeting and reported that he would discuss with the Lead Governor about the frequency of meetings and the format and content of the meetings. The Chair reported that Governors had indicated that they would like to be more involved in the Integrated Care System work. The Chair reported that he had raised the issue with his counterparts in the other Trusts. **The Trust Board:** noted the update.
19/023	**Any Other Business** (agenda item 11)
	There was no other business.
19/024	**Date of Next Meeting** (agenda item 12)
	Tuesday, 09 April 2019
19/025	**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 12 February 2018.

Signed……. Date 09 April 2019
(Martin Earwicker, Chair)

Berkshire Healthcare NHS Foundation Trust

AGENDA ITEM 5.2

BOARD OF DIRECTORS MEETING: 09/04/2019

Board Meeting Matters Arising Log – 2019 – 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
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	18/136	Strategy Summary Document 2018-21	The Trust's strategy to be distilled into three or four lines of text which would be discussed at the Board's Annual Strategic Planning Away Day in	May 2020	**BS**	To be considered when the three year strategy is refreshed in May 2020.	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
			October 2018.				
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	**DF**	A 9 month secondment of a part time Accessible Officer commenced on 1st April 2019. The initial focus for this post holder will be improving the offer of reasonable adjustments for our disabled staff. Secondly, the post holder will scope what "good" looks like and will identifying any gaps regarding the accessible information standard. The main focus will be on patients with visual and hearing loss and the	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
						aim is at the end of the 9 month secondment, we will have an action plan with accountability for improving our ability to meet the needs of disabled patients, particularly with hearing and sight loss.	
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 2020	**BS**	To be incorporated into the 3 year Strategy Document refresh in April 2020.	
12.02.19	19/006	Matters Arising – Peer Mentors	The Peer Mentor Programme Evaluation to include the impact on the Peer Mentors as well as the impact of the Programme on patients.	09.07.19	**DF**	This will be provided as part of the next Peer Mentor Programme evaluation update to the July 2019 Trust Board	
12.02.19	19/009	Patient Experience Report	The Acting Director of Nursing and Governance to consider adding some narrative in either the quarterly or the Annual Report to explain the reasons behind any complaints themes together with a summary of any actions being	09.07.19	**DF**	This will be included in the Annual Complaints Report reported to the Trust Board in July 2019.	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
			taken to address the issues.				
12.02.19	19/010	Annual Community Health Survey	The 2gether Trust to be contacted to see if there was any learning in respect of their higher scores.	09.04.19	**DF**	Any learning will be identified when available	
12.02.19	19/015	Equality, Diversity and Inclusion Strategy Update Report	Future reports to include information about BAME staff in senior clinical roles.	09.07.19	**BS**	The next update is scheduled for the July Trust Board meeting.	
12.02.19	19/015	Equality, Diversity and Inclusion Strategy Update Report	Future reports to include information about the percentage of BAME staff in agenda for change bands 2-6.	09.07.19	**BS**	The next update is scheduled for the July Trust Board meeting.	
12.02.19	19/016	Health and Safety Annual Report	The Campion Unit to be invited to give a presentation to a future Trust Board meeting on their Quality Improvement Programme work on reducing the number of physical assaults.	TBC	**DT**	The date of the presentation to be confirmed.	
12.02.19	19/018	Audit Committee Minutes	The Trust Board to receive a paper setting out the work around improving the interface between CRHTT and CMHT services.	09.04.19	**DT**	On the agenda for the In Committee meeting.	
12.02.19	19/020	Fit and Proper Persons Test	The Company Secretary to brief the Trust Board on the Kark Review's recommendations following a review of	09.04.19	**JH**	Included as part of the Executive Report.	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
			the Fit and Proper Persons Test.				
12.02.19	19/021	Annual Trust Board Planning	The Annual Trust Board Planner to include Discursive Trust Board meetings.	Jan 2020	**JH**	Future Annual Trust Board Planners will include the Discursive Trust Board meetings.	

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	9 April 2019
Title	**Board Visit Report – West Berkshire Community Nursing Team**
Purpose	To receive the report of the Board Visit undertaken by Naomi Coxwell, Non-Executive Director
Business Area	Corporate
Author	Company Secretary
Relevant Strategic Objectives	To provide good outcomes from treatment and care
CQC Registration/Patient Care Impacts	Providing additional Board level assurance on patient safety and quality of care
Resource Impacts	None
Legal Implications	None
Equalities and Diversity Implications	N/A
SUMMARY	Board members conduct Visits to Trust services and Localities throughout the year and reports are produced which are circulated to all Board members for information. At regular intervals during the year, a Board Visit report is selected for inclusion on the agenda for discussion.
ACTION REQUIRED	To receive and note the report and discuss any matters raised.

BERKSHIRE HEALTHCARE BOARD VISIT TO THE COMMUNITY NURSING TEAM FOR WEST BERKSHIRE BASED AT WEST BERKSHIRE COMMUNITY HOSPITAL

PEOPLE PARTICIPATING

Mandy Hennessy, Integrated Community Services Manager (West)

Helen Daw, Team Leader -Central

Emma Rockall, Joint Care Services Team Manager

Diane Owen, Integrated Community Services Manager (Central)

Tracy Clifton, Clinical Development Leader

Alison Morgan ,PA to Integrated Community Service Manager

INTRODUCTION

Upon my arrival at West Berkshire Community hospital I was met by Mandy Hennessey and asked if I would like to join the team manager meeting taking place that morning. The management team (shown above) meet on a weekly basis to review the joint working

across their activities and areas of operation and welcomed my visit to the community nursing operation.

The team were very open and spoke with real pride about the significant progress that has been made over the past year with a vacancy factor of around 40% that existed 12 months ago reducing to a level that means the teams are now virtually up to quota and has been stabilised to provide a firm foundation upon which the work can be planned and conducted.

A consequence of this significant recruitment activity is that the workforce lacks an element of 'maturity' in terms of experience and as a result there has been, and continues to be, a lot of development work being undertaken to establish the newly formed teams.

It should also be recognised that the teams have undergone a major change programme with the introduction of an integrated service proposition aimed at reducing duplication of effort and demarcation of activity between teams. This cross-skilling of staff has enabled them to undertake a wider range of work when meeting with patients. This has delivered a real performance improvement for the teams with fewer visits needed from the different staff that attend to the patients' needs.

Staff responses to this up-skilling has been positive recognising the patient benefits from the integration of services and roles although time is needed for the integrated services to be fully operational and forming part of an established operation. Examples of how various assessments or routine activities are now available from a wider range of staff necessitating fewer visits appeared impressive and well received by patients.

Another example of this integrated approach is the pilot running in conjunction with West Berkshire Council social services looking at working together more closely to improve hospital discharges. Initiatives like this are directly targeting improved patient experience and reducing duplication of effort and workload across different parts of the care pathway.

INSIGHT INTO OPERATIONS

My visit had been organised to include two different patient visits with Helen Daw and conducted as part of a routine community nursing role. Helen has been with BHFT around a year having joined us from Oxford Healthcare. She has a four day a week contract which suits her as a working mother with young children and works effectively in her opinion for both herself and the Trust.

The first was a patient with diabetes requiring a daily insulin injection which they are unable to personally administer. This visit was in Newbury and Helen was able to access the patients records on RIO remotely and plan accordingly for her visit.

The patient was very complimentary about the support she receives from the community nursing team and Helen's visit extended well beyond just attending to the insulin assessing the patient's general health and wellbeing.

Our next visit was a rural setting in a village 20 minutes drive from the town and illustrated the difficulties encountered with accessing RIO and other systems when the connectivity is disrupted. This inability to access records is apparently quite commonplace and proves to be a regular frustration for the community nursing team. Various work arounds are used to compensate for the lack of access but all of them result in additional work and extra activity for the nurse.

The couple being visited were both requiring Helen's attention. The husband required blood sugar level testing and insulin whilst his wife had sustained an injury following a fall and required a wound assessment and dressing change. The husband was clearly very dependant upon his wife as a carer and Helen was keen to ensure that she was able to fulfil this role despite her fall and that her recovery was progressing well.

Following this second visit we drove to a GP surgery in Thatcham to attend Helen's daily handover team meeting which is held midday as an opportunity for all of the team to share an update on Patients seen and any new issues arising over the past 24 hours. Helen was keen to point out the necessity of these meetings as a chance for the team members to share insights on the patient population and give each other support as they are so geographically spread and lone working.

The meeting was well attended with a range of staff and I could witness the effective sharing of information and good peer support between the team members. As an aside it was interesting for me to meet Felicity Mahmoudi who I first met during my induction several years ago and spent time with her visiting patients around the Lambourn and Hungerford area. At the time Felicity was a District Nurse and has during the interim completed a year long course at Southampton to become a Special Practitioner in District Nursing and has now returned to us and is a great example and advocate for our employment and development practices.

CHALLENGES/FRUSTRATIONS

Recently we introduced a discharge letter which apparently came from NHS England and was to be implemented in a fairly rigid and mandatory manner. The letter would appear to have been designed for a hospital setting and according to some of our staff have benefitted from being customised for our own patients but this proved to be not possible during our implementation and caused some frustrations among the team.

During my visit there was frequent reference made to the need for a dependency tool to be available which could be used for more effective rostering and scheduling of work across the teams. I am aware that a tool is being developed and trialled which should replace the paper based system which currently being used.

The issues of connectivity with our systems for people working remotely was very evident during my visit and frequently mentioned by staff as a source of real frustration for them.

The situation did leave me wondering whether there is a facility for us to better monitor and understand the impact on staff due to this issue rather than just monitor and record up time for systems such as RIO etc. which could prove mis-leading.

CONCLUSIONS

The team I spent time with were recently awarded clinical team of the year by the Trust and they are justly proud of this achievement which they feel reflects the level of teamwork they developed as a group of professionals.

I would like to thank all of the people I met on my visit which was very open and participative with all of the staff displaying a professional and enthusiastic approach to their work and for the patients in their care.

Mark Day

Non Executive Director

2nd January 2019

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	9 April 2019
Title	**Quality Assurance Committee – 19 February 2019**
Purpose	To receive the unconfirmed minutes of the meeting of the Quality Assurance Committee of 19 February 2019
Business Area	Corporate
Author	Julie Hill, Company Secretary for Ruth Lysons, Committee Chair
Relevant Strategic Objectives	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 19 February 2019 are provided for information. Attached to the minutes are the following reports which were discussed at the Quality Assurance Committee meeting and are presented to the Trust Board for information: • Learning from Deaths Quarterly Report • Guardians of Safe Working Hours Quarterly Report
ACTION REQUIRED	The Trust Board is requested to receive the minutes and the quarterly Guardians of Safe Working Hours and Learning from Deaths Reports and to seek any clarification on issues covered.

Berkshire Healthcare
NHS Foundation Trust

Minutes of the Quality Assurance Committee Meeting held on Tuesday, 19 February 2019, Fitzwilliam House, Bracknell

Present:	Ruth Lysons, Non-Executive Director (Chair Mehmuda Mian, Non-Executive Director Julian Emms, Chief Executive Dr Minoo Irani, Medical Director Dr Guy Northover, Lead Clinical Director *(present until 11.10)* Debbie Fulton, Acting Director of Nursing and Governance Amanda Mollett, Head of Clinical Effectiveness and Audit David Townsend, Chief Operating Officer
In attendance:	Julie Hill, Company Secretary Karen Watkins, Programme Manager *(present for item 5.0)* Hayley Clarke, Mental Health Clinical Pathways Co-ordinator *(present for item 5.0)* Bridget Gemal, Head of Psychological Therapies Jagjit Sethi, Clinical Director for East Physical Health Locality *(present for item 6.2)* Sue McLaughlin, Acting Deputy Director of Nursing *(present for item 6.2)*

1 Apologies for absence and welcome

The Chair welcomed everyone to the meeting.

Apologies had been received from: 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 20 November 2019

The minutes of the meeting held on 20 November 2019 were confirmed as an accurate of the proceedings.

4.2 Matters Arising Log

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

Carers
The Chair asked when the Carers Strategy Group would be meeting.

The Chief Operating Officer reported that a date had not yet been set for a Carers Strategy Group meeting as further work was needed to undertake the "A3" problem solving exercise using Quality Improvement methodology.

The Chief Executive reported that the Trust Chair was also interested in the role of Carers and had suggested a full Trust Board discussion. It was agreed that the Executive would discuss whether it would be more appropriate to have a full Board discussion about Carers or whether the issue should be discussed at the Committee.

Action: Chief Executive/Company Secretary

The Committee noted the schedule of actions.

5. Patient Safety and Experience

5.0 Mental Health Pathways Programme Presentation

The Chair welcomed Bridget Gemal, Head of Psychological Therapies, Karen Watkins, Programme Manager and Hayley Clarke, Mental Health Clinical Pathways Co-Ordinator and invited them to give a presentation on the Trust's Mental Health Pathways Programme.

During the presentation, the following key points were made:

- The Mental Health Pathways Programme had been running for a number of years and had now had developed NICE concordant, Commissioner approved Clinical Pathway Specifications;
- There had been continuous multi-disciplinary clinical engagement during the development and implementation phases;
- "Pathways on a Page" had been developed with "supercluster" posters providing "at a glance" guidance;
- Patient leaflets and posters will set out the core offer and clarify expectations from the outset;
- The Trust was the first in the country to have developed ePathways as part of the RiO electronic patient record system. This enabled the reporting of Clinician reported outcome measures (CROMs) and Patient reported outcome measures (PROMs);
- A task and finish group had been established led by two Locality Directors to transition the Mental Health Pathways work to "business as usual".

Mehumda Mian, Non-Executive Director asked about the main benefits of the programme.

Hayley Clarke, Mental Health Pathways Co-Ordinator said that a key benefit was clarity around the patient offer by clearly setting out what the core therapeutic interventions should be based on NICE guidance.

The Chief Executive commented that the development of the new Mental Health Pathways would reduce the "post code lottery" element by providing a consistent approach.

The Head of Psychological Therapies said that it would also help to manage patients' expectations and provide reassurance that they were being offered

the “right” interventions as recommended by NICE. The Head of Psychological Therapies also pointed out that a more consistent approach to the recording of outcome measures via the e-Pathways would help Clinicians to have a better understanding of the effectiveness of the individual therapeutic interventions.

The Chief Executive pointed out that Clinicians had the option of deviating from the standard pathways, but they would have to record their reasons, and this would be subject to peer challenge.

The Chair thanked Bridget Gemal, Karen Watkins and Hayley Clarke for their excellent presentation.

The Committee noted the presentation.

5.1 Electronic Prescribing and Medicine Administration (ePMA) Programme Update Presentation

The Chair invited the Lead Clinical Director to give a presentation on the Electronic Prescribing and Medicine Administration (ePMA) Programme.

The Lead Clinical Director highlighted the following points:

- In 2015, the Trust had implemented a new electronic medication stock management system and automated dispensing system (the robot);
- In 2018, the Trust had fully implemented the electronic Medicine Management (eMM) and ePMA modules interface with the Trust’s electronic patient record system (RiO); to provide a complete end to end working solution;
- The clinical system contained a full record of all medicines prescribed and administered; provided 24/7 access to medicine’s information; direct drug decision support; interactions alert; and audit capabilities;
- Feedback from nursing staff had been very positive;
- ePMA would continue to be rolled out across the Trust, including community health wards and the community outpatient clinic which use the Prospect Park Pharmacy;
- The ePMA Project Board met monthly and included the Chief Pharmacist as the Senior Responsible Officer and the Chief Financial Officer as the Executive Sponsor.

The Medical Director said that the ePMA Programme had been a significant undertaking and had identified and addressed weakness in systems and processes. The Medical Director said that the most important benefit of ePMA was in relation to reducing medication errors.

The Chair asked what steps were taken to mitigate the risk of the right medication being administered to the wrong patient.

The Lead Clinical Director reported that the Trust was currently updating the Patient Identification Policy which would include a photograph of the patient on the RiO system in addition to the existing patient Identification processes.

The Chief Operating Officer reported that the Business and Strategy Group meeting on 18 February 2019 had received a presentation on Cyber Security and commented that the Trust was increasingly reliant upon IT systems and asked about the business continuity plans if the ePMA system went down.

The Lead Clinical Director confirmed that there was a good back up system in place which enabled drug charts to be printed off.

The Chief Operating Officer noted that there were only two suppliers of ePMA systems and asked whether the Trust's contract included access to the system's source codes.

The Lead Clinical Director agreed to find out and inform the Committee.

Action: Lead Clinical Director

The Chair thanked the Lead Clinical Director for an excellent and informative presentation.

The Committee noted the presentation.

5.2 Quality Concerns Status Report

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

The Chair commented that it was encouraging that the staffing situation on Sorrel Ward, Prospect Park Hospital had improved and that the female beds were now open. The Chair asked whether the decision to offer an additional financial premium for staff working on Sorrel Ward had resulted in staff transferring from other wards.

The Acting Director of Nursing and Governance reported that three or four staff had transferred from other wards to work on Sorrel Ward, but this had not destabilised the other wards. The Acting Director of Nursing and Governance reported that the staffing situation overall at Prospect Park Hospital remained challenging and that safe staffing was achieved by moving staff around.

Mehmuda Mian, Non-Executive Director asked whether there was overlap between the role of the matron and the ward manager.

The Acting Director of Nursing and Governance confirmed that the two roles were complimentary with the ward manager having day to day responsibility for a ward and the matrons providing support in particular areas, for example patient experience and safety.

The Chair referred to the Quality Concern in relation to the interface between the Common Point of Entry, Crisis Resolution Home Treatment Team and Community Mental Health Teams and asked when West Regional Director's work around managing the interface would be reported.

The Chief Operating Officer reported that the West Regional Director had recently held a workshop event with the relevant mental health teams and that the outcome of the workshop would inform the Trust's further work to improve the interface between the three services.

The Chief Executive suggested that the wording of the interface Quality Concern should be changed to make it explicit that the concern was around the Trust's internal service interfaces.

Action: Acting Director of Nursing and Governance

The Chair noted that the Quality Concern around the waiting time for the Children's Eating Disorder service had been escalated to the East and West Berkshire Clinical Commissioning Groups and a review of the current model of care and costs was being undertaken.

The Acting Director of Nursing and Governance agreed to report back on the outcome of the Children's Eating Disorders review at the next meeting.

Action: Acting Director of Nursing and Governance

The Chair noted the on-going challenges because of Reading Borough Council's decision to disintegrate the Reading Community Mental Health Team. The Acting Director of Nursing and Governance reported that the West Regional Director and Reading Locality Director were working closely with Reading Borough Council manage the on-going issues.

The Committee noted the report.

5.3 Serious Incidents Report – Quarterly Report

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

- For Quarter 3, there were initially 18 Serious Incidents with none currently downgraded;
- Trends and learning from incidents closed within the Quarter were detailed within the report together with the actions being taken to address any incident themes.

The Chair referred to page 53 of the agenda pack and commented that caseload management and caseload review had featured in more than one Serious Incident this Quarter in relation to Care Co-ordinators leaving the Trust or going on leave and patients not being managed in their absence. The Chair asked for clarification about the number of Serious Incidents where this had been identified as an issue.

Action: Acting Director of Nursing and Governance

The Chair referred page 54 of the agenda pack which highlighted that 8% of staff had reported that they felt that there was a culture of blame in the Trust in the 2018 NHS Staff Survey and asked what the Trust was doing to address these concerns.

The Acting Director of Nursing and Governance reported that changing the perception of a culture of blame was part of the Trust's Zero Suicide Programme.

The Chief Executive said that the Quality Improvement Programme was also about delivering cultural change and that a key focus of Serious Incident investigations was around identifying failures in systems and processes when things went wrong rather than seeking to blame individuals.

The Chief Executive commented that staff attending Inquests were often left feeling that they were blamed when patients had died.

The Committee noted the report.

5.4 Learning from Deaths Quarterly Report

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

- 983 deaths were recorded on the clinical information system (RiO) during Quarter 3 where a patient had been in contact with a Trust service in the year before they died;
- Of the deaths, 95 met the criteria to be reviewed further. All 95 deaths were reviewed by the Executive Mortality Review Group. 41 deaths were closed with no further action; 13 deaths were classified as "Serious Incidents" requiring further investigation; and 41 deaths required further review (using and initial findings review/structured judgement review methodology);
- During Quarter 3, the Mortality Review Group reviewed the findings of 28 initial findings review/structured judgement review reports, of which nine related to patients with a learning disability.
- Of the 28 case reviews, 3 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 investigation process was completed;
- Of the Serious Incidents which were completed in Quarter 3, one lapse of care had been identified in respect of a death that had occurred in Quarter 1. A number of learning points were identified from the reviews and actions arising from the learning points had been completed and monitored through the Mortality Review Group.

The Committee noted the report.

5.5 WestCall Out of Hours Service Care Quality Commission "Must Do" Action Plan

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

- The Westcall Out of Hours Service Inspection was undertaken in July 2018 and had identified five key areas for improvement;
- Whilst most actions identified to address the key areas for improvement were now completed, cultural change was required to ensure that elements such as consistent incident reporting and learning from incidents were sustained and embedded in practice;
- The action plan was monitored by the Clinical Director with responsibility for the service and progress updates were received by the Quality Executive Group and Quality Assurance Committee for assurance on progress.

The Chair commented that the action plan was well documented and that actions were mainly on track. The Chair asked why the introduction of the Matron's Walk Around" as part of infection and control prevention systems and processes was RAG rated as "amber".

The Acting Director of Nursing and Governance explained that the Matron was a new post which had now been recruited to.

The Committee noted the report.

5.6 Care Quality Commission (CQC) "Should Do" Action Plan

The Acting Director of Nursing and Governance presented the paper and reported that following the Trust's last Care Quality Commission inspection of seven core services, the CQC had identified a number of "should do" actions. Action plans had been developed to address the CQC's concerns.

The Committee noted the report.

5.7 Response to Regulation 28 Notice Issued Following the Inquest of Anne Roberts

The Acting Director of Nursing and Governance presented the paper which set out the Trust's response to the Coroner's Section 28 report to prevent future deaths issued to both the Trust and NHS Professionals following the Inquest of Anne Roberts who died from choking at Prospect Park Hospital.

The Chair requested that the Committee be informed of the progress made to address the Coroner's areas of concern.

Action: Acting Director of Nursing and Governance

The Committee noted the report.

5.8 Themes from Board Visit Reports

The Acting Director of Nursing and Governance presented the paper and reported that the three areas identified that featured in more than one service visit report were: car parking, IT and recruitment and retention.

It was noted that some Non-Executive Directors preferred to raise issues from Board visits verbally at Trust Board or Sub-Committee meetings or directly with the Executive and therefore the report did not provide a complete picture.

The Chief Executive pointed out that as part of the Quality Improvement Programme, the Executive Directors were now spending more of their time visiting the frontline rather than undertaking Board visits.

The Chief Executive suggested that it would be helpful to have a discussion about the how the Board gained its "Floor to Board" assurance at a future Trust Board Discursive meeting.

Action: Company Secretary

The Committee noted the report.

5.9 Review of Gosport War Memorial Hospital Report (June 2018)

The Acting Director of Nursing and Governance presented the paper which provided positive assurance that the similar events to those relating to Gosport War Memorial Hospital between 1989 and 2001 were not occurring within the Trust's community in-patient wards and to demonstrate the oversight and scrutiny of all deaths that occurred within the community in-patient wards.

The Chair commented that the Gosport Report had highlighted that the concerns of carers and relatives were not listened to.

The Medical Director reported that the Trust had a range of formal and informal processes to ensure that concerns raised by carers and relatives were addressed and pointed out that reviewing the care provided to a patient who had died, especially in response to complaints, was part of the Serious Incident Investigation and Mortality Review systems and processes.

The Committee noted the report.

5.10 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 Chair reported that the Finance, Investment and Performance Committee (which she was a member) had agreed to support the Trust's recruitment and retention work and therefore proposed that oversight of the Board Assurance Framework risk should be transferred to the Finance, Investment and Performance Committee.

Action: Company Secretary

The Committee noted the report.

5.11 CAMHS Waiting Times Report

The Chief Operating Officer presented the paper and reported that the CAMHS continued to face a number of challenges and was performing well in difficult circumstances.

It was noted that referrals into the service had continued to rise with a 17.4% increase by the end of November 2018.

The Chief Operating Officer reported that the Quality Executive Committee received quarterly waiting times reports and had agreed a number of actions to address the issue, including using Quality Improvement methodology to try and increase productivity and discussions about managing demand with the Commissioners.

Mehmuda Mian, Non-Executive Director pointed out that some parents were waiting a year for their child to receive an autism assessment and asked what support was provided to parents whilst they were on the waiting list.

The Chief Executive said that parents were signposted to sources of support, such as online resources and voluntary groups and pointed out that cuts to local authority funding had reduced the provision of early help and targeted services (Tier 2 CAMHs services).

It was noted that children on the waiting list were contacted to ascertain whether there had been a change in their health to ensure that any patient safety issues were escalated.

The Chief Executive said that the NHS Ten Year Plan had highlighted the need for more investment in CAMHS services but it would be several years before this would reduce waiting lists.

The Chair asked whether CAMHS waiting times should be added to the Quality Concerns.

The Chief Executive said that the Trust's systems and processes ensured that high risk children and young people were seen urgently and therefore the issue was around poor patient experience rather than patient safety. The Acting Director of Nursing and Governance agreed to consider whether CAMHS waiting times should be added as a new Quality Concern.

Action: Acting Director of Nursing and Governance

The Committee noted the report.

5.12 Annual Ligature Audit Report

The Chief Operating Officer presented the paper and reported that the annual Ligature Risk assessments had been completed across all mental health in-patient sites and mitigation plans had been reviewed and updated.

The Chief Operating Officer reported that risk reduction work had continued across community mental health sites and improvements would continue to be delivered through the capital and estates programme.

The Committee noted the progress on the management of ligature risks in mental health services.

Clinical Effectiveness and Outcomes

6.1 Quality Accounts Report 2018-19 Quarter 3 Report

The Head of Clinical Effectiveness and Audit presented the paper and reported that the areas which had been updated from the Quarter 2 report had headers highlighted in green.

It was noted that the Quarter 3 report would shortly be shared with the Governors and with Stakeholders, including Patient Groups and Local Authority Overview and Scrutiny Committees for comment.

The Head of Clinical Effectiveness and Audit reported that NHS Improvement had requested two further relevant additions to the Quality Accounts, both of which had been included in the Quarter 3 report:

- Following the publication of the Gosport War Memorial Hospital Report, a section on the ways in which staff can speak up (including how feedback was given to those who speak up) and how the Trust ensured that staff who do speak up did not suffer any detriment. The section also needed to explain the different ways in which staff can speak up if they had concerns over quality of care, patient safety or bullying and harassment within the Trust; and
- Under the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016, the Quality Accounts to detail a consolidated report on rota gaps and the plan for improvement to reduce those gaps.

The Head of Clinical Effectiveness and Audit invited members of the Committee to forward her any specific comments on the Quarter 3 report. It was noted that because of the timing, an electronic version would be forwarded to the Committee for any final comments prior to its approval by the Trust Board in May 2019.

The Chair referred to page 211 of the agenda pack and suggested that the Chief Executive may like to include a statement about being proud of the professionalism of staff.

The Chief Executive thanked the Chair for her suggestion and confirmed that he was happy to include the statement.

Action: Head of Clinical Effectiveness and Audit

The Chair referred to page 213 of the agenda pack queried whether the section on improving the Friends and Family Test response rate should explain that the Trust had changed the methodology about how it reported the Friends and Family Test and therefore could not compare with last year's performance. The Head of Clinical Effectiveness and Audit agreed to amend the text accordingly.

Action: Head of Clinical Effectiveness and Audit

The Chief Executive commented that it was a challenge to ensure that the Quality Accounts Report met NHS Improvement's requirements and was also accessible and easy to read by a non-clinical audience.

The Chair referred to page 2019 of the report and asked whether it was possible to include an explanation about why on average 9.4% of mental health inpatients experienced a delayed transfer of care.

The Acting Director of Nursing and Governance said that the reason for delayed transfers of care would be different in each case.

Mehmuda Mian, Non-Executive Director referred to the section on service improvements and commented that this was a very informative and readable overview.

Ms Mian highlighted the impressive performance of the West Berkshire Intermediate Care Service which had developed a new pathway which had reduced the waiting list from 11 months to 1 week and suggested that this should be drawn to the attention of the Governors.

Action: Head of Clinical Effectiveness and Audit

The Committee noted the report.

6.2 Clinical Audit Reports

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

a) Prescribing Observatory for Mental Health (POMH) Topic 16b: Rapid Tranquilisation (Re-audit)

The Chair welcomed Sue McLaughlin, Acting Deputy Director of Nursing and thanked her for attending the meeting.

Ms McLaughlin presented the paper and highlighted the following points:

- The re-audit was conduced in March to May 2018. The re-audit followed on from the first audit which was published in July 2017 and was focussed on reviewing practice against standards for administration and monitoring around rapid tranquillisation in the

context of the pharmacological management of acutely-disturbed behaviour in in-patients.

- Since the re-audit, the Trust had improved the rapid tranquillisation process, and this would be taken into account in the next clinical audit;
- The current audit identified three areas for improvement:
    - i) A prompt debrief needed to be completed and recorded on the patient's RiO record within 24 hours;
    - ii) Physical health monitoring and recording in the hour post rapid tranquillisation; and
    - iii) Physical health monitoring for at risk patients at 15-minute observations
- An action plan had been developed and a number of improvements had been made, including a prompt to record the rapid tranquillisation debrief onto the RiO system within 24 hours, a staff training video and mandatory rapid tranquillisation face to face training;
- The Physical Health Lead was now in post at Prospect Park Hospital. Training and been provided to staff and there was now greater clarity around the difference between 15 minute physical heath checks and mental health monitoring.
- Staff had also received training in how to monitor physical health of patients who refused a hands-on physical health check.
- Improvements to the monitoring of the physical health of mental health in-patients were identified in other audits.

The Chief Executive suggested that a brief summary of the improvements made to the physical health monitoring of mental health in-patients be included in the matters arising log of the next meeting. The Medical Director confirmed that this information would be provided by the interim Clinical Director for Inpatient Mental Health Service and Acting Deputy Director of Nursing.

Action: Interim Clinical Director for Inpatient Mental Health Service/Acting Deputy Director of Nursing

The Chair thanked Sue McLaughlin for presenting the Clinical Audit Report.

b) National Diabetes Audit – Care Processes and Treatment Targets Report 1

The Chair welcomed Jagjit Sethi, Clinical Director to the meeting. Ms Sethi presented the report and highlighted the following points:

- The report followed on from the previous 2016-17 National Diabetes Audit results that were reported to the Committee in November 2018. The results presented in November 2018 had been updated to include the newly published data for 2017-18.
- The previous report identified a data quality issue which would affect the 2017-18 results as it was identified that the service had stopped entering manual data on the Diamond system in terms of clinical results since the Pathology electronic system (ICE) was introduced. As of January 2019, the data for all of the required metrics had been entered weekly and directly to the national system which will ensure that the Trust's 2019-20 data was an accurate reflection of the service provided.
- The audit found that all patients with Type 1 Diabetes were generally referred to the service at the point of diagnosis. Type 2 Diabetes patents were predominantly managed by Primary Care and were only

referred to the service when they required additional input and support.

The Chair noted that the audit suggested that the needs of people with Diabetes who were from the most deprived areas were not being addressed and asked what more the Trust could do to engage with this cohort of patients.

Ms Sethi reported that the Trust's Diabetes service provided a lot of educational support to patients to help them manage their Diabetes.

The Chair asked about those patients who for whatever reason did not engage with the service.

The Chief Executive pointed out that the Trust provided a specialist Diabetes service and that responsibility for a shift in population health fell outside of the Trust. The Medical Director reported that the Integrated Care Systems should take a system view of the management of Diabetes.

The Chief Executive suggested that that would be helpful if the Medical Director, the Chief Operating Officer and himself met with the Slough Alliance GPs to discuss working together to improve access from deprived communities to Diabetes services.

Action: Medical Director

Mehmuda Mian, Non-Executive Director referred to page 307 of the agenda pack and asked whether the demise of the non-recurrent funding in 2017 and 2018 in respect of the structured education programme had impacted on the service.

Action: Chief Operating Officer

The Chair thanked Jagjit Sethi, Clinical Director for attending the meeting.

c) Internal Auditors Report – Clinical Audit Process

The Medical Director presented the Internal Auditors' Clinical Audit Assurance Process Report. It was noted that the Internal Auditors had awarded the process as providing "significant assurance" and had only made two "low priority" recommendations. The recommendations related to the need to update the Clinical Audit Policy to include reference to the changes implemented during the roll out of the new process in May 2018 and developing a consistent process across the Clinical Audit Team in relation to documenting progress within the DATIX system.

The Medical Director reported that in view of the "significant assurance" rating from the Internal Auditors, the Trust would not be re-auditing the Clinical Audit Assurance Process in the near future.

The Medical Director paid tribute the work of the Head of Clinical Effectiveness and Audit and her team.

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 during the reporting period (1 November 2018-5 February 2019), there was one exception report totalling an extra 1.5 hours worked over and above the trainee's work schedule. The exception report was upheld and the trainee was offered time off in lieu. The exception report was due to a combination of reduced medical cover on the ward due to sickness and annual leave and two patients becoming acutely physically unwell.

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

The Committee noted the report.

7.2 Quality Executive Committee Minutes

The minutes of the Quality Executive Committee meetings held on: 12 November 2018, 10 December 2018 and 14 January 2019 were noted.

Closing Business

8.1 Standing Item – Horizon Scanning

The Chair suggested the following topics for future meetings:

- The sustainability of CAMHS given the increasing demands; and
- NHS Ten Year Plan

The Chief Executive reported that the changes to the GP model outlined in the NHS Ten Year Plan would be discussed at the March 2019 Trust Board Discursive meeting. The Chief Executive agreed to consider whether other aspects of the NHS Ten Year Plan should be discussed further by the Committee.

Action: Chief Executive

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

8.2. Any Other Business

There was no other business.

8.3. Date of the Next Meeting

21 May 2019 at 10.00

These minutes are an accurate record of the Quality Assurance Committee meeting held on 19 February 2019.

Signed:-_____

Date: - 21 May 2019_____

Berkshire Healthcare NHS Foundation Trust

Quality Assurance Committee Paper

Committee Meeting Date	19 February 2019
Title	**Learning from Deaths Quarter 3 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	983 deaths were recorded on the clinical information system (RiO) during Q3 where a patient had been in contact with a trust service in the year before they died. Of these 95 met the criteria to be reviewed further. All 95 were reviewed by the executive mortality review group and the outcomes were as follows: • 41 were closed with no further action • 13 were classed as Serious Incident Requiring Investigation • 41 required further review (using an initial findings review (IFR)/ Structured Judgement Review (SJR) methodology. During Q3 the mortality review group reviewed the findings of 28 IFR/SJR reports (detailed on p8), of which 9 related to patients with a learning disability (these are cases reviewed in Q3 and will include cases reported in previous quarters). **Lapse in Care** Of the 28 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 Q4/Q1. Of the SI which were completed in Q3 one lapse of care has been identified: The death occurred in Q1 of 2018 A Clinical review and a Serious Incident Investigation suggest that there is a greater than 50% likelihood that problems in care of the patient could have contributed to the patient death. A number of learning points were identified from the review and actions arising from the learning points have been completed and monitored through the trust mortality review group.

	Learning Several themes and areas of learning from a review of the deaths are being implemented, and the Q3 learning builds and supports the learning identified previously. In Q3 we identified a number of new areas for learning, as well as areas we continue to embed which include: Main new area of learning – from physical health: • Management of suspected DVT or Vascular concerns • Pain management • Rationale for admission and clear plan for assessing patients acuity and needs • Recognition and management and escalation of sepsis. • LD: learning has been identified regarding the team processes and the need to ensure there is sufficient information provided within the RIO risk assessment. Specifically around any identified risks and the need for a management plan to minimise/ mitigate these. • Mental capacity and processes when patient does not want to engage with services Bereavement Information The trust has made progress with implementation of the recommendations from the Guidance on working with bereaved families and carers (National Quality Board, July 2018). As of October 2018 the Trust is using the SJR methodology for case notes review across all services.
ACTION REQUIRED	The committee is asked to receive and note the Q3 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 could have potentially 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 (SJR/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 Q3

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

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

Note: These are the last Specialty Teams seen before death as recorded on RiO	October 18	November 18	December 18	Total Q3
Nursing episode	179	148	179	506
Dietetics	48	45	44	137
Community health services medical	31	35	27	93
Old age psychiatry	20	23	18	61
Podiatry	15	14	14	43
Speech and language therapy	11	13	5	29
Adult mental illness	8	5	10	23
Rehabilitation	7	7	8	22
General medicine	7	9	3	19
Cardiology	4	2	9	15
Respiratory medicine	3	2	5	10
Physiotherapy	2	2	3	7
Learning disability	3	2		5
Clinical psychology	1	2	1	4
Genito-urinary medicine	2		2	4
Intermediate care		2	1	3
Community paediatrics		1		1
Geriatric medicine			1	1
Grand total	341	312	330	983

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.

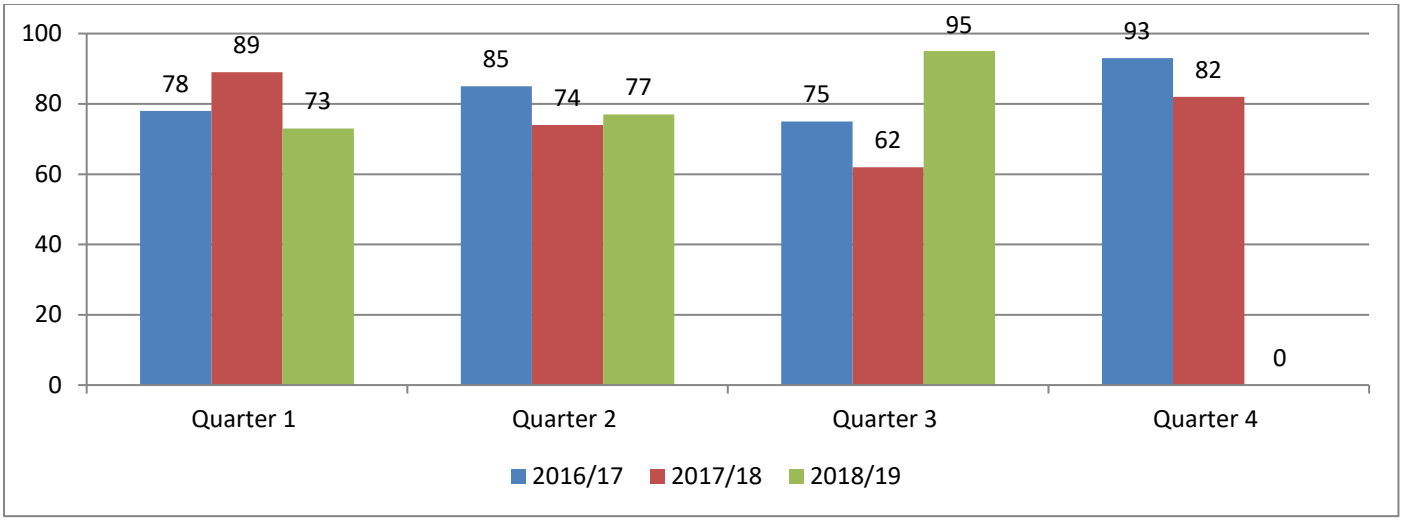
These are the last Specialty Teams seen before death	October 2018 to December 2018				
	A:0-17	B:18-65	C:66-75	D:Over 75	Grand Total
Nursing episode	4	68	92	342	506
Dietetics		28	27	82	137
Community health services medical		8	11	74	93
Old age psychiatry		1	3	57	61
Podiatry		6	8	29	43
Speech and language therapy		2	2	25	29
Adult mental illness		16	1	6	23
Rehabilitation		5	5	12	22
General medicine		6	4	9	19
Cardiology		1	2	12	15
Respiratory medicine		4	2	4	10
Physiotherapy	1		1	5	7
Learning disability		2	1	2	5
Clinical psychology		4			4
Genito-urinary medicine				4	4
Intermediate care			1	2	3
Community paediatrics	1				1
Geriatric medicine				1	1
Grand total	6	151	160	666	983

*** 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 by service which the patient had contact with.

Service	Total
Mental Health Inpatients	3 (Inc 1 post discharge and 1 transfer)
Community Nursing	5
Psychological medicine and liaison	2
Community Dietetics	1
Out of Hours GP	2
Specialist children services and Health Visiting	5
Talking Therapies	2
Criminal justice and liaison service	1
Common Point of Entry	3
Crisis Resolution and Home treatment team	6
Older People's Mental Health	3
Learning Disability	10
Hard to Reach Homeless	1
Community Mental Health	9
Community Hospital Inpatient	42 (13T)
Total Datix	**95**

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 a review (SJR/IFR) report

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

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

Figure 6. Outcome following review at EMRG in Q3

	Number
Datix closed no further action required	41
Classified as a Serious Incident (SI)	14*
Review (SJR/IFR) requested	41
Total	96

*14 SI have been declared in total in Q3 with one from Q2 subsequently declared.

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; 28 reviews have been received as Initial Findings Reports (IFRs) or Infection Control Reviews and considered by the group in Q3.

Figure 8: Reviews Conducted in Q3

	Total Number	**Services**
October	8 new IFRs/SJRs reviewed	West Berkshire Community Hospital -1 case Wokingham Community Hospital – 1 case Court liaison and Divert service – 1 case Common Point of Entry – 1 case Mental Health Inpatients Transfer to Acute – 1 case Crisis Resolution and Home Treatment Team – 1 case Learning Disability Service – 1 case Children's specialist services – 1 case
November	12 new IFRs / SJRs reviewed	Wokingham Community Hospital – 3 case's East Berkshire Psychological Medicine – 1 case Talking Therapies – 1 case Learning Disabilities – 3 cases Crisis Resolution and Home Treatment Team – 1 case Common Point of Entry – 1 case Oakwood Physical Health Ward – 2 cases
December	8 New SJR reviewed	Upton Community Hospital – 1 case West District Nursing - 2 cases Learning Disabilities – 5 cases

Note: these are cases reviewed in Q3 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 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 Q3.

5.2 Potential Lapse in care

Of the 28 IFRS which have been reviewed in Q3 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 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 Q3

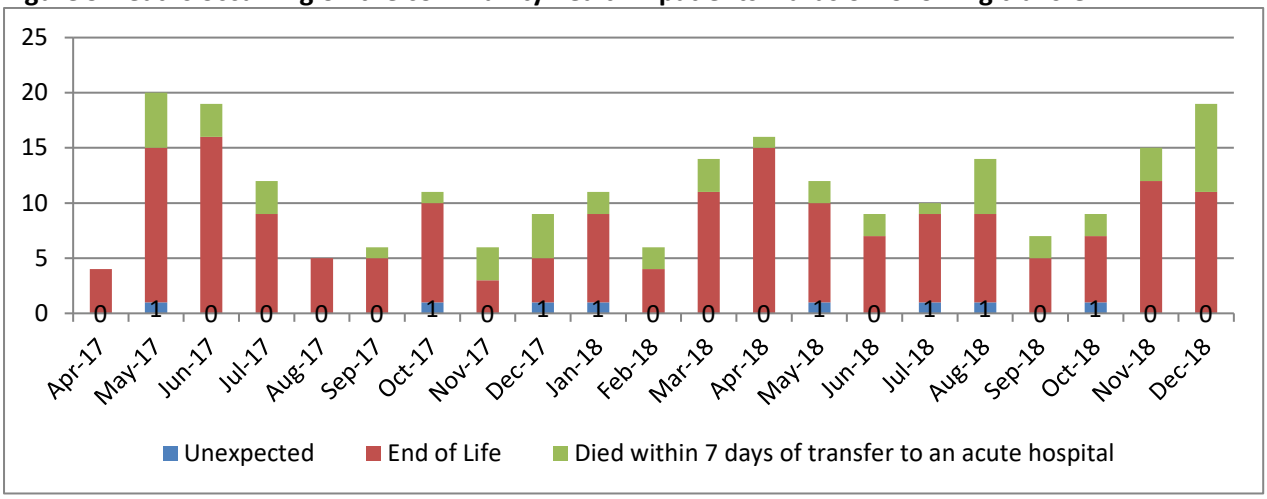
Service (Source Q3 Serious Incident Report)	**Number**
Mental Health Inpatients	1
*Neuropsychology	1
West Berks CMHT	1
WAM CMHT	1
Talking Therapies	1
CRHTT	2
*Transfer from a Community Physical Health Ward	2
Mental Health Ward (Inc 1 transfer and 1 discharge).	3
Community Mental Health services	2
Total	**14**

*escalated for a SI following TMRG review

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 Q3 42 deaths in total were reported by the Community Inpatient Wards, of these 29 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.
13 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, SJR/IFR's have been requested for all 13.

1 death in Q3 was 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
6 deaths were recorded where the child or young person had been in contact with one of our services in the year before their death. Initial reviews have been completed for 4 and closed by EMRG and two reviews are to be completed. All related to neonates or children with complex health conditions under the care of an acute trust.

5.6 Deaths of adults with a learning disability
In Q3 the Trust Mortality Review Group reviewed a total of 9 deaths of adults with learning disabilities who had received services from Berkshire Healthcare in the 12 months prior to their death. Of these 9 people, 4 reviews were undertaken using the IFR process, with the new Structured Judgement Review methodology being used for the other 5 people. All 9 deaths were subsequently reviewed by the LD Clinical Review Group (CRG) prior to being reviewed by the TMRG

Of these 9 deaths there were no identified lapses in care provided by Berkshire Healthcare.

The deaths were attributed to the following causes:

- 4 - Diseases of the Respiratory System
- 2 - Heart and Circulatory System
- 2 - Sepsis
- 1 – Digestive System

Demographics:
Gender:

Female	3
Male	6

Age:
The age at time of death ranged from 32 to 83 years of age (median age: 57yrs)

Severity of Learning Disability:

Mild	4
Moderate	1
Severe	3
Not Known	1

Ethnicity:

White British	8
White Other	1

National Learning Disability Mortality Review Process (LeDeR) Notifications
Notifications have been made to LeDeR for each of the people who died in the quarter.

6. Additional Case Review

It was agreed at the Trust mortality review group that there would be a focus on two areas for additional case note review, community end of life patients and community older peoples mental health. Randomised case note review will be conducted for both in Q1 of 2019/20.

In addition it has been agreed to extend the scope of reporting as of 1st January 2019 to include any unexpected death of a patient open to the Community Nursing service to be reported if:

- the patient had a Category III or IV pressure ulcer
- the patient had suspected sepsis

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 Q3.

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.

We have agreed a bereavement letter to go out for deaths of In-patients on an EoL care pathway. For all deaths where a SJR is to be conducted the service are required to send a letter of condolence and the trust bereavement leaflet.

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 12 families in Q3. Telephone contact was attempted for the other two families but they could not be contacted due to:

1. The family had returned to Romania and could not to be reached by phone or letter
2. A call screening system prevented a call being made

For 13 families this was followed up with a written request for a meeting and the opportunity for a face to face meeting, 6 families accepted this opportunity, 6 families have not taken this opportunity up to date and 1 cancelled

7.2 For non SI deaths

Engagement and feedback with family members

The Learning Disability Service makes contact with the family and/or staff team following the reported death of a person with a learning disability.

The Head of Learning Disability Services sends a card of condolence to the family with information on how to contact the service 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 9 individuals whose deaths were reported, 4 people's family were sent condolence cards. Contact had not been made for the remaining 5 individuals for the following reasons:

- 2 people had no known family / no details known
- In 1 instance there had only been recent contact by extended family member with care provider and no postal address being available - therefore contact to be made via LeDeR process
- 1 person had received no services from Learning Disability Services but the Community Nursing Service Matron had made contact to offer condolences and offer post bereavement support – therefore no letter sent due to no Learning Disability Services involvement
- In 1 instance there was no contact due to the extended time which had elapsed between the date of the person's death and the notification (therefore the review had been completed recently but the person had died in an earlier quarter of the year) – therefore it was decided that contact would be more appropriately followed up through LeDeR process

In this quarter, of the 4 cards & information sent to family members, there have been no responses received to date from those contacted.

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 Q3

8.1 Themes and learning from serious incidents (SI)

- **Overall quality of documentation:** A number of SI investigations, internal learning reviews and pressure ulcer learning summits highlight areas for improvement in the overall quality, completeness and robustness of documentation and care plans to meet a gold standard. This includes ensuring that documentation and care plans are time specific and relevant to the current condition of the patient.

- **Caseload management / caseload review**: This has appeared in more than one SI this quarter in relation to care coordinators leaving Trust / going on leave and patients not being managed in their absence.

- **Safety planning informed by robust risk formulation**: This continues to be a theme that requires improvement in mental health SIs. It was highlighted in the Q1 SI report and actions are in place to embed this cultural change in terms of using safety plans and an intervention. Actions are being undertaken to address these main themes'.

8.2 Theme: Mental Health

The Crisis Resolution Home Treatment Team (CHRTT) has adopted a model of 360 degree learning from the Serious Incident Requiring Investigation (SIRI) process into their routine practice for those team members directly involved and it takes place after the action plan has been agreed. The aim is to:

1. Bring together those directly involved
2. To review the reports allowing a full understanding of the process of the investigation
3. Listen to family's feedback to help understand their perspective of the incident under investigation
4. The investigating officer is encouraged to present their report of the investigation as well as their personal narrative about conducting the investigation process.
5. Clinicians can talk again about their feelings of loss and often unresolved guilt surrounding the loss. Good

practices are also identified and outlined at this point.

These events not only offer shared opportunity for learning, it is hoped that this facilitates the required closure to those professionals most affected by the incident, in a supportive and close group.

East pychological medicine service have idenitifed learning around the clarity on risk rating and detail on records to support decision making. Good practice with regard to Family engagement to support discharge planning was idenitifed and shared.

Talking Therapies a new template has been created to support detailed capture of risk factors including situational risk factors and greater use of Joiner's model to support assessment. A training session was undertaken in November with the team around questioning techniques for suicidal clients and case discussion was undertaken related to this case with the practitioner involved.

Proactive involvement with families to try and engage patients to work with CRHTT and IRIS has been identified as positive learning.

8.3 Learning from deaths of patients with a learning disability (LD)

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

In Q3, learning has been identified regarding the team processes and the need to ensure there is sufficient information provided within the RIO risk assessment. Specifically around any identified risks and the need for a management plan to minimise/ mitigate these. There was also identified learning related to the need for clear assessment and recording of an individual's capacity to make unwise decisions. This was identified in relation to an individual who had refused to engage with his GP surgery or to attend health appointments which resulted in an increased risk of self-neglect. The GP had therefore made a referral to the Learning Disability Service for advice regarding the individual's mental capacity and advice on how to best engage with him.

In Q3, there was also evidence of good communication and information sharing across services, organisations and with family members. Referrals were also responded to promptly.

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 completion of the CRG and TMRG processes.

8.4 Learning from LeDeR reviews

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.

8.5 Learning from Community Health

- Staff to ensure that regular discussions happen with families where possible and are documented clearly when patients are discharged from community wards.

- Staff to ensure that there is an adequate handover of information regarding resuscitation status for patients transferred from community wards to other hospitals and this is documented clearly in the notes.

- Timely referral to be made for patients where Deep Vein Thrombosis (DVT) is suspected through clinical examination and not to delay referral for treatment whilst waiting for a Doppler examination.

- Staff to take adequate measures to assess, monitor and manage pain in the community wards and patients' homes.

- Staff to be clear about the acuity of patients getting admitted to the community wards and identify ways to ensure that the admission criteria is followed when accepting admissions to the community wards.

- Staff to ensure that they are trained in using NEWS2 and escalate concerns in a timely manner based on the NEWS scores both within the team during working hours and to Westcall during out of hours.

- Staff to ensure that sepsis is identified early and interventions are put in place in a timely manner for patients admitted to community wards.

9. Conclusion

In Q3, of the 28 deaths concluded through the trust mortality review group, 3 reviews received in Q3 have been escalated for SI investigation following review by the TMRG.

Several themes and areas of learning from a review of the deaths are being implemented and the Q3 learning builds and supports the learning previously identified. In Q3 we identified a number of new areas for learning, which include:

Main new area of learning – from physical health:

- Management of suspected DVT or Vascular concerns
- Pain management
- Rationale for admission and clear plan for assessing patients acuity and needs
- Recognition and management and escalation of sepsis.
- LD: learning has been identified regarding the team processes and the need to ensure there is sufficient information provided within the RIO risk assessment. Specifically around any identified risks and the need for a management plan to minimise/ mitigate these.
- Mental capacity and processes when patient does not want to engage with services

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

This report covers the period 1st November 2018 to the 5th February 2019

Executive summary

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

This report focusses on the period 1st November 2018 to the 5th February 2019. Since the last report to the Trust Board we have received 1 exception report. This remains a very low number of reports compared to other trusts locally.

In the last report we advised that the out of hours rota was being redesigned due to the identification of one week within the rota representing a higher than desirable number of hours worked. This is still within the hours allowed by the contract. An initial proposal on this was discussed in the Junior Doctor Forum, and a number of concerns were raised. Further work has therefore been done on this by medical staffing, and a new proposal is being finalized around this issue.

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 Approved 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	1	1	0
Dentistry	0	0	0	0
Sexual Health	0	0	0	0
Total	0	1	1	0

Exception reports by grade				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
FY1	0	1	1	0
Total	0	1	1	0

Exception reports by rota				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Psychiatry	0	1	1	0
Dental	0	0	0	0
Total	0	1	1	0

Exception reports (response time)				
	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
FY1	0	1*	0	0
ST4-6	0	0	0	0
Total	0	1	0	0

* Clear evidence seen on DRS system that TOIL was agreed 3 days after the exception occurred in a discussion with the CS, however, the report remained open until closed by the Guardian of Safe Working**.**

In this period we have received 1 exception report totaling an extra 1.5 hours worked over and above the trainee's work schedule. This is less than in the preceding report, and may possible reflect the return to baseline following a spike representing increased awareness following the trainee induction, or may reflect new trainees getting more used to working in the trust. Exception reporting is a neutral action and is encouraged by the Guardians and DME. We continue to promote the use of exception reporting by trainees, and make sure that they are aware that we will support them in putting in these reports.

The exception report was upheld and the trainee offered time off in lieu. The exception report was due to a combination of reduced medical cover on the ward (sickness and leave) and two patients becoming acutely physically unwell.

The reason for non-completion of the sign-off of exception reports by trainers from time to time probably reflects the low number of reports – around 15 since the introduction of the new contract – meaning that many consultants will never have had to respond to one.

It has very recently come to the attention of the Guardians that one FY1 trainee has worked late on a number of occasions, but did not seem to have the appropriate log-in to do an exception report. At the same time the trainee seemed to not be initially aware of who their Guardian was, until they attended the recent Junior Doctor Forum.

We have looked into these issues with medical staffing and the following points address the issues this has raised:

1. **Lack of Log-in:** Foundation year doctors rotate outside of the main rotations for two out of their three rotations. There are only five doctors at this grade, and we do not directly employ them (they are employed by their acute trusts). This meant that for the December rotation an administrative omission occurred, and while everything else was set up for them, Medical Staffing neglected to set up the exception reporting login, for this one cohort. **Outcome:** This has now been addressed and to ensure that this does not occur again, as part of every rotation, an email will go out to all new trainees informing them that they have been sent an exception reporting login and that if they have not received it, or if they have any problems to contact Medical Staffing. This new process has been actioned for the rotation that has just occurred on the 6th February 2019.
2. **The Trainee did not initially know the names of the Guardians of Safe Working, who have not been invited to Foundation Year One (FY1) Inductions:** Whilst the Guardians attend all the main inductions, we have not historically been invited to the FY1 inductions, as this is a much smaller process due to the limited number and the fact that they have induction at the acute trust also. In addition, the Guardians of Safe Working act for these trainees in lieu of the Guardian at Royal Berkshire NHS Trust under a local agreement, as a pragmatic approach to allow local responsiveness to exception reports. Not doing out of hours work, reduces the chances of FY1 doctors exception reporting. **Outcome:** Guardians of Safe Working have asked to be invited to future inductions for FY1 trainees. We will either attend in person or provide information via a delegate party.
3. **Limited Time to Submit GOSW Report:** There is very little time between the deadline for an exception report being submitted relating to a period covered in a quarterly report, and submission date for that report. **Outcome:** Given the timeframe for submission of the GOSW quarterly report to the Quality Assurance Committee of the trust Board, it may be necessary to include information about some exception report(s) in the next quarterly report, allowing due process for understanding the reason for the exception and any actions taken to resolve the issue leading to the exception reporting by the trainee.

In relation to the specific trainee in this case, the guardians will respond to the exception reports when they are formally submitted (extra time has been permitted) and will report on any systemic issues identified in the next quarterly 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 November 2018 to the 5th February 2019).

Psychiatry	Number of shifts requested	Number of shifts worked	Number of shifts worked by:			Number of hours requested	Number of hours worked	Number of hours worked by:		
			Bank	Trainee	Agency			Bank	Trainee	Agency
	100	100	86	14	0	912	912	800	112	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	45	45	34	11	0	340	340	256	84	0
Sickness	55	55	52	3	0	572	572	544	28	0
Maternity	0	0	0	0	0	0	0	0	0	0
Total	100	100	86	14	0	912	912	800	112	0

The gaps were already known and covered from before the first half of this rotation period began. Sickness on reflection appears high and was the result of a number of individuals on the rota having short term sicknesses; however, we were able to cover all of the gaps.

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. Trainees have been appointed into more formal representative posts to improve the trainee leadership in the forum.

No immediate patient safety concerns have been raised to the guardians in this quarter.

Issues arising

On reflection it seems that in other trusts the Guardians produce an annual report to present to the trust board in addition to the quarterly reports. With the low numbers of exception reports, and the lack of any clear emerging patterns in the reporting, it may not add a great amount to provide this additional report. However, a FOI request has highlighted that when comparing organisations to each other, and when agencies collect national data, the standard request is for an the annual reports to the board, so we will provide one each year. The first of these will be in August 2019, accounting for the training year which for this purpose will be considered to be from end of August each year. It will be a brief summary of the cumulative data and any clear patterns arising.

NHS Employers in conjunction with the BMA are requesting that trusts review their rota patterns in order to make them less onerous. This is currently advice, but NHS Employers have said that this will probably become a contractual requirement as a result of the current junior doctor's contract review which is currently being undertaken. We were already looking at this before the guidance came out from NHS England as we have a heavy, but legal, rota pattern. Our aim, therefore, is to introduce a new rota pattern, probably for the August 2019 rotation. This new pattern will reduce their overall working hours, increase the amount of time they spend with their teams, but not reduce the cover provided out of hours.

As described above an issue has emerged about a trainee without appropriate DRS log-in for exception reporting and we have addressed this and taken steps to prevent this occurring again, as described above. We have also described how we intend to include some exception report occurring, or being resolved, late in a reporting period, in the next subsequent quarterly report.

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

An annual report will be submitted to the board after August changeover each year.

A new rota pattern will be discussed with trainees and implemented when mutually agreed.

Medical staffing will communicate with all trainees to ensure they have the appropriate log-in on arrival

Guardians of Safe Working to be invited to all inductions.

Quarterly Reports will include a section updating the Quality Assurance Committee of the trust Board of any issues or exception reports occurring to late for the previous quarterly report.

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 by our trainees, whilst having no evidence of this. Trainees are strongly encouraged to make reports by the Guardians at induction and at every Junior Doctor Forum. They are assured that it is a neutral act, and asked to complete exceptions so that the Guardians of Safe Working can understand working patterns in the trust.

Questions for consideration

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

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

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

Appendix A: Glossary of frequently used terms and abbreviations

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

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

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

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

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

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

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

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Date	9th April 2019
Title	Quality Impact Assessment Review
Purpose	The purpose of this report is to inform the board of the process undertaken to quality impact assess the Cost Improvement Programme for 2018/19
Business Area	Nursing & Governance
Author	Debbie Fulton, Acting Director of Nursing and Governance
Relevant Strategic Objectives	True North goals of Harm free care, Supporting our staff and Good patient Experience
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	N/A
SUMMARY	The Cost Improvement Programme (CIP) of 2018/19 initially identified 3 clinical areas for inclusion in the Cost Improvement Programme: • Out of Area Placements (OAPs) • Westcall • Crisis Resolution Home Treatment Team (CRHTT) A Quality Impact Assessment was completed for the OAPS programme. For the other clinical CIP schemes (CRHTT and Westcall) tender model processes were completed to ascertain realistic assumptions of any savings; no savings have been released for this financial year against these 2 services although some small changes to workforce and skill-mix have been made. The Medical Director and Acting Director Nursing met with Westcall and CRHTT service leads and responsible clinical directors during February 2019 to review quality impact of changes made over 2018/19 and potential plans made to achieve any CIP in 2019/20. Based upon the discussion with relevant operational Directors/ service leads and Clinical Directors and available data the

	Medical Director and Director of Nursing are satisfied that the changes made to workforce and skill–mix within these services has not had a detrimental impact on service provision. Where changes are made to workforce/skill-mix over 2019/20 Quality Impact assessments will be required.
ACTION REQUIRED	The Board is asked to: • Note the Quality Impact Assessment process and assessment for 2018/19

Berkshire Healthcare
NHS Foundation Trust

Quality Impact Assessment Review

1. Introduction

The board has an obligation to maintain or improve quality whilst ensuring affordability of the services that the organisation delivers, following the Francis Report all Directors of Nursing are held to account for ensuring quality is maintained and that they report to the Board if they believe their concerns have not been heeded.

Over the past few years the continuing requirement for Trusts to achieve annual efficiency targets through cost improvement planning has become more challenging and identification of realistic programmes to achieve this is required with boards needing to satisfy themselves that any cost improvement plans are not detrimental to the quality of patient care.

To ensure that realistic cost improvement programmes are identified requires robust quality impact assessment (QIA) at the time of potential identification of any programmes and a refresh of these as the plans progress / come to fruition to ensure that quality and safety of service has not been adversely affected.

2. The QIA process

To do undertake QIA effectively, the right information is needed in order to understand the potential risks to quality and plans need to be put in place to ensure action is taken before quality deteriorates. If there is a negative impact on quality, the board will be made aware as soon as it occurs.

A QIA has to be undertaken for all CIPs and service changes that have a potential impact on quality, safety, and workforce or on the working arrangements for staff. The majority of QIAs are undertaken as part of the annual planning cycle when CIPs are agreed by individual localities and at Trust level. QIAs will also be undertaken when further in-year CIPs or service changes that may impact on quality and safety are agreed.

The responsibility for completing a quality impact assessment (QIA) relating to a CIP or service change in a locality rests with the Service Lead and Clinical Director. The Director of Nursing and Governance and Medical Director provide a quality assurance function.

Commissioner medical and nurse directors are required to provide a quality assurance function to their Clinical Commissioning Group Boards and NHS England.

3. 2018/19 Cost Improvement

The cost improvement target for Berkshire Healthcare Foundation Trust for 2018/19 was £4.8M with 3 clinical areas initially identified to deliver cost improvement plans to the total value of 3.4M.

The 3 Clinical programmes identified were:

- CRHTT – £0.5M
- Westcall - £0.5M
- OAPS (specialist Placement and acute overspill)- £2.4M

A QIA was completed for the OAPS programme and for the other clinical CIP schemes (CRHTT and Westcall) tender model processes were completed to ascertain how realistic achievement of any savings was.

At the time of writing this report OAPS is expected to deliver £1.5M of the initially identified £2.4M. CRHTT and Westcall are not expected to deliver any savings this financial year and there is a recognition that pressures remain in both services with neither expected to revert back to plan by the end of the current year. The trust continues to offset its recurrent cost improvement challenge with its underlying vacancy factor. Lack of workforce is our most significant risk.

3.1 OAPS

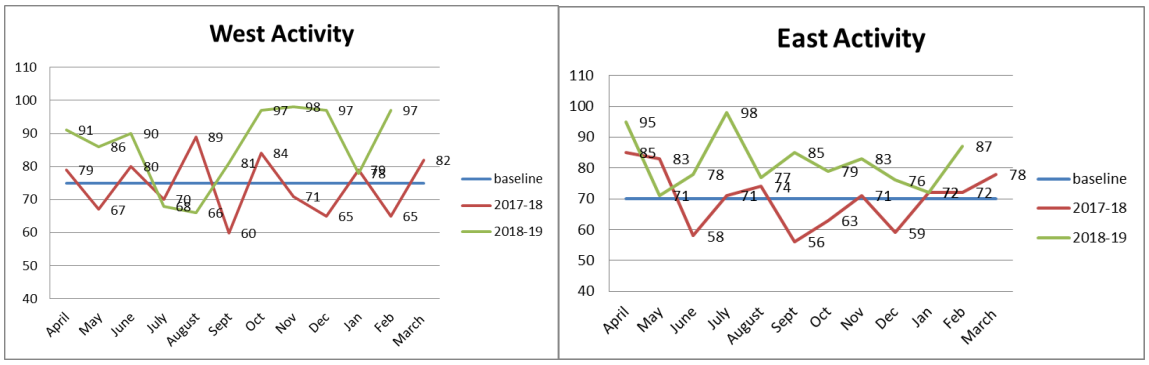
For the OAPS programme the initial QIA undertaken in May 2018 did not identify or anticipate any risks to quality or safety; a further QIA will be undertaken once the work programme for continued OAP's reduction has been formally agreed through the relevant executive committee. The Director of Nursing is satisfied that the programme has not revealed any detrimental impact to patients.

3.2 CRHTT/ Westcall

Dr Irani, Medical Director and Debbie Fulton, Acting Director Nursing met with Westcall and CRHTT service leads and responsible clinical directors during February 2019 to review quality impact of changes made over 2018/19 and potential plans made to achieve any CIP in 2019/20.

3.2.1 CRHTT

The tender model process for CRHTT indicated that with current activity it would not be possible to achieve savings initially identified within the 2018/19 CIP plan due to level of activity being experienced by the service; this activity has continued to rise in 2018/19 as detailed below



Over the last year CRHTT have made changes to service delivery model and skill-mix as a result of patient feedback and workforce challenges as detailed below:

- Converted 4 band 6 roles to band 4 Assistant Psychologists (AP) and now have an AP allocated to each of the 6 Home Treatment teams. The AP's work under the direct supervision of the Principal Psychologist delivering a combination of individual and group based interventions. The decision to appoint AP's was based upon service user feedback that they felt interventions were around medication and risk management, and lacked therapeutic psychological intervention. Turnover with this group of staff is higher than with other staff groups, however we have been able to provide development opportunities for band 3 support workers in the service to progress into these roles if they have the required level of psychology degree.

- Converted 2 registered practitioner posts to band 3 posts to pilot a dedicated telephone triage service within the East Crisis Hub. These posts are supervised by an Advanced Mental Health practitioner (band 7) who is based within the Hub. The feedback from service users is that their experience of calls in the service has improved with better access and a more consistent approach. The service is in the process of scoping this model for the West and plan to implement in the new financial year by converting 2 qualified posts in Band 3 support workers.

- Increased the number of band 7, Advanced Mental Health Practitioners within the Home Treatment Teams (HTT) so that now each team has 2, one focusing on operational leadership and the other providing clinical leadership. The post holders provide face to face interventions, enabling support, coaching and mentoring to more junior staff within the HTT's. Within the 2 Crisis Hubs the aim is to always have a band 7 Clinical Lead available to provide shift co-ordination and real time support and supervision to more junior staff within the service.

- Appointment of band 5 nurses and social workers into band 6 vacancy - Over the past year the service has seen an increase in applications from newly qualified band 5 nurses and social workers. These applicants have been appointed into long term band 6 vacancies with the expectation that they will be supported through preceptorship and competency frameworks to work towards band 6 roles within the service. Over the past year the Crisis Resolution and Home Treatment Teams have produced Competency Workbooks for qualified staff which clearly set out the required training and development for individuals within their role, including supervised practice opportunities for team members which link into reflective pieces of work, which can be directly utilised to support the NMC revalidation process for Nurses.

Quality/ Safety and patient experience is monitored by the service and any concerns are reported to the QEG by the Clinical Director. Based upon the discussion with the Regional Director, CRHTT service head and Clinical Director alongside available data; the medical Director and Director of Nursing are satisfied that the changes made to workforce and skill – mix within CRHTT has not had a detrimental impact on service provision with changes

The workforce remodelling undertaken this year is not expected to achieve financial savings moving forward into 2019/20. It is possible that converting current temporary staffing to substantive appointments will achieve a small saving of around £100k.

3.2.2 Westcall

Over the last year although Westcall have made some small changes to service delivery model, these have been modest and have resulted in

- Employment of 4wte emergency practitioners to provide skill-mix within the clinical workforce. Currently this means that the split of emergency practitioners to GP is 17% /83% split although this actually translates into <10% rota fill as Westcall hours

are, by nature, unsocial so day time working is facilitated for the emergency practitioners within MIU service in order to provide a reasonable shift pattern.

Clinical practice of the emergency practitioners is reviewed in the same way as the medical staff practice through clinical supervision / caseload review. In addition complaints and patient safety incidents are reviewed for Westcall in line with all other trust services. Quality/ Safety and patient experience is monitored by the service and reported to QEG by the Clinical Director. Based upon the assurance provided by the service manager and Clinical Director, the medical Director and Director of Nursing are satisfied that the changes made to workforce and skill –mix within Westcall has not had a detrimental impact on service quality.

It is the intention of the service manager and senior leadership team to continue to introduce a richer skill-mix within the service although how to achieve this is not currently formulated into a clear plan. The service is exploring potential options such as rotational posts with SCAS; this is unlikely to provide any savings opportunities in 2019/20. A QIA will be required from Westcall for any further changes to workforce/ skill-mix to enable an informed decision to be made around the quality and safety impact of any proposed changes

4. Quality Assurance Statement

To conclude the process of assessing the quality impact of CIP for 2018/19 where there was potential for clinical impact has been robust and there has been no identified impacts on quality of care or service provision as a result of implementing cost improvement plans.

Debbie Fulton
Acting Director of Nursing and Governance
March 2019

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	9 April 2019
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.

Berkshire Healthcare
NHS Foundation Trust

Trust Board Meeting 9 April 2019

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. Reliance on Overseas Doctors

Figures from the General Medical Council (GMC) show that last year 53% of those joining the medical register came from overseas compared with 39% in 2015.

The figures show that last year, 8,115 doctors joined the medical register after training abroad, along with 7,186 doctors from United Kingdom medical schools. This is the first time since 2006 that overseas doctors have outnumbered United Kingdom medics joining the register.

The figures from the GMC also show that in the first four months of last year, the number of doctors from beyond Europe applying to work in Britain rose by 49%, compared with the previous year.

Executive Lead: Julian Emms, Chief Executive

3. Workforce Report

At the end of March 2019, the three big health Think Tanks: Health Foundation, King's Fund and Nuffield Trust published a comprehensive joint report on the issue of the NHS workforce crisis. Entitled *Closing the Gap*, the report sets out urgent measures to address the care workforce shortage in England.

The Think Tanks predict that there will be 250,000 NHS vacancies in a decade. It also adds that more staff are leaving each year, and the most cited reason for doing so is dissatisfaction with their work-life balance. It argues that the Government's job would be easier if workforce planning for health and care was not so fragmented and sets out a number of recommendations, which if adopted, properly funded and well implemented across the NHS, would over time, create a sustainable model for general practice and help to eliminate nursing shortages.

The key recommendations include:

- Introducing a £5,200 cost of living grant for student nurses, tripling postgraduate nurse training, bringing 5,000 more students onto nursing courses and ethically recruiting 5,000 more nurses from abroad each year.

- Developing new models of general practice with expanded teams drawing on the skills of other professionals such as physiotherapists and pharmacists.

- Making the NHS a more attractive place to work including measures on pay, professional development, work-life balance and equality and inclusion.

The report estimates that the recommended measures would require investment of an extra £900 million per year by 2023/24 into the budget of Health Education England (approximately one-twentieth of the promised funding increase for the NHS).

In the NHS Long-Term Plan, almost all workforce issues were parked for the Workforce Implementation Plan which Dido Harding, Chair of NHS Improvement was asked to lead upon. Her office has recently reported the Interim Workforce Implementation Plan will not answer any key questions until after the Spending Review in the autumn, but would instead set out a direction of travel for workforce policy.

In my opinion, *Closing the Gap* is one of the more coherent and well evidenced documents on the current workforce issues and hopefully will have significant influence on the final Workforce Implementation Plan.

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

4. Kark Review of the Fit and Proper Persons Test

In his report published in 2013, Sir Robert Francis QC concluded that the failures at Mid Staffordshire were:

"primarily caused by a serious failure on the part of a provider Trust Board. It did not listen sufficiently to its patients and staff or ensure the correction of deficiencies brought to the Trust's attention. Above all, it failed to tackle an insidious negative culture involving a tolerance of poor standards and a disengagement from managerial and leadership responsibilities."

Sir Robert made a total of 290 recommendations, including the introduction of the Fit and Proper Person Test (FPPT). The Fit and Proper Persons Test was designed to ensure that senior staff who were responsible for quality and safety of care were fit and proper for their roles and to prevent corrupt or untrustworthy people from serving on NHS boards.

The Kark review into the scope, operation and purpose of the Fit and Proper Person Test reported back in early February 2019. The review, as recommended by Dr Bill Kirkup in his report into Liverpool Community Health NHS Trust, looked in particular

at how effective the FPPT is in preventing unsuitable staff from being redeployed or re-employed in the NHS.

A range of issues have been identified with the test and the way it is currently interpreted and applied. The review concluded that the FPPT does not do everything that it holds itself out to do and has no real impact on patient care of safety. It does not ensure directors are fit and proper for the post they hold, and it does not stop people who are unfit from moving around the system.

The Kark Review made seven recommendations:

1. All directors should meet specified standards of competence to sit on the board of any health providing organisation.
2. A central database should be created, holding relevant information about qualifications and history about each director (including non-executive directors).
3. Full, honest and accurate mandatory employment references should be required from any relevant employer where an employee is moving from a post covered by Regulation 5 to a post covered by Regulation 5.
4. The FPPT should be extended to all commissioners and other appropriate Arm's Length Bodies (including NHS Improvement and NHS England).
5. An organisation should be set up with the power to suspend and to disbar directors who are found to have committed Serious Misconduct.
6. In relation to the FPPR, the words 'been privy to' serious misconduct or mismanagement are removed.
7. Further work is done to examine how the test works in the context of the provision of social care. The review team concluded that the question of how the FPPT works in social care was too big and complex to be dealt with in this short review.

Of the seven recommendations put forward following the review, recommendations 1 and 2 were accepted by the Secretary of State for Health and Social Care upon publication of the report.

Dido Harding, Chair of NHS Improvement is leading the response to the Kark review on behalf of the Government and has told the Commons Health Committee that she backs the idea of professional regulation for senior NHS managers as one way to improve what she described as a "rotten culture" in the NHS. Ms Harding told MPs that she hoped to consult on the competencies against which managers would be measured during the summer with a database on managers' careers established after that. Ms Harding is still considering the remaining five recommendations and how they can be implemented.

NHS Provider's briefing paper on the Kark Review is attached at appendix 1 of the report.

Executive Lead: Julian Emms, Chief Executive

Presented by: Julian Emms
Chief Executive
April 2019

on the day BRIEFING

NHS Providers

NHS Providers On The Day Briefing: The Kark review of the Fit and Proper Person Test

Background

In July 2018, the former Minister of State for Health, Stephen Barclay MP, commissioned Tom Kark QC to review the scope, operation and purpose of the Fit and Proper Person Test (FPPT). The review has looked in particular at how effective the FPPT is in preventing unsuitable staff from being redeployed or re-employed in the NHS. The review was recommended by Dr Bill Kirkup in his report into Liverpool Community Health NHS Trust, in February 2018.

This briefing sets out the key recommendations and findings of the review, which are significant and potentially far reaching. Members will also want to familiarise themselves with the details in the review report. Should you have any comments or questions about the review or this briefing, please get in touch with Ella Jackson, policy advisor, via Ella.Jackson@nhsproviders.org.

The Fit and Proper Person Test

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires all trusts to ensure that all executive and non-executive director posts (or anyone performing similar or equivalent functions) are filled by people that meet the requirements of the Fit and Proper Person Regulations (FPPR). The definition of directors includes those in permanent, interim or associate roles, irrespective of their voting rights at board meetings. These regulations were introduced in November 2014 and the fundamental standards came into force in April 2015.

The regulations (Section 1, Paragraph 5, or 'Regulation 5' as CQC refers to them in its guidance) place a duty on trusts to ensure that their directors, as defined above, are compliant with the FPPR. The regulations stipulate that trusts must not appoint or have in place an executive or a non-executive director unless they meet certain standards. While it is the trust's duty to ensure that they have fit and proper directors in post, CQC has the power to take enforcement action against the trust if it considers that the trust has not complied with the requirements of the FPPR.

Effectiveness of the FPPT

The Kark review has identified a range of issues with the test and the way it is currently interpreted and applied. The review concludes that the FPPT does not do everything that it holds itself out to do and is

regarded by some as a distraction or a tick box exercise, with no real effect on patient care or safety. It does not ensure directors are fit and proper for the post they hold, and it does not stop people who are unfit from moving around the system.

The review identifies a range of problems with the FPPT, including:

- The test only applies to providers. The universal view among those who gave evidence was that it should apply to all areas of the NHS including commissioners and NHS arms length bodies (ALBs).
- The test is applied fairly vigorously on issues such as bankruptcy, Disclosure and Barring Service (DBS) and convictions, but considerably less vigorously (or not at all) on other important aspects such as whether the director has the competence, experience and qualifications to perform the role.
- The quality of information retained by each trust about each director and in support of its decision on the FPPT is of very varying quality and is sometimes non-existent.
- In some cases, the test is being used as a vehicle for trusts to remove individuals on the ground that they were not compliant with the FPPR, after disciplinary proceedings had been concluded with only a warning or suspension.
- There is a lack of clarity as to who is regarded as covered by the test. The responsibility for deciding, beyond those on the board, to whom the test should be applied sits with the trust. This leads to disparity between different trusts as to whom the test is applied.
- The FPPT requires that individuals have the qualifications, competence, skills and experience necessary, but there are no set criteria or standards; the test is much more fluid and will vary for different roles and vary over time.
- Currently, someone is not fit and proper if they have been 'privy to' serious misconduct or mismanagement. The review suggests that anyone on a board is privy to the issues raised before the board or which come to light and are revealed to the board; therefore this regulation would apply to the most junior member of a board which many years ago was responsible for serious mismanagement. It argues this does not seem to allow for insight, reparation, reskilling, rehabilitation, remorse or understanding. The review recommends the words 'privy to' are removed.
- There is confusion about the checks that should be made on directors. The review concludes all directors (clinical and non-clinical) should have a DBS check.
- There is confusion and dissatisfaction regarding CQC's role in relation to the FPPT. The CQC inspects organisations and cannot regulate individual directors, therefore it assesses whether trusts have the systems and processes in place to ensure that all new and existing directors are, and continue to be, fit and proper. A trust could have all the correct processes in place but these may not elicit all the relevant information about a director. This could result in the appointment of potentially unfit director which would not be picked up by the CQC. The review suggests that, as a result, the assurances given by the CQC via their 'Well-Led' rating, may be optimistic and not well-founded.
- There are difficulties for trusts trying to investigate a director's historical conduct in previous employments.

The review suggests it would be relatively easy to reinforce the FPPT by prescribing further tests by which a director can more easily be excluded or barred from appointments. However, it warns that a higher bar might make these jobs even less attractive, recognising that there is a dearth of suitable, qualified people willing to apply for senior executive jobs in NHS trusts.

The review suggests that while progress has been made to improve the culture of providing care within the NHS, the reality is that steps taken to deal specifically with failures in management have been less effective than they should have been. There are cases where directors commit serious acts of misconduct or mismanagement and yet are able to move to other roles within trusts or another part of the NHS. The use of settlement agreements and pay-outs, together with a bland agreed reference and confidentiality clauses has facilitated this.

Recommendations

The review concludes that a system has to be devised to ensure that those who take on the role of senior management at board level in the NHS are equipped with the skills necessary to undertake that important function; that they can be critically assessed to ensure they have those skills; that such assessment is continuous throughout their career; that they can be supported where appropriate to improve their skills; that they are supported and receive further training if things go wrong or if they are found not to have all the skills necessary.

It recommends that this system include the following (set out in more detail below):

1. All directors should meet specified standards of competence to sit on the board of any health providing organisation.
2. A central database should be created, holding relevant information about qualifications and history about each director (including NEDs).
3. Full, honest and accurate mandatory employment references should be required from any relevant employer where an employee is moving from a post covered by Regulation 5 to a post covered by Regulation 5.
4. The FPPT should be extended to all commissioners and other appropriate ALBs (including NHS Improvement (NHSI) and NHS England (NHSE)).
5. An organisation should be set up with the power to suspend and to disbar directors who are found to have committed Serious Misconduct.
6. In relation to the FPPR, the words 'been privy to' are removed (as described above).
7. Further work is done to examine how the test works in the context of the provision of social care. The review team concluded that the question of how the FPPT works in social care was too big and complex to be dealt with in this short review.

Recommendations 1 and 2 were accepted by the Secretary of State for Health and Social Care upon publication of the report. Baroness Dido Haring (Chair, NHSI) has been asked by the Health Secretary to consider the remaining recommendations and how they can be implemented.

There was very strong resistance from the majority of those the review team spoke to, to imposing more formal regulation than was absolutely necessary. Consequently, the review team has not gone so far as to recommend a new, director-focused regulator to oversee and regulate the appointment and continued employment of trust directors. In their view, the effect of doing so would risk creating a new problem of devolving or diminishing responsibility from trust boards for their own appointments. However, they recommend this position should be kept under review.

The review team also make clear that it is crucially important to distinguish the treatment of those directors who are not currently very good at the job (i.e. their competence is poor or the task too great) and who could, with support and/or training, become competent, from those who have been involved in serious misconduct.

The review team also acknowledge that the great majority of trust "Boards and Chief Executives, Chairs and Directors perform an outstanding job, with determination, insight, self-reflection, with a careful view as to the effectiveness of the Board's function, and often, if not always, in challenging financial circumstances". They point out that none of the recommendations should remove from the trust board the overarching responsibility for good corporate governance and the overall responsibility of trust boards to protecting staff and patients.

Recommendation 1: Standards of competence

This recommendation was accepted by the Secretary of State for Health upon publication of the report.

The report concludes that there is a lack of required, adequate, quality training as to what the function of a board is, how a good board operates and how to be an effective board member in the NHS.

The review recommends that:

- In order to assist the effectiveness of boards and board directors and to encourage people within the service to consider board posts, NHSI should, in consultation with other bodies such as the NHS Leadership Academy and the Academy of Medical Royal Colleges, define, design and set high level core competencies which must be met by any person holding or aspiring to a directorship post (including Interim directors and NEDs. Whether or not a director meets the FPPR should be assessed against the identified competencies.
- The high-level core competencies should be embodied in a schedule to the Regulations and that further guidance should be issued when appropriate by NHSI to set out in detail the competencies to be met by every health trust board director and equivalent post.
- The required high-level core competencies relevant to directors should include knowledge and a general understanding of a number of core issues, no matter what role is undertaken: Board governance; Clinical governance; Financial governance; Patient safety and medical management; Recognising the importance of information on clinical outcomes; Responding to serious clinical incidents and learning from errors; The importance of learning from whistleblowing and 'speaking up'; Empowering staff to make autonomous decisions and to raise concerns; Ethical duties towards patients,

relatives and staff; Complying and encouraging compliance with the duty of candour; The protection, security and use of data; Current information systems relevant for health services; The importance of issues of equality and diversity both within the hospital in workforce issues and in relation to appointments to the Board; and the importance of complying on a personal basis with the Nolan principles.

- As part of trusts' ongoing responsibility to assess the competency of each member of the board or those applying for a directorship post, trusts should ensure any necessary training is undertaken by board members where gaps in competency have been identified.
- During the 'Well-Led' inspection, CQC should review the evidence, including sampling appraisals in respect of the directors, to ensure that they are currently able to meet the core competencies, have regular appraisals and are up to date with personal development plans.
- This approach should be kept under review with consideration to be given in due course as to whether a more formalised gateway, registration and validation system is necessary to ensure all directors have acquired and demonstrate the necessary core competencies.

Recommendation 2: A central database of directors

This recommendation was accepted by the Secretary of State for Health upon publication of the report.

The review team believe there is a 'startling' lack of information about the people who manage health trusts at director level'. For example, there is no background information held in relation to board members, no compulsory or comprehensive training at CEO or board level, no accreditation, continuous development scheme or 360-degree appraisal.

The review recommends that:

- A body (such as NHSI) (referred to as the 'Central Database Holder') creates and retains a database which will hold information about each director (including NEDs) to be accessible to potential employers, the NHSI and CQC and where necessary the Health Directors Standards Council (see below). This could be held in any part of the NHSI system and stored in a 'NHSI Directors' Database'. Until this can be placed on a statutory footing the consent of each director about whom information is held will be required.
- The database will hold a list of directors and information about each director such as the following: Name; Current employer; Job description of current employment; A full employment history and explanation of gaps (any gaps that are because of any protected characteristic as defined in the Equality Act 2010 would not need to be explained); History of training and development undertaken; Available references from previous employers; All relevant appraisals and 360 reviews; Any upheld disciplinary findings; Any upheld grievance findings; Any upheld whistleblowing complaint; Any upheld finding pursuant to any Trust policies or procedures concerning employee behaviour; Any Employment Tribunal judgment relevant to the director's history; Any settlement agreements relating to work in any health-related service; Criminal convictions; and Whether the director is or has ever been disqualified or disbarred as a director.

- Consideration should be given to ensuring that the information required to be held by trusts for provision to the CQC by reason of the FPPR should mirror the information to be held by the Central Database Holder so as not unnecessarily to add a burden to trusts. The CQC should be given access to the Central Database when appropriate to assist CQC to carry out its function.
- All relevant employers should be required within a reasonable time to provide to the Central Database Holder the information listed above in relation to each person identified as a director (or those holding equivalent positions) and trusts should keep the information provided to the Central Database Holder regularly updated and current
- The CQC should review whether or not trusts have complied with this duty during their 'Well-Led' reviews. We recommend that all relevant employers be required within a reasonable time to identify all those in 'equivalent' directorial positions whom it considers fall within the FPPR test to the Central Database Holder and to the CQC.

Recommendation 3: Mandatory references

The review recommends that:

- Full, honest and accurate mandatory employment references should be required from any relevant employer where an employee is moving from a post covered by Regulation 5 to a post covered by Regulation 5. Such references must not be subjected to any limitation by the terms of a compromise or settlement agreement and any such attempted limitation shall be regarded as of no effect. The 'old' employer must provide such a reference and the 'new' employer must require one.
- Where an applicant for a role covered by Regulation 5 is being promoted from a non-board director position or is moving from a directorship role in an organisation not covered by Regulation 5, the 'new' employer must make every reasonable attempt to obtain a reference meeting the requirements of the mandatory reference form and to acquire any missing information from the 'old' employer and from the incoming employee.
- The precise nature and requirements of the mandatory reference form is to be devised by NHSI in conjunction with the CQC, NHSE, NHSLA and other relevant organisations
- Each mandatory reference form written for an outgoing director must be signed off by a board director or other director covered by regulation.
- Each employee concerned should have the right to see and note a challenge to the accuracy and fairness of the mandatory reference and provide such explanation as he or she wishes to in writing.
- Any relevant employer employing a director must require to be furnished with such a reference as is specified and should retain it on its records as well as supplying a copy to the Central Database Holder. The Regulations should be amended so as to incorporate reference to a mandatory reference form.
- The CQC should review employment references provided by trusts including forward references as part of their 'Well-Led' review. This assessment should review whether they have met the mandatory reference criteria both for current employees (as directors) and the references written by the employer for onward transmission to future employers.
- A failure to comply with the mandatory reference requirement should be considered by the CQC as part of their 'Well-Led' reviews and should lead to the referral of the director signing-off the reference to

the Trust or the HDSC for Serious Misconduct where there is evidence of deliberate concealment of relevant information or dishonesty. CQC should provide further guidance on this aspect of the Trust's duties.

Recommendation 4: Extending FPPT to all commissioners and ALBs

The review recommends that:

- The FPPT should be extended to apply to all commissioners although because of the current lack of an appropriate regulator of non-providers, the review recommends that, as a first step, that the test is extended by means of voluntary adoption.
- A scoping exercise be undertaken with a view to the test being extended by statute to apply to CCGs and appropriate ALBs but that in the meantime the Senior Appointments Guidance be updated and the principle components of the FPPT be adopted.

Recommendation 5: The power to disbar directors

The review recommends that:

- An organisation is set up which will have the power to suspend and to disbar directors covered by Regulation 5, who are found to have committed Serious Misconduct (see below). In order to affect this, legislation is likely to be required. Such an organisation could be housed within NHSI, and could be known as the 'Health Directors' Standards Council' (HDSC).
- Serious Misconduct should be defined, but the review offers a view on the behaviours that should be included. This definition should be incorporated into the FPPR.
- Consideration should be given to ensuring that the FPPT incorporates as Serious Misconduct the same issues as described above by listing these factors as a separate schedule to the Regulations.
- In considering allegations of misconduct the following process should be adopted: All Serious Misconduct where an employee is still employed by the Trust (the relevant Trust) at which the Serious Misconduct is said to have occurred would first have to be investigated by that Trust. Any Serious Misconduct alleged to have occurred at a previous Trust would be investigated by the HDSC; and If following an investigation by the relevant Trust, Serious Misconduct was found to have occurred, the director concerned would require referral to the HDSC. Such a referral would be mandatory.
- There should be separate routes of referral and or escalation or appeal, to the HDSC from Trusts, other institutions (such as the CQC and professional regulators such as the General Medical Council and Nursing and Midwifery Council) or individuals (which would have to pass a reasonable prospects test).
- The HDSC should have the power permanently to disbar a director although the HDSC's powers should also include shorter periods of disbarment.
- The HDSC should have the power to impose an interim (paid) suspension while an investigation takes place, of no longer than six months, where the safety of the public or other public interest requires it.
- A director who is currently disbarred by the HDSC may not be regarded as a fit and proper person under Regulation
- The Department of Health and Social Care should take steps to ensure that employment contracts for board level directors and their equivalents reflect that a finding of Serious Misconduct by the HDSC is to

be regarded as gross misconduct for the purposes of the employment contract and would normally operate so as to prevent an individual from receiving notice period monies and any 'golden goodbye'.

- The CQC and all appropriate ALBs should amend their appointment rules to prevent them employing someone who has been disbarred by the HDSC for Serious Misconduct.
- All NHS commissioners, commissioning services from the independent sector, should be prohibited from commissioning services from any provider where a disbarred or suspended director sits on the board of the provider or who holds an equivalent director's post.
- If necessary the HDSC be provided with the same powers as the CQC to require Trusts to supply information relevant to the exercise of its powers.
- There should be a statutory time limitation period of five years in relation to historic complaints about Serious Misconduct, unless there are exceptional circumstances and the public interest requires action to be taken.
- All other misconduct (not falling to be categorised as serious) ought to continue be dealt with within the employing Trust as a disciplinary issue.

NHS Providers view

NHS foundation trusts and trusts have a duty to ensure patient safety and the provision of high quality care. In the words of the Kark report itself, "the great majority of Trusts [have] Boards and Chief Executives, Chairs and Directors perform[ing] an outstanding job". We also need to recognise, however, that a very small number of boards and directors have failed in their duties.

The fundamental principle which lies at the heart of foundation trust and trust governance is that the unitary trust board is responsible for everything that happens within the trust. This brings vital clarity in an environment which contains a significant amount of risk – for example safety risk, clinical risk and financial risk. The ability of trust boards to appoint their own directors and oversee their conduct is a key part of that responsibility. We therefore need to consider anything that cuts across this with real care and attention.

Striking the right balance between ensuring the vast majority of trust boards and directors have appropriate autonomy to do their job effectively and intervening to prevent serious failure is difficult but vital.

The proposals in today's Kark Review are significant and potentially far reaching. These recommendations would normally be the subject of a full consultation with opportunity for trusts who will be most affected, and will have to implement the proposals, to give their views.

It is therefore regrettable for the Government to have announced today that they will accept some of the recommendations without such consultation. We will seek to ensure that the views of trusts are fully and properly heard as those recommendations are implemented.

We note the Government's decision to remit consideration of some of the recommendations to Baroness Harding, the Chair of NHS Improvement, as part of her work on workforce issues. We will be writing to

Baroness Harding shortly to seek her assurance that she will create a full and proper consultation process that, in our view, should follow well established Government/NHS best practice on consultation. We also note that the report itself attributes views to NHSI on the issues covered by the report which we believe trusts will disagree with. So we will also be seeking assurances on how NHSI will treat any feedback from the provider sector and how NHSI will formulate its final views.

We have engaged extensively with our membership and the review team on these issues, giving evidence to the review twice, including involving member chief executives and a company secretary on the second occasion. We will want to talk to our members in detail about the proposals but already have a series of questions where we know trusts will have concerns. These include:

- How the operation of any central database of directors will work in practice to ensure the burden of compliance is proportional and reasonable, particularly given the vast majority of directors perform an outstanding job
- How to create a meaningful and proportionate set of core competences and accompanying assessment process to ensure individuals' fitness to be directors. Assessing the effectiveness of an NHS board director is not simply about checking whether a director has the right basic knowledge of NHS finances and clinical safety processes. Judgement, behaviour and cultural approach – issues that are not amenable to a tick box assessment of knowledge - are often more important. That's precisely why trusts need appropriate autonomy to judge the fitness of their directors and decide who to appoint.
- How possible it will be to create a robust, universally applicable, definition of "serious misconduct" given that this has been notoriously difficult to define in the past and that many of the areas the Kark review suggests it covers are not amenable to black and white judgements.
- Whether a Health Directors' Standards Council is required, and if one is created, how it would work in practice. This will include exploring issues such as rights of appeal and the interactions with both employment law and the trust's duties and responsibilities as the director's employer.

Trust board directors have a complicated and difficult set of responsibilities to undertake. We owe it to them to listen to their views and carefully think through any changes to the environment in which they operate. There's a danger of failing to do that here.

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	9 April 2019
Title	Gender Pay Report (2018)
Purpose	To update the Board on the data submitted for March 2018 and next steps for the year ahead.
Business Area	Corporate
Author	Carol Carpenter, Director of People
Relevant Strategic Objectives	Implementation of our Workforce Strategy Trust Equality, Diversity and Inclusion Strategy
CQC Registration/Patient Care Impacts	Implementation of our Workforce Strategy facilitates all of the CQC domains.
Resource Impacts	N/A
Legal Implications	N/A
Equality and Diversity Implications	1) Gender of workforce 2) Equity in the pay between the genders
SUMMARY	It is a mandatory requirement to report the gender pay gap each year. We have published the data and the pay gap remains the same as last year at 20%. There are a couple of reasons: The workforce is divided with 82% / 18% in favour of women. But the proportion of women in the lowest quartile of the pay bands is higher than 82% and lower than 82% in the highest quartile. The proportion of our female workforce which works part time and use the salary sacrifice scheme is higher than 82%.

	The number of male medical consultants applying for and receiving Clinical Excellence Awards is disproportionate and an independent report make recommendation's as to what we can do to improve this situation. The recommendations have been accepted in full.
ACTION REQUIRED	To note that next steps: No immediate action. A detailed report analysing the data will go the Finance, Performance and Risk Committee in May 2019 which may lead to further actions beyond those associated with the Clinical Excellence Award, recruitment and talent management.

Gender Pay Gap report

March 2018

As from March 2018, it has been a legal mandatory requirement for an organisation of more than 250 employees to report their gender pay gap each March.

The Government requires us to do the following:

- Publish the gender pay gap data and a written statement on our public facing website
- Report our data on a form on the gov.uk website

We must produce the data as set out in annex 1 below.

The gender pay gap is the difference between the average earnings of men and women, expressed relative to men's earning.

The NHS Electronic Staff Record system has been updated to produce the reports for this annual exercise using data held on our system over the year.

Points to highlight:

1. 82% of the workforce are female and 18% are male

2. Since reporting last year, the lowest and highest quartiles of pay have remain unchanged, but the in quartile two and three there is a slight improvement (c1.5%) in the number of males

3. The pay gap in the average hourly rate (20.30%) reflects the higher proportion of men in more senior grades within the Trust. Females are 82% of the total workforce but only represent 75% of the workforce in the upper quartile

4. The proportion of females in the lowest quartile of pay (86.6%) is higher than the proportion of females employed by the Trust (82%)

5. 1,760 employees work part time in the Trust and 92% of this group are female

6. The calculation of the hourly rate is based on the gross pay after any deductions for salary sacrifice. 275 employees use the childcare salary sacrifice scheme. 89% of the scheme users are female. This will have a disproportionate impact on the hourly rate of female staff resulting in a lower average

7. The bonus data relates only to Clinical Excellence Awards (CEA) paid to consultant medical staff. There remains a significant variance in the number of females who receive an award and the value of the awards.

Actions for the Trust to take:

- Continue to encourage more males to apply to work for the Trust. Adverts and social media now include pictures of our male workforce, especially in Agenda for Change Bands 2-5 and we will ensure adverts and recruitment encourages more applications

- Continue to support the development of female staff through mentoring, leadership development and talent management ensuring females have the confidence and skills to apply for Agenda for Change band 8a to Very Senior Manager (VSM) roles

Next steps:

- Dr Minoo Irani, Medical Director, commissioned an independent review into the Clinical Excellence Awards and will implement the recommendations from this report in full.

- This recommendations include actions to encourage more females to apply for Clinical Excellence Awards, offer training sessions on how to complete the paperwork, and to encourage more female consultants to be members of the assessment panel.

- Communicate the gender pay gap and actions we will take to our staff.

- Human Resources, Finance and the Performance Team to undertake analysis of the data and report the findings to the Finance, Performance and Risk Committee (May 2019) with the associated action plan for 2019/2020

Annex 1

The Trust employs 82% female and 18% male staff.

Average & Median Hourly Rates

Gender	Avg. Hourly Rate	Median Hourly Rate
Male	20.64	17.72
Female	16.45	15.21
Difference	4.19	2.51
Pay Gap %	20.30	14.17

Number of employees in each quartile (Q1 low to Q4 high pay)

Quartile	Female	Male	Female %	Male %
1	860.00	132.00	86.69	13.31
2	839.00	149.00	84.92	15.08
3	879.00	161.00	84.52	15.48
4	753.00	254.00	74.78	25.22

Bonus payments

Gender	Avg. Bonus Pay	Median Bonus Pay
Male	8,300.69	5,529.37
Female	4,678.85	4,423.43
Difference	3,621.84	1,105.94
Pay Gap %	43.63	20.00

Payment of bonuses by gender

Gender	Employees Paid Bonus	Total Relevant Employees	%
Female	14	3662	0.38
Male	21	838	2.51

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	9 April 2019
Title	Financial Summary Report – M11 2018/19
Purpose	To provide the Month 11 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
Equality and Diversity Impacts	N/A
SUMMARY	The Financial Summary Report provides the Board with summary of the M11 2018/19 financial position.

ACTION REQUIRED	The Board is invited to note the following summary of financial performance and results for Month 11 2018/19 (February 2019):
	
	The Trust reports to NHS Improvement its 'Use of Resources' rating, which monitors risk monthly, 1 is the highest rating possible and 4 is the lowest.
	
	YTD (Use of Resource) metric:
	• Overall rating 1 (plan 1)
	  ○ Capital Service Cover rating 2
	  ○ Liquidity days rating 1
	  ○ I&E Margin rating 1

	○ I&E Variance rating 1 ○ Agency target rating 1 **YTD Income Statement (including PSF Funding; excluding donations):** • Plan: £2.2m surplus • Actual: £3.6m surplus • Variance: £1.4m better than plan. **YTD Cash** £21.5m vs Plan £22.8m. **YTD Capital expenditure:** £8.6m vs Plan £9.8m.

Berkshire Healthcare NHS
NHS Foundation Trust

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

Finance Report

Financial Year 2018/19

Month 11 (February 2019)

Purpose

To provide the Board and Executive with a summary of the Trusts financial performance as at 28th February 2019.

Document Control

Version	*Date*	*Author*	*Comments*
1.0	13/03/19	Bharti Bhoja	1st Draft
2.0	18/03/19	Paul Gray	Final

Distribution

All Directors

All staff needing to see this report.

Contents

1.0 Key Messages

Key Metric	YTD Actual £'m	YTD Plan £'m	Variance £'m	vs Last Mth	vs Prior Year
Surplus / (Deficit) for PSF	1.4	0.1	1.4	▲	▼
PSF - Trust	1.3	1.3	(0.0)	▼	▲
PSF - System	0.9	0.9	0.0		
Control Total Surplus / (Deficit)	**3.6**	**2.2**	**1.4**	▼	▲
Statutory Surplus / (Deficit)	4.1	2.2	2.0	▲	▲
CIP Delivery	2.7	4.0	(1.4)	▼	▲
Agency Spend	5.5	4.9	0.6	▼	▲
OAPs - Specialist Placements (incl LD)	8.6	7.7	0.9	▼	▼
OAPs - Overspill Beds	2.1	1.1	1.0	▲	▼
Capital Expenditure	8.6	9.8	1.2	▲	▼
Cash	21.5	22.8	(1.3)	▼	▲

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 made £0.2m surplus pre-PSF, £0.2m ahead of plan. Our YTD surplus is £1.4m, £1.4m ahead of Control Total. After accounting for PSF and Donations, our YTD statutory surplus is £4.1m.
- The Trust remains on course to deliver a £1.5m forecast surplus.
- Use of Resources rating remains at a"1" overall.
- Pay costs fell this month but remain ahead of plan, £0.3m. Agency costs fell from last months peak but remain high compared to annual run rate.
- Cash is £1.3m below anticipated levels, however during March, we settled overdue debts with NHSPS, providing a net £1.9m benefit to the reported cash balance.
- Capital spend is £1.2m below plan YTD, with the forecast spend remaining at £9.4m.

Key Risks

- Out of Area placement usage has been at a higher level than anticipated in the forecast. This has increased costs and, given the reduction trajectory and savings required in 19/20, presents a significant challenge.
- Although agency costs reduced in month, spend is still higher than run rate, despite permanent head count increases.
- As we move into the final month of 18/19, we must ensure we continue to control costs. Where budgets are currently underspend, efforts should be made to continue at the lower than plan run rate and not increase spending to 'hit' budget.

2.0 Income & Expenditure

Income Statement	In Month			YTD			FY			Prior Year YTD		
	Act	Plan	Var	Act	Plan	Var	Forecast	Plan	Var	Act	Var	
	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	+/-	%
Operating Income	18.9	18.9	(0.0)	210.0	208.3	1.7	229.1	227.2	1.9	208.2	1.8	0.9%
DoH Pay Award	0.2	0.2	0.0	2.2	2.1	0.1	2.4	2.3	0.1	0.0	2.2	
Other Income	1.6	1.5	0.1	17.9	17.1	0.8	19.2	18.6	0.6	17.4	0.6	3.2%
Total Income	***20.7***	***20.6***	***0.1***	***230.1***	***227.5***	***2.6***	***250.7***	***248.2***	***2.5***	***225.5***	***4.6***	***2.0%***
Staff In Post	13.0	13.0	0.1	141.9	143.9	(2.0)	154.9	156.9	(2.0)	138.3	3.6	2.6%
Bank Spend	1.1	1.0	0.1	12.7	11.3	1.4	13.8	12.3	1.5	11.2	1.6	13.9%
Agency Spend	0.6	0.4	0.1	5.5	4.9	0.6	5.8	5.3	0.5	7.0	(1.5)	(21.6)%
Total Pay	***14.8***	***14.4***	***0.3***	***160.1***	***160.1***	***(0.0)***	***174.5***	***174.5***	***(0.0)***	***156.5***	***3.6***	***2.3%***
Purchase of Healthcare	0.6	1.0	(0.4)	14.7	12.6	2.0	16.7	13.7	3.0	15.0	(0.4)	(2.5)%
Drugs	0.4	0.4	0.0	5.4	4.6	0.8	6.2	5.0	1.2	4.4	1.0	23.8%
Premises	1.4	1.2	0.2	14.1	13.1	1.0	14.9	14.3	0.6	14.0	0.1	0.4%
Other Non Pay	1.8	2.0	(0.2)	19.3	21.4	(2.0)	20.5	23.4	(2.9)	19.9	(0.5)	(2.6)%
PFI Lease	0.5	0.5	0.0	5.8	5.8	0.0	6.4	6.3	0.1	5.7	0.2	3.3%
Total Non Pay	***4.8***	***5.2***	***(0.4)***	***59.4***	***57.5***	***1.9***	***64.7***	***62.7***	***1.9***	***59.0***	***0.4***	***0.7%***
Total Operating Costs	***19.6***	***19.6***	***(0.1)***	***219.4***	***217.6***	***1.9***	***239.2***	***237.3***	***1.9***	***215.4***	***4.0***	***1.9%***
EBITDA	***1.2***	***1.0***	***0.2***	***10.7***	***10.0***	***0.7***	***11.5***	***10.9***	***0.6***	***10.1***	***0.5***	***5.3%***
Interest (Net)	0.3	0.3	(0.0)	3.2	3.3	(0.1)	3.5	3.6	(0.1)	3.2	(0.0)	(1.1)%
Impairments	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	(0.1)	(54.7)%
Disposals	0.0	0.0	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.0	(0.0)	0.0	(0.0)	
Depreciation	0.5	0.6	(0.1)	4.5	5.1	(0.6)	4.8	5.6	(0.8)	4.4	0.0	0.5%
PDC	0.1	0.1	(0.0)	1.5	1.5	(0.0)	1.6	1.6	(0.0)	1.3	0.2	14.5%
Total Finanacing	***0.9***	***1.0***	***(0.1)***	***9.2***	***9.9***	***(0.7)***	***10.0***	***10.9***	***(0.9)***	***9.1***	***0.1***	***1.4%***
Surplus/ (Deficit) for PSF	***0.2***	***0.0***	***0.2***	***1.4***	***0.1***	***1.4***	***1.5***	***(0.0)***	***1.5***	***1.0***	***0.4***	***41.0%***
PSF - Trust	0.2	0.2	(0.0)	1.3	1.3	(0.0)	1.5	1.5	0.0	1.6	**0.6**	**37.3%**
PSF - System	0.1	0.1	0.0	0.9	0.9	0.0	0.7	1.0	(0.2)	0.0		
Surplus/ (Deficit) for CT	***0.5***	***0.3***	***0.2***	***3.6***	***2.2***	***1.4***	***3.7***	***2.4***	***1.3***	***2.6***	***1.0***	***38.8%***
Donated Income	0.0	0.0	0.0	0.6	0.0	0.6	0.6	0.0	0.6	1.6	(1.0)	(63.5)%
Donated Depreciation	(0.0)	(0.0)	0.0	(0.1)	(0.0)	(0.0)	(0.1)	(0.1)	(0.0)	(0.0)	(0.0)	(206.1)%
Surplus/ (Deficit) Statutory	***0.5***	***0.3***	***0.2***	***4.1***	***2.2***	***2.0***	***4.2***	***2.3***	***1.9***	***4.2***	***(0.1)***	***(1.8)%***

Key Messages

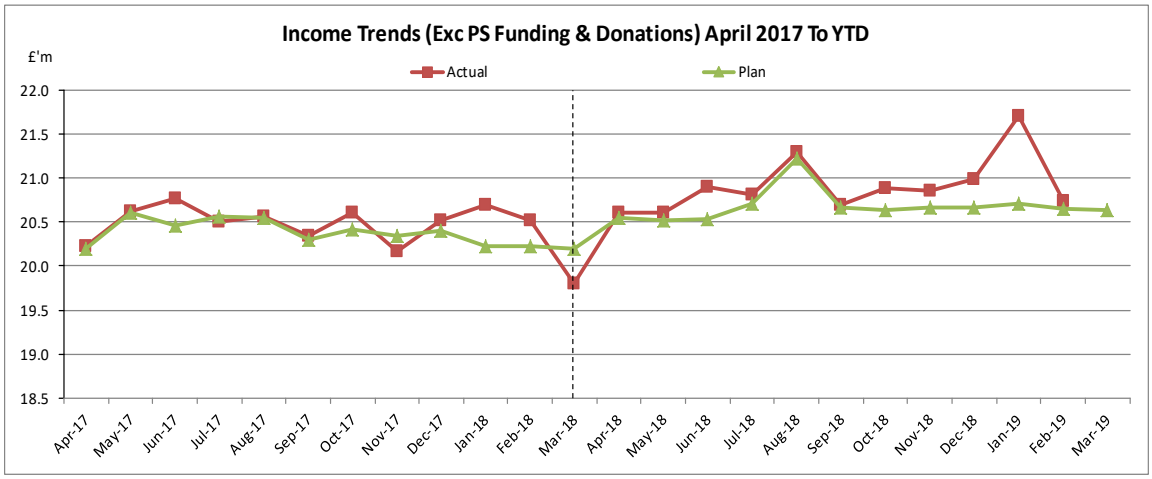
Our YTD pre-PSF surplus is £1.4m, £1.4m ahead of plan. After incorporating £2.7m of PSF and donations, our reported surplus is £4.1m, £2.0m better than planned.

Overall pay costs fell by £0.1m compared to last month. This was the result of a £0.1m expected reduction from non recurrent costs included last month, offset by increased IAPT and MHEP trainee pay costs of £0.1m, both funded. Temporary staffing costs fell by £0.1m, but remain high compared to this years run rate. Despite the reduction in costs this month, Pay costs overall remain above plan.

Non pay costs were £0.4m lower than plan. This include a £0.7m reduction as a result of ending pass through arrangements with Berkshire West CCG for LD OAPs costs. Charges are now billed and settled directly by the CCG, with reduction in cost offset by a £0.7m reduction in income. The remaining increase in costs relates to OAPS expenditure and reserve funded, non-recurrent wheelchair investment of £0.2m.

Income & Contracts

Income Statement	In Month			YTD			FY			Prior YTD		
	Act	Plan	Var	Act	Plan	Var	Forecast	Plan	Forecast Var	Act	Var	
	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	+/-	%
Block Income	16.5	16.5	0.0	182.8	181.7	1.1	199.0	198.2	0.8	178.7	4.2	2.3%
Tariff Income	0.2	0.3	(0.1)	2.4	2.8	(0.4)	2.7	3.1	(0.4)	2.7	(0.3)	(10.0)%
Pass Through Income	0.3	0.3	0.1	3.7	2.8	1.0	4.4	3.0	1.3	2.6	1.1	44.1%
DoH Pay Award	0.2	0.2	0.0	2.2	2.1	0.1	2.4	2.3	0.1	0.0	2.2	
Other Income	3.6	3.4	0.2	38.9	38.1	0.8	42.2	41.5	0.7	41.6	(2.7)	(6.5)%
Total Operating Income	***20.7***	***20.6***	***0.1***	***230.1***	***227.5***	***2.6***	***250.7***	***248.2***	***2.5***	***225.5***	***4.6***	***2.0%***
PSF - Trust	0.2	0.2	(0.0)	1.3	1.3	(0.0)	1.5	1.5	0.0	1.6	0.6	17.8%
PSF - System	0.1	0.1	0.0	0.9	0.9	0.0	0.7	1.0	(0.2)			
Donated Income	0.0	0.0	0.0	0.6	0.0	0.6	0.6	0.0	0.6	1.6	(1.0)	(63.5)%
Total Reportable Income	***21.0***	***20.9***	***0.1***	***232.8***	***229.7***	***3.2***	***253.5***	***250.6***	***2.9***	***228.7***	***4.1***	***1.8%***



Income

YTD	£'m
2018/19	209.3
2017/18	205.0
▲	*2%*

Prior Yr	£'m
Feb-19	20.7
Feb-18	20.5
▲	*2%*

Key Messages

Operating Income was above plan this month. The relatively static performance includes a £0.7m pass through reduction for Berkshire West LD OAPs costs, offset by £0.2m of planned CQUIN provision release to cover wheel-chair investment costs, recognition of £0.1m additional immunisation activity and EMHP funding of £0.1m off-setting increased pay costs. Pass through income continues ahead of plan, relating to rechargeable drugs. The ma-terial movement in the trend chart over the past 2 months reflects the planned release of CQUIN provision last month, increasing run rate, and the adjustment for Berkshire West LD OAPs this month, reducing run rate.

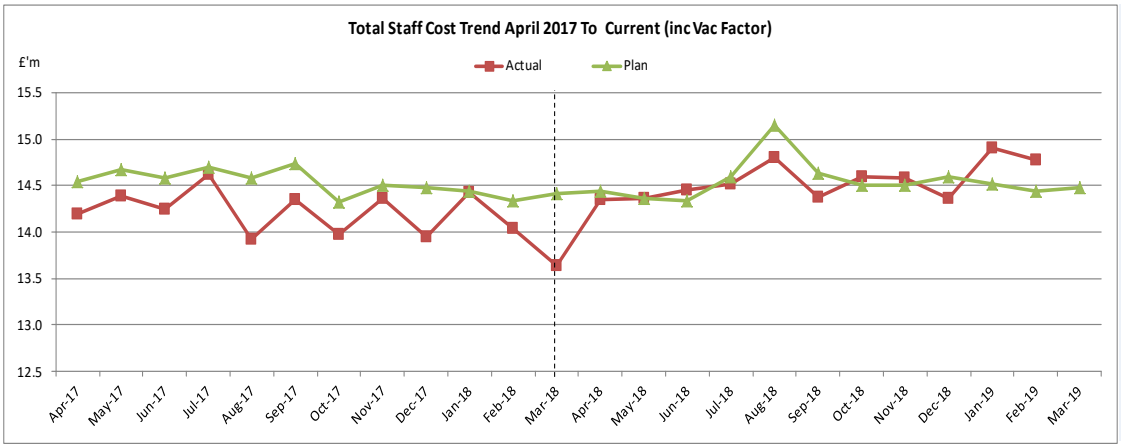
Commissioner Focus

We have agreed contract values for 19/20 with both Berkshire West and Berkshire East CCG, both at values higher than included in our draft plan to NHSI. This will enable CIPs for the coming year to be reduced to achievable lev-els. Both contracts were signed, on time regarding NHSi guidance, on the 21st March with CQUIN schemes to be agreed in long stop.

System Focus

We have included full Trust and System PSF in our YTD surplus. There remains a level of risk for both Frimley and Royal Berkshire in delivering their YE Control Total, however both are still forecasting delivery. NHSI have still not agreed the £0.6m offset to Frimley Health, as reported last month, and have offered no indication as to whether this will be agreed. If it is not agreed, then in achieving a £1.5m surplus, the Trust will be eligible for incentive pay-ments of £0.6m.

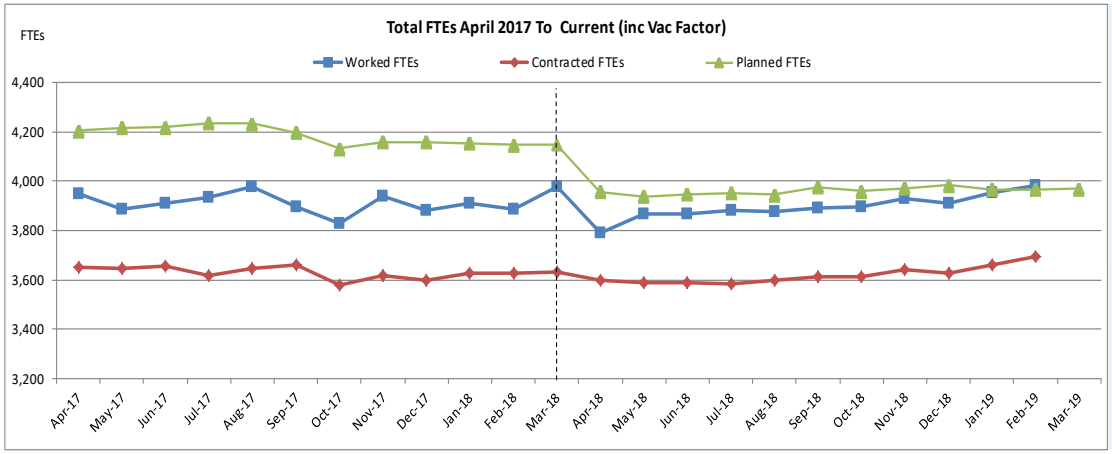
Workforce



Staff Costs

YTD	£'m
2018/19	160.1
2017/18	156.5
▲	2%

Prior Yr	£'m
Feb-19	14.8
Feb-18	14.0
▲	5%



FTEs

Prior Yr	CFTE	WFTE
Feb-19	3,693	3,982
Feb-18	3,628	3,888
	-2% ▲	-2% ▲

Prior Mth	CFTE	WFTE
Feb-19	3,693	3,982
Jan-19	3,660	3,955
	-1% ▲	-1% ▲

Key Messages

Pay costs were £0.3m ahead of plan, with substantive and non permanent costs above plan.

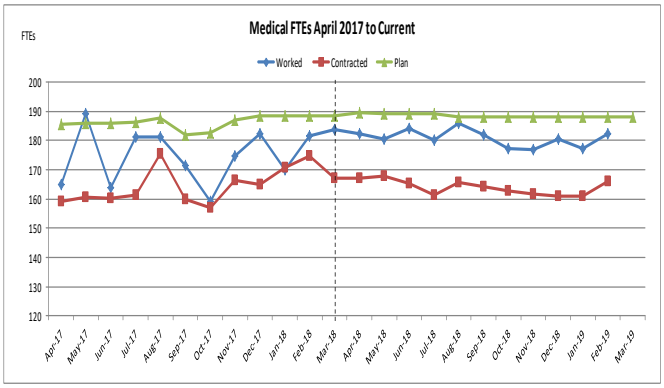
Permanent staff costs fell in February but were ahead of plan. Costs were expected to reduce given the non recurrent medical costs and holiday payments in last months position. However the full benefit of this reduction has been offset with an increase in permanent headcount 33 FTE. The most notably increases were IAPT and MHEP trainees, 29 FTE, although these increases in costs were in turn offset by additional income.

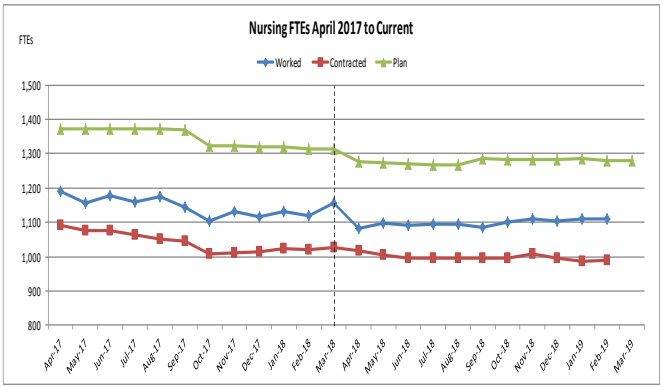
Despite temporary staffing costs reducing, spend remains higher than run rate and £0.2m higher than last February. Agency costs include agreed increases to cover operational pressures and short term appointments, including CAMHS Rapid Response and HR.

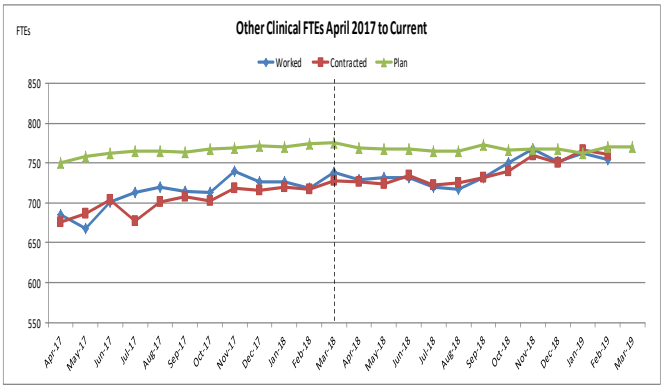
Our overall Worked FTEs were 14 ahead of plan, allowing for vacancy factor and non permanent usage. This aligns to our costs being above plan in the month.

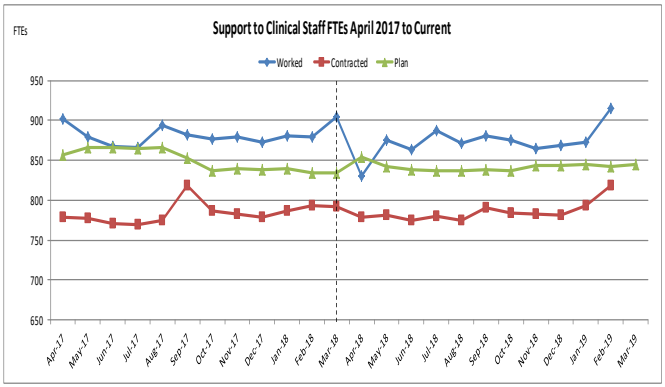
There remains continuing pressures in CRHTT and WestCall, neither of which will revert back to plan by the end of the current year, and both of which are being reviewed as part of planning to ascertain the appropriate level of funding and savings which can be delivered. Campion Unit observation costs this month were more than December with YTD overspend now at £594k.

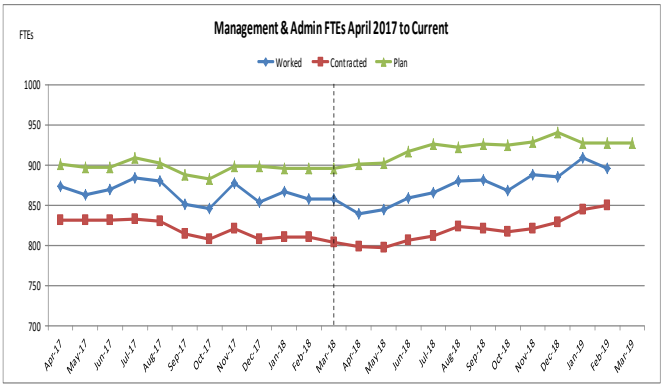
Workforce: Staff Groups

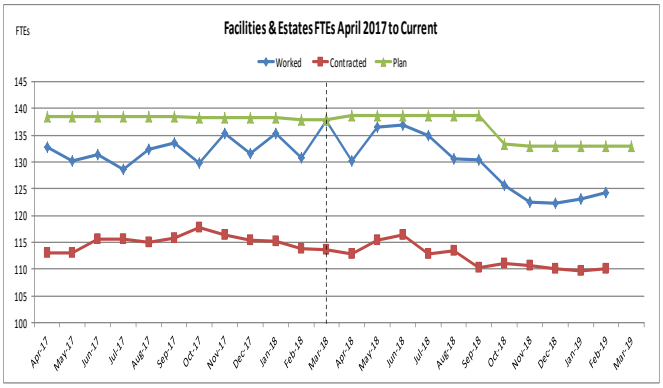












Key Messages

The charts above do not included the assumed vacancy factor incorporated into the plan. They indicate that all staffing groups are operating below established levels, with the exception of Other Clinical staff who are ahead of plan and Non Nursing Clinical staff who are at plan. Support to clinical staff are over recruited in some cases to offset qualified vacancies.

Support to Clinical Staff increase in contracted WTEs was primarily due to recruitment of trainees in CAMH IAPT and EMHP 20 WTEs. However, there were also increases in permanent staff in District Nursing of 3 WTEs.

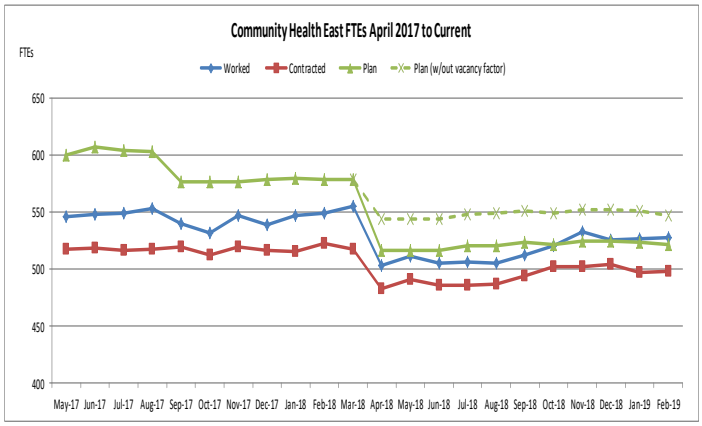
Other Clinical contracted staff reduced minimally across a number of areas, however these were offset by increases in psychologists and speech therapists across CAMHS IAPT 10 FTEs and ASD Pathway 2 FTEs.

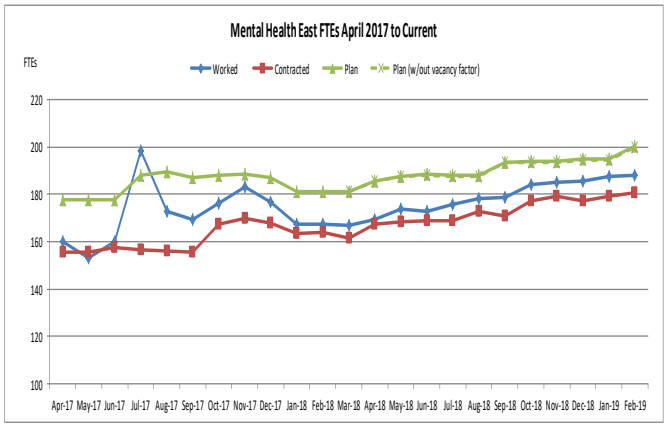
Contracted Medical staff increases were Junior doctors 3 WTEs and Westcall GPs 2.

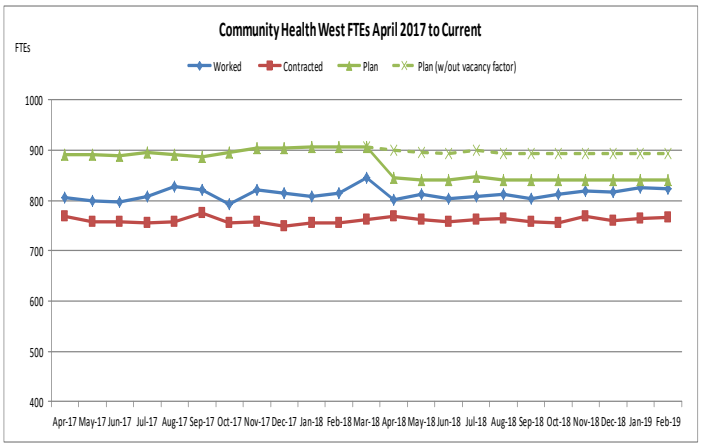
Management and Admin staffing numbers continued to increase with appointments in a number of areas including Willow House, Rapid Response, IT Server Support, Nursing, Physio Reading and CH West.

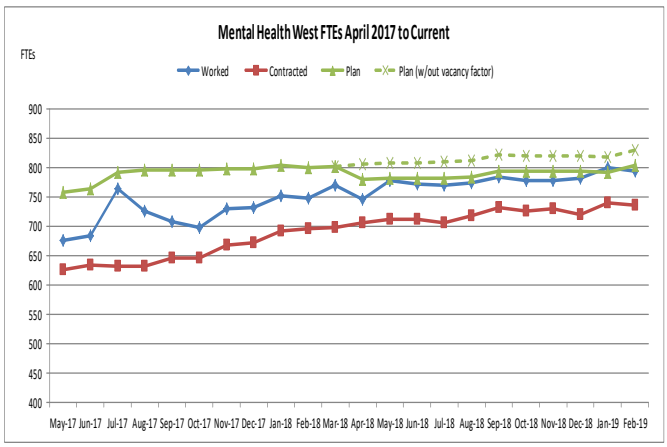
Qualified Nursing WTEs remained constant in February.

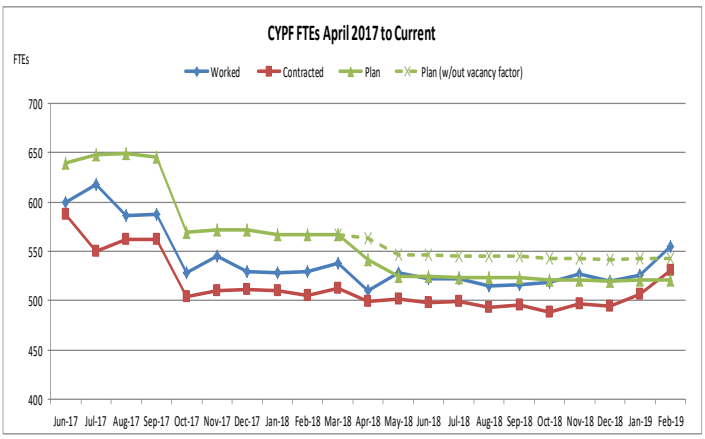
Workforce: Divisional

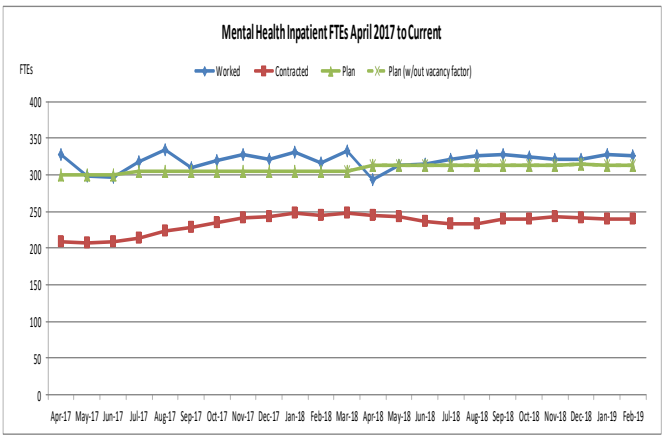


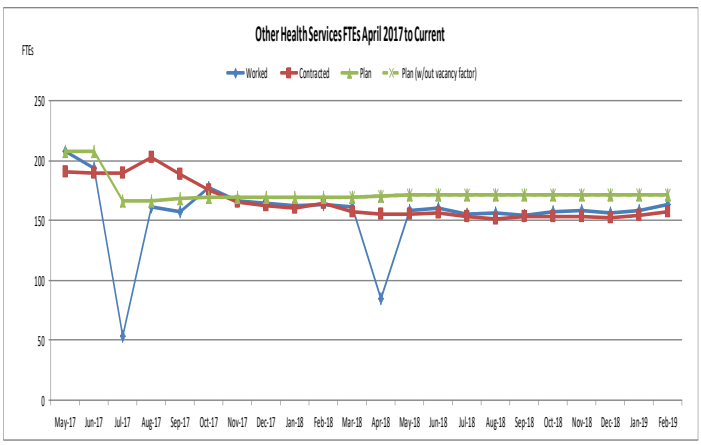


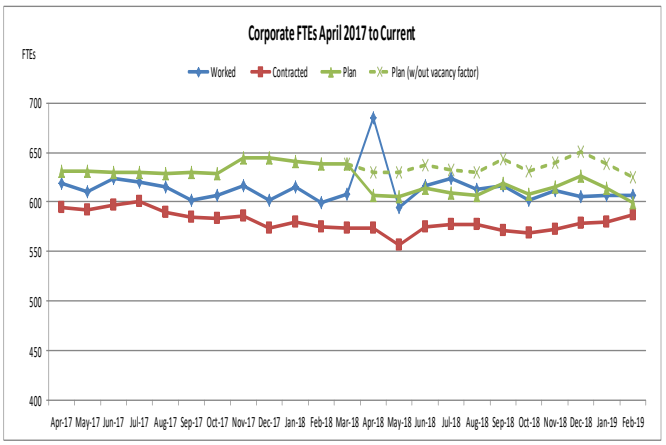




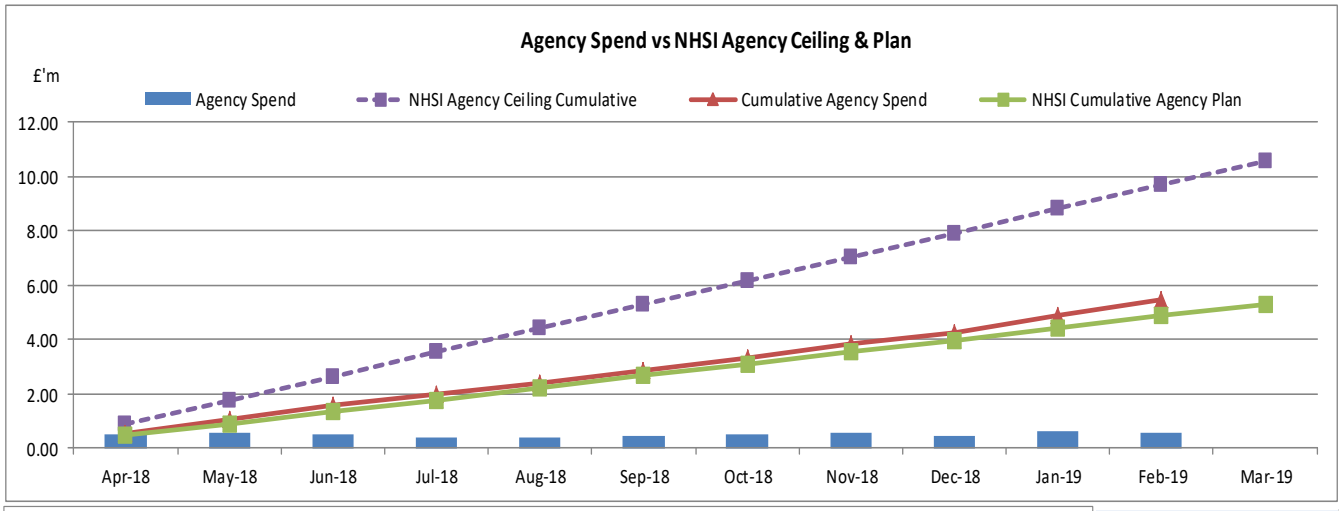


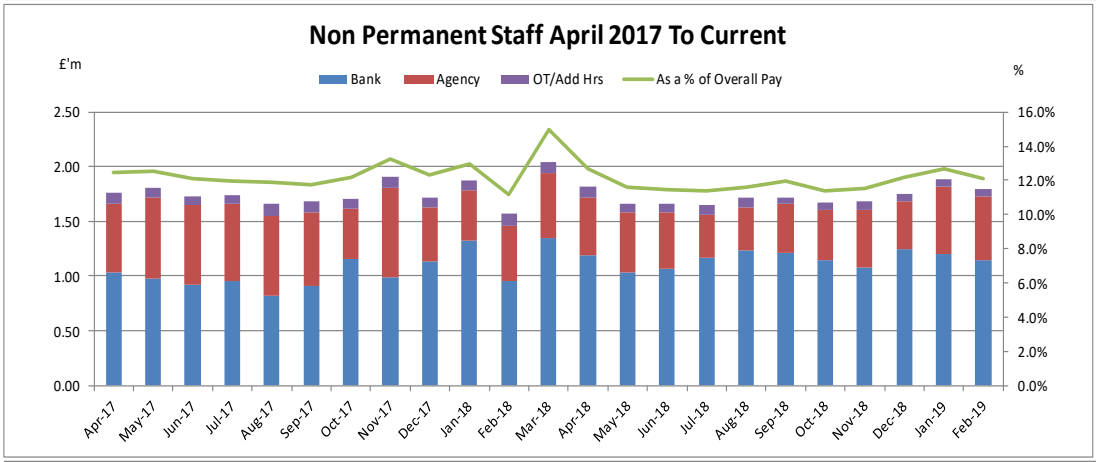






Non Permanent Pay

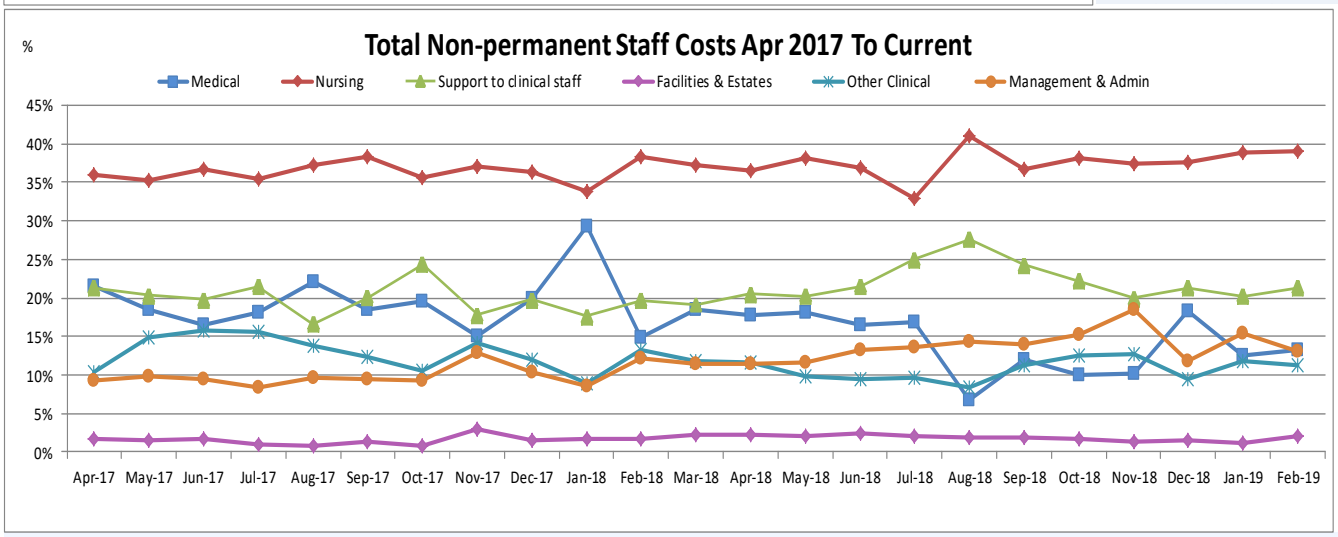




Non Permanent Pay

YTD	Bank	Agency	OT/Add Hrs
2018/19	12.7	5.5	0.9
2017/18	11.2	7.0	1.0
	12% ▲	-28% ▼	-21% ▼

Prior Yr	Bank	Agency	OT/Add Hrs
Oct-18	1.1	0.6	0.1
Oct-17	1.2	0.6	0.1
	-4% ▼	-7% ▼	-66% ▼



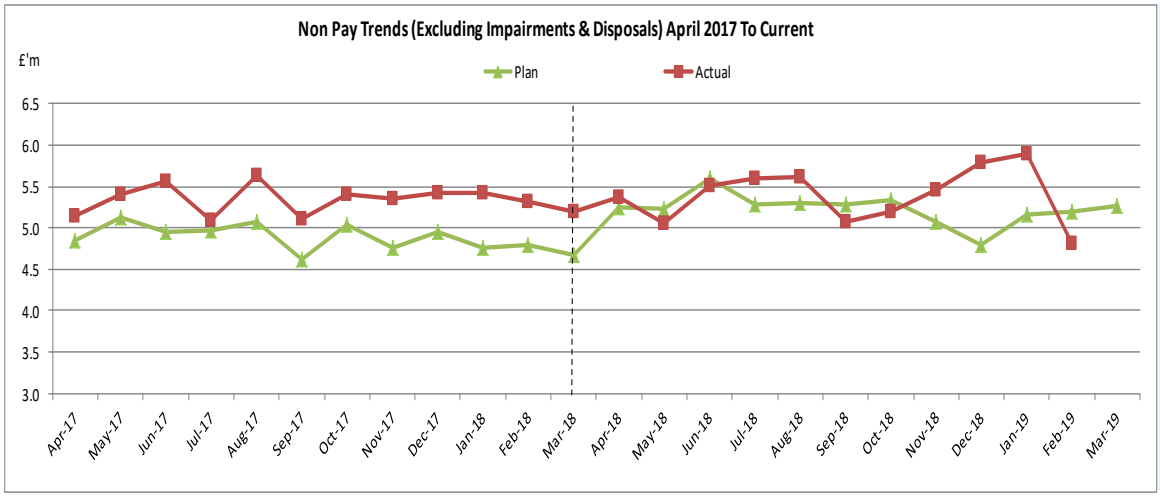
Key Messages

Costs in February (excluding overtime and additional hours) were £1.7m. Agency and bank costs reduced this month by £39k and £49k respectively. There were notable reductions in temporary staffing costs in CAMHS, Facilities, Scheduled Services and LD. However, both agency and bank are still £70k and £199k higher than February 18 respectively, Agency cost run rate has increased with costs over the past 3 months £180k higher than the previous 3 months, and £330k higher than the period before that.

A Staffing & Resources Group has been formed and beginning its review of non clinical spend, pending expected NHSI guidance on continue usage in this area.

Non Pay Expenditure

Non Pay	In Month			YTD			FY			Prior YTD		
	Act	Plan	Var	Act	Plan	Var	Forecast	Plan	Forecast Var	Act	Var	
	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	+/-	%
Purchase of Healthcare	0.6	1.0	(0.4)	14.7	12.6	2.0	16.7	13.7	3.0	15.0	(0.4)	(2.5)%
Drugs	0.4	0.4	0.0	5.4	4.6	0.8	6.2	5.0	1.2	4.4	1.0	23.8%
Premises	1.4	1.2	0.2	14.1	13.1	1.0	14.9	14.3	0.6	14.0	0.1	0.4%
Supplies and services – clinical	0.6	0.4	0.2	4.7	4.8	(0.1)	4.9	5.2	(0.3)	4.6	0.2	3.3%
Transport	0.3	0.3	(0.1)	2.9	3.6	(0.7)	3.0	3.9	(0.9)	3.1	(0.2)	(6.9)%
Establishment	0.3	0.3	0.0	3.4	2.8	0.6	3.7	3.1	0.6	4.6	(1.2)	(25.6)%
Other Non Pay	0.7	1.0	(0.3)	8.3	10.2	(1.9)	8.8	11.2	(2.4)	7.6	0.7	9.5%
PFI Lease	0.5	0.5	0.0	5.8	5.8	0.0	6.4	6.3	0.1	5.7	0.2	3.3%
Total Non Pay	**4.8**	**5.2**	**(0.4)**	**59.4**	**57.5**	**1.9**	**64.7**	**62.7**	**1.9**	**59.0**	**0.4**	**0.7%**



Non Pay

YTD	£'m
2018/19	59.4
2017/18	58.9
▲	*1%*

Prior Yr	£'m
Feb-19	4.8
Feb-18	5.3
▼	*-10%*

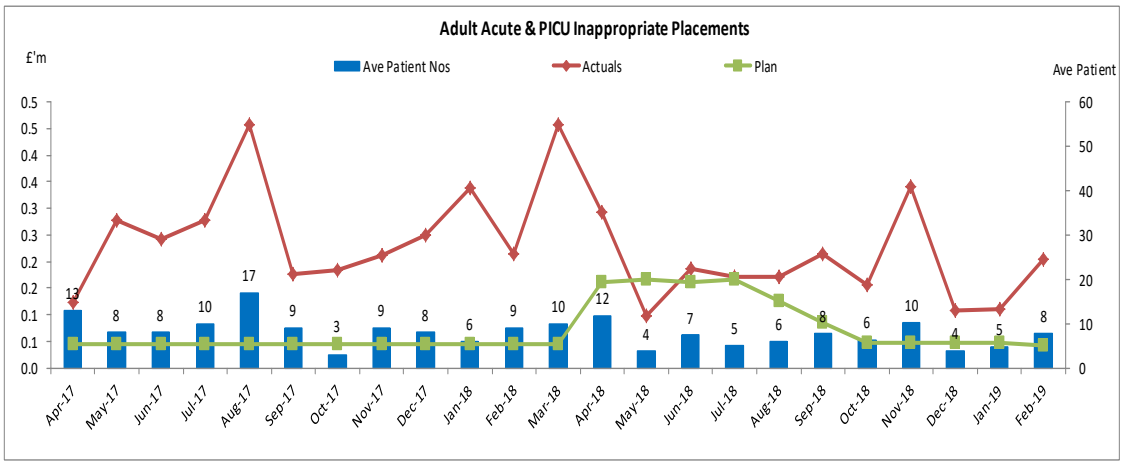
Key Messages

Overall non pay expenditure was £0.4m lower than planned. The in month underspend has reduced the YTD over-spend to £1.9m.

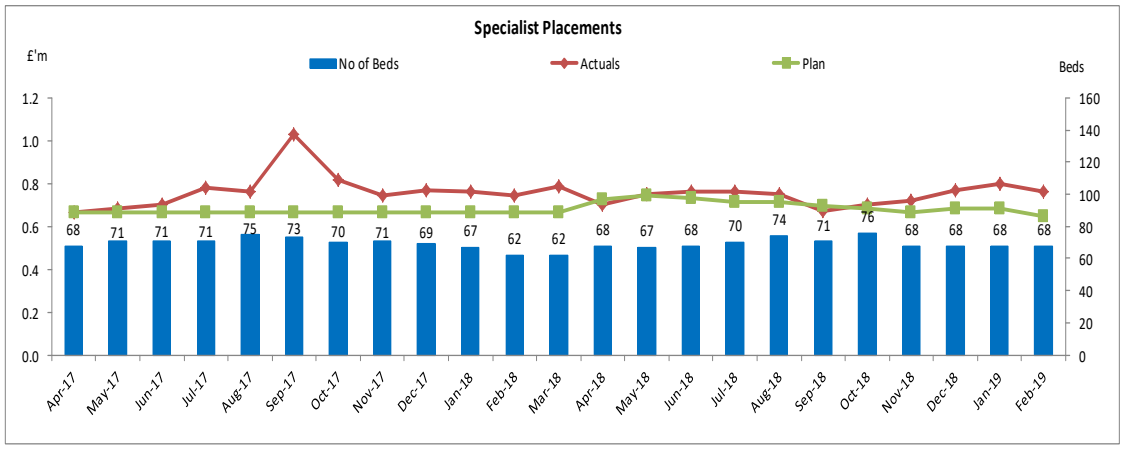
Spend this month includes several non-recurrent items. The first being a £0.7m pass through reduction for Berkshire West LD OAPs costs, the offset reflected through income. Secondly there was a £0.2m internal investment in upgrading the wheelchair fleet. This is being internally funded, and again the offset is reflect in our income numbers. Excluding these items, underlying spend has fallen £0.3m vs January.

OAPS and Drug costs continue to be above plan, the latter directly recovered through income. Inappropriate placements costs increased in February by £0.1m due to the increase in number of patients by 3, while specialist placements remained in line with recent trends. LD OAPs excluding the Gloucester patients' adjustment, reduced by £22k in month.

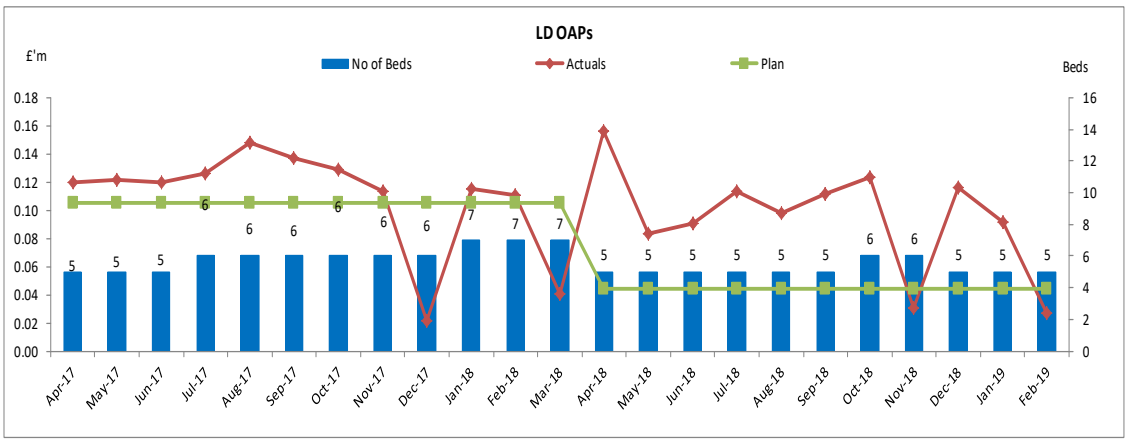
Non Pay Expenditure - Focus on OAPs



Non Pay	
YTD	£'m
2018/19	2.1
2017/18	2.7
▼	-25%
Prior Yr	£'m
Feb-19	0.2
Feb-18	0.2
▼	-4%



Non Pay	
YTD	£'m
2018/19	8.2
2017/18	8.5
▼	-4%
Prior Yr	£'m
Feb-19	0.8
Feb-18	0.7
▲	3%



Non Pay	
YTD	£'m
2018/19	1.0
2017/18	1.3
▼	-18%
Prior Yr	£'m
Feb-19	(0.6)
Feb-18	0.1
▼	-631%

Key Messages

Inappropriate Placements' costs in February were £0.2m higher than plan but in line with February 18. YTD cost are £1m higher than planned, but still £0.7m lower than prior YTD. In February PICU patients increased by 1 and Acute by 2.

Specialist Placements cost were £0.1m overspent in February and were £0.5m overspent YTD. Again considerable efforts have been made with spend down on last year by £0.3m.

LD OAPS continue to be the area where we see the largest pressure compare to last year. Costs are £0.6m overspent YTD which represents an increase of £0.5m compared to last year (excluding contract adjustment). The chart has been normalised for the Berkshire West LD patients funding transfer.

3.0 Divisional Summary

Income Statement	In Month			YTD			Full Year			Prior YTD		
	Act £'m	Plan £'m	Var £'m	Act £'m	Plan £'m	Var £'m	Forecast £'m	Plan £'m	Var £'m	Act £'m	+/-	Var %
Community Health West												
Income	0.4	0.5	(0.0)	4.6	5.0	(0.5)	5.0	5.5	(0.5)	3.9	0.7	16.9%
Pay	2.9	2.9	0.0	31.7	32.3	(0.6)	34.4	35.3	(0.8)	31.1	0.6	1.9%
Non Pay	0.5	0.5	(0.0)	5.2	5.2	(0.0)	5.7	5.7	(0.0)	4.9	0.3	5.7%
Net Cost	***3.0***	***2.9***	***0.0***	***32.3***	***32.5***	***(0.2)***	***35.1***	***35.5***	***0.4***	***32.1***	***0.2***	***0.7%***
Mental Health West												
Income	0.1	0.2	(0.1)	2.5	2.8	(0.3)	2.9	3.0	(0.1)	2.7	(0.2)	(7.3)%
Pay	2.9	2.9	(0.0)	31.2	31.2	0.0	33.9	34.1	(0.2)	28.1	3.1	11.1%
Non Pay	(0.2)	(0.3)	0.2	5.9	4.0	1.9	7.1	4.3	2.8	6.3	(0.4)	(6.2%)
Net Cost	***2.6***	***2.4***	***0.2***	***34.6***	***32.4***	***2.2***	***38.1***	***35.4***	2.7	***31.7***	***2.9***	***9.3%***
Community Health East												
Income	0.3	0.3	(0.0)	2.8	3.0	(0.2)	3.2	3.3	(0.1)	4.0	(1.2)	(30.7)%
Pay	1.9	1.9	(0.0)	19.8	20.2	(0.4)	21.6	22.0	(0.4)	21.0	(1.2)	(5.6%)
Non Pay	0.5	0.6	(0.1)	5.8	6.3	(0.5)	6.4	6.9	(0.5)	6.2	(0.4)	(5.9%)
Net Cost	***2.1***	***2.2***	***(0.1)***	***22.8***	***23.5***	***(0.6)***	***24.8***	***25.6***	(0.8)	***23.1***	***(0.3)***	***(1.3%)***
Mental Health East												
Income	0.0	0.1	(0.1)	1.5	1.3	0.3	1.8	1.4	0.4	1.5	0.0	0.9%
Pay	0.7	0.8	(0.1)	7.5	7.8	(0.3)	8.2	8.5	(0.3)	6.8	0.7	9.7%
Non Pay	0.9	0.8	0.1	9.3	8.9	0.5	10.0	9.7	0.4	9.4	(0.1)	(1.1%)
Net Cost	***1.5***	***1.5***	***0.1***	***15.3***	***15.4***	***(0.1)***	***16.5***	***16.8***	(0.3)	***14.7***	***0.5***	***3.7%***
CYPF												
Income	0.4	0.2	0.2	2.9	2.5	0.4	3.0	2.7	0.3	3.1	(0.2)	(6.9)%
Pay	1.9	1.8	0.0	20.3	20.4	(0.2)	22.3	22.3	0.0	21.5	(1.3)	(5.9%)
Non Pay	0.2	0.1	0.0	1.6	1.5	0.1	1.5	1.6	(0.0)	1.4	0.1	10.3%
Net Cost	***1.7***	***1.8***	***(0.1)***	***18.9***	***19.4***	***(0.5)***	***20.8***	***21.1***	(0.4)	***19.8***	***(0.9)***	***(4.6%)***
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	126.3%
Pay	1.0	0.9	0.1	10.6	10.2	0.4	11.5	11.1	0.4	9.8	0.8	8.1%
Non Pay	0.1	0.1	(0.0)	0.8	1.0	(0.1)	0.9	1.1	(0.1)	1.0	(0.2)	(15.4%)
Net Cost	***1.1***	***1.0***	***0.1***	***11.5***	***11.2***	***0.3***	***12.5***	***12.2***	0.2	***10.8***	***0.6***	***5.9%***
Other Health Services												
Income	0.2	0.1	0.1	2.5	1.1	1.4	2.9	1.2	1.7	1.2	1.2	99.3%
Pay	1.2	1.2	0.0	13.7	13.5	0.2	15.0	14.7	0.3	13.4	0.3	2.2%
Non Pay	0.1	0.0	0.1	1.6	0.3	1.3	1.8	0.3	1.5	0.3	1.2	389.2%
Net Cost	***1.1***	***1.2***	***(0.0)***	***12.8***	***12.7***	***0.1***	***14.0***	***13.8***	0.1	***12.5***	***0.3***	***2.3%***
Corporate												
Income	1.6	1.7	(0.1)	16.3	14.2	2.1	16.6	15.4	1.2	17.7	(1.4)	(7.8)%
Pay	2.3	1.9	0.4	25.3	24.5	0.8	27.5	26.5	1.0	24.6	(0.7)	2.8%
Non Pay	2.7	3.4	(0.7)	29.2	30.4	(1.2)	31.3	33.2	(2.0)	29.3	0.2	(0.5%)
Net Cost	***3.5***	***3.7***	**0.2**	***38.2***	***40.6***	**2.5**	***42.2***	***44.3***	(2.2)	***36.2***	**(1.9)**	**5.3%**
Corporate Income & Financing												
Income	18.0	17.9	0.1	199.8	199.8	(0.0)	218.1	218.2	(0.1)	194.6	5.2	2.7%
Financing	0.926	1.004	(0.1)	9.242	9.9521	(0.7)	10.0	11.0	(1.0)	9.1	0.1	1.3%
Surplus/ (Deficit) Statutory	***0.5***	***0.3***	**0.2**	***4.1***	***2.2***	**2.0**	***4.2***	***2.3***	***1.9***	***4.4***	**(0.2)**	**(5.1)%**

Key Messages

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

Mental Health West: Non pay is entirely due to OAP overspends.

Mental Health East: Income lower as S117 now in Corporate income and non pay higher because of OAPs overspend.

Other Health: Non-pay variances relate to Pharmacy pass through drugs.

Corporate: Income includes adjusted CQUIN provision, funding non recurrent investments. Non-pay includes the West Berkshire LD OAPs adjustment, wheelchair investment and estates overspends.

4.0 Cost Improvement Programme

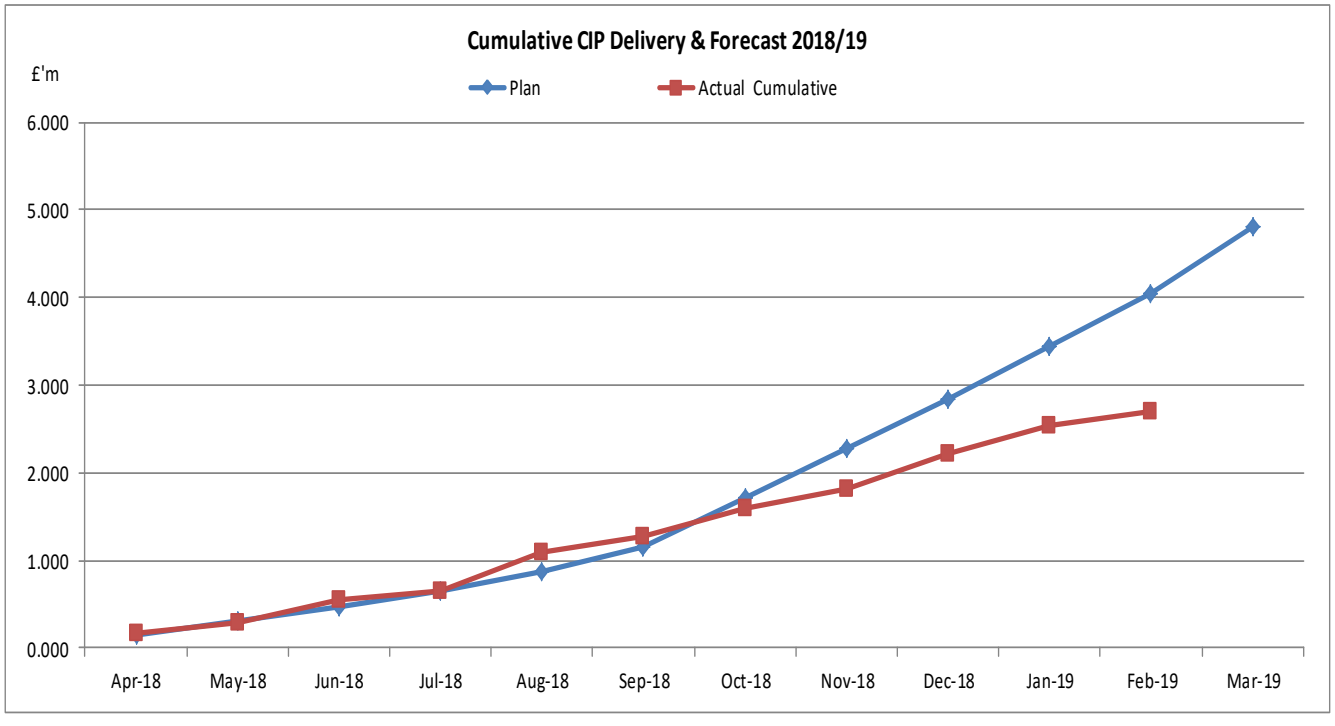
The table below illustrates current performance of the Trusts Cost Improvement Programme.

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	(0.08)	0.07	(0.15)	0.17	0.52	(0.35)	0.30	0.59	(0.29)
Overspill Beds	0.10	0.26	(0.16)	1.06	1.56	(0.50)	1.20	1.82	(0.62)
Total OAPS Saving	***0.02***	***0.33***	***(0.31)***	***1.23***	***2.08***	***(0.85)***	***1.50***	***2.40***	***(0.91)***
Service Line Review									
WestCall	0.00	0.08	(0.08)	0.00	0.42	(0.42)	0.00	0.50	(0.50)
CRHTT	0.00	0.08	(0.08)	0.00	0.42	(0.42)	0.00	0.50	(0.50)
Total Service Line Savings	***0.00***	***0.17***	***(0.17)***	***0.00***	***0.83***	***(0.83)***	***0.00***	***1.00***	***(1.00)***
Procurement									
NHSP Contract	0.02	0.02	0.00	0.17	0.17	0.00	0.18	0.18	0.00
Procurement Spend	0.02	0.03	(0.00)	0.393	0.275	0.118	0.40	0.30	0.10
Total Procurement Savings	***0.04***	***0.04***	***(0.00)***	***0.56***	***0.44***	***0.12***	***0.58***	***0.48***	***0.10***
Other Schemes									
Community NCA	0.02	0.02	0.00	0.28	0.23	0.05	0.25	0.25	0.00
Liaison & Diversion Contract	0.02	0.02	0.00	0.23	0.23	0.00	0.25	0.25	0.00
Other Contracts	0.02	0.02	0.00	0.23	0.23	0.00	0.25	0.25	0.00
Scheme to be Identified	0.01	0.00	0.01	0.15	0.00	0.15	0.17	0.17	0.00
Total Other Savings	***0.08***	***0.06***	***0.02***	***0.88***	***0.69***	***0.20***	***0.92***	***0.92***	***0.00***
Total CIP Delivery	***0.13***	***0.60***	***(0.47)***	***2.67***	***4.04***	***(1.37)***	***3.00***	***4.80***	***(1.81)***

Key Messages

The Trust delivered a £2.7m of savings YTD against a plan of £4.0m. Forecast savings are expected to be £3.0m reflecting the current position of OAPs.

Specialist placements continue to under deliver with CIP in month impacted by planned step down and contract negotiations continuing slower than anticipated. Risk remains with regards to overspill beds in March as the number of beds used averages around 8 against a plan of 2. Forecast is dependent on the average in month not exceeding 6 across both out of area acute and PICU placements.



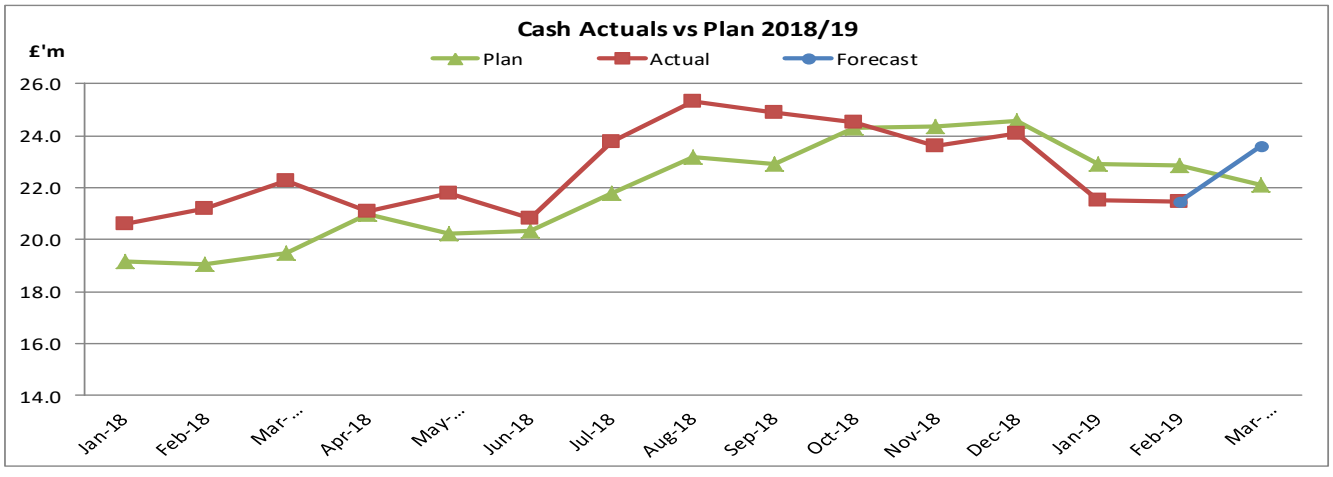
5.0 Balance Sheet & Cash

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	4.8	5.5	(0.7)	4.8	5.5	(0.7)	5.5
Property, Plant & Equipment (non PFI)		35.1	36.9	33.9	3.1	36.9	33.9	3.1	38.5
Property, Plant & Equipment (PFI)		55.6	58.6	59.6	(1.0)	58.6	59.6	(1.0)	55.6
Total Non Current Assets		**95.2**	**100.3**	**98.9**	**1.4**	**100.3**	**98.9**	**1.4**	**99.6**
Trade Receivables & Accruals		13.4	17.7	10.8	6.9	17.7	10.8	6.9	10.8
Other Receivables		0.3	0.2	1.3	(1.1)	0.2	1.3	(1.1)	1.3
Cash		22.3	21.5	22.8	(1.4)	21.5	22.8	(1.4)	22.1
Trade Payables & Accruals		(23.7)	(26.3)	(24.8)	(1.5)	(26.3)	(24.8)	(1.5)	(24.6)
Current PFI Finance Lease		(1.0)	(1.2)	(1.2)	(0.0)	(1.2)	(1.2)	(0.0)	(1.2)
Other Current Payables		(2.3)	(3.1)	(2.3)	(0.8)	(3.1)	(2.3)	(0.8)	(2.3)
Total Net Current Assets / (Liabilities)		**9.0**	**8.8**	**6.6**	**2.1**	**8.8**	**6.6**	**2.1**	**6.1**
Non Current PFI Finance Lease		(29.7)	(28.6)	(28.6)	0.0	(28.6)	(28.6)	0.0	(28.5)
Other Non Current Payables		(1.6)	(1.6)	(1.6)	0.0	(1.6)	(1.6)	0.0	(1.6)
Total Net Assets		***72.9***	***78.9***	***75.4***	***3.5***	***78.9***	***75.4***	***3.5***	***75.6***
Income & Expenditure Reserve		19.9	24.0	22.0	2.0	24.0	22.0	2.0	22.2
Public Dividend Capital Reserve		16.0	17.8	16.3	1.5	17.8	16.3	1.5	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***	***78.8***	***75.4***	***3.5***	***78.8***	***75.4***	***3.5***	***75.6***

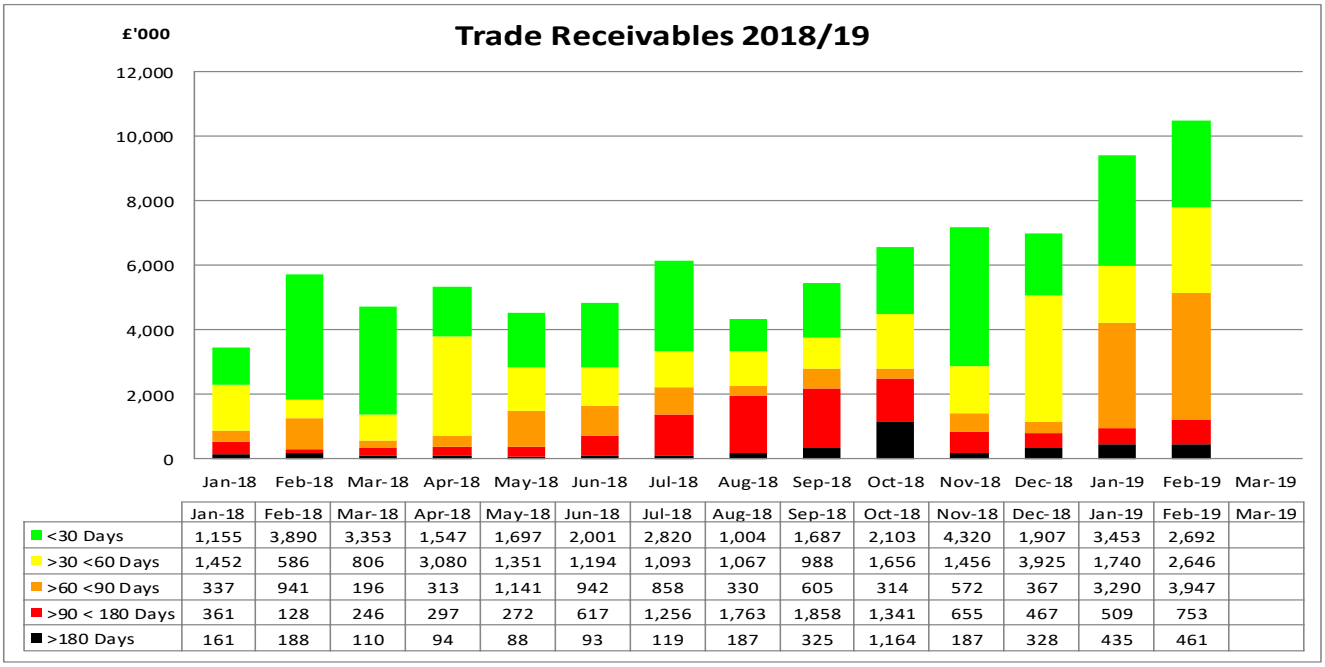
Cashflow		17/18 Actual £'m	Current Month Act £'m	Current Month Plan £'m	Current Month Var £'m	YTD Act £'m	YTD Plan £'m	YTD Var £'m	18/19 Plan £'m
Operating Surplus/(Deficit)	+/-	10.7	0.9	0.7	0.2	8.9	6.3	2.6	7.8
Depreciation and Impairments	+	5.4	0.5	0.6	(0.1)	4.5	4.5	(0.1)	5.7
Operating Cashflow		***16.1***	***1.4***	***1.3***	***0.1***	***13.3***	***10.8***	***2.5***	***13.4***
Net Working Capital Movements	***+/-***	***(2.1)***	***(1.9)***	***(0.1)***	***(1.7)***	***(3.3)***	***0.8***	***(4.1)***	***1.6***
Proceeds from Disposals	+	0.0	0.0	0.0	0.0	0.8	0.8	0.0	0.0
Donations to fund Capital Assets	+	1.7	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Donated Capital Assets	-	(1.7)	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Capital Expenditure (Net of Accruals)	-	(8.0)	(0.4)	(0.8)	0.3	(8.3)	(7.2)	(1.1)	(9.1)
Investments		***(10.2)***	***(0.4)***	***(0.8)***	***0.4***	***(7.5)***	***(6.4)***	***(1.1)***	***(7.5)***
PFI Finance Lease Repayment	-	(1.0)	(0.1)	(0.1)	(0.0)	(1.0)	(0.9)	(0.1)	(1.0)
Net Interest	+/-	(3.5)	(0.2)	(0.3)	0.1	(3.2)	(3.0)	(0.2)	(3.6)
PDC Revieved	+	1.8	1.3	0.0	1.3	1.8	0.3	1.5	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)***	***1.0***	***(0.4)***	***1.3***	***(3.3)***	***(4.5)***	***1.2***	***(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***	***0.1***	***(0.0)***	***0.1***	***(0.8)***	***0.7***	***(1.5)***	***(0.3)***
Opening Cash		20.7	21.4	22.9	(1.5)	22.3	22.3	0.0	22.3
Closing Cash		***22.3***	***21.5***	***22.8***	***(1.3)***	***21.5***	***22.8***	***(1.3)***	***22.0***

Key Messages

Closing cash balance was £21.5m, £1.4m below plan. The higher than planned surplus in addition to capital slippage, is being offset by an adverse working capital position driven in the main by outstanding NHSPS debt. With the resolution of NHSPS debt, we are forecasting a higher than planned cash balance for YE. This now also includes £1.3m GDE funding brought forward from 19/20.



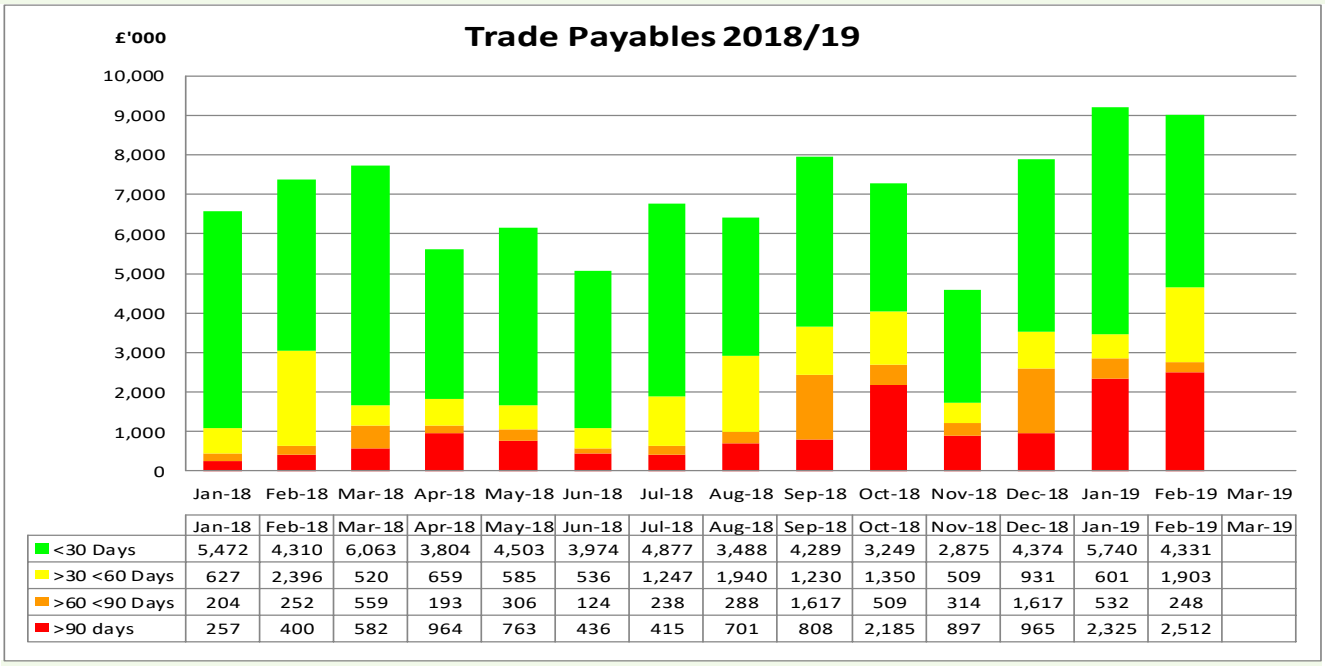
Cash Management



	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	4,320	1,907	3,453	2,692	
>30 <60 Days	1,452	586	806	3,080	1,351	1,194	1,093	1,067	988	1,656	1,456	3,925	1,740	2,646	
>60 <90 Days	337	941	196	313	1,141	942	858	330	605	314	572	367	3,290	3,947	
>90 < 180 Days	361	128	246	297	272	617	1,256	1,763	1,858	1,341	655	467	509	753	
>180 Days	161	188	110	94	88	93	119	187	325	1,164	187	328	435	461	

Key Message

The Trust was owed £5.6m by NHSPS, of which £3.4m is now overdue by 60-90 days. The NHSPS debt issue was escalated to their CFO, given existing channels of recourse had been exhausted. On 15th March, NHSPS made a £5.0m payment to the Trust, reducing total overdue debt to £2.7m. The remaining debt is the accumulation of £0.1m to £0.3m balances across local providers and commissioners which we expect to be reduced by YE.



	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	2,875	4,374	5,740	4,331	
>30 <60 Days	627	2,396	520	659	585	536	1,247	1,940	1,230	1,350	509	931	601	1,903	
>60 <90 Days	204	252	559	193	306	124	238	288	1,617	509	314	1,617	532	248	
>90 days	257	400	582	964	763	436	415	701	808	2,185	897	965	2,325	2,512	

Key Message

In response to the on-going issue of non payment by NHSPS, we continued to hold payments and the figures above include £3.3m of debt owed to NHSPS at the end of February. Other than NHSPS, the remains material debt over 90 days relates to charges from Frimley of £0.2m, which we are working to resolve.

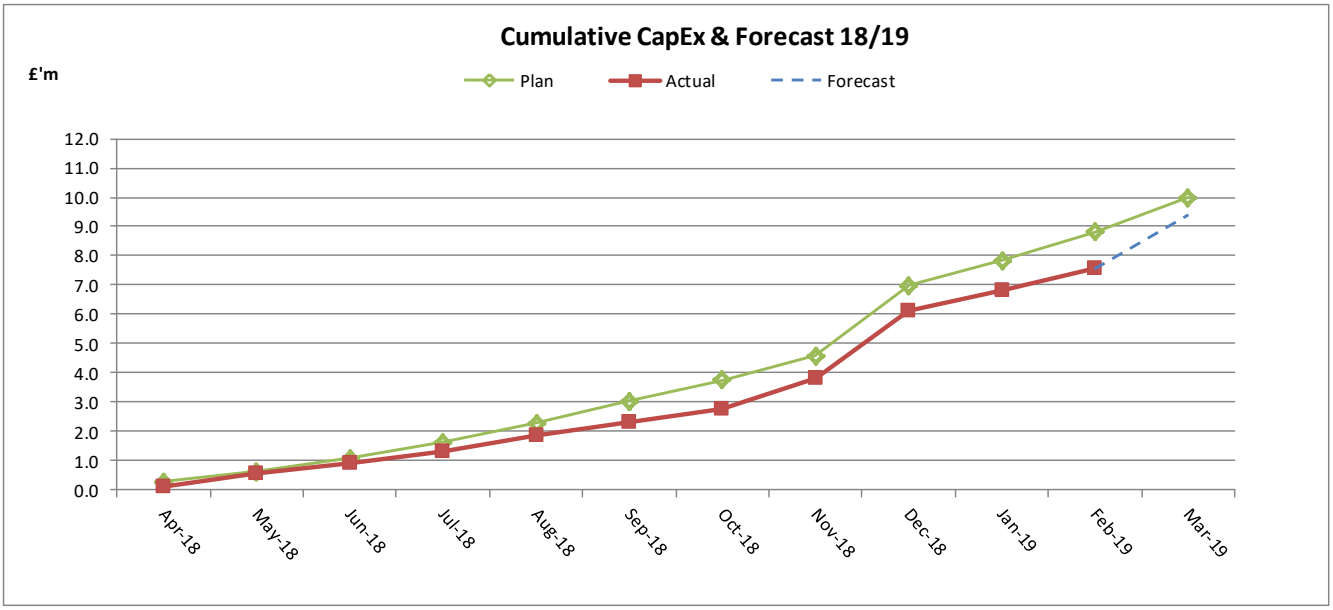
Following NHSPS's payment to the Trust, we have released £3.1m owed to them.

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	0	70	(70)	322	742	(420)	755
Leased Non Commercial (NHSPS)	21	21	(0)	556	553	3	735
Leased Commercial	0	0	0	15	0	15	0
Statutory Compliance	36	11	25	283	210	73	448
Locality Consolidations	3	250	(247)	60	1,300	(1,240)	1,600
PFI	257	230	27	717	940	(222)	1,380
Subtotal Estates Maintenance & Replacement	**317**	**582**	**(265)**	**1,953**	**3,745**	**(1,791)**	**4,918**
IM&T Expenditure							
IM&T Refresh & Replacement	130	269	(139)	3,137	2,668	469	3,187
IM&T RiO Licences	0	0	0	57	0	57	0
IM&T Business Intelligence and Reporting	0	10	(10)	75	125	(50)	130
IM&T System & Network Developments	0	0	0	(3)	0	(3)	0
IM&T Other	(11)	1	(12)	43	48	(5)	95
IM&T Locality Schemes	39	0	39	500	0	500	200
HSLI Community Mobile Working	16	0	16	53	0	53	0
Subtotal IM&T Expenditure	**174**	**280**	**(106)**	**3,863**	**2,841**	**1,022**	**3,612**
GDE Expenditure							
GDE Trust Funded	233	131	102	1,648	2,188	(540)	2,320
Subtotal GDE Expenditure	**233**	**131**	**102**	**1,648**	**2,188**	**(540)**	**2,320**
Other Locality Schemes	13	0	13	86	0	86	150
Subtotal Capital Expenditure	**737**	**993**	**(256)**	**7,551**	**8,774**	**(1,223)**	**11,000**
Assumed Slippage within NHSI Plan		0	0		0	0	(1,000)
Subtotal Capital Expenditure vs NHSI Plan	**737**	**993**	**(256)**	**7,551**	**8,774**	**(1,223)**	**10,000**
Donated Assets							
Renal Unit at WBCH	32	32	0	1,064	1,064	0	1,064
Subtotal Donated Assets	**32**	**32**	**0**	**1,064**	**1,064**	**0**	**1,064**
Total Capital Expenditure	**769**	**1,025**	**(256)**	**8,614**	**9,837**	**(1,223)**	**11,063**

Key Message

Spend is being monitored against our NHSI plan of £10m. Spend in February was £0.8m, £0.3m below plan. YTD the programme is £1.2m behind plan and the forecast for YE is expected to be c£9.4m. This is in-line with our most recent forecast. The Trust has received £1.3m PDC funding from NHS Digital for re-phased GDE funding brought forward from 19/20.



Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	9th April 2019
Title	**Finance Plan 2019/20**
Purpose	Provide the Board with a summary of the financial plan submitted to NHSI on 4th April 2019.
Business Area	Finance
Author	Paul Gray, Director of Finance Alex Gild. Chief Financial Officer
Relevant Strategic Objectives	Money Matters
CQC Registration/Patient Care Impacts	N/A
Resource Impacts	N/A
Legal Implications	Compliance with NHSI Planning Guidance
Equality and Diversity Implications	N/A
SUMMARY	The paper provides a summary of the 2019/20 Financial plan which was reviewed at the Finance, Investment and Performance Committee meeting at the end of March 2019 and submitted to NHS Improvement on the 4th April 2019. The plan has been built to deliver our £1.8m NHS Improvement Control Total. During the planning process we have agreed a fair contract with Commissioners whilst resisting increases in our cost base. As a result, we have been able to set a plan which requires the delivery of a realistic £4m Cost Improvement Program in line with NHS Improvement's efficiency expectations for 2019/20. The Mental Health Investment Standard has also been confirmed, with key service investments supporting continued progress towards national commitments. Our cash forecast remains strong, with a closing

	balance expected to be £21.2m, after in year capital investment of £12.4m. The plan also assures a Financial Risk Rating of 1 for each quarter end and 19/20 overall. Key risks include Out of Area Placements Cost Improvement Programme delivery and containing underlying pay bill at current levels, excluding new service investment and inflation.
ACTION	The Board is asked to endorse the plan and acceptance of NHS Improvement's control total.

Trust Board (public) – 9th April 2019

Financial Plan 19/20 Summary

Key Updates

The 19/20 plan is due to be submitted to NHSI on the 4th April, further to final draft review by the March Board and final review by the FIP Committee at the end of March.

The key updates to note are:

- CCG contracts were signed on 21st March.
- The gap to Control Total, and CIP plan submitted is £4.0m, with £3.7m of 'Low Risk' schemes
- Closing Cash at the end of 19/20 is forecast to be £20.6m, after Capex of £12.4m

Summary Financial Plan

The table below outlines a summary of the 19/20 financial plan. It reflects the bottom up aggregation of all operational plans, CCG contracts and the £4.0m cost improvement programme.

	FOT	*Q1*	*Q2*	*Q3*	*Q4*	*19/20*	*+/-*
	£'m	*£'m*	*£'m*	*£'m*	*£'m*	*£'m*	*£'m*
Clinical Income	228.67	60.80	60.70	60.56	60.56	242.59	13.92
Other Income	19.59	4.91	4.91	4.91	4.64	19.36	(0.22)
18/19 Pay Award Funding)	2.41	0.00	0.00	0.00	0.00	0.00	(2.41)
Donated Income	0.52	0.00	0.00	0.00	0.00	0.00	(0.52)
PSF, FRF and MRET funding	2.43	0.35	0.46	0.69	0.81	2.30	(0.13)
Total Income	**253.62**	**66.06**	**66.07**	**66.16**	**66.00**	**264.26**	**10.64**
Substantive Pay	154.92	42.86	41.95	41.66	41.54	168.01	13.10
Bank staff including on-costs	13.83	3.23	3.15	3.15	3.23	12.76	(1.07)
Agency	5.78	1.25	1.25	1.25	1.25	4.99	(0.79)
Total Pay	**174.52**	**47.34**	**46.35**	**46.06**	**46.02**	**185.76**	**11.24**
Purchase of Healthcare	16.68	3.29	3.53	3.53	3.78	14.14	(2.54)
Supplies and Services	5.98	1.48	1.48	1.48	1.48	5.93	(0.05)
Drugs costs	6.24	1.68	1.68	1.68	1.68	6.73	0.50
Establishment	3.71	0.79	0.79	0.79	0.79	3.16	(0.56)
Premises	14.88	3.76	3.73	3.77	3.79	15.04	0.16
Transport	3.03	0.90	0.90	0.90	0.90	3.60	0.57
PFI	6.35	1.71	1.73	1.73	1.70	6.86	0.51
Other	8.04	2.06	2.22	2.25	2.19	8.72	0.68
Total Non Pay	**64.91**	**15.67**	**16.06**	**16.13**	**16.31**	**64.17**	**(0.74)**
Interest	3.63	0.90	0.90	0.90	1.02	3.71	0.07
Depreciation	4.86	1.54	1.72	1.78	1.77	6.81	1.95
PDC dividends payable/refundable	1.64	0.50	0.50	0.50	0.50	2.02	0.37
Total Financing	**10.14**	**2.94**	**3.12**	**3.18**	**3.29**	**12.53**	**2.39**
Total Cost	**249.57**	**65.95**	**65.54**	**65.37**	**65.62**	**262.47**	**12.89**
Surplus / (Deficit)	**4.04**	**0.11**	**0.53**	**0.79**	**0.38**	**1.79**	**(2.25)**
Donated Depreciation		0.03	0.03	0.03	0.03	0.11	
PSF		(0.35)	(0.46)	(0.69)	(0.81)	(2.30)	
Target for Control Total		**(0.24)**	**0.07**	**0.10**	**(0.43)**	**(0.40)**	
NHSI Use of Resource Rating		1	1	1	1		

Plan Financial Risk Rating

At the time of writing the phasing of the income statement is under review. The non-consolidated AfC pay award in April (one-off payment to staff at top of scale) is expected to generate an in-month deficit, enough to push the Trust's overall use of resources risk rating to a '3'. This is due to the adverse impact on Capital Service Cover and I&E Margin Ratings. The plan recovers to a '1' by the end of Q1 and remains a '1' over the remainder of the year and NHSI have confirmed that this phasing would have no impact on the Trust's overall segmentation. We are exploring alternatives prior to submission which would mitigate this risk.

Commissioner Contracts

We have agreed fair contract values with Berkshire East and West CCGs, that meet the Mental Health Investment Standard including providing growth and offset to inflationary pressures. The contracts secure recurrent baseline funding for Perinatal and continuation of CPE as well as investing new funding into IAPT in the West (East had already provided expansion funding for 19/20) securing in year access targets. Children's Eating Disorders service funding has also been provided to increase capacity towards the end of year in preparation for 20/21 access standards.

Our NHSE contract is still under discussion, NHSE having proposed CAHMS Tier 4 service (Willow House) bed day pricing below our affordability. Work is on-going to resolve this contract in the context of the new unit expected to be commissioned at Prospect Park Hospital, enabled by STP capital funding awarded to support the development.

Budget Panel Review

All divisions, including corporate services, participated in budget review panels. Participants are to be thanked for their time and the work what went into this process. We have managed to contain several pressures, keeping CIP levels realistic with stretch, and enabled key supporting internal investments including EUPD pathway development.

Cost Improvement Programme

The table below illustrates the Cost Improvement Programme for the coming year. During the planning process we have been able to challenge internal cost growth and agree with commissioners reasonable contracts for the year ahead. The result of this has seen the required cost reduction target land as a minimum of £4.0m. This is the value of the programme to be submitted to NHSI, and against which we will be monitored.

In addition to the schemes we have committed to NHSI, we plan to internally to report against a £6.0m stretch target. This will incorporate schemes identified during the planning process, as well as in year opportunities as they develop. This 'stretch target' should ensure the delivery of the £4.0m plan commitment and prepare in part for possible increased employers pension contribution pressure in 20/21.

Area	Scheme	Q1 £'000	Q2 £'000	Q3 £'000	Q4 £'000	Total £'000	Risk
EOORR	Bed Optimisation (Acute/PICU overspill beds)	99	198	300	403	1,000	High
Contract	Sexual Health Tender	108	108	108	108	430	Low
Contract	Court L&D Hampshire	213	174	136	98	620	Low
Contract	Veterans Expansion	93	76	59	43	270	Low
Procurement	19/20 Procurement Programme	52	65	93	91	300	Low
Procurement	NHS Supply chain Margin Removal	38	38	38	38	153	Low
Procurement	NHS Supply chain Profit Share	11	11	11	11	45	Low
Procurement	NHS Supply chain Category Towers	12	12	12	12	48	High
Procurement	Medicines Optimisation	13	13	13	13	50	Low
Operations	CRHTT	25	25	25	25	100	Medium
Estates & Facilities	NHSPS VAT saving	250	250	250	250	1,000	Low
Total NHSI Plan Submission		***912***	***969***	***1,044***	***1,091***	***4,016***	
EOORR	LD Patients	0	100	100	100	300	High
EOORR	Papist Way Contract	35	52	52	52	190	Medium
EOORR	Cloisters Contract - Income Loss Avoidance	68	68	68	68	272	Low
EOORR	Cloisters Contract - Bed Reduction	140	140	140	140	560	Low
Contract	SLT (Slough)	15	15	15	15	60	Medium
Estates & Facilities	PFI Benchmarking / Review	0	43	43	43	130	Medium
Corporate	Corporate Benchmarking Target	0	30	60	60	150	High
Other Pay	Admin / Estates Agency Trade Out	30	50	60	60	200	Medium
Other Pay	E-Roster Efficiencies (Carter)	0	0	50	50	100	Medium
Additional Schemes		***288***	***498***	***588***	***588***	***1,962***	

For the NHSI submission, we have a fully identified plan of which 71%, £2.9m, of schemes are rated 'Low Risk', indicating a definite, to high, probability of delivery. In terms of actual delivery; including a further £0.8m from the additional schemes, £3.7m of the required £4.0m is viewed as secured.

The schemes above, in addition to a list of further opportunities will continue to be reviewed at the Trust Business Group, continuing to make the identification of productivity and savings opportunities part of business as usual.

Risks & Mitigations

In respect of CIP, the most material concern is the delivery of the OAPs financial target, which is implicitly linked to the delivery of the agreed NHSI inappropriate placement reduction trajectory (adult acute and PICU). Given the plan is based on forecast outturn, assuming costs are no worse than 18/19, the exposure equates to the £1.0m allocated CIP target currently 'red' rated.

The other key risk in the plan is the view that staffing costs will be held broadly to current levels, excluding agreed service investments and inflation. To maintain the plan within this affordability assumption, an on-going vacancy adjustment has been built into budgets at a similar level to 18/19.

Against both risks we have built a £1.6m contingency, £0.8m of which is non-recurrent.

Cash & Capital Plan

The table below presents a summarised version of our cashflow. It does not assume any 18/19 bonus or incentive payments which may be due and is predicated on our current year end cash forecast, which includes some additional CCG funding agreed during planning discussions.

	Income £'m
Closing Cash 18/19	***25.2***
Forecast Surplus 19/20	*(0.4)*
Provider Sustainability Fund 18/19	*0.8*
PSF Bonus Payments 18/19	*0.0*
Provider Sustainability Fund 19/20	*1.5*
Depreciation	*6.8*
GDE/HLIS Funding	*0.9*
Capital Programme	*(12.4)*
PFI Finance Lease	*(1.2)*
Other Workng Capital Movements	*0.0*
Net Cash Inflow / (Outflow)	***(4.0)***
Closing Cash 19/20	***21.2***

It is anticipated that our net cash balance will reduce by £4.0m in 19/20, but that we will still maintain a +£20m balance by the end of March 2020. This is after allowing for an increased capital allocation and adjusting for changes to GDE funding and profiling.

The Capital Programme for 19/20 is detailed below.

Capital Scheme	Site	Q1 £'m	Q2 £'m	Q3 £'m	Q4 £'m	19/20 £'m
Estates Schemes						
Statutory Compliance for 2019/20		48	52	48	52	***200***
Mobility Relocation	STM	200	200	-	-	***400***
CHH Roof Replacement	CHH	170	-	-	-	***170***
Ligature Removal Work (Basins & Baths)	PPH	145	145	-	-	***290***
STC Phase 3	UNI	-	723	720	720	***2,163***
Carpark at White Knights	UNI	-	100	80	-	***180***
LD to Jasmine	PPH	-	-	1,225	1,025	***2,250***
Place of Safety	PPH	25	25	25	25	***100***
Windsor Ward Floor Coverings Replacement	WCH	120	120	-	-	***240***
Ryeish Green LD Team Relocation	Ryeish	-	100	-	-	***100***
CCTV in Ward Communal Areas	PPH	-	100	100	-	***200***
Upton Hospital Upgrade of Accomodation facilities	UPT	-	-	175	175	***350***
Other Schemes		159	215	122	-	***496***
Total Estates Schemes		***867***	***1,780***	***2,495***	***1,997***	***7,139***
IM&T Programme						
IM&T Refresh & Replacement		50	2,102	107	96	***2,355***
IM&T Business Intelligence and Reporting		80	80	80	80	***320***
IM&T System & Network Developments		-	-	-	-	-
IM&T Other		15	15	15	15	***60***
IM&T Locality Schemes		-	-	-	-	-
IM&T GDE capital		773	423	423	423	***2,043***
HSLI Community Mobile Working		60	60	60	60	***239***
Other Locality Schemes		50	50	50	50	***200***
Total IM&T Programme		***1,028***	***2,730***	***735***	***724***	***5,217***
Total 19/20 Capital Expenditure		***1,895***	***4,510***	***3,230***	***2,721***	***12,356***

The capital programme for 19/20 allows for a number of significant investments as well as ensuring IT equipment is refreshed and facilities are maintained. The plan represents a £2.4m increase on our commitment in 18/19.

Estates spend is dominated by two major projects. The first being the re-location of our learning disability inpatient assessment and treatment unit, from Campion to Jasmine Ward at Prospect Park

Hospital. In addition, we plan to conclude our development of the Whiteknights (STC) building on the Reading University campus, which will enable the move of a number of poorly accommodated services into new purpose designed accommodation. We are also ensuring that key statutory and compliance work can be accommodated, including the conclusion of the Ligature Removal works at PPH.

The remaining key elements of the programme reflect our continued investment in the latest technology. We have built in sufficient provision for a continued rolling replacement programme; ensuring staff have access to the latest, compliant and user supportive equipment/devices.

We are still to agree the inclusion of the STP funded Willow House relocation, but as this is externally funded from PDC, there is no cash impact. This will be dependent upon the timing of the business case approval, both internally and with NHSI.

Actions Required

The Board is asked to:

- Endorse the 19/20 Financial Plan as outlined in this paper.
- Confirm acceptance of the 19/20 Control Total, as supported by March FIP committee.

Paul Gray, Director of Finance

Alex Gild, Chief Financial Officer

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	9th April 2019
Title	**Summary Board Performance Report M11 2018/19**
Purpose	To provide the Board with a performance summary dashboard, including narrative and Key Performance Indicator exception highlights.
Business Area	Trust-wide Performance
Author	Chief Financial Officer
Relevant Strategic Objectives	2 - To provide safe, clinically effective services that meet the assessed needs of patients, improve their experience and outcome of care and consistently meet or exceed the standards of CQC and other stakeholders.
CQC Registration/Patient Care Impacts	All relevant essential standards of care.
Resource Impacts	None.
Legal Implications	None.
Equality and Diversity Implications	None.
SUMMARY	The enclosed summary performance report provides information against the Trust's performance dashboard for February 2019. **Month 11** **2018/19 <u>EXCEPTIONS</u>** **The following Trust Performance Scorecard Summary indicator grouping is Red rated:** The "red" indicator grouping has been rated on an override basis, related to 1 specific indicator: • Service Efficiency and Effectiveness – RED **The following Trust Performance Scorecard Summary indicator groupings are Amber rated:** • People – AMBER Further detail on the AMBER dashboard ratings is narrated within the section commentaries of the

	summary performance report. **The following individual performance indicators are highlighted by exception as RED with their link to the Trust Performance Dashboard Summary identified in brackets:** • **US-02a -** Mental Health Physical Patient to Patient Assaults **(User Safety)** • **US-05 -** Self-harm incidents: Number **(User Safety)** • **US-06** - Mental Health: AWOLs on MHA section **(User Safety)** • **US-07** - Mental Health: Absconsions on MHA section **(User Safety)** • **US-19** – Use of Prone Restraint **(User Safety)** • **PM-01** - Staff Turnover Rate **(People)** • **PM-03** – Sickness Rate **(People)** • **SE-03** - Mental Health: Acute Average Length of Stay (bed days) **(Service Efficiency & Effectiveness)** • **SE-03a** - Mental Health: Acute Average Length of Stay Snapshot **(Service Efficiency & Effectiveness)** • **SE-06a** - Mental Health: Acute Occupancy rate (Ex Home Leave) **(Service Efficiency & Effectiveness)** • **SE-06b -** Mental Health: Acute Occupancy rate by Locality (Ex Home Leave) **(Service Efficiency & Effectiveness)** • **SE-07** - Mental Health Non-Acute Occupancy Rate **(Service Efficiency & Effectiveness)** • **SE-08** – New Birth Visits Within 14 days (**Service Efficiency & Effectiveness)** • **SE-10** - Mental Health Clustering within target **(Service Efficiency & Effectiveness)** Further RED KPI performance detail and trend analysis is provided in the summary performance report.
ACTION	The Board is asked to note the above.

Board Summary Performance Report

M11: 2018/19 February 2019

Performance Scorecard Summary: Month 11 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; M11: February 2019:

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

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

Subjective

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

Performance Scorecard Summary: Month 11: 2018/19

Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

Exception report

Summary of Red Exceptions M11: 2018/19			
Indicator	**Indicator No**	**Comments**	**Section**
Mental Health Physical Patient to Patient Assaults	US 02a	Reduced from 58 to 49	User Safety
Self-Harm incidents	US 05	Increased from 190 to 193	User Safety
Mental Health: AWOLS on Mental Health Act Section	US 06	Decreased from 25 to 24	User Safety
Mental Health: Absconsions on Mental Health Act Section	US 07	Decreased from 40 to 33	User Safety
Use of Prone Restraint	US 19	Decreased from 6 to 3	User Safety
Staff Turnover Rate	PM 01	Increased from 17.1% to 17.15%	People Management
Sickness Rate	PM 03	Increased from 4.10% to 4.42%	People Management
Mental Health Acute Average Length of Stay	SE 03	Decreased from 49 days to 39 days	Service Efficiency
Mental Health Acute Snapshot Length of Stay	SE 03a	Decreased from 49 days to 47 days	Service Efficiency
Mental Health Acute Occupancy Rate by Locality and Ward	SE 06 a & b	Increased from 98% to 99%	Service Efficiency
Mental Health Non-Acute Occupancy Rate	SE 07	Remained at 93%	Service Efficiency
New Birth Visits within 14 days	SE 08	Reduced from 92% to 91%	Service Efficiency
Mental Health Clustering	SE 10	Reduced to 78%	Service Efficiency

User Safety Commentary

There were 5 serious incidents in February 2019, two suspected suicides; 1 for Bracknell and Reading Care Pathways, 1 alleged non-accidental injury of a baby of a client under the care of Perinatal Mental Health services, 1 fall with fracture on Rowan ward, and 1 unexpected death of a Slough Care Pathways client.

The number of assaults on staff decreased to 68 in the rolling quarter to February 2019 and is now amber rated. In the rolling quarter, Mental Health Inpatients reported 68 incidents (74 last month), 14 incidents were reported on Sorrel ward (28 last month), 7 on Daisy ward (8 last month), 4 incidents on Bluebell ward (5 last month), 6 on Snowdrop ward (2 last month), 15 on Rowan ward (19 last month), 8 incidents were reported on Rose ward (4 last month). In addition, 1 incident took place in the place of safety, 1 in a car and 2 in patient or staff home. In the rolling quarter, 8 incidents were reported at Willow House (CAMHS) (6 last month). 3 incidents have been reported by Mental Health West. At the time of reporting one moderate incident was reported by Mental Health Inpatients and all other incidents in February 2019 were rated as low or minor risk.

For Learning Disabilities there was a decrease in the number of assaults on staff from 48 in the rolling quarter to January 2019 to 39 in the rolling quarter to February 2019. This shows an increasing trend.

Patient to Patient Assaults has reduced to 49 in the rolling quarter to February 2019 and remains red rated against a local target. 6 incidents occurred in Willow House in the rolling quarter. 40 incidents occurred in Mental Health Inpatients in the rolling quarter and these were as follows; 4 incidents took place on Sorrel ward (8 last month), 5 on Rowan ward (same last month), 4 on Daisy ward (5 last month), 20 on Rose ward (14 last month), 1 on Bluebell ward (3 last month), 1 on Snowdrop ward (4 last month), 1 incident each was reported in place of safety, the corridor, and no specific location Prospect Park Hospital. In the rolling quarter, in the community 1 incident each was reported by Reading Care Pathways, West Berkshire Care Pathways and Criminal Justice and Liaison. All incidents in February 2019 were rated as low or minor risk. At the time of reporting a total of 27 clients carried out assaults on other patients, including 1 client who has carried out 13 assaults. This shows an increasing trend.

Learning Disability Patient to Patient Assaults reduced to 3 (previously 8) in the rolling quarter to February 2019 and is now rated as green against a local target. The incidents were rated as low or minor risk and the assaults were carried out by 2 clients. This shows a decreasing trend.

Slips Trips and falls - Orchid ward (12 falls), Ascot ward (7 falls), and Rowan ward (6 falls) are above target. The Trust is 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 increased to 193 in the rolling quarter to February 2019 and remains rated as red against a local target. In Willow House there were 52 incidents (33 last month) reported in the rolling quarter, there was 1 incident reported by Community CAMHS services in the rolling quarter. There were a total of 97 incidents reported in the rolling quarter to February 2019 by Mental Health Inpatients which is reduced from 109 in the rolling quarter to January 2019. Of these, 5 incidents were reported on Rose ward (same as last month), 9 on Bluebell ward (15 last month), 11 on Daisy ward (13 last month) and 5 on Snowdrop ward (9 last month). There were also incidents reported as follows; Prospect Park Hospital and 1 other or unknown location. In the community in the rolling quarter 41 incidents were reported by Mental Health West, 30 by Crisis Services, 7 by Talking Therapies, 1 for the South Central Veterans service, 1 for the Traumatic Stress service, 1 for Common Point of Entry, and

West Berkshire Older Persons Service. For Mental Health East, 2 incidents were reported by the Care Pathways team. At the time of reporting 3 incidents in February 2019 were rated as moderate; all other incidents were rated as low or minor risk. This shows an increasing trend. For Mental Health inpatients including Willow House, this is a Quality Improvement programme breakthrough objective.

Learning Disability Self-Harm reduced to 4 in the rolling quarter to February 2019. This shows a decreasing trend.

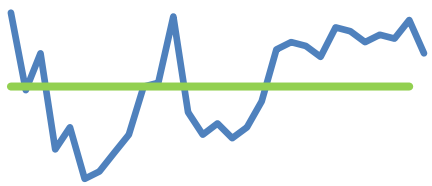
AWOLS and Absconsions data covers only those clients detained on a Mental Health Act Section and is measured against a local target. Both AWOLS (25 to 24) and Absconsions (40 to 33) reduced in the rolling quarter to February 2019. In February 2019, there were a total of 5 absconsions reported; 3 from Daisy ward, 1 from Rose ward and 1 from RBH. In February 2019 there were 4 AWOLS; 1 each from Daisy ward, Snowdrop ward and Rose ward, and 1 public place or street.

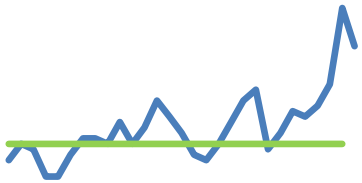
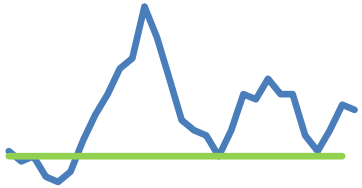
PMVA (Control and Restraint of Mental Health patients) – at the time of reporting, there were 33 uses of PMVA in February 2019. There were 10 reported on Snowdrop ward, 4 on Daisy ward, 2 each on Bluebell ward, Rose ward and at the place of safety, 7 on Sorrel ward and 1 each on Orchid ward and mental health reception. There were four incidents at Willow House (CAMHS).

There were 3 uses of prone restraint in February 2019, 2 on Snowdrop ward and 1 in the place of safety. 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. Target is less than 2 per month.

There were no uses of Strategy for Crisis Intervention and Prevention in February 2019.

Uses of seclusion in February 2019 in Mental Health Inpatients was 10 incidents and the longest one was for 13 hours and 5 minutes. There were no uses of seclusion in Learning Disability Services.

KPI	Target	Feb-19	Trend	Context/Reasons	Commentary of Trend
Mental Health Physical Patient to Patient Assaults	<40	49		Physical Patient to Patient Assaults were carried out by 27 patients in the rolling quarter. 1 of which carried out 13 assaults. This is measured against a local target.	In 2017/18 Mental Health NHS Benchmarking exercise, the Trust was below the mean of incidents of physical violence to patients at 311 per 100,000 occupied bed days excluding leave.
Self-Harm incidents	<75	193		Self-harm incidents continue to reduce in Adult Acute Mental Health Inpatients and is at its lowest level for 12 months. There was an increase in reported incidents in CAMHS Inpatients and Crisis Services.	Self Harm is a quality improvement breakthrough objective.

KPI	Target	Feb-19	Trend	Context/Reasons	Commentary of Trend
Absconsions on Mental Health Act section	<15	33		There were 15 absconsions from Daisy ward, 8 from Bluebell ward, 3 from Snowdrop ward, and 1 each from Rose ward, Rowan ward, and the corridor. This is measured against a local target.	In the 2017/18 NHS Benchmarking exercise, the Trust was above the mean at 156 AWOL incidents per 100,000 bed days excluding leave.
AWOLs on Mental Health Act section	<15	24		AWOLs increased to 24 in the rolling quarter to February 2019. There were 7 AWOLs reported on Daisy ward, 6 on Snowdrop ward, 3 on Rose ward, 1 each on Bluebell ward and Sorrel ward. This is measured against a local target.	In the 2017/18 NHS Benchmarking exercise, the Trust was in the upper quartile at 260 AWOL incidents per 100,000 bed days excluding leave.

KPI	Target	Feb-19	Trend	Context/Reasons	Commentary of Trend
Use of Prone Restraint	<2	3		The Trust target reduced to 2 from September 2018. In February 2019, there were 3 uses of Prone Restraint, 2 on Snowdrop ward and 1 in the Place of Safety.	In the 2017/18 NHS Benchmarking exercise, the Trust was above the mean of users of prone restraint at 262 uses per 100,000 bed days excluding leave.

Other Key Performance Highlights for this Section

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

- Mental Health Self-Harm incidents have worsened from 190 in the rolling quarter to January 2019 to 193 in the rolling quarter to February 2019.

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

- Mental Health Physical Assaults on Staff improved from 83 in the rolling quarter to January 2019 to 68 in the rolling quarter to February 2019.
- Mental Health: Preventing and Managing Violence and Aggression improved from 58 in the rolling quarter to January 2019 to 33 in the rolling quarter to 33 in February 2019.
- Mental Health Seclusion uses improved from 12 in January 2019 to 10 in February 2019.
- Learning Disability Physical Assaults on Staff improved from 48 in the rolling quarter to January 2019 to 39 in the rolling quarter in February 2019.
- Learning Disability Physical Patient to Patient Assault improved from 8 in the rolling quarter to January 2019 to 3 in the rolling quarter to February 2019.
- Learning Disability Self-Harm improved from 5 in the rolling quarter to January 2019 to 4 in the rolling quarter to February 2019.
- No uses of Learning Disability Strategy for Crisis Intervention and Prevention in January 2019 or February 2019.
- No uses in seclusion in Learning Disability in January 2019 to February 2019.

People Commentary

Performance in this category drives an "amber" rating on the performance scorecard summary on a subjective basis. Sickness, turnover, and gross vacancies are stretch targets internally and PDP is a local target. Of the 8 indicators; 2 are red (Staff turnover and Sickness rates for December 2018), 2 are amber (Fire and Information Governance training) and 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 January was 4.39%, an increase from 4.10% in December 2018. There was an associated increase in the cost of absences in January 2019 to £442,877, from a final cost in December of £393,165.

• This increase in the overall sickness rate is attributed to an increase in the short-term sickness rate, which was 1.22% in January 2019 (December 2018 was 0.93%) and is the result of an increase in cold/cough/flu absences. The total sickness rate for cold/cough/flu absences in January 2019 has increased to 0.67%, from 0.50% in December 2018 and is showing a significant upward trend in the last three months. Cold/cough/flu absences accounted for 15% of all absences in January (an increase from 12.2% in December). The total sickness rate for this reason remains lower than the same period last year (January 2018 was 1.07%).

• There has been a further decrease in long-term sickness rate to 2.18% (from 2.25% in December and 2.52% in November 2018) which is the result of the closure of some cases.

• The total sickness rate attributed to musculoskeletal absences increased in January to 0.66%, from 0.62% in December 2018, but is still showing a downward trend from 0.92% in October 2018. The long-term sickness rate for this reason has also increased to 0.43% in January 2019, from 0.38% in December 2018, but compares with an average over the previous three months of 0.48%. These slight increases in the January data will be analysed further to identify any particular hot spots, with a view to preventing any further increases next month.

• The total sickness rate attributed to anxiety/stress/depression decreased further in January 2019 to 1.17% (from 1.22% in December) and remains the lowest rate since August 2018. The long-term sickness rate for this reason has remained consistent with December at 0.92%. Proportionally the percentage of absence in January attributed to anxiety/stress/depression has also decreased to 26.3%, from 28.8% in the previous two months. Approval has been secured for the appointment of a Health & Wellbeing Lead on a three-year fixed-term contract. This role will focus on implementing the health & wellbeing action plan, which includes a focus on stress and mental health at work.

Recruitment

• The #greatplacetowork recruitment campaign has now resulted in 224 leads across all advertising channels. The channel which has yielded the most contacts is Facebook with a total of 136 (61%). A further 26 leads were generated via the SCAS open day. One confirmed job offer has been made to a community nursing post in Reading as a direct result of the campaign. The bus campaign will continue until 25th March 2019, following which the data will be analysed further to quantify the success of the campaign.

• Open days are being arranged in West Berkshire Community Hospital (April) and Prospect Park Hospital (May) with an associated marketing plan in place. The event in April will be advertised via social media and a leaflet drop to households in the Newbury area including Newbury train station. These marketing materials will direct individuals to our website where a specific open day page will provide detailed information about the event.

Turnover

• The Trust-wide turnover rate in February is consistent with last month at 17.15%.

• Further ongoing work to address recruitment and retention at Prospect Park Hospital includes:

  o in addition to an open day in May, a student 'meet and greet' event is planned in April with invitations extended to all students completing mental health and learning disability degree courses

  o an induction booklet is being developed for all new starters to Prospect Park Hospital, with a view to providing a more standardised and consistent induction programme and experience for new joiners

Statutory and Mandatory Training

Information Governance is the main priority to ensure 95% compliance by 31st March 2019. A simple online form has been developed for staff to complete and submit and if correctly answered then Learning and Development are updating the staff's competence on ESR. At the beginning of March, an email was sent from Minoo Irani to all staff who were non-compliant or about to become non-compliant and follow up emails as reminders are being sent by Learning and Development. The compliancy rate has increased and as of 25/03/2019 we reached 95.24%.

Fire training: The 8-minute fire training video, developed as part of the response to the enforcement notice at PPH has been completed and is being shown to all staff that attend the PMVA course. In addition it is available via the ward managers to show to all members of staff on the ward, including agency and bank staff. The venue

for the current training for staff in areas with high risk patients is being reviewed to potentially take the training out of the wards. Andrew Walker has been involved as part of working group to review and improve the national online fire e-learning package.

Safeguarding Adults level 2: due to new arrangements, there is a requirement for more staff to complete level two/three safeguarding adults training and in addition some staff from CYP&F services have been given level two as a competency for the first time and this has reduced the competency level. The Safeguarding lead has emailed all staff who are non-compliant to chase. Courses have also been added to the online booking system and all 13 courses between March and July are now fully booked. The staff SMART week training at PPH is also now Level two/three.

Manual Handling: following a competency review, most staff at PPH moved from requiring low risk training to needing high risk training. To increase compliance levels, bespoke courses are being run at PPH for staff and the lead is regularly liaising with the HR manager at PPH to work with the ward managers to book staff onto courses.

In addition a Quality Improvement A3 workshop is being planned, to include all relevant stakeholders, to improve compliancy levels across all statutory and mandatory training.

PDP - Target for May 2018 was achieved.

People Exception Report Month 11 - 2018/19

KPI	Target	Feb-19	Trend	Context/Reasons	Commentary of Trend
Staff Turnover	**<15.2%**	**17.15%**		Increase in turnover target from September 2016. This remains a challenging stretch target for the Trust. Turnover rates had reduced over 12 months but have increased since September 2018. This includes end of fixed-term contracts, retirements as well as voluntary resignations.	NHS Digital published data on The Stability Index which is the percentage of staff in post at the start of the period that do not leave the specified group (e.g. organisation, staff group or the NHS in England) during the period in question. The Trust score of 81.62% is lower than an England average of 88.38%. Oxford Health scored 78.85%, Surrey and Borders Partnership 77.02%, and Southern Health at 80.22%. The next report is due in July 2019.

Sickness rate	**<3.5%**	**4.39%**		Short-term sickness has increased to 1.22%, and the long-term sickness has increased to 2.18%.	The most recently published NHS Staff Sickness Absence rates published on 21st March 2019 show that for the period for November 2018 the sickness rate for England was 4.08%, and 3.65% for Thames Valley.

Other Key Performance Highlights for this Section

- Gross vacancies have improved from 7.8% in January 2019 to 7.0% in February 2019.
- Statutory Training: Fire training improved from 87% in January 2019 to 88% February 2019.
- Mandatory Training: Information Governance has improved from 89% in January 2019 to 92.2% in February 2019, and the target was achieved by 25th March 2019.

NHS Improvement Non-Financial and Financial Commentary

The Single Oversight Framework for 2018/19:

- DM01, 6-week compliance for Audiology Diagnostics compliance was 100% February 2019.

The Trust was given an overall mental health data set (MHSDS) Data Quality Maturity Index (DQMI) Score of 99.9% against a target of 95% according to the most recent data published in February 2019.

• Inappropriate Out of Area placements, 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 4 2018/2019 - quarter to date inappropriate bed days against a target data is:

- Berkshire West CCG -105 inappropriate OAP bed days against a Quarter 4 2018 target of 316 bed days.
- East Berkshire CCG - 231 inappropriate OAP bed days against a Quarter 4 2018 target of 304 bed days.
- Trust Total is a total of 336 occupied bed days against an overall target of 620 bed days.

• Proportion of people completing treatment who move to recovery (from IAPT minimum dataset). For February 2019 the Trust achieved 58% 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 February 2019, 1 case of Klebsiella bacteraemia occurred on Ascot 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:

- 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; 6 are rated as "Green" including Did Not Attend (DNA) rates, Community Health Inpatient Length of Stay, Mental Health Readmissions, Community Health Inpatient Occupancy rate and Mental Health 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, Non-Acute Occupancy, Mental Health Clustering and New Birth Visits within 14 days, and 1 of which does not have a target (place of safety). As more than 50% of indicators are rated as red, this section is rated as red.

The DNA rate increased from 4.77% in January 2019 to 4.80% in February 2019 but remains rated as green. East Mental Health (7.52%) and West Mental Health (6.52%) and CYPF (7.28%) are above target. This indicator shows a decreasing trend.

In CPE, the DNA rate reduced from 9.15% in January 2019 to 8.67% in February 2019.

In Children and Families Community Paediatrics at 10.86%, Health Visiting 8.74%, School Nursing 7.52%, CAMHS 7.15%, were above the 5% target.

For Mental Health East; IMPACTT at 12.83%, East Adult CMHTs at 9.65% are above target. In West Mental Health, Clinical Health Psychology 13.14%, Adult Mental Health 6.83%, Trauma 7.95%, Neuropsychology 12.75% are above target. The portal, interactive voice message and SMS text messaging can be used for reminders for appointments which take place in clinics provided that a mobile number is collected and entered into RiO in the correct format. In February 2019, 21,523 digital messages were sent.

Community Health Inpatient Average Length of Stay remained at 22 days with only West Berkshire and Wokingham above target. Delayed transfers have been some worsening of performance in Wokingham 16.2% (last month 11.7%) and Reading 14.6% (last month 1.7%). There was an improvement in West Berkshire 8.7% (last month 19.8%), Slough 6.3% (9.7% last month) and WAM 2.6% (6.5% last month). A total of 50 patients' discharges were delayed in February 2019, 32 of these are the responsibility of the NHS, and 8 are the responsibility of social care and 10 are joint health and social care responsibility. The most common reason for a delay was awaiting care package in own home (total 23; 14 for health, 3 for social care, and 6 joint responsibility health and social care). 10 are awaiting care home placement 2 are social care responsibility and 3 are NHS responsibility and 4 are joint health and social care responsibility.

Mental Health Acute Occupancy excluding home leave increased to 99% in February 2019.

The Average Acute Length of Stay for Mental Health decreased to 39 days in February 2019 and the snapshot length of stay reduced to 47 days and both continue to remain above target. Of the 186 clients discharged during December 2018 to February 2019, the median length of stay was 20 days. 24 clients who were discharged in the period had lengths of stay above 90 days, including 21 above 100 days and 1 at 266 days. There are a number of clients who have accommodation needs for which funding must be obtained and placements sought before they can be discharged from the ward. At 13th March 2019, there were 2 acute clients delayed; 1 each on Snowdrop ward and Daisy ward. By locality, these were for Wokingham and Windsor and Maidenhead.

There is 1 Wokingham client delayed on Campion Unit, who is detained under the Mental Health Act who was discharged on 12th March 2019.

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 except Bracknell remain above target.

Older Adults Mental Health wards length of stay is 95 days for Rowan ward and 65 days for Orchid ward for clients discharged.

As at 12th March 2019, there were 2 male and 2 female acute patients, and 2 female Psychiatric Intensive Care Unit patients placed out of area.

Community Health Inpatient Occupancy increased to 87% and is now rated as green.

Mental Health Readmission rates increased to 7.9% in February 2019 which is below the 9% target, with only Wokingham and Slough above target.

Mental Health Clustering has declined to 78% compliance and remains below the 95% target. The revised figure excludes some historical clustering data.

Place of Safety increased to 39 uses in February 2019 and includes 5 uses for minors. Of these 39 uses of the place of safety, 20 were admitted following assessment including 19 under Section 2 of the Mental Health Act. 11 clients waited over 8 hours for an assessment but 8 had no waiting time recorded and none are recorded as being over 24 hours. The reasons for the delays in assessment include bed availability, patient intoxication, and availability of AMHP/assessing Doctor. 8 out of the 39 assessments were carried out by Berkshire Healthcare NHS Foundation Trust Section 12 Doctors. The most common time in February 2019 to be brought to the place of safety was between 3pm and 6 pm followed by 6pm to 9pm. The most common days for detention in February 2019, was Thursday with 8 detentions followed by 6 detentions each on a Wednesday and a Friday.

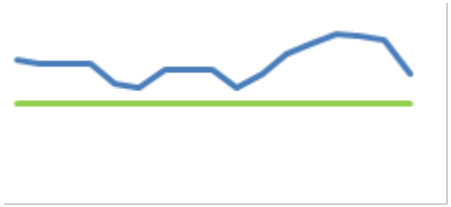
Health Visiting is below target at 91% however this compares favourably from the most recently published national data which shows that in Quarter 4 2017/18 only 88.5% of New Birth Visits took place within 14 days. Of the 27 cases not seen within 14 days 48% (13) were due to baby still being in hospital, 22% (6) no access at time of visit, 14% (3) family declined appointment, 7.5% (2) no response from the family, 4% (1) each or no reason recorded, late notification and staff capacity.

System Resilience – Frimley Health NHS Foundation Trust achieved 81.1% for Type 1 A&E attendances in February 2019.

In the West – the A&E waiting times national return for February 2019 show the Royal Berkshire Hospital achieved 87.4% Tier 1 A&E attendances and 89.7% against Tier 1-3 attendances. Nationally only 75.7% of patients waiting at a Tier 1 A&E service met the target for the discharged, admitted transferred within 4 hours of arrival, and a national average 84.2% for all Tier 1-3 attendances during February 2019. The Trust's Minor Injury Unit (MIU) achieved 99.9% for discharged, admitted transferred within 4 hours of arrival.

The system wide report showed, Reading Rapid Access had limited capacity on 13th March 2019. In terms of Inpatients on 14th March 2019, there were a total of 15 community beds available at our community hospitals in the Berkshire West area including 6 on Windsor ward. There were however a total of 36 patients waiting for admission to the community wards, including 11 waiting for admission to Oakwood ward, 12 waiting for admission to West Berkshire Community Hospital wards, and 13 waiting for Wokingham Community Hospital wards.

Service Efficiency and Effectiveness Exception Report Month 11: 2018/19

KPI	Target	Feb-19	Trend	Context/Reasons	Commentary of Trend
Mental Health: Acute Average Length of Stay	**<30 Days**	**39**		Bed optimisation project underway to look at alternatives to admission, productive stay and productive discharge. Median Length of stay was 20 days. One client discharged after 266 days (excluding leave).	Delayed transfers and lack of onward accommodation have impacted on this metric. In the 2017/18 NHS Benchmarking Exercise the Trust was above the national mean with an average length of stay of 31.3 days at 38 days.
Mental Health Acute Length of Stay Snapshot	**<30 Days**	**47**		This is a decrease on the preceding month and reflects the acuity of clients and number of delayed transfers of care and impact on long stayers.	

KPI	Target	Feb-19	Trend	Context/Reasons	Commentary of Trend
Mental Health Acute Occupancy rate (excluding home leave by ward/ Locality) (2 indicators)	**< 90%**	**99%**		All localities are above target except Bracknell. New bed management process including gatekeeping of clients has been introduced. There has been an increase in the number of clients brought in on Section 136 to the place of safety and subsequently detained under the Mental Health Act.	Increase in the number of patients admitted whilst detained under the Mental Health Act. There have been increases in these patients over the last few years. It is predicted for 2019/20 there will be a 15.5% reduction in informal admissions and a 72% increase in formal admissions.
Mental Health: Non-Acute Occupancy rate (excluding home leave)	**< 80%**	**93%**		This has been driven by increases in occupancy to Sorrel ward (100%), Rowan ward and Orchid ward 91% each.	

KPI	Target	Feb-19	Trend	Context/Reasons	Commentary of Trend
Health Visiting: New Birth Visits Within 14 days	**95%**	**91.0%**		Of the 27 cases not seen within 14 days 48% (13) were due to the baby still being in hospital, 22% (6) no access at time of visit, 14% (3) family declined appointment, 7.5% (2) no response from family, 4% (1 each) were due to staff capacity and late notification and 1 case had no details recorded.	The Trust is above the 89.6% England average in Quarter 2 2018/19, which is the latest data available on the Public Health England New Birth Visits, published on 30th January 2019.
Mental Health Clustering	**95%**	**78%**		There are frequent reviews required for certain clusters which mean that it is challenging to achieve the target. There have been changes to clustering reports to ensure that historical clusters are no longer counted.	Teams with high numbers of outliers are being targeted.

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	9th April 2019
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 into February 2019. Performance highlights are noted as follows: • Benchmarking shows we have improved in the following areas: • Mental Health Patient on Patient Physical Assaults from 19th out of 55 English Mental Health Trusts for 2017/18 from 51st in 2016/17. • Mental Health Patient on Staff Assaults at 24th out of 55 English Mental Health Trusts from 44th in 2016/17. • Mental Health Use of Restraint worsened from 19th to 20th out of 55 English Mental Health Trusts for 2017/18. • Latest National Confidential Inquiry data on suicide rates per 10,000 in mental health services (4.3 from 7, below 8.2 target). • Staff engagement score: Trust achieved third highest scoring in cohort of 32 combined trusts in latest staff survey. • Patient Friends and Family Test Response Rate improved to 21% above the 15% target from 15.19%.

ACTION	The Board is asked to note current performance against the vision metrics.

Board Vision Metrics: performance update to end February 2019

Supporting delivery of the Trust's Vision

Trust Board – public meeting

Alex Gild, Chief Financial Officer
9th April 2019

Purpose

Update the Trust Board on Vision Metrics.

Document control

Version	*Date*	*Author*	*Comments*
0.1	27/03/2019	I Hayward & C Magee	
1.0	27/03/2019	I Hayward & C Magee	Updates from I Hayward / Alex Gild

Distribution

Trust Board

Document references

Document title	*Date*	*Published by*

Contents

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 in order to assure the Trust on its progress towards the vision.

1.4. This is a performance update as per the quarterly interval (or as agreed with the Board) over the next three years. A number of the indicators are annual, so updates will occur when information is available in 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 providers and the 32 Combined Mental Health and Community Trust respondents in 2017/18. Indicator performance has been updated from the 2016/17 data set previously reported, to the latest available.

2. Rationale for Metric Inclusion

Sections

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

Quality

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

2.3. A long-term stretch performance measure is maintained in the dashboard to achieve top 3 ranking of all Mental Health service providers in the national benchmarking cohort, however, where data is available we have shown how we compare to the combined community and mental health trust cohort in the descriptions below. The 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. 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 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 worsening in our position from 2016/17, where the Trust was below the mean and ranked 19th out of 55 English benchmarking respondents. The Trust ranks 12th out of 32 combined Mental Health & Community respondents and this was an improvement from our 2016/17 position where the Trust was below the mean and ranked 13th out of 32 combined Mental Health & Community respondents. Absolute and benchmark improvement in this area is a driver metric within our QI programme.

Safety

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

- **Falls –** where the fall results in significant harm due to a lapse in care. The process for identifying where falls with significant harm have been the result of a lapse in care was developed and approved by the Safety Experience and Clinical Effectiveness Group in April 2017. In the financial year 2017/18, 2 relevant incidents occurred 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. 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 February 2019 and shows 99% against a target of 85%. This is an increase from 98% in October 2018.

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

- **Pressure Ulcers -** Reduction in the level of developed category 3 and 4 pressure ulcers due to lapse in care in our community health services. The cumulative total is 18 incidents in the period 1st April 2017 to 31st March 2018, and 14 so far in 2018/19. Pressure ulcers are an improvement focus under the QI programme's Harm Free Care domain. Six learning summits which will determine if any Lapse in Care has occurred have been scheduled for quarter 1 2019/20, so this metric is rated as amber.

- **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 people 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 at the end of 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 and now 2019/20 per contract agreements.

- **Stakeholder Satisfaction - Survey of System Partners –** a survey was developed in the second half of 2017/18. 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 (ICS) we operate in. Survey respondents included our six Local Authorities, and NHS commissioner and provider system partners. Target to be agreed A similar survey will be run during 2019/20.

- **Patient Friends & Family Test Response Rate –** 21% in February 2019 against the target of 15% is an improvement from October 2018 (15.19%). This is a QI metric.

- **Staff Survey Engagement Rating –** latest available performance ranking published on 26th February 2019 and is shown against our cohort of 32 combined mental health and community Trusts (3nd), which is one place lower than the 2017/18 results.

Regulatory Compliance

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

- **Care Quality Commission Rating –** Good rating

- **NHSI Segmentation -** maintained segment 1 of the Single Oversight Framework in the latest

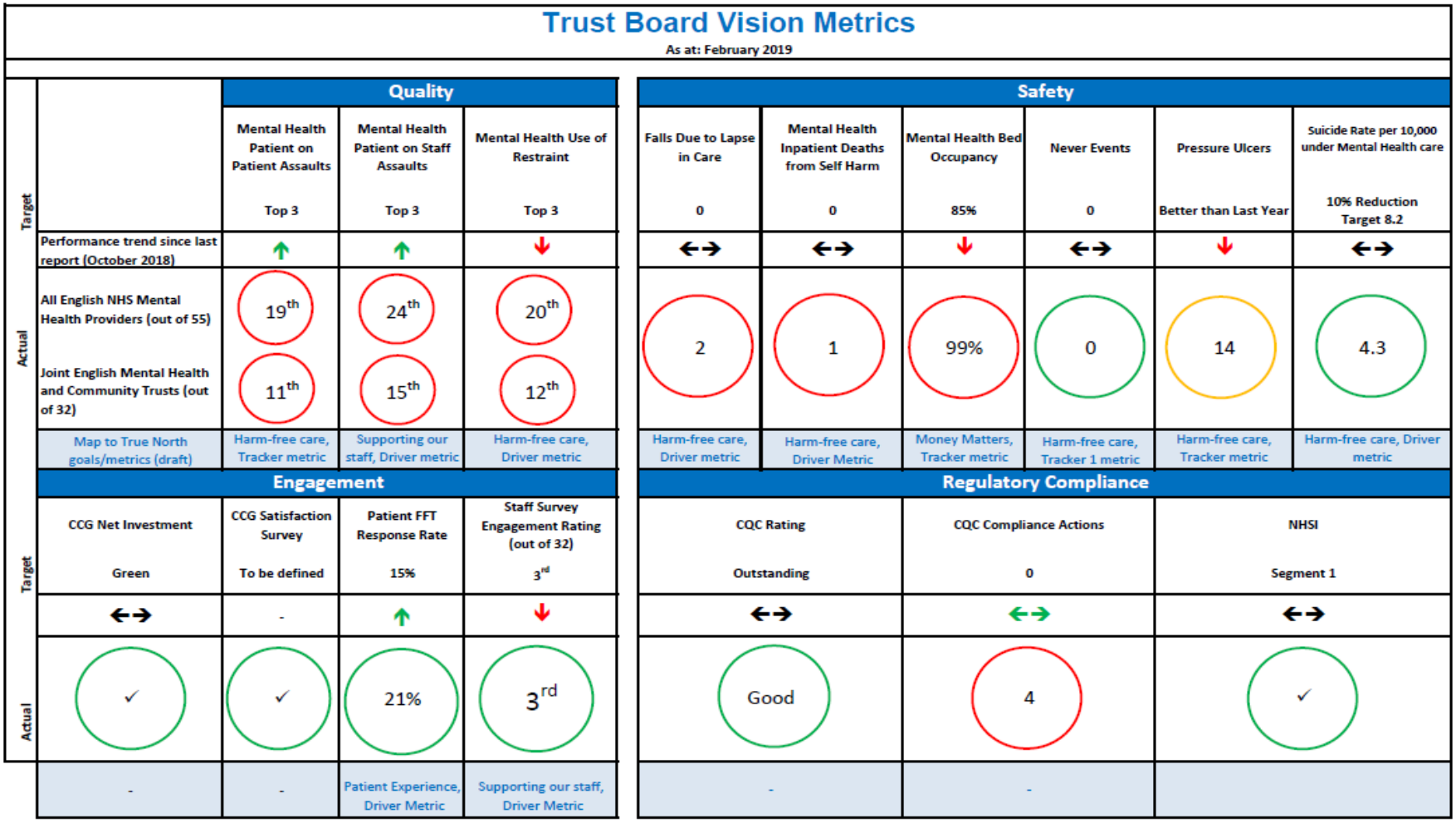
assessment. Highest autonomy, with no NHSI support required. Also maintaining NHSI Use of Resources rating of 1 (lowest financial risk rating available on scale of 1 to 4).

- **Number of CQC Compliance Actions –** there are four compliance actions, one for Willow House, which forms part of our core services and three for WestCall which does not form part of our core services. Quality Improvement Programme: supporting delivery of our vision

2.7. As the QI programme develops during 2019/20, the underpinning driver and tracker metrics aggregating to the performance view of True North delivery will be integrated into the Trust Board's summary performance reporting, supported by review at Finance Investment and Performance (FIP) committee. New True North focused performance reporting is expected to commence in May 2019.

2.8. As we develop the new improvement focused performance reporting above there will be an opportunity to incorporate / align vision metrics performance reporting into Board level reports. This will be reviewed during 2019/20.

Appendix 1 – Board Vision Metrics



Trust Board Vision Metrics

As at: February 2019

		Quality			Safety					
		Mental Health Patient on Patient Assaults	Mental Health Patient on Staff Assaults	Mental Health Use of Restraint	Falls Due to Lapse in Care	Mental Health Inpatient Deaths from Self Harm	Mental Health Bed Occupancy	Never Events	Pressure Ulcers	Suicide Rate per 10,000 under Mental Health care
Target		Top 3	Top 3	Top 3	0	0	85%	0	Better than Last Year	10% Reduction Target 8.2
	Performance trend since last report (October 2018)	↑	↑	↓	↔	↔	↓	↔	↓	↔
Actual	All English NHS Mental Health Providers (out of 55)	19th	24th	20th	2	1	99%	0	14	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, Tracker metric	Supporting our staff, Driver metric	Harm-free care, Driver metric	Harm-free care, Driver metric	Harm-free care, Driver Metric	Money Matters, Tracker metric	Harm-free care, Tracker 1 metric	Harm-free care, Tracker metric	Harm-free care, Driver metric

		Engagement				Regulatory Compliance		
		CCG Net Investment	CCG Satisfaction Survey	Patient FFT Response Rate	Staff Survey Engagement Rating (out of 32)	CQC Rating	CQC Compliance Actions	NHSI
Target		Green	To be defined	15%	3rd	Outstanding	0	Segment 1
		↔	-	↑	↓	↔	↔	↔
Actual		✓	✓	21%	3rd	Good	4	✓
		-	-	Patient Experience, Driver Metric	Supporting our staff, Driver Metric	-	-	